# Mental State Examination

- Mental state examination aims to *objectively* assess the patient's state of mind at the time of the interview – it is therefore different to the history, which is concerned with the development and progression of the patient's *subjective* experiences over time
- The mnemonic **ACT MAD** is very useful in helping to remember the different areas you need to assess:

  **A**ppearance and behaviour

  **C**onversation and speech

  **T**hought: form and content

  **M**ood

  **A**bnormal perceptions

  **D**ementia & cognitive screen

  Also remember to assess the patient's **insight** and **risk** of harm to self or others *(ACT MAD IR?)*

- **Appearance and behaviour**
  - **Manner of dress and grooming** – are they well-kept or do they look neglected?
  - Note any significant **bedside examination features** e.g. needle marks, pallor, jaundice, scars
  - **Behaviour** – is there a normal level of activity and arousal? Are they excitable or passive? Can they sit still? Do they appear agitated, anxious or afraid? Do they look sad or tearful?
  - **Unusual actions or movements** – listening to voices, hiding/searching, repetitive actions, odd gestures, echopraxia, unexplained laughter, tremors, tics, dyskinesia, unusual posture or gait
  - **Rapport** – eye contact, smiling, open/closed body language, cooperation, suspicion/aggression
  - Describe the patient's overall appearance and THEN say **what impression this gives you** about them – you need to be specific about why you feel this way about them
- **Conversation and speech**
  - This refers the patient's **production of speech** rather than the content of the conversation
  - **Spontaneity** – do they willingly volunteer information or just passively give yes/no answers?
    - Is there any **perseveration** or **echolalia**?
  - **Volume** – loud or quiet? Do they make any sound at all or are they mute?
  - **Rate** – slow/retarded or fast? Is there true pressure of speech or flight of ideas?
  - **Tone & prosody** – normal or low and monotonous?
  - **Articulation** – are sentences clearly articulated or slurred?
  - **Coherence** – is speech coherent and understandable? Do they use any neologisms?
- **Thought: form and content**
  - This refers to **what the patient actually says** during the conversation – assessing this relies heavily upon their ability to coherently articulate and express their thoughts, so it is sometimes difficult to differentiate a true thought disorder from a speech disorder!
  - **Form:** this refers to how well the patient's thoughts are put together to make ideas
    - **Flight of ideas** is a symptom of mania – ideas are (loosely) linked but hard to follow
    - **Knight's move:** "derailment" of ideas results in conversation moving onto a different track
    - **Word salad:** random assembly of words results in incoherent gibberish
    - **Circumstantiality:** excessively long-winded speech due to meandering train of thought
    - **Thought block:** common in schizophrenia – train of thought is brought to a complete stop
    - **Poverty of thought:** global reduction in quantity of thoughts
  - **Content:** this is what the patient is actually thinking about and the ideas these thoughts produce
    - **Fixed ideas/preoccupations** e.g. fear, danger, suspicion, nihilism, suicide, homicide
    - **Circumstantial thinking** is common in anxiety disorders → excessive details, "what if's"
    - **Obsessions** e.g. washing hands, light switches, locking doors
    - **Delusions** e,g, persecutory, grandiose, thought interference, hypochondriac, nihilistic
  - Try to ascertain if abnormal thoughts and ideas have arisen *de novo* or because of the voices!
- **Mood**
  - Are they **euthymic, elated or low**?
    - Important to get the patient's **subjective** view and your **objective** impression
  - **Congruent or incongruent** with their thoughts?
  - **Reactive** to the content of the conversation?
  - Emotionally **labile**?
  - Ask about **anhedonia**, **confidence**, **guilt**, **worthlessness**, **nihilism**, **whether life is worth living**
  - Ask about **biological symptoms** e.g. energy levels, sleep, appetite, weight, concentration
- **Abnormal perceptions**
  - Specifically ask about **hallucinations** in any sensory modality – get them to describe in detail
    - Third person auditory hallucinations are the most common and indicate schizophrenia
    - Second person auditory can occur in psychotic depression → say nasty things about patient
    - Visual hallucinations often indicate underlying organic cause e.g. epilepsy, Charles-Bonnet
    - Tactile hallucinations are less common and can occur in organic disease, substance misuse or withdrawal, and florid psychosis
  - **Pseudohallucinations** occur when the patient is aware the stimulus is in the mind, and the voice therefore comes from within their body instead of being externalised
  - **Hypnagogic and hypnopompic hallucinations** are common whilst falling asleep and waking up
  - **Illusions** are an abnormal perception of a genuine stimulus, e.g. mistaking wallpaper patterns for insects, making assumptions about late-night noises or overheard conversations
  - **Depersonalisation** and **derealisation** are features of anxiety disorders
  - Other **unusual sensations** of any kind e.g. *déjà vu*, *jamais vu*, *presque vu*
- **Dementia and cognitive screen**
  - In younger patients it's usually sufficient to note that they are *"orientated to time, place and person"*
  - It may be necessary to perform some simple cognitive tests just to be sure:
    - **Orientation:** *"Who are you? Where are you? What is the date?"*
    - **Short-term memory:** registration and recall of an address or a short list of objects
    - **Long-term memory:** who the Prime Minister is, who is the monarch, some current affairs
    - **Concentration:** recite months of the year backwards, subtract serial 7s from 100
  - In older patients an organic pathology is much more likely, so it is best to perform a **MMSE** or **AMTS** +/- frontal lobe tests and judgement tests
  - For suspected dementia, there are many much more complicated specialised tests available
- **Insight**
  - Is the patient **aware that their experiences are abnormal or extraordinary**?
  - Is the patient **aware that their experiences are the result of a pathological process**?
  - Does the patient **accept the need for treatment** to improve their symptoms?
  - Is the patient **concordant** with any currently prescribed treatment regimes?
  - Is the patient **able to recognise the recurrence of their symptoms** and seek advice or help?
- **Risk assessment (ALL PATIENTS)**
  - Asking patients about suicide does NOT increase their risk of killing themselves!
  - There are many sensitive ways of approaching this important issue
  - *"How do you feel about the future?"*
  - *"Do you ever feel that life is no longer worth living or that you'd be better off dead?"*
  - *"Have you ever thought about harming yourself?"*
    - Details of current **patterns of self-harm** e.g. cutting, burning; any relief of dysphoria gained
    - **Clarity of suicidal thoughts**: feeling like dying vs actually determining to end life
    - Have they **planned** how they will actually do it? Get as much detail as you can.
      - high risk indicators: previous unsuccessful attempts, detailed plan, violent means, concealment, no access to help, complicit assistants, suicide pacts
    - If so, do they have **access** to the required means? e.g. stockpiling medications, firearms
    - Have they **told anyone** about their plans? (people are often relieved to tell *somebody*!)
    - Have they started **putting their affairs in order**? e.g. sorting finances, writing a will
    - Have they written a **suicide note**?
  - Also very important to always ask: *"Have you ever thought about harming other people?"*
  - The psychiatric history will provide valuable information about **risk factors** e.g. past history of self harm, attempted suicide (methods + outcomes) or violent behaviour; substance misuse; stress
  - The history will also provide details of **protective factors** e.g. family, friends, fear

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