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***Format of
Psychiatric History and Mental Status Examination***

Structure:

1. Introduction
2. interview Technique
 - Identification data
 - Informants
 - Presenting chief complaints
 - History of present illness
 - Past psychiatric history
 - Past medical and surgical history
 - Treatment history
 - Family history
 - Personal history
 - Personal history
 - Childhood history
 - Educational history
 - Play history
 - Puberty
 - Menstrual and Obstetric history
 - Occupational history
 - Sexual and marital history
 - Pre-morbid personality
 - Physical examination
 - Mental status examination
 - General speech and behavior
 - Speech
 - Mood and affect
 - Thought
 - Perception
 - Cognition and neuropsychiatric assessment
 - Insight
 - Judgment
 - Investigations
 - Diagnostic formulation
 - Summary
 - Revision exercises

Introduction

The technique of psychiatric assessment is important not only for the psychiatrist but also for a medical specialist or practitioner, since large percentage (more than one third) of medical patients have psychiatric disorders.

A. PSYCHIATRIC HISTORY

1. Identification data

It is best to start the interview by obtaining the identification data, i.e.

- Age
- Sex
- Marital status
- Education
- Occupation
- Income
- Residential address
- Official address
- Religion
- Socio economic background
- Informants: - Since some times the history provided by a psychiatric patient may be incomplete due to factors like absent insight or uncooperativeness, it is important to take the history from the patient's relatives or friends or acting as informants. Their identification data should be recorded along with their relationship to the patient, whether they stay with the patient or not, and the duration of stay together. Finally, a comment should be added regarding reliability of the information in percentage, provided by the informants.

2. Presenting chief complaints

Presenting complaints and /or reasons for consultation should be recorded. Both the patient's and the informant's version should be recorded separately. Use the patient's own words while recording patient's version and note the duration of each presenting complaint. Finally students have to record the psychotic and associative symptoms separately with the duration in a chronological order.

Example:	Psychotic symptoms:	
	• Auditory Hallucinations	since 15 days
	• Delusions	since 10 days
	• Aggressiveness	since 5 days
	Associative symptoms:	
• Decreased appetite	since 10 days	
	• Decreased sleep	since 10 days

Additional points to be recorded by the students are:

- Onset of present illness
- Duration of present illness
- Course
- Precipitating factors including life stressors if any
- Aggravating and relieving factors, if any.

3. History of present illness

- When the patient was well the last time should be noted.
- The time of onset should be established.
- The symptoms of the illness from the earliest time at which a change was noticed until the present time should be narrated chronologically, in a coherent manner.
- The presenting chief complaints should be expanded.
- In particular, any disturbances in body functions like sleep, appetite and sexual functioning should be inquired.

4. Life chart

- Graphical representation of the previous episodes with year and duration, precipitating factors, treatment duration and place, symptoms presented in each episodes, drug compliance in between the episodes and complete asymptomatic periods etc.

5. Past psychiatric history

- Explanation of the previous episodes from the first episode till the episode prior to the present episode.
- Other history regarding alcohol or drug abuse or dependence.

6. Past medical and surgical history

- History of any serious medical, neurological or surgical illness, surgical procedure, accident and hospitalization is obtained.
- Past history of head injury, convulsions, unconsciousness, diabetes mellitus, hypertension, coronary artery disease etc.

7. Treatment history

- Details of the treatment given in the present episode and the previous episodes should be asked along with the response to treatment.

8. Family history

- **Family structure:** - Drawing of a family tree (pedigree chart) helps in recording all the relevant information in very little space and is easily readable. It should be noted whether the family is nuclear or extended nuclear family. If consanguineous relationship is present it should be recorded. Age and cause of death should be asked. Three generations including patient should be included in the genogram.
- **Family history:** - of similar or other psychiatric illnesses, major medical illnesses, alcohol or drug dependence and suicide or suicide attempts should be recorded.
- **Current social situation:** - home circumstances, per capita income, socio economic status, leader of the family and current attitude of the family members towards the patient's illness should be noted. The communication patterns in the family, range of affectivity, cultural and religious values and social support system should be inquired about, when relevant.

