

History Taking & Risk Assessment

&

Mental State Examination

Resource Pack

for use with videos

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Introduction

History taking, risk assessment and the mental state examination are core clinical skills. They are best learned by practice and repetition, and we recommend that you see as many patients as possible in order to enhance your skills.

The purpose of the videos and this accompanying resource pack is to give you a starting point to work from as you learn to take a psychiatric history and do a mental state examination.

The History Taking and Risk Assessment video and The Mental State Examination video feature extracts from patient interviews (conducted by Dr Jan Melichar), divided into sections to illustrate various stages of the interview process. There is also a submenu for further study and revision designed for use with the exercises suggested in this pack. They are suitable for varying levels of skill and can be used independently or in groups. A facilitator or clinical tutor should be able to offer further assistance with the tasks if necessary.

Video 1: Psychiatric History Taking: Main Menu

- ◇ Introduction
- ◇ Presenting Complaint & History of Presenting Complaint
- ◇ Past Psychiatric History
- ◇ Past Medical History & Medication
- ◇ Family History
- ◇ Personal History
- ◇ Premorbid Personality
- ◇ Difficult Questions
- ◇ Risk Assessment
Dr Jonathan Evans
- ◇ Further Study

Video 2: Mental State Examination: Main Menu

- ◇ Introduction
- ◇ Appearance & Behaviour
- ◇ Speech
- ◇ Mood
- ◇ Thought
- ◇ Perceptions
- ◇ Delusions
- ◇ Cognition
- ◇ Insight
- ◇ Conclusion and Credits to both DVDs
- ◇ Further Study - submenu further subdivided into MSE categories

2. Video 1: History Taking & Risk Assessment

Taking a psychiatric history has things in common with any clinical history you take. The major difference is in the social and developmental history, which we cover in more depth.

You may find it helpful to jot down notes as you go along, and this can help you to be methodical in your history taking.

The areas you need to cover include:

- **presenting complaint/history of presenting complaint**
- **past psychiatric history**
- **past medical history**
- **medication**
- **family history**
- **family psychiatric history**
- **personal history -**
 - **birth & early life**
 - **school & qualifications**
 - **higher/further education**
 - **employment**
 - **psychosexual history**
 - **forensic history**
 - **substance use**
- **premorbid personality**

It's not always appropriate to ask all of the questions all of the time. Sometimes it can be better to leave gaps to fill in later, especially if your patient is particularly suspicious and paranoid, or acutely distressed. Some of the history can be gathered from old notes, and from speaking to an informant.

Start off with open questions and focus in on areas with more specific, closed questions as necessary. This gives the patient a chance to talk about their experiences and concerns, whilst allowing you to get the information you need.

Over time you will develop your own style of interviewing. You need to feel comfortable with the style you adopt, so that your questions don't seem awkward or forced.

2.1 Presenting Complaint & History of Presenting Complaint

In the extracts shown, Jan encourages Mrs. Down to describe the problem in her own words. At first, she is not very specific, but with gentle prompting and some echoing of her own words back to her she soon elaborates the problem and talks more freely. Jan then picks up on the complaint of tiredness and asks about specific problems with sleep, aimed at eliciting symptoms of depression. He then goes on to ask about other associated symptoms.

Appendix 1 sets out the symptoms of depression as classified in DSM-IV and ICD-10

Further Study:

- (1) Think about how you might use the symptoms of depression as a framework to structure your history taking. What sort of questions could you use to get the information you need?
- (2) Look up the ICD-10 diagnoses of other common disorders and make a similar list of questions for these.

The presenting complaint and the history of presenting complaint may be difficult to separate, especially in more complicated cases. This doesn't matter: what is important is that you get a good account of what is troubling the patient and thoroughly investigate any associated symptoms.

2.2 Past Psychiatric History

Remember that the patient's understanding of their illness may be different from the formal diagnosis. Corroborative evidence such as previous notes is often helpful. Don't get bogged down with rambling accounts of past admissions if these are frequent; rather, get the basic facts such as rough dates and length of admissions, treatment given and follow-up arrangements.

Further Study: What would be your diagnosis and management plan for Mrs. Jackson before you saw the old notes? How are these altered by the notes?

Further information about Mrs. Jackson is provided by her old notes. These are summarised in Appendix 2.

2.3 Medication

The patient's beliefs about their medication can give useful insight into what they believe is wrong with them. Remember to ask about **side effects** and **compliance** and bear in mind possible **drug interactions**.

Further Study: Look up psychiatric drugs in the BNF and learn the most common side effects and drug interactions for each group. It is particularly useful to do this for each patient you see, looking specifically at the medications they are taking.

