THE WETC PSYCHOLOGY NEWSLETTER

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Mental Status Examination

"Perhaps the entire purpose of the Mental Status Examination can be found in the answers to two questions, the first being more important than the second: First, what did the doctor observe? And, second, what does it mean?"

Virtually every medical-legal report in psychology and psychiatry has a section called "Mental Status Examination." A reading of this section written by various doctors reveals that a variety of information is contained that is not always the same. Thus, it is reasonable to spend some time talking about Mental Status Examinations and what their contents should and should not contain.

Essentially, a Mental Status Examination (MSE) provides a set of observations of the patient that are made by the doctor employing a relatively standard set of examining techniques and questions. Data that also should find their way into the doctor's report of their Mental Status Examination include observations that are made when the patient enters and leaves the consulting room, as well as those made during the remainder of the face-to-face clinical interview.

What should not be in the Mental Status Examination report is a discussion of the patient's complaints or, as they are sometimes called, symptoms. In this regard, psychology and psychiatry distinguish between signs and symptoms. Signs are things a doctor observes. Symptoms are what the patient complains about or reports they experience. Sometimes they are the same and sometimes they are different. But, for example, if a doctor states in a Mental Status Examination something like "Ms. Jones told me that she had been feeling especially depressed since her daughter died," that is a complaint, not a sign or observation. On the other hand if the doctor observed some evidence of a clinical depression while Ms. Jones was talking about the death of her daughter, such as crying, a loss of concentration, wailing or any other visible behaviors, then that material belongs in the Mental Status Examination.

Similarly, the Mental Status Examination report does not contain a history of what happened to the patient nor does it discuss the results of the psychological testing, the doctor's review of the patient's medical records or anything that a friend or relative accompanying the patient to the doctor's office might have said. The Mental Status Examination report also does not provide any clinical conclusions, other than the ones that can be drawn from the direct observations made during the course of the Mental Status Examination. In this regard, if the doctor observes some signs of depression they will undoubtedly point out that what they have observed is either indicative of, or consistent with, a clinical depression. Finally, there is no room in a Mental Status Examination for a summary conclusion such as, "the patient appeared depressed."

Mental Status Examinations grew out of the field of neurology. Traditionally they were used to discriminate between individuals who have neurological conditions that are sometimes called brain damage, organicity, an organic brain syndrome, or a neuro-behavioral disorder, and those who have a psychological disorder, most frequently a clinical depression. The need for an examination to discriminate between brain damage and psychological disorders, particularly clinical depression, arose out of the fact that these two conditions often superficially present with the same signs and/or symptoms. Thus, virtually all psychological evaluations include a Mental Status Examination, which provides a wide variety of information about an individual's psychological status as well as data concerning any possible brain damage.

Perhaps the entire purpose of the Mental Status Examination can be found in the answers to two questions, the first being more important than the second: First, what did the doctor observe? And, second, what does it mean? In this regard, the doctor's report of their Mental Status Examination should clearly describe the entire set of observable elements common to all such examinations.

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In reading a report of a Mental Status Examination, you will typically discover that the doctor has written it with descriptions of the most general observations of the simplest types of behavior first, and the most specific observations of the more complex behaviors last.

Probably the most general piece of Mental Status Examination data is the orientation of the person examined. This portion of the Mental Status Examination survives from examining relatively severely brain-damaged individuals, usually in the context of their hospital room. Without doubt, most individuals who present themselves for an examination in a medical-legal context do not have any orientation problems and this portion of the examination is simply a *pro forma* matter of making the patient's record complete. Nevertheless, without necessarily being direct, patients are asked if they know who they are, their age, their birth date, where they are, their home address, the date, the day of the week, the time of the day, the season and the year. They will also typically be asked how they got to the office and if they know why they are being evaluated.

The next pieces of data typically found are information about the person's affect or emotional reaction on meeting the interviewer. Among the multitudes of possibilities are: were they friendly, withdrawn, cooperative, unsmiling, tense, communicative, well-spoken, terse, distressed, relaxed, insightful, apprehensive, unsophisticated, hostile, angry, or verbose. Clearly, a friendly, smiling, relaxed, insightful and communicative person would be much less likely to be suffering from a severe clinical depression than someone whose initial affect was tense, withdrawn, hostile and angry. Also relevant is whether or not the patient developed some rapport with the interviewer, and how easily this came about. It is also important to observe and comment on the nature of their narrative, specifically, on the appropriateness of the detail they provide. i.e., was it sparse, over-inclusive or normal for the situation. Did they speak in a calm and self-assured manner in a natural tone of voice, or did they speak in a barely heard voice, yell, speak non-stop or provide little or no speech at all. All of this information addresses their psychological status and the possibility that they have a psychological disorder.

