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A Peer Reviewed International Journal for the Advancement of Clinical Skills
- *'docendo ac discendo' - 'by teaching and learning'*



In this issue:

The art of basic wound suturing

Prescribing skills of trainee medical staff
Insight as a measure of educational efficacy
The mental state examination
myPaediatrics

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The International Journal of Clinical Skills looks forward to contributing positively towards the training of all members of the healthcare profession.

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Foreword



As we head into the New Year of 2010, the International Journal of Clinical Skills (IJOCS) can feel justifiable pride that it has fulfilled its ambition to provide the international healthcare community with an arena for clinical skills education and research. For almost all the healthcare professions, clinical skills form the basic foundations and therefore a combined approach is absolutely what is needed for the future provision of a high quality health service.

The role of the ePortfolio in both education and continuing professional development of healthcare professionals continues to evolve as training and revalidation become increasingly important. Clinical skills are an essential element of this process and in 2010 the IJOCS will be proud to publish abstracts and papers from the 8th international ePortfolio conference hosted by EIFEL London Learning Forum 2010. Further information can be found at www.ijocs.org/eportfolio

This year will also see the launch of the new and exciting 'CliniTube' website – a free resource providing a single portal for accessing and sharing an array of information. It should be a valuable resource for students and should give teachers of numerous disciplines the opportunity to share educational materials. I'm certainly looking forward to seeing the 'Clinical Skills Lab' which should become an integral component of CliniTube and will comprise information on a variety of clinical skills.

The International Journal of Clinical Skills is a unique publication in its devotion to clinical skills. I encourage professionals all over the world to continue contributing to its on-going success. After all, our patients deserve nothing less than the best.

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The mental state examination

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Abstract

This article details a practical routine for examining the mental state that is appropriate both for day-to-day clinical practice and for sitting Objective Structured Clinical Examination (OSCE) type exams. The emphasis is on the steps involved in examining the mental state, rather than on specific signs and symptoms. For a full description of the signs and symptoms of mental disorders, please refer to the other articles and references cited in this paper.

Introduction

The mental state examination (MSE) is, strictly speaking, a snapshot of the patient's behaviour and mental experiences at or around that point in time. Just as an abdominal examination is used to seek out the signs of gastrointestinal disorders, so the MSE is used to seek out the signs of psychiatric disorders. In addition, the MSE is also used to seek out the *symptoms* of psychiatric disorders, and in this respect it also resembles the functional enquiry of a medical history. Being as it is part examination and part functional enquiry, the MSE relies on a firm grasp of the signs and symptoms of psychiatric disorders.

The MSE's role is to ensure that all important signs and symptoms of mental disorder are screened for and fully explored. The MSE can be considered as a 'core and module' questionnaire: simple screening questions about important psychiatric symptoms are asked, with any positive responses prompting further, in-depth questioning around the symptom(s) in question. If there are no signs or symptoms of mental disorder, or if these have already been explored in the psychiatric history, the MSE is usually quick and easy to administer.

Although the MSE is usually administered after the psychiatric history, it can also be administered *during* the psychiatric history, immediately after the presenting complaint and history of presenting complaint – an approach that often makes more sense.

The MSE consists of the following seven sections, which are further summarised in this paper:

1. Appearance and behaviour
2. Speech
3. Mood, plus anxiety and risk assessment
4. Thoughts
5. Perception
6. Cognition
7. Insight

For the sake of simplicity, this paper refers to the patient as being male, but the examination is identical for a patient of the female gender (unless otherwise specified).

Appearance and behaviour

Note the following about the patient: (1) level of consciousness; (2) physical appearance; (3) behaviour and attitude; and (4) motor activity and any disorders of movement.

With regard to the level of consciousness, most patients can be described as 'alert'. However, in some cases, for example, in mania or schizophrenia, the patient may be hyperalert or vigilant. At the other end of the spectrum, he may be somnolent or even unconscious, for example, as a result of sleep deprivation or the side-effects of antipsychotic medication.

When considering physical appearance, take note of the patient's body build, posture, general physical condition, dress, grooming and hygiene, and physical stigmata such as scars, piercings and tattoos. Remember that scars result not only from accidents and surgical operations, but also – and importantly – from deliberate self-harm (DSH).

Assessment of behaviour and attitude includes taking note of facial expression, degree of eye contact and quality of rapport. Is the patient doing anything odd or unusual? How does he make you feel?

With regard to motor activity and disorders of movement, first take note of the amount of movement. Excessive motor activity and restlessness is described as agitation, whereas a lack of motor activity is described as retardation or, in extreme cases, as stupor, in which condition the patient is both immobile and mute. Then take note of any abnormalities of spontaneous movements, such as tremors, tics, or mannerisms.

Extrapyramidal side-effects (EPSEs) of antipsychotic medications are common and involve one or several of acute dystonia, akathisia, Parkinson-like symptoms, or tardive dyskinesia (Table 1). Note that abnormalities of induced movements such as echopraxia (the abnormal repetition of the actions of another person) and perseveration (the repetition of a requested movement or behaviour even after it is no longer appropriate) are relatively rare and are mostly seen in catatonic schizophrenia.

