

# Mental Status Examination

The Mental Status examination is an important part of a full evaluation of every patient. This portion of the patient's evaluation begins with the very first contact with the patient, continues during history taking, and is later completed by means of a more formal detailed inquiry into the patient's mental functioning. The Mental Status can be considered the physical examination and review of systems of that portion of the brain which supports the higher mental functions. Since the brain cannot be directly percussed or palpated, the mental status consists of two separate parts:

1. Observations
2. Specific questioning

One begins the evaluation of the mental status immediately by observing the patient and continuing to do so throughout any contact with him. Many aspects of his mental functioning can be picked up by observation, with the formal outline of mental status providing a structure for purposes of recording and reviewing to see that nothing has been left out.

The direct questioning of the patient allows one to evaluate specific mental functions. To be done effectively and with understanding, this part must be repeatedly practiced. As one listens to many hearts or observes many ocular fundi in order to delineate the normal from the abnormal, one must also ask many patients the questions that examine mental functioning.

Much practice is necessary so that one can have the questions at hand spontaneously and develop flexibility in the use of the mental status exam. In this way one will become comfortable with the questions and will experience hearing a range of responses from those that are completely normal to those that are very pathological. Part of the mental status exam can be done in five to thirty minutes, at the most.

Attached is an outline of a mental status examination. This is to be used as part of the history gained from each patient and should be used in write-ups to provide a basic format for presentation. The patient's behavior (thinking, feeling and acting) and attitudes are described under the following headings:

1. General behavior
2. Speech
3. Emotional state
4. Thought processes
5. Sensorium and mental capacity
6. Insight and judgment

## **DEFINITIONS OF TERMS USED IN THE MENTAL STATUS EXAMINATION**

**Anxiety:** Apprehension, tension or uneasiness which stems from the anticipation of danger, the source of which is largely unknown or unrecognized. Anxiety is primarily of intrapsychic origin, in contrast to fear which is the emotional response to a consciously recognized and usually external threat or danger. Anxiety and fear are accompanied by similar physiologic changes. Anxiety may be regarded as pathologic when it is present to such extent as to

interfere with effectiveness in living, the achievement of desired realistic goals or satisfactions, or reasonable emotional comfort.

**Apathetic**: Showing lack of interest, or indifference; lacking feeling.

**Association**: Relationship between ideas or emotions by contiguity, by continuity, or by similarities.

**Autism (autistic thinking)**: A form of thinking which attempts to gratify unfulfilled desires without due regard for reality. Objective facts are distorted, obscured, or excluded in varying degree.

**Blocking**: Difficulty in recollection, or interruption of a train of thought or speech, due to emotional factors usually unconscious.

**Circumstantial**: A characteristic of conversation that proceeds indirectly to its goal idea, with many tedious details and parenthetical and irrelevant additions.

**Clang Association**: Associations that are governed by rhyming sounds, rather than meaning, e.g., "This what I thought, bought, knot, caught, rot, sought."

**Compulsion**: An insistent, repetitive, intrusive, and unwanted urge to perform an act which is contrary to the person's ordinary conscious wishes or standards. A defensive substitute for hidden and still more unacceptable ideas and wishes. Anxiety results from failure to perform the compulsive act.

**Confabulation**: The more or less unconscious, defensive "filling in" of actual experiences, often complex, that is recounted in a detailed and plausible way as though they were factual.

**Delusion**: A false belief out of keeping with the individual's level of knowledge and his cultural group. The belief is maintained against logical argument and despite objective contradictory evidence. Common delusions include:

1. **Delusions of Grandeur**: Exaggerated ideas of one's importance or identity.
2. **Delusions of Persecution**: Ideas that one had been singled out for persecution.
3. **Delusions of Reference**: Incorrect assumption that certain casual or unrelated remarks or the behavior of others applies to oneself.

**Depersonalization**: Feelings of unreality or strangeness concerning either the environment or the self.

**Depression**: Psychiatrically, a morbid sadness, dejection or melancholy; to be differentiated from grief which is realistic and proportionate to what has been lost. A depression may vary in depth from neurosis to psychosis.

**Dissociation**: A psychological separation or splitting off; an intrapsychic defensive process which operates automatically and unconsciously. Through its operation, emotional significance and affect are separated and detached from an idea, situation, or object. Dissociation may, unconsciously, defer or postpone experiencing the emotional impact, as for example, in selective amnesia.

**Euphoria**: An exaggerated feeling of physical and emotional well-being not consonant with apparent stimuli or events; usually of psychologic origin, but also seen in organic brain disease and toxic states.

