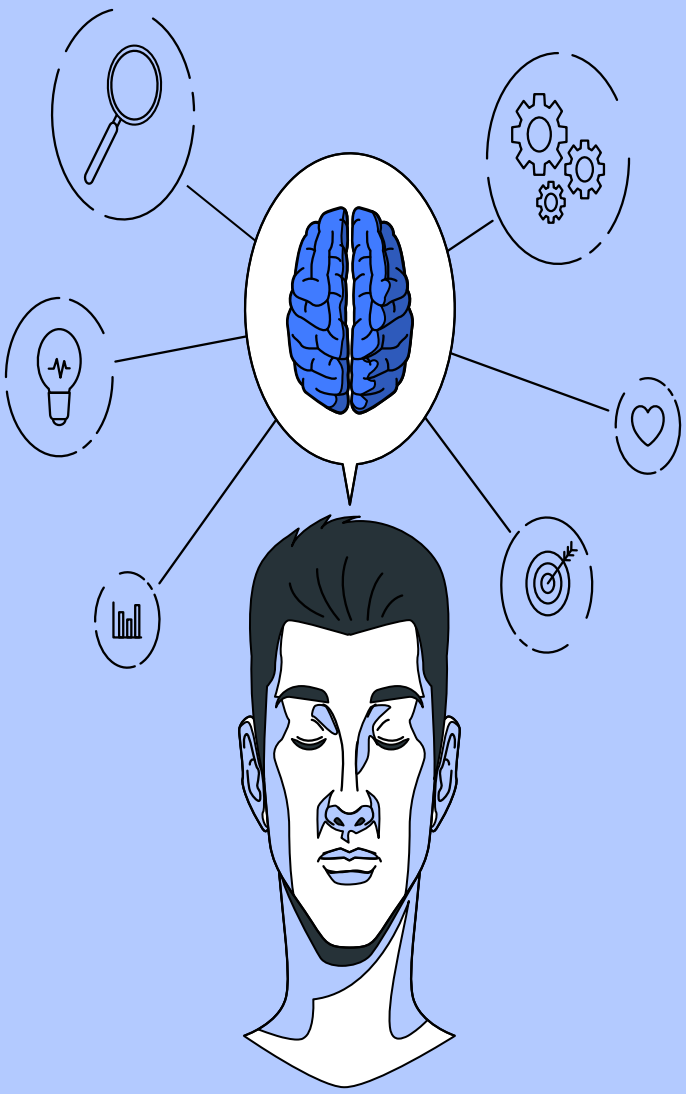


# HISTORY TAKING AND MENTAL STATE EXAMINATION (MSE)

Objectives:

- To describe History taking in psychiatry
- To see how to take Psychiatric History To describe MSE component
- To see how to do MSE

Done by:
Shahad Aljebreen-Rania Alessa-Norah Alkadi

# Introduction

- One supreme skill of any physician is active listening.
- Physicians should monitor:
  - The content: of the interaction (what patient and doctor say to each other)
  - The process: (what patient and doctor may not say but clearly convey in many other ways)
- Physicians should be sensitive to the effects of patient history/background, culture, environment, and psychology on the doctor–patient relationship
  - Because patients are multifaceted people.
  - Physician should not consider disease/syndromes only.
- The more that doctors understand themselves, the more secure they feel, and the better able they are to modify destructive attitudes.
- Increased flexibility leads to a responsiveness to the subtle interplay between doctor and patient and also assumes a certain tolerance for the uncertainty present in any clinical situation with any patient

Models of the doctor–patient relationship include:

The mutual participation model
This is the best model.

The dr. takes the pt's opinion into account. E.g. when pt refuses to continue specific medication due to side effects the dr. will try to look for another option.

The active-passive model

يسمع كلامك المريض في كل شي

The teacher–student (or parent–child, guidance–cooperation) model

If pt. Refuses dr's advice, dr. will ask him to never come again.

زي علاقة الأم والأب بالإبن
يقولون له سوي كذا ولما يعترض
يقول سوي كذا لان انا عارف مصلحتك

The friendship (or socially intimate) model

some ethical boundaries are crossed.

## Goals for Psychiatric Interview:

- Obtain the necessary information to make a diagnosis.
- Understand the person with the illness.
- Understand the circumstances of the patient.
- Form a therapeutic relationship with the patient (rapport).
- Provide the patient with information about the illness, recommendation, and prognosis.

# Every Interview has three main components:


Balance in monitoring Content Vs Process during the interview

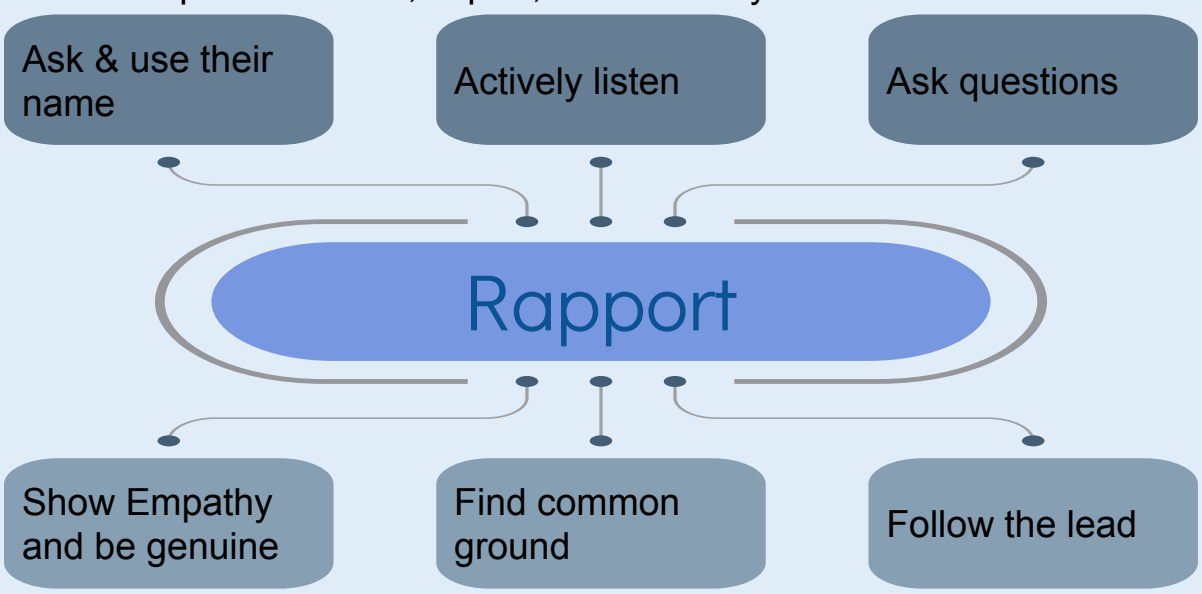
# Opening (General advice):

