Chapter 5: The Mental State Examination

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Introduction

The mental state examination is an essential component of a psychiatric assessment and involves a systematic way of recording observations of the patient as well as specific questions about psychiatric phenomena. It is structured and refined. It requires practice, experience and the learning of a new vocabulary of descriptive terms (psychopathology). The mental state examination is a cross-sectional assessment of an individual's mental state. It can provide an easily understood and objective evaluation of how unwell a patient is, and this provides a good reference point for comparing the mental state from one time point to another.

The format of presenting a mental state examination

Appearance
Behaviour
Speech
Mood
Affect
Thought form
Thought content
    Includes assessment of suicidal ideation
Perception
Cognition
Insight
Judgement

Appearance

The mental state examination begins with a detailed description of the individual's appearance. It can help to imagine how you might describe this person's appearance if you were introducing a character in a novel. The description usually begins with physical features from general features to more specific features. It then comments on added features such as hair, nails, bruises, scars, tattoos, piercings, make up, clothing and other apparel. All of which may point to psychopathology.

For example, *"On mental state examination, Mr Smith is a middle-aged male with a stooped posture and a pale sickly appearance. Despite his thin limbs he has considerable central adiposity. He is dishevelled with matted blonde hair, long dirty nails and he is somewhat malodourous. He wears a torn and discoloured suit coat with shorts and no shoes. His T-shirt has an image of a skull with the letters "R.I.P.""*

Behaviour

The description of behaviour should begin with an assessment of the individual's attitude to the examiner and their current situation, followed by any psychomotor changes, abnormal movements and any overt behaviours. The description of behaviour should commence from the time of referral (e.g., repeated phone calls, waiting room behaviour). For example, *"Mr Smith was guarded and hostile. He was suspicious towards the accompanying nursing staff, displaying hypervigilance and psychomotor agitation. He had mild oral tardive dyskinesia, but no other obvious abnormal movements or behaviours."*

Terms used to describe behaviour.

- **Mannerisms:** A repeated, habitual movement of the face, hands or body.
- **Stereotypies:** Rhythmic, repetitive and predictable movements, e.g., rocking associated with autism.
- **Catatonic posturing**: The maintenance of an inappropriate posture for a prolonged period of time, like a statue.
- **Echopraxia:** The imitation of movements performed by an examiner or another person.

Speech

Speech can be described in terms of its volume, quantity, rate and quality. Prosody or the stress, rhythm or intonation of speech can also be commented on.

Terms used to describe speech

- **Pressured speech:** Rapid speech with increased quantity of speech that is difficult to interrupt.
- **Poverty of speech:** Little substance is conveyed in the speech despite a normal quantity of speech. This may be due to vagueness or repetitive empty phrases.
- **Stuttering:** Repetition or prolongation of sounds and/or syllables to the extent that the content of speech takes longer to be conveyed.
- **Alogia:** Very few words are uttered. This usually occurs in the context of negative symptoms of schizophrenia or dementia.

Mood

Mood is defined as an emotional state that influences the patient's behaviour and outlook. Mood can be assessed by asking the patient how they feel. It can also be assessed by aspects of their behaviour and speech. For example, a patient who is psychomotor retarded and their thought content is characterised by negative ideas is likely to have depressed mood.

Terms used to describe mood

- **Anxious:** An emotional state characterised by fear, dread and concern.
- **Depressed:** An emotional state characterised by sadness and a negative outlook.
- **Euthymic:** A normal mood state which is neither depressed nor manic.
- **Elated:** An emotional state characterised by joy, energy and optimism.
- **Euphoric:** Intensely elated mood with excitement, but without associated psychomotor agitation or pressured speech.
- **Expansive:** Unrestrained emotional expression with excessive enthusiasm, friendliness and superiority.
- **Alexithymic:** An inability to describe emotions or mood.
- **La belle indifference:** Incongruent feelings of indifference towards one's disability or problem, as in conversion disorder.

Affect

Affect refers to the range of emotional expression observed by the examiner in the individual.

Terms used to describe affect

- **Restricted:** Reduced intensity and range of emotions.
- **Blunted:** Severe reduction in intensity and range of emotions.
- **Flat:** Absent or near absent emotional expression.
- **Labile:** Rapidly alternating range of emotional expression from depressed and tearful to manic and laughing.
- **Incongruent:** Emotional expression is not consistent with what is expressed verbally, e.g. laughing when describing the tragic death of a loved one.

