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Mental Status Examination (MSE)

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Summary: The Mental Status Examination (MSE) is the (psychiatric) equivalent of the ‘physical exam’ in the assessment of a patient with mental health needs.

What is the MSE?

The Mental Status Examination (MSE) is the psychiatric equivalent of the ‘physical exam’ in the Psychiatric Assessment.

The MSE are your observations from the patient encounter. Observations from the MSE are started from the moment you meet the patient and throughout the interview until the patient leaves.

Main Elements of the MSE (Mnemonic “ASEPTIC”):

1. A)PPEARANCE AND BEHAVIOUR

Apparent Age	Stated age? Younger/older?
Dress	Casually? Formally? Poorly?

Grooming	Good or poor?
Hygiene	Good or poor?
Gait	Brisk, slow, intoxicated, ataxic, rigid, shuffling, staggering, uncoordinated?
Psychomotor activity	Normal, reduced, excessive?
Abnormal movements	Grimaces, tics, tardive dyskinias, foot tapping, ritualistic behaviour?

Eye contact: Good or poor?

Attitude: Cooperative, belligerent, oppositional, submissive, etc.?

2. S)PEECH

Rate: Rapid, pressured, slowed?

Rhythm: Hesitant, rambling, halting, stuttering, jerky, long pauses?

Tone of voice: Appropriate or inappropriate tone of voice?

Volume: Loud, soft, whispered, yelling, inaudible?

Any accent?
Pronunciation, articulation
Responds only to questions, offers information, repetitive, verbose?

Affect Quantity

3. E)MOTION (MOOD AND AFFECT)

When the clinician asks, "How is your mood?" and the patient responds, “Good”, “Depressed”, “Down”, etc.

Mood: Patient's subjective emotional state

Affect: objective emotional state

What you actually observe about how they appear to be feeling, e.g. if their affect appears down, euphoric, etc.

Congruent mood means that the mood is appropriate to the situation, e.g. patient's father has passed away and the patient is sad
Incongruent mood means that the mood is inappropriate to the situation, e.g. patient's father has passed away and the patient is laughing hysterically

Congruence to mood Appropriateness

Quality	Euthymic, elevated, depressed?
Range	Broad/ restricted?
Stability	Fixed / labile?

4. P)ERCEPTION

Hallucinations	Auditory: Are you hearing any things that others can't hear? Visual: Are you seeing any things that others can't hear? Olfactory: Any unusual smells that you notice, e.g. burning smells? (classically seen in temporal lobe epilepsy)
Illusions	Distortions of real images or sensations
Depersonalization	Patient feels that they are not real Clinician: "Do you ever feel that you are not real?"
Derealisation	Patient feels that the world is not real Clinician: "Do you ever feel that things around you aren't real?"

5. T)HOUGHT CONTENT AND PROCESS

Thought Process	How well are the patient's thoughts connected? Are the patient's thoughts coherent, logical, relevant? Does the patient tend to go off topic? (e.g. circumstantial) Does the patient completely go from one thing to the next? (e.g. tangential (as in mania, psychoses); flight of ideas (as in mania, disconnecting rambling from one idea to the next); loosening of associations (as in psychosis with shifting from one subject to another) Thought blocking (as in psychosis, where person stops suddenly in the middle of a sentence) Word salad (as in schizophrenia, with seemingly random words and phrases) Echolalia (as in Tourette's where patient copies another's speech), Neologisms (as in psychosis with patient making up new words)
Thought Content	

Delusions	Delusions: (to friends and family): “Does your loved one have any strong or unusual beliefs?” Delusions: (to the patient) “Everyone has beliefs. Some people are religious. Some people believe in UFOs. Some people believe that the government is spying on us. Any strong beliefs that you have?” (NOTE: Having any of the above believes can be on the normal spectrum. It is when these beliefs are to an unhealthy extreme that causes problems, that one wonders about psychosis. E.g. On one hand, it is normal for many to believe in God. On the other hand, if one believes that God has given them special powers that allow them to jump off a building and fly, this would likely be delusional.) Paranoid delusions: “Do you feel that people are watching you, following you or trying to hurt you?” Delusions of grandeur: “Do you have any special powers or skills?”
Suicidal ideation	Suicidal: “With all the stress that you’ve been under, has it ever gotten to the point that you feel life isn’t worth living?” If positive, then ask: “What’s the strongest those thoughts have gotten?” “At this moment, do you have any thoughts of ending your life?”
Homicidal ideation	Homicidal ideation: “Any thoughts of hurting other people?”

6. I)NSIGHT AND JUDGEMENT

Insight	Assuming the patient has difficulties and/or an illness, does the patient understand this? • Good insight: Patient understands they are ill and need treatment (similar to being in action phase)) • Partial insight may indicate that the patient acknowledges a problem, but is not willing to seek appropriate help or treatment (similar to being contemplative) • Poor insight means that the patient does not see that they are ill nor does the patient need any help or treatment (similar to being pre-contemplative)
Judgment	Is patient able to use facts and make reasonable decisions? May be good, fair, impaired

7. C)OGNITION

Level of consciousness	Alert, confused, lethargic, stuporous
Orientation in 3 spheres	Name: What is your name? Place: Where are you right now? Time: What year, month, day is it?
Attention/Concentration	How well does the patient seem to be able to focus? (Good, poor)
Memory	How well can the patient remember? Short-term: Can the patient recall recent things that have happened? Long-term: Can the patient recall distant events?
Intelligence (globally and intellectual functions)	Based on your observations and patient’s use of speech, does the patient’s overall intelligence and cognition appear to be 1) below average, 2) average, or 3) above average?

About this Document

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