- Introduce yourself and greet the patient by name.
- Reassure privacy and confidentiality.
- Separate room.
- L-shaped position and private comfortable setting. To avoid feeling like an interrogation.
- Suitable distance (e.g. with geriatric ,with aggressive patient) Best distance: if limbs are stretched they shouldn't touch the pt.
- Be supportive, attentive, non judgmental and encouraging.
- Explain about, yourself, the purpose of interview, and expected time needed.
- Observe the patient's nonverbal behavior and Avoid excessive note-taking.
- With whom you will start (Patient or his/her relative).
- Why he come with a relative ? (Psychosis Vs. Neurosis).
- Diagnose based on criteria and constellation of symptoms that affect functioning level (e.g. Social phobia Vs. paranoid schizophrenia).
- Start with open ended questions.
- Appropriate clothing and be professional.

When to break the patient confidentiality?
1-when he has a plan to harm himself or other people.
2-if the patient is a child and there is something is threatening his safety.

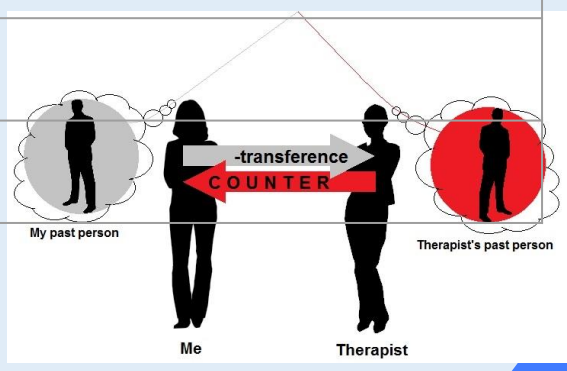
# Six strategies to develop Rapport:

1. Putting patient at ease.
2. Finding patient's pain and expressing compassion.
3. Evaluating patients' insight and becoming an ally.
4. Showing expertise.
5. Establishing authority as physician or therapist.
6. Balancing the roles of empathic listener, expert, and authority.



# Interview Techniques

| | |
|---|---|
| | Pay attention to both content & process |
| | Open-ended question versus Closed-ended questions |
| Reflection | In the technique of reflection, a doctor repeats to a patient in a supportive manner something that the patient has said. |
| Facilitation | Doctors help patients continue in the interview by providing both verbal and nonverbal cues. |
| Silence | |
| Confrontation | The technique of confrontation is meant to point out to a patient something that the doctor thinks the patient is not paying attention to, is missing, or is in some way denying.<br>هذه تجي مع الخبرة ومهم تكون علاقتك مع المريض قوية عشان ما ينفر منك<br>مثال; المريض ماراح لعيد أهله ثلاث مرات اصير اقوله اتوقع انك مو جالس تروح لانك تبغى تتحاشى فلان |
| Clarification | Doctors attempt to get details from patients about what they have already said. |
| Interpretation | The technique of interpretation is most often used when a doctor states something about a patient's behavior or thinking that a patient may not be aware of. |
| Summation | Periodically during the interview, a doctor can take a moment and briefly summarize what a patient has said thus far. |
| Explanation | Doctors explain treatment plans to patients in easily understandable language and allow patients to respond and ask questions |
| Transition | The technique of transition allows doctors to convey the idea that enough information has been obtained on one subject; the doctor's words encourage patients to continue on to another subject. |
| Self-revelation | Limited, discreet self-disclosure by physicians may be useful in certain situations, and physicians should feel at ease and should communicate a sense of self-comfort.<br>يسالك عن معلومات عنك كطبيب او انت تتبرع وتقول له بحدود طبعا واذا تعدى المريض الحدود ترد عليه وتوقفه بادب |
| Positive Reinforcement | When pt tells you sensitive info thank him and reassure him that it's confidential etc. |
| Reassurance | |
| Advice | Usually shouldn't be done unless it's medical advice. |




## Transference vs. Counter-transference:

Transference: The patient are transferring feelings toward others in their life onto the physician. E.g. dr. looks like pt's father who was abusive. Include positive and negative feelings.

Counter-transference: Emotional reactions to the patient from the doctor that often involve the doctor past experience.
عكس الأولى, احيانا المريض Projects his emotions يعني يحس بخيبة أمل تجاه حالته وينقل هالشعور لك

# The Psychiatric History vs. The Mental Status Exam:

| THE PSYCHIATRIC HISTORY | THE MENTAL STATUS EXAMINATION Equivalent to physical exam |
|---|---|
| It is the chronological story of the patient's life from birth to present | MSE is a cross-sectional, systemic documentation of the quality of mental functioning at the time of interview |
| It includes information about who the patient is, his problem (Bio-Psycho-Social aspects) and its possible causes and available support | It serves as a baseline for future comparison and to follow the progress of the patient. It should be different before and after treatment |
| Information elicited both from the patient and from one or more informants | Observation of patient's feelings, thoughts, perception, and behavior during the interview |

# The Psychiatric History

## Structure of History:

➔ Identification of the Patient: Name, age, gender, marital status, occupation, education, nationality, residency, and religion. Info here is more than usual history bc it's important.

➔ Referral Source: Brief statement of how the patient came to the clinic and the expectations of the consultation.

➔ Chief Complaint: Exactly why the patient came to the psychiatrist, preferably in the patient's own words (a verbatim statement).

