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The Mental Status Examination

Hagop S. Akiskal, MD

Abstract  The Mental Status Exam represents a crucial part of the psychiatric interview in that it is devoted to a systematic elicitation of psychopathologic signs and symptoms that are important in diagnosis and differential diagnosis. It is an essential tool for all psychiatrists and mental health professionals, but, in abbreviated form, it is an important tool for all physicians.

This chapter is derived from the author’s teaching experience to medical students, psychiatry residents, and family physicians, and considers both classic and modern psychopathologic concepts. It is divided into appearance and behavior, psychomotor activity, affect and mood, speech, thinking, perceptual disturbances, orientation, attention and memory, as well as reliability, judgment, and insight. Finally, common errors in mental status in clinical evaluation are discussed.

Keywords  Mental status · Psychiatric history · Psychiatric interview

This chapter is devoted to the science and art of eliciting the signs and symptoms of mental disorders. The systematic perusal of these manifestations during the psychiatric interview constitutes the mental status examination, which can be viewed as analogous to physical examinations in other branches of medicine (1).

Consider, as an example of this process, the mental examination of a 26-year-old single, white male engineering student who was brought to the hospital because of “acute sinus trouble.” He had locked himself in his apartment for a week and refused to speak to anyone. When asked about his reasons for this behavior, he stated that he did not wish other people to hear the “noise emanating from my sinuses.” The patient looked disheveled and had a frightened facial expression. Despite the psychotic content of his verbalizations, associations were grossly intact. After further questioning, he admitted that the “sinus noise” actually consisted of “voices, as if a transistor was installed up there in my head.” The voices were of the greatest concern to him argued in the third person about whether or not he was a “female.” He was tremulous and restless during the interview, and, on one occasion, he walked to a mirror and began to examine his facial features; with great reluctance, he admitted that he was being transformed into a woman, as the voices implied. At one point, he became hostile and threatened to take legal action against a surgeon who, he believed, had “implanted a device” into his sinuses during an operation for a deviated nasal septum 8 months earlier; he added that, subsequent to this operation, he had intermittently experienced “foul smells,” which, like his thoughts, had been “implanted from outside.” All of these manifestations occurred in clear consciousness, without evidence of disorientation or memory disturbances.

To arrive at a diagnostic formulation, the examiner considers the signs and symptoms observed during the mental status examination in combination with information obtained from the psychiatric history. In this case, the diagnosis of paranoid schizophrenia was suggested by lifelong traits of seclusiveness, suspiciousness, and litigiousness; the absence of a history of substance abuse; and persistence of this clinical picture for longer than 6 months in the absence of major mood symptoms. Laboratory studies (e.g., negative urinary drug screen for stimulants and a normal sleep-deprived electroencephalogram [EEG]) were used to exclude, respectively, the remote possibility of stimulant-induced psychosis or complex partial (temporal lobe) seizures as the basis for his presenting complaints. Such physical workup to exclude somatic contributions is often a necessary step in psychiatric presentations with complex symptomatology, especially in patients with first psychotic breakdowns (2, 3). The presence of a positive family history for schizophrenia in a paternal cousin provided further support for a schizophrenia diagnosis.

Thus, the diagnostic process in psychiatry is analogous to that used in other branches of medicine: personal history, family history, examination, and laboratory tests constitute the essential steps. Because the raw data of psychopathology are often subjective and may elude precise characterization,
the mental examination is of particular importance in psychiatry. Accurate description is difficult to obtain without careful and skillful probing during face-to-face interviews. The faithful description of subjective experiences in psychiatry, known as phenomenology, was perfected by the German psychiatrist Karl Jaspers (4). His approach differs from that of Freudian psychodynamics, which concerns itself with the unconscious meaning and interpretation of symptoms. In contrast to the Freudians, who focused on the content of psychopathology, hypothesized to arise from early life situations and current interpersonal distortions, Jaspers thought that phenomenology—by its emphasis on the form of psychopathologic experiences—would eventually disclose “primary” symptoms, which are closest to the neurophysiologic substrate of the illness and that would, therefore, carry the greatest diagnostic weight. For instance, in the case of the engineering student, the fact that he heard voices arguing about him in the third person is more important diagnostically than what those voices said about him (that he was a woman). The latter can variously be interpreted psychodynamic or by some other theoretical frame of reference, which pertains to the formulation of the case, not formal diagnosis.

