

The Mental Status Examination

Uniformed Service University of the Health Sciences
Department of Psychiatry

Objectives: At the completion of the class, students should be able to:

1. Describe the main components of the mental status examination
2. Compose a mental status examination based on a patient observation and interview
3. Recognize the difference between thought process and thought content
4. Estimate degree of psychopathology based on the mental status examination
5. Document adequate safety (suicidal and homicidal) assessment of each patient

The **Mental Status Examination** is an integral portion of the psychiatric interview. It serves as a “snapshot” of the person you are evaluating. It should include all of the pertinent observations and findings you accomplish during your encounter with the patient. Not only is it important for describing the “state” of the patient, it is an important tool that can help substantiate a diagnosis, convey information to another provider, and assist in determining most appropriate step in treatment.

Based on the following sections, the mental status examination may appear quite involved and complicated. *This is not the case.* As you will see, much of the information for the mental status examination is obtained from the natural course of the interview.

It is important to state that the goal is not pinpoint the absolute correct term to describe an observation. The beauty of the mental status examination is, even if you do not know the specific term, *you can use your own words and observations.*

APPEARANCE

Yes, this is as straightforward as it sounds – this section describes how the patient looks, smells, behaves, speaks, establishes eye contact, etc. If this section is thorough enough, a reader of your mental status exam should be able to pick out the person out of a room. The mental status exam starts when you first set eyes on the patient. The following is a sample of items that should be included in the APPEARANCE section:

- Ethnicity
- Apparent age (younger, older, or appeared stated age)
- Sex
- Coordination/gait/notable movements
- Adherence to social conventions (i.e., shakes hands, military bearing)
- Build (Average, underweight, emaciated, petite, thin, obese, muscular)
- Grooming (Good, poor, adequate, immaculate, neglected)
- Dress (Casual, stylish, mismatched items, formal, tattered, appropriate for particular setting)
- Psychomotor activity (Described as increased in the case of agitation; decreased in cases of depression or catatonia)

A description of how the patient **relates to the interviewer is a necessary component** of the APPEARANCE section. This is sometimes also described as the “interpersonal style.”

- Congenial
- Guarded
- Open/candid
- Cooperative
- Withdrawn
- Distant
- Annoyed/Irritable
- Engaging
- Hostile
- Shy
- Relaxed
- Cautious
- Defensive
- Resistant

Speech is something you can also comment on in the APPEARANCE section. Some patients will speak volumes, while others will say only a few words. Some patients will speak very fast, and others will not make any sense. A good speech section of the mental status examination comments on the rate, rhythm, volume, and spontaneity. Some ways to help describe speech patterns are:

- Clear
- Coherent
- Normal rate
- Pressured (fast)
- Soft-spoken
- Stuttering
- Includes profanity
- Impoverished
- Monotone
- Mumbled
- Animated/Excited
- Difficulty finding words
- Slurred
- Spontaneous speech
- Confabulation
- Impressionistic/little detail
- No speech
- Poor articulation

In describing speech, it would be appropriate to comment on “what” was said. This can also be deferred to the THOUGHT content section; however, if there are prominent themes – there should be a brief comment describing them.

Eye contact is also described in the APPEARANCE section. Usually is described with one or more of the following:

- Good
- Fleeting
- Avoided
- Intense/unwavering
- None
- Sporadic

Example of appearance section:

Vicky is a 65 year old obese African American woman who appeared older than her stated age. She was dressed in a wrinkled, dirty (riddled with food stains), and obviously expensive red business suit with matching red bonnet, which made her appear overdressed for the intake interview. Her hair was immaculately cut and styled; she also had copious amounts of make-up applied as well as dirty fingernails and mismatched earrings. She was noted to be quite gregarious, cooperative, and overly familiar with the interviewer, commenting on several occasions that the interviewer looked like her grandson, Dwayne. She had obvious, low, rhythmic motions of her lower jaw and tongue, as well as a slow tremor in her hands bilaterally – these appeared not to bother her. Eye contact was noted to be intense and, at times, unwavering as she looked at the interviewer

with wide eyes. Her manner of speech was noted to be quite loud accompanied with a pressured rate, rhythm, and spontaneity with overvalued content around “hogs not being pigs.”