➔ History of Present Illness:

- Chronological background of the psychiatric problem: Nature, Onset, Course, Severity, Duration, Effects on the patient (social life, job, family...)
- Review of the relevant problems
- Symptoms not mentioned by the patient (e.g. Sleep, appetite, ...)
- Treatment taken so far (nature and effect)
- Important –Ve (e.g. history of mania in depressed patient )
- Suicide, homicide, substance abuse, and organic disease

لما يكون المريض عنده قابلية للإضرار بنفسه وهو غير متعاون، تأخذ معلومات من اهل المريض بدون ما تستأذن منه

➔ Past Psychiatric History: Any previous psychiatric illness (nature, dates, treatment, outcome).

➔ Medical history: All major illnesses should be listed.

# Structure of History (cont.):

- Family History
  - Ask about mental illnesses in first and second-degree relatives (grand parents, uncles, aunts, nephews, & nieces).
  - Mother and father: current age (if died mention age and cause of death, and patient's age at that time)

- Personal and Social history
  - Birth & Early development
  - School
  - Occupations
  - Puberty & Adolescence
  - Marital history
  - Current social situation
- Tobacco and substance abuse

- Legal (forensic) problems

- Personality Traits
  - Attitude to self (self-appraisal, performance, satisfaction, past achievements, and failures, future).
  - Moral and religious attitudes and standards.
  - Prevailing mood and emotions.
  - Reaction to stress (ability to tolerate frustration and disappointments, pattern of coping strategies).
  - Personal interests, habits, hobbies and leisure activities.
  - Interpersonal relationships.

Focus on hx of mania in diagnosing depression since it changes the whole diagnosis

# The Mental Status Exam

## The Outlines:

- Appearance: Include body build, self-care, clothes ,grooming, hair, nails, facial expressions, and any unusual features (e.g. weight loss).

- Behaviour: Both the quantitative and qualitative aspects. Note level of activity, posture, eye to eye contact and unusual movements (tics, grimacing, tremor, disinhibited behaviour, hallucinatory gestures,...etc.) .

- Attitude: Note the patient's attitude (verbal & non verbal) during the interview (interested, bored, cooperative, uncooperative, sarcastic, guarded or aggressive)

What are your impressions on these people?

- Mood
  - Euthymic
  - low, depressed
  - expansive, elated
  - Irritable
- Affect
  - Appropriate ,inappropriate
  - Restricted, blunted, flat
  - Labile

Note any affect abnormalities in:
-Its nature (e.g. anxiety, depression, elation...).
-Its variability (constricted affect, labile affect..).
Restricted (constricted) affect: there is some remaining
Flat and blunted: complete. E.g. pt. Talks about horrible events with zero expression
Labile: talks happily and after a few seconds starts crying.
-Its appropriateness whether the affect is to the thought content.
Mismatch occurs in convergence disorder and schizophrenia
المريض عنده اكتئاب وحاس بهالشي لمدة شهرين وقبل يدخل علي جته مكالمه أن ولده تخرج من الجامعة وفرح شوي ودخل عليك, هذا Affect. لكن أحيانا يكون inappropriate (mismatch) يتكلم عن ابوه اللي مات ويضحك

زي فصول السنة مثلا فصل الشتاء بارد لكن فيه أيام دافئة
:Mood
الشيء المستمر (الشتاء)
:Affect
الأيام القليلة اللي يدفئ فيها الجو

| Mood | Affect |
|---|---|
| The long term feeling state through which all experience are filtered | The visible and audible manifestations of the patents emotional response to external and internal events |
| The emotional background | The emotional foreground |
| Last days to weeks | Momentary (seconds to hours) |
| Changes spontaneously & not related to internal or external stimuli | Changes according to internal & external stimuli |
| Symptom (ask patient) | Observed by others/dr (sign ) (Current emotional state) |

# The Outlines (cont.):

- Speech: Speech can be described in terms of its quantity, rate of production, and quality
  - Listen to and describe how the patient speaks, noting: coherence, spontaneity, volume, flow, tone, continuity and speech impairments (stuttering, dysarthria,. etc).
- Thoughts:
  - Thought stream: Pressured thought, poverty of thought, and thought block
  - Thought form or process: Flight of ideas, loss of association, and perseveration
  - Thought content: Delusion, obsession and, overvalued ideas

# Thought form vs. Thought content:

- Thought form: The way in which a person puts together ideas and associations, Examples:

From the most organised to the most disorganised

| | |
|---|---|
| 1- Goal-directed thinking | ٦ الصباح |
| 2- Circumstantiality | بيجاوبك ويعطيك معلومات غير ضرورية<br>انا نمت متاخر لان تعشيت متأخر وصحيت اليوم برضو متأخر |
| 3- Tangentiality | يعطيك معلومات غير مفيدة عن الموضوع لكن ما يجاوبك عن السؤال نفسه<br>انا نمت متاخر وطلبت عشاء من المطعم الفلاني وحصل كذا كذ |
| 4- Flight of ideas | معلومات خارج الموضوع<br>يجاوبك يقولك الله خالق كل شيء |

| | |
|---|---|
| 5- Loosening of associations or derailment | الصباح كان جميل، امس تغدينا كبسة، انا عندي سيارة حمراء |
| 6-Clang associations (Rhyming) | زي السجع |
| 7-Thought blocking | يقولك انا صحيت الساعة ويسكت (ينسى) |
| 8-Word salad or incoherence | الكلمات على حدى مفهومة لكن الجملة غير مفهومة |
| 9-Neologisms | اخترع كلمة جديدة ما راح تفهمها وغالبا مع مرضى الفصام |

- Thought content: What a person is actually thinking about, Examples:

مخه ما فيه افكار حياته متمحورة حول فكرة أو فكرتين وغالبا تكون في مرضى الفصام

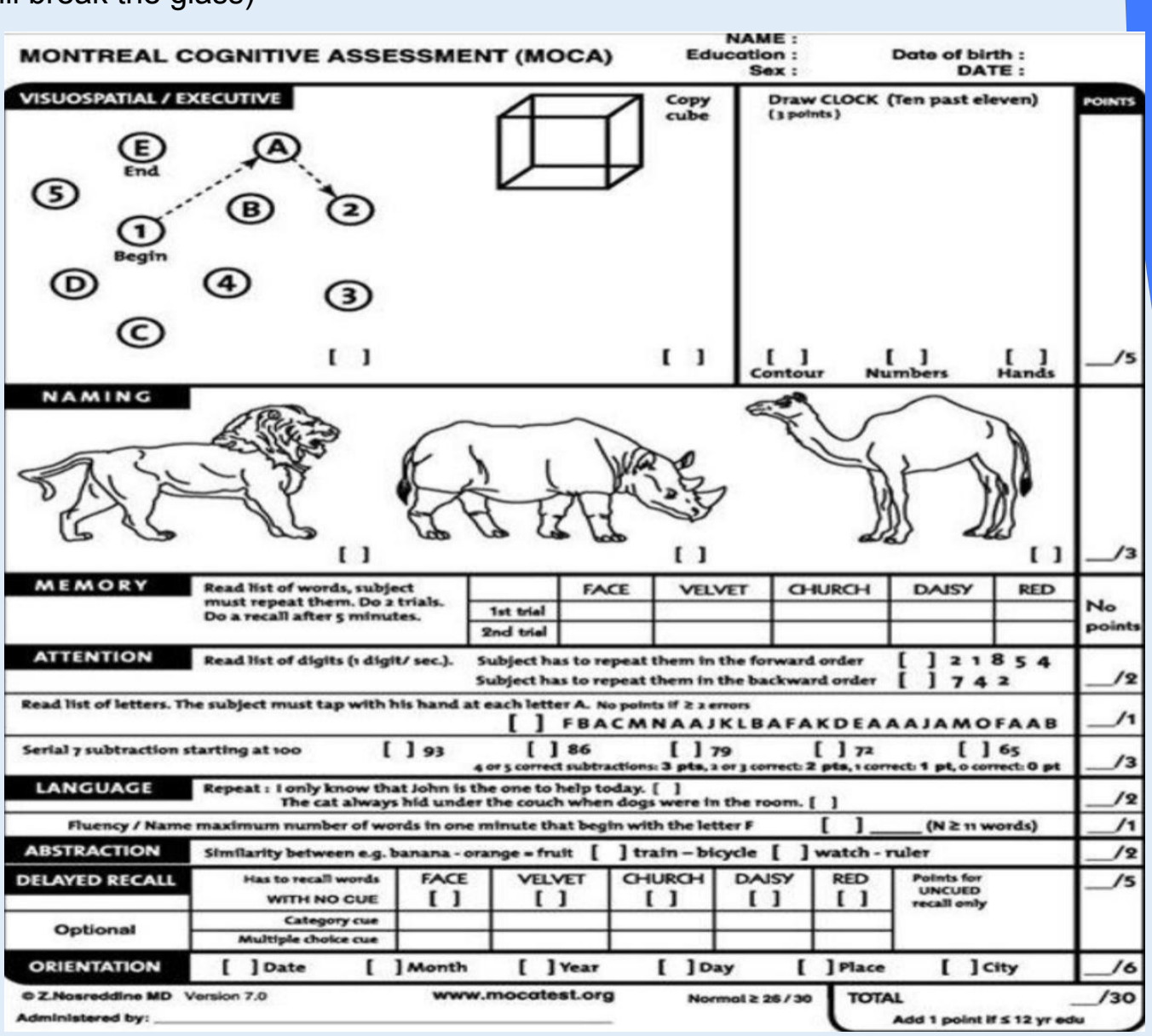
Delusions | Preoccupations | Obsessions and compulsions | Phobias | Suicidal or homicidal ideas | Ideas of reference and influence | Poverty of thoughts

- Perception:
  - Illusion: Misperception of external stimulus. ثوب معلق على الشماعة والمريض يشوفها شبح
  - Hallucinations: No external stimulus
    - Which sensory system (e.g. auditory, visual..etc...) Content
    - Third person جماعة يتكلمون عن المريض Vs Second person الصوت يتكلم للمريض
    - Patient reaction to hallucination
    - Hypnagogic hallucinations hypnopompic hallucinations
    - Pseudo hallucinations
  - Depersonalization and derealization: extreme feelings of detachment from the self or the environmen
  - Formication: The feeling of bugs crawling on or under the skin

