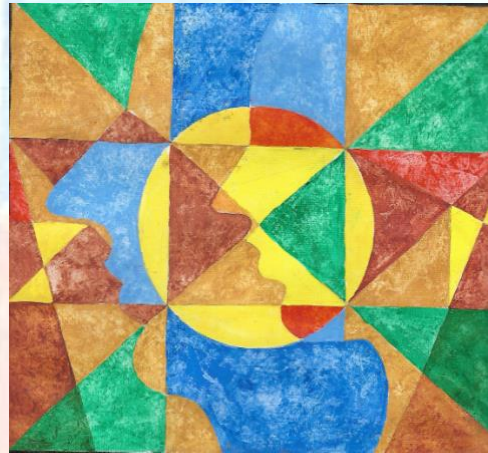

Consensus on Mental State Examination

Endorsed & Recommended by Indian Psychiatric Society (IPS)

Psychiatry Teachers Forum Subcommittee, IPS

PG Education Subcommittee, IPS

UG Education Subcommittee, IPS

Indian Teachers of Psychiatry (IToP)

Year 2023-24

Indian Psychiatric Society Karnataka Chapter

Committee on Mental Status Examination (MSE)

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The Committee requested all institutions, experts, postgraduates, and undergraduates to submit their suggestions and proforma being followed. The committee met many times for deliberations and finalised.

Report Submitted On 17th Sept 2021 at KANCIPS, Mangalore

Based on IPS KC request again, the committee validated and submitted on 22nd July 2022 with the involvement of all Institutional Heads, Faculties, Postgraduates & Undergraduates

For More Details, The Proceeding from IPS KC MSE Committee is Video Recorded & Available With IPS KC

IPS KC further requested the committee to take input from reputed institutions and experts across India. The Committee requested the same and suggestions from NIMHANS, AIIMS, PGI, CIP, TNMC & others were incorporated wherever it was appropriate.

The report was submitted on 12th August 2023 at KANCIPS Bagalkot

A Brief Introduction to the ‘Mental Status Examination

The ‘Mental Status Examination’ (MSE) is a particularly important aspect of psychiatry examination. The process of carrying out MSE is both an art and a science. In the pursuit of doing MSE in right manner and learning the skills, one has to repeatedly carry out the process in different sets of patients and in various clinical scenarios.

Mental status examination encompasses all domains of human experience: cognitive status, affective experience, perceptual phenomena, thought processes and speech, motoric / psycho-motoric behaviour, and more. The ‘process’ of the MSE begins from the first interaction with the patient and information can also be further obtained in subsequent interactions. While the History of presenting illness, Family history, Personal history, Premorbid personality, etc captures information that is related to the patient’s development, the prior normal state of functioning, and past information regarding patient’s illness, the MSE focuses on components that indicate the current mental functioning of the patient. This also includes the footprint of individual experience & mood, self-reported in one’s social media.

The process of MSE involves compassionate listening, keen observation, appropriate communication, and inquiry. It is important that all components/domains of the MSE are assessed wherever possible, however, it is not necessary to proceed in the order mentioned in the proforma. This is because in many scenarios, a focused approach would be better to gather information

regarding the immediately relevant (from the patient's experience) components of MSE. Subsequently, other areas of the MSE which have been left out may be attended to. This method of performing the MSE as a 'free-flowing conversation' will immensely help in maintaining rapport and will improve the productivity of the overall exercise. The order of the MSE 'as printed in the proforma' is to facilitate accurate documentation and will aid systematic professional communication.

The MSE for cooperative and uncooperative patients should ensure that both formats are appropriately utilised and skills are learned by repeatedly carrying out the process. There is no time limit to carrying out the MSE, but it should be possible to complete the process in less than an hour as one learns the skills. The MSEencompasses a time of the preceding seven days including the current state. However, terminology such as 'cross-sectional' or 'current MSE' is sometimes used for that process that has been carried out in the last hour or last few hours. The date and time of carrying out the MSE should always be documented.

The MSE should be carried out in the patient's language. The verbatim of the conversation should be recorded in the same language as used by the patient, especially with reference to thought, perception, affect & mood, some of the cognitivefunctions, insight etc. However, when this is not possible, the verbatim should be translated and recorded as a "translated" version. In situations, where a patient can give information only in the written format, the same can be used. When the above strategies are not possible, audio recording can be used with appropriate consent as verbatim for a limited period, and the matter transcribed

onto the case sheet. It should be remembered that during the MSE, three distinct features of each phenomenon should be recorded separately – the broad heading of the phenomena under examination, the verbatim of the patient's experience including the patient's responses to clarificatory probes, and finally the examiner's interpretation of the nature of the phenomenon (its formal characteristics and content).

The components of MSE can vary with time and circumstances, hence one must be judicious in interpreting the phenomenon in the best possible way that is relevant by comprehensively understanding the psychopathology in relation to the individual & the circumstances, educational and sociocultural background.

