The Mental State Examination

The moment one sets eyes on a patient an assessment of mental state is underway. Although the mental state is recorded at the end of a set of interview notes, the examination takes place throughout the assessment.
It is important to remember that the mental state examination can be affected by a number of factors and these need to be considered when trying to reach a diagnosis.
For example:

- The presence of significant others in the room. (Wherever possible try to see the patient at some point alone.)
- Time of day. (Important if there is diurnal variation of mood, fatigue etc.)
- The place in which the examination is performed.
- The gender of the examiner.

Historically, the examination is recorded under the following headings:

- **Appearance and behaviour**
- **Rapport**
- **Speech**
- **Mood**
- **Thought**
- **Perception**
- **Cognition**
- **Insight**

Appearance and Behaviour

Ideally, this should provide a detailed description of the patient, which evokes a clear image in the mind of someone who subsequently reads the notes.
Important areas to cover are:

- Physical characteristics- hair and eye colour, ethnic origin, stature and posture.
- Facial characteristics- e.g. furrowing of brow, tear-rimmed eyes facial expression and eye contact.
- Overall quality of appearance- kempt or unkempt, personal hygiene standards (including body odour)
- Additional body adornments- body piercings, tattoos and slogans (e.g. ‘Ganja’ on T-shirt), make-up.
- Clothing- note – shoes tell a lot about some one! People who are trying to project a particular image will pay attention to their clothing, but often shoes are the last things they think about. Is the clothing appropriate to the time of year and occasion?
- Is the appearance consistent with the chronological age?
- What is the general behaviour of the patient- is there disinhibition, psychomotor retardation, are there any abnormal movements (tics, myoclonic jerks, mannerisms, stereotypies , catatonic signs) any sign of response to hallucinatory experiences.
- What is the patient’s response to the strange situation of the interview?.

Rapport

This is a measure of the quality of the interaction between the patient and examiner. Instead of simply commenting on whether or not rapport is present, it is helpful to describe the actual characteristics of the interaction and how it changes throughout the interview. For example, total lack of rapport can develop into a warm and confiding discussion and vice versa. Comment on any suspiciousness, hostility or inappropriate ‘chumminess’. It is normal for there to be a degree of anxiety in any initial interview. Rapport may be improved when the parents leave the room.

Speech

It is usual to comment on several aspects of speech:

Is speech spontaneous or does it have to be squeezed out of the patient.

Are responses made in sentences or are they monosyllabic.

Is there the usual change in tone throughout a sentence or is there lack of emphasis or intonation (dysprosody).

Is the speech to the point and relatively succinct or does the patient take forever to get to the point, including lots of unnecessary detail (circumstantiality).

Is the speech coherent and understandable or not. There may be loss of coherence for a number of reasons i.e. impaired intellect, organic disorder, formal thought disorder or anxiety. Disorders of form of thought are deduced by speech, but are commented upon in the section of the mental state headed 'thoughts'.

Is the rate of speech increased (pressured) or decreased (poverty of).

Is there a 'satellite delay' in the patient's answering of a question (latency)

'Flight of ideas' is observed in speech and is also an example of a disorder of form of thought.

Content of speech should also be described. For example: depressive, hypochondriacal, disinhibited.

Does the patient answer repetitively to different questions with the same answer (this is called perseveration and is indicative of an organic disorder)

Definitions of speech irregularities

Approximate answers the patient avoids giving the correct answer to a simple question indicating that the actual question has been understood. This occurs in hebephrenic schizophrenia, hysterical pseudodementia, the Ganser syndrome and organic conditions.

Paraphasia This is the evocation of an inappropriate sound in the place of a word or phrase. It can be caused by an organic disturbance of speech, but can also occur in the situation where somebody makes a sound, which may be deliberate or unconscious, to change the topic of conversation.

Pseudologica fantastica This is fluent and plausible lying associated with hysterical or asocial personality disorders.

Aphonia The loss of the ability to vocalise. The patient talks only in a whisper.

Dysphonia is impairment with hoarseness, but without complete loss of function.

Hysterical aphonia occurs with no organic cause.

Dysarthria This is a disorder of articulation caused by an organic lesion. Idiosyncratic disorders of articulation are sometimes seen in schizophrenia and may be consciously produced in personality disorders.

Logoclonia The spastic repetition if syllables that occurs with Parkinsonism. The patient may get stuck on a particular word.

Echolalia The patient repeats words or part of phrases that he hears. There is usually no understanding of the meaning of the word. It is most often seen in excited schizophrenic states, mental handicap and with organic states such as dementia, especially if dysphasia is also present.

Paragrammatism This is a disorder of the grammatical construction of speech.

Neologisms These are new words with an idiosyncratic meaning.

Stock words and phrases are existing words that are used in an idiosyncratic way.

Cryptolalia A private language which is spoken.

Cryptographia A private language which is written.

Aphasia This implies the loss of language altogether.

Dysphasia This implies impairment of or difficulty with language.

Sensory dysphasia (receptive) The patient is unable to understand spoken speech, with loss of comprehension of the meaning of words and the significance of grammar. Hearing is not impaired. Speech is fluent, with no appreciation of the many errors in the use of words, syntax and grammar.

Conduction dysphasia This is a type of sensory dysphasia in which the sensory reception of speech and writing are impaired, in that the patient cannot repeat the message, although he can speak and write. If he is questioned about the message he is able to give ‘yes’ and ‘no’ answers correctly indicating that he has comprehension.
Nominal dysphasia The patient is unable to produce sounds and names at will.
Jargon aphasia Speech is fluent, but there is a gross disturbance of syntax, which makes it intelligible. This is a severe type of sensory aphasia.
Motor aphasia The patient understands spoken speech and writing and can respond to comments. Writing is preserved, but speech is indistinct and cannot b produced at will. There is no disturbance of muscles required in speech.
Agraphia Inability to write.
Primary motor dysphasia There is disturbance in the process of selecting words, constructing sentences and expressing them. Speech and writing are both affected and there is a difficulty in carrying out complex instructions. The patient finds it difficult to choose and pronoun