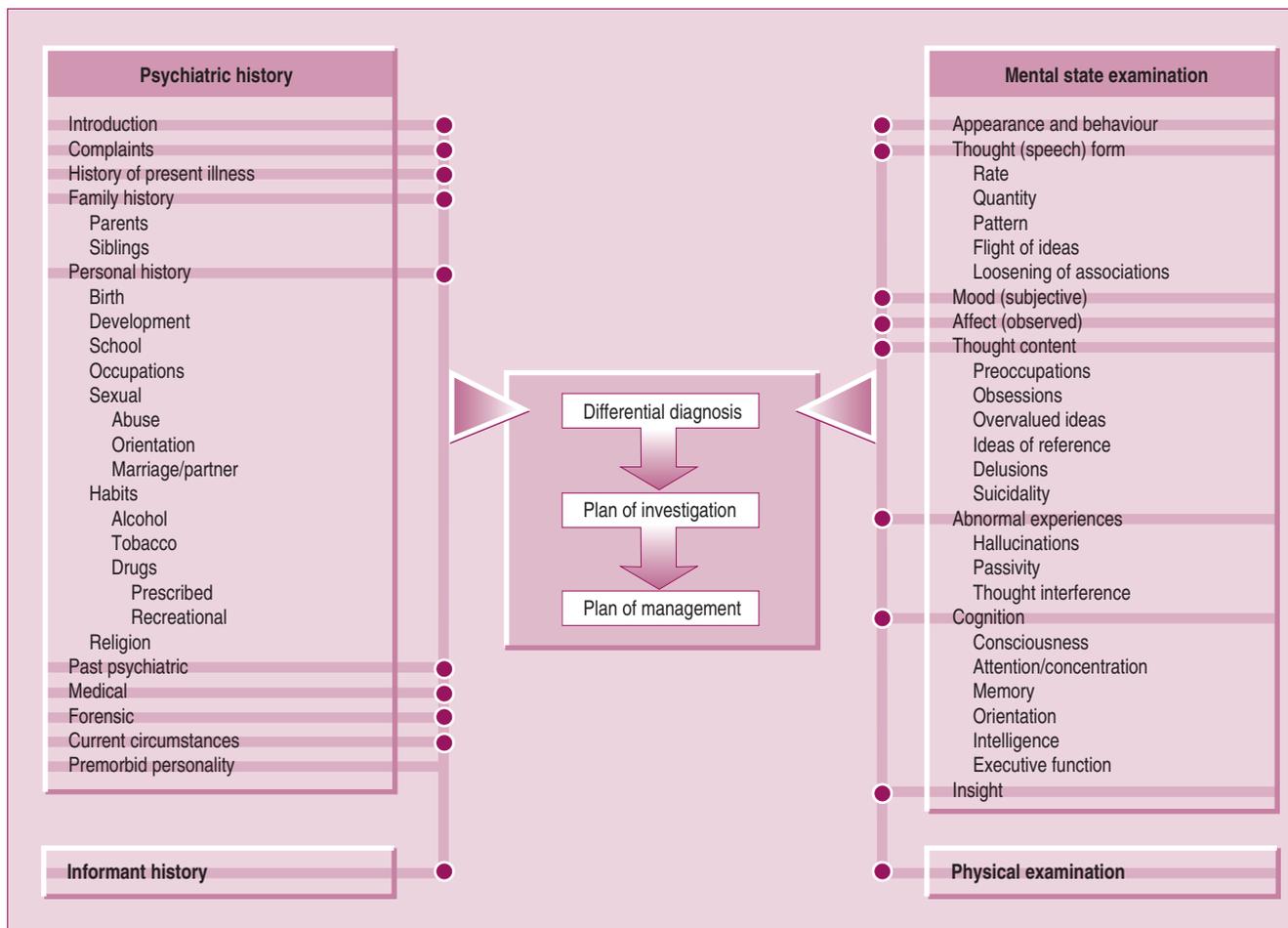


1 The psychiatric history and mental state examination (MSE)



In taking a psychiatric history and assessing the mental state, it is crucial both to establish and maintain rapport and to be systematic in obtaining the necessary information. The outline below is intended as a schema for written documentation. Greater flexibility is clearly required during the interview.

The psychiatric history

The history begins with an **introduction** noting the patient's name, age, marital status, occupation, ethnic origin, religion and circumstances of referral. Then follows the **complaint** (in the patient's own words) and the **history of the present illness** (duration, precipitating factors, effect on interpersonal relationships, working capacity and details of treatment to date). In the **family history**, note parents'/siblings' ages, occupations, physical and mental health and relationships with the patient. If a relative is deceased, note the cause of death and the patient's age at the time of death. Enquiry is made into family history of psychiatric illness ('nervous breakdowns'), suicide, drug/alcohol abuse and forensic encounters.

The **personal history** begins with the patient's **early life and development** including details of the pregnancy (? planned) and birth (especially complications). Any serious illnesses, separations

in childhood or delays in development are noted. The childhood home environment is described (geographical situation, atmosphere) as are details of school (academic achievements, relationships with peers, teachers). The occupational history should list jobs, reasons for change, work satisfaction, relationships with colleagues. Document details of sexual practices (past/present abuse, sexual orientation, difficulties, satisfaction), relationships, marriage (duration, details of partner, children) and, in the case of women, menstrual pattern, contraception, miscarriages, stillbirths and terminations of pregnancy.