* *The template of the mental status examination for the adult patient provided here, may be considered as a skeletal, minimum standard for acquiring information. Trainees and teachers are however encouraged to expand on this, in terms of categories for collecting information and also the content of information collected, depending on the exigencies of the clinical situation.*

Mental Status Examination

Date: Time: Language: Translator Used/Not Used

1. **Consciousness/Sensorium**
2. **General Appearance and Behavior**

   a) Gait and posture
   b) Dressing and grooming
   c) Eye to eye contact, Facial expressions, Abnormal movements including Tics, Mannerisms etc.
   d) Attitude towards examiner
   e) Psychomotor activity
   f) Rapport

3. **Cognitive Status**

   a) Attention and Concentration
   b) Orientation
   c) Language function (Phonation, articulation, fluency, comprehension, naming, repetition etc.)
   d) Memory:
      Immediate
      Recent
      Remote
   e) Calculation: Verbal and written
   f) Fund of information

g) Abstraction: Similarities, dissimilarities and proverbs

h) Judgement: Personal/Social/Test

4. Speech quality:

a) Spontaneity
b) Amount

c) Volume

d) Tone

e) Tempo

f) Prosody

5. Thought

a) Stream

b) Form

c) Possession

d) Content

6. Mood

a) Quality

b) Reactivity

c) Intensity

7. Affect

a) Quality

b) Range
c) Reactivity
d) Intensity
e) Lability
f) Volatility
g) Communicability
h) Appropriateness

8. Perception

a) Distortions
b) Deceptions

9. Other aspects not recorded elsewhere: including motivation, somatic passivity, made action, made affect and made impulse, negative symptoms, de-personalization, de-realization, body image disturbance etc.

10. Insight:

Mental Status Examination (MSE Concise Version for UGs and Interns)

MSE as a part of the completion of psychiatric evaluation incorporates information from the preceding **one week.** However, cross sectional or current MSE means which incorporates the signs elicited only during the interview.

Date and time of Interview .... Language used ……….and use of translator – Yes/No

Appearance & Behaviour: (Describe Consciousness, Physical appearance, All activities during interview, Attitude towards examiner,Abnormal motor behaviours)

Comprehension:(Clinical observation/ following simple commands)

Attention & Concentration: (Clinical observation/ week days backwards)

Orientation to time, place and person: (Clinical observation)

Memory – Recent & Remote: (Clinical bedside assessment of recentand past events confirmed by the attendant)

Speech (Description of Tone-Tempo-Volume)

Thought –Description of Content (Predominant thought content in the past week including delusions, ideas, preoccupations, worry, Obsessions, Phobias etc)

Mood & Affect: Subjective mood and Affect during the interview

Perceptions: Distorted perceptions if any, Hallucinations in all modalities and response to them

Insight: Absent/Partial/Present (Awareness, Attribution, Acceptance ofHelp)

NB: The details of test / examination procedures may be tailored to the needs of the Department concerned.

Mental Status Examination - Annexure

In the Mental Status Examination, the definitions of terminologies may be referred from World Health Organization (WHO) "Lexicon of psychiatric andmental health terms" (https://psychiatr.ru/download/2172?view=1&name=924154466X.pdf)

Standard books and journal articles on psychiatry, psychopathology, and phenomenology,

Conventionally the MSE focuses on the descriptive psychopathology of the pastone week, so one must be careful to not let previous history findings overlap with the past week's experiences. It is but the latter only that will be amenable to the test of phenomenological clarification. While initiating the MSE it is important to normalise the process (Eg "these are usual set of questions we incorporate in an interview of all people").

Individual domains of the MSE:

Level Consciousness may be commented upon to begin with. Stages of arousal / level of activation (Alertness/Lethargy/Drowsy) should be recorded. Appearance and Behaviour during the whole period of observation should be detailed verbatim. Attitude towards examiner should be recorded (Co-operative, Uncooperative, Hostile/Indifferent etc). Even subtle deviations of behaviour can be clinically very significant. In the case of non-cooperative patients, a proforma such as by 'Kirby' may be used to supplement the information.

Attention and concentration can be assessed in the context of the clinical interview and may be supplemented by standard tests such as 100-7, 40-3 and soon. Digit forward and backward is best done from a pre-arranged set of series of digits rather than creating digit series at the spur of the moment It is useful to remember that if the patient can do the more difficult task, he need not be asked to do a similar but easier task.

Orientation needs to be tested under all three heads of time, place and person andthe exact responses documented. Before interpreting the responses, one should keep in mind the motivational and attentional states of the patient as well as the availability of orienting cues in patient's environment.

Documentation of Language & different aspects about it has been elaborated to distinguish organic causes.