9. Personal history

- **Perinatal history:** - Any febrile illness, medications, drugs and/or alcohol use, trauma to abdomen and any physical or psychiatric illness during pregnancy (particularly in the first three months of gestation) should be asked. Other relevant questions are: whether a wanted or unwanted child, date of birth, whether normal or abnormal delivery, any instrumentation, where born (hospital/home), any perinatal complication (cyanosis, convulsions, jaundice), birth cry (immediate or delayed), birth defects, any prematurity.

10. Childhood history

- Patient was brought up by mother or someone else
- Breast feeding
- Weaning
- Maternal deprivation
- Age and ease of toilet training
- Occurrence of neurotic traits such as Stuttering / stammering / tics / enuresis / encopresis / night terrors / thumb sucking / nail biting / head banging / body rocking / morbid fears or phobias / somnambulism / temper tantrums.

11. Educational history

- Age of beginning and finishing formal education, academic achievements and relationships with peers and teachers should be asked.
- Any school phobia, non-attendance, truancy, any learning difficulties, and reasons for termination of studies (if occurs prematurely) should be noted.

12. Play history

- What games were played at what age with whom and where.
- Relationships with peers, particularly the opposite sex should be recorded.
- Leadership roles / aggressive behaviors should be recorded.

13. Menstrual and obstetric history

- Regularity and duration of menses, the length of each cycle, any abnormalities, the last menstrual period, the number of children born, termination of pregnancy if any should be asked.

14. Occupational history

- The age starting work
- Jobs held in chronological order
- Reasons for changes
- Job satisfactions
- Ambitions
- Relationships with authorities, peers and subordinates
- Present income and whether the job is appropriate to the educational and family background should be asked.

15. Sexual and marital history

- Sexual information, how acquired and what kind,
- Masturbation
- Adolescent sexual activity
- Premarital and extramarital sexual relationships
- Sexual practices (normal/abnormal)
- Any gender identity disorder
- Duration of marriage
- Marriage arranged with or without consent of parents or by self choice
- Number of marriages/ divorces/separations
- Role in marriage, interpersonal and sexual relations
- Contraceptive measures used
- Sexual satisfactions
- Mode and frequency of sexual intercourse
- Psychosexual dysfunctions if any

16. Premorbid personality (PMP)

- **Interpersonal relationship:-** Interpersonal relationship with family members, friends, work-mates and superiors, introverted / extroverted, ease of making and keeping the social relations
- **Use of leisure time:-** hobbies; interests; intellectual activities; energetic and sedentary
- **Predominant mood:** - optimistic / pessimistic; stable / prone to anxiety; cheerful / despondent; reaction to stressful life events.
- **Attitude to self:** - self – confidence level; self-criticism; selfish/thoughtful of others/ self appraisal of abilities, achievements and failures.

- **Attitude to work and responsibility:** - decision making; acceptance of responsibility; flexibility; perseverance; foresight.
- **Religious beliefs and moral attitudes:** - religious beliefs; tolerance to other's beliefs and standards; altruism.
- **Fantasy life:-** sexual and non sexual fantasies; daydreaming – frequency and content; recurrent or favorite daydreams; dreams
- **Habits :-** food habits; alcohol, tobacco, drug use; sleep habits

B. PHYSICAL EXAMINATION

A detailed general physical examination and systemic examination is a must in every patient. Physical disease which is etiologically important, accidentally co-existent or secondarily caused by the psychiatric condition, is often present.

C. MENTAL STATUS EXAMINATION

1. General appearance and behavior

- ❖ **General appearance:-** the points to be noted are
 - a) Body build and physical appearance
 - b) Looks comfortable / uncomfortable
 - c) Physical health
 - d) Grooming
 - e) Hygiene
 - f) Self care
 - g) Dressing(adequate / appropriate)
 - h) Face – non verbal expression of mood
- ❖ **Attitude towards the examiner**
 - a) Cooperation
 - b) Guardedness
 - c) Evasiveness
 - d) Hostility
 - e) Attentiveness
 - f) Shows interest
 - g) Appears disinterested
- ❖ **Comprehension**
 - a) Intact / impaired
- ❖ **Gait and posture**
 - a) Normal/abnormal
 - b) Way of sitting/standing/waking/ lying
- ❖ **Motor activity**
 - a) Increased/decreased
 - b) Excitement / stupor
 - c) Abnormal involuntary movements like tics, tremors
 - d) Restlessness/akathisia
 - e) Catatonic signs (mannerisms, stereotypes, posturing, waxy-flexibility, negativism, ambitendency, automatic

obedience, echopraxia, psychological pillow, forced grasping/ conversion and dissociative signs, withdrawal)

