

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

Mental Status Examination

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The Three-Function Model of the Medical Interview

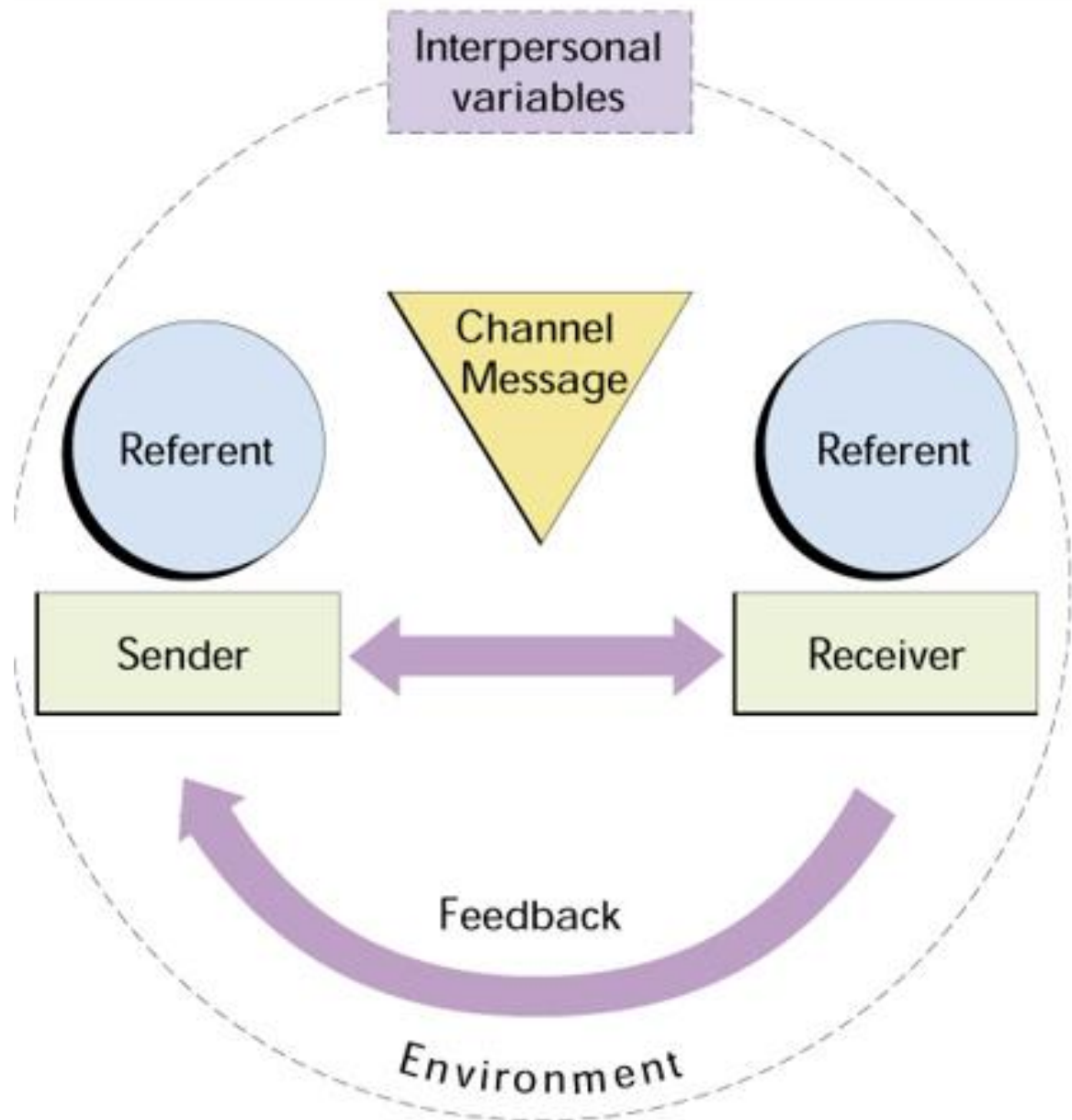
Bird and Cohen-Cole

- doctor–patient encounters generally involve three separate, occasionally overlapping, functional domains:
 - ❖ **Gathering information**
 - ❖ **Dealing with emotions**
 - ❖ **Changing patient behaviors**

- **Disease** based
- Patient(**Customer**) based
- **People** centered

Physicians should monitor :

- ❑ 1) the content of the interaction (what patient and doctor say to each other)
- 2) the process (what patient and doctor may not say but clearly convey in many other ways).