Johnny appeared to be his stated age of 30. He was a fairly tall, thin, and slightly balding Caucasian male. While he greeted the interviewer appropriately with a handshake, his palm was notably sweaty. He nervously and sheepishly apologized for this. Throughout the course of the interview, he tapped his fingers on his knees, looked around the room frequently, and smiled nervously every few seconds. He was well-groomed, dressed in well-maintained in his Class B uniform, cooperative, and interactive throughout the entire interview. Eye contact was sporadic. Speech was of normal rate, rhythm, volume, and spontaneity; speech content was overrepresented with themes of worry. For example, these included worry whether he locked his car door or not and if he said “hello” to his boss this morning.

MOOD and AFFECT

Mood describes the subjective state of the patient. This can be directly asked (i.e., “What would you say your mood is right now?” “How do you feel right now?”). Even if it is not asked, it can be thought of as the predominant or average feeling state during the interview. Some mood examples are:

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|---------------------|-------------------|---------------|
| ➤ Euthymic (normal) | ➤ Elated/euphoric | ➤ Alexithymic |
| ➤ Anxious | ➤ Calm | ➤ Dysphoric |
| ➤ Depressed | ➤ Irritated | |

If mood is the subjective portion, affect describes the objective portion (i.e., what you see and observe). Affect can be described in terms of four variables: Range, Intensity, Lability, and Appropriateness to mood/context.

Range refers to the amount of variation in behavior/emotion during the interview (such as enthusiasm that fluctuates with sadness). There is a normal amount of variation patients will display during an interview, usually equivalent to those seen in every day conversations with associates, friends, significant others, etc. If the patient demonstrates more variation in affect than is usual, this is considered an increased range of affect. For example, if a patient expresses euphoria and then changes, within the same interview, to a deep, non-responsive depressed appearance, this would be increased range. Likewise, if another patient were to present with extreme, sustained euphoria – this might be described as expansive. The other presentation may also be seen – decreased range of affect (also described as *restricted, constricted, blunted, or limited range*). An example of this is often seen in depressed individuals. They will most likely be confined to a depressed range of affect, with little indication of joy, hope, or smiling. Finally, when there is absolutely no change in affect (as seen in negative symptoms of psychosis), this can be described as *flat*.

Intensity can be thought of as the emotional amplitude and power is coming forth from the patient.

Lability can be thought of as of rapid, extreme, brief swings of emotion followed by a quick return to normal. A presentation of labile affect would a be patient who appears

depressed and solemn, breaks into sudden laughter with little prompting for one minute, followed by crying for another minute, and then back to appearing depressed again.

Appropriateness of affect refers to whether the emotion is expected for the patient's current expressed thought. For example, a patient who laughs uncontrollably while recalling a tragic event is demonstrating an inappropriate affect. It is also important to examine if the affect is *congruent* to mood (which is another area to assess appropriateness). For example, if a patient states he is "deeply depressed" and laughs, jokes, and smiles throughout the entire interview – this would demonstrate an affect that is *not congruent* with mood.

Examples of Mood and Affect section:

Valarie stated her mood as being, "okay ... no, actually it is really good." Her range of affect was expansive and of increased intensity; she often gestured wildly with her hands and appeared as if she were on the brink of moving toward the interviewer. Her affect was noted to be labile, as she would be happy and elated one moment which would quickly change to tears with a return to being extremely happy. Her affect was not appropriate to given context, as she was extremely emotional while relating even the trivial portions of her account.

Ernest stated his mood to be "pretty depressed." His affect was restricted to the depressed range and was noted to be quite blunted, with very little change even while discussing potentially happy content. His affect was not labile and was appropriate to given context and congruent with his stated mood.

