Mental State Examination (MSE)

Appearance and behaviour

Appearance is described as well groomed/dishevelled, how they are dressed, demeanour in interview, level of eye contact. In males -shaving. As appropriate, physical behaviour such as restlessness, motor activity [retardation/overactivation] Level of co-operation, any evidence of aggression or hostility. Overfamiliarity, for instance touching interviewer inappropriately.

Speech

Rate ranges from "poverty of speech" with few utterances to "pressure of speech", spontaneity with little or no spontaneous utterances to circumstantiality with overinclusion of detail, volume: from low to high, rhythm: monotonous, without variation or inflection; staccato, with frequent pauses between fluent speech, and normal., tone: ranges from low to high.

Mood

Described subjectively, i.e. the patients own perception, and objectively, i.e. outside observation by interviewer. Comment also on congruity with presentation. Described as mildly/moderately/severely depressed, normothymic [i.e. "even" or "normal"] or mildly/moderately/severely elated, or labile - when mood abruptly changes from one state to another.

Affect

Overall emotional tone as objectively observed during interview. Reactivity to what is being discussed - i.e. being appropriately distressed describing upsetting occurrences, laughing or smiling if appropriate.

Thought form and content

Refer to psychopathology lecture on Blackboard for definitions used. **Thought form is** how the person's thoughts are expressed in their speech. **Thought content** relates to the actual thoughts described. Thought form ranges from easily understandable, coherent speech to loosening of associations to incomprehensible "word salad". Thought content refers to delusions, overvalued ideas, preoccupations, and obsessions. Refer to lecture material on Blackboard on psychopathology.

Perception

Abnormal perceptions refer to illusions and hallucinations. Please refer to psychopathology material for definitions. The most commonly encountered hallucinations in psychiatry are auditory. Need to assess if a true hallucination (occurring in external space and not subject to control by the individual). If auditory hallucinations present, the quality (happening in internal or external space, whether any control is exerted by the person, whether they are first/second person, whether they comment on the person's thoughts or actions, whether they command the person to do things (important from risk assessment point of view)

Risk

A vital part of history taking in clinical practice. Risk to self - self-harm/suicide. Distinguish between thoughts, planning, intent. Refer to psychopathology lecture on Blackboard. Risk to others. Other risks (self-neglect, carer abuse etc). This important theme is further developed in MDSA40150 Final Year Psychiatry.

Cognition

Need to assess orientation in time, place and person, and gross tests of long and short term memory. If indicated, Folstein's MMSE and other tests to be performed.

Insight

Not "all-or-nothing." Can be broken down into acceptance of their being a problem, it being psychological/psychiatric in nature, acceptance that help is needed and agreement with recommended help of treating team.