The Mental Status Examination
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Introduction
The mental status examination (MSE) is a formal component of any psychiatric evaluation. It goes above and beyond a typical physical examination that is used in most specialties to assess psychological functioning of a patient, which includes aspects such as memory, mood and affect, and perceptions, among others. It is a “snapshot” of a patient’s psychological state at the time of assessment, and the findings of a MSE can be compared over time to track a patient’s progress. Here we will review the basic components of a MSE.

I. Observations

Appearance
Appearance is one of the first things we observed about a patient as they enter the room. It includes concepts such as

- Stature – is the patient tall, short, average height? Are they of average build or are they thin or obese?
- Dress – what is the patient wearing? Is it appropriate? Is it flamboyant? Is the patient disheveled in appearance, possibly indicating more severe mental illness?
- Hygiene – is there any body odor? Is the patient’s grooming appropriate or poor?
- Accessories – is anything peculiar about the patient’s appearance in terms of jewelry, piercings, scars, or tattoos? Have they brought anything with them such as papers, folders, or a briefcase?
- Gait – does the patient walk appropriately, or do they require assistance with a cane, walker, or wheelchair?

Attitude
The patient’s attitude can tell the provider a lot about their psychological state at the time of assessment. Qualities of attitude that we can observe for in an evaluation include

- Is the patient cooperative, uncooperative, or superficially cooperative (in which they appear to be cooperative and compliant, yet the provider is able to sense an underlying resistance throughout the assessment)?
- Is the patient friendly and pleasant throughout evaluation, or are they guarded, evasive, confrontational, or even hostile?

Behavior
Similarly to a patient’s attitude, their behavior during the assessment can give the evaluator a lot of information about their psychological state and any underlying pathology. For example:

- Psychomotor activity – does the patient appear agitated or restless? Do they appear to have psychomotor slowing or retardation, or do they appear frozen and motionless (i.e. catatonic)?
- Eye contact – is the patient’s eye contact average or normal, or is it fair to poor?
- Abnormal movements – does the patient show signs of any tics, tremors, or other stereotypies or mannerisms? This is important to assess for possible pathology but also to assess for medication side effects, as many psychiatric medications can cause abnormal muscle movements (and in these cases, the addition of an Abnormal Involuntary Movement Scale to the evaluation is warranted).

Eye Contact
We can also assess for eye movements that may indicate possible underlying neurological issues and could indicate consideration of a neurology referral.

Speech
As with many of the other components of the MSE, speech can and should be assessed throughout the evaluation. It includes

- Rate – is it normal, fast, or slow? Pressured?
• Rhythm – is it regular, slurred, monotone?
• Volume – is it normal, loud, or soft?
• Latency - how long does the patient pauses before responding?
• You should also include information about any accents, stuttering, or lisps present.

II. Emotions

Mood

Mood versus affect is an important concept when it comes to evaluation of patients and their emotions. A patient’s mood is how they are feeling in their own words, oftentimes written as a direct quote with quotation marks, or marked on a scale of 1-10 with 10 being their best mood and 1 their worst.

Affect

On the other hand, affect is how the evaluator would describe the patient’s emotions during assessment. It is from the viewpoint of the evaluator, and we can also describe affect as compared to the patient’s mood. Terms used can include:

• Whether the patient appears depressed, sad, anxious, angry, euphoric, etc.,
• The patient’s range of affect. This could be normal, where the patient displays a full range of affect (which includes being appropriately sad and happy throughout assessment depending on the content discussed), or labile (where the patient appears overly emotional), or restricted or blunted, where very little to no emotion is shown by the patient during assessment.
• Whether the patient’s affect is congruent to mood. For example, if the patient describes their mood as “depressed” but is noted to be jovial, laughing, and generally happy throughout assessment, this would indicate an affect that is incongruent with their reported mood.
• Whether the patient’s affect is appropriate to the content of discussion. For example, if the patient is discussing terrible traumas and is appearing visibly tearful, crying and upset during this, it would be considered as appropriate to the content being discussed.

