

Case Management: The Mental Status Examination

Part 1: Introduction

The *mental status examination* (MSE) is based on your observations of the client. It is not related to the facts of the client's situation, but to the way the person acts, how the person talks, and how the person looks while in your presence. A mental status examination can be an abbreviated assessment done because someone appears to be in obvious need of hospitalization, or it can be an elongated process that takes place over several interviews. The MSE always has the same content, and you write your observations in roughly the same order each time.

Although a formal MSE would be done by a physician or psychologist, you can do an informal MSE in which you systematically look at the person's thinking process, feeling state, and behavior. You will want to understand the way the person functions emotionally and cognitively.

Much of the examination is done by *observing* how people present themselves at the interview and the manner in which they spontaneously give information about themselves and their situations. The examination is not done separately but is an integral part of the assessment interview. Questions that relate to mental status are framed as part of the overall assessment and not as a separate pursuit. There will be times when you or a clinician might ask for psychological testing to confirm your evaluation of the person, but during your own MSE of the person, this is not done.

Some of the terms you learn in this chapter are not necessarily words you will use in describing your clients and their appearance or behavior. This chapter is meant to familiarize you with the way some professional practitioners describe their clients and patients. If you know these terms, you will be able to follow the notes and discussions better.

Part 2: Observing the Client

What to Observe

Your mental status examination of the individual involves observations of the following:

- General appearance
- Behavior
- Thought process and content
- Affect
- Impulse control
- Insight
- Cognitive functioning
- Intelligence
- Reality testing
- Suicidal or homicidal ideation
- Judgment

A good case manager is a good observer. You pick up many details about the person, all of which are relevant to understanding the client's mental status. In a sense, you watch for the most obvious and the most subtle visual and verbal clues as to who your client is. Use what you see and hear to give you direction in regard to what questions to ask.

How to Observe

Throughout the interview note how the person communicates verbally and nonverbally and how the person behaves. In addition, you look at the content of the communication. You are looking at both *what* the person tells you and *how* the person tells it.

As people talk about why they came to your agency for services and about the main problems they are confronting, you will make some judgments about how they functioned in the past and how well they are functioning currently. You will note how they tell their stories. Is the person cooperative and friendly? Does he appear to be relieved and eager to talk to you, or is he mute, guarded, and uncooperative? Is she weepy and hesitant as she speaks, or is she forthright and stern? Does the person twist a tissue in her hands or rock back and forth in her chair, or does she use appropriate gestures? Does he relax during the interview or remain guarded and uncooperative?

At times you may need to assess the client's mental status through the observations of others who are close to them. Your clients may not always be able to tell you much about past events or functioning, and you will need to turn to others for that information. If there is no reliable source, you may not be able to perform a complete MSE that has a clear degree of certainty.

Documenting Your Observations

To back up your observations, use both descriptions of the individual's behavior during the interview and direct quotes made by the person in the interview. In this way, you carefully document your observations and your resulting conclusions.

When you describe the person, be sure that your values and prejudices do not appear in your notes. Use adjectives that describe the individual, but are objective. All editorial comments and value judgments should be omitted. Figure 18.1 defines some general terms that are commonly used when documenting observations of clients.

FIGURE 18.1 General terms used in documentation

Primary language: When you see this on a form, give the person's native language, and if it is not English, tell how well the person functions with English.

Presenting problem: In one or two sentences, tell why the person is coming to see you now. Use the person's own way of telling about it.

Past psychiatric history: Use incomplete sentences. Give dates, approximately how long, and summarize if there is much detail.

Functional ability: Note particularly if the person is able to display and carry out age- and stage-appropriate skills and tasks. Also note any recent change.

Moods/emotions: What does the person or the person's family say? How do they seem to you?

Physiologic: What does the person or the family say about the person's appetite, sleep, and sexual activity?

Thinking: What is the person saying about how she is thinking? Are you able to follow her thinking? Does the story make sense? Are there delusions?

Perception: Are there any hallucinations?

Orientation/cognition/memory: Does the person think he can find his way? Does he know where he is? Does he remember well? Does he know what day this is?

Mental status examination: This is a word picture that tells what the person looks like now, not all the time.

Part 3: Mental Status Examination Outline

Anthony LaBruzza (1994), in his book *Using DSM-IV*, provides a good outline for the mental status report that you will complete after the interview. He stated that his outline is not meant to be followed precisely, but it does give the major points and a framework to determine what is important. The outline in Figure 18.2 [not shown here] provides the major categories you must cover in a mental status report.

This section discusses the outline for the mental status examination and report in detail, defining terms to use and identifying items on which to focus for each category you will cover in mental status examinations and reports. Pay particular attention to the terms that have **Always** in boldface in the descriptor, as these are important items to which you must always give attention.