Previous psychiatric history (dates of illnesses, symptoms, diagnoses, treatments, hospitalizations) and **past medical and surgical history** are obtained. The patient's alcohol, drug (prescribed and recreational) and tobacco **consumption** and any **forensic** history are recorded. The patient's attitude to and practice of religion, politics and hobbies are noted. The **premorbid personality** (e.g. character, social relations) and finally, details of the present circumstances (accommodation, occupation, financial details), are described.

The MSE

The patient's **appearance and behaviour** are documented, includ-

ing general health, demeanour, manner, rapport, eye contact, degree of cooperation, cleanliness, clothing, self-care, facial expression, posture, motor activity, which may be excessive (agitation) or decreased (retardation), abnormal movements (tics, chorea, tremor), stereotypy (purposeless), mannerisms (goal-directed, understandable), gait abnormality or striking physical features.

Speech is described in terms of rate, quantity (increased = pressure [often with associated ‘flight of ideas’]; decreased = poverty), and pattern (spontaneity, coherence, rationality, directness [to the point or discursive] and perseveration [repeating words or topics]). Abnormal words (neologisms), puns or rhymes should be noted, giving verbatim examples if abnormal. Abnormal *form of thought* may be deduced, for example where connections between statements are difficult to follow (‘loosening of associations’). The patient’s subjective experience of thought may be abnormal as in thought block (thoughts disappear: ‘my mind goes blank’).

Changes in *mood and affect* are the commonest symptoms of psychiatric disorder, but also occur in physical illness and in healthy people at times of adversity. *Mood* refers to subjective emotion as experienced by the individual, while *affect* is the observed (and often more transient) external manifestation of that emotion. Mood has been compared to climate, and affect to weather. Abnormalities of affect include blunting, lability, perplexity and suspiciousness. Abnormal mood states include depression, elation, euphoria (unconcerned contentment), anxiety and anger. It should be noted whether mood is consistent with thoughts and actions, or ‘incongruous’.

Disorders of *thought content* include non-psychotic phenomena such as obsessional ideas (recurrent thoughts, feelings, images or impulses which are intrusive, persistent, senseless, unwelcome but recognized as the patient’s own [in contrast to delusions]) and phobias (fear/anxiety which is out of proportion to the situation, cannot be reasoned or explained away and leads to avoidance behaviour). Suicidal ideation (thoughts) and intent (plans) are crucial.

Abnormal beliefs include overvalued ideas (abnormal beliefs or intense preoccupations, firmly held but comprehensible in the light of the subject’s past experience and culturally shared belief systems). An example of this would be an intense but non-delusional feeling of guilty responsibility following bereavement. Ideas of reference are when the patient feels that other people look at or talk about him/her because they notice things about him/her, but insight (see below) is retained. Delusions (fixed, false, firmly held beliefs out of keeping with the patient’s culture, unaltered by

evidence to the contrary, and for which the patient has no insight) may be primary (no discernible connection with any previous experience or mood; autochthonous) or secondary (e.g. to mood). Passivity feelings are when the patient experiences outside control or interference with his/her actions, feelings, perceptions and thoughts (thought interference). The latter may involve thought insertion or withdrawal (thoughts being put into and taken out of the person’s mind) and thought broadcast (the experience that others can hear or read the individual’s mind/thoughts).

Abnormal experiences include depersonalization—the unpleasant experience of subjective change, feeling detached, unreal, empty within, unable to feel emotion, watching oneself from outside (e.g. ‘it feels as if I am cut off by a pane of glass’). The related phenomenon of derealization is the experience of the world or people in it seeming lifeless (‘as if made out of cardboard’).

Abnormalities of perception include illusions (distortions of perception of an external stimulus, e.g. interpreting a curtain cord as a snake); hallucinations (perceptions in the absence of an external stimulus which are experienced both as true and coming from the outside world); and pseudo-hallucinations (internal perceptions with preserved insight). Hallucinations can occur in any sensory modality, although auditory and visual are commonest. Some auditory hallucinations occur in normal individuals, when falling asleep (hypnagogic) or on waking (hypnopompic).

Within the *cognitive assessment*, the following are noted: level of consciousness, memory (long- and short-term, immediate recall), orientation in time (day, date, time), place, person, attention and concentration, general knowledge and intelligence. Educational background must be taken into account.

An assessment of the patient’s *insight* (degree of correct understanding a patient has of his/her condition and its cause as well as his/her willingness to accept treatment) is made, after which the examiner notes his/her *reaction to the patient*.

The *physical examination* should focus on identifying (or excluding) conditions of which a suspicion has been raised in the history and MSE and/or with a known association with psychiatric illness.

In presenting a case, the history and MSE should be followed by a justified statement of diagnosis (or differential diagnosis), and concluded by a summary of possible aetiological factors (predisposing, precipitating and maintaining) and a plan for further investigation and management.