HISTORY TAKING AND MENTAL STATE EXAMINATION (MSE)

Dr. Ali Bahathig, FRCPC, Assistant Professor and Consultant of Psychiatry & Psychosomatic Medicine

Psychosomatic Unit, Psychiatry Department

King Saud University Medical City (KSUMC)

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SPECIAL TAHNKS TO:

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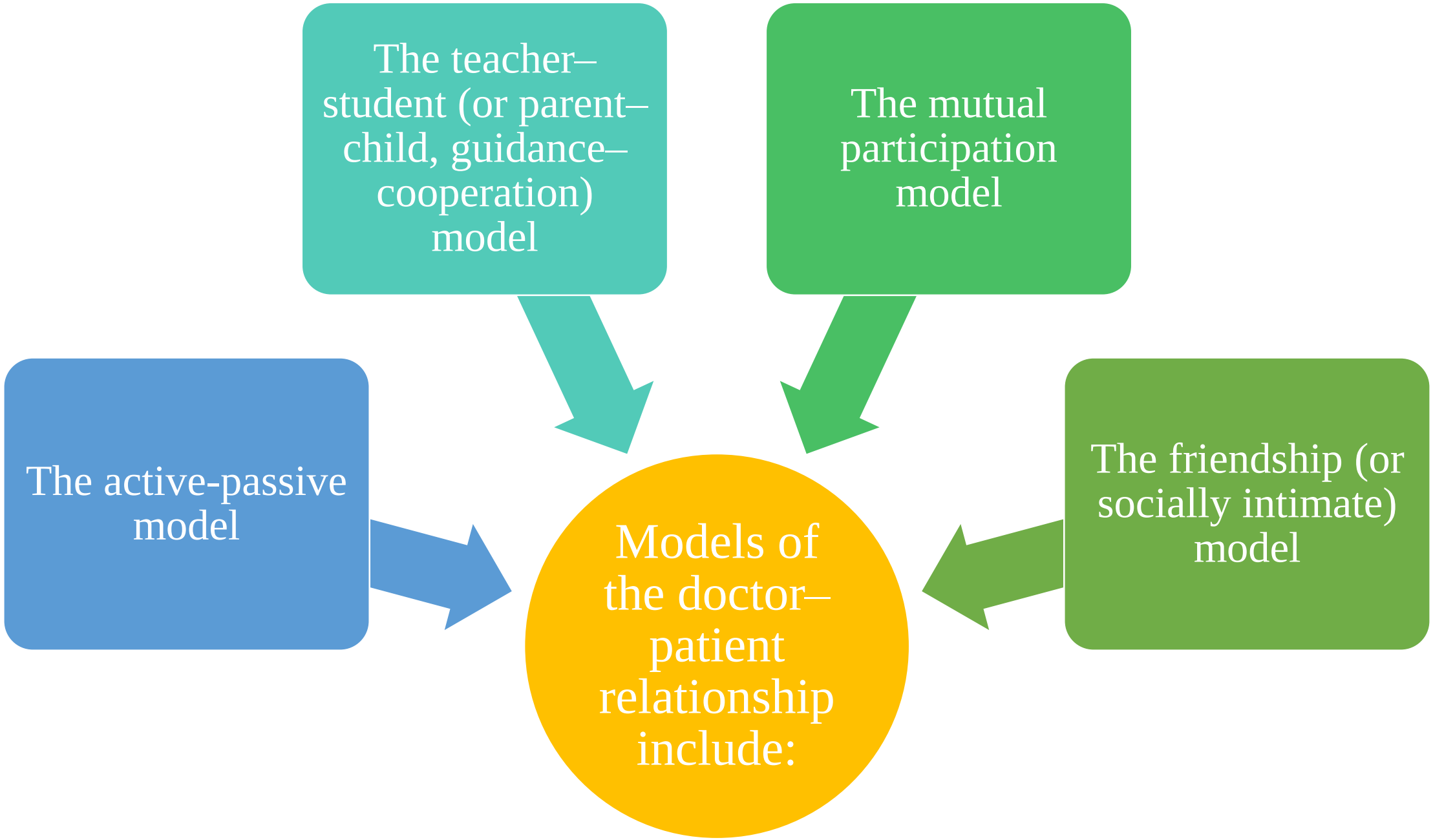
3. Dr. Mohammed Al-Sughayir, MD, Professor and Consultant of Psychiatry, College of medicine, King Saud University

Objectives:

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

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 teacher–student (or parent–child, guidance–cooperation) model
The mutual participation model
The active-passive model
Models of the doctor–patient relationship include:
The friendship (or socially intimate) model

Introduction:

- 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

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

- 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 advices):

- Introduce yourself and greet the patient by name
- Reassure privacy and ***confidentiality***
- Separate room
- L-shaped position and private comfortable setting
- Suitable distance (e.g. with geriatric ,with aggressive patient)
- Be supportive, attentive, non judgmental and encouraging
- Explain about ,yourself ,the purpose of interview, and expected time needed