I. General Description

A. Appearance

1. **Dress and Grooming.** You may find the person's appearance to be average, meticulous, slightly unkempt, or disheveled. The person may have body odor, no makeup, makeup that is skillfully applied, or garish makeup.
 - **Meticulous:** The appearance is perfect, unusually so.
 - **Skillfully applied:** The person is made up [skillfully].
 - **Garish:** The person looks outlandish.
 - **Self-neglect: Always** indicate when you think this is present. It involves such things as having body odor or looking disheveled and unkempt. Dress would be dirty, stained, or rumpled. This can be a sign of a mental illness such as depression or schizophrenia.
 - **Dress:** You may find it casual, business, fashionable, unconventional, immaculate, neat, stained, dirty, rumpled.
 - **Immaculate:** This means the person is [very] neat.
 - **Unconventional:** Use this term to refer to clothes that are inappropriate to the setting.
 - **Fashionable:** This is fine unless the person looks like something out of *Vogue* in an office in a small town or average city.
2. **Physical Characteristics.** Note those features that are outstanding. Look at body build, important physical features, and disabilities. Note voice quality. Is it strong, weak, hoarse, halting?
3. **Posture and Gait.** Note gait and any need for devices such as a cane or crutches. Look at coordination and gestures. For instance, does a right-handed person make most of her gestures with her left hand? Something like this could be a clue to neurological difficulties. Does the person limp or appear to slump? Does the person seem unsteady or shuffle?

B. Attitude and Interpersonal Style

Look at the attitude the person has with you. You may find it cooperative, attentive, frank, playful, ingratiating, evasive, guarded, hostile, belligerent, contemptuous, seductive, demanding, sullen, passive, manipulative, complaining, suspicious, guarded, withdrawn, or obsequious.

- **Hostility:** **Always** note when the person is hostile.
- **Uncooperative:** **Always** note when the person does not or cannot cooperate.
- **Inappropriate boundaries:** **Always** note if the client is too friendly, touches you, or attempts to draw you out personally.
- **Seductive:** Too close a relationship too soon; might call you by your first name or touch you
- **Playful:** Jokes, uses puns, self-deprecating humor
- **Ingratiating:** Goes along with whatever you think; wants to please
- **Evasive:** Talks, but gives nothing
- **Guarded:** Is more reserved than evasive; contributes the bare minimum, often with suspicion
- **Sullen:** Angry and somewhat uncommunicative
- **Passive:** Barely cooperates, needs to be led; generally without overt hostility
- **Manipulative:** Asks for special favors, uses guilt, solicits pity, threatens
- **Contemptuous:** Superior, sneering, cynical
- **Demanding:** Sense of entitlement
- **Withdrawn:** Volunteers little, appears sad

Watch your own emotional reactions to the people. Your reactions will give you important clues. Also pay attention to the person's *facial expression*. You may find it pleasant, happy, sad, perplexed, angry, tense, mobile, bland, or flat.

- **Bland:** Intense material, but looks casual
- **Flat:** No facial expression
- **Mobile:** Rapid changes in facial expression and mood

C. Behavior and Psychomotor Activity

Look at the quality and quantity of the person's motor activity. You may find the individual is seated quietly, hyperactive, agitated, combative, clumsy, limp, rigid, or has retarded motor function. You may find the person has mannerisms, tics, twitches, or stereotypes.

- **Seated quietly:** Uses normal gestures, but does not move around much
- **Hyperactive:** Is busy with hands and possibly feet
- **Agitated:** Cannot sit still (could be secondary to antipsychotic medication)
- **Combative:** Looks ready to hit, threatening
- **Awkward:** Unable to manage activity like sitting in the chair or writing; drops things (may be part of the illness or reaction to medication)
- **Rigid:** Sits like a tin soldier
- **Mannerisms:** These are unconscious repetitive actions
- **Posturing:** The person assumes certain postures and holds them inappropriately
- **Tics and twitches:** Less voluntary body movements
- **Stereotypes:** Four mannerisms strung together
- **Motor hyperactivity:** **Always** report this when you see a lot of hyperactivity, restlessness, and agitation. It may indicate a manic state, reaction to medication, or anxiety.
- **Motor retardation:** **Always** report this when you see the patient moves slowly, in a constricted manner and with minimal motor responses. Speech and thought are slowed, often depressed. Depression can give the appearance of cognitive impairment.
- **Mannerisms and posturing:** **Always** indicate mannerisms you see and any posturing.

- **Tension: Always** note tension, particularly if the person seems tense and the interview does nothing to relax the person.
- **Severe akathisia: Always** note severe restlessness. Sometimes it may be part of an illness, and sometimes it may be due to medication. If the physician believes it is due to an illness and increases the medication, the person may grow much worse. Therefore, try to establish when it started, how long it has gone on, and whether it has grown worse recently.

Always note the following when present: pacing, fidgeting, nail biting, trembling or tremulousness (a common side effect of lithium carbonate and tricyclic antidepressants), and abnormal movements such as rocking, bouncing, or grimacing (particularly strange facial movements).

