2 The mental state examination

Mental state examination		Example
Appearance and behaviour		***Appearance and behaviour***: Mr Smith was a thin gentleman, appropriately dressed in casual clothes, with no evidence of poor personal hygiene or abnormal movements; he was not objectively hallucinating. He was polite, appropriate in behaviour, maintained good eye contact, and although it was initially difficult to establish a rapport, this improved throughout the interview.
Speech and thought form		***Speech***: normal in tone, rate and volume. Relevant and coherent, with no evidence of formal thought disorder.
Tone	Flight of ideas	
Rate	Loosening of associations	
Volume		
Mood (subjective and objective)		***Mood***: subjectively "fine", objectively euthymic.
Affect (observed)		***Affect***: suspicious at times, particularly when discussing treatment; reactive.
Thought content		***Thoughts***: persecutory delusions and delusions of reference elicited. Could not "rule out" retaliating against neighbour, but no current thoughts, plans or intent to harm neighbour, self or anyone else. No evidence of depressive cognitions or anxiety symptoms. No suicidal ideation.
Depressive/anxious cognitions	Overvalued ideas	
	Ideas of reference	
Preoccupations	Delusions	
Obsessions	Suicidal/homicidal	
Perception		***Perception***: no abnormality detected
Hallucinations	Pseudo-hallucinations	
Illusions		
Cognition		***Cognition***: alert, orientated to time, place and person. No impairment of concentration or memory noted during interview.
Consciousness	Orientation	
Attention/concentration	Intelligence	
Memory	Executive function	
Insight		***Insight***: Patient believes he is stressed; he is aware that others think he has a psychotic illness but he disagrees with this. He does not want to receive any treatment and does not think he needs to be in hospital. He would be willing to see a counsellor for stress.
Physical examination		

This chapter describes the information that should be reported in the mental state examination.

Appearance and behaviour

Describe general health, build, whether of good personal hygiene and tidily dressed/well-kempt; any unusual clothing or striking physical features; manner, rapport, eye contact, degree of cooperation, facial expression, posture, whether responding to hallucinations. Also note any unusual tattoos, piercings, venepuncture sites or lacerations (especially on the forearm). Motor activity may be excessive (psychomotor agitation) or decreased (psychomotor retardation).

Look for extrapyramidal symptoms or side-effects of antipsychotic medication. These include Parkinsonian symptoms such as tremor and bradykinesia (slowness of movement), akathisia (restlessness); tardive dyskinesia (movements most often affecting the mouth, lips and tongue [e.g. rolling the tongue or licking the lips]) and dystonia (muscular spasm causing abnormal face and body movement or posture). Other abnormal movements include tics, chorea, stereotypy (repetitive, purposeless movements [e.g. rocking in people with severe learning disability]), mannerisms (goal-directed, understandable movements [e.g. saluting]); and gait abnormality.

Speech

Describe tone (variation in pitch; reduced sometimes in depression), rate (speed) and volume (quantity). In pressure of speech, rate and volume are increased and speech may be uninterruptible. In depression, tone, rate and volume are often decreased, and there may be poverty of thought.

'Normal' speech can be described as 'spontaneous, logical, relevant and coherent'; 'circumstantial' speech is discursive and takes a long time to get to the point. Note any perseveration (repeating words or topics) and abnormal words (neologisms, e.g. headshoe to mean hat).

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Thought form

This may be deduced where connections between statements are difficult to follow. In flight of ideas there is an abnormal connection between statements based on a rhyme or pun rather than meaning (e.g. 'You come in here swinging your stethoscope, telling me about my horoscope'). Speech is often pressured. In 'loosening of associations' there is no discernible link between statements: 'The tablets are red, I think climate change is a concern, what do you want with the piano?'

Give verbatim examples if thought form is abnormal. The patient's subjective experience of thought may be abnormal as in thought block (thoughts disappear: 'my mind goes blank').

Mood and affect

Abnormalities are the commonest symptoms of psychiatric disorder, but also occur in physical illness and in healthy people.

Mood is the underlying emotion; report subjective mood (in patient's own words) and objective mood (described as dysthymic, euthymic or elated/hyperthymic).