Opening (General advices):

- 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***

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

Every Interview has three main components:

Interview Techniques:

- Bay 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

Interview Techniques:

- 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
- CLARIFICATION: In 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

Interview Techniques:

- 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

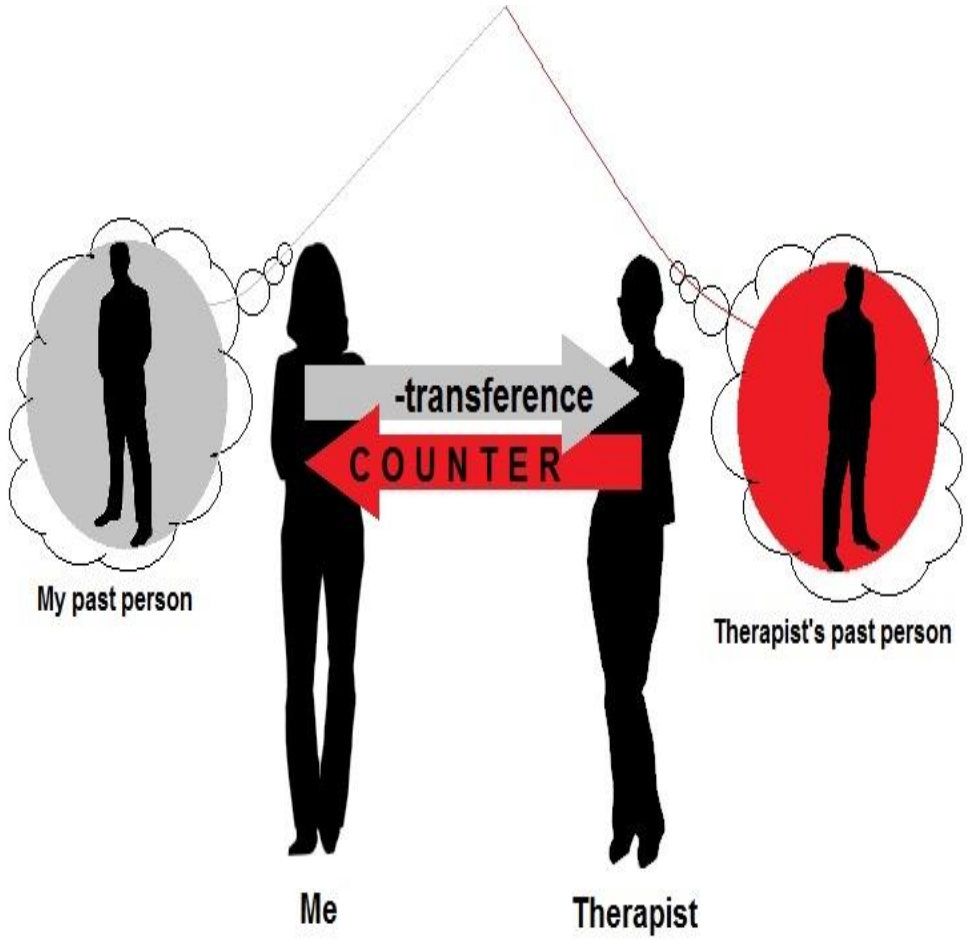
Interview Techniques:

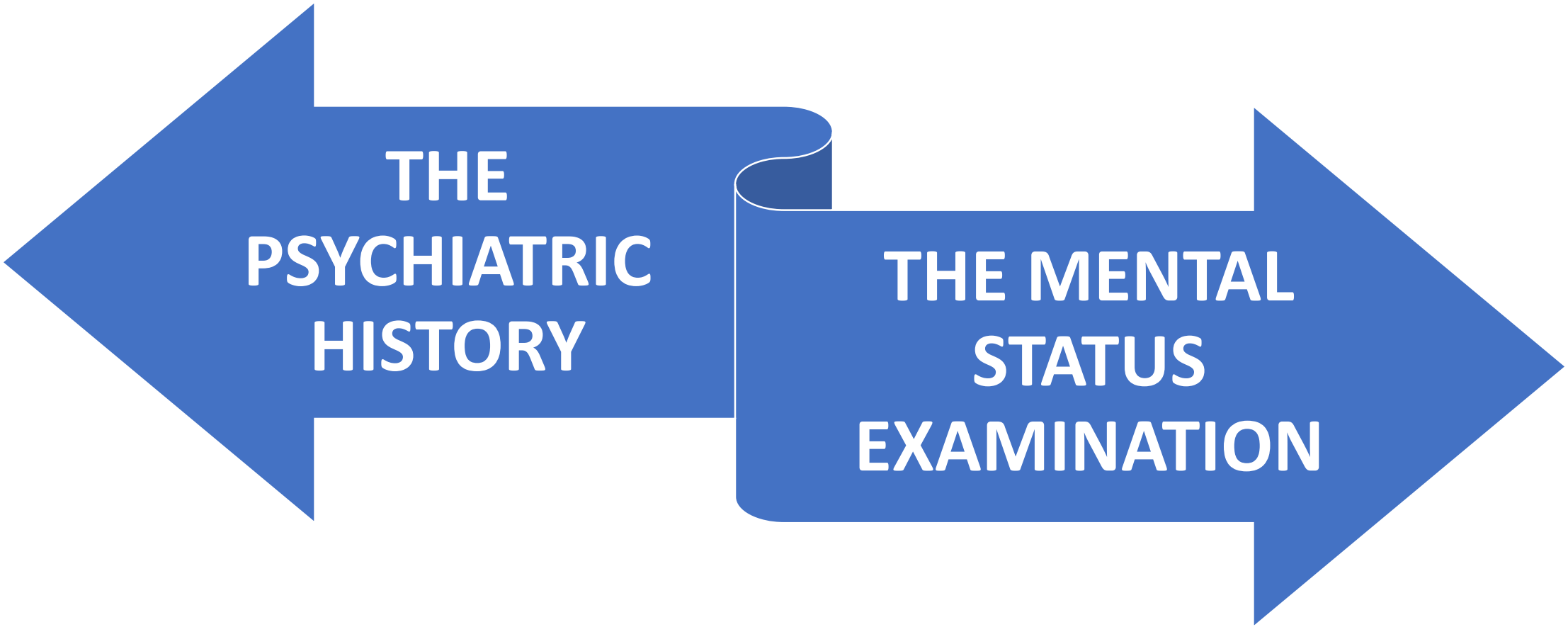
- SELF-REVELATION: Limited, discreet self-disclosure by physicians may be useful in certain situations, and physicians should feel at ease and should communicate a sense of self-comfort
- POSITIVE REINFORCEMENT
- REASSURANCE
- ADVICE

Interview Techniques:

- ***Transference:***
  - The patient are transferring feelings toward others in their life onto the physician

- ***Counter-transference:***
  - Emotional reactions to the patient from the doctor that often involve the doctor past experience

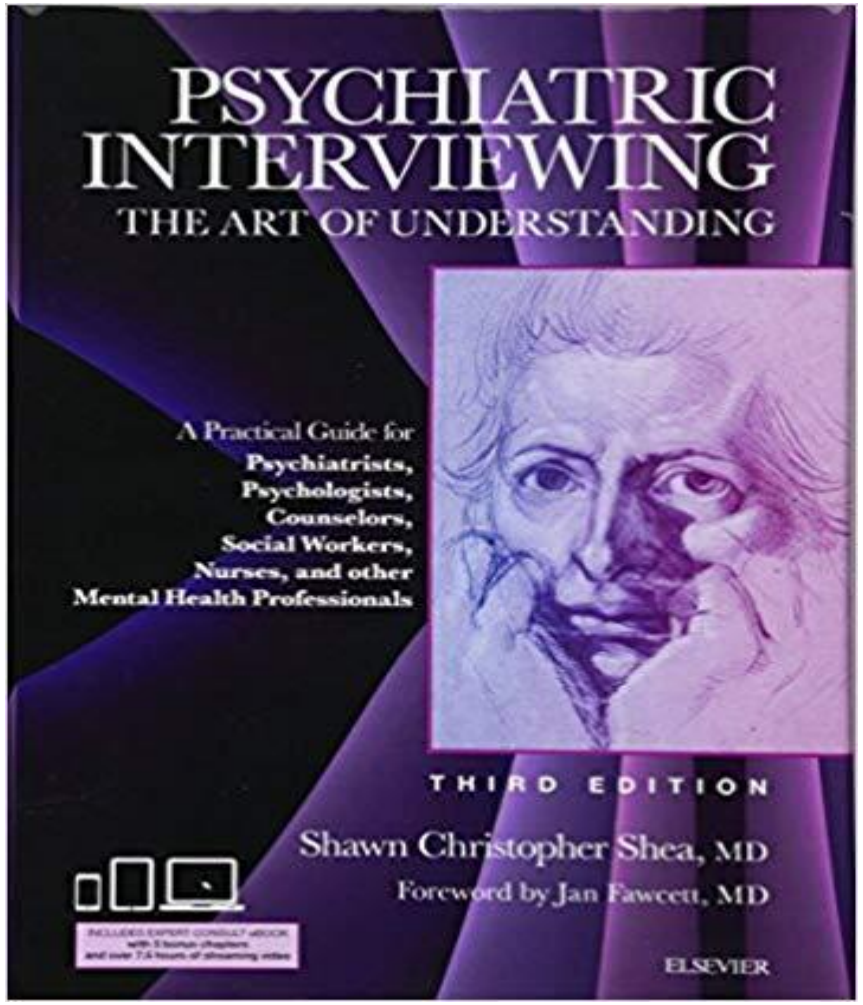



THE PSYCHIATRIC HISTORY
THE MENTAL STATUS EXAMINATION

THE PSYCHIATRIC HISTORY	THE MENTAL STATUS EXAMINATION
➢ 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
➢ 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:

- Identification data
- Referral Source
- Chief Complaint
- History of present illness
- Past Psychiatric history
- Medical history
- Family history
- Personal and Social history
- Tobacco and substance abuse
- Legal (forensic) problems
- Personality traits



Structure of History:

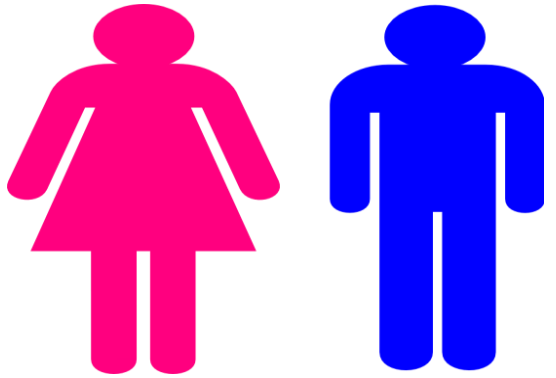
- **Identification of the Patient:**
  - Name, age, gender, marital status, occupation, education, nationality, residency, and religion
- **Referral Source:**
  - Brief statement of how the patient came to the clinic and the expectations of the consultation
- **Chief Complaint:**
  - Exactly why the patient came to the psychiatrist, preferably in the patient's own words (a verbatim statement)

Structure of History:

- **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

Structure of History:

- **Past Psychiatric History:**
  - Any previous psychiatric illness (nature, dates, treatment, outcome)
- **Medical history:**
  - All major illnesses should be listed
- **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)

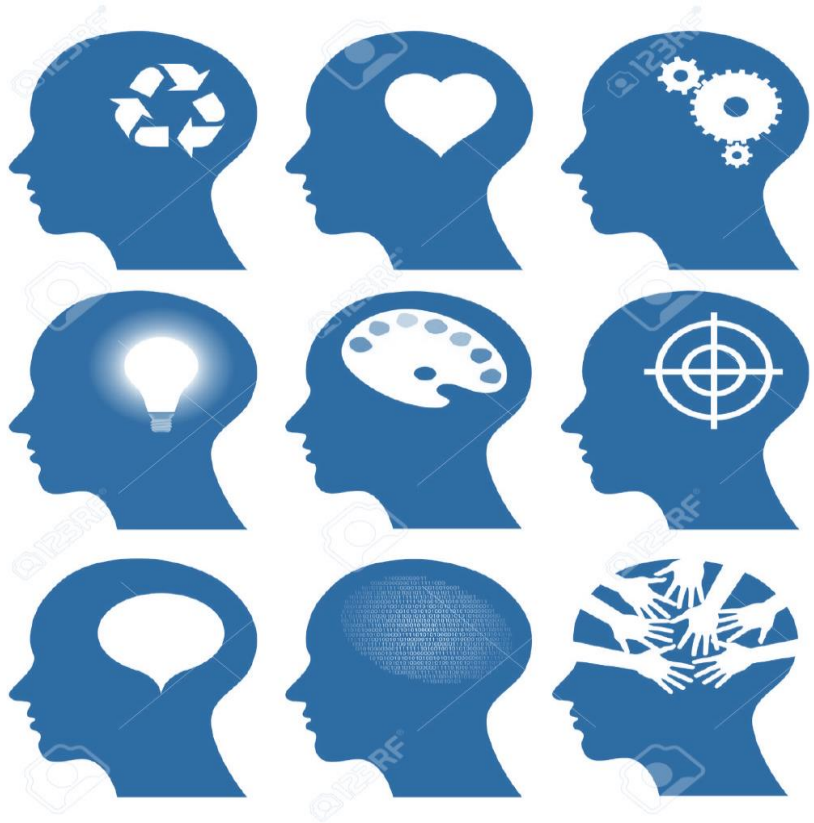


Structure of History:

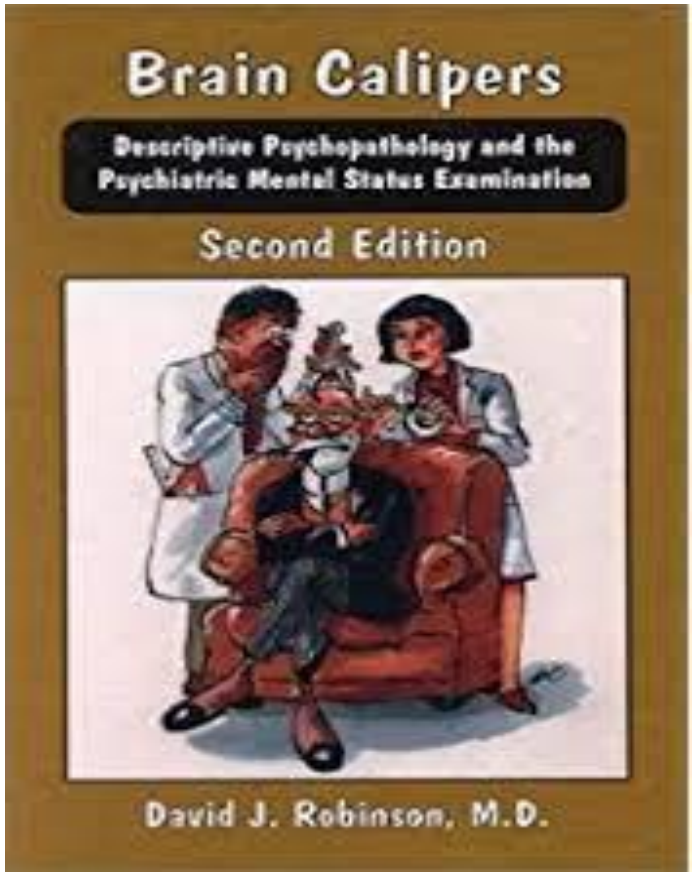
- **Personal and Social history:**
  - Birth & Early development
  - School
  - Occupations
  - Puberty & Adolescence
  - Marital history
  - Current social situation
- **Tobacco and substance abuse**
- **Legal (forensic) problems**

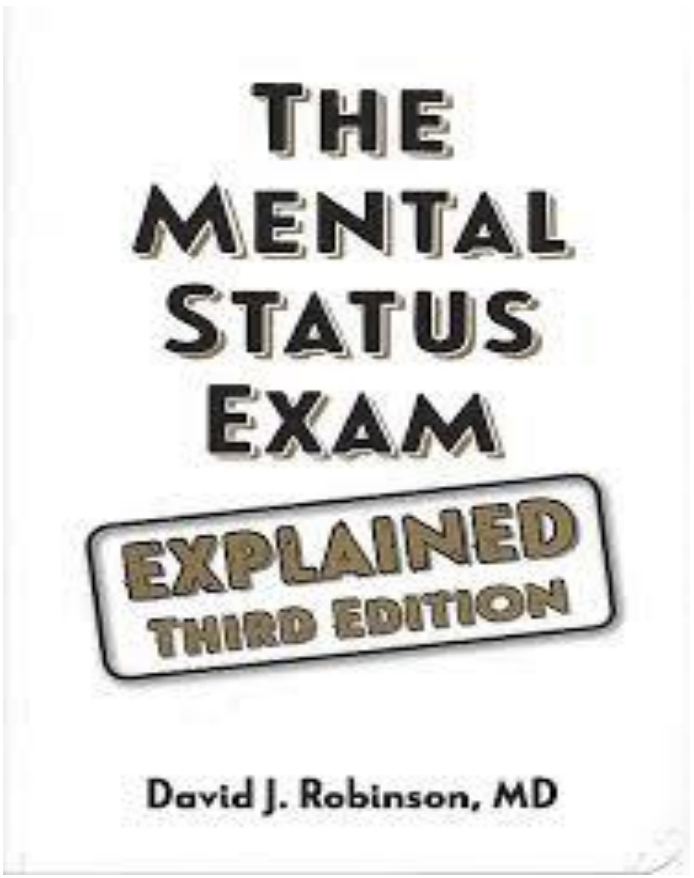
Structure of History:

- **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



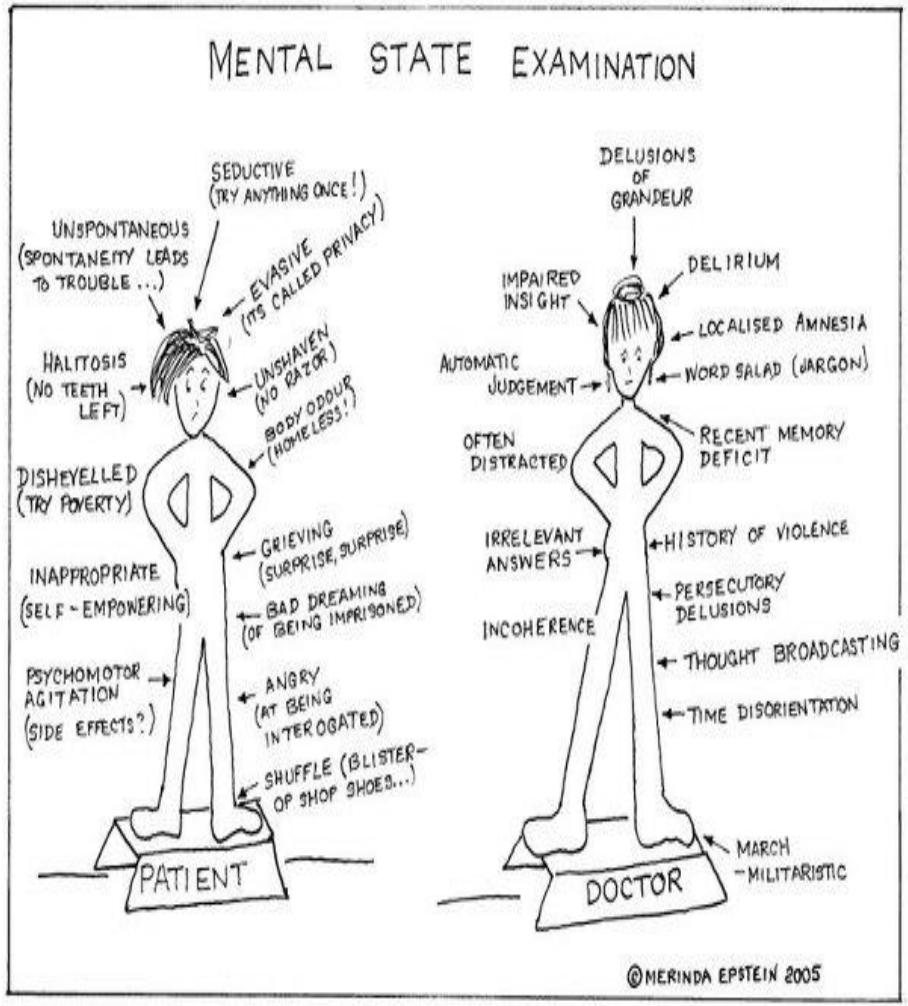
The Mental Status Examination(MSE)





Outlines of MSE:

- Appearance , Behaviour & Attitude (Cooperativeness)
- Speech
- Mood & Affect
- Thoughts
- Perceptions
- Cognitive functions:
  - Consciousness level
  - Orientation (Time, Place, Person)
  - Attention & concentration
  - Memory
  - Language and Reading
  - Visuospatial ability
  - Abstract thinking
- Judgment & Insight



MSE:

- **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)

Impression?!

Impression?!

Impression?!

Impression?!

MSE

- **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
    - Speech impairments (stuttering, dysarthria,. etc)

MSE

- **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..)
  - Its appropriateness whether the affect is to the thought content

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 (sign) (Current emotional state)

MSE

- **Thoughts:**

MSE

- **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

MSE

- **Thoughts:**
- ***Thought form:***
  - ***The way in which a person puts together ideas and associations***
  - ***Examples:***
    1. Goal-directed thinking
    2. Circumstantiality
    3. Tangentiality
    4. Flight of ideas
    5. Loosening of associations or derailment
    6. Clang associations (Rhyming)
    7. Thought blocking
    8. Word salad or incoherence
    9. Neologisms

Most organized

Most disorganized

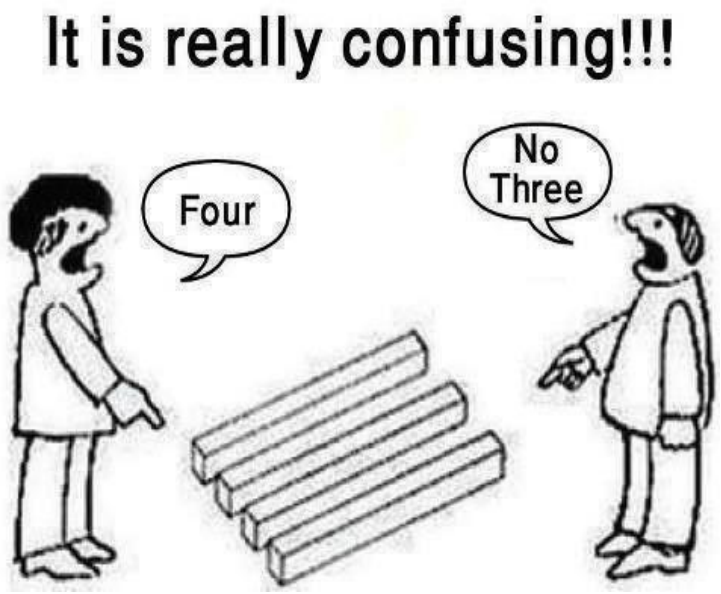
MSE

- **Thoughts:**
- ***Thought content:***
  - What a person is actually thinking about
  - Examples:
    1. Delusions
    2. Preoccupations
    3. Obsessions and compulsions
    4. Phobias
    5. Suicidal or homicidal ideas
    6. Ideas of reference and influence
    7. Poverty of thoughts

Forms (Process)	Contents
➢ The way in which a person puts together ideas and associations. ➢ Examples: 1. Goal-directed thinking 2. Circumstantiality 3. Tangentiality 4. Flight of ideas 5. Loosening of associations or derailment 6. Word salad or incoherence 7. Neologisms 8. Clang associations (Rhyming) 9. Thought blocking	➢ What a person is actually thinking about. ➢ Examples: 1. Delusions 2. Preoccupations 3. Obsessions and compulsions 4. Phobias 5. Suicidal or homicidal ideas 6. Ideas of reference and influence 7. Poverty of thoughts