SENSORIUM

The patient's orientation is described in this section. Areas of orientation are person, place, time, and situation. Also, it would be appropriate to place your patient's mini-mental status exam (MMSE, otherwise known as the "Folstein") score here. Remember, the score relates very little without specific context. If there were points missed from the exam, it would be helpful to state what the patient missed. Remote/immediate memory, if tested, can also be commented in this section as well.

Examples of Sensorium:

She was oriented to person, place, time, and situation. She achieved a 27/30 on the mini-mental status exam, which she missed one point for recall of one of the three objects, one point for sentence writing, and one point for repetition of phrase.

Bobby was oriented to person and place; however, he was not oriented to time (a couple of days off and noted it to be the incorrect year) and was not entirely sure of why he was in the emergency room giving the reason, "They just want to look at my stuff." He obtained a 22/30 – missing 3 points for the time/date, 2 points for "WORLD" backwards, 2 points for recall, and 1 point for sentence writing.

INTELLECTUAL FUNCTION and COGNITIVE FUNCTIONING

Intellectual functioning can be clinically *estimated* based on patient's (1) general fund of information, (2) vocabulary, and (3) ability to understand/employ complex concepts. This estimation is usually quantified by one of the following descriptions: *Below average, average, or above average*. Again, it would be good practice to supplement a *below average* or *above average* description with specific examples.

Examples of intellectual functioning:

Mr. Roberts' intellectual functioning was estimated to be above average. He demonstrated a large fund of knowledge, with an emphasis on religion and philosophy. He discussed recent events of the world and how these were predicted by previous events. He also quoted correctly many famous authors and discussed the "timelessness" of such prose. His vocabulary was quite extensive and utilized the words correctly.

Trisha's intellectual functioning appeared to be below average. She supplied simple one to two words answers to questions. These questions had to be repeated numerous times by the interviewer because she stated, "I cannot understand such big words." More complex questions were met with literal interpretations followed with literal answers. For example, when asked "Where do you live?" - she answered "in a house," and did not elaborate on this.

Closely tied to intellectual functioning are elements of cognitive functioning. While intelligence might be considered an estimate based on the history and an overall impression, cognitive functioning can be tested within the exam. This would be especially important to test if a patient is consistently not able to accurately follow instructions within the interview or has a chief complaint of memory problems. The *visuospatial* portion of cognitive functioning, for example, can be tested with the drawing of a clock or copying the intersecting pentagrams on the mini-mental status examination. *Abstraction* can be tested with proverbs (i.e., "What does the proverb, 'Don't cry over spilled milk mean?") or similarities (i.e., "How are a banana and apple alike?") might be able to elicit problems with thought processes by revealing concrete thinking, which might suggest a thought disorder. *Memory* can also be tested with the recall components within the mini-mental status examination, or by asking the patient the order of the past presidents, what he/she had for breakfast, recent significant national events, etc. *Executive functioning* (i.e., ability to sequence, plan, and initiate action) can also be tested with the drawing of a clock and a variety of other neuropsychiatric bedside tests.

Example of cognitive functioning:

Ernie's intelligence appeared average based on his use of vocabulary and general fund of knowledge. In regard to his cognitive functioning, he appeared to not to maintain attention and concentration to the interviewer's tasks and had to be frequently reminded and redirected. His clock drawing portrayed a very narrow oval with the numbers squeezed to one side of the oval, repeated numbers (for example, "3" was on the clock 4 times), and without hands. He also could not recall what he had for breakfast (even

though the remnants were right in front of him) and the past three U.S. Presidents, even with prompting.

Trent was easily able to follow the instructions and questions of the interview. His clock drawing was completed without difficulty and his memory for recent events was intact. He had difficulty with abstraction. For example, when asked what "Every dark cloud has a silver lining" meant, he paused, smiled, and stated, "It means that behind that dark cloud is Mr. Ziebius who is tormenting me and has always done so. There is no silver, but just the darkening of other metals." When asked what "Don't cry over spilled milk" meant – he stated, "It means if you spill the milk on the floor, really you shouldn't cry."

THOUGHT SECTION

Thought Process involves the flow and organization of thought.