**Flattened Affect**: Displaying an abnormally small range of emotional expression.

**Flight of Ideas**: Verbal skipping from one idea to another before the last one has been concluded; the ideas appear to be continuous, but are fragmentary and determined by chance associations.

**Hallucination**: A false sensory perception in the absence of an actual external stimulus; may be of emotional or external chemical (drugs, alcohol, etc.) origin, and may occur in any of the five senses.

**Illusion**: The misinterpretation of a real, external sensory experience.

**Inappropriate**: Emotional expressions that are not in accord with the Affect situation, or what is being said, e.g., giggling when talking about the death of a parent.

**Insight**: Self-understanding; a major goal of psychotherapy; the extent of the individual's understanding of the origin, nature, and mechanisms of his attitudes and behavior. More superficially, recognition by the patient that he is mentally ill.

**Loss of Goal**: Failure to follow a chain of thought through to a logical conclusion usually elicited by asking a question which the patient starts to answer, but then seems to wander off the subject.

**Neologism**: In psychiatry, a new word or condensed combination of several words coined by a patient to express a highly complex meaning related to his conflicts; not readily understood by others; common in schizophrenia.

**Obsession**: Persistent, unwanted idea or impulse that cannot be eliminated by logic or reasoning.

**Orientation**: Awareness of oneself in relation to time, place and person.

**Perseveration (stereotype)**: Persistent, mechanical repetition of an activity, common in schizophrenia.

**Phobia**: An obsessive, persistent, unrealistic fear of an external object or situation such as heights, open spaces, dirt, and animals. The fear is believed to arise through a process of displacing an internal (unconscious) conflict to an external object symbolically related to the conflict.

**Sensorium**: Roughly approximates consciousness. Includes the special sensory perceptive powers and their central correlation and integration in the brain. A clear sensorium conveys the presence of a reasonably accurate memory together with a correct orientation for time, place, and person.

## MENTAL STATUS EXAMINATION OUTLINE

1. **General Appearance, Attitude & Behavior:**

Clothes: tidy, slovenly, neat, careless, dirty, decorative, mourning.

Facies: smiling, crying, blank, scared, sad, mask-like.

Attitude: cooperative, resistive, sociable, reserved, seclusive, belligerent, negativistic, suspicious, apathetic, fearful, confident, over-confident, sarcastic, superior.

Motor Activity: hyperactive, bizarre gestures, mannerisms, posture, tics, gait, paralysis, tremors.

2. **Speech:** Volume, rate, latency, push or pressure, loquacious, retarded, mute, increased or decreased.

3. **Emotional State (Mood and Affect):** Elated, euphoric, calm, placid, depressed, perplexed, anxious, apathetic, flattened, labile, inappropriate.

4. **Thought Processes (Form vs. Content):** Logical, circumstantial, loose associations, flight of ideas, clang associations, loss of goal, preoccupations, areas of concern, imaginations, suicidal/homicidal ideation in thought content, delusions, hallucinations, anxiety, phobia, compulsions, obsessions.

5. **Sensorium and Mental Capacity:**

Orientation: place, time, person.

Memory:

Remote: dates of service, marriage, jobs.

Recent: account of past 24 hours; three words after five minutes.

Immediate: numbers, name objects, digits forward and backward.

Symbolization and Proverb: abstract words' "rolling stone"/"glass houses" proverb interpretation.

Grasp of General Information: 5 presidents, governor, wars, recent newspaper reports.

Calculations: arithmetic tests, serial seven's subtraction.

Attention and Concentration: digit repetitions; serial seven's subtraction; story repetition.

6. **Insight and Judgment:** Realization and recognition of degree and nature of illness; ability to make reasonable and practical plans; goals and ethics.

## MENTAL STATUS EXAMINATION

1. **General Appearance, Behavior and Attitude:** A brief, vivid description of the patient it is hoped that a colleague, after reading it, will be able to recognize the patient by sight. It should include the following:
  - **Age and Grooming:** A brief description of the patient's dress, neatness and the appropriateness of his appearance; his apparent and real age.
  - **Posture:** This should include such things as the way he sits or lies during the interview, restlessness, tension and bizarre or unusual positions.
  - **Facial Expressions:** A brief description of the appropriateness, mobility and expression of emotion or inner conflict which can be observed on the patient's face such as alert, dull, stuporous, fearful, depressed, elated, etc.
  - **Psychomotor Activity:** Describe in detail the motor activity which you observe in the patient. Is this activity increased or reduced? Are his actions spontaneous? Does he initiate activity? Take note of the appropriateness of his motor activity, and of such things as compulsive rituals, fumbling at the bed clothes, assaultness, negativism, attempts to escape and so on. Is he restless, agitated, slowed, pacing, immobile, tremulous, etc.? Are there tics present?
  - **Manner and Attitude:** A description of the patient's general manner and attitude to the interview and the impression that one gets from this such as frightened, distracted, angry, etc.
  
