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Diagnosis and the Mental Status Examination

And here's the final piece of the diagnostic puzzle. In general, the MSE is simply a statement of how a person looks, feels, and behaves at the moment of examination. Nearly as important are the characteristics a person *doesn't* show. For example, although Carson's MSE (see Chapter 1) specifically reflected depression, feelings of panic, tearfulness, trouble concentrating, worries, and feelings of abandonment, he *didn't* have hallucinations or delusions. Findings such as these, which help rule out a diagnosis that seems otherwise a real possibility, are called *pertinent negatives*. They should not only be inquired after, but faithfully reported in the clinician's write-up.

In addition to noting pertinent negatives, we clinicians must keep in mind that though the MSE is important, it is really only a snapshot of a patient at a single point in time. It can be tempting to overemphasize particular symptoms observed during the MSE at the expense of other building blocks of diagnosis, and clinicians sometimes yield to this temptation (see the sidebar "Is the MSE Overrated?").

Appearance

Much of the MSE requires no questioning at all, only observation of the patient during an ordinary conversation. Nearly all the material in this section and the next two ("Mood/Affect" and "Flow of Speech") falls into that category.

General Appearance

Information concerning general appearance should be evident even to an unpracticed eye. You probably won't be able to diagnose your patient based on appearance alone, though it can signal some possibilities. As Mark Twain almost said, clothes make the individual. For example, if you see an adult who wears tattered, bizarre, or dirty clothing (or is otherwise gener-

Is the MSE Overrated?

Although the MSE is an important part of diagnosis and the database, can it ever be overrated? I'm afraid that it sometimes is. Traditionally coming at the very end of a diagnostic examination, the MSE is nonetheless where too many clinicians begin. Scientific studies of diagnosis have shown that we clinicians may too quickly jump to conclusions based on a single, arresting symptom. That's because we wrongly assume that really dramatic symptoms can mean only one thing; in the case of hallucinations and delusions, for example, this would be schizophrenia.

We forget that there is probably no mental symptom that can have only one interpretation. Even a symptom as seemingly specialized as the belief that one is pregnant (when one is not) can be found in conditions as diverse as mania, depression, dementia, and substance use. Consider the writer Virginia Woolf: On at least five occasions throughout her life, she became acutely and severely ill with delusional ideas about her supposed guilt and the worthlessness of her work. She hallucinated voices so terrifying that she could never bring herself to describe them. Yet within weeks or months she recovered completely—each time except the last, when she weighted her fur coat with a stone in the pocket and drowned herself in the icy March waters of the river Ouse. The lesson: Mental status symptoms should never put us into a box, but onto a decision tree.

Far from being the only important factor in diagnosis, the MSE often isn't even the *most* important. MSE information doesn't usually make or break a diagnosis; much of the time, the longitudinal evaluation has greater diagnostic value than does the cross-sectional appearance. What the MSE should do is set flags that warn you of the possibilities, which you must in turn evaluate in the context of all you have learned from the patient's own history and from the information provided by relatives, old charts, and previous clinicians.

ally untidy), schizophrenia and other psychoses, dementia, and the more extreme effects of substance use come to mind. If the patient is a teenager or child, the options will be broader still. And of course, excessive thinness can signal anorexia nervosa, especially if the person is a young woman.

An office patient I once evaluated turned out to be one of the most anxious individuals I have ever known. My first clue was upon shaking hands with Douglas, when I felt a bulge of enlarged muscle at the base of his right palm. He said that he was a draftsman, and he habitually clutched his pen as if it were trying to escape. Over the years, that muscle had grown huge from the tension of his grip.

Level of Attention

How alert is your patient? If the patient is drowsy or inattentive, delirium, possibly coupled to a medical disorder or a substance use problem, may be responsible. On the other end of the attention spectrum is hypervigilance, in which the patient glances frequently around the room, as though trying to locate the source of voices or a threat. Hypervigilance suggests PTSD, but it is also often associated with paranoid delusions found in psychoses. Perhaps it is more frequently encountered in someone like Lester, who accompanied his wife to counseling, though evidently not in spirit. His wandering gaze, refusal to give eye contact to anyone in the room, and frequent responses of “Huh? Oh, sorry!” clearly proclaimed his lack of investment in the proceedings. He reminded me of my high school civics course, conducted—I wouldn’t say taught—every spring by the baseball coach. Even when he lectured, he mostly gazed out the window that overlooked the diamond. It was crystal clear that he wished himself elsewhere (a sentiment fervently endorsed by his students).

Of course, ability to sustain attention is famously associated with ADHD, which typically occurs in children and adolescents, but is increasingly found to affect adults too. More than once, ADHD has been finally diagnosed in a parent whose child has just been evaluated for inattention and motor restlessness.

