The Purpose of the Mental Status Exam (MSE) and How to Conduct an MSE.

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The history and Mental Status Examination (MSE) are the most important diagnostic tools a psychiatrist has to obtain information to make an accurate diagnosis. Although these important tools have been standardized in their own right, they remain primarily subjective measures that begin the moment the patient enters the office. The clinician must pay close attention to the patient's presentation, including personal appearance, social interaction with office staff and others in the waiting area, and whether the patient is accompanied by someone (i.e. to help determine if the patient has social support). These first few observations can provide important information about the patient that may not otherwise be revealed through interviewing or one-on-one conversation.

When patients enter the office, pay close attention to their personal grooming. One should always note things as obvious as hygiene, but, on a deeper level, also note things such as whether the patient is dressed appropriately according to the season. For example, note whether the patient has come to the clinic in the summer, with 3 layers of clothing and a jacket. These types of observations are important and may offer insight into the patient's illness. Other behaviors to note may include patients talking to themselves in the waiting area or perhaps pacing outside the office door. Record all observations.

The next step for the interviewer is to establish adequate rapport with the patient by introducing himself or herself. Speak directly to the patient during this introduction, and pay attention to whether the patient is maintaining eye contact. Mental notes such as these may aid in guiding the interview later. If patients appear uneasy as they enter the office, attempt to ease the situation by offering small talk or even a cup of water. Many people feel more at ease if they can have something in their hands. This reflects an image

of genuine concern to patients and may make the interview process much more relaxing for them.

Legally, a mental status if conducted against the patient's will is considered assault with battery. Therefore, it is important to secure the patient's permission or to document that a mental status is being done without the patient's approval if in an emergency situation.

The time it takes to complete the initial interview may vary; however, with experience, interviewers develop their own comfortable pace and should not feel rushed to complete the interview in any time that is less than comfortable for either the interviewer or the patient. All patients require their own time during this initial interview and should never be made to feel they are being timed.

Beginning with open-ended questions is desirable in order to put the patient further at ease and to observe the patient's stream of thought (content) and thought process. Begin with questions such as "What brings you here today?" or "Tell me about yourself." These types of questions elicit responses that provide the basis of the interview. Keep in mind throughout the interview to look for nonverbal cues from patients. As they speak, for example, note if they are avoiding eye contact, acting nervous, playing with their hair, or tapping their foot repeatedly. In addition to the patient's responses to questions, all of these observations should be noted during the interview process.

As the interview progresses, more specific or close-ended questions can be asked in order to obtain specific information needed to complete the interview. For example, if the patient is reporting feelings of depression, but only states "I'm just depressed," determining both the duration and frequency of these depressive episodes is important. Ask leading questions such as "How long have you had these feelings?" or "When did these feelings begin?" and "How often do you feel this way?" or "How many days in the past week have you felt this way?" These types of questions help patients understand what information is needed from them. For safety reasons, both the patient and the interviewer should have access to the door in case of an emergency during the interview process.

At some point during the initial interview, a detailed patient history should be taken. Every component of the patient history is crucial to the treatment and care of the patient it identifies. The patient history should begin with identifying patient data and the patient's chief complaint or reason for coming to the clinic. The patient's chief complaint should be a quote recorded just as it was spoken, in quotation marks, in the patient's record. This also is where all history of illness is recorded, including psychiatric history, medical history, surgical history, and medications and allergies. Of interest, it is important to make direct inquiry to items such a family history of members being murdered—patients often do not volunteer this information.

Additionally, listing any family history of illness is important. This information can be very useful later, when determining treatment options. If a family member has a history of the same illness and had a successful drug regimen, that regimen may prove to be a viable option for the current patient. If possible, record the medications and dosages family members took for their illnesses. If these medications and dosages worked for family members, the chance is good that they may work for the current patient.

Obtain a complete social history. This addition to the patient history can be most crucial when discharge planning begins. Inquire if the patient has a home. Also ask if the patient has a family, and, if so, if the patient maintains contact with them. This also is the area in which any history of drug and alcohol abuse, legal problems, and history of abuse should be recorded.