2.4 Family History

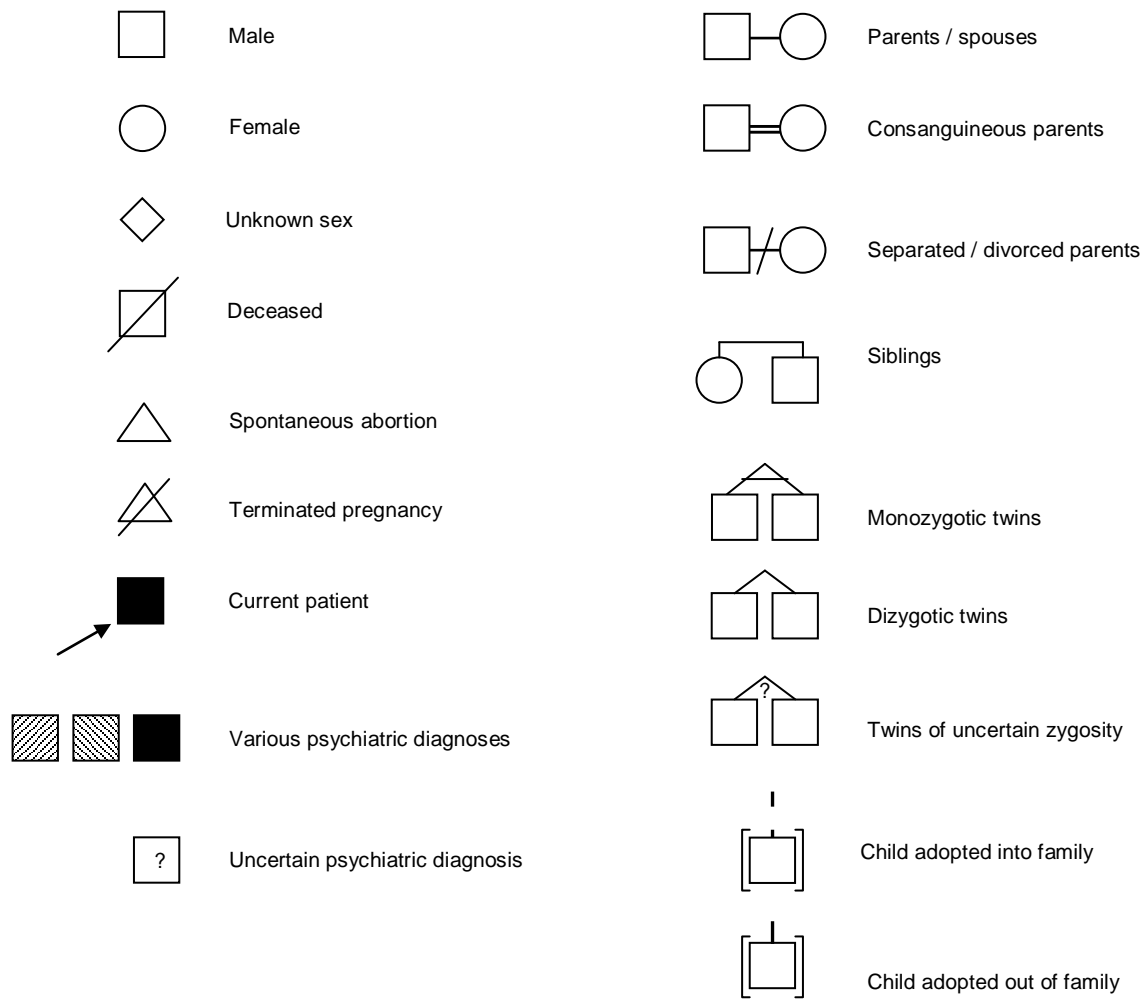
The family history should give you a good indication of a person's family relationships. Find out which members of the family they feel close to, and why. Equally, reasons for discord within the family should be explored. Bear in mind social, psychological and genetic risk factors for mental illness, and remember to ask about family psychiatric history.

Further Study:

1. In pairs, take a family history and draw up a genogram for each other.
2. Think about your own family history and how your family has shaped your attitudes and attributes as an adult.

See figure 1 for the symbols used in genograms.

Figure 1: a list of symbols used in genograms



From Goldberg & Murray *The Maudsley Handbook of Practical Psychiatry*, 4th ed. 2002. Oxford University Press

2.5 Personal History

Personal history is important, as it helps you to understand what has led to your patient becoming the person they are.

It's easiest to work through this in chronological order, remembering that some of the information may have been gathered earlier on. Things you need to ask about briefly include:

- family of origin;
- early experiences;
- schooling;
- friendships;
- qualifications;
- further or higher education.

You can then move on to ask about the following areas:

- employment history;
- interests and current friendships
- significant relationships, marriage and children
- psychosexual history
- forensic History
- use of alcohol and illicit drugs

If there are any problem areas you can go into these in more detail.

Further Study:

1. What features of Alex's personal history suggest a diagnosis of schizophrenia?
2. Using Jan's interview, write down Alex's personal history, and think about ways to take and record this information in a way that makes sense to you.