Affect is the observed (and often more transient) external manifestation of emotion. Mood has been compared to climate and affect to weather. Abnormalities of affect include being blunted/unreactive (lacking normal emotional responses); conventionally, this affect is often described as blunted if resulting from negative symptoms of schizophrenia, and unreactive in depression; labile (excessively changeable); irritable (which may occur in mania, depression); perplexed; suspicious; or incongruous (grossly out of tune with subjects being discussed, e.g. laughing about bereavement). Where no abnormality is detected affect is reactive (appropriate response to emotional cues).

Disorders of thought content

Report here any negative (depressed) cognitions of guilt, hopelessness, worthlessness or low self-esteem. Ruminations (persistent preoccupations) may occur in depression or anxiety.

Report any subjective anxiety and main subject of worries, obsessional ideas (Chapter 12) and phobias (Chapter 11). Record the presence and frequency of any panic attacks during the interview.

Depersonalization is the unpleasant experience of subjective change, feeling detached, unreal, empty within, unable to feel emotion, watching oneself from the outside ('It feels as if I am cut off by a pane of glass'). Derealization is the experience of the world or people in it seeming lifeless ('as if all in the world is made out of cardboard'). Depersonalization and derealization are not psychotic phenomena, although some erroneously describe them as such.

Abnormal beliefs include overvalued ideas (an acceptable, comprehensible idea pursued by the patient beyond the bounds of reason and to an extent that causes distress to the patient or those around him or her). An example of this would be an intense but non-delusional feeling of guilty responsibility following bereavement. Ideas of reference are thoughts that other people are looking at or talking about the patient, not held with delusional intensity. Delusions are fixed, false, firmly held beliefs out of keeping with the patient's culture which are unaltered by evidence to the contrary.

Here are some types of delusions, and questions you might ask to elicit them (see also Chapter 6).

Delusion type:	Content	Example question
Persecutory	Someone or something is interfering with the person in a malicious/ destructive way	Do you worry that people are against you or trying to harm you?
Grandiose	Being famous, having supernatural powers or enormous wealth	Do you have any exceptional abilities or talents?
Of reference	Actions of other people, events, media etc. are referring to the person or communicating a message	Have you heard people talking about you? Have you heard things on the TV or radio you think are about you?
Thought insertion/ withdrawal/ broadcast	Thoughts can be controlled by an outside influence: inserted, withdrawn or broadcast to others	Do you feel your thoughts are being interfered with or controlled? Are they known to others, e.g. through telepathy?
Passivity	Actions, feelings or impulses can be controlled or interfered with by outside influence	Do you feel another person can control what you do directly, as if pulling puppet strings?

Suicidal ideation, should be recorded, and whether the patient intends to act on these thoughts or has a plan about how he or she would do so.

Perception

Describe here any illusions (distortions of perception of an external stimulus, e.g. interpreting a curtain cord as a snake). Illusions can occur in healthy people. Hallucinations (perceptions in the absence of an external stimulus which are experienced both as true and as coming from the outside world); and pseudo-hallucinations (internal perceptions with preserved insight). Hallucinations can occur in any sensory modality, although auditory and visual are commonest. Some auditory hallucinations occur in normal individuals when falling asleep (hypnagogic) or on waking (hypnopompic).

Cognition

Note at least level of consciousness, memory (long- and short-term, immediate recall), orientation in time (day, date, time), place, person; attention and concentration. In people over 65 or who have any evidence of cognitive impairment, this section should be extended to include formal testing of memory, orientation, dyspraxia, agnosia, receptive and expressive dysphasia and executive functioning (e.g. by completing a Mini-Mental State Examination [MMSE] with additional tests of frontal lobe function). These could include estimating (e.g. approximate the height of a local landmark); abstract reasoning (ask how many camels in Belgium – answer 1–50); tests of verbal fluency (can they think of at least 15 words beginning with each of the letters F, A and S in a minute?) and proverb interpretation.

Insight

Record here the patient's understanding of their condition and its cause as well as their willingness to accept treatment.

Physical examination

This should focus on identifying (or excluding) conditions of which a suspicion has been raised in the history and mental state examination and those with a known association with psychiatric illness.