MSE

- **Perception:**
  - **Illusion:** Misperception of external stimulus.
  - **Hallucinations:** No external stimulus
    - Which sensory system (e.g. auditory, visual..etc...)
    - Content
    - Third person Vs Second person
    - Patient reaction to hallucination
    - Hypnagogic hallucinations hypnopompic hallucinations
    - Pseudo hallucinations
  - **Depersonalization and derealization:** extreme feelings of detachment from the self or the environment
  - **Formication**: The feeling of bugs crawling on or under the skin



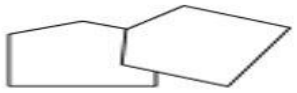
MSE

- **Cognitive functions:**
  - Consciousness level and orientation
  - Attention and concentration : e.g. Serial 7 test
  - Memory:
    1. *Immediate memory / Registration (Spell the word "world" backward)*
    2. *Short term memory*
    3. *Recent memory*
    4. *Remote memory* (long-term memory)
  - **Language and Reading: (When brain pathology is suspected)**
    - Nominal aphasia: name two objects (e.g. a pen and a watch)
    - Expressive aphasia: repeat after you certain words
    - Receptive aphasia: carry out a verbal command
    - 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

Formal Cognitive testing (MMSE)

Mini-Mental State Examination (MMSE)

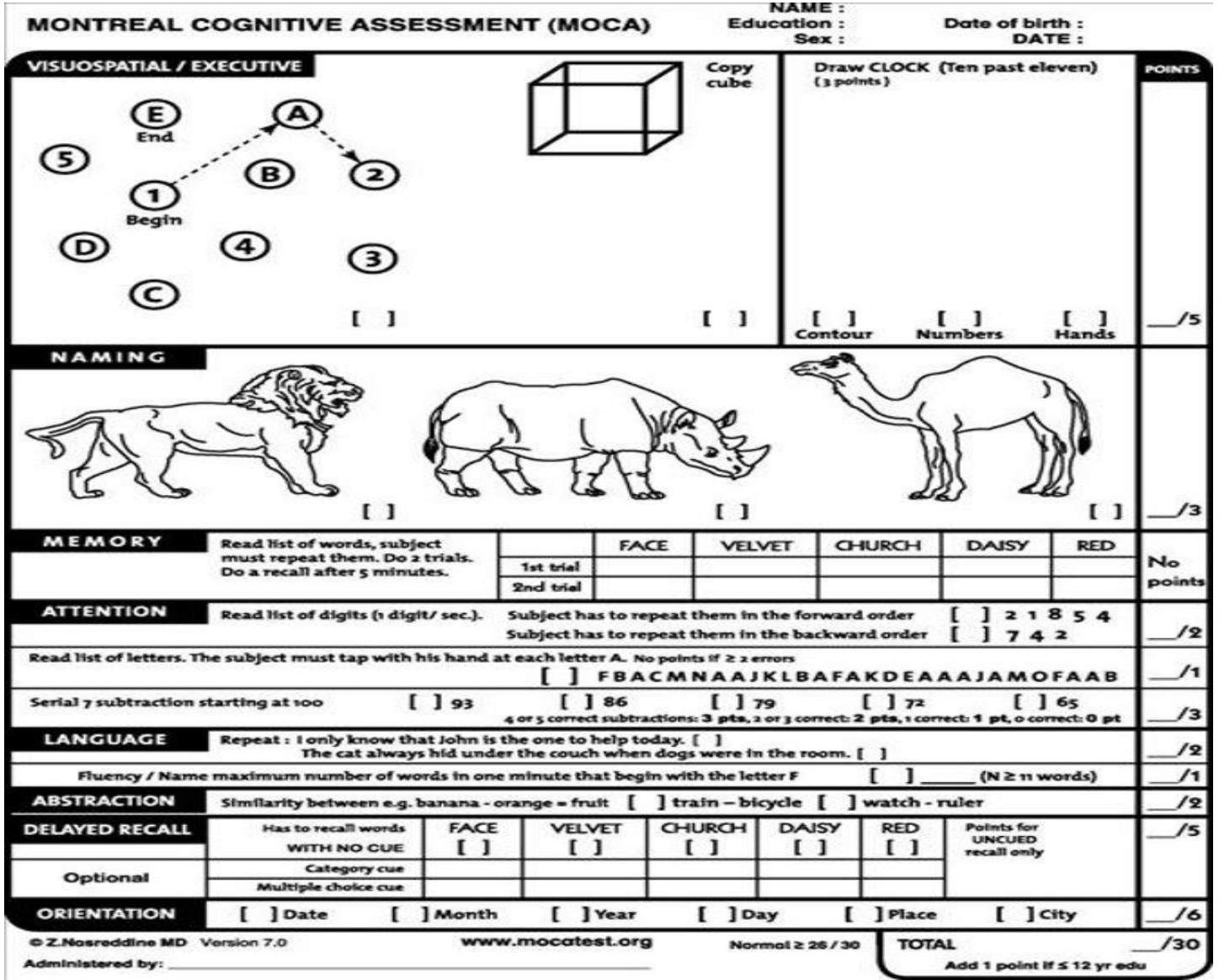
Maximum Score	Score	
		ORIENTATION
5	( )	What is the (year), (season), (date), (day), (month)
5	( )	Where are we (state), (county), (town or city), (hospital), (floor)
		REGISTRATION
3	( )	Name 3 common objects, (e.g. 'apple', 'table', 'penny'). Take 1 second to say each. Then ask the patient to repeat 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 _____

