

Mental Status Exam (MSE) — Factors and Definitions

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A mental status examination is a vital tool to the psychiatrist and neurologist in the evaluation of the mental status of the patient. A mental status examination is concerned with the patient's appearance, attitude, mood, affect, speech, thought process, thought content, insight, judgement, impulsivity, and reliability. It is an objective way of examining how the patient's mind works and can help in establishing a diagnosis when combined with a proper psychiatric history.



Overview

A mental status examination, just like a physical examination, **is an intrusion on the patient's rights and should not be conducted against the patient's will.** Before performing a mental status examination, the patient should consent to the procedure. Additionally, the patient should understand that the results of such an exam are going to be documented and he should agree on that. If a mental status examination is needed in an emergency setting where the patient cannot give consent, it should be documented that the patient did not agree on this mental status examination.

Patient's Appearance

The patient's general appearance should be noted and documented. **The patient's sex, apparent age, stated age, race, and ethnicity should be documented.** The patient's nutritional status should be also documented. Anorexia nervosa is characterized, for example, by severe low weight.

- **The patient's entrance** to your office should be noted. A highly suspicious patient, for instance, might have paranoia.
- **The patient's posture and motor activity** should be noted. It should also be noted whether the patient appears relaxed or anxious.

- **Patient's grooming and hygiene** can give important clues to the psychiatrist.
- **Patient's eye contact** is also part of the patient's appearance and should be noted here.
- **Avoidance of eye contact** should be noted and should be detailed as whether it happened most of the time or during certain topics.
- **Staring at the floor or ceiling or scanning the room** should be documented if present.

Patient's Attitude towards the Psychiatrist

The patient's facial expressions and attitudes towards the interviewer should be documented. The patient's interest and degree of engagement during the interview are vital and should be included in the mental status exam. Hostility is usually seen in bipolar or psychotic patients and should be documented if present. If the patient is overly friendly, that should also be documented.

Patient's Mood

The patient's current and sustained emotion should be inquired about and noted in your mental status examination.

Note: You should ask open-ended questions such as how do you feel most days. The patient's answer might be helpful and straightforward such as depressed, anxious or tired.

Sometimes, patients give vague answers such as OK or don't know. In that case, further questioning is needed to document the patient's mood accurately.

Once the current mood of the patient is established, questions about the length of that specific mood are needed. **When mood changes over time or is unstable, a bipolar disorder is more likely** for instance.

Patient's Affect

The patient's affect reflects how the patient currently feels. **The patient might have an expansive mood with a lot of laughter when he or she is in a manic episode.** A euthymic or normal affect is appropriate to the patient's current mood. Sometimes, the patient's affect is constricted and limited. This is commonly seen in depressed patients.

A blunted affect is characterized by a very minor variation during the interview. Such a patient might be severely depressed or might have a thought disorder. A patient with a flat affect shows no variation whatsoever in relation to the patient's current emotion.

The patient's affect should also be documented if it agrees with the current expressed emotion by the patient. For instance, a cheerful patient who has just been diagnosed with cancer might be in denial.

Patient's Speech

The patient's **quality, rate, and quantity of speech should be documented.** The patient's responses to open-ended and close-ended questions should be noted. Patients

who provide too much detail to a close-ended question might be trying to divert the conversation to something else they are more comfortable with.

One-word answers are also troubling as they can hint towards the possibility of withholding information from the psychiatrist. A depressed patient might have a slow speech rate when an open-ended question is asked.

Thought Process

The status of thought process should be noted as this is vital for a thought disorder diagnosis such as schizophrenia. The process of thoughts might be described as without association, with a flight of ideas, rapid thoughts, tangential, circumstantial, word salad, derailment, neologism, clanging, punning, thought blocking or thought poverty.

Loss of association between thoughts and flight of ideas are characterized by the rapid movement of one topic to another. This might be seen in a bipolar patient in the manic phase. In patients with flights of ideas, a previous topic might be re-visited again. Patients with tangential thought processing tend to switch from topic to another without ever returning to the previous topic. Racing of ideas is similar to flights of ideas but the topics might be more rapidly provided. A complete word salad is seen in psychotic patients. This word salad can include known words or newly invented words known as neologism. The use of rhyming words is known as clanging.