A detailed mental status examination constitutes an area of psychiatric expertise, but, in briefer format, it is an essential tool for all physicians. A brief mental status examination should be performed as part of the routine physical examination on all patients. When indicated, this should be followed by a more detailed mental examination.

1. The Importance of Signs and Symptoms in Psychiatry

Precision in the use of clinical terms to describe signs and symptoms is essential in all branches of medicine, promoting professional communication and preparing the ground for differential diagnostic workup. Imagine, for instance, what would happen if a patient with hemoptysis was erroneously described as having hematemesis. This would certainly confuse one’s colleagues regarding the medical status of the patient and could lead to an inappropriate series of diagnostic procedures. One can cite many other examples, such as jaundice versus pallor, ascites versus obesity, a functional versus an aortic stenosis murmur, which can all lead to difficulties in differentiation. In brief, genuine difficulties in eliciting, describing, and differentiating the myriad signs and symptoms that characterize diseases occur in all branches of medicine. Psychiatry is certainly not immune to such difficulties, but the belief—regrettably voiced by some medical educators—that differential diagnosis in psychiatry is haphazard and unproductive is both unfounded and dangerous. It is such attitudes that often lead patients with “functional” complaints to be labeled as “crock,” without the benefit of appropriate diagnostic evaluation. They may be viewed as having “imaginary” somatic complaints that waste the physician’s time. The potential dangers of such attitudes can be seen in a study in the Annals of Internal Medicine (5), which reported that the majority of a sample of completed suicides in St. Louis were seen by physicians within 6 months before their deaths; not only was the depressive nature of their ailment missed, but sedatives, in lethal quantities, were prescribed for their complaints of disordered sleep.

Although physicians typically spend many years mastering the art and science of physical diagnosis, little attention is given in medical education to the mental status examination. Many physicians are unaware that there exist systematic rules—allogous to those used in physical diagnosis—that can serve to assess mental status. Moreover, it is seldom recognized that the failure to distinguish, for instance, whether a patient is sedated or depressed can be as grave as the failure to distinguish between dyspepsia and angina: just as angina can be the prelude to myocardial infarction, unrecognized depression can be the prelude to jumping out of the hospital window.

The mental status examination is not just common sense or an expression of humane attitudes that assist the physician in empathizing with the patient while probing his inner experiences. Good judgment in complex human situations (an uncommon form of common sense!) and an approach that considers the patient in his or her totality are not the sole prerogative of psychiatry, they are important in all branches of medicine. These attitudes merely set the stage for the practice of the clinical principles that constitute the body of scientific knowledge in any field. In psychiatry, there are established rules in the use of phenomenologic terms to arrive at diagnostic formulations that are the product of nearly 200 years of systematic clinical observation (6, 7). International consensus and standardization have now been reached on the description and clinical probing of psychopathologic experiences as exemplified in the World Health Organization development of the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) (8). The SCAN covers in depth all facets of psychopathology. The Mini-Mental Status Examination (9), widely used at the bedside, is another more focused interview.

2. Special Problems in Psychiatric Phenomenology

Admittedly, there are many difficulties in the application of psychiatric terms and concepts. These fall into several categories.

Many psychiatric phenomena are subjective and do not easily lend themselves to objective description. For instance, one of the author’s patients described herself as being “transformed into a pig” while looking in the mirror. Here, the patient’s verbal report is the only evidence for the occurrence of this experience. It is important to record such symptoms—in the patient’s exact words—to decide whether the incident