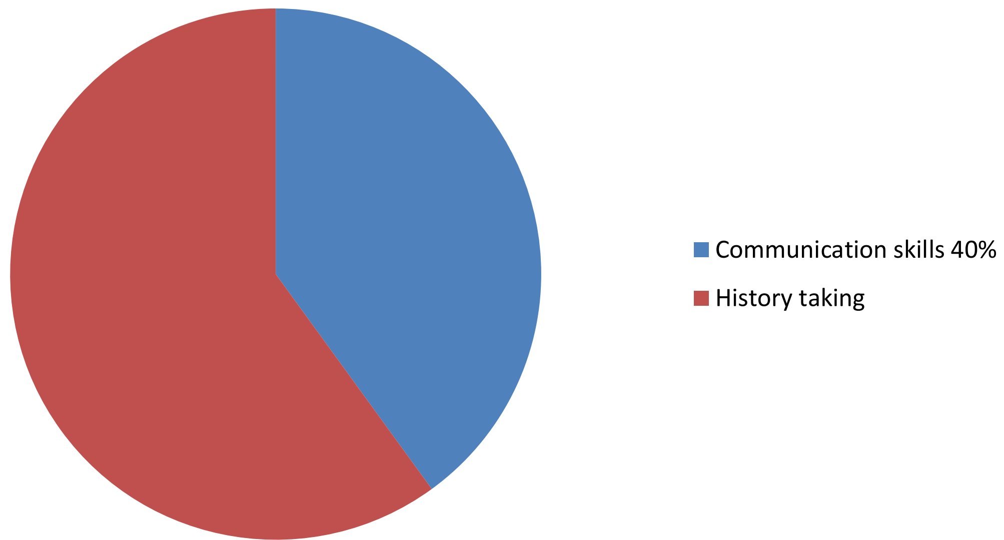

A 28 year old female believe that she is having the devils baby. She has some superficial self-inflicted lacerations to her abdomen that have already been treated. Assess her mental state

Washed hands	
Introduces self	
Checks patient identity	
Obtains verbal consent for interview	
Comments on appearance	
Asks about thought disorders	
Asks about hallucinations	
Asks about insight	
Comments on speech pattern	
Asks about mood	
Attempts to check cognition	
Asks about psychiatric hx	
Asks about psychiatric follow-up	
Asks about medical history	
Asks about medications and compliance	
Asks about illicit drugs	
Has management plan	
Patient global score	

The mental state examination (MSE) *is a structured way of observing and describing a patient's current state of mind, under the domains of appearance, attitude, behaviour, mood, affect, speech, thought process, thought content, perception, cognition and insight.*

The purpose of the MSE is to obtain a comprehensive cross-sectional description of the patient's mental state, which when combined with the biographical and historical information of the psychiatric history, allows the clinician to make an accurate diagnosis and formulation. Below is a framework that demonstrates the type of information that the mental state examination hopes to gain.

Appearance - The appearance of the patient may provide some clues as to their lifestyle and ability to self-care:

- Distinctive features
- Clothing
- Posture/gait
- Grooming/hygiene
- Grooming/hygiene
- Evidence of self-harm

Behaviour - A patient's non-verbal communication may provide insights into their current mental state:

- Eye contact
- Facial expression
- Psychomotor activity – *motor activity related to mental processes (can be slowed or increased)*
- Body language / gestures / mannerisms
- Level of arousal – *calm / agitated / aggression*
- Ability to follow requests
- Rapport / engagement
- **Speech**
- **Rate of speech** – pressured / slowed
- **Quantity of speech** – minimal *(e.g. only in response to questions)* /excessive speech / complete absence of speech
- **Tone of speech –** monotonous / tremulous
- **Volume of speech –** loud / quiet

Mood and Affect - Mood and affect both relate to emotion, however, they are not the same thing:

- **Affect** represents an immediately expressed and observed emotion (e.g. the patient's facial expression or overall demeanour)
- **Mood** represents a sustained emotion present over a prolonged period of time that can alter an individual's perception of the world
- *To understand the relationship between the two it can be useful to think of mood as the climate and affect as the weather*
- *In the mental state exam affect is what you observe, whereas mood is what you enquire about as shown below*