2.6 Premorbid Personality

Unless you know what the person is usually like, it's difficult to fully understand how their illness has affected them. In asking about premorbid personality, the information from a third party or informant can be particularly helpful. Think about coping styles, interests and activities and how the person usually relates to other people.

Further Study: Look up personality traits in a textbook and try to relate these to people you know.

Make a list of characteristics you might recognise easily and another list of those which are less familiar. Try to look out for these less familiar traits over the next week. How many did you identify?

2.7 Difficult Questions, Difficult Patients

2.7.1 Asking Difficult Questions

You will need to ask some questions which might feel difficult. You might find that the patient doesn't want to talk about a particular topic, or glosses over things. Some techniques you can use in these circumstances include:

- **normalizing statements** (*'Often when people are that down, they feel like they can't carry on . . . have you ever felt like that?'*)
- **symptom expectation/gentle assumptions** (*'What drugs do you use?' rather than 'do you do drugs?'*)
- **symptom exaggeration** (*'3 bottles of vodka. . . four?'*)

When asking about **psychosexual history** be sensitive to your patient's mental state and phrase your questions thoughtfully.

Don't be frightened to ask about suicidal thoughts and plans. Be sensitive in your questioning and remind the patient that you will share information with other professionals as necessary.

2.7.2 Assessing Difficult Patients

Sometimes patients will be reluctant to be interviewed for a variety of reasons. It may be that their mental state makes them suspicious of your motives, or frightened to disclose information. In these circumstances it is important to emphasise that you want to help without giving false reassurances; don't make promises you can't keep ("don't worry, I won't tell anyone"). Be mindful of your own safety and trust your instincts; if you feel threatened it's best to remove yourself from the situation and seek help from a more experienced colleague. It might help to leave a particular line of questioning for a time and move on to more neutral information-gathering until the patient relaxes. Reiterate your aim to help the person with the difficulties they are having, and explain that to understand the problem you do need to ask lots of questions.

Another problem is that of the over-inclusive patient, who wants to tell you about the dress their sister wore at her wedding and the engraving on the groom's cufflinks. You will have to interrupt this monologue, unless you are willing to forgo at least one meal! Keep bringing them back to the point, or change tack entirely if this fails. You can interrupt and be firm without being rude. Consider any implications of the patient's mental state - are they showing signs of mania, or anxiety, or delusional beliefs?

Further Study

- (1) Think about good ways of phrasing difficult questions. Come up with your own list of good questions. See what works well for you.
- (2) Observe your colleagues - what techniques do they use? Try to sit in with as many clinicians as you can.
- (3) Role play exercises: Try out your questions in pairs, with one taking on the role of a "difficult" patient. Think about what makes the situation easier, and how you might inadvertently make it worse.

2.8 Risk Assessment

Questions: these are answered in the interview on the DVD:

1. What kinds of risk are we concerned with?
2. What are the indicators for a risk of self harm and suicide?
3. How can you manage an immediate risk of self harm and suicide?
4. What is the longer term management?
5. How is repeated self harm managed?
6. What are the risk factors for violence?
7. How can you manage the risk of violence?
8. What are the indicators of risk relevant to the Mental State Examination?
9. When should risk be assessed?

2.9 Further Study

Further Study: Mrs. Down

The ***Further Study*** option on the first DVD brings together a number of clips of Mrs. Down.

Further Study:

- (1) Summarise the main points of the history and mental state examination.
- (2) What is your differential diagnosis?
- (3) Are there any important points missing from the history? What else would you like to know?
- (4) Imagine you are seeing Mrs. Down in a follow-up clinic three months later. What will you ask her now?

As an example, Appendix 3 is a transcript of Jan's written notes from the interview with Mrs. Down.

Video 2: Mental State Examination

The mental state examination is an important clinical skill. You will become more accomplished at performing it the more you practise.

Some areas of the mental state examination will be covered in your history taking and will not necessarily need to be revisited. What is important is that you develop a framework in your mind so that you are aware of gaps still to be filled in. It can help to start with a list written down, with space to write in the relevant sections. This will help you to be methodical, but be careful not to be too rigid, and remain empathic.

Areas we look at in the mental state examination DVD:

- Appearance and Behaviour
- Speech
- Mood
- Thought
- Perception
- Delusions
- Cognition
- Insight

3.1 Appearance & Behaviour

Assessment of appearance and behaviour takes place from the first meeting and throughout the interview. In general you need to consider:

- Eye contact and rapport
- Clothing
- Hygiene
- Facial expressions
- Motor behaviours
- Signs of autonomic arousal
- Affect*

* When we talk about a person's affect we're referring to how people convey their **mood** by their **behaviour**.

A "normal" affect, within reason, would be described as reactive and appropriate - that is, laughs at a joke, or cries when sad.

Further Study:

(1) Read some clinical notes to familiarise yourself with terms used in describing appearance and behaviour.