مهارت های ارتباطی

1. Responds to cues
2. Active Listening
3. Use Empathy
4. Offer Support
5. Non-judgemental
6. Avoid personal beliefs
7. Simple language
8. Use appropriate body language
9. Information giving
10. Information gathering

What the Mental Status Examination is?

- Mental State Examination is the equivalent of the Physical Examination in General Medicine
- It can be defined as the systematic examination of one patient's psychopathological disturbances within discrete functional and symptomatologic domains
- The Mental Status Examination (MSE) is the psychological equivalent of a physical exam that describes the mental state and behavior of the person being seen. It includes both objective observations of the clinician and subjective descriptions given by the patient.

How to recruit elements for MSE?

- Direct patient evaluation (by interview)
- Relatives' and care-givers' interviews (after patient's authorization; without patient's authorization in selected exceptional cases only)
- Previous clinical records
- Medical certificates (drug prescriptions; disability certification)
- Connection with the GP and with other physicians that cared the patient

How to complete the MSE?

- Proximal and remote psychiatric history
- Drug history
- General medical history
- General physical examination
- Prior laboratory or instrumental analyses or previous medical records (not psychiatric)
- Rating scales

- The MSE provides information for diagnosis and assessment of disorder and response to treatment.
- A Mental Status Examinations provides a snap shot at a point in time

- To properly assess the MSE, information about the patients history is needed including education, cultural and social factors
- It is important to ascertain what is normal for the patient. For example some people always speak fast!
- There is none (or almost none) behavioral conduct that *per se* may be considered pathological or enough to make a diagnosis of a mental disorder

The Mental State Examination

- Appearance, Behavior & Attitude
- Psychomotor Activity
- Speech
- Mood & Affect
- Thoughts
- Perception
- Cognitive functions and consciousness
 - Consciousness level
 - attention
 - concentration
 - orientation(time, place, person)
 - memory
- Abstract thinking
- Visuospatial ability
- Language and reading.
- Judgment
- Insight

General Appearance

- It includes the analysis and description of signs describing the exterior features of the patient.
- Among subdomains are:
 - Self-care
 - Clothing
 - Prominent physical abnormalities
- Among the points to investigate are:
 - Build, gait, posture, dress, grooming, hair, nails
- It is investigated by observation. Evaluations are based on adequacy/congruence

General Description

- Attitudes
 - How the patient related
 - "degree of cooperativeness"
 - Evaluator's attitude

Motor Behavior

- Gait
- Freedom of movement
- Firmness and strength of handshake
- Any involuntary or abnormal movements
- Pace of movements
- Purposefulness of movements
- Degrees of agitation

Psycho-motor activity

- It is defined as the expression, at the motor level, of the social life of the individual and of its inner affective-instinctual dispositions
- It includes:
 - *Facial expressions*: facial gestures and movements that accompany and enrich verbal expressions
 - *Gestures*: non-verbal communications by the body (mostly by the limbs)
 - *Voluntary motor activity*: all voluntary movements different from facial expressions and gestures. Often considered equivalent to general motor activity. May be diminished, augmented, or standard.

- These are mostly expression of both neurological and psychiatric disturbances. Often, as iatrogenic outcomes. Infrequently, they may be present in “pure” psychiatric conditions
- *Dyskinesia*: abnormal involuntary movements, frequently in the oral district
- *Distonia*: involuntary and painful paroxysmal contractions of groups of muscles
- *Akathisia*: involuntary restlessness, in some cases subjective (i.e., not observable by the examiner but referred by the patients)