Amount of Activity

Your patient’s activity level can be an important indicator of diagnosis. The most common observation is increased motor activity, such as the jiggling leg or frequent hand wringing that indicates simple anxiety, or perhaps the desire to run away. Abnormal body movements can indicate that the person has been using a medication, perhaps one of the older, now less popular antipsychotic drugs such as Prolixin or Haldol; then you might suspect a psychotic disorder. The classic back-and-forth “pill-rolling” tremor, which may indicate naturally occurring Parkinson’s disease, can also result from these medications. An involuntary movement of lips, mouth, and upper limbs referred to as *tardive dyskinesia*, and the restless inability to sit still referred to as *akathisia* (such a patient feels the need to keep quite literally on the move), are two additional movement disorders related to these drugs. Table 9.3 lists some of the motor behaviors related to substance misuse. Although excessive motion is probably the more common finding in mental health patients, a facial expression that shows little mobility—

sometimes seeming nearly frozen—can be found in patients suffering from dementia or severe depression. The classic, nearly complete immobility of catatonia is now rare.

Mood/Affect

We'll define *mood* as how we feel, *affect* as how we appear to feel. Let's briefly discuss three qualities of mood/affect: its *type*, *lability* (the degree to which it changes in a given time frame), and *appropriateness*.

We think of mood as diagnostic: We equate euphoria with mania, sadness with major depression or dysthymia. But who among us hasn't experienced these feelings, without other indicators of illness? Indeed, a person's emotional state doesn't usually convey much about diagnosis. Anger (and its cousin, hostility), anxiety, shame, joy, fear, guilt, surprise, disgust, and irritation are emotions that can occur in mental disorders, though most of the time they are perfectly normal. Patients who worry about normal moods will often benefit from simple reassurance.

Excessive lability of mood may yield more accurate diagnostic inferences. For example, a person whose mood often shifts between extremes (from laughter to weeping and rapidly back, or into sudden fury without apparent cause) should be considered for somatizing disorders, mania, and the dementias. Unheralded outbursts of temper occasionally indicate medical conditions such as brain infections or tumors. Affect that hardly budges (decreased lability) can suggest Parkinson's disease, severe depression, schizophrenia, or dementia.

The third quality of mood is its appropriateness to the person's content of thought. When I interviewed Joan, she giggled as she talked about the recent death of her mother. That sort of inappropriateness of affect to content brings to mind two possibilities: mania and the form of schizophrenia that used to be called *disorganized* (before DSM-5 discarded the subtypes). Joan had had episodes of psychosis, followed by depression, then long stretches when she was completely normal—clearly suggesting bipolar I disorder. You'll also encounter inappropriate mood when someone with somatic symptom disorder discusses a current physical problem, such as paralysis or blindness, with none of the apprehension you'd expect for such a serious condition.

Depression is the mood symptom most often noted during the MSE. Because of its ubiquity, potential for harm, and response to treatment, I look for depression in every new patient—and a lot of old ones. This is important

Diagnostic Principle: Because of their ubiquity, potential for harm, and ready response to treatment, *always* consider mood disorders.

enough to rate its own diagnostic principle. Of course, *always* is always a bit over the top, but depression is so common, so important, and so often missed that I've left in the intensifier.

Flow of Speech

Although flow of speech can reveal several possible clues to diagnosis, let's first acknowledge that most of us have speech quirks that aren't usually pathological at all. Examples include verbal tics (such as "you know," "what-ever," "awesome," and "like, no way"), *circumstantial speech* (where a person relates several life histories before coming to the point), and speech so distractible that it nearly drives you nuts trying to communicate.

Probably the best-known type of actual speech pathology is known as *loose associations*, or sometimes *derailment*. Loose associations occur when thought coherence breaks down, so that one idea skids into another that isn't clearly related. Although you can understand the sequence of words, the direction they take is nowhere on the compass. The result is illogical speech or writing that may mean something to the patient, but that doesn't communicate this meaning to others. Here is an extreme example:

"I found out that the English tea which the British drink. And that clam chowder isn't different, like Indian corn is American food. But England has a king, queen, and a prince. Princess Anne is married to an Englishman. Now medication is for help of accidents, sickness, burned people, and blackouts and dizzy spells like me. The truth of Europe, in fact Japan has tea, too. And America. Thanks."

Loose associations and other, less common speech patterns (such as *incoherence*, *neologisms*, *perseveration*, and *echolalia*) are usually said to be characteristic of schizophrenia, though they can also occur in mania and dementia.

How rapidly someone responds to questions is called *latency of response*; marked deviations often point to a mood disorder. Very long latency is characteristic of severe depression, whereas reduced latency, in which the patient answers almost before you reach the question mark, is often found in mania. In *poverty of speech*, a patient will spontaneously speak little or not at all; it can suggest depression or schizophrenia.

Content of Thought

In the history of the present illness, you will have already encountered most of the material usually considered content of thought. The implications of this information are pretty straightforward.