Note: When the patient changes the topic, one should note how many times he or she needed to intervene to get the patient back to the original topic being discussed.

Some Disorders that Affect the Thought Process

Loosening of associations	No logical connection from one thought to another
Flight of ideas	A fast stream of very tangential thoughts
Neologisms	Made up words
Clang associations	Word connections due to phonetics rather than actual meaning
Thought blocking	Abrupt cessation of communication before the idea is finished
Tangentiality	Point of conversation never reached due to lack of goal-directed associations between ideas
Circumstantiality	Point of conservation is reached after a circuitous path

Thought Content

In addition to the thought process, the content of the thoughts should also be noted.

Hallucinations

The content might include hallucinations. Documentation of auditory or visual hallucinations in a patient with a word salad or neologism provides stronger evidence for a possible psychotic disorder. **If hallucinations are present, inquiry about command-type hallucinations is necessary.** Open-ended questions should be used here. For instance, ask the patient if the voices are telling him to do something.

Obsessions and compulsions

Obsessions and compulsions are also part of the thought content one should ask about. If the patient shows evidence for possible obsessions or compulsions, close-ended questions should be used.

Phobias

Phobias should be also inquired about and any specific phobias should be documented in the mental status examination.

Suicidal ideation

Suicidal ideation should be documented during your mental status examination. Direct inquiry about suicidal ideation is recommended. If the patient has a positive suicidal ideation, specific inquiry about any suicidal plans should be done. **If a plan is put, the patient's readiness for that plan should be assessed.** These are the main risk factors for a true suicidal attempt. Homicidal ideation should be also inquired about, especially in psychotic patients or those with suicidal ideation. Patients who blame someone for their depression might eventually become homicidal instead of suicidal.

Comprehension

The patient's comprehension should be checked. Ask the patient a direct question such as squeeze my fingers. A patient in delirium might fail to follow commands. **The level of consciousness should also be noted.**

Orientation

Orientation to time, person, place and situation should be documented. Ask the patient about his or her full name, do they know where they are, what is the date today and the current time, and why do they think they are here or if they know why they are here.

Ask the patient to subtract 7 from 100 sequentially. This tests the patient's ability to concentrate and pay attention. An easy word such as "world" should be spelled by the patient forward and backward to further test the patient's concentration.

The patient's ability to draw interlocking pentagons should be checked. A patient unable to perform this task is said to have constructional apraxia. This can be seen in neurologic diseases such as a stroke.

Memory

Note: The patient's memory should be also checked. Short-term and long-term memory might be impaired in a depressed patient. This is known as depressive dementia.

The patient's ability to determine similarities between two things is known as abstract thought. If a plane and a bus are presented to the patient and the patient is asked what is common between the two, a satisfactory answer would be both are modes of transportation. Someone with impaired abstract thoughts might say that both are rectangular.

Based on this information, **one should determine the patient's intelligence level as below average, average or above average.**

Patient's Insight

When obtaining your psychiatric history, you should document whether the patient has a good understanding of their illness and acknowledge that they need help or not. A patient with a mood disorder might have a good insight, whereas someone with psychosis is very unlikely to have a good insight.

Judgement

The patient's judgment should also be evaluated. **Ask the patient about their response to an imaginary situation or scenario and evaluate their response** to what they would do in that scenario. The response behavior might be considered as appropriate or inappropriate to the situation.

Impulsivity

Inquiry should be made about whether the patient might engage in certain activities without thinking or planning. This is known as impulsivity.

Reliability

Once you have finished your mental status examination of the patient, you should determine whether the patient was reliable, unreliable or not possible to tell. This is important as it increases the credibility of the obtained history and **can determine the necessity for interviewing other individuals close to the patient** in addition to the patient. The patient's reliability can be assessed from your mental status examination, and can be determined from the patient's compliance with your treatment plan.

References

[History and Mental Status Examination](#) via emedicine.medscape.com

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