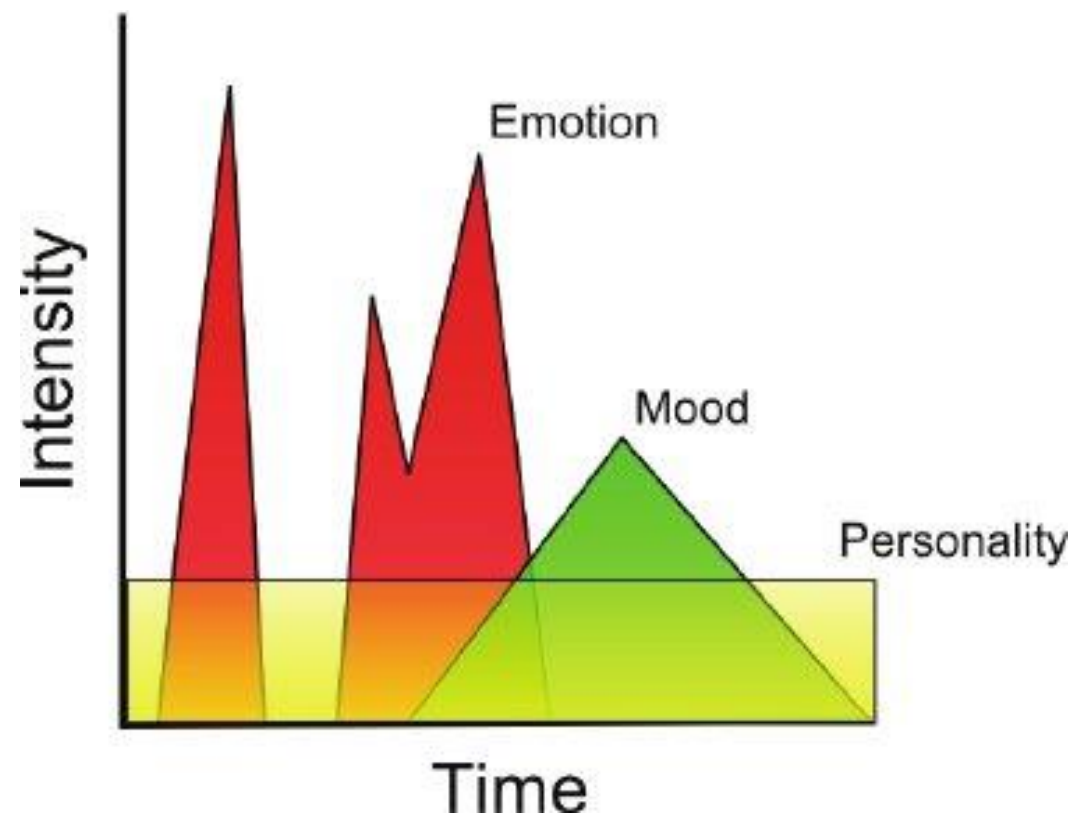
- *Stereotypies*: non finalistic and complex repetitive movements
- *Tics*: non finalistic (often) simple repetitive movements
- *Mannerisms*: odd, partially finalistic complex movements. In some cases, bizarre facial expressions (known as grimace), typical of schizophrenia

Speech

- Rate
- Spontaneity
- Intonation
- Volume
- Defects

Mood

- A sustained and relatively stable state of inner feeling.
- It may be observed, but the patient must be inquired to express her/his inner feelings as completely as possible
- Euthymic
- Depressive mood
- Elated mood
- Dysphoric mood
- Dysthymic mood
- Hyperthymic mood
- Cyclothymic mood
- Suicidal thoughts or intentions



Affect

- Affect is not equivalent to mood. It describes the observed expression of inner feeling. Mostly, clinicians should assess:
 - Appropriateness to situation, consistency with mood, congruency with thought content.
 - Fluctuations: Labile, even.
 - Range: Broad, restricted.
 - Intensity: Blunted, flat, normal intensity.
 - Quality: Sad, angry, hostile, indifferent, euthymic, dysphoric, detached, elated, euphoric, anxious, animated, irritable.