No matter how you frame them, delusions and hallucinations almost always mean psychosis. However, the sort of delusion you encounter can help define the type of psychosis. Delusions of influence, persecution, passivity (a patient is being acted upon by some outside influence), reference (comments are being made about the patient), thought control, or thought broadcasting (patients feel their thoughts are being transmitted, as by radio waves) often suggest schizophrenia, especially what we used to call (again, before DSM-5 took away all the subtypes) paranoid schizophrenia. Delusions of ill health (having a terrible disease) or even of being dead can indicate either schizophrenia or severe depression. Delusions of grandeur, in which patients believe they have great powers or are famous beings such as God or Madonna (either of them), are classic for mania but can also be encountered in schizophrenia. Delusional guilt suggests either depression or delusional disorder, whereas a delusion that one has become impoverished usually indicates profound depression.

Also note mood *congruence*, which refers to how well mood matches the content of the person's delusion. When I asked a woman I once treated for a postpartum manic psychosis why she seemed so happy and contented, she said it was because she knew she had "the little baby Jesus at home in his crib." Such mood-congruent delusions usually indicate a mood disorder. On the other hand, the delusions of schizophrenia are often mood-incongruent, as with the young man who believed that he was the son of Jay Leno and that he could change the weather. Despite these grandiose delusions, he knew that his mental condition had prevented him from maintaining a job and having a normal social life, and he felt severely depressed as a result.

You might encounter hallucinations of any of the senses in a psychosis caused by a medical or substance use disorder, such as delirium tremens, dementia, brain tumor, toxicity, or seizures. In schizophrenia, whereas most hallucinations are auditory, some are visual, and infrequently you will encounter hallucinations of the other senses. The vivid, dream-like states that we have when awakening or falling asleep are respectively called *hypnopompic* and *hypnagogic* hallucinations, but they are completely normal. Also normal are illusions, *déjà vu*, overvalued ideas (such as a belief in the superiority of one's religion or ethnic background), and depersonalization that is neither protracted nor extreme.

Although phobias or obsessions and compulsions often signal a specific anxiety disorder or OCD, keep in mind two general issues. One is that, as with anxiety in general, a minor degree of these symptoms is common and not at all abnormal. The second, which we'll discuss further in Chapter 12, is the clinical tendency to focus on dramatic phobias and compulsions while ignoring the quiet little depression that sometimes lurks underneath.

Finally, we must mention thoughts about suicide, homicide, and other forms of violence. Suicidal ideas most often point to depression, though they can also indicate a personality disorder (especially borderline), substance use, or schizophrenia. If ideas concerning violence indicate any mental disorder at all, it will usually be one of the three conditions just named. But violence and homicide are more typical of plain old criminal activity. Remember the Godfather.

Cognition and Intellectual Resources

Reasoning, mathematical ability, and abstract thinking (such as recognizing similarities and differences) largely depend on the person's education and native intelligence; these abilities will therefore be prominently deficient in intellectual disability and other developmental disorders, such as autism spectrum disorder. They can also be clouded by serious mental illnesses such as dementia, schizophrenia, and mood disorders. Problems with comprehension, fluency, naming, repetition, reading, and writing, other than those you might expect from non-native speakers, suggest the need for neurological evaluation.

Orientation is only occasionally deficient, and then almost always it indicates a cognitive disorder—either delirium or dementia. Occasionally a psychotic patient may claim to be Zog from Mars who lives in the Fifth Dimension, but we would say that such a person is delusional, not disoriented. Impairment of short-term memory can point to dementia, delirium, a psychosis, a mood disorder, or just plain anxiety.

Insight and Judgment

The amount of specific diagnostic information you can gather from the patient's insight may be less than overwhelming. Poor insight into the fact of having a mental disorder often indicates psychosis, but it is also common in patients with dementia and delirium, and can even occur in alcoholism.

You'll also encounter deficient insight in diagnoses we don't automatically associate with psychosis, such as severe mood disorders, dissociative identity disorder, anorexia nervosa, body dysmorphic disorder, and instances of OCD so severe that the individual may not identify the compulsive behaviors as irrational.

Both insight and judgment also heavily depend on factors that no one would consider abnormal. One is the person's age: Up to the early teen years, children lack perspective on their own behavior and emotions, and even later on they still do not have a fully developed ability to comprehend the consequences of their own actions. Hence the 2005 U.S. Supreme Court ruling against capital punishment for minors. To a degree, the insight and judgment of adults are also affected by native intelligence, education and cultural issues such as superstition and prejudice.

Like insight, judgment may be affected by psychosis and delirium. Any personality disorder can also affect insight (who among us readily admits to having character flaws?), but judgment is especially vulnerable to the more severe forms of personality disorder, such as borderline and antisocial.

With the conclusion of Part II, *you* now have insight into the full range of information you'll need to make accurate diagnoses in your patients. This is the raw material we use during the diagnostic levels already described in Part I. Always keep mentally prepared, however, for new information that could necessitate a reassessment of the facts—as you thought you knew them.