III. Thoughts & Perceptions

Thought Process

Thought process assesses the way the patient is thinking during evaluation. Assessment can include:

• Is the patients thinking logical and coherent or illogical and disorganized?
• Is the patients thinking goal-directed, and future-oriented? This is especially important when assessing suicidality.
• Is the patient displaying any abnormal thought patterns such as circumstantiality, tangentiality, loose associations, flight of ideas, or word salad?
• Abstraction can also be tested and can help better identify how the patient thinks (i.e. are they very concrete in their thought process, or are they able to abstract concepts from a phrase). This can be tested by asking them the meaning of a well-known proverb, such as, “don’t cry over spilled milk” or “the grass if always greener on the side.”

Though Content

This looks at the actual content of what the patient is saying and assesses for

• Suicidal or homicidal ideations,
• Ruminations or perseverations,
• Delusional, paranoid, bizarre, or grandiose thinking, and
• Obsessions, phobias, or ideas that are emotionally valuable to the patient.

Perceptions

When it comes to perceptions, we are concerned with sensory perceptions that the patients experience. These can be auditory or visual, and less commonly they can be tactile or olfactory. There are two main types of perceptions:
- **Hallucinations**, in which the patient experiences a sensory perception in the absence of a stimulus, and
- **Illusions**, in which the patient experiences a misinterpretation of a stimulus that truly is present. These can be pathological but are also quite common among healthy individuals (i.e. at nighttime, an individual misinterprets a shadow out of the corner of their eye to be the figure of a person. Upon looking again, they realize it was just a shadow).

### IV. Cognition

**Orientation**

Orientation tests the patient’s ability to recall where they are, when they are, and the context of their current situation. It is typically thought of as “alert, awake, and oriented to person, place, time and event” (i.e. AAOx4). You want to assess whether the patient is alert and aware, or drowsy, somnolent, etc. Ask them the date and the time, and the place/location where they are currently located.

**Attention**

Attention can be tested by asking the patient to perform serial 7’s, in which they are asked to count backwards from 100 by 7’s. It is important to not assist the patient with the task, as the point is that they are able to perform the task on their own and maintain their attention throughout. The patient can also be asked to spell WORLD forwards and backwards.

**Memory**

Memory can be subdivided on the MSE into four main components:

- **Immediate recall**, or the patient’s ability to relay information directly back to the observer after receiving that information, can be tested by asking a patient to repeat three words back to you in order.
- **Delayed recall**, or the patient’s ability to retain information for a brief period of time, can be tested by asking the patient to remember those words and then asking them to repeat them back to the observer after a period of about five minutes, during which other questioning and discussion should take place.
- **Short-term recall**, or the patient’s ability to remember information more long-term than the just interview period itself, can be assessed by asking the patient to remember what they had for breakfast earlier that day, or what they did yesterday.
- And finally, **long-term recall** tests their memory over time, and can be assessed by asking historical questions (as is performed naturally throughout the history portion of the interview) about where they grew up, what school they went to, etc.

There is also the concept of **fund of knowledge**, which tests the patient’s general overall knowledge and awareness of various social topics. This could be tested by asking them to remember the last five presidents or asking other relevant topics of the time period.

**Insight and Judgment**

**Insight** is an individual’s ability to identify that a problem exists and to possess understanding of the nature of that problem. It is important in assessing for possible compliance issues with patients. For example, if a delusional patient does not believe they are having delusions and believes that what is happening to them is real, they will not be inclined to take their medications as they do not see themselves as having a problem. In this case, the patient would be said to have poor insight. Insight could also be fair, appropriate, or good.

**Judgment** is an assessment of the patient’s response to various situations, and whether or not their responses are poor or appropriate decisions. A common question that can be used to assess judgment is, “if you were walking in the street and saw an envelope on the ground with an address and a stamp, what would you do?” A patient’s response to this question can give you further information about their decision-making processes.