Thinking:

- Goal-directed flow of ideas and
- associations initiated by a problem and leading toward a reality-oriented conclusion.
- Thinking is a very complex and complicated psychic function.
- The evaluations of thoughts is based on what the patient says.

speed of thinking

a) slowed thoughts:

- **slowing of the flow of associations , slowed and diminished verbal production (bradypsychism)**
- **blocking of thoughts - cessation of the flow of associations (patient stops the verbal production without any recognisable impulse from surroundings)**

b) flight of thoughts:

- **excessive rapidity of thinking manifested as extreme rapidity in speech (= logorrhoea)**

Form of Thought

- poverty of thought
- thought blocking
- flight of ideas
- perseveration
- loosening of associations
- word salad - incoherent thinking
- neologisms
- verbigeration

a) perseverative thinking:

- **involuntary persistence of response to some question or topic, verbigeration - a meaningless repetition of specific word or phrase**

b) circumstantiality:

- **indirect speech that is delayed in reaching the point, characterised by an overinclusion of details**

c) tangentiality:

- **patient never gets from desired point to desired goal**

“I was
home”

Start



“I felt some
chest pain”



“So I told
my son”



“And he
called an
ambulance”

“And now
I’m here”

Finish

“I was
home”

Start

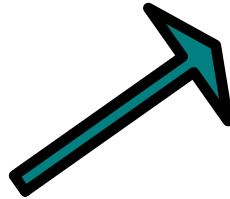
“I felt
some
chest
pain”



“So I
told
my
son”



“My son,
maybe
you know
him”



“He’s a
doctor
too”



“He
always
worries so
much”



“And now
I’m here”

Finish

“What
was my
point?
Oh, yeah”



“I was
home”

Start

“I felt
some
chest
pain”

“So I
told
my
son”

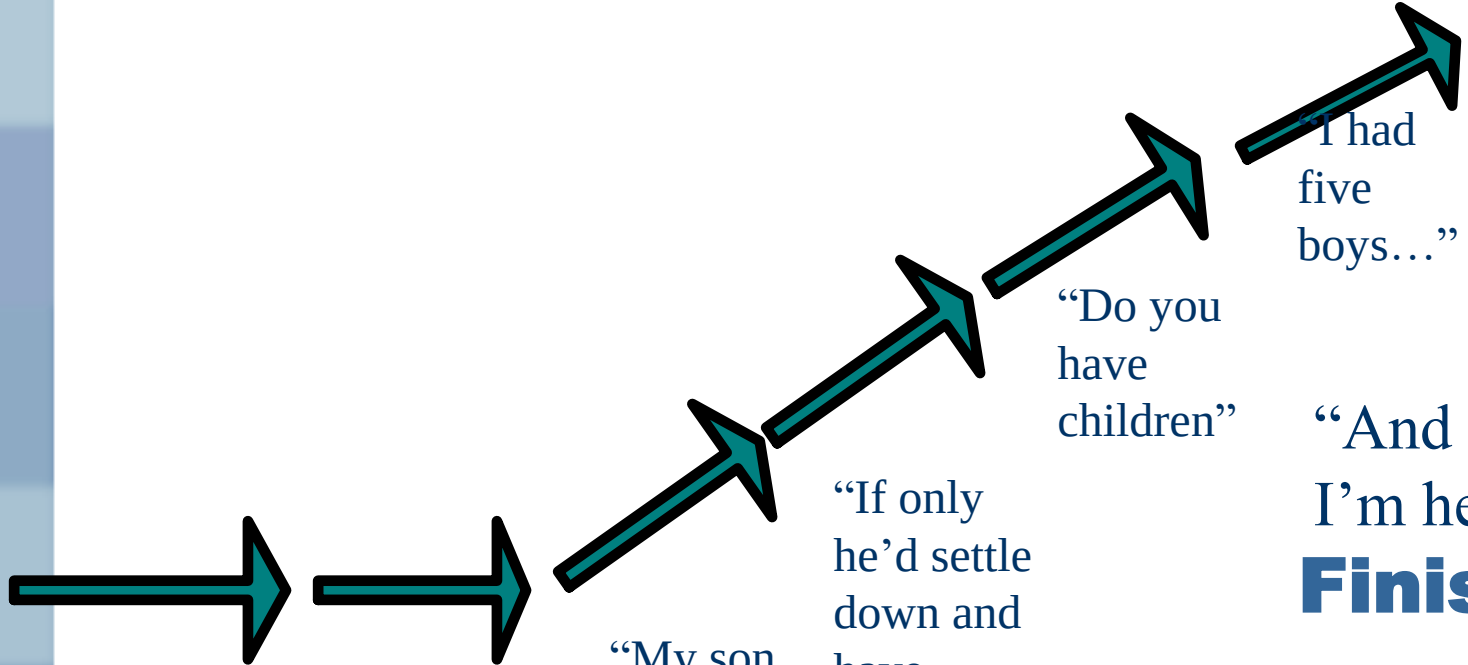
“My son,
He’s
really
great”

“If only
he’d settle
down and
have
some
children”

“Do you
have
children”

“I had
five
boys...”