Thought Form

Thought form refers to the way that ideas or thought content are associated. The main object of assessment of thought form is to evaluate whether thought content flows in a logical and coherent manner. Disorder of thought form usually indicates the presence of a psychotic disorder (see Chapter 15).

Terms used to describe abnormal thought form

- **Tangential:** Questions are never really answered. Patient may start to answer the question, but goes off on a tangent.
- **Derailing:** Questions begin to be answered, but train of thought abruptly changes to another topic.
- **Circumstantial:** Content is over-inclusive and the individual takes a long time to eventually answer the question.
- **Loosening of associations:** Flow of ideas are not well connected or are very loosely associated.
- **Clang associations:** Flow of ideas is not connected by meaning, but by the sound of the words, e.g. "the cold mould rolled".
- **Flight of ideas:** Ideas tend to be connected, but rapidly change from one topic to another.
- **Thought blocking:** The abrupt termination of the flow of thought. When asked, the individual says that the thought disappeared.
- **Word salad:** An incomprehensible collection of words.
- **Echolalia:** The repetition of another person's words or phrases.
- **Neologism:** A word created by the patient that is unlikely to be used by another person.
- **Perseveration:** The repetition of the same words or phrases, despite different questions.

Thought Content

Thought content attempts to assess "what is on the person's mind". Thought content might describe one's preoccupations, obsessions, over-valued ideas or delusions. It should also include an assessment for thoughts that might be dangerous, e.g., suicidal ideation, self-harm ideation or homicidal ideation. Ideas are more transitory (e.g., "Wouldn't it be nice to go to the beach today."), whereas beliefs are more enduring (e.g., "It's bad luck to go to the beach at night."). A belief is defined as a feeling that something is true when there is neither concrete evidence

to support or refute the belief, for example, the belief that life exists on another planet in the universe. A belief becomes a delusion when it is held with absolute conviction and is not amenable to any change even when an individual is presented with evidence that might suggest that the belief is not true. Although most definitions regard delusions as false beliefs that are not in keeping with the beliefs of others from a similar socio-cultural or religious background, delusional beliefs can sometime be proven true. Thus, delusions are better defined by the way beliefs are held and by the behaviours associated with the belief of the individual. For example, people are frequently admitted to psychiatric units with persecutory delusions where they may strongly believe that their neighbour is attempting to seriously hurt them. During the course of the admission, it might be discovered that the neighbour did indeed threaten to kill the patient. The conviction with which the belief is held, the patient's inability to consider viable alternatives, their associated distress and their associated behaviours, for example, covering the windows with foil, are factors that would support them having had a delusional belief despite the belief being true.

Overvalued ideas are held with less conviction than delusional beliefs and tend to be more acceptable or understandable. Overvalued ideas tend to dominate over other ideas over long periods of time and to be associated with changes in behaviour and functioning. Some regard overvalued ideas occurring on a spectrum between delusions and obsessions.

Obsessions (see Chapter 19 Obsessive-Compulsive and Related Disorders) are defined as recurrent intrusive thoughts, images or impulses which tend to be ego-dystonic (in contrast to the wishes and desires of the individual). An example would be the recurrent thought that a mother might give her children food poisoning if she doesn't count to one hundred when washing her hands. With an obsession, the mother views this belief as completely irrational, whereas with an overvalued idea, the mother will not view this belief as irrational. If the mother holds this belief with absolute conviction, she will be regarded as having a delusional belief.

Content of thought needs to be contextualised to the patient's condition and may be mood congruent or incongruent. A depressed individual may have negative cognitions that include negative views of themselves (themes of worthlessness and guilt), negative views of the future (themes of hopelessness) and negative views of the world around them (pessimism). When negative thoughts are repeatedly experienced, they are commonly termed depressive ruminations.

