If you do nothing else when assessing mental state - assess suicide risk

The Mental State Examination

Practitioners should maintain a high index of suspicion for suicidal thinking / plans

The moment one sets eyes on a person 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 person 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 person, 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 person - 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 person's response to the strange situation of the interview?

Rapport

This is a measure of the quality of the interaction between the person 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.

Speech

It is usual to comment on several aspects of speech:

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

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 person 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 person'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 person 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 person 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 person 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 person may get stuck on a particular word.

Echolalia The person 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 person 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 person 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 person 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 person 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 person finds it difficult to choose and pronounce words, and speech is hesitant and slow. Gesture may be used to replace verbal communication.

Mood

It is important to note that ***mood is different from affect***. Sometimes they are used interchangeably, but this is incorrect.

Mood is the prevailing feeling emotional state or the dominant 'hedonic tone'. It is longer lasting than affect, which is an observed short-term emotion.
In the mental state examination one asks the person what has been their predominant feeling state or 'mood'. This is recorded as 'subjective mood'. One also records any biological symptoms of mood disorders e.g. sleep, appetite, energy, libido and enjoyment. Suicidal ideation can be noted here (or under thought content)

The objective mood is recorded. Strictly speaking one is observing the 'affect'.

The mood can be: -

- Elevated
- Euthymic
- Depressed
- Labile
- Angry
- Irritable
- Blunted
- Flattened
- Euphoric
- Incongruent
- Anxious

Thought

This is best divided into the following categories:

Stream

Possession

Content

Form

Abnormalities of Stream (or flow, speed or pressure)

There is an alteration in either the amount or the speed of thought.
At one extreme there is pressure of thought and at the other is poverty of thought.
Pressure occurs in mania and poverty occurs in depression. Either can occur in schizophrenia.
Stream can be interrupted suddenly. Minor degrees can observe in anxiety or fatigue. In contrast, thought blocking, which is a particularly abrupt and complete interference, strongly suggests schizophrenia. Because thought blocking has this diagnostic significance it should only be identified if there is absolutely no doubt about its presence. The diagnostic association with schizophrenia is strengthened if the person interprets the experience unusually. (E.g. having his thoughts taken away by a cosmic yellow submarine)

Possession

We usually take for granted that our thoughts are our own. We assume that they are private experiences that are only known to others if spoken out aloud or revealed through gesture, action or facial expression.
Delusions of possession of thought can take different forms.

Thought insertion:

the person believes that their thoughts have been implanted by some outside agency. This is different from somebody who is experiencing obsessional thoughts, because no matter how unpleasant they are, the person realises that they are their own thoughts. Obsessional thoughts are homemade but disowned. The person with delusions of thought insertion will refuse to accept that the thoughts he possesses originate from his own mind.

Thought withdrawal:

the person believes that their thoughts have been taken out of their mind. This delusion usually accompanies thought blocking.

Thought broadcasting:

The person believes that others know their unspoken thoughts in some way. Some believe that their thoughts can be heard directly as they are thought (Gedankenlautwerden or Echo de la pensé)

Content

Disorders of content of thought include the following:

- Delusions
- Preoccupations
- Obsessional thoughts (with or without compulsions)
- Phobias
- Plans
- Intentions
- Recurrent ideas about suicide or homicide
- Hypochondriacal thoughts
- Overvalued ideas
- Specific antisocial urges

Delusions A delusion is a firmly held belief (which is usually untrue, but very occasionally can be true) which cannot be explained by taking into account the sociocultural and educational background of the person. It is unshakeable and held with extraordinary conviction and subjective certainty.

They can be either mood congruent or mood incongruent.

Categories include:

- Delusions of reference
- Hypochondriacal delusions
- Nihilistic delusions
- Grandiose delusions
- Delusions of control
- Delusions of guilt
- Delusions of jealousy
- Delusions of infidelity
- Delusions of love
- Delusions of poverty

Delusions of pregnancy

Delusions of prejudice

Delusions of special purpose

Delusions of unworthiness

Persecutory delusions

Religious delusions

Somatic delusions

Note: sometimes there are slightly different ways of categorizing the disorders of thought. Obsessions, compulsions and phobias are sometimes included under disorders of possession rather than content

Form
Disorders of form of thought can be divided into three types:

Flight of ideas

Perseveration

Loosening of associations

Flight of ideas is where the person's thoughts and conversation move quickly from one topic to another so that one train of thought is not completed before another begins. These rapidly changing topics are understandable because the links between them are normal, a point which distinguishes them from loosening of associations. In practice the links between the topics are difficult to make because the person talks so rapidly.
Two ideas or parts of speech can be linked in the following ways:
Rhyming
Punning
Clang association (using two words with a similar sound)
A response to cues in the environment, which the person picks up on.
E.g. 'Hello Dr Bassett, ha ha here comes Dr Bassett with a bloody great liquorice allsort on his head-bed –bed-ooh- I say what a day –a day to be caught in the wind with your tickling stick- don't tickle me-you'll give me a tickly cough------ etc.'
Flight of ideas is characteristic of mania.

