A mental status examination is a vital tool for the physician to evaluate the patient’s mental status. A mental status examination reviews the patient’s appearance, attitude, mood, affect, speech, thought process, thought content, insight, judgment, impulsivity, and reliability. It is an objective way of examining how the patient’s mind works and can help establish 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 a physician performs a mental status examination, s/he must explain the procedure to the patient and ensure the patient understands that exam results will be documented. If a mental status examination is needed in an emergency setting, where the patient cannot give consent, document that the patient did not consent to the mental status examination.

Patient’s Appearance

The patient’s general appearance, apparent age, stated age, race, and ethnicity should be documented. The patient’s nutritional status should be also documented. For example, anorexia nervosa is characterized by severe low weight.

- The patient’s demeanor upon entering the 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.
- The patient’s attention to grooming and hygiene can give important clues to the psychiatrist.
- **Whether the patient makes eye contact** with the physician is also part of the patient’s appearance. If the patient **avoids eye contact**, document this. Provide details, such as whether the patient avoided eye contact throughout the procedure or when discussing certain topics.
- **If the patient stares at the floor or ceiling, or scans the room**, document the behavior.

**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**

Talk with the patient about his/her emotional state and document it.

**Note:** You should ask open-ended questions such as, “How are you feeling 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 “I don’t know.” In that case, ask more questions to document the patient’s mood accurately.

Once the patient’s current mood is established, determine how long the patient has experienced that mood. For example, **when mood changes over time, or is unstable, bipolar disorder is more likely.**

**Patient’s Affect**

The patient’s affect reflects how the patient currently feels. **A patient who is in an expansive mood, with a lot of laughter, might be having a manic episode.** A depressed patient’s affect will be constricted or limited. A euthymic, or normal, affect is appropriate for the patient’s current mood.

**A blunted affect is characterized by a very minor variation during the interview.** Such a patient might be severely depressed or have a thought disorder. A patient with a flat affect shows no emotional variation.

Document the patient’s affect in the context of emotional events. 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 closed-ended questions should be noted. Patients who provide too much detail in response to a closed-ended question may be trying to divert the conversation from an uncomfortable topic.

One-word answers are also significant since they may indicate the patient is withholding information. Depressed patients might speak more slowly when responding to an open-ended question.
Thought Process

The patient’s thought process should be noted since this is vital for a thought disorder diagnosis, such as schizophrenia. It might be described as without association, 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 is characterized by the rapid movement from one topic to another.** This might be seen in a bipolar patient experiencing a manic episode. 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. The racing of ideas is similar to flights of ideas, but the topics might change more rapidly. A complete word salad is seen in psychotic patients. This word salad can include known words or newly invented words, known as neologisms. The use of rhyming words is known as clanging.

**Note:** When the patient changes the topic, the psychiatrist should note how many times s/he needed to intervene to get the patient back to the original topic being discussed.

### Some Disorders Affecting the Thought Process

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Description</th>
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<tbody>
<tr>
<td>Loosening of associations</td>
<td>No logical connection from one thought to another</td>
</tr>
<tr>
<td>Flight of ideas</td>
<td>A fast stream of very tangential thoughts</td>
</tr>
<tr>
<td>Neologisms</td>
<td>Made up words</td>
</tr>
<tr>
<td>Clang associations</td>
<td>Word connections due to phonetics rather than their actual meanings</td>
</tr>
<tr>
<td>Thought blocking</td>
<td>Abrupt cessation of communication before an idea is expressed completely</td>
</tr>
<tr>
<td>Tangentiality</td>
<td>The patient does not make a point because of a lack of goal-directed associations between ideas</td>
</tr>
<tr>
<td>Circumstantiality</td>
<td>The patient reaches the point after a circuitous path</td>
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</tbody>
</table>

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 of a possible psychotic disorder. **If hallucinations are present, the psychiatrist must ask the patient about command-type hallucinations.** Open-ended questions should be used here, such as asking the patient whether the voices are telling him/her 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 of possible obsessions or compulsions, closed-ended questions should be used.
Phobias

The psychiatrist should ask the patient about phobias and document any expressed/noted phobias as part of the mental status examination.

Suicidal ideation

Suicidal ideation should be documented during the mental status examination. Asking the patient about suicidal ideation directly is recommended. If the patient has positive suicidal ideation, ask about specific plans. **If the patient describes a plan, his/her readiness to carry out that plan should be assessed.** These are the main risk factors for a true suicidal attempt. The physician should also ask the patient about homicidal ideation, especially psychotic patients or those with suicidal ideation. Patients who blame someone else for their depression might eventually become homicidal instead of suicidal.

Comprehension

The patient’s level of comprehension should be checked. Give the patient a direct command, 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 to state his or her full name, location, the current date and time, and why s/he thinks s/he is in the office.

**Ask the patient to subtract 7 from 100 sequentially.** This tests the patient’s ability to concentrate and pay attention. Ask the patient to spell an easy word, such as “world,” forward and backward to test the patient’s concentration further.

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 neurological 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 the patient’s psychiatric history, the psychiatrist should document whether the patient has a good understanding of their illness and acknowledge whether
s/he needs help. A patient with a mood disorder might have a good insight, whereas someone with psychosis probably will not.

**Judgment**

The patient’s judgment should also be evaluated. **Ask the patient about their response to an imaginary situation or scenario and evaluate his/her explanation** of what s/he would do in that situation. The response behavior might be considered appropriate or inappropriate for the situation.

**Impulsivity**

The psychiatrist should ask the patient whether s/he might engage in certain activities without thinking or planning. This is known as impulsivity.

**Reliability**

Upon finishing the mental status examination of the patient, the psychiatrist should determine whether the patient was reliable, unreliable, or impossible to tell. This is important since it increases the credibility of the obtained history and **can determine the need to interview other individuals close to the patient** in addition to the patient. The patient’s reliability can be assessed from the mental status examination as well as the patient’s compliance with the treatment plan.

**References**

[History and Mental Status Examination](https://emedicine.medscape.com) via emedicine.medscape.com

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