Memory testing can be performed using standard bedside techniques. One can ask the patient to recall events occurring in patient's life in the past 24 – 48 hours in detail and cross checking this with the informant, to assess recent memory. Similarly assessing semantic and episodic memory can be performed to commenton 'remote memory' routinely. Formal memory testing may not be necessary in all patients, however as a rule formal tests (such as three/five object test, address test, memory span etc.) should be done when there is any doubt of the possibility of cognitive deficits.

Abstract ability is assessed with at least three sets of similarities, differences (It isbest to discard the example of Stone Versus Potato) and proverbs. Inferences can be drawn on concrete or abstract attitude.

Assessment of judgement is performed, by convention, across three domains of ‘test judgement’, ‘social judgement’ and ‘personal judgement’. Interpretation ofthe responses should be made keeping in the mind the context and intellectual background of the patient. Test judgement utility is limited and should be evaluated in the context, the Social judgment to be specified during interview orin last one week.

General fund of information is assessed with sufficient number of probes appropriate to the educational status and social context of the patient. It is recommended to eschew using standard probes for every patient as such probes may be out of context for several patients. It may be useful to have a separate pool of questions for persons with sufficient formal education and others without. Some questions may be common to all patients – as in information that everyone is ‘expected to know’ in that area/culture.

Calculational ability may be checked using one and two step verbal and written arithmetic tests. However, in some patients it may be more productive to convert the test into a real-world calculation to assess price of certain commodities etc.

Intelligence is usually grossly assessed on the basis of the combined performance of the patient on assessments of comprehension, abstraction, judgement, fund of information and calculation ability. In view of the subjectivity involved in this assessment, it is usually possible to comment only whether the person has average or sub-average intelligence provided the responses are adequate.

Assessment of 'Stream' of thought focuses on spontaneity, volume, tonal fluctuations, retardation, acceleration, volubility, pressure etc. of the spoken speech.

To assess the 'Form' of thought, a sufficiently lengthy sample of speech is required which can be either spontaneous or in response to a relatively open ended but not emotionally charged cue. The spoken speech sample can be recorded withpermission and transcribed in the same language to preserve the fidelity of the patients' speech output. The sample "should not be translated and recorded", norshould be reproduced from memory. The second option if the previous method isnot possible, is to give the patient a topic/cue as described above and ask patient to write extensively in his/her preferred language. Assessment of Form requires a sufficient sample and knowledge of the psychopathology of form of thought.

Disorders of 'Possession' of thought need to be elicited by detailed interviewing.The patients' statements and the interviewer's queries need to be documented verbatim to support the conclusions on psychopathology.

The 'Content' of thought is not restricted to delusions or depressive / anxious / hypochondriacal cognitions etc. only. In most patients it will include, experiencessuch as dominant preoccupations, worries, somatization, current perception of stressors and their salience, concerns about illness (physical as well as mental) and treatment if any. Delusions/Overvalued ideas/Ideas are documented keepingin mind their "Vectors" and other relevant descriptors. Documenting patients' verbatim report is important to substantiate the inferences.

Assessing Mood and Affect can be challenging because of subjectivity of observations and possibly low inter-rater reliability. Breaking them down into different subheadings helps in bringing some objectivity and reliability. It is necessary to document Mood (over the past seven days as experienced by the patient) and Affect (during the period of the interview as observed by the examiner) separately, as the same characteristics may not be appropriate for bothMood and Affect. For example, it would not be possible to comment on range, mobility appropriateness in mood of the last seven days as it may be subject to greater recall bias. The first point to comment on is the "quality" of the Mood / Affect ie the name that is given to the mood state by the patient or

the clinician will give to the affect state observed by the patient. It is necessary to remember that one can experience more than one predominant Mood / Affect in a given period of time (for e.g., anxious and depressed). The depth (intensity) of the moodcan be assessed by asking the patient to quantify the emotion experienced. The reactivity of the Mood in the past week may also be assessed from the reportage of the patient. In the case of Affect comment may be made on 'quality' as mentioned above as well as on reactivity, range, mobility and communicability. Volatility is variation in same affective state and Lability is shift to opposite affective state. Assessing the congruence of Affect may be difficult as it requires an assumption of the thought content of the patient at that point in time. Hence restricting one's self to appropriateness of Affect may be more practical.

Perception can be divided into deceptions and distortions. In order to conclude the presence of a deception such as Hallucination/Pseudo hallucination/Imagery/ Illusion etc. the phenomenological characteristics of these experiences need to behighlighted clearly and documented. Following this, the content of the experienceshould be documented verbatim. Distortions are often not picked up but they canbe noted often in highly emotional states, somatising states, and mood disorders.

Other psychotic and nonpsychotic phenomena which do not clearly fit into the above subheadings may then be described as best possible. For example in Substance Use Disorders, Motivation for change can be recorded.

Insight is usually assessed using the three criteria of awareness, attribution and acceptance. The comment may be made on the insight as being present/absent or partial, or may be further graded along a 0-5 scale depending on the context. Here again, verbatim documentation of the patients' responses is desirable.