Perseveration is the persistent and inappropriate repetition of the same thoughts. The disorder is detected by examining the person's words and actions. In response to a series of questions the person may give the correct response to the first question, but continue to give the same response to subsequent questions. Perseveration indicates that there is a strong possibility of an organic disorder.
E.g.
'What is your name' 'Mr Bottoms'
'Where do you live' 'Bottoms'

What time is it' 'Bottoms'

Loosening of associations denotes the loss of the normal structure of thinking. In other words there is a loss of the usual association between two thoughts. To the interviewer the conversation appears muddled and things do not get any clearer with further inquiry. There is a general lack of clarity in the person's conversation. This muddled thinking differs from that which occurs with people who are anxious or of low intelligence. Anxious people give a more coherent account if they have been put at ease. Those with low intelligence express their ideas more clearly if the questions are simplified. When there is loosening of associations the more one tries to clarify matters the worse matters seem. Loosening of associations occurs most often in schizophrenia.

It can take several forms:
Knights move thinking (shooting from one topic to an unrelated another)
Derailment ('running off the rails ' of the conversation)
Word salad (complete jumble of words)
Verbigeration (sounds, words or phrases are repeated in a senseless way)
Vorbierden (Talking past the point-the person seems to get near the point but never quite reaches it.
Etc.etc.etc.
It is loosening of associations that occurs most often in schizophrenia

Concrete thinking- this may occur in schizophrenia and organic states. It is a literalness of expression and understanding. Symbols are interpreted superficially or without finesse. The person is unable to escape from the literal meaning of the word.

Perception
Under this category any abnormalities in the way in which the person perceives the world is recorded.
An alteration of perception can occur in any of the sensory modalities.

For example:
Vision
Hearing
Touch (superficial and deep)
Smell
Taste
Perception of the passage of time
Perception of movement

A hallucination is defined simply as a 'percept in the absence of a stimulus'
One can either tell that some one is experiencing hallucinations by their appearance, or from what they tell you.
It is important to distinguish between true hallucinations and pseudohallucinations.
With pseudo hallucinations the person realises that the experiences are a product of his own imagination.
True hallucinations are viewed in external space, have clear edges and are experienced in the same way that a real perception is. Pseudo hallucinations tend to be viewed in internal space, are less clear cut and lack the 'solidity' of true hallucinations.

Hallucinations can be the result of:

Intense emotions

Suggestion

Disorders of the sense organs

Sensory deprivation

Disorders of the central nervous system

Mental disorders

Types of hallucination:

Gustatory= taste

Auditory

Visual

Somatic

Tactile

Olfactory= smell

Vestibular= sensation of movement

Auditory hallucinations

The type of auditory hallucination experienced can have diagnostic significance.
Second person hallucinations tend to occur more so in affective rather than schizophrenic disorders.
Here the person would experience a voice talking to them e.g. 'You dirty rat'
Third person hallucinations are more indicative of a schizophrenic disorder. Here the person would hear e.g. 'He's such a dirty rat'
If the person experiences any of the following:
His thoughts spoken out aloud (echo de la pensé)
His thoughts being broadcast to all and sundry (thought broadcasting) then this is strongly indicative of a schizophrenic condition.

<u>Other types of hallucination:</u>

A **functional hallucination** occurs when a hallucination is experienced in response to an environmental stimulus For example: hearing voices when a tap is running.
(This is different from an **illusion**, which is when a stimulus from a perceived object is combined with a mental image to produce a false perception. For example: when looking

at a swirly seventies' carpet one sees hideous faces.) Note an illusion is not a hallucination.

A **reflex hallucination** is a morbid variety of synaesthesia. A stimulus in one sensory field produces a hallucination in another. For example a person feels a pain in her head when she hears someone sneeze.
An **extracampine hallucination** occurs outside the limit of the sensory field. For example one can see some body is behind them when they are looking straight ahead.
Also recorded under this section are:
Experiences of **depersonalisation** (change in oneself) or **derealisation** (changes in the outside world)
Disorders of the experience of time.

Cognition
In this section one records the **cognitive function** of the individual.
A basic cognitive test involves establishing whether the person is orientated in time, person and place.
More complicated testing methods are available to try and establish the nature or the degree of any cognitive impairment.
These include the 'mini mental state examination' (designed to screen for dementia)

Insight
It is usually insufficient to say 'insight is absent or present'
It is more helpful to describe the following:

Does the person think they are ill

Do they think they have a mental illness

Do they think they need treatment

If so do they accept medical treatment

If they don't think they are ill but accept treatment why do they do this

Just because someone refuses treatment does not mean they have no insight.

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