# The Outlines (cont.):

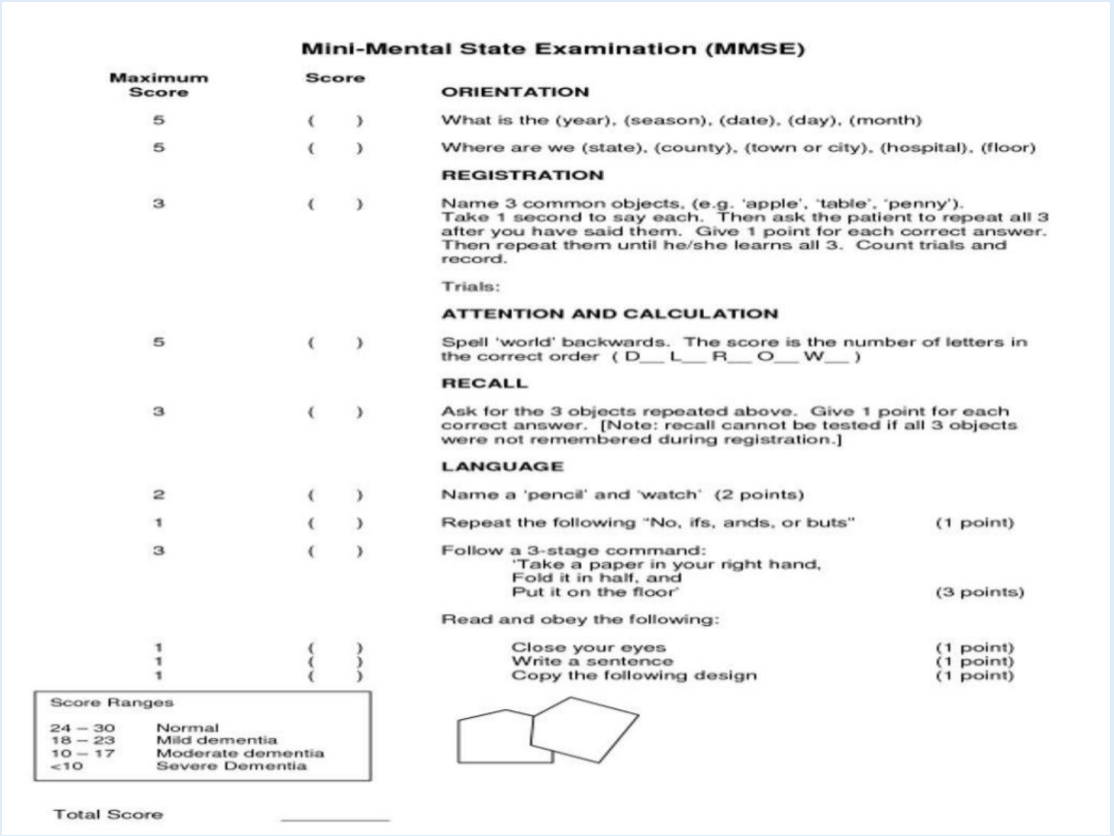
- Cognitive functions:
  - Consciousness level and orientation (to rule out delirium)
  - Attention and concentration: e.g. Serial 7 test
  - Memory:
    i. Immediate memory / Registration (Spell the word “world” backward)
    ii. Short term memory E.g. give pt three words and ask about them after 5 mins.
    iii. Recent memory E.g. asking about recent national event.
    iv. Remote memory (long-term memory) E.g. asking about pt’s graduation.
  - Language and Reading: (When brain pathology is suspected)
    i. Nominal aphasia: name two objects (e.g. a pen and a watch )
    ii. Expressive aphasia: repeat after you certain words
    iii. Receptive aphasia: carry out a verbal command
    iv. Reading comprehension: read a sentence with written command (e.g. close your eyes)
  - Visuospatial Ability: (When brain pathology is suspected): Ask the patient to copy a figure such as interlocking pentagons
  - Abstract Thinking:
    i. It is the ability to deal with concepts and to make appropriate inference.
    ii. It can be tested by :
      1. Similarities: ask the patient to tell you the similarity between 2 things (e.g. car and train), and the difference between 2 things (e.g. book and notebook)
      2. Proverbs: ask the patient to interpret one or two proverbs (e.g. people in glass houses should not throw stones) the patient may give a concrete answer (e.g. stones will break the glass)
  - Formal Cognitive testing (MOCA)

It covers the executive functions the rest is simliar to MMSE



# The Outlines (cont.):

- Formal Cognitive testing (MMSE)



**Mini-Mental State Examination (MMSE)**

| Maximum Score | Score | |
|---|---|---|
| | | **ORIENTATION** |
| 5 | ( ) | What is the (year), (season), (date), (day), (month) |
| 5 | ( ) | Where are we (state), (county), (town or city), (hospital), (floor) |
| | | **REGISTRATION** |
| 3 | ( ) | Name 3 common objects, (e.g. 'apple', 'table', 'penny'). Take 1 second to say each. Then ask the patient to repeat all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. |
| | | Trials: |
| | | **ATTENTION AND CALCULATION** |
| 5 | ( ) | Spell 'world' backwards. The score is the number of letters in the correct order ( D__ L__ R__ O__ W__ ) |
| | | **RECALL** |
| 3 | ( ) | Ask for the 3 objects repeated above. Give 1 point for each correct answer. [Note: recall cannot be tested if all 3 objects were not remembered during registration.] |
| | | **LANGUAGE** |
| 2 | ( ) | Name a 'pencil' and 'watch' (2 points) |
| 1 | ( ) | Repeat the following "No, ifs, ands, or buts" (1 point) |
| 3 | ( ) | Follow a 3-stage command: "Take a paper in your right hand, Fold it in half, and Put it on the floor" (3 points) |
| | | Read and obey the following: |
| 1 | ( ) | Close your eyes (1 point) |
| 1 | ( ) | Write a sentence (1 point) |
| 1 | ( ) | Copy the following design (1 point) |

Score Ranges

| | |
|---|---|
| 24 – 30 | Normal |
| 18 – 23 | Mild dementia |
| 10 – 17 | Moderate dementia |
| <10 | Severe Dementia |

Total Score _____

- Judgment:
  - The patient's predicted response and behaviour in imaginary situation. E.g. Asking what he/she would do in a fire.
  - From recent history.

- Insight: Dr said don't memorize the levels in the slide memorize them as: مهمة في الاختبار

1- Full/complete insight: he knows he has disease + knows he needs treatment

2- Partial insight: knows he has disease but treatment isn't needed OR thinks he doesn't have disease but believes tx helps him

3-Poor Insight: Thinks he doesn't have disease and doesn't need treatment.

- The degree of awareness and understanding the patient has that he or she is mentally ill.
- levels of insight:
  i. Complete denial of illness
  ii. Slight awareness of being sick and needing help but denying it at the same time
  iii. Awareness of being sick but blaming it on others, on external factors, or on organic factors Awareness that illness is due to something unknown in the patient
  iv. Intellectual insight: admission that the patient is ill and that symptoms or failures in social adjustment are due to the patient's own particular irrational feelings or disturbances without applying this knowledge to future experiences
  v. True emotional insight: emotional awareness of the motives and feelings within the patient and the important people in his or her life, which can lead to basic changes in behavior
- Patient's compliance with psychiatric treatment depends on his insight.