(2) Role play (group work):

Try these short role play exercises. Take it in turns to play the role of patient, doctor and observers, and discuss as a group.

- Patient attending their GP presents with back pain, but their appearance and behaviour prompt the doctor to ask questions about depressive symptoms.
- GP has been asked to see a patient by their spouse. The patient is elated and grandiose and doesn't think anything is wrong - puts any problem down to spouse "trying to put a spanner in the works".
- Patient at GP surgery wanting sick note - employer is fed up with frequent late starts and brief (self certified) absences and has asked for an official sick note. The patient is clearly drunk.

(3) To assess Appearance & Behaviour in various mental states, go to the following buttons. Watch the vignettes and note down your observations as you go.

- Further Study - Appearance and Behaviour - Mrs. Jackson well
- Further Study - Appearance and Behaviour - Mrs. Jackson unwell
- Further Study - Mood - Mrs. Down Monologue
- Further Study - Thoughts - Joe & Sarah (café)
- Further Study - Speech - Alex

3.2 Speech

Speech can be described in terms of its form and volume and content. Form of speech includes the rate, rhythm and fluency of speech, all of which may be affected by mental illness. The content of speech - what the person actually says - reveals their thoughts. Usually we do have some conscious control over which thoughts we vocalise.

Further Study:

(1) Look in notes to familiarise yourself with terms used to describe speech, and look them up in a suitable textbook (see bibliography/suggested reading).

(2) Watch and assess the following extracts and describe the person's speech:

- Further Study - Speech - Joe
- Further Study - Speech - Mrs. Down
- Further Study - Speech - Sarah
- Further Study - Speech - Alex
- Further Study - Insight - Angry
- Further Study - Thoughts - Joe & Sarah (café)
- Further Study - Mood - Bad Doc

3.3 Mood

Mood is often described in terms of elevated or depressed mood, but it is also important to enquire about other mood states such as anxiety and panic. Ask the patient to describe their mood subjectively; you also need to assess their mood and affect objectively. Associated symptoms can be enquired about here if they have not been covered while taking the history.

Further Study:

Have a look at the following sections. For each one try to describe the patient's mood from an objective position:

Further Study - Speech - Sarah

Further Study - Thoughts - Joe & Sarah (café) : Concentrate on Sarah.

Further Study - Mood - Suicide

Further Study - Mood - Panic attack

Further Study - Speech - Alex*

***Alex** displays *incongruent* affect - he giggles when talking about his apparently frightening experiences.

3.4 Thought

Thought is described in terms of *Form* and *Content*.

The café sequence illustrates the connection between thought content and speech. Note that we often edit our thoughts before expressing them in speech, although facial expressions and body language might betray what we are really thinking.

Thought content may be revealed by what the person says, but you will also need to ask questions about their thoughts. Obsessional thoughts, anxious thoughts, and overvalued ideas all need to be considered as they may not be volunteered by the patient. Do their thoughts seem clear to them or muddled, do they have ruminations on particular themes, do their thoughts trouble them.

The animated sequences *Trains of Thought* illustrate various abnormalities of the form of thought. These can be described by a number of terms, and illustrate the breakdown of normal thought processes in psychotic states:

thought block - the flow of thought stops abruptly. This may be interpreted by the patient as

thought withdrawal - the experience of thoughts being removed by a third party

thought insertion - thoughts are experienced as alien, not arising from oneself but being placed there by a third party

thought broadcast - represents a loss of the internal quality of thought, as the patient experiences their thoughts as being accessible to everybody; this is similar but not identical to **gedankenlautverten** where the patient "hears" their own thoughts as they arise

derailment occurs when the thought process changes track abruptly and is similar to **knight's move thinking** and is a more extreme example of **loosening of associations**

flight of ideas is particularly seen in mania. The association between each thought is clear if sometimes unusual.

Further Study:

Look at the following sections on the DVD and think about the thought processes illustrated:

Further Study - Mood - Somatic symptoms

Further Study - Speech - Mrs. Down

Further Study - Speech - Sarah

Mrs. Down describes her sleep disturbance and also describes some **anxious ruminations**. These involve her worrying that she will make a mistake with the accounts, and that as a result she will be in trouble with the Inland Revenue. She knows that this is an irrational fear, and readily admits this but is unable to stop worrying. Further questioning would identify whether this is an **overvalued idea**. She also ruminates on her mother's criticisms which seem unfair, but she is unable to ignore them.

In the Speech section Mrs. Down shows some evidence of **retardation of thought** - her thoughts and speech seem slow and it seems hard for her to find the right words. She has **nihilistic ideas**: she expresses the belief that everything is evil and that destruction of the human race would be a good thing.