- Coherence – Is the patient's thoughts organized well enough that they make sense to the listener?
- Logical – Are the conclusions a patient reaches based on sound or flawed logic? Remember that coherence and logic are two separate variables. For example, a patient may give a coherent account, but not necessarily logical (such as a person with delusions).
- Goal directedness – *Does the patient get to the point in a direct manner?* Non goal-directed thought patterns include *circumstantiality* (i.e., patient makes numerous detours with non-essential details, but eventually does reach the goal of the original thought or posed question). *Tangentiality* is also another non goal-directed thought pattern describes a patient who never gets to the point and does not reach the goal of the original thought or posed question.
- Associations – How well connected are the thoughts? Disordered associations include *loose associations* (i.e., examiner cannot discern connection between ideas), *blocking* (i.e., train of thought either fails to begin or stops usually in mid sentence – sometimes seen in thought disorders, like schizophrenia), and *flight of ideas* (i.e., thoughts jump rapidly from one idea to the next, but obvious connection to each is preserved).

Thought Content involves actual statements, themes, and beliefs presented by the patient.

- Perceptions – False perceptions include *hallucinations* (i.e., auditory, visual, or other sensory experiences in the absence of external stimuli), *illusions* (misinterpretation of actual sensory stimuli), *depersonalization* (feelings of unreality or strangeness concerning one's self), *derealization* (feeling that the external world is foreign or strange), and *distortion of body image* (erroneous self-assessment that one's physique is flawed).
- Delusions – Fixed, false beliefs. Many of the types that belong here are somatic, persecution, jealousy, grandiosity, etc. *Delusion/Ideas of reference* or *delusions of control* are also part of this category. There is also *thought broadcasting* (feeling that one's thought are being "put out there" for all to see/hear), *thought withdrawal*

- (feeling that others can remove thoughts from them), and *thought insertion* (others can put thoughts into one's head).
- **Dangerousness** –This should always be a part of your mental status examination. In this section, it is paramount to place any suicidal and/or homicidal ideation, intent, and/or plan here. It would also be helpful here to be as specific as possible with regard to intent and plan.
 - **Other items** included in the content section are:
 - Overvalued ideas (differs from delusions in that the belief is less firmly held, is less bizarre, and is not systematized).
 - Obsession themes
 - Phobias

Additional components of Thought

- Judgment – This is the ability to make good decisions concerning the appropriate thing to do in various situations.
- Insight – This is related to correct understanding of presence, nature, cause, and significance of any mental or emotional problem.
- Impulse Control – this is an estimate of the patient's ability to control their actions (and thinking about them prior to acting on them). This can be seen during the interview – for example, physically attacking the interviewer or copious swearing might indicate poor impulse control. This also might be estimated through immediate history, such as fights (might indicate being quick to provocation), sexual behavior, and drug usage.
- Abstract reasoning – Please see “Intellectual function and Cognitive Functioning” section. Abstract reasoning is sometimes placed in this section.

Example of Thought section:

While Thomas' thought processes were coherent and goal directed, his conclusions that the young lady he just met was in love with him was illogical. He believed that her calling the police, calling his Command, striking him, and being arrested and thrown in jail as “Testaments of her love ...” and that she was testing him. He did not demonstrate looseness of associations, thought blocking, or flight of ideas. In regard to thought content, prominent delusions were apparent, as he believed, despite evidence to the contrary, that this woman was for him and that all of these activities were a “test” he must pass. He exhibited ideas of reference, as demonstrated by interpreting her wearing pink on Monday and waiting by Bus Stop number 5 as definite signs that he must pursue her. He denied auditory and visual hallucinations, paranoia, thought broadcasting, thought insertion, thought withdrawal, and suicidal ideation. Although he denied specific homicidal ideations, he mentioned that if “I can't have her ... then I will make it so no one does.” His insight was noted to be poor; his judgment was also poor. Impulse control was noted to be poor, as he continued to pursue this young lady despite many warnings not to do so. His abstraction ability, as demonstrated by discussing the meaning of certain proverbs, was intact.