“And now
I’m here”
Finish



Thought

a) thought form:

- **the way ideas are linked (logical, goal-directed, loose associations)**

b) thought content:

- **delusions (Almost false beliefs)**
 - **thought insertion, thought withdrawal**
- **preoccupations, obsessions - unwanted idea that cannot be eliminated by reasoning**
- **phobia- obsessive, unrealistic fear**
- **Self Harm and Suicide Ideas**

Examples of questions (concerning thought disorder):

- **Do you think anyone wants to hurt you?**
- **Do you feel that others can hear your thoughts or read your mind?**

Additional tips:

- **When something does not appear to make sense, always ask for clarification!!**

a) preoccupation of thought:

- **certain idea is in the centre of thinking, is coming back, usually associated with a strong affective tone**

b) obsession:

- **pathological persistence of an irresistible thought or feeling that cannot be eliminated from consciousness by logical effort, associated with anxiety**

c) autistic (derealistic) thinking:

- **preoccupation with inner, private world**

d) overvalued idea:

- **unreasonable, sustained false belief maintained less firmly than a delusion**

e) poverty of content:

- **thought that gives little information because of vagueness, empty repetitions, or obscure phrases**

f) symbolic and magical thinking:

- **real objects have other, symbolic meaning, in magical thinking words, situations, action have special power and meaning**

Delusions

Delusions are Almost false beliefs based on incorrect inference about external reality, not consistent with patient's intelligence and cultural background that cannot be corrected by reasoning.

Characteristics:

- bizarre content**
- not corrected by reasoning**
- influence on behaviour**

Thought Content Disturbances

- Prevalent (or dominant) ideas
 - Bizarre ideas
 - Ruminations
 - Delusional ideas (systematic or non-systematic; odd vs. likelihood)
 - Secondary (or affective) delusions
-
- Clinicians should evaluate formal aspects of thought content: psychic dynamism; pressure to act; pervasiveness

Division of delusions:

- according to onset
 - a) primary (delusion mood, perception)
 - b) secondary (systematized)
 - c) shared (folie a deux)
- according to theme
 - a) paranoid (persecutory) - d. of reference, d. of jealousy, d. of control, d. concerning possession of thought
 - b) megalomaniac (grandiose, expansive) – d. of power, worth, noble origin, supernatural skills and strength, amorous d.
 - c) depressive (micromaniac, melancholic) – d. of guilt and worthlessness, nihilistic d., hypochondriacal d.
 - d) concerning the possession of thoughts
 - thought insertion
 - thought withdrawal
 - thought broadcasting

Perception:

- misinterpreting sensory input - illusion
- perceiving sensory input in the absence of any actual external stimulus - hallucination

(„Do you ever hear voices or see things other people do not hear or see?“)

Determine to what extent the patient is driven to actions based on a hallucination !

Perceptual abnormalities/disturbances

- Perceptual abnormalities
 - Altered perceptual intensity
 - Altered perceptual quality (macropsy; micropsy)
- False perceptions
 - Illusions
 - Pareidolia: the tendency to perceive a specific, often meaningful image in a random or ambiguous visual pattern
- Hallucinations
- Pseudo-hallucinations

Hallucinations

- Auditory
 - Thought Echo
 - Command
 - Third person
 - Commenting
- Visual
- Somatic
- Olfactory
- Gustatory

Cognition

- **Sensorial and intellectual functions:**
- **alertness (degree of wakefulness)**
- **orientation to person, place, time and situation**
- **concentration (to focus and a sustain attention)**
- **memory recent and remote, immediate recall (repeat 5 number forwards and backwards)**
- **calculation (simple arithmetic)**
- **fund of knowledge**
- **abstraction (proverbs, similarities)**
- **judgement and insight**

Memory:-

Remote (long-term) :-

Qs?. – ‘ where were you born?’ – ‘ Date of marriage?’