Here is a transcript of Sarah's speech:

That programme last night - it was brilliant! I'm going to make one of those extractabubbles - got the design here, it's going to solve the world's problems, take all the bad thoughts away - I'm going to save the world - win the world cup - do you want a cup of tea - tea for two's company - three's a crowd - no fleas allowed - my cat got fleas she hurt her knees . . .

3.5 Perceptions

At the beginning of the perception section, a second voice is heard. Think about your reaction to this voice. Was it disconcerting at all? Where did you think the voice was coming from? Did you find it difficult to follow what the lecturer on-screen was saying?

This voice was a representation of how, to the person experiencing a hallucination, the perception is real.

Hallucinations may be experienced in any sensory modality, but are most commonly auditory. A number of characteristics of auditory hallucinations are particularly important. These are: voices giving a **running commentary** on the person's actions; **command hallucinations** - that is, voices giving orders; and voices arguing in the **third person**.

Further Study: Other areas to look at:

- Further Study - Thoughts - Sarah:
Is there any evidence of perceptual abnormality? At the beginning of the scene she has her (purple) sunglasses on - it could be that she is experiencing visual hyperaesthesia - a heightening of visual perception.
- Further Study - Appearance and Behaviour - Mrs. Jackson unwell:
Does Mrs. Jackson appear to be responding to hallucinations?
- Further Study - Perception - Alex:
Have a look at Alex's interview where he clearly describes a variety of auditory hallucinations including third person auditory hallucinations, voices giving a running commentary and command hallucinations.

3.6 Delusions

Delusions have been described as “un-understandable”, and yet we need to try to understand what they mean to our patient.

Definition:

“A delusion is a false, unshakeable idea or belief which is out of keeping with the patient’s educational, cultural and social background; it is held with extraordinary conviction and subjective certainty.”

A. Sims: Symptoms in the Mind: an introduction to descriptive psychopathology. WB Saunders (2nd ed. 1995)

Further Study:

- Further Study - Delusions - Primary delusions
What are the key features of Mrs. Jackson's beliefs?
- Further Study - Delusions - Whole interview
Look first at the whole interview with Alex, in which he describes a number of delusional beliefs and a complex delusional system. This includes some passivity phenomena - with some prompting he reports that the “telebrain” is able to influence both his thoughts and his emotions. Can you distinguish between *primary* and *secondary* delusions?

You can also look at the questions Jan asks to elicit these phenomena. The Further Study - Delusions menu is further subdivided to help you focus on the questions asked.

3.7 Cognition

You will get a general impression of your patient's cognitive state as the interview progresses, from their vocabulary, level of education and how easily they recall important personal information and dates. Unless you detect a problem, for most people you can briefly screen the following areas:

- **orientation** for time, person and place
- **registration** - ability to repeat new information such as a name and address -
- **recall** - repeating the new information five minutes later
- **concentration and attention** - spelling WORLD backwards or serial sevens
- **general knowledge** - name of prime minister, recent news items etc.

Further Study

- Further Study - Cognition - Folstein MMSE
This section shows an interview with Mrs. Jackson conducted by Dr Jonathan Hewitt, Consultant in Old Age Psychiatry.
- Practice the Folstein MMSE on each other. The questions can be found in Appendix 4. You can photocopy these pages as necessary.
- Appendix 5 has more detailed notes on cognitive examination.

3.8 Insight

One of the questions you need to ask yourself about each patient you see is, why has this particular person presented with this particular problem at this particular time? The patient's ability to answer that question for you during the course of the interview is one measure of their insight. This is true for all patients to some extent, not just those with psychiatric problems.

Further Study:

- The Further Study - Insight menu has examples of patients who are angry, compliant and insightful. How does each one's attitude to their illness affect their insight, and vice versa?
- Think about Sarah in the café. Does she have any insight into her behaviour?

4.1 Appendix 1: Depression

DSM-IV (positive) criteria for a major depressive episode (code 296.xx)
<p>Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure</p> <ol style="list-style-type: none"> (1) depressed mood most of the day ... (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day ... (3) significant weight loss when not dieting or gain... or decrease or increase in appetite ... (4) insomnia or hypersomnia ... (5) psychomotor agitation or retardation... (6) fatigue or loss of energy ... (7) feelings of worthlessness or excessive or inappropriate guilt ... (8) diminished ability to think or concentrate, or indecisiveness (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
ICD-10 description of depressive episode (category F32)
<p>In typical mild, moderate or severe depressive episodes the patient suffers from lowering of mood, reduction of energy and decrease in activity. Capacity for enjoyment, interest and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self confidence are almost always reduced and, even in the mild form, some ideas of guilt and worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so-called 'somatic' symptoms such as</p> <ol style="list-style-type: none"> (1) loss of interest and pleasurable feelings, (2) waking in the morning several hours before the usual time, (3) depression worst in the morning, (4) marked psychomotor retardation, (5) agitation, (6) loss of appetite, (7) weight loss and (8) loss of libido. <p>Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe.</p>

4.2 Appendix 2: Mrs. Jackson: extracts from the notes:

Copies of letters from notes:

Southernhay Belle Psychiatric Unit

Discharge Summary
Jennifer C. Jackson dob 27/09/55

Admitted: 12/2/84
Discharged: 18/3/84

Diagnosis: Major Depression with
Psychosis

Medication on discharge:

Haloperidol 5mg tds
Procyldine 5mg prn
Amytryptiline 75mg bd

Follow-up: 3 month appointment OP
clinic

Notes: Refused to see husband
for first week of admission. Well
on discharge. Denies problems with
marital relationship.