Imperative to the recording of a patient's social history is any information that may aid the physician or other clinicians in making special accommodations for the patient when necessary. This would include an accurate record of the last grade completed in school, whether the patient was in special education classes, or if the patient required special assistance at work or school (ie, special listening devices for the hard of hearing).

Following completion of the patient's history, perform the MSE in order to test specific areas of the patient's spheres of consciousness. To begin the MSE, once again evaluate the patient's appearance. Document if eye contact has been maintained throughout the interview and how the patient's attitude has been toward the interviewer. Next, in order to describe the mood aspect of the examination, ask patients how they feel. Normally, this is a one-word response, such as "good" or "sad."

Next, the interviewer's task is to define the patient's affect, which will range from expansive (fully animated) to flat (no variation). The patient's speech then is evaluated. Note if the patient is speaking at a fast pace or is talking very quietly, almost in a whisper. Thought process and content are evaluated next, including any hallucinations or delusions, obsessions or compulsions, phobias, and suicidal or homicidal ideation or intent.

Then, the patient's sensorium and cognition are examined, most commonly using the Mini-Mental State Examination. The interviewer should ask patients if they know the current date and their current location to determine their level of orientation. Patients' concentration is tested by spelling the word "world" forward and backward. Reading and writing are evaluated, as is visuospatial ability. To examine patients' abstract thought process, have them identify similarities between 2 objects and give the meaning of proverbs, such as "Don't cry over spilled milk." Once this is completed, perform the physical examination (medical doctors) and needed laboratory tests to help exclude medical causes of presenting symptoms.

A compilation of all information gathered throughout the interview and MSE leads to the differential diagnosis of the patient. Once this diagnosis is established,

a treatment plan is formulated. At this point, involving the treatment team (eg, social workers, nurses, others) is important to help carefully explain to patients what their treatment will entail. Be sure to ask patients if they have any questions regarding their treatment plans. Discuss the details of the medications chosen, including adverse effects. Give details of the hospital stay if patients are to receive inpatient treatment, such as estimated length of stay, visiting hours, and other aspects. Inform patients that even though the interviewer is the treating physician, their input and concerns are valuable and necessary in order to fulfill treatment goals.

Every patient interview affords the health care professional an invaluable opportunity to provide patient education. While different illnesses may require specialized attention, this time can be used to discuss such patient issues as medication compliance, nutrition, the importance of follow-up appointments with primary care physicians and other specialists (eg, obstetricians, gynecologists), the urgency of seeking emergency medical help at the emergency department when necessary, the prevalence of psychiatric disorders, and general education concerning the patient's illness. Never overlook providing needed education to patients.

The process of conducting an accurate history and MSE takes practice and patience, but it is very important in order to evaluate and treat patients effectively. This part of psychiatry is so important that it comprises part II of the Board Certification Test. The history and MSE are crucial first steps in the assessment and are the only diagnostic tools psychiatrists have to select treatment for each patient and, therefore, ultimately are the deciding factor for initial treatments. This fact alone should make the interviewer cognizant of the essential role the history and MSE play each time a patient is evaluated.

Once the history and MSE are complete, documenting this event accurately and efficiently is important.

Chief complaint

This is the patient's problem or reason for the visit. Most often, this is recorded as the patient's own words, in quotation marks. This statement allows identification of the problem by identifying symptoms that lead to a diagnosis and, eventually, a specific treatment plan. To elicit this response, the interviewer should ask leading questions such as "What brings you here today?"

History of present illness

This is the main part of the interview because there are no specific elements that will lead to the diagnosis and ultimately treatment besides the interview.
An exact history allows one to gather basic information along with specific symptoms including timing in the patient's life to allow the healthcare provider to take care of the whole patient.