People with different types of psychological disorders, normal individuals, and those with brain damage may appear physically different. In this regard, it is well known that clinically depressed individuals often appear disheveled and completely unconcerned with their physical appearance and taking care of themselves. On the other hand, a person with obsessive-compulsive behaviors would be much more likely to present with an impeccable appearance. While it may not always be true that first impressions make a difference, how a person initially appears is often a statement about their mental status. Thus, after discussing the patient's general orientation, the first thing a doctor writing a report of their Mental Status Examination will probably tell you is what the patient looked like. This is helpful because it assists the reader in developing a mental picture of the person being evaluated. Normally, the doctor will describe their apparent age, height, weight, posture, clothing, hair, and appropriateness of their grooming, as well as the timeliness of their appearance in the office, their locomotion and/or gait, their mannerisms, their linguistic skills, judgment, insight, psychological-mindedness and ability to articulate or describe their thoughts, behaviors and feelings. By this point, the reader of the doctor's Mental Status Examination should have a pretty good visual picture of the patient.

Another major question to be answered concerns the individual's mood. Is the patient's mood normal or are they angry, anxious or depressed? The purpose of this segment of the examination, as well as the corresponding portion of the report, is to describe the patient's mood or observations concerning their likely internal feelings. Essentially, a mental health practitioner asks and looks for answers to general questions such as: What is the person feeling? What do they think and feel about themselves and their lives? This is done throughout the interview process by getting the person to talk about him or herself, significant others, and events in their lives. It is also done by observing what they do as well as what they say and how they say it.

In most cases these data are not obtained by applying any particular techniques or asking any specific questions. They come out of the overall conversation with the examinee and the presentation of their narrative or story. Nevertheless, conclusions about these factors are based on observations made by the doctor that can be placed in the physician's report. Unfortunately, some doctors may never do so, being content to provide their summarily stated conclusions and hoping that the court will accept them at face value. <u>In fact, nothing should ever find its way into a psychologist's medical-legal report that cannot be backed up with observational data</u>.

Individuals who are clinically depressed but who have developed a reasonable amount of rapport with the interviewer, will talk about feelings and thoughts of worthlessness, hopelessness, helplessness, incompetence, self-reproach, guilt, pessimism, failure, a loss of interest in pleasure, demoralization and thoughts of death and/or suicide. Even when the patient is not asked directly, they will frequently complain of fatigue, weight changes when not dieting or attempting to gain weight, insomnia, frustration, anger and/or decreased libido. Moreover, in listening to them talk, they can often be observed to exhibit what for them is reduced

cognitive functioning, abnormally slowed or agitated behavior, attention deficits, sadness, tearfulness, irritability, indecisiveness and evidence of social withdrawal. Conclusions about their feelings, which are backed up by specific examples of their verbalizations and behavioral observations, should be found at this point in the doctor's report.

While individuals who are clinically depressed often talk about the things described above, people who are clinically anxious tend to talk about different things. Specifically, they can be expected to talk about unrealistic fears and/or worries. In talking about themselves and their lives, their narrative typically contains themes of threat, danger, unpredictability, uncertainty or terror. Even before an attempt is made to obtain a complete history of their current complaints they may speak of having chest tightness or pain, shortness of breath, heart palpitations, racing heartbeats, choking and/or smothering, diarrhea, frequent urination, tingling sensations in the extremities, dizziness, lightheadedness, cold sweats, hot flashes, dry mouth, shaking, jitteriness and/or trembling. Additionally, when observed in the consulting room they will often exhibit fidgeting, restlessness, hand wringing, a strained voice, tremulousness, tension, motor hyperactivity, jumpiness, autonomic hyperactivity, vigilance, scanning and/or poor reality testing. Once again, these observations find their way into the doctor's report of their Mental Status Examination. Or, at the very least, if observations of these narrative expressions or behaviors were made during another portion of the examination process, the doctor will make note of this in their report.