- **Tardive dyskinesia: Always** note this condition if you see it or suspect this is what you are seeing. It occurs among psychiatric patients who have been on antipsychotic medications over a long period of time. The term literally means "late appearing abnormal movements" and seems to involve the muscles of the face, mouth, and tongue. Sometimes the trunk and limbs are also affected.

These movements can be slow and irregular (*athetosis*) or quick and jerky (*choreic*). All the movements are brief, involuntary, and purposeless. A person may twist the tongue and lips, make odd faces, bounce or tap the feet, or actually writhe and squirm in the seat.

- **Catatonic behavior: Always** note this behavior. It is generally a sign of severe depression or schizophrenia, catatonic type. It generally appears as a rigidity of posture wherein attempts to reposition the person are rigidly resisted. The person may voluntarily pose in bizarre and inappropriate ways. In waxy flexibility, the limbs of the person will remain in the position in which they are placed.

There is also a *catatonic excitement* wherein the patient engages in almost continual, purposeless activity that is nearly impossible to interrupt. Sometimes the patient engages in echolalia (repetition of everything that is heard) or mimics and imitates others during this episode.

D. Speech and Language

Speech is important because it is the primary means of communicating. Important to note are such things as rate, clarity, pitch, volume, quality, quantity, impediments, use of words, the ability to get to the point, and articulation.

You may find speech to be a normal rate, slow, hesitant, rapid, pressured, monotonous, emotional, loud, whispered, mumbled, precise, slurred, accented, stuttering, stilted, rambling.

- **Pressured:** Often rapid but constantly talking; cannot be interrupted (often a sign of a manic episode). Person appears to have racing thoughts.
- **Monotonous:** No variation in tone
- **Emotional:** Very expressive
- **Accented:** Note a native accent and also if the patient seems to accent certain words or syllables inappropriately
- **Impoverished:** May say very little either because of depression or because he is being interviewed in a language other than his native one; may also indicate a lack of facility with language
- **Neologisms: Always** note when the person makes up entirely new words with idiosyncratic meanings. (This can occur due to aphasia or brain injury due to accident or stroke.)

You should be able to identify any *neurological language disturbances*. Strokes, head trauma, and brain tumors can cause patients to lose their facility with language. Try to determine if the client has always had a language difficulty. Patients with schizophrenia may use loose associations as they talk. Those in a manic state may be prone to flight of ideas.

- **Aphasia:** Loss of ability to understand and produce language; damage usually to left hemisphere of the brain (left-handed people often have this in the right hemisphere)

The type and extent of aphasia depends on location and extent of brain injury.

- **Global aphasia:** Can neither speak nor understand, read, write, repeat words, or name objects
- **Broca's aphasia:** Can understand written and spoken language, but has trouble expressing own thoughts verbally
- **Wernicke's aphasia:** Inability to understand language and uses fluent, bizarre, nonsensical speech (The person may also act strangely and appear euphoric, paranoid, or agitated. It is easy to think this is a psychotic thought disorder, but in schizophrenia the person is generally able to write and speak in her language, repeat words, and name objects.)
- **Dysarthria:** Difficulty articulating due to problems with the mechanisms that produce speech. This sometimes produces distorted or unintelligible speech. The person usually can read and write normally. Ask the patient to repeat "No ifs, ands, or buts" to hear dysarthria better.
- **Perseveration:** Defined as the persistence "in repeating a verbal or motor response to a prior stimulus even when confronted with a new stimulus" (LaBruzza, 1994, p. 113). The client may give the same answer to different questions, stay on the same subject, or repeatedly return to the same subject.
- **Stereotypy:** "Constant repetition of speech or actions" (LaBruzza, 1994, p. 113). The patient may pull a shoe on and off, twist and untwist the hair, or repeat the same phrase or word over and over. These behaviors appear to be ritualistic and are common in childhood autism.

Give verbatim examples of what the individual has said to support your assessment of speech.

II. Emotions

A. Mood

This is the way a person is feeling at any given time. You may find it euthymic, depressed, sad, hopeless, empty, guilty, irritable, angry, enraged, terrified, expansive, euphoric, elated, sullen, dejected, or anxious. Ask yourself, what seems to be the dominant mood of the person?

- **Euthymic:** Normal mood
- **Expansive:** Feels very good and is getting better
- **Euphoric:** Out-of-sight happy
- **Anxious:** Worried and distressed

B. Affect

Affect refers to the underlying flow of moods. This would be the outward expression of the emotional state. You can see it in the way patients use and position their bodies and in their tone and manner of speaking. You may find it broad, appropriate, constricted, blunted, flat, labile, or anhedonic.