The important part of taking a history of present illness is listening. One should have an organized format but not too rigid in administering the examination.
For example, if asking about medication allergies and the patient brings up problems with alcohol, follow the patients lead and obtain information regarding the new data but then guide the patient back to the interview to allow all information to be gathered. Without a specific format, important information may be missed.

Remember to include both pertinent positives and negatives because these could be important aspects in determining diagnosis and treatment in complicated cases. Record important life events to complete this part of the evaluation, and this may help in establishing rapport with a patient.

This is *the patient's story of the presenting problem* and any additional details that led the patient to visit the psychiatrist. This includes information regarding why the patient is seeking help at a particular time (the "why now" aspect of the patient's life). This usually involves a triggering event or something that caused the patient to choose this point in life to seek help.

Realize there is no one particular way to take the history of present illness. Each person may differ in obtaining this important part of the examination.
Remember different approaches may be needed depending on the circumstances (e.g., emergency department consult versus a forensic evaluation).

Past medical history

List medical problems, both past and present, and all medical illnesses. At least ask a few screening questions regarding medical illnesses such as do you see a doctor regularly. If possible, try to obtain the patient's entire medical records rather than depending solely on the patient's self-report. Even the most minute detail of a patient's medical history, from as far back as childhood, could play a significant role in the presenting problem. Be certain to inquire about specific events that may have occurred in childhood, such as falls, head trauma, seizures, and injuries with loss of consciousness. All of these could be relevant to their current problems.

Past surgical history

List all surgical procedures the patient has undergone, including dates. Be as specific as possible when recording dates, and obtain medical records for review when possible. Patients may not volunteer this information unless asked specifically about operations.

Medication

List the patient's current medications, including dosages, route, regimen, and whether or not the patient has been compliant. If possible, have the patient bring his or her medications to the visit. Also, inquire about past medications. Additionally, with all past medications, look for signs or patterns of noncompliance. If noncompliance issues or

even drug-seeking behaviors appear evident, ask the patient who prescribed the medications and when or why the patient discontinued taking them.

Allergies

List all drug and food allergies the patient currently has or has had in the past, and list what type of reactions the patient had to the medications.

Past psychiatric history

List all of the patient's treatment, including outpatient, inpatient, and therapy-based (ie, individual, couples, family, group), including dates. Inquire about past psychotropic medications and response, compliance, and dosages. Ask patients if they feel that they received any benefits from the treatments. If so, inquire about the specific type of benefit. Additionally, ask patients which medications they feel helped them most in the past and ask which ones helped them least. From an insightful patient, this information may offer clues as to which class of medication the patient responds to best. If possible, try to obtain old psychiatric records.

Family history

List any psychiatric or medical illnesses, including method of treatment such as hospitalization (medical and psychiatric) of family members and response.
Once again, the emphasis here is strong. Record any information obtained because it may help in treatment planning. If a patient's family member has been diagnosed with the same psychiatric illness and has been treated successfully, treating the current patient with that same medication may be appropriate. This may be a reasonable place to begin.

Social history

Obtain a complete social history of the patient. Ask patients their marital status. Also, inquire about employment status. If the patient is employed, inquire about the frequency of absences from work. If the patient is not employed, inquire about whether the patient currently is looking for work. Also inquire if a previously held job was lost as a result of the illness. Obtain as much detailed information as possible.

Recording an accurate educational history is imperative. Inquire how far the patient went in school. Ask if he or she was in special education classes.
Ask if the patient has a learning disability and if the patient has any other problem such as a hearing impairment or speech problem. These issues are very important in the evaluation of patients undergoing psychiatric assessment, and patient care could be jeopardized if they are not addressed. A patient's communication problems, for example, could be due to a language disorder rather than a thought disorder, and the initiation of psychiatric medications could further affect communication, not to mention cause legal concerns for the prescribing physician. All of these things must be kept in mind at all times when completing the social history.

Record the number, sex, and age of the patient's children. Ask if any of the children have any medical or psychiatric problems. List the patient's toxic habits, including past and current use of tobacco, alcohol, and street drugs. This is important because many patients can become dependent on prescribed medications. Try to determine whether the patient has a history of drug abuse.