# Closing

- Differential diagnoses
- Provisional (working ) diagnosis
- Investigations
- Management:
  - (Acute Vs .chronic )
  - Outpatient Vs. inpatient
  - Bio-Psycho-Social treatment
- Full explanation about the plan (S/E, efficacy, risk of addiction, and any other questions from the patient)
- Doctors explain treatment plans to patients in easily understandable language and allow patients to respond and ask questions
- Prognosis
- Professional Boundaries It's Dr's responsiliblity to maintain it
- Difficult Doctor-Patient: (Relationships)
  - The Seductive Patient
  - The "Hateful" Patient
  - The Patient With a Thousand Symptoms The Patient in the Hospital Setting
  - The Mentally Disturbed Patient
  - The Dying Patient

# 4- Clinical Interview in Psychiatry

Channel and video.

A 20-year-old male seen at the emergency department appeared fully awake but unable to talk, unresponsive to stimuli, and immobile. **How would you assess him?**

A thorough assessment of a psychiatric patient consists of a psychiatric history, mental status examination, physical examination, and certain relevant laboratory and psychological tests. The psychiatric history and mental status examination are usually obtained during the initial psychiatric interview.

## Psychiatric Interview

**Goals** :

1. To establish a relationship with the patient.
2. To obtain information.
3. To assess psychopathology (nature, severity ...) of the illness.
4. To provide feedback and formulate a treatment plan.

The clinical interview is very important in psychiatry; it requires practical skills, which cannot be learnt effectively without enough practical training under supervision of experienced interviewers.

## Interview Skills

**A--Opening phase** (5 min):
1- Greet the patient by name and introduce yourself.
2-Put the patient at ease; arrange for a private comfortable setting, and appropriately tell the purpose of the interview.
3- Build good rapport and alliance.

**B—Interview Proper** (35 min):

1- Be attentive, encouraging, supportive, and observe the patient's nonverbal behavior.

2- Use open-ended questions and facilitative verbal and non-verbal techniques.

3-Avoid excessive note taking, premature reassurance, advice, and diagnosis.

4- Make graceful transitions throughout the interview.

5- Pay attention to the severity and complications of the problem.

6- Utelize time efficiently. 7- Use interview techniques:

**C--Closing phase**(5min) :
1- Know when to close the interview.
2- Give the patient a chance to ask questions and let him know future plans.

**Interview Techniques:**

1- **Facilitation:** providing verbal and nonverbal cues that encourage the patient to keep talking. E.g. saying, Yes, go on, or Uh-huh, leaning forward in the chair, nodding one's head.

2- **Clarification:** getting details from the patient about what he has already said.

3- **Direction/redirection:** gracefully using focused questions to maintain the proper track of the interview.

4- **Obstruction:** providing verbal and nonverbal cues that block a very talkative patient..

5- **Reflection:** a doctor repeats to a patient, in a supportive manner, something that the patient has said, to let the patient know that the doctor is perceiving what is being said & to assure the doctor that he has correctly understood what the patient said.

6- **Summation:** periodic summarization of what a patient has said thus far to make sure that the doctor has heard the same information conveyed by the patient.

7- **Silence**: not every moment must be filled with talk. Silence , allow patients to ventilate emotions (e.g. weeping) and to contemplate.

***The Psychiatric History*** is the chronological story of the patient's life from birth to present (history=his-story). It includes information about who the patient is, his problem and its possible causes and available support. It should be emphasized that:

1. Much more attention needs to be paid to psychological and social aspects.
2. Patient's feelings, thoughts, perception and behavior during the interview are considered part of the mental status examination (*not the psychiatric history*).

The history should be compiled from the patient and other informants (the informant's relationship to the patient should be noted together with the interviewer's impression of the informant's reliability).

### The main items of the psychiatric history

| | |
|---|---|
| 1 | Identification data |
| 2 | Source of referral |
| 3 | Chief complaint |
| 4 | History of present illness |
| 5 | Family history |
| 6 | Personal history |
| 7 | Medical history |
| 8 | Past psychiatric history |
| 9 | Personality traits |


- **Identification of the Patient:** Name, age, sex, marital status, occupation, education, nationality, residency and religion.

- **Referral Source:** Brief statement of how patient came to the clinic and the expectations of the consultation.

- **Chief Complaint:** Exactly why patient came to the psychiatrist, preferably in the patient's own words (a verbatim statement). Note if the chief complaint differs significantly from the reports of those who accompany patient (other informants).

- **History of Present Illness:** Chronological background of the psychiatric problem: nature, onset, course, severity, duration, effects on patient (social life, job, family…), review of the relevant problems, symptoms not mentioned by patient (e.g. sleep, appetite …), and treatment taken so far (nature and effect).

**How to start history taking in psychiatry :**

Channel and video.

- **Family History:** Family history is important in psychiatry for several reasons:

1. Events happening currently to a family member may act as a stressor to patient.
2. Family atmosphere has an effect on the patient's psychological condition.
3. Some psychiatric disorders run in families and have an important genetic contribution.

* Mother and father: current age (if died mention age and cause of death, and patient's age at that time), relationship with each other and with patient.

* Siblings: list, in order of age, brothers and sisters, education, occupation, marital status, major illnesses and relationship with patient. Ask about mental illnesses in second-degree relatives (grandparents, uncles, aunts, nephews, & nieces).

- **Personal History:** (relatives may be a source of information). Personal history helps in constructing a brief biography of the patient & forms a background against which you understand the presenting complaints and predict future behavior.

  - *Birth*: any known obstetric or prenatal difficulties?.

  -*Early development*: developmental milestones (motor and language), early childhood attitudes and relationships with parents, siblings and others, any emotional or behavioral difficulties.

  - *School*: age at starting and end of school life, approximate academic ability, specific difficulties, attitudes and relationships with teachers and pupils and highest grade attained.

  - *Occupations*: age at starting work, jobs held, reasons for change, satisfaction in work, relationships with workmates and with supervisors.

  - *Puberty:* age at onset, knowledge, attitude and practice of sex.

  - Adolescence: attitude to growing up, to peers, to family and authority figures, and emotional or behavioral problems.

  - *Marital history*: age at marriage, relationships within the marriage, number of children and attitude toward them.

  - *Current social situation*: social environment and social relationships, financial circumstances and social difficulties.

  - Tobacco and substance abuse, and legal (forensic) problems.