2. **Speech:** The patient's style of talking should be studied carefully, and its various features recorded under the general headings of rate, form and quantity. This includes a spectrum from slowed to accelerated. The quality of talk should also be noted; that is, such things as hesitant, whispering, shy, humorous, screaming, mumbling, etc. Is there latency of response? Is it pushed or pressured? Can the patient stop talking, if requested?
  
3. **Emotional State:** The patient's emotional state should be evaluated in conjunction with all the other findings of the examination and with the facts obtained in the history. This is essential for the detection of emotions which the patient tries to conceal. A statement with regard to the probable dependability of the patient's description should be included. The points to be stated in every record are:
  - **Mood:** describes the general emotional state from the patient's subjective point of view, and involves feelings present at the time of the examination and a few hours or days preceding it. It is best assessed by asking the patient directly and recording a verbatim response. Mood tends to be stable over time. Examples of descriptors are neutral, depressed, sad, angry, anxious, happy, frightened.
  - **Affect** is your objective assessment of the immediate emotional expression that flows with the interview. A person may have a primarily depressed mood for several months, but may have a brightened affect when talking about his or her children or job. It is your job as an interviewer to try and elicit a full range of affect. Facets of affect to note are:

- **Qualitative descriptions:** Type and intensity of emotions, whether of a sweeping character or primarily connected with definite topics and strivings. Attention is focused on the emotions of depression, elation, euphoria, anger, anxiety, fear, suspiciousness, resentment, on the absence of clearly experienced emotions, on apathy, and on lability of emotion. Under objective data one might seek answers to the following questions - questions which are usually unspoken. Is the patient composed, complacent? Is he irritable, angry, happy, elated or exalted? Is he boastful, self-satisfied or expansive? Is he suspicious, distant or aloof? On the other hand, is he indifferent, apathetic, dissociated, perplexed, fearful, anxious or tense?
- **Range:** Does the patient exhibit a full range of emotion (objectively) in response to the interview? Is the range constricted, blunted, or completely absent?
- **Lability:** Are his emotional reactions labile and quickly changing or unstable, or is he phlegmatic and not easily moved? In all this, note the somatic evidences of his emotions such as flushing, tachycardia, perspiration, tears, facial expression, moist palms, and so on. Any of these, or similar observations should be noted.
- **Appropriateness to content and situation:** Is his affect, as far as one can observe it, compatible and appropriate to the ideas he expresses, the general content of his thought, and his appearance and motor activity? Is it consistent with his subjectively described mood? Or is his affect not compatible with these aspects of his functioning?

#### 4. **Thought Processes:**

- **Thought Form:** This is the verbal record of how (as opposed to what) a patient is thinking. Normal thought form is logical and goal directed. A formal thought disorder may be characterized by circumstantiality or tangentiality, blocking, neologisms, clang associations, flight of ideas, loose associations.

One should always record verbatim a brief extract of the patient's conversation in order to demonstrate the way his thought is produced, the way he associates and connects one subject with another. One should note whether this train of thought is logical or autistic? Can you follow his associations easily? If you cannot do this, can you describe why?

NOTE: if the patient is easily distractible during the interview, whether he gets off the subject and whether he comes back to it or not spontaneously. Ask him if he has difficulty concentrating or making decisions.

- **Thought Content:** This refers to what the patient is thinking with less emphasis on the form or process. A great deal of the patient's thought content is known by now. However, it may be necessary to ask specific questions in order to delineate in detail certain features. In addition to evaluating in general what the patient holds to be important, you will assess his reality testing, looking for the presence of delusions or other psychotic symptoms. This would be an

appropriate place to address any suicidal ideations or plans, or homicidal ideations/plans.