- **Broad:** Normal range of moods
- **Appropriate:** Appropriate to the situation
- **Constricted:** Restricted range of emotional expression
- **Blunted:** Even more restricted
- **Flat:** No change of mood, unemotional
- **Labile:** Rapid change in mood (crying, then laughing)
- **Anhedonic:** Incapable of any pleasurable response, depressed
- **Blunted affect:** **Always** note a blunted affect where you find no change in mood throughout the interview and no change in facial expression. It generally indicates depression.
- **Emotional withdrawal:** **Always** note if the person seems emotionally withdrawn to you. The person would be inexpressive and probably have a blunt affect.
- **Excitement:** **Always** note if the person seems inappropriately excited to you. It means the person is overly enthused or terrified about the given situation.
- **Full range of affect:** This refers to an appropriate affective response to the entire interview. **Always** note inappropriate affect (such as giggling when there is nothing funny happening), as this can be a sign of schizophrenia.

C. Neurovegetative Signs of Depression

In major depression, body functioning often becomes irregular. Always inquire about sleep and appetite, and report a loss or gain of more than 5% of body weight. Listen for symptoms such as changes in energy levels, interest, enjoyment of everyday activities, or sexual functioning; constipation; and weight changes (LaBruzza, 1994, p. 115).

- **Initial insomnia:** Trouble falling asleep
- **Middle insomnia:** Middle-of-the-night waking
- **Terminal insomnia:** Early morning waking. Depressed individuals will often wake several hours earlier than usual and feel most depressed in the morning.
- **Hypersomnia:** Some depressed individuals, especially those with bipolar disorders, tend to sleep a great deal.

III. Cognitive Functioning

A number of medical and neurological problems, as well as substance abuse, affect one's cognitive functioning. The concern is that many patients who have a disease of the brain may appear with what seems to be emotional and behavioral changes. In taking the history from the person, note previous levels of functioning and any previous emotional problems. If these are appearing in middle or late life, it is quite possible the person has a neurological problem.

A. Orientation and Level of Consciousness

Nearly all of the people who come to you will be alert and aware of their environment and their body. Occasionally, however, you may see individuals who are inattentive, drowsy, or who have a clouded consciousness. If these symptoms are present, use the proper term to indicate the person's level of awareness and briefly describe how the person exhibits this level. Medication can contribute to these stages as well.

- **Lethargy:** The person has trouble remaining alert and appears to want to drift off to sleep, but can be aroused. The person has trouble concentrating on the interview and seems unable to maintain a coherent train of thought.
- **Obtundation:** The person is difficult to arouse and needs constant stimulation to stay awake. The person may seem confused and unable to participate in the interview.

- **Stupor:** The person is semicomatose, and it takes vigorous stimulation to arouse her; she cannot arouse herself. There is no normal interaction during the interview as a result.
- **Coma:** This is the most severe consciousness problem wherein the person cannot be aroused and does not respond to any stimulation.
- **Oriented x3:** Means the person is oriented as to who he is, where he is, and when it is. Even when a person is having difficulty with consciousness, he may be oriented. If orientation problems occur as a result of lack of consciousness, it typically happens that the sense of time is affected first, followed by the sense of place, and finally by the sense of person. To be fully oriented requires an intact memory; thus, disorientation means there are memory deficits.
 - **Ask for current date:** Reasonably accurate dates are acceptable.
 - **Ask where the person is:** You can also ask for a home address, the present city or state, or for directions from here to the person's home or another familiar place. Sometimes people confused about place will behave as if they are at home or in another very familiar setting while in your office.
 - **Ask who the person is:** Ask for personal identifying information (age, birth date, name). Ask if the person recognizes or knows other people who might be present. Does she know her relationships to these other people?

B. Attention and Concentration

Always note inability to pay attention and if the person appears easily distracted.

- **Attention:** Can the person remain focused on the interview?

If you feel a need to test this in the person, you can use digit repetition. Say five numbers, and then ask the person to recite them back to you.

Concentration is needed to learn new tasks and for academic success.

- **Concentration:** The person can concentrate on one thing for an extended period of time.

You can test the person's concentration by asking the person to perform a complex mental task. (Serial 7s is one way of testing; in this method, you ask the person to add in increments of 7 or subtract from 100 by 7s. Be sure your instructions are on the client's level of education, and do not use this exercise if severe academic problems are present. Be careful not to humiliate people!)

C. Memory

Memory involves the ability to learn new material, to retain and store information, to acknowledge and register any sensory input, and to retrieve or recall stored material. When there are problems, they usually have to do with three areas:

1. Registration
2. Retention
3. Retrieval

Destruction of significant parts of the brain causes problems with memory. All memory deficits should be noted. The physician or clinician will want to do further tests. If you suspect something, ask others who know the individual about their perceptions of the patient's memory functioning.