Terms associated with abnormal thought content

- **Delusional mood:** The perplexing feeling that something (which is not clearly definable) has changed in one's environment.
- **Ideas of reference:** The idea that the television, radio or newspaper is making special reference, e.g., "when the news presenter smiled at the end of the programme it was as if they knew that my life wasn't funny".
- **Thought insertion*:** The belief that thoughts are being put into one's mind from an external source.
- **Thought withdrawal*:** The belief that one's thoughts are being withdrawn by an external source.
- **Thought broadcast*:** The belief that one's thoughts are being broadcast (as if through speakers) so that they are audible to others.
- **Thought echo (echo de la pensées)*:** The experience of one's thoughts being repeated within one's mind, like an echo.
- **Passivity phenomena*:** The belief that one's movements are being controlled not by them, but by an external force.
- **Persecutory delusion:** A belief that one is under threat or surveillance from others or as part of a conspiracy.
- **Folie a deux:** When a delusion is shared among two people.
- **Grandiose delusion:** A belief that one has more power, prestige, intelligence, beauty or wealth than is actually true.
- **Religious delusion:** A belief that one is God, a Saint or a religious figure, or that one has a special connection with a religious figure.
- **Hypochondriacal delusions:** A belief that one has a terrible disorder, e.g., cancer or a disorder of the bowels.

***Schneiderian first rank symptoms:** Together with delusional perception (where external events have special meaning), hallucinations of running commentary and hallucinations where the voices talk to each other, these symptoms form what are termed Schneiderian first rank symptoms. The presence of these symptoms support (but are not necessarily pathognomonic of) a diagnosis of schizophrenia.

Perception

Perceptual disturbances refer to either hallucinations or illusions. Hallucinations are false sensory perceptions that can occur in all of the five senses (auditory, visual, tactile, olfactory and gustatory). Auditory hallucinations occur more frequently than perceptual disturbances in the other senses in schizophrenia. If hallucinations in other senses are prominent, organic causes should be considered. Illusions are considered a misperception of a real stimulus, for example, mistaking the folds in one's bedsheets for a snake.

Terms associated with perceptual disturbances

- **Hypnopompic hallucination:** Hallucination occurs on waking from sleep.*
- **Hypnagogic hallucination:** Hallucination occurs on falling asleep.*
- **Pseudohallucination:** There is awareness that the hallucination is not real and that it arises from within oneself.
- **Derealisation:** The external world feels unreal, distant or unfamiliar.
- **Depersonalisation:** One's own self and/or body feels unreal, unfamiliar or unusual.

* Not necessarily related to psychopathology.

Cognition

The assessment of cognition includes a variety of factors, such as level of consciousness, alertness, orientation, concentration, memory, abstract thinking, construction, disinhibition and intelligence. Testing is tailored to the subject's history and mental state examination thus far. Cognitive testing may be very brief in a fit and healthy medical student where no cognitive impairment is suspected, but it can be very comprehensive in a forgetful 85-year-old hospitalised nursing home resident. Comprehensive testing (see Chapter 6) is often aided by assessment tools such as the Folstein Mini Mental State Examination (MMSE) (Folstein et al., 1975) or the Montreal Cognitive Assessment (MoCA) (Nasreddine et al., 2005).

At a basic level, delirium should always be excluded by observing for fluctuating levels of consciousness (i.e., may be coherent at one time and disorientated and perplexed at others) and by assessing orientation (e.g., "Can you tell me where you are?"). A test of concentration, for example serial sevens (where one is asked to subtract 7 from 100 and to continue to subtract 7 from the answer) or asking one to spell the word "WORLD" backwards is also important as depression and states of distress can significantly impair concentration. If the subject is found to be forgetful when the history is taken, memory impairment and dementia can be assessed with a brief test of memory, for example asking the subject to recall three objects after five minutes. A good indication of an individual's level of intelligence can be obtained by considering the extent of their vocabulary when they are narrating their history to you.

Insight

Insight refers to the individual's level of awareness that they are unwell and/or that they require treatment. It is not uncommon for patients with schizophrenia to be completely insightless. They may have no insight into their illness, for example, "there is nothing wrong with me.", their belief, e.g. "I am not delusional" and to their need for treatment, for example "Let me out of here doctor, I am not taking those psych drugs because I am not crazy…". Sometimes, patients have partial insight, in that for instance, they may be aware of the need to stay in hospital but disagree with the doctor that they need to be given medication."

Judgement

Judgement refers to the ability of an individual to appropriately consider and weigh up pros and cons and make good decisions. Judgement is evaluated during history taking by considering whether various actions described in the course of taking the history displayed good judgement or not. If a patient with limited finances tells you that they were looking to buy a new expensive luxury sports car because the price of public transport had increased, then the patient is likely to be displaying poor judgement. Imaginary scenarios can also be given to individuals to assess judgement. Common examples include: "What would you do if you received an email that was addressed to a very good friend of yours?", "What would you do if you were in a cinema and you could smell smoke?".

Further Reading

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