

History and Mental State Examination

Introduction

The psychiatric interview is the opportunity for the clinician to make an assessment of the patient's mental state and establish a therapeutic relationship. The ability to do this well requires the use of non-directive (open) questioning followed up by systematic probe (closed) questions. Ambiguities and inconsistencies require clarification by sensitive enquiry or recapitulation.

Common errors made in this process include failure to seek precise clarification, failure to pick up on non-verbal cues and a willingness to rely on patient's use of jargon.

Many students when starting their psychiatric attachment feel intimidated by this process, feeling it to be alien to their previous history taking experiences. It is, however, simply a variant of normal medical history taking but with a greater emphasis in exploring the meaning behind what the patient reports.

This section gives a model for history taking and mental state examination, including cognitive testing. It is not intended to be used as a checklist, nor to be prescriptive and, as with all patient contact, will need to be shaped by the actual interaction between you and the patient.

History

Like everything else taking and, eventually, presenting a good history relies upon a structure being imposed upon the information obtained from the interview. In the early stages this seems daunting, particularly when you are trying to think of pertinent questions. A few tips that may help include using big enough paper (i.e. A4 not a reporters notebook), numbering your pages and writing out the headings, with plenty of space to fill in your information, in advance as patients rarely give a linear narrative. Presentation will be covered in the section on the Formulation seminars.

Referral and informants

Here you need to record where and when the patient was seen, were they voluntary or detained patients, how they came to be seen (GP, self, police referral *etc.*) and who the history and other information was obtained from.

Presenting complaints

Record in the patients own words what they felt their problems are and how long they have been present. They may feel they have no problems, in which case it may be appropriate to comment on the presenting complaint as described by an informant.

History of presenting complaints

In this section record the information obtained as the patients complaints are explored, and the details surrounding them, for example if a patient complains of hearing voices this needs to be explored in the same way that a complaint of pain would be. It is also important at this point to describe the impact of the patient's problems on their life and the lives of those around them.

Past psychiatric history

Explore in detail previous contact with psychiatric and other services for mental health problems. Include dates, diagnoses, treatment and duration and legal status of admissions.

Past medical history

This is little different from any other discipline but remember to ask about obstetric complications, epilepsy, head injury *etc.*

Family psychiatric & medical history

Try and obtain the same sort of information about the family as you did for the patient. Remember to include history of neurological disorders, suicides/DSH, criminal behaviour, abuse, alcoholism *etc.*

Personal history

The following topics need to be covered:

- Early development
- Childhood behaviour
- School history
- Occupational history
- Sexual History
- Relationships/marriage history
- Children
- Forensic history

Current social circumstances

Consideration needs to be given to alcohol consumption, illicit substance use and smoking, finances, legal problems, employment (or not), current social supports/relationships, dependants, housing *etc.*

Premorbid personality

The following should be covered:

- Social relationships
- Hobbies/interests
- Predominant mood e.g. anxious, pessimistic, optimistic, stable or fluctuating *etc.*
- Character e.g. shy, suspicious, irritable, self-centred, impulsive, unconfident, obsessional
- Habits : food, alcohol, tobacco, drugs

Medication

Include **all** medication, prescribed and otherwise.

Mental State Examination (MSE)

This seems to be the one aspect of psychiatric assessment that intimidates students the most. It begins as soon as you see the patient, if not before i.e. when they are shouting, or when you turn up to their house and see windows covered in tin foil *etc.* It may seem obvious, but it is worth stressing, that this is an *examination* of the patient's mental *state* at the *time* you see them. It is not the history of their morbid experiences. So, if you see a patient that was hallucinating the day before you saw them, their morbid experiences would be described in their history not the MSE.

Appearance & Behaviour

Self care - often impaired, in severe depression and dementia especially.

Eye contact - may be reduced in depression. Eyes may appear staring in patients suffering from Parkinsonian drug side effects.

Agitation - excessive motor activity with a background of anxiety e.g. pacing hand wringing. A feature of depression (elderly in particular) or marked anxiety. Also a high level of activity or excitement may be seen in mania but then anxiety is usually not a feature.

Motor retardation - slowing of movements, to a variable degree. Think of depression but other causes include psychotropics.

Superimposed abnormal movements

Dyskinesias, - a wide variety of movement patterns e.g. choreoathetosis, rocking, pouting, with a wide range of causes e.g. drugs, schizophrenia, structural brain disease.