* Alzheimer’s → remote remain longer than recent.

* confabulation → filling gaps in memory.

Recent :-

Qs?. – ‘ where were you yesterday?’.

* organic mental diso. → recent lost before remote.

Immediate (short-term):-

Qs?.- Name 6 digits forward then backward. Remember 3 non-related items after 5 minutes.

*

Attention & Concentration:-

Qs?.- ' days of the week' – ' serial 7 (100 – 7) and keep
subtracting' – ' simple math (3+4)'
* poor → anxiety, depression. * impaired → OMD.

Knowledge:-

Qs?.- ' Name the last 3 kings' – ' Capital of UAE'
* check educational level to r/o Intellectual Disability

Judgment:-

ability to understand relationships b/w facts and draw conclusions.

Qs?.- ' if you find an envelopment in the street that is sealed, stamped & addressed what are you going to do with it?

Insight:-

- = realize that he/she has an illness,
- = is it physical or mental problem?,
- = dose it need treatment?.

Qs? - ' Do you think you have a problem?'

- ' What could the nature of the problem?'
- ' Do you need treatment?'

Insight

- Patient's capacity to
 - Acknowledge/Appreciate illness
 - Associated implications
 - Consequences

Judgement

- The process of
 - Consideration
 - Formulation
- Leading to a
 - Decision
 - Action

Judgement

- Requires
 - Insight
 - Cognitive functioning
 - Other abstract abilities
 - Conceptualization
 - Forward thinking
 - Appreciation of what “rational people” would do.

Abstract Thinking:

- It is the ability to deal with concepts and to make appropriate inference.
- It can be tested by :
 - (1) similarities: ask the patient to tell you the similarity between 2 things (e.g. car and train), and the difference between 2 things (e.g. book and notebook),
 - (2) proverbs: ask the patient to interpret one or two proverbs (e.g. people in glass houses should not throw stones) the patient may give a concrete answer (e.g. stones will break the glass).

levels of insight

- **Complete denial** of illness.
- **Slight awareness** of being sick and needing help but denying it at the same time.
- Awareness of being sick but **blaming it on others**, on external factors, or on organic factors.
- Awareness that illness is **due to something unknown** in the patient.
- **Intellectual insight**: admission that the patient is ill and that symptoms or failures in social adjustment are due to the patient's own particular irrational feelings or disturbances without applying this knowledge to future experiences.
- **True emotional insight**: emotional awareness of the motives and feelings within the patient and the important people in his or her life, which can lead to basic changes in behavior.

Level of Consciousness

- It investigates the level of vigilance and the sensory of an individual
- Vigilance is the level of alertness
- In normal conditions, sensory is intact
- Both conditions are investigated during the interview by observation
- Level of alertness may also be increased, such as in some anxious or paranoid states
- However, the most alarming conditions are when both these parameters are diminished

Level of Consciousness

- Quantitative Alterations
 - Augmented consciousness
 - Reduced level of consciousness
 - Confused: disoriented; impaired thinking and responses
 - Somnolent: excessive drowsiness. Often, confused and somnolent are considered equivalent
 - Obtunded: decreased alertness; slowed psychomotor responses
 - Stuporous: sleep-like state (not unconscious); little/no spontaneous activity
 - Comatose: cannot be aroused; no response to stimuli

Orientation

- Time/Place/Self
- Disturbances of orientation may be inferred by observation during the interview
- However, the easiest way to analyze the orientation of a subject is to directly inquire her/him
 - What is your full name? And your husband's? And your son's?
 - Where are we at (floor, building, city, county, and state)?
 - What is the full date today (date, month, year, day of the week, and season of the year)?

Attention

- It may be investigated by observing the patient during the interview. Some attempts may be performed to elicit focusing
- Level of voluntary and involuntary attention
- Attentional status increased, reduced, or circumscribed
- Distractibility vs. Selective attentions
- Focusing attitudes