Southernhay Belle Psychiatric Unit

21/06/84

Dear Dr

I reviewed Mrs. Jackson in clinic on
18 June. She remains well and
denies any recurrence of the
auditory hallucinations or
persecutory delusions which she
displayed during her admission. She
reports a steady improvement in her
mood. Sleep and appetite are
normal. She denies suicidal ideas.

I have advised her to reduce her
haloperidol to 5mg nocte and have
asked one of the community
psychiatric nurses to see her to
monitor this reduction.

Yours sincerely

(dictated but not signed)

Notes from conversation with her CPN:

Mrs. Jackson has depression. She has associated psychotic symptoms.

She has had depression on and off for the past ten years and often when she gets low she develops odd beliefs about her husband.

Her first depressive episode happened shortly after she found out that he was having an affair. Their relationship has never fully recovered and it is likely that he has had more affairs in the following years and her bizarre beliefs are some sort of defence against her knowing this.

Recently she has decided that his odd behaviour - leaving the house early, coming home late, keeping his mobile on all the time and jumping to answer it quickly whenever it rings - mean that he is working for MI5.

She takes antidepressant tablets and when she becomes unwell she has antipsychotics which she is happy to take - usually she gets better quite quickly.

She has paranoid and persecutory ideas about her neighbours as well as her husband and that much of her life at the moment is taken up with her delusional interpretation of everyday events.

She does not give up personal details very easily; although she trusts doctors and has faith in medication she also believes that there is nothing wrong with her and that it's everyone else who doesn't realise what is happening.

4.3 Appendix 3: Mrs. Down: transcript of notes

Personal Details

Mrs. Down is a 34 year old housewife and accountant, married with two children (Charlie, age 10, Rachel, age 6).

She has been referred to the psychiatric team by her GP, Dr Patel, who is concerned about her symptoms of anxiety and depression.

Presenting Complaint

"I just don't seem able to cope"

History of Presenting Complaint

Precipitants: Father died suddenly 6 months ago.

Mother has been staying with them on and off since then, is round all the time.

Mother criticising ++.

Now sleeping badly - initial insomnia and EMW and worries about finances and ruminates over her mother's comments.

c/o low mood ("3-4/10")

Appetite - poor - lost 2 or 3 kilos in weight.

snappy with children, arguing with husband

anhedonia - "not enjoying anything much"

c/o poor memory and concentration

suicidal ideas +

1 x impulsive od attempt - got as far as counting out tablets

- no ongoing plans or intent

panic attacks x2 - 1st related to od; 2nd in supermarket

- c/o: hot, sweaty, nausea, palpitations, dyspnoea, dizziness, fear of dying

Past Psychiatric History

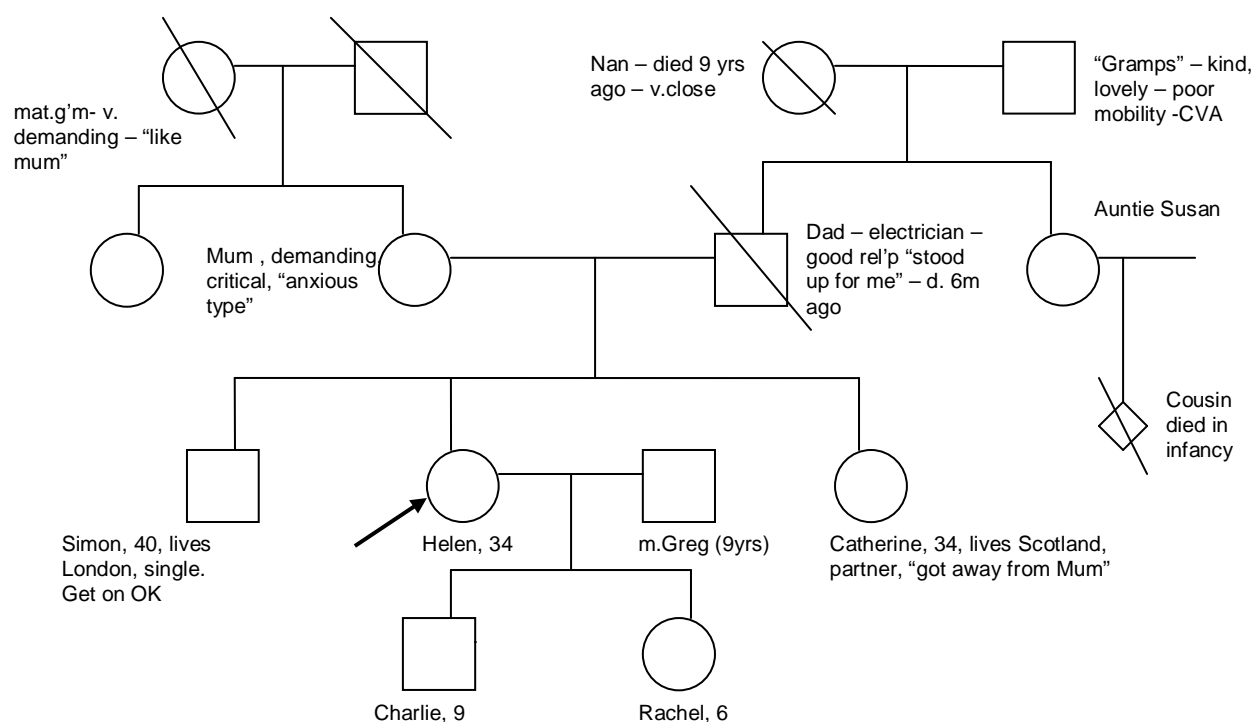
Post-natal depression following birth of 1st child (now aged 9)

