

## ***Principles of the Mental Status Examination***

### ***What is the Mental Status Examination?***

The Mental Status Examination (MSE) is the component of an interview where cognitive functions are tested and inquiries are made about the symptoms of psychiatric conditions. It is a set of standardized observations and questions designed to evaluate:

- Sensorium
- Perception
- Thinking
- Feeling
- Behavior

The MSE is an integral part of any clinical interview, not just one that takes place in a psychiatric context. An assessment of cognitive functioning must be made before information from patients can be considered accurate. The MSE records only observed behavior, cognitive abilities and inner experiences expressed during the interview. The MSE is conducted to assess as completely as possible the factors necessary to arrive at a provisional diagnosis, formulate a treatment plan and follow the clinical course.

The MSE is a portable assessment tool that helps identify psychiatric symptoms and gauge their severity. With experience, it is a specific, sensitive, and inexpensive diagnostic instrument. The MSE takes only a few minutes to administer and yields information that is crucial to making a diagnostic assessment and starting a course of treatment.

### ***What are the components of the MSE?***

The MSE can be thought of as a psychiatric “review of symptoms.” As outlined on the previous page, the assessment of five main areas yields information necessary for a differential diagnosis and treatment plan. Expanding these five areas gives us the psychological functions that are assessed and recorded in the MSE.

#### **Sensorium & Cognitive Functioning**

Level of consciousness and attentiveness

Orientation to person, place and time

Attention

Concentration

Memory

Knowledge

Intelligence

Capacity for Abstract Thinking

### Perception

Disorders of sensory input where there is no stimulus (hallucinations), where a stimulus is misperceived (illusions), or of bodily experiences

### Thinking

Speech

Thought Content (*what* is said)

Thought Form (*how* it is said)

Suicidal or Homicidal Ideation

Insight & Judgment

### Feeling

Affect (visible emotional state)

Mood (subjective emotional experience)

### Behavior

Appearance

Psychomotor agitation or retardation

Degree of cooperation with the interview

### ***How do I remember all that?***

A mnemonic can help. The following memory aid not only lists the main areas, but does so in the order that they are usually asked about and presented.

#### **“ABC STAMP LICKER” \***

Appearance

Behavior

Cooperation

Speech

Thought - **form** and **content**

Affect - moment to moment variation in emotion

Mood - subjective emotional tone throughout the interview

Perception - in all sensory modalities

**Level of consciousness**

**Insight & Judgment**

**Cognitive functioning & Sensorium**

**Orientation**

**Memory**

**Attention & Concentration**

**Reading & Writing**

**Knowledge base**

**Endings - suicidal and/or homicidal ideation**

**Reliability of the information**

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### ***Do I have to perform an MSE?***

Yes.<sup>¶</sup> It is as essential to a complete psychiatric assessment as the physical examination is to other areas of medicine. The MSE has been adroitly called the “*brain stethoscope.*” \*

**All psychiatric diagnoses are made clinically in interview situations.** There is no blood test, x-ray or single identifying feature for any psychiatric condition. This emphasizes the necessity of a thorough assessment, of which the MSE is an essential component.

The MSE is often unpopular for two reasons:

- The questions are difficult to formulate because they are not asked in other types of interviews or in other areas of medicine, psychology, nursing, etc.
- The questions appear to be of dubious relevance.

Once these two difficulties are surmounted, the MSE becomes an enjoyable and interesting aspect of interviewing. To achieve this level of comfort, it helps to

realize that almost half of the MSE is obtained “free” through observation and discussion from the initial parts of the interview.