Include any military history, including length of service and rank. This could help determine if a patient is eligible for US Veterans Administration benefits or other assistance.

Another important issue in obtaining a very thorough patient history is the patient's housing status. This becomes a vital part of the discharge plans.
Ask if the patient has a home. Inquire if they have a family and if they have contact with that family. Ask where the patient will go at the completion of his or her hospital stay. Also ask who will ensure that the patient remains compliant with medication therapy. These become crucial points when finding placement for patients at discharge and planning long-term follow-up care. Therefore, careful recording of housing and support is very important.

Inquire about the existence (and number) of siblings, their names and phone numbers, and any church affiliations, just in case the information is needed later.

Also in the history section, record any legal problems the patient may have had in the past. This should include jail time, probation, arrests (eg, for driving while intoxicated or driving under the influence of drugs), and any other relevant information that can provide insight into the patient's problems with the law.

Patient history also should include hobbies, social activities, and friends. If the patient has any history of abuse, mental or physical, it should be recorded here. Any other relevant information that may be useful in treating the patient or helpful in aiding in aftercare should be recorded in the patient history.

Inquire about the patient's and the patient's parents' religious beliefs. Did the patient grow up in a strict religious environment? Does the patient have a particular religious belief and has that changed since childhood, adolescence, or adulthood? Investigate what effect the patient's beliefs have on treatment of psychiatric illnesses or suicide.

Perinatal and developmental history

Record any relevant perinatal and developmental history. Ask if the patient was born prematurely. Ask about any complications associated with their birth.
Ask if they were told how old they were when they spoke their first word or took their first step.

Assets

List attributes of the patient. Examples may include that the patient agreed to voluntary acceptance of treatment, has strong verbal skills, or exhibits above average intelligence, just to name a few.

MENTAL STATUS EXAMINATION

Appearance

Record the patient's sex, age, race, and ethnic background. Document the patient's nutritional status by observing the patient's current body weight and appearance. Remember recording the exact time and date of this interview is important, especially since the mental status can change over time such as in delirium.

Recall how the patient first appeared upon entering the office for the interview. Note whether this posture has changed. Note whether the patient appears more relaxed. Record the patient's posture and motor activity. If nervousness was evident earlier, note whether the patient still seems nervous. Record notes on grooming and hygiene. Most of these documentations on appearance should be a mere transfer from mind to paper because mental notes of the actual observations were made when the patient was first encountered. Record whether the patient has maintained eye contact throughout the interview or if he or she has avoided eye contact as much as possible, scanning the room or staring at the floor or the ceiling.

Attitude toward the examiner

Next, record the patient's facial expressions and attitude toward the examiner. Note whether the patient appeared interested during the interview or, perhaps, if the patient appeared bored. Record whether the patient is hostile and defensive or friendly and cooperative. Note whether the patient seems guarded and whether the patient seems relaxed with the interview process or seems uncomfortable. This part of the examination is based solely on observations made by the health care professional.

Mood

The mood of the patient is defined as "sustained emotion that the patient is experiencing." Ask questions such as "How do you feel most days?" to trigger a response. Helpful answers include those that specifically describe the patient's mood, such as "depressed," "anxious," "good," and "tired." Elicited responses that are less helpful in determining a patient's mood adequately include "OK," "rough," and "don't know." These responses require further questioning for clarification.

Establishing accurate information pertaining to the length of a particular mood, if the mood has been reactive or not, and if the mood has been stable or unstable also is helpful.

Affect

A patient's affect is defined in the following terms: expansive (contagious), euthymic (normal), constricted (limited variation), blunted (minimal variation), and flat (no variation). A patient whose mood could be defined as expansive may be so cheerful and full of laughter that it is difficult to refrain from smiling while conducting the interview. A patient's affect is determined by the observations made by the interviewer during the course of the interview.