- treated with medication (?dothiepin) and counselling

Past Medical History & Medication

asthma - carries salbutamol inhaler but only uses it once or twice a week - usually related to exercise especially in cold weather.

Family History



Family Psychiatric History

- Auntie Susan - ? depression
- Mother "anxious" - no formal diagnosis/Rx

Family Medical History

- Cardiovascular - dad MI, Grandfather CVA
- ?genetic cause for death of cousin in infancy

Personal History

Normal milestones, little memory of early life. Felt responsible for younger sister while growing up - Mum expected her to help out but older brother didn't have to. Liked school, made good friends, did well.

9 GCSE's, 2 A levels, studied accountancy at college

Graduated at 22 and worked in accounts dept publishing company where she met her husband. Enjoyed work but gave up when had first child.

Psychosexual history - 1st sexual experience at 16 - long-term relationship (4 years).

Couple of boyfriends at college. Met husband aged 22

Married at 24 - already 8 months pregnant when got married.

Now the kids are at school helps out in the office doing the accounts for husband who has set up his own business, it's hard work, long hours, "sometimes it feels like only see each other at the office".

Premorbid Personality

"happy-go-lucky"

"coper", "I just get on with things"

Mental State Examination

Appearance & Behaviour

Appears preoccupied, anxious. Eyes downcast. Biting nails, fiddling with wedding ring, chewing lips. Hair appears unwashed, lack of personal care. Clothing drab. Reasonable rapport.

Speech

Hesitant, low volume speech.

Mood

Subjectively - low "3-4/10"

Objectively - depressed, anxious

Suicidal ideas + impulsive attempt but denies ongoing ideas intent - "would never do that to my kids"

Thought content

Anxious ruminations + ? overvalued ideas re. making mistakes with accounts causing catastrophic problems with finances

No formal thought disorder

Perceptions

No hallucinations

Delusions

None but see above re. overvalued ideas

Cognitive Function

c/o poor concentration and memory
registration and recall intact
serial 7's correct, oriented TPP

Insight

Aware she is unwell, feels silly and ashamed about panic attacks and frightened by previous suicidal ideas. Willing to take medication if advised. Hopes to resume more social activities when feeling better.

Summary

34 year old woman with history of depression post-natally but also temporal relationship to bereavement (Nan died shortly before she got married). Recent bereavement - father died 6 months ago exacerbating difficult relationship with mother.

Diagnosis

Recurrent depressive disorder, current episode moderate.

Risk assessment

- Risk to self - admits to suicidal ideas but denies ongoing plans or intent.
- Denies any thoughts of harming others (specifically asked about risks to children).
- Remains able to take care of day-to-day needs of herself and her family.

Notes: *In the Speech section of the Mental State Examination DVD we see Mrs. Down when she is more severely unwell, as she has retardation of speech, retardation of thought and expresses nihilistic ideas.*

4.4 Appendix 4: The Folstein Mini-Mental State Examination (Adapted)

Name:

Date:

You may give support and encouragement, and force a precise reply, but you should not give clues, verbal or non-verbal.

1. Orientation

1. What is today's date?
2. What is the year?
3. What is the month?
4. What day is it today?
5. What season is it?
6. What is the name of this hospital / clinic / place?
7. What floor are we on?
8. What is the name of a street nearby (or near your home)?
9. What town or city are we in?
10. What country are we in?

Score /10

2. Immediate Recall

*Ask the subject to repeat these words. Allow 1 second per word (up to 6 trials).
Score number recalled after the first try.*

11. Ball, Chair, Tree

Number of trials needed to learn all 3: .