- **Feelings of Unreality and Depersonalization:** The phenomenon of déjà vu may be demonstrated by asking--did you ever have the feeling on entering a strange place you had been there before? Concerning other aspects of depersonalization one may ask--do persons and objects appear strange to you? Do you feel as if you are in a fog? Do you feel unnatural or as if your identity was lost? Is time or space distorted? Do you feel a change in yourself?
- **Passivity Feelings:** One may ask the patient--have you had any unusual, unpleasant or perplexing experiences? Or have you had any peculiar thoughts, imaginations or dreams? Then if the patient signifies that he may have experienced something like this, have him tell you about it and expand the story when necessary by such questions as--do you feel your thoughts or actions are controlled by others? Do people read your mind? Are your thoughts taken away from you? Is your mind or body influenced by machines, electricity, radio or television, mind reading, hypnotism or telepathy? Always, if he signifies that some of this may be so, ask him how he explains it; how could such a thing happen?
- **Persecutory Trends:** If a degree of suspiciousness has been noted throughout the story, one may attempt to explore this by asking such questions as--are you considered friendly or popular? Do you enjoy the company of others? Do they treat you well? Do people refer to you by changes in facial expression, side glances or mumblings? Do people gossip about you? Do you find yourself seeing meanings in little things? Are you a suspicious kind of person or a jealous person? Have you ever felt that strangers in the street were talking about you? Have you ever felt that you were being wronged by someone or annoyed by them purposely or being robbed or poisoned? Again, if the patient signifies that some of these may be so, ask him how he explains such happenings.
- **Obsessions and Compulsions - Fears:** These are common symptoms and almost all patients will talk about them freely. One should always as a routine ask such questions as--are you aware of thoughts that you are unable to control or rid yourself of? Are you the kind of person who is afraid of heights, crowds, small rooms, traffic, bridges, water or storms? You know children have to avoid sometimes walking on the cracks in the sidewalks, have you ever found yourself following some ritual like that? Have you ever felt tense if you did not follow one of these rituals? What do they mean to you?
- **Somatic Trends:** How is your health and strength? Do you have any aches or pains? How are your appetite, digestion and excretory function? Are you ever conscious of your heart beat? What is your sexual power? What is the condition of your blood? What does this mean to you?

- **Expansive Trends:** Do you feel confident in yourself or superior to others? Have you any unusual powers? Have you a great physical strength, a brilliant mind, tremendous wealth? Are you of a high birth? Have you a special mission in your life? Have you great sexual attraction?
- **Illusions:** Have you ever found yourself misinterpreting shadows or noises? Did you ever feel you were being touched? Did you ever see a ghost?
- **Hallucinations:**
  - **Auditory:** These may be inquired about with such questions as-- do you hear buzzing in your ears or noises or voices that other people don't seem to hear? Where - when - on what occasions? Are they subdued or loud or clear? Are they men's or women's voices? Do you recognize them? What do they say? Are they pleasant or unpleasant? How do you explain such happenings?
  - **Visual:** Ask first - did you ever see a vision? Or did you ever imagine you were seeing things as if in a dream? Were your eyes open or shut? Was it nighttime or daytime? Where - when? What was the attitude of these things you say you saw? And again, what does all this mean?
  - **Gustatory:** Does everything taste normal? Have you noticed any peculiar tastes? Sour - bitter - metallic? Did your food ever taste as if it were being tampered with?
  - **Olfactory:** Have you ever been bothered by queer odors - have you smelled ether or gas? Have you been forced to bathe frequently?
  - **Organic:** Do you ever feel any peculiar pressures, tingling or numbness? Ever feel as if your bones were broken or your brain dried up? Ever feel any queer sexual sensations? Or feelings of electricity or vibration?
  - **Motor:** Did you ever notice any peculiar change in your body positions? Do you have strange sensations from muscles or joints?

5. **Sensorium and Mental Capacity:**

- **Orientation:** Determine how well the patient is oriented in the realm of time, place, persons present and in the present situation. In every record, all four points must be specifically mentioned.
- **Memory:** The following subgroupings are to be recorded:
  - **Recall of Remote Past Experiences:** Test the recall of personal experiences which generally are considered of importance and evaluate any discrepancies and contradictions in time relationships. It may frequently happen that all the pertinent data, with careful recording of the time relationships, have been obtained from the patient when the "personal history" was taken. In this case, the physician may merely refer to these facts. The following points should be tested--time and place of birth, of various schools, of occupations or jobs; date of marriage and birth of children (with recording of their names) and of patient's illness.
  - **Recall of Recent Past Experiences:** Test for occurrences in the past twenty-four hours and whether any change in memory functions has occurred since the onset of the present illness.

- **Recall of Immediate Impressions:** Repetition of three non-related words (e.g., "table," "red," "63 Broadway") and recall after three minutes. Present the patient with the three words, telling him you will ask him to repeat these soon. Continue your history taking and after timing three minutes, ask the patient to recite the three words previously presented.
- **Attention and Concentration:**
  - **Digit Span:** Immediate repetition of digits, starting with three digits and increasing to failures, recording digits and actual returns. Repeat the digits at the rate of one per second, in an even tone of voice. It is very important to avoid grouping or clustering digits, as in a telephone number.