- **Short-term memory:** Refers to immediate recall limited to about seven items and generally lasts for about one minute. Some problems may be due to inattention, so evaluate attention before memory.
- **Long-term memory:** Rehearsal allows material in short-term memory to convert to long-term memory. Anxiety about the interview or the person's situation or even depression can interfere with this.
- **Amnesia:** Inability to remember
- **Anterograde amnesia:** Cannot learn *new* material
- **Retrograde amnesia:** Cannot recall *recent past* events
- **Head injuries:** Most common deficits are inability to recall names, recent events, and spoken messages, and forgetfulness or forgetting to do something important. The person may have trouble telling you what she is experiencing with her memory. Memory loss may be permanent if there was severe or repeated head injury.
- **Transient global amnesia:** Lasts minutes to several hours and is usually seen in older people. The person experiences sudden confusion, loss of memory, and disorientation and cannot recall what happened during the time period in question. Retrograde amnesia will be present. Person will be distraught, asking for reassurance as to where he is and what he is doing. This is caused by an insufficient amount of blood to the brain.

Memory Testing. First, ask the person if she has been having any problems with memory. A family member may be able to shed some light on memory issues if any exist. During the interview, note memory lapses and difficulty recalling what the interviewer has just said. If you notice memory loss, note it so that further testing can be done. All the memory tests described in the following would be done only if you had considerable questions about a person's memory:

- **To test immediate recall:** Use a random list of digits, saying them in a normal tone of voice, about one digit per second. Ask the person to repeat them. Start with two digits and keep adding until the person fails. Give the person two times to try this. If the person fails at five digits or less, there is reason for concern about sustained effort, attention span, and immediate memory. Anxiety and depression are the most common reasons people fail this test (LaBruzza, 1994, p. 125). Strokes and other brain injuries can also affect recall.
- **To test recent memory:** Ask the person to recall events that have happened in the last few hours or days before she came to see you. You might ask what she had for lunch or where she parked the car. It is helpful if you can validate the answers with someone close to the client who knows. Another way to test is to ask about something that may have happened or been discussed earlier in the interview.

You may get several different versions. In cases of assault or trauma and where the victim feels comfortable with you, the different versions may indicate the she is able to recall more of the details each time she goes over what happened. With some people, you might give three or four unrelated words and ask them to recall these words after a short interval. Begin by saying the words in a normal tone of voice and ask them to repeat the words back to you. Note how many times a client must do this before learning the words. About 3 to 5 minutes later, ask clients to

recall the words. With a normal memory, a person should be able to recall them (LaBruzza, 1994, p. 126).

- **To test remote memory:** You can ask people about personal events in their lives and commonly known public events that happened in years past, such as major news stories. Use material that should be known by a person who is reasonably well informed. If the person does not appear to be able to do this test because of a lack of education, a difference in culture, or mental retardation, decide carefully what you will ask the person (LaBruzza, 1994, p. 128).

Additional information on memory and aging and how to assess memory can be found in Chapter 8 of *Fundamentals/or Practice with High Risk Populations* (Summers, 2002).

D. Ability to Abstract and Generalize

Proverbs. Cultural background and intelligence can influence how well a person thinks abstractly or how well the person can deal with similarities. Proverbs are generally used to see how well a person thinks abstractly. You need a general fund of information to be able to use proverbs in this way. Tell the person you are going to say a proverb and you would like the person to tell you in his own words what he thinks the proverb means. Then judge how concrete or abstract the reply is. Repeat the person's response verbatim in your report.

Individuals who are psychotic or on the verge of psychosis will often indicate this in their response to a proverb. Use proverbs that are free of gender and racial bias. The following are some proverbs you can use (LaBruzza, 1994, p. 129):

- A stitch in time saves nine.
- A rolling stone gathers no moss.
- Don't judge a book by its cover.
- Two wrongs don't make a right.

"A rolling stone gathers no moss" could be explained by a person who thinks concretely as, "If you roll a stone down the hill, it can't collect moss." A more abstract response might be, "If you keep moving, life remains interesting and challenging."

Similarities and Differences. Ask the person to tell you how two objects or two events are different or alike. This will require the individual to think somewhat abstractly about categories and relationships. Name two items and ask the person how these differ and how they are similar. The following are some combinations you might use (LaBruzza, 1994, p. 129):

- Apples and oranges
- Trees and flowers
- Houses and cars
- Dogs and cats

E. Information and Intelligence

To get an idea of the person's overall intelligence, ask questions that tap the person's fund of general information. It should be information known by the general public. Again, you must be sensitive to the person's cultural background, level of education, and intelligence. The following are examples of some questions you might ask (LaBruzza, 1994, p. 130):

- Who were the last four presidents?
- Who is the governor of the state?

- How many weeks are there in a year?
- What is the capital of the state (or the country, or France)?
- Who was Mark Twain?

IV. Thought and Perception

When a person's perceptions are disordered, it offers important clues to what the diagnosis might be. Here you want to know how people actually perceive themselves, the world around them, and others in their world. What does the person think, and what thoughts and concepts are most on his mind? Perception is the way in which we form an awareness of our environment. People who have difficulties with perceptions often perceive their world inaccurately (LaBruzza, 1994, p. 131).