### “Free” parameters

Level of consciousness  
Appearance  
Behavior  
Cooperation  
Reliability  
Affect  
Thought Form

### Parameters to ask about

Orientation  
Cognitive Functioning  
Suicidal/Homicidal Thoughts  
Knowledge Base  
Perception  
Mood  
Thought Content

¶ The American Psychiatric Association listed the MSE as one of the essential “**Domains of Clinical Evaluation**”

*American Journal of Psychiatry*, Vol.152:11, Suppl., p. 72, Nov. 1995

D. O'Neill, **Brain Stethoscopes: The Use and Abuse of Brief Mental Status Schedules;**  
*Postgrad. Medical J.*, (69), p. 599-601, Aug. 1993

### ***How do I start the MSE?***

The MSE begins as soon as the patient is in view. A moment of observation before the interview begins reveals important information such as: grooming, hygiene, behavior, gait, level of interest in and interaction with surroundings, etc.

Other elements of the MSE are obtained as the interview proceeds. Most interviewers begin an interview with open-ended questions and allow patients at least five minutes of relatively unstructured time to “tell their story.”

Invariably, there are items that will have to be specifically asked about, which can be done in one of three ways:

- Taking the opportunity when the chance arises in the interview. This is the most natural approach, allowing the MSE to be woven into the flow of the interview. For example, many patients will complain of poor memory and decreased attention span, presenting an ideal opportunity to test cognitive functioning. The disadvantage to this method is that it can disrupt the

structure of an interview. For those new to interviewing and the MSE, this approach may be better left until more facility has been gained in coping with such tangents.

- Taking note of key points in the history that allow a smooth transition back to these items. For example, “You mentioned before that your vision was blurred. Did this ever cause you to see something unusual?” This lets patients know that they have been listened to, while adhering to a more structured approach. If patients say something that introduces an important area, but at an inopportune time, say something like, “It’s important for me to know about that, and we’ll get back to it in a few minutes\*, but right now could you tell me more about . . .”

\*Just remember to ask about it later!!

- Asking about these items at the end of the interview. This too has the advantage of helping preserve the structure of the interview. Additionally, the two other more elegant approaches don’t always present themselves. Specific parts of the MSE can be introduced as follows:

“At this point, I’d like to ask you some questions that are separate from what we’ve been discussing so far, but will give me some important information about you.”

or

“Right now, I’d like to ask you some questions to give me an idea about some aspects of your mental functioning.”

or

“I’d like to switch now and ask you a set of questions that will help me evaluate your . . . (thinking, memory, etc.).”

or

“There are some other areas that I need to formally test to get an idea about your . . . (concentration, attention, etc.). ”

or

“In order to be as thorough as possible, I need to ask you some questions about your mental functions and inner experiences.”

N.B. These questions are only suggestions. Ask instructors or colleagues for their own patented phrases. While conducting the MSE is essential, it can be done in a variety of ways and in any order. You can draw on the experiences of others initially, and then eventually develop your own approach. Specific questions regarding certain sections of the MSE (e.g. hallucinations and delusions, suicidal or homicidal thoughts) are included in their respective chapters.

### ***How is the MSE different from the history?***

Many parts of the MSE are indeed covered in the body of the interview. However, it is rare for all aspects of the MSE to be covered without being addressed specifically.

In one extreme case, an interview can consist solely of the MSE. Patients who are delirious, severely demented or grossly psychotic cannot provide reliable information. Interviews under these circumstances are principally a record of appearance, behavior, speech, thought form, etc.

On the other hand, someone can answer questions in a straightforward, logical manner and demonstrate no obvious abnormalities of behavior, but still have a serious mental illness. Most clinicians can recall a situation where they were fooled by not pursuing a thorough MSE. The best example of this situation is a patient who suffers from a delusional disorder. Other than the theme of the delusion (paranoia, jealousy, etc.), the interview can be largely unremarkable. Unless specific inquiries are made about the presence of these fixed, false ideas, they will be missed.

Other components of the psychiatric history and the MSE interact dynamically so interviewers learn where to most profitably direct their inquiries. Consider a patient who is disheveled, wearing a kevlar jacket to ward off gamma radiation, and conversing with a light bulb using unusual language. These are the areas to immediately ask about:

- The recent ingestion of substances
- Serious medical illnesses, head injuries, etc.
- A history of schizophrenia, past psychotic episodes or previous hospitalization
- Compliance with recommended treatment