<b><u>Digits Forward</u></b>	<b><u>Digits Backward</u></b>
582	629
694	415
6439	3279
7286	4968
42731	15286
75836	61843
6194732	539418
392487	724856
5917428	8129365
4179386	4739128
58192647	94376258
38295174	72819653
275862584	
713942568	

(In presence of anxiety, the patient will repeat two digits less.)

**Highest Trial of 2 Trials:**

<b>Digits Forward</b>	<b>Digits Backward</b>
7 - Good average	5 - Average
6 - Low average	4 - Marginal
5 - Marginal	

- **Serial Subtraction:** Request patient to "subtract seven from 100 and continue subtracting seven until you can go no further." Record carefully and time patient. (In presence of tension and anxiety one or two mistakes are made; four to six errors are marginal; seven errors or more constitute failure. Average time is about 60 seconds.)
- **General Intellectual Evaluation:** By the investigation of a patient's knowledge, an understanding may be obtained of the character of his intellectual functions in general and of the way he has applied them in acquiring information in school and in life. The following topics are to be recorded:

1. **General Information:**

- The five largest cities in the United States.
- The capital of the state, United States, England, France and Germany.
- Dates of the principal wars of the United States and the issues involved.
- The last four presidents and their political parties.

- The governor of the state and mayor of the city.
  - Explanation of the seasons.
  - What is the Gulf Stream?
  -
2. **Calculation:**
    - Compute 1-1/2 years interest on \$200 at four percent.
    - If five times X equals 20, how much is X?
  3. **Symbolization:** Differences and similarities between abstract words (idleness and laziness; poverty and misery; character and reputation; irresponsible and incapable).
  4. **Proverb Interpretation:** The use of proverb interpretation test associations, abstraction and the ability to symbolize and synthesize. These abilities are actually dependent on many things, for instance, intelligence, education, culture and the presence of organic defect and anxiety, but they are also dependent on the disturbances of thinking which occurs in schizophrenia.
  5. **Abstraction:** These proverbs may be interpreted at several different levels of abstraction. Using the proverb, "a rolling stone gathers no moss" as an example, the following are illustrations of the different levels of abstraction:
    - **Refusal or Inability to Interpret:** The patient says "I don't know," or he refuses to cooperate.
    - **The Completely Literal Interpretation:** The patient repeats the proverb with no or only very slight modifications. For instance, "a stone that keeps rolling doesn't stay still long enough to have moss grow on it."
    - **The Concrete Interpretation:** The patient remains literal and emphasizes a concrete situation although not the same situation as is referred to in the proverb. For instance, "if you run around, you don't get any moss; that is, you don't get any money."
    - **The Egocentric Interpretation:** The patient says something like, "that's me, I never get anywhere."
    - **The Incoherent or Bizarre Interpretation:** The patient might say, "a rolling stone gathers no moss-Christ, breaking chain stores all together, independency."
    - **The Interpretation Showing False Desymbolization or Pseudoabstraction:** Here one should include a tendency to interpret one proverb with another. For instance, "a person standing still doesn't let any grass grow under him," or "keep on the move and don't let the grass grow under your feet."

- **Adequate Abstraction**: The patient may say, "a person who goes from place to place gains no success in the world," or "if an individual does not seek new challenges, he will vegetate."
- **The Over-abstract Interpretation**: The patient in his attempt to abstract over-shoots the mark. For instance, "dissipation of energy rather than concentration."

6. **Insight and Judgment**: This refers to the extent to which the patient realizes that he suffers from an illness or from personal difficulties and to the extent to which he recognizes the need for treatment. It includes the understanding of his illness in general and of any psychopathological experiences in particular. The patient's spontaneous suggestions for treatment should be recorded. The performances of reasoning and judgment show the present ability to apply involved intellectual functions to life situations which are of importance to the patient. Ask (according to individual needs) about the patient's plans for business and work, financial situations, home and social situations.

The patient should always be asked what he believes is the explanation of the current situation. Does he feel he is ill? Does he feel that there has been any change in him? If so, what is the explanation? Is it external? Does he feel that treatment is needed, or is he unconcerned? Does he feel his emotions may be involved? Does he understand the difference between a lie and a mistake, dwarf and child, idleness and laziness, poverty and misery, character and reputation?