A. Disordered Perceptions

Following are some terms that describe various disordered perceptions:

- **Illusions:** The person either misperceives or misinterprets a sensory stimulus. A tree branch brushing the side of the house in the wind sounds like people entering the house, or a dishwasher running sounds like people talking in another room.
- **Hallucinations:** In the absence of external stimuli, the person perceives something. The most common hallucination is hearing voices. Voices generally increase when the person is around white noise. White noise is even background noise, such as the dishwasher running, a roomful of people chattering, or rain drumming on the roof. If you can, find out who is talking, what they are saying, and how the person feels about it. Is there a command for the person to do something? If so, include the command in your report. Some commands are dangerous to the person or to others. **Always** note hallucinatory behavior.
- **Depersonalization:** The person feels estranged or detached from herself.
- **Derealization:** The person feels detached from what is going on around her. Be sure to note this. A person who dissociates cannot always be sure that what is happening is real (LaBruzza, 1994, p. 132).

B. Thought Content

The following terms are used to describe thought content:

- **Distortions:** A person distorts a part of reality. A woman with anorexia believes she is fat when she is thin. A person who is well believes his cough indicates tuberculosis. A person whose neighbor does not think to wave assumes the neighbor is angry.
- **Delusions:** An inappropriate idea from which a person cannot be dissuaded using the normal means of argument or evidence. Sometimes it is culturally inappropriate as well. Evidence to the contrary has no effect. For example, a client might insist that she has a case in court that will eventually yield her a great sum of money. No amount of persuasion or documentation can dissuade her from that belief and convince her that this isn't so. **Always** report the content of a delusion. Note if the delusion is incongruent with the client's mood. Delusions indicate psychosis. **Always** note if delusions are present.

People with *paranoid delusions* believe they are being singled out for harassment or are being controlled by forces outside of themselves. They may have an entire system of interconnected ideas developed that support their delusions. Common to schizophrenia are:

- **Thought withdrawal:** Belief that one's thoughts are being taken out of one's mind by an outside force
- **Thought insertion:** Belief that thoughts are being placed into one's mind by an outside force
- **Thought broadcast:** Belief that thoughts are being taken and broadcast so that others know what one is thinking
- **Suspiciousness: Always** describe this and the object of the suspicion.
- **Grandiose delusions:** The false belief that one is extremely important or a false belief that one is imbued with special powers. **Always** describe ideas of grandeur and any grandiose behavior.
- **Somatic delusions:** False beliefs about one's physical health
- **Delusional guilt:** Falsely believing that one is the reason or cause for terrible things that have happened or will happen
- **Nihilistic delusions:** A false belief in the meaninglessness of life and all events and circumstances, in nothingness; hopelessness; belief in the end of the world
- **Ideas of inference:** Refers to the ideas the person holds about what others do to affect him
- **Ideas of reference:** Refers to beliefs that people are talking and thinking about one. Messages on TV and radio are meant specifically for this person.
- **Magical thinking:** Means belief in astrology or a superstition, or the person thinks he has magical powers in his words, thoughts, or actions. This thinking is found in children who have not developed reality testing. It is part of human development and is not pathological until it becomes extreme, as in obsessive-compulsive disorder or a delusion. **Always** check religious beliefs or cultural background to see how this thinking fits with what is going on in the person's life and these aspects of the person's life (LaBruzza, 1994).
- **Thought content: Always** specify unusual or important thought content such as: (a) what the person is suspicious about, (b) what the person feels guilty about, and (c) what the person is preoccupied about.
- **Bizarre behavior: Always** note any that you witness or any that is reported to you by reliable others.

c. Thought Processes

You may find the form of the person's thoughts to be spontaneous, logical, goal directed, coherent, impoverished, blocking, nonspontaneous, incoherent, perseverative, circumstantial, tangential, or illogical. You may find it to have loose associations or flight of ideas. You may find that it contains neologisms or is distractible.

- **Flow of ideas:** Refers to the quality of the associations the person makes between ideas or between points in the person's discussion. Note the stream of the client's thoughts, the rate of thinking, the coherence, the continuity, and whether the thought process is goal directed (LaBruzza, 1994, p. 134).
- **Spontaneous:** Means you do not have to keep asking questions. The person readily volunteers information.

