Psychiatric History and Mental State Examination
Unit learning outcomes relevant to this session

By the end of the Unit students will

Be able to perform and record a full mental state examination of patients who have a range of major psychiatric conditions
Overview of this session

- Theory and Practice
- How to take a psychiatric history
  - The technique (Basic Interviewing Skills)
  - The structure
- The Mental State Examination
  - The technique
  - The structure
- Any questions?
History Taking DVD

• Remember to use the History Taking/ Mental State Examination DVD to help you understand how to take a history and do a MSE.

• The best way to learn though is to practise

• Theory alone is dry … like a lecture on dancing. You only know how it feels when you’ve done your first tango!
Basic interviewing skills

- Introduction
- Positioning of chairs
- Appropriate use of open and closed questions
- Giving encouragement to talk
- Eliciting feelings as well as facts
- Clarifying
- Focusing
Psychiatric History:
The structure

- Presenting problem
- History of presenting problem
- Past Psychiatric and Medical History
- Drug History
- Family History
- Personal History
- Forensic History
- Premorbid Personality
Presenting problem

• keep it short + simple
• you might want to use the patients own words, if appropriate
History of presenting problem

- list relevant events leading up to presenting problem
- knowledge of specific disorders required!
Drug History

• prescribed:
  – dose + duration
  – ? compliance (?side-effects)

• illicit drug + alcohol use:
  – build bridges . . .
  – useful screening tool, (but not more!): CAGE
  – be prepared to explore all features of dependency, if necessary
Past psychiatric and medical history

• outpatient treatment + admissions
• informal or under section?
• any previous episodes of deliberate self harm?
• if very long, summarise!
Family History

- use genograms
- ask about occupations (social status . . .)
- any mental health problems?
- any suicides, suicide attempts?
Personal History I

• Early childhood:
  – place + circumstances of birth
  – early milestones + development (bed-wetting, soiling)
  – family atmosphere, moves

• Education:
  – schools attended
  – attitude to schools, regularity of attendance
  – Exams passed, age at leaving

• Occupational History:
  – details of jobs as far as possible
  – reasons for changing!
Personal History II

• Psychosexual development:
  – tailor to what’s appropriate and needed
  – orientation
  – relationships
  – family attitudes + instruction
  – first experiences

• Present social circumstances:
  – own or rented accommodation
  – financial problems, debts
Forensic History

• we live in the age of risk assessment!
• “Have you ever had any trouble with the police?”
• History of violence:
  – get all the details, if present!!
  – distinguish between violence against property or people
Premorbid Personality

“When you are well, . . .”

• Volition
  – “. . . how (what kind of person) would you describe yourself?”

• Mood
  – “. . . what’s your usual mood like?”

• Social
  – “. . . how do you get on with other people?”

• Cognitive
  – (intellectual capacity) general knowledge etc.

• Reaction patterns to stress
  – “. . . how do you react to stress?”
Mental State Examination

The indirect approach

(pictures from Andrew Sims: Symptoms in the Mind, 1995)
MSE: The structure

- Appearance & Behaviour
- Speech
- Affective State
- Thoughts
- Perceptual abnormalities
- Cognitive and intellectual function
- Insight
Appearance & Behaviour

• Physical appearance:
  – body build, (nutritional state)
  – significant distinguishing features
  – cleanliness (hair, teeth, nails)
  – Quality, style and state of clothing

• General Attitude:
  – rapport
  – attitude towards interview
  – eye contact

• Motor behaviour:
  – restless, fidgety or apathetic, retarded
Speech

• Volume and speed
  – pressure of talk <-> retardation

• Construction
  – flight of ideas, rhyming, punning, incoherence

• Enunciation
  – dysarthria, stammer
Affective state

- subjective experience
  - ask!
- objective impression
  - elevated, euthymic, low, angry, cheerful, distraught, despondent, resentful . . .
- congruity with speech content
- stability
- emotional reactivity
- suicidal ideation or intent !!!!!!
Thoughts

• content
  – preoccupations?
  – ideas of reference?
  – delusions?
• obsessional thoughts
  – +compulsive rituals?
• objective signs of thought disorder
• subjective experience of thought disorder
Thoughts: Content

- recurring, pervasive theme,
- depressive ruminations
- grandiose ideas
- self-referential ideation
- delusions
How to probe for delusions

• “Have you had the feeling that something odd is going on that you can’t explain?”

• “Do you feel puzzled by strange happenings that are difficult to account for?”

• “Do familiar surroundings seem strange?”

(These and the following questions were all taken from: Schedule for Clinical Assessment in Neuropsychiatry (SCAN))
How to probe for obsessional thoughts (+ compulsive rituals)

• “Some people find they have unpleasant and unwanted thoughts or images coming into their mind, which can’t be resisted. Has that been a problem?”

• “There are other difficulties of a similar kind where people have to keep on checking things that they know they have done; like gas taps, switches, whether the front door is locked, and so on. Do you have problems like that?”
Subjective experience of thought disorder

- Probing questions
  - “Can you think quite clearly, or does there seem to be some kind of interference with your thoughts?”
  - “Are you fully in control of your thoughts + actions?”

- Thought withdrawal
  - “Are your thoughts actually taken out or sent out of your mind? Do they actually feel like that? So that they are outside your head?”

- Thought insertion
  - “Do there seem to be thoughts in your mind which are not your own; which seem to come from somewhere else?”

- Thought broadcasting
  - “Do your thoughts seem to be somehow public; not private to yourself, so that others can know what you are thinking?”
How to probe for auditory hallucinations

“We ask this question routinely of everyone, because sometimes people under stress seem to hear noises or voices when there is nobody around and no ordinary explanation is possible. Has anything like this ever happened to you?”

• Loud thoughts (Gedankenlautwerden)
  – “Do your thoughts seem to sound aloud in your head, almost as if somebody standing near you could hear them?”

• Thought echo (Écho de la pensées)
  – Does a thought in your mind seem to be repeated over again, like an echo?”
Auditory hallucinations

- get an exact description!!
- familiar or unfamiliar voices?
- 2nd or 3rd person?
- do the voices give commands?
- if so, how does the patient react?
Cognitive Function

• Level of consciousness

• Orientation
  – Time, Place, Personal Identity

• Attention and concentration
  – Test: Serial Sevens, months in reverse

• Memory:
  – immediate recall: digit span
  – recent: address
  – remote: Personal History!

• General Knowledge + Intelligence
Insight

• Attitude towards illness
  – “How do you see your difficulties?”
  – “Do you feel there is something wrong with your nerves?”

• Attitude towards treatment
  – “What sort of treatment do you feel is needed?”
  – “How do you feel about: being in hospital / taking tablets?”
For a fee

“Who in the rainbow can draw the line where the violet tint ends and the orange tint begins?

Distinctly we see the difference of the color, but where exactly does the first one visibly enter into the other?

So with sanity and insanity.

In pronounced cases there is no question about them. But in some cases, in various degrees supposedly less pronounced, to draw the line of demarkation few will undertake, though for a fee some professional experts will.”

Herman Melville in *Billy Budd*, Dale Books 1978