Mood - Mood refers to a sustained state of the patient's inner feelings. To explore these you need to ask the patient questions about their mood:

- *"How are you feeling?"*
- *"What is your current mood?"*
- *"Have you been feeling low/depressed/anxious lately?"*

Examples of various mood states:

- Low/depressed
- Anxious
- Angry/irritable
- Apathetic
- Elated

Affect - **Affect refers to an observable expression of a patient's inner feelings. You therefore should observe the patient's facial expressions/demeanor to assess affect.**

Quality of affect:

- Sad/agitated/hostile
- Euphoric/animated

Range of affect:

- Restricted
- Normal
- Expansive

Intensity of affect:

- Normal
- Blunted
- Flat

Fluctuations in affect:

- Labile – *easily changed between states*

Thought form

Speed – accelerated / racing / retarded
Flow/ coherence:

- Linear – in a logical order
- Incoherent – makes no logical sense
- Circumstantial – lots of irrelevant/unnecessary details (*not to the point*)
- Tangential – the patient goes off on tangents relating loosely to the initial thought (*flight of ideas)*
- Perseveration – repetition of a particular response despite the absence/removal of the stimulus

Thought content

Abnormal beliefs/ delusions
Obsessions – patient is aware they are irrational, but obsessive thoughts continue to enter their head
Overvalued ideas – *e.g. the perception of weight in a patient with anorexia nervosa*
Suicidal thoughts
Homicidal/violent thoughts

Examples of questions to screen for thought content abnormalities:

- *"What's been on your mind recently?"*
- *"Are you worried about anything?"*
- *"Do things seem unreal to you?"*
- *"Are there any thoughts you have a hard time getting out of your head?"*
- *"Do you think anyone is trying to harm you?"*
- *"Do you have any beliefs that aren't shared by others you know?"*
- *"Do you ever think about ending your life?"*
- *"Have you ever felt your life was not worth living?"*
- *"Have you ever attempted to end your life?"*
- *"Do you ever think about harming other people?"*

Thought possession

Thought insertion – belief that thoughts can be put into the patient's mind
Thought withdrawal – belief that thoughts can be removed from patient's mind
Thought broadcasting – belief that others can hear the patient's thoughts

Examples of questions to screen for thought possession abnormalities:

- *"Do you think people can put ideas in your head?"*
- *"Have you ever felt like people have removed/erased things/memories from your mind?"*
- *"Do you ever feel like others can hear what you're thinking?*

Perception

Hallucinations – a sensory perception without any external stimulation of the relevant sense that the patient believes IS real *(e.g. hears voices but no sound present)*
Pseudo-hallucinations – the same as a hallucination but the patient is aware that it IS NOT real
Illusions – illusions are misinterpreted perception such as mistaking a shadow for a person (*whereas a hallucination is a false perception)*

Examples of questions to screen for perception abnormalities:

- *"Do you ever see, hear, smell, feel, or taste things that are not really there?"*
- *"Did you think this was real at the time?"*
- *"Do you still believe it was real?"*

Cognition

Basic testing:

- **Orientation** *(time/place/person)*
- **Attention and concentration**
- **Short-term memory**

Detailed testing – *Mini-mental state exam (MMSE/ACE-III)*

Insight and Judgement

Insight

Is the patient able to recognise they have a problem or recognise what they're experiencing is abnormal?
What does the patient think is the cause of the problem?
Does the patient want help with their problem?

Judgement

Assess the patient's general problem-solving ability
Example question:

- *"What would you do if you could smell smoke in your house?"*
- Introduces themselves
- Confirms patient details
- Observes patient's appearance
- Observes patient's behaviour
- Attempts to establish rapport
- Speech quality (clarity/volume)
- Rate of speech
- Quantity of speech
- Asks about patient's mood
- Notes patient's affect
- Speed of thoughts
- Flow/fluency of thoughts
- Abnormal beliefs or delusions
- Obsessions Suicidal/violent thoughts
- Thought possession abnormalities
- Hallucinations Illusions
- Assesses cognition (e.g. MMSE)
- Assesses insight
- Assesses judgement
- Thanks patient
- Summarises salient points of the history using MSE structure