❖ **Social manner**

- a) Increased / decreased / inappropriate

❖ **Rapport**

Whether working empathic relationship can be established with the patient

❖ **Hallucinatory behavior**

- a) Smiling without reason
- b) Crying without reason
- c) Muttering/talking to self
- d) Odd gesturing in response to auditory or visual hallucination

2. **Speech**

- a) **Rate and quality of speech:-** mutism; if present whether it is spontaneous/increased or decreased productivity, rate is rapid or slow; pressure of speech; poverty of speech
- b) **Volume and tone of speech:-** increased or decreased
- c) **Flow and rhythm of speech:-** smooth and hesitant, dysprosody, blocking, circumstantiality, tangentiality, loosening of associations, verbigeration, stereotypes (verbal), flight of ideas, clang associations

3. **Mood and affect**

In addition to nonverbal mood observed and described under general appearance and behavior patient is asked about present mood. This is recorded as *subjective affect*, while the observed emotional change is described as *objective affect*.

Mood is described as general warmth, euphoria, elation, exaltation, and ecstasy in mania; anxious and restless in anxiety and depression; sad, irritable, angry despaired in depression.

Shallow /blunted, indifferent, restricted, inappropriate, and labile in schizophrenia. Anhedonia may occur for schizophrenia and depression.

4. **Thought**

- a) **Stream and thought:** - stream of thought overlaps with examination of “speech”.
 - Spontaneity,
 - Productivity
 - Flight of ideas
 - Poverty of content of speech
 - Thought block
 - Loosening of associations
 - Tangentiality

- Circumstantiality
- Illogical thinking
- Perseveration
- Verbigeration

b) Content of thought

- Obsessions
- Phobias
- Delusions
- Ideas
- Hopelessness
- Hypochondriacal symptoms
- Helplessness
- Worthlessness
- Suicide
- Neologism

5. Perception

- a) **Hallucinations** :- reason for hallucination, type of hallucination(visual, auditory...), detailing of hallucination if present, and it is second person or third person hallucination
- b) **Illusions and misinterpretation**:- visual/auditory/ or other sensory/ occur in clear consciousness or not.
- c) **Depersonalization and derealisation**
- d) **Somatic passivity phenomenon**
- e) **Others**:- abnormal vestibular sensation

6. Cognition

- ❖ **Consciousness**: - conscious/ confusion / clouding / delirium / stupor / coma. Any disturbances should be rated in Glasgow Coma Scale.
- ❖ **Orientation** :- well oriented to time , place and person
- ❖ **Attention**: - is the attention easily aroused and sustained. Digit span test.
- ❖ **Concentration**: - can the patient concentrate; ease of distractibility.
E.g.: -Serial subtraction test.
- ❖ **Memory**:-
 - a) **Immediate retention and recall**
 - b) **Recent memory**
 - c) **Remote memory**
- ❖ **Intelligence**: - Ask questions about general information, keeping in mind patient's educational and social background, his experiences and interests. Tests for reading and writing. Give simple tests of calculation.
- ❖ **Abstract thinking**: - It assesses patient's concept formation. Proverb testing, similarities and differences.

7. Insight :- 6 – point scale

- a) Complete denial of illness
- b) Slight awareness of being sick and needing help, but denying it at the same time
- c) Awareness of being sick, but attributes it to external or physical factors
- d) Awareness of being sick, due to something unknown to self
- e) Intellectual insight
- f) True emotional insight

8. Judgment

- ❖ **Social judgment**
- ❖ **Test judgment**

Formulation of case diagnosis:-

After a complete psychiatric assessment the diagnostic formulation summarizes the detailed positive (and important negative) information regarding the patient under focus before listing a differential diagnosis. Inference of each component of MSE should be taken in to account while formulating the diagnosis.

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