Clearly, the above discussion of anxiety and depression is not an inclusive list of all of the possible observations that can be made of a person's narrative. Let's just note that at this stage of the Mental Status Examination, the job of the interviewer is to keep their ears and eyes open and take in all of the information that is being provided by the patient, regardless of where that information might lead and what it might reveal. To mention just a few possible observations, it would not be unusual at this stage of the interview to gain information about the person in the following areas: trust of others, preferences for relationships, openness, honesty, trustworthiness, emotional consistency, assertiveness, self-centeredness, and dependence. In fact, many people, when given the opportunity will go on for an extended period of time and provide all sorts of information not explicitly asked for, which may or may not be relevant. At that point the interviewer may be forced to gently take more control of the interview process in order to complete the examination within a reasonable period of time.

In addition to the above, the doctor obtains information about the individual's basic cognitive processes such as memory, concentration ability, judgment and reasoning.

Individuals with various mental disorders frequently have problems in the area of memory. Historically, memory functions have been divided into three types: immediate, recent and remote memory. Objective data about all three types of memory are easily obtained during the normal course of a Mental Status Examination.

Short-term memory can be assessed by presenting a digit memory task. In this task the individual is verbally presented with a series of digits at the rate of approximately one per second and asked, after hearing all of the numbers, to repeat the entire series in the order in which it was given. Typically, the examiner starts with a series of digits that they fully expect the person to recall with ease. This might be a three digit series. Generally, the examiner continues to lengthen the series until the person fails two sets of numbers in a row. In a similar task, the person is again asked to recall a series of digits but this time they are asked to recall them in the reverse order, so if the examiner says, "1-2-3" the person must respond, "3-2-1." The first task is much easier than the second and a person with a high school education can be expected to recall 5 to 7 digits forward and 4 or 5 digits backward.

When memory problems are discovered in the consulting room, it is important to try to determine if the difficulties are actually due to a memory deficit or to a problem in attending to or concentrating on the task at hand. Attention refers to the person's ability to regard a specific aspect of their environment with minimal or no distraction. Concentration is the ability to attend on a more or less continuous basis for an extended period of time. That is, concentration simply involves a relatively long period during which one attends to a task. In the context of the consulting room, mental status examiners often assess attention and concentration by simply noticing when the person is distracted and seemingly cannot complete or perform tasks because of their inability to focus. One specific task measuring attention is called the Random Letter

Task. It involves the examiner reading a list of letters to the person and asking them to raise a finger when they hear a particular letter, say an "M." The letters used are randomly generated except for the "M's," which are inserted at a relatively high frequency. A person with intact attention and concentration processes should be able to listen to a series of approximately 100 letters with approximately 25 of them being "M's" and make no more than one or two errors.

Recent memory involves the ability to learn new material and then to be able to recall that material after a relatively short period of time. In the context of the consulting room, one measure of recent memory involves the examiner identifying three objects in the examination room and then asking the person to recall that information after a few minutes. For example, the doctor may point out three unrelated objects in the room and then, after proceeding to some other tasks for approximately five minutes, ask the patient to recall the names of those three objects.

Remote memory, or what is sometimes called long-term memory, can be assessed by asking the person to recall items from their background. For example, a favorite task of interviewers is to ask the person to recall the names of prior United States Presidents, working backwards from the current president until they make an error. One would expect that not being able to recall the name of the president who preceded the current president would suggest the possibility of memory impairment. A similar task is to ask the subject to recall their first schoolteacher's name and/or their address at the time. Of course one would have to be confident that the person was not making the answer up to conceal a memory problem. However, asking the person to recall their Social Security number and/or their driver's license number from memory is not subject to this potential confabulation problem, since the answers are easily verified.

Finally, interview data that may not be part of the Mental Status Examination but is obtained during the taking of the person's history can also provide information about a person's memory. Thus, if in taking a 45-year-old person's employment history they tell me that they cannot recall where they worked for four years in their 30's, I might suspect they have a remote memory problem. In this regard, if they actually do have such a problem then they could be expected to have other similar deficits in recalling historical data. Most frequently, however, such occurrences are found in individuals who do not deem it important to retain such data, or who are motivated to hide some facts about their past. Additionally, one special problem that is encountered in some cases involves true amnesic periods in which the individual tells me that they cannot recall anything from the time they were 4 until they were 9. Frequently, after some amount of investigation this turns out to be a sign of an extremely abusive childhood that has resulted in what sometimes is called motivated forgetting.