- **Medical History:**
  All major illnesses should be listed (nature, extent, dates, treatment, outcome, and patient's reaction and attitude). Women should be asked about menstrual (and, if appropriate, about menopausal) difficulties.

- **Past Psychiatric History:**
  Any previous psychiatric illness (nature, extent, dates, treatment, outcome and patient's reaction and attitude).

- **Personality Traits:** It is important to obtain adequate information (from a variety of sources) about patient's characteristic traits that distinguish him as an individual. Patient's personality usually interacts with his illness and should be separated from episodes of illness. Elicit information about the following:

  - Attitude to self (self-appraisal, performance, satisfaction, past achievements and failures, future..)
  - Major values, moral / religious attitudes, and standards.
  - Prevailing mood and emotions.
  - Reaction to stress (ability to tolerate frustration and disappointments, pattern of coping strategies).
  - Interpersonal relationships (width & depth).
  - Personal interests, habits, hobbies and leisure activities.
  - Others>

Channel and video.

## ***MENTAL STATE EXAMINATION (MSE)***

It is a cross-sectional, systematic documentation of the quality of mental functioning at the time of interview. It serves as a baseline for future comparison and follow-up of the progress of the patient.

### Items of MSE:

1. **Appearance;**
   Note and describe overall appearance, body build, self-care, grooming, facial expressions, and any unusual features (e.g. weight loss)

**2- Behavior;** Note level of activity, posture, and unusual movements (tics, grimacing, tremor, disinhibited behavior…)

**3- Attitude;** Note patient's attitude during the interview (interested, bored, cooperative, uncooperative, sarcastic, aggressive …).Patient's attitude is reflected on his non-verbal behavior (eye contact, posture…).

**4- Speech;** Listen to and describe how patient speaks, noting: (1) amount of speech (2) flow (3) tone (4) coherence (5) continuity (6) speech impairments (stuttering, dysarthria…).

**5 - Affect** (See below).

**6- Perception** (See below).

**7-Awareness of self and others;** When indicated ask about the extreme feelings of "as if detached from self" (depersonalization) & "as if detached from the environment" (derealization).

**8-Thoughts & Abstract thinking** (See below).

**9- Judgment;** Test patient's predicted response and behavior in imaginary situations (e.g. what would you do if you smelled smoke in a crowded place?/ if you heard a loud scream coming from your neighbor' house? ).

**10- Insight** (مدى بصيرة المريض بمرضه النفسي): see below

**11-Cognitive functions and consciousness**

-Consciousness level.

-Attention.

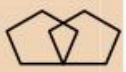
-Concentration.

-Orientation (time, place, person).

-Memory.

(See below).

**12- Visuospatial ability;** Ask patient either;
1- to copy a figure such as *interlocking pentagons*



0r 2- to draw a clock (*clock Drawing Test):* to indicate a specific time (e.g.10:10).

**13-Language and reading**

(See below; Mini-mental state Examination).

**Affect** (the patient's *present* emotional state):

- *Subjective affect*: verbal expression of feelings by the patient (some authors call it mood; however , **mood** actually is defined as a pervasive and sustained emotion -over several days-weeks - that colors the person's perception of the world).
- *Objective affect:* examiner's evaluation of patient's observable expression of affect, through nonverbal signs; facial expression, posture & movements.
  Note any abnormality in the nature of affect (e.g. anxiety, depression, elation…), the variability of affect (constricted affect, labile affect..), and whether the affect is appropriate to the thought content, the culture, and the setting of the examination.

**Perception:** Ask patient about perceptual disturbances (auditory, visual, olfactory, gustatory, tactile and somatic), and ascertain whether the disturbances are **illusions** (misperceptions of real external stimuli), **hallucinations** (perceptions without external stimuli) or **pseudo-hallucinations** (sensory deceptions perceived as emanating from within the mind). Determine the exact nature and complexity of perceptual distortions. Hallucinations of voices discussing patient (third person hallucinations) should be distinguished from voices talking to patient (second person hallucinations). Ask patient about the content of the hallucinations (e.g. what do the voices tell you) his reaction to hallucinations.


Channel and video.

**Thought:** Thoughts are usually reflected in the person's speech. Note stream, link, & content of thoughts see abnormalities in thoughts p 19 & 20.


Channel and video.

**Abstract vs. Concrete Thinking:**

**Abstract thinking** is the ability to deal with concepts beyond literal meaning and to make appropriate inferences from sentences. It can be tested by: **1. *Similarities & difference:*** e.g. tell me the similarity between "car and train" or the difference between "book and notebook". **2. *Proverbs:*** ask patient to interpret one or two proverbs e.g., "Mr. X has two faces" this means Mr. X has hypocritical double-dealing (abstract thinking). Some patients (psychotics or mentally retarded) may give a concrete answer (e.g., Mr. X has two real combined faces). **Concrete Thinking**: thinking characterized by actual visual image of things, rather than by abstractions; seen in schizophrenic persons and in young children

Channel and video.


Channel

**Insight:** the degree of patient's awareness of his/her mental illness.

1. Do you believe that you have abnormal experiences?
2. Do you believe that your abnormal experiences are symptoms of illness?
3. Do you believe that the illness is psychiatric?
4. Do you believe that psychiatric treatment might benefit you?

***Patient's compliance with psychiatric treatment depends on his insight.***


Channel and video.

## Consciousness and Cognitive Functions:

- **Consciousness:** note patient's general state of awareness (alert, drowsy…)
- **Attention:** (*The ability to focus on the matter in the hand)*. Attention is assessed by asking patient to spell a word backward (e.g. World), to mention 5 words with the same letter, or by the digit span test (see memory below).
- **Concentration:** (*The ability to sustain attention*). Concentration is tested by naming the months of the year in reverse order or by subtracting serial 7s from 100 (serial 7s test): patient is asked to subtract 7 from 100 then to take 7 from the remainder repeatedly until it is less than seven. Psychiatrist assesses whether patient can concentrate on this task. Serial 3s test can be used if patient lacks skill in arithmetic.