- **Goal directed:** The person answers the main questions about why she came and what she needs, and does not stray to other related topics.
- **Impoverished:** The person uses words but is very skimpy with them. There are too few ideas, and thinking is slow. Often attributable to depression or schizophrenia.
- **Racing thoughts:** The person thinks rapidly. Speech appears pressured. Often attributable to manic or hypomanic state.
- **Blocking:** The person stops, pauses, and starts somewhere else. There is an interruption to the normal flow of speech. The person may appear to forget where she was in the conversation when she resumes talking.
- **Circumstantial:** The person appears to throw in too many irrelevant details. The person has too many ideas associated with one another and too many digressions. Often thought to be a defense against dealing with troubling issues or feelings (LaBruzza, 1994).
- **Perseverative:** The person goes over and over the same point or idea.
- **Flight of ideas:** The person goes from one thought to another in logical sequence but is headed far from the original topic.
- **Loose associations:** The person's points do not hang together logically. Ideas shift in an apparently unrelated way. Characteristic of schizophrenia.
- **Illogical:** What the person is saying does not make sense.
- **Incoherent:** There is no meaning; the speech is disorganized; the person may be schizophrenic.
- **Neologism:** The person makes up new words.
- **Distractible:** Person cannot stay focused; may indicate mania.
- **Clang association:** "The sound of a word, rather than its meaning, triggers a new train of thought" (LaBruzza, 1994, p. 136).
- **Tangentiality:** Means "veering off" on somewhat related, but irrelevant, topics. May show a difficulty with goal-directed thinking. Common in mania and hypomania (LaBruzza, 1994, p. 136).
- **Overvalued ideas:** The idea might be possible, but it is used or seen by the person to explain more than it could possibly explain.
- **Conceptual disorganization: Always** note conceptual disorganization. This refers to an inability to conceptualize the problem clearly and may involve a number of the terms previously noted, such as loose associations, flight of ideas, tangential thinking, or incoherent content.

A note about the word **confused**: Students often say a client is confused when they are describing a person who is having trouble deciding what to do or a person who is feeling very ambivalent about a particular decision. In the mental status examination, however, the word confused means that the client was not oriented to time and place and person. In other words, confused clients do not know where they are, cannot understand what is being said to them, or do not recognize familiar people.

When a client is **ambivalent**, use that word; and when a client cannot make up his/her mind, say just that. Reserve the word confused for describing true cognitive confusion.

D. Preoccupations

These are thoughts and issues that appear to be the primary focus of the patient's thinking. There is an "obsessive quality" to the preoccupation (LaBruzza, 1994, p. 136).

- **Somatic preoccupation:** Focus on bodily functions, physical health. There is a hypochondriachal quality to the preoccupation. List and describe somatic concerns. Do not assume these are not real problems without proper medical documentation.
- **Obsessions:** Persistent thoughts that are intrusive and unwanted and that appear to haunt the person (LaBruzza, 1994, p. 136). The person may hold an idea that is not true in that intensity.
- **Compulsions:** Actions that are often the "counterpart of the obsession." These are "persistent, intrusive and unwanted urges" to take some action. If one does not complete the action, there is intense anxiety. These actions can be repetitive and ritualistic, such as checking the stove, counting steps, and straightening picture frames (LaBruzza, 1994, p. 136).
- **Phobias:** These are "irrational, intense, persistent fears" of such items as dogs, heights, elevators, insects, leaving home, closed spaces, and flying (LaBruzza, 1994, p. 136). The person will go to great lengths to avoid the situation or object of the phobia.

When writing out notes we need to be clear about the difference between perseveration and obsession. Note that *perseveration* is the term we use when a person focuses on one topic and comes back to it over and over, unable to change to another topic or stay on another topic relevant to the interview. Sometimes [managers] describe this as an obsession. *Obsession*, as noted above, are thoughts that intrude on the person beyond their control and are experienced as intrusive and unwanted.

V. Suicidality, Homocidality, and Impulse Control

Suicidality and Homocidality. You have a clinical and a legal responsibility to assess whether the person is a danger to herself or to others. A person who is dangerously impulsive or holds thoughts of suicide or homicide needs special observation. When conducting an interview, look for these thoughts. These are called suicidal ideation or homicidal ideation. Discover if there are plans to carry out these ideas or if the person seems to have an undeniable intention. Thoughts present some danger, plans make the situation more dangerous, and the clear intention to go forward with the plans creates an extremely dangerous situation.

The mildest form would be thoughts, followed by actually making plans. If the individual tells you she has purchased a gun and learned the intended victim's work schedule, you may assume there is a plan. If the individual tells you he has saved 3 months' worth of medication for an overdose, this would appear to be a plan. If the individual has a plan and expresses to you her obvious intention to carry out this plan, the situation becomes more serious (LaBruzza, 1994).

Always include the plan, the means, and the timetable in your report. If the person is homicidal, include toward whom the thoughts are directed as well.

Impulse Control. When you assess impulse control, you want to know how the person deals with aggressive urges, sexual urges, and strong desires to carry forward any plan not particularly well considered. Look at ways the client has handled stressful situations in the past. Is there a history of acting

on impulse without much thought as to the consequences? Does the person seem unable to tolerate stress? How did this person handle stress in the past? Is there a history of uncontrolled aggressive behavior, either sexual behavior or hostile behavior? Can this client tolerate frustration?