Score /3

3. Attention and concentration

12: Begin with 100 and count backwards by 7. (100, 93, 86, 79, 72, 65)

Correct response = any reply that is 7 less than the previous number.

and /or spell the word "WORLD" backwards (DLROW)

Score /5

4. Recall

13. Can you recall the words I said before? (Ball, Chair, Tree)

Score /3

5. Language

14. What is this? (point to 2 objects: Pen, Watch)

Score /2

15. Repeat after me "No ifs, ands or buts" (must be fully correct first time)

Score /1

6. Praxis (three stage command)

16. Take this paper in your right hand (1),
fold it in half (2)
and give it back to me(3).

Avoid non-verbal cues.

Score /3

7. Language, Reading, Comprehension

17. Write "CLOSE YOUR EYES" in large letters on a separate piece of paper.
Ask the subject to read the command and perform the task.

Score /1

8. Praxis

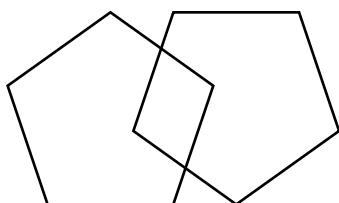
18. Ask the subject to write a sentence, of their own choice.

Correct if it has a subject, an object and a verb.

Score /1

18. Draw the design printed below. Ask the subject to copy the design.

Correct if all sides and angles are preserved and if the intersecting sides form a quadrangle.



Score /1

Total /30.

Adapted from: Folstein MF, Folstein SE, McHugh PR (1975). Mini-Mental State. A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research* 12: 189-198.

4.5 Appendix 5: Cognitive State Examination (Dr Jonathan Hewitt)

Cognition is a term relating to those processes by which we become aware of, make sense of and respond to sensory inputs. The components of cognition are complex and overlapping. They may be divided into 2 groups:

1. Simple functions:

- arousal
- attention
- language
- memory
 - one of many classifications is:
 - immediate (working) / recent (STM) / remote (LTM)
- praxis
- recognition
- visuospatial

2. Complex - or central executive functions

- Functions involving integration / selection / manipulation of information
- Dependent on intact frontal lobe and its connections

The purpose of assessing cognitive function is two-fold.

Firstly, to detect dysfunction, of which the patient may be unaware and which may be due to:

- dementia - chronic, progressive, clear course
- delirium - acute, fluctuating, related to systemic disorder; may be the only symptom or sign of infection etc.
- depression – i.e. “depressive pseudodementia” : acute onset , often past or family psychiatric history, inconsistent and self deprecatory “Don’t know “ answers, depressed demeanor

Secondly to monitor response to treatment or disease progression.

There are countless neuropsychological tests, some of which are highly complex and take hours to complete.

Thankfully there is a brief screening tool, which is very widely used, known as the Mini Mental State Examination (MMSE) or Folstein (1975).

This tests:

- orientation to time and place
- registration
- attention
- recall
- language
- visual constructional abilities

and takes 10 minutes to complete. It produces a score out of 30. At a cut-off of 24/30 it has a sensitivity of 81% and a specificity of 83% for detecting dementia .

As with any screening tool, you need to be aware of its limitations, which are:

- that it is not diagnostic, merely alerting the examiner to the need for further assessment
- floor & ceiling effect - 3 line address test of recall is more sensitive for picking up very early deficits
- language bias
- educational bias
- no test of central executive/ frontal lobe function

In performing the test, you must begin by

- ensuring the subject can see and hear
- explaining what you're doing - some patients may find it threatening or an insult to their intelligence.

Remember to examine:

- demeanor - ? anxious / distracted, ? depressed
- response to questioning - ? covering up gaps, ? crestfallen , catastrophic reaction (marked and sudden irritability in a cognitively taxed patient)

The Mini Mental State Examination can be augmented by other tests:

- 3 line address
- clock drawing test (tests parietal and frontal function)
- frontal lobe tests

Frontal Lobe Tests:

Not included in MMSE

Frontal dysfunction is very disabling and easily missed

History is important - look for

- personality change
- poor judgement
- deteriorating performance at work
- antisocial behaviour
- decreasing self care
- rigidity, inflexibility
- inability to multitask
- inability to solve problems and think in an abstract manner

Bedside tests of frontal lobe function:

- **Verbal fluency** - *semantic* (animals in 1 minute)/ *phonemic* - words beginning with P in 1 minute (normal = 20 and 15 respectively)
- **Proverb interpretation** (i.e. ability to think in an abstract manner) e.g. a bird in the hand is worth two in the bush; people in glass houses shouldn't throw stones.
- **Pattern completion**
- **Similarities** e.g. chair /table, boat/car
- **Differences** e.g. dwarf/child, river/canal
- **Clock drawing test**

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