George's thought processes were coherent, logical, and goal directed. While he denied auditory hallucination, visual hallucination, and delusions, his thought content was significant for near obsessive quality themes of worthlessness and how those around him would be "better off without me." He endorsed present suicidal ideation, intent, and plan stating that he "did not want to live this way anymore," and considered using his revolver in order to "end it all in the most definite and fastest way possible." He denied homicidal ideation. Insight and judgment were poor, as he was brought in by the police after waving his revolver at his apartment complex and does not see that he has a problem. His impulse control was considered poor, based on his activities at his apartment complex and other self-harming behavior preceding this event.

Closing Considerations

Taken in its entirety, a properly done mental status examination describes quite a bit about the patient.

A frequently asked question is, "Will I have to document such a complete exam on each patient on my psychiatry rotation?" The answer is "Yes and no." While at the clinical sites, your mental status examinations will likely be succinct while still containing the pertinent information. However, your preceptors (for whom you will complete weekly write-ups for) will expect a more detailed, thorough, and considerate mental status examination.

In closing, here are some examples of mental status examinations. They are pulled from various sources. They are with explanations where appropriate.

Examples of Mental Status Examinations:

The following example is complete example. This is part of a formal Temporary Disability Retirement List (TDRL) evaluation. This level of *mental status examination would be expected for your preceptor papers during the third year rotation.*

Peter appeared his stated age of 26. He was noted to be well-groomed, tall, thin Caucasian male who was causally dressed in civilian attire. This consisted of a cowboy hat, black Metallica concert shirt, jeans, large shiny rodeo belt buckle, and clean white sneakers. He walked with a stiff and slow gait into the interview room with very little arm swing as he walked. He greeted the interviewer with a quick glance and did not offer to shake hands until the interviewer presented his hand. Even so, he appeared somewhat confused by the gesture, but eventually shook hands after a tentative 15 second pause. Although he was noted to be very cooperative, forthright, and volunteering during the entire interview, he was quite restricted in his range of facial expressions and movements of his extremities. He resembled a statue for the entire 60 minutes. Psychomotor activity was noted to be decreased; he was without odd mannerisms, tics, or dyskinetic movements. Eye contact, for the most part, was appropriate with occasional bouts of unremitting staring at the interviewer. Speech was of a slightly stilted rate and rhythm, but with otherwise normal volume and spontaneity. Mood was described as "good." Affect was noted to be flat (nearly no variation) in range, not labile or intense, not appropriate to stated mood, and contained very little change with content of interview. Sensorium was intact to person, place, time, and situation. He scored a 30/30 on the mini-mental status

exam. Thought processes were significant for blocking –in which he would start a thought, then stop for 30 seconds, and then continue on with his thought. Otherwise, his thought processes appeared coherent, logical, and goal directed. In regard to thought content, he denied suicidal and homicidal ideation. He denied auditory and visual hallucinations and ideas of reference. He expressed some thoughts of paranoia (not well focused, he labeled it as “just a feeling”), but was without overt delusional content. Insight was fair; judgment was fair. Impulse control appeared to be intact.

The following might be an example of one that might be included for follow-up appointments and/or intake appointment.

Carrie appeared her stated age of 33. She was an attractive, petite female dressed well-groomed, in a blue blouse and jeans. Overtly, she noted to be dysphoric and tired. This was maintained throughout the entire interview. She ambulated to the interview room with minor limping and obvious discomfort. She was cooperative, forthright, and engaged well. Eye contact was appropriate; speech was of quiet volume with regular rate, rhythm, and spontaneity with prominent discussion about the pain in her foot, how no one understands how bad it is, and how doctors have not been able to help. Psychomotor activity was slightly increased with shaking of her right leg and foot, which protruded in the space between her and the interviewer. Mood appeared dysphoric; affect was restricted, contained no lability, congruent with mood, and appropriate to given context. Insight was fair; judgment was fair. Sensorium was intact to person, place, and time. Thought processes were linear, logical, and goal directed. Thought content: She denied suicidal and homicidal ideation. She denied auditory and visual hallucinations, phobias, obsession themes, and overvalued ideas.

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