The three behaviors to look for in childhood are setting fires, cruelty to animals, and bedwetting. When these behaviors all occur in childhood, they appear to be significantly associated with cruel adult behavior. In adulthood, you might find behaviors such as punching holes in the wall, smashing furniture, slitting one's own wrists, drinking excessively, or turning to drugs or a drug overdose.

VI. Insight and Judgment

Insight. The person understands that she is "suffering from an illness" or has an emotional or personal problem. Make a note if the person completely denies any problems or denies having any part in a problem that obviously affects the client's relationships with significant others. For instance, some people have extremely acrimonious relationships with their relatives but seem unaware that their hostile responses actually elicit more hostility from these relatives. As another example, a person may come in seeking help for a substance abuse problem and genuinely believe that there is no problem and that his behavior is appropriate. In addition, he may indicate that those who are concerned are actually inappropriately concerned. People hold insight in "varying degrees" and may show only partial understanding of their difficulties (LaBruzza, 1994, p. 137).

Judgment. The person can critically evaluate her situation and make good decisions about a course of action. Look for risky behavior in the past that could have been potentially harmful (practicing unsafe sex, binge-drinking and reckless driving, and so forth). "Assess whether clients are able to understand the potential consequences in their behavior" and can plan preventive measures. You might ask what the individual would do if he spotted a fire in a movie theater or what he would do if he found a stamped, sealed, and addressed envelope (LaBruzza, 1994, p. 138).

VII. Reliability (Accuracy of the Client's Report)

You need to state briefly your impression of [the] person's reliability and accuracy in giving you the details of their situations. If a person is psychotic, the material presented is likely to be extremely unreliable. A person who is suffering from dementia or delirium may be having considerable difficulty remembering what has happened or what is happening now. Some people deliberately tell falsehoods to qualify for disability or to give false impressions of themselves to the worker (LaBruzza, 1994, p. 139).

VIII. The Environment

Sometimes you will be asked to go to someone's home to do an assessment or to do an interview. People's surroundings often hold clues to the way they are currently structuring their lives.

- ***Inappropriate surroundings:*** Means the person has arranged furnishings inappropriately. It may be that furniture blocks doors and windows or that the windows are covered oddly, perhaps with tin foil or some other material. There might be strange wires leading nowhere, odd decorations, or strings of odd things hung across a room. You might find household objects being used inappropriately. Sometimes a person believes the people on TV can see into his home or the people on the radio can hear what he says. In such cases, you may find these devices covered or blocked in some way.

Be very careful in making these judgments. At one time a worker decided that windows partially covered with foil-wrapped insulation were a sign of something amiss in the person he was seeing. It turned out the man was doing that to save energy. In another home, a worker decided the blanket over the TV indicated her woman was paranoid. In fact, it turned out the TV was very new and she was very proud of it; she had put a blanket over it the day before when her young nieces came to visit so the TV would not get scratched. It helps to inquire matter-of-factly about what you see.

- **Waste and Trash:** Look at the way the person keeps his home. Are there unusual collections of junk or trash? Are there piles and piles of paper and magazines everywhere, or collections of string, bags, and other objects? Sometimes the home is very cluttered or dirty, with unwashed bed linens and with unwashed dishes stacked all over the kitchen. This tells you something about the person's capacity to attend to the routine details of living, or it may indicate a debilitating mental illness, such as hoarding. You might find urine or feces on the floor or walls. You might find the pets in the home neglected, their food bowls full of rotten food. Sometimes the house might be overrun with strays the person has taken in, but is unable to adequately care for.

Note: It is not unusual for a middle-class worker to assume that the manifestations of poverty are the signs of a person who is mentally ill. You must be very careful not to ascribe mental problems to someone who is actually too poor to live by middle-class standards.

Always report environmental cues that seem to support the rest of your mental status examination.

Clinical Definitions. There are two words we tend to use in everyday conversation that mean one thing when we do but mean something entirely different when we use these words clinically.

- **Confused:** [People] often use the word "confused" to mean that a person is not clear what decision to make or what would work in the person's best interest. They describe their client as being confused when it would be better to say the person was uncertain, ambivalent, or unsure. Confused is a term we use clinically to describe someone who is not oriented as to person, place and time.
- **Obsessed:** [People] often use "obsessed" to indicate that the person is focused on a topic to the exclusion of most other things. If the person does keep returning to one topic and it is hard to steer the discussion to other topics or issues we would say the person is perseverating, not obsessed.

Part 3: Summary

Every contact you have with clients must be documented, and every documentation of a client contact must contain your impressions of how the person seemed at the time of that contact. In social histories and evaluations, these impressions are lengthy and contain material observed by you during your contact with the client.

The mental status examination is a snapshot of where the individual is at a particular time. You are not trying to document how the client will always seem. Tomorrow the person may be different. Your notes can be used to follow peoples' progress or regression. Using the material in this chapter will help you to write full, accurate impressions of clients that will help clinicians understand what has been going on with them between sessions and determine the best course to follow with each individual.

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Additional Resources

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