Speech

Document information on all aspects of the patient's speech, including quality, quantity, rate, and volume of speech during the interview. Paying attention to patients' responses to determine how to rate their speech is important. Some things to keep in mind during the interview are whether patients raise their voice when responding, whether the replies to questions are one-word answers or elaborative, and how fast or slow they are speaking.

Thought process

Record the patient's thought process information. The process of thoughts can be described with the following terms: looseness of association (irrelevance), flight of ideas (change topics), racing (rapid thoughts), tangential (departure from topic with no return), circumstantial (being vague, ie, "beating around the bush"), word salad (nonsensical responses, ie, jabberwocky), derailment (extreme irrelevance), neologism (creating new words), clanging (rhyming words), punning (talking in riddles), thought blocking (speech is halted), and poverty (limited content).

Throughout the interview, very specific questions will be asked regarding the patient's history. Note whether the patient responds directly to the questions.
For example, when asking for a date, note whether the response given is about the patient's favorite color. Document whether the patient deviates from
the subject at hand and has to be guided back to the topic more than once. Take all of these things in to account when documenting the patient's thought process.

Thought content

To determine whether or not a patient is experiencing hallucinations, ask some of the following questions. "Do you hear voices when no one else is around?"
"Can you see things that no one else can see?" "Do you have other unexplained sensations such as smells, sounds, or feelings?"

Importantly, always ask about command-type hallucinations and inquire what the patient will do in response to these commanding hallucinations. For example,

ask "When the voices tell you do something, do you obey their instructions or ignore them?" Types of hallucinations include auditory (hearing things), visual (seeing things), gustatory (tasting things), tactile (feeling sensations), and olfactory (smelling things).

To determine if a patient is having delusions, ask some of the following questions. "Do you have any thoughts that other people think are strange?" "Do you have any special powers or abilities?" "Does the television or radio give you special messages?" Types of delusions include grandiose (delusions of grandeur), religious (delusions of special status with God), persecution (belief that someone wants to cause them harm), erotomanic (belief that someone famous is in love with them), jealousy (belief that everyone wants what they have), thought insertion (belief that someone is putting ideas or thoughts into their mind), and ideas of reference (belief that everything refers to them).

Aspects of thought content are as follows: list of 14 items

• *Obsession and compulsions*: Ask the following questions to determine if a patient has any obsessions or compulsions. "Are you afraid of dirt?" "Do you wash your hands often or count things over and over?" "Do you perform specific acts to reduce certain thoughts?" Signs of ritualistic type behaviors should be explored further to determine the severity of the obsession or compulsion.

• *Phobias*: Determine if patients have any fears that cause them to avoid certain situations. The following are some possible questions to ask. "Do you have any fears, including fear of animals, needles, heights, snakes, public speaking, or crowds?"

• *Suicidal ideation* or intent: Inquiring about suicidal ideation at each visit is always important. In addition, the interviewer should inquire about past acts of self-harm or violence. Ask the following types of questions when determining suicidal ideation or intent. "Do you have any thoughts of wanting to harm or kill yourself?" "Do you have any thoughts that you would be better off dead?" If the reply is positive for these thoughts, inquire about specific plans, suicide notes, family history (anniversary reaction), and impulse control. Also, ask how the patient views suicide to determine if a suicidal gesture or act is ego-syntonic or ego-dystonic. Next, determine if the patient will contract for safety. For homicidal ideation, make similar inquiries.

• *Homicidal ideation or intent*: Inquiring about homicidal ideation or intent during each patient interview also is important. Ask the following types of questions to help determine homicidal ideation or intent. "Do you have any thoughts of wanting to hurt anyone?" "Do you have any feelings or thoughts that you wish someone were dead?" If the reply to one of these questions is positive, ask the patient if he or she has any specific plans to injure someone and how he or she plans to control these feelings if they occur again.

• *Sensorium and cognition*: Perform the Folstein Mini-Mental State Examination.
• Consciousness: Levels of consciousness are determined by the interviewer and are rated as (1) coma, characterized by unresponsiveness; (2) stuporous, characterized by response to pain; (3) lethargic, characterized by drowsiness; and (4) alert, characterized by full awareness.