Formal Cognitive testing(MOCA)



MONTREAL COGNITIVE ASSESSMENT (MOCA)

NAME :
Education :
Sex :
Date of birth :
DATE :

VISUOSPATIAL / EXECUTIVE — POINTS

Copy cube

[ ] [ ]

Draw CLOCK (Ten past eleven) (3 points)

[ ] Contour [ ] Numbers [ ] Hands — /5

NAMING

[ ] [ ] [ ] — /3

MEMORY — Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

No points

ATTENTION — Read list of digits (1 digit/ sec.).

Subject has to repeat them in the forward order [ ] 2 1 8 5 4

Subject has to repeat them in the backward order [ ] 7 4 2 — /2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors

[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B — /1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65

4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt — /3

LANGUAGE — Repeat : I only know that John is the one to help today. [ ]

The cat always hid under the couch when dogs were in the room. [ ] — /2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words) — /1

ABSTRACTION — Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler — /2

DELAYED RECALL

	Has to recall words	FACE	VELVET	CHURCH	DAISY	RED	Points for UNCUED recall only
	WITH NO CUE	[ ]	[ ]	[ ]	[ ]	[ ]	
Optional	Category cue						
	Multiple choice cue						

— /5

ORIENTATION — [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City — /6

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Normal ≥ 26 / 30

Administered by: _____

TOTAL — /30

Add 1 point if ≤ 12 yr edu

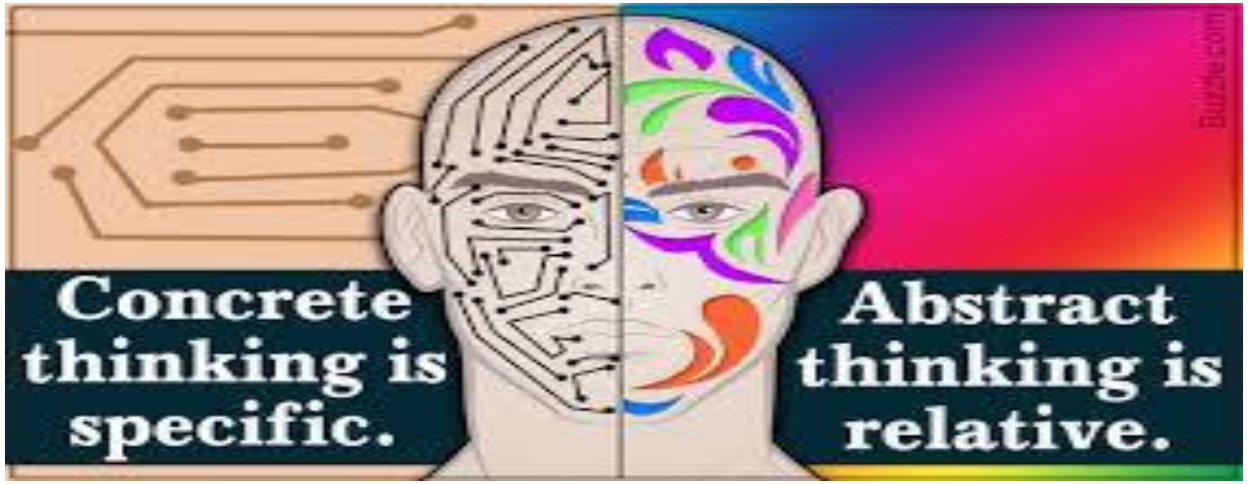
MSE

➢ Cognitive functions:

➢ Abstract Thinking:

- ➢ It is the ability to deal with concepts and to make appropriate inference.
- ➢ 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)



MSE

- **Judgment:**
  - The patient's predicted response and behaviour in imaginary situation.
  - From recent history.
- ***Insight:***
  - The degree of awareness and understanding the patient has that he or she is mentally ill.

MSE

- **levels of insight:**
  - **Complete denial** of illness
  - **Slight awareness** of being sick and needing help but denying it at the same time
  - 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
  - **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
  - **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

Every Interview has three main components:

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

- 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


thank
you