- **Orientation to Time, Place and Person**.
  - **Time**: note whether patient identifies the day correctly (e.g. Monday), time of the day (e.g. afternoon) and the approximate date (day, month, and year).
  - **Place**: note whether patient knows where he or she is (city- area-building).
  - **Person**: note whether patient knows other people in the same place (e.g. relatives, hospital staff).

Disorientation is an important feature of **delirium,** which indicates impaired consciousness. It usually appears in this order: time - place -person, and clears in the reverse order: person - place - time.

- **Memory** (registration >> retention >> recall):

1. ***Immediate memory*** (registration and immediate recall/ frontal lobe function): it is tested by the digit span test; ability to repeat 7 digits (e.g. 3,8,1,4,7,2,9) after an examiner dictates them slowly, first forward, then backward. A normal person can repeat 7 digits correctly, impaired registration should be considered if less than 5 digits could be repeated. This test is also used to assess attention because it requires enough focus. Defect indicates **frontal lobe impairment.**

2. ***Short term recall***: mention **3** names to the patient to remember (e.g. a banana, a clock and a car), and then after 5 minutes ask for recall, during which time you distract patient by doing something else. Defect indicates temporal lobe impairment **(Amnestic Syndrome).**

3. ***Recent memory*****:** ask questions regarding the last few days in patient's life events that you can verify (e.g., what the patient did yesterday morning), defect occurs in **early dementia but may occur in normal elderly and because of medications side effects (e.g., SSRIs, antipsychotics). Recent past memory**: ability to recall events in the past few months, defected in **dementia.**

4. ***Remote memory*** (long-term memory): ask patient to recall personal events (e.g. birth date, wedding date) or well-known public events from some years before, provided that these events (personal or public) are known with certainty to you. Note also the sequence of events. Defect indicates global cortical impairment; **advanced dementia.**


Channel and video.

**Mini-Mental State Examination (MMSE);**

It is a brief instrument designed to assess higher mental functions. It is widely used as a screening test that can be applied during a patient's clinical examination, and as a test to track the changes in a patient's cognitive state. It assesses orientation, memory, calculations, writing and reading capacity, language, and visuo-spatial ability.

| Function / test | Score |
|---|---|
| **1. Orientation** | |
| What is the day, time of the day & date (day, month, and year)? | 5 points |
| Where are we (building/hospital, area, city, country)? | 5 points |
| **2. Registration;** Name three objects (e.g. a tree, a pen, and a car) repeat them (after the interviewer). | 3 points |
| **3. Attention and calculation** | |
| Spell "world" backward (attention). | 5 points |
| Tell the months of the year backward (concentration), or serial 7s test. | |
| **4. Retention & Recall;** Name the three objects mentioned above 5 minutes later. | 3 points |
| **5. Language** ( aphasias) | |
| Ask patient to name two objects (e.g. a pen and a watch)- for *nominal aphasia*-. | 2 points |
| Ask patient to repeat after you certain words Say, "No ifs, ands, or buts." -for *expressive aphasia*-. | 1 point |
| Ask patient to carry out a three-step verbal commands e.g., take a pencil in your right hand, put in your left hand, and then put it on the floor-for *receptive aphasia* (auditory functions)-. | 3 points |
| **6. Reading comprehension**; ask patient to read a sentence with written command | |
| Close your eyes. | 1 point |
| Write a sentence. | 1 point |
| Copy a design. | 1 point |
| **TOTAL** | **30 points** |

A score of less than 24 points suggests impairment, and a score of less than 20 indicates a definite organic mental impairment (most common are delirium & dementia).It is advised to be done by more than one interviewer and repeated over a period of time.

# Questions:

1-Q2: Which part of MSE grandiosity delusion fall in?

A. Thought content B. Mood C. Speech D. Affect

Ans: A

2- 74-year-old male presented with 2 days history of agitation, confusion and anger. What is the most important step to reach a diagnosis?

A. Dopamine level B. Complete physical examination C. Mini mental state exam D. Drug level

Answer: C

3- A psychiatrist requested his patient to remember 7 digit-number after the psychiatrist dictated it slowly five minutes earlier. What was the psychiatrist assessing?

A. Registration. B. Short term recall. C. Long term memory. D. Concentration.

Answer: B

4- 68-years-old man presented to the emergency with 3 days history of disorientation to time, place and agitation.What is the most important initial diagnostic method?

A. Brain MRI. B. Proper history. C. Electroencephalogram. D. Cognitive Behavioral therapy.

Answer: B

5- Patient came to you with delirium, which one of the following you will assess?

A. Orientation. B. Mood C. Attention D. Concentration

Answer:A

6- A 30 years old patient presented to the psychiatry clinic with complaints of weight loss, reduced activity. Which mental state exam would you do to confirm the diagnosis?

A. Mood B. Attention C. Concentration D. Orientation

Answer: A

7- A psychiatrist feels comfortable to the patient , after while he know that the patient remind her of his mother died before 3 years. which of the following express the psychiatrist emotion?

A- countertransfer B- transfer C- blocking D- denial

Ans: A

# Questions:

1-video from 5:25-6:32

Scenario:

“A patient with a respiratory problem when asked about the place and time gave a wrong answer and when asked to count backward from 10 answered incorrectly”

Q1: 2 psychopathology: disoriented and unable to concentrate

Q2: The nurse perform an examination to reach a diagnosis what was it? MMSE

Assessing cognitive function (orientation and concentration)

Q3: Differentials? Dementia and delirium

2- A 42-year-old man was brought unconscious to the emergency department. He is not known to have any history of mental illness.

(The video shows the man trying to get out of the room while a psychiatrist tries to de-escalate the situation)

Questions:

A-Mention 3 positive mental state findings .Agitated, Uncooperative, Disoriented to place and person, Anxious.

B-Mention 3 things the doctor did right to de-escalate the situation .-Speaks in calm and clear tone

-Not touching the patient

-Stay in same hight with the pt

-Maintain safe distance

-Show empathy and avoid

confrontation with the pt.

3-If you were to interview the patient, mention 3 things to do to be safe .

Sit near the door, not stay in closed room with the patient, sit limit, have a security near the room.