• *Orientation*: To elicit responses concerning orientation, ask the patient questions, as follows. "What is your full name?" (i.e., person). "Do you know where you are?" (ie, place). "What is the month, date, year, day of the week, and time?" (ie, time). "Do you know why you are here?" (i.e., situation).

• *Concentration and attention*: Ask the patient to subtract 7 from 100, then to repeat the task from that response. This is known as "serial 7s." Next, ask the patient to spell the word "world" forward and backward.

• *Reading and writing*: Ask the patient to write a simple sentence (noun/verb). Then, ask patient to read a sentence (eg, "Close your eyes."). This part of the MSE evaluates the patient's ability to sequence.

• *Visuospatial ability*: Have the patient draw interlocking pentagons in order to determine constructional apraxia.

• *Memory*: To evaluate a patient's memory, have them respond to the following prompts. "What was the name of your first grade teacher?" (ie, for remote memory). "What did you eat for dinner last night?" (ie, for recent memory). "Repeat these 3 words: 'pen,' 'chair,' 'flag.' " (ie, for immediate memory). Tell the patient to remember these words. Then, after 5 minutes, have the patient repeat the words.

• *Abstract thought*: Assess the patient's ability to determine similarities. Ask the patient how 2 items are alike. For example, an apple and an orange (good response is "fruit"; poor response is "round"), a fly and a tree (good response is "alive"; poor response is "nothing"), or a train and a car (good response is "modes of transportation"). Assess the patient's ability to understand proverbs. Ask the patient the meaning of certain proverbial phrases.
Examples include the following. "A bird in the hand is worth 2 in the bush" (good response is "be grateful for what you already have"; poor response is "one bird in the hand"). "Don't cry over spilled milk" (good response is "don't get upset over the little things"; poor response is "spilling milk is bad").

• *General fund of knowledge*: Test the patient's knowledge by asking a question such as, "How many nickels are in $1.15?" or asking the patient to list the last 5 presidents of the United States or to list 5 major US cities. Obviously, a higher number of correct answers is better; however, the interviewer always should take into consideration the patient's educational background and other training in evaluating answers and assigning scores.

• *Intelligence*: Based on the information provided by the patient throughout the interview, estimate the patient's intelligence quotient (ie, below average,average, above average).
list end

- *Insight*

Assess the patients' understanding of the illness. To assess patients' insight to their illness, the interviewer may ask patients if they need help or if they believe their feelings or conditions are normal.

- *Judgment*

Estimate the patient's judgment based on the history or on an imaginary scenario. To elicit responses that evaluate a patient's judgment adequately, ask the following question. "What would you do if you smelled smoke in a crowded theater?" (good response is "call 911" or "get help"; poor response is "do nothing" or "light a cigarette").

- *Impulsivity*

Estimate the degree of the patient's impulse control. Ask the patient about doing things without thinking or planning. Ask about hobbies such as coin collecting,
golf, skydiving, or rock climbing.

- *Reliability*

Estimate the patient's reliability. Determine if the patient seems reliable, unreliable, or if it is difficult to determine. This determination requires
collateral information of an accurate assessment, diagnosis, and treatment.

OTHER DIAGNOSTIC EVALUATIONS

Perform a complete physical examination, including a neurological examination. Obtaining collateral information from family members, friends, and colleagues
is important. These individuals all can help in formulating an accurate account of the events that led to the patient's visit to the psychiatrist.

• *Psychological evaluation*: Some evaluations require a battery of psychological tests, including neuropsychological testing when deemed appropriate. This series of tests can help determine what types of deficits the patient might have, can help identify DSM V diagnosis and can help identify other factors, such as factitious disorders or malingering.

• *Laboratory testing* (See Lab studies inTreatment Plan.)
• *Diagnosis:* Use the Diagnostic and Statistical Manual of Mental Disorders – DSM V