Another simple and effective method for assessing cognition in the context of a Mental Status Examination is to give the individual various mental arithmetic problems. This task simply asks the patient to solve addition, subtraction, multiplication and division problems without the aid of a pencil or paper or calculator. Generally, the interviewer starts with simple problems that the individual will probably be able to solve, and proceeds to more complex and difficult ones. The decision of where to start is usually based on the individual's educational and occupational background. What the examiner is looking for is consistency or inconsistency between the individual's educational and occupational background and other performances in the Mental Status Examination.

A frequently used test that measures a higher level of cognition is an abstraction of similarities task. In this task, the person is typically given the names of two nouns and asked to state what they have in common or how they are similar. For example, the two nouns may be "an elephant" and "a whale." A high-level response is "mammal" whereas a somewhat lower-level response is "big" or "gray." An even more demanding cognitive task that is frequently used is the interpretation of proverbs. In this task the interviewer asks the person to provide the meaning of a series of proverbs, such as "A bird in the hand is worth two in the bush." Whether using proverbs, similarities or other tasks, it is crucial to consider the answers given in terms of the individual's education, background and socio-economic class.

Another area of concern to a doctor administering a Mental Status Examination is the presence or absence of evidence of a major psychological disorder such as Schizophrenia or one of the Bipolar Disorders. During the normal progress of a Mental Status Examination, no specific tests, questions, or examining techniques are typically needed to determine if the individual has a major psychological disorder, unless that disorder is not currently active. If the disorder is inactive, or as psychologists sometimes say, In Full Remission, then the existence of the disorder can usually be determined during the taking of the person's history or, if that fails, during

the reading of their medical records. Regardless, what the examiner in the Mental Status Examination is looking for is any evidence of hallucinations or delusions or other aspects of a thought disorder. Does the person's narrative indicate that they appear to be hearing voices or seeing things? Do they express any unusual or bizarre ideas?

An essential part of any psychological evaluation involves the collecting of data that leads to a conclusion concerning the ability of the person to conduct their normal life without any mental disability. Thus, the examiner looks to draw inferences about the person's ability to concentrate, attend and utilize their memory and other cognitive functions in their everyday life. Do they display any behaviors, thoughts or emotions that would seem to interfere with this ability? Can they understand and follow written and oral instructions in completing the examination or is something getting in the way? Are they assertive and can they make normal requests consistent with their history, or do they appear to have some abnormal difficulties in this area? Do they perform all of the tasks required by the examination in a normal period of time? Can they form a normal relationship with the interviewer and office personnel? Can they control themselves? Are they overly emotional? Do they appear to be able to draw conclusions from their experiences and make reasonably good decisions? And finally, are they motivated to perform in a socially acceptable and responsible manner? Typically, there are no techniques or questions that the interviewer can use to obtain information about these questions, but observations made during the entire clinical interview provide data about these issues.

A Mental Status Examination also provides information about the individual's social behavior and interactions. Once again, there are no specific questions or techniques that are used to gain these data, but the doctor arrives at their conclusions by observing the patient during the course of the entire face-to-face interview. The data are also obtained from hearing the patient talk about their relationships during the taking of their life history and listening to their current complaints. The questions answered are: Do they have the ability to get along with others? Are there any unusual behavioral characteristics bearing on social relationships? How do they feel about their relationships with others? Do they see themselves as likeable? How are other people likely to relate to them? Do they exhibit any abnormal behavioral characteristics that would likely be disruptive such as depression, anxiety, aggressiveness, compulsivity, over emotionality, distancing, abrasiveness, morbidity, or bizarreness?

Overall, by watching and listening very carefully during the entire clinical interview and by applying some specific techniques and asking some special questions during the Mental Status Examination, the psychologist can form a reasonably good picture of the patient's status that can then be compared to data collected from the taking of their history, their performance on the psychological tests, a reading of their medical records and possibly interviewing significant people in their lives about their behavior, thoughts and feelings. Only when all of these data are examined and correlated is it possible to provide a thorough portrayal of the examinee's psychological status.

This is the nineteenth of a series of monthly newsletters aimed at providing information about psychological evaluations and treatment that may be of interest to attorneys and insurance adjusters working in the areas of workers' compensation and personal injury. If you have not received some or all of our past newsletters, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.