Tremors - assorted, may be related to level of arousal, medication or neurological disorder.

Stereotypies - uniform, repetitive non goal-directed actions (may take a variety of forms from simple movement to an utterance. Usually ascribed to schizophrenia.

Waxy flexibility - patient remains in any position in which he is placed. Found rarely in (catatonic) schizophrenia and structural brain disease.

Stupor (a.k.a. akinetic mutism) - more or less complete loss of activity with no response to stimuli; may mark a progression of motor retardation; found in a wide range of neurological and psychiatric conditions.

Speech

Slowing - may be a feature of retardation. Usually associated with a lack of spontaneous, and reduced speed of, reply.

Mutism - may be elective or involuntary; like slowing it is a feature of retardation and shares its causes, or may result from schizophrenia, hysteria or be behavioural (e.g. elective in children).

Fast speech - often results from 'normal' anxiety, but may indicate mania or schizophrenia.

Pressure of speech - far less common and is highly suggestive of mania.

Neologism - found mainly in schizophrenia and structural brain disease.

Incoherence and other abnormalities of semantics and syntax - see Thought.

Perseveration - mainly seen in dementia.

Echolalia and echopraxia - may be a feature of dementia or schizophrenia.

Mood

Persistent abnormalities of mood may indicate an affective disorder for instance depression (anxiety is often a feature of depression in addition to low mood) or mania. Altered mood is often secondary to other psychiatric disorders, however, for example the not uncommon co-existence of depression and schizophrenia, or depression and dementia. The mood exhibited by an individual may also be normal!

Thought

Be aware that when assessing thought we are dependent greatly on its manifestation through speech and thus also how much of thought disorder is in truth 'speech disorder'.

Content - thought content may betray illness by virtue of morbid thoughts and preoccupations; obsessional ruminations, rituals and compulsions or phobias.

Form - the form of thought may be disrupted in any of a number of recognised patterns which benefit verbatim description as much as the allocations of a label:

Flight of ideas - exhibited in pressured speech and highly suggestive of mania.

Thought block - found in schizophrenia. It is quite distinct from the loss of train of thought that is a normal experience.

Word salad

Concrete thinking

Abnormal ideas fall into a number of categories:

Overvalued ideas - may be of doubtful psychiatric significance.

Delusions - primary or secondary delusions. Delusions may develop one from the other becoming intertwined or 'systematised'.

Simply being deluded does not offer a single diagnosis however certain delusions are commoner in certain conditions such as: primary delusions, persecutory delusions and thought alienation in schizophrenia; nihilistic and hypochondriacal delusions, delusions of worthlessness, guilt and poverty in depression; grandiose delusions in mania.

Obsessions (see OCD)

Perception

Hallucinations - auditory hallucinations are commonest; in schizophrenia third person voices can help to make the diagnosis; in depression the patient may hear voices (second person) abusing him (and feel that he deserves it). Visual hallucinations raise suspicions of organic brain disease. These are generalisations and must be taken in the context of all other symptoms and signs.

Illusions - these may be normal or may occur in the clouded consciousness of delirium.

Depersonalisation and derealisation - both states may occur through fatigue or marked anxiety.

Cognitive testing

Like every other facet of the MSE this commences as soon as the interviewer comes in contact with the patient. It can be divided into multitude of functions only a few of which will be discussed here. Remember that cognitive tests test the ability of the patient to perform on that task from which inference can be drawn about their cognitive function.

Abnormalities of cognitive function occur in a wide range of psychiatric and neurological conditions. Progressive dementia results in a global impairment of higher function, in the early stages remote memory may appear spared though later this too will be affected. An isolated memory deficit is best called an amnesic (or dysmnestic) syndrome, a classic example being Korsakoff's psychosis, although this is also characterised by confabulation. Occasionally an apparent global cognitive deficit or pseudodementia is seen in elderly depressives. An acute confusional episode (delirium) may be indicated by drowsiness, impaired concentration and attention and poor memory.

The areas that a student should be able to cover are:

Orientation.

Attention and concentration - impaired concentration is frequently seen in depression and anxiety.

Memory. (this includes, at the very least, registration and recall of 3 objects or 5 part name and address plus recent and remote memories)

Insight

Insight can usefully be regarded as having three facets of awareness:

- that the abnormal experiences are extraordinary.
- that they are the result of a disease process.
- that they are open to medical intervention.