Table 1: Extrapyramidal side-effects of antipsychotic medications

| | |
|---|---|
| Acute dystonias | Often painful spasmodic contraction(s) of certain muscles or muscle groups, most commonly affecting the neck, eyes and trunk; for example, tongue protrusion, grimacing or torticollis |
| Akathisia (Greek, 'not to sit') | Distressing feeling of inner restlessness manifested by fidgety leg movements, shuffling of feet, pacing and so on |
| Parkinson-like symptoms | Triad of parkinsonian tremor, muscular rigidity and bradykinesia |
| Tardive dyskinesia (TD) | Involuntary, repetitive, purposeless movements of the tongue, lips, face, trunk and/or extremities that may be generalised, or affect only certain muscle groups; typically the orofacial muscle groups |

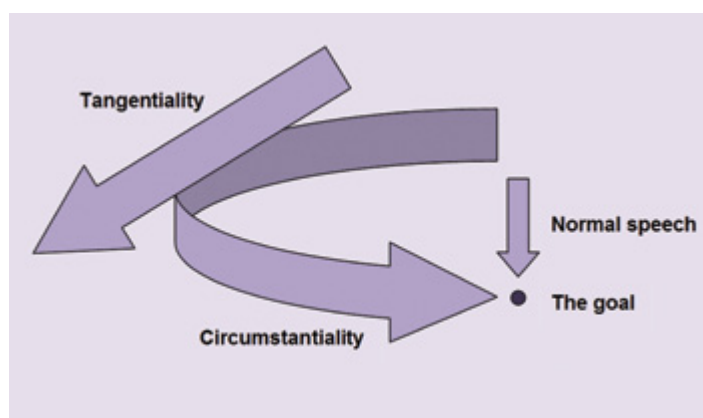
Speech

A person's speech mirrors his thoughts, but under 'speech' you should limit yourself to recording the technical aspects of speech. The *content* of speech is best recorded under the separate MSE section 'thoughts'.

When assessing speech take note of the amount, rate, volume and tone of speech, as well as 'the form of speech'. An increased amount of speech is called logorrhoea, whereas a reduced amount of speech is called poverty of speech. Logorrhoea and poverty of speech should not be confused with 'pressure of speech' and 'speech retardation', which describe increased and decreased rate of speech respectively. An extreme form of speech retardation is mutism, which is defined as the failure to speak despite the physical ability to do so.

The two most common abnormalities of the 'form of speech' are circumstantiality and tangentiality. Circumstantiality describes speech that is organised and goal-oriented, but that is cramped by excessive or irrelevant detail and parenthetical remarks. Tangentiality in contrast, describes speech that is organised but not goal-oriented in that it relates only very indirectly to the question asked (Figure 1 on next page).

Figure 1: Normal speech, circumstantiality and tangentiality



Other abnormalities of 'the form of speech' include neologism (the use of a new word or condensed combination of words), metonym (the use of an existing word, but with a new meaning attached) and clang association (the linkage of words based on sound rather than meaning). Neologism, metonym and clang association are most commonly seen in mania.

Mood

Assess the patient's mood with general screening questions. For example, screening questions for depressed mood include: "have you been keeping reasonably cheerful?" or "have you felt tearful in the past few days?" or "how would you rate your mood on a scale of 0 to 10, with 0 being the worst you have ever felt and 10 being normal?" Good screening questions for elevated mood include: "have you been feeling particularly cheerful or energised?" or "have you been feeling on top of the world?"

If there is any suggestion of a mood disorder, this must be explored further. Note that it is customary to report both 'subjective mood' (the patient's report of his mood) and 'objective mood' (the examiner's impression of the patient's mood).

After assessing the patient's mood, assess his 'affect'. Whereas mood is a pervasive or sustained emotional state such as anxiety, depression or euphoria, 'affect' is an observable behaviour that results from changing emotions, such as joy, sadness or fear. In short, 'affect' is to mood as weather is to climate. If you have not done so already, you must ask about self-harm and suicide.

Asking about suicide can, in particular, feel uncomfortable. Use a formulation such as: "people with problems similar to those that you have been describing, often feel that life is no longer worth living; have you felt that life is no longer worth living?" If the response is 'yes' you need to explore this further. If appropriate, ask also about ideas of harm to others.

Finally, ask about anxiety and anxiety symptoms such as butterflies, giddiness, clamminess, palpitations and difficulty catching breath. A good screening question for anxiety is: "are there times when you become very anxious or frightened?"

Thought

Assess the form of thought. Common disorders of the form of thought are 'flight of ideas' and 'loosening of associations', which are both typically seen in mania. In flight of ideas, thoughts move quickly from one idea to another and seem to be only loosely connected, for example, by clang associations, punning or rhyming. In loosening of associations, thoughts move quickly from one idea to another but, unlike in flight of ideas, they do not appear to be connected to one another.

Once you have assessed the form of thought, assess the content of thought. In particular, does the patient harbour any delusions? A delusion is defined as a fixed belief that is held in the face of evidence to the contrary and that cannot be explained by culture or religion. It should be distinguished from an overvalued idea, which is defined as an idiosyncratic and firmly (although not fixed) held belief that is in itself acceptable and comprehensible, but that comes to dominate thinking and behaviour.

For obvious reasons you cannot ask directly about delusions. Begin with an introductory statement and general questions such as: "I would like to ask you some questions that might seem a little strange. These are questions that we ask to everyone who comes to see us. Is this all right with you?" and "Do you have any ideas that your friends or family do not share?"

Then, if need be, ask specifically about common delusional themes (Table 2, next page). Explore any delusions and in particular ask about their onset, their effect on the patient's life and the patient's explanation for them (degree of insight).

You should also ask about obsessions and be able to distinguish obsessions from delusions and overvalued ideas. An obsession is defined as a recurrent idea, image or impulse that is perceived as being senseless, that is unsuccessfully resisted, and that results in marked anxiety and distress. For an obsession, determine the underlying fear, the degree of resistance to the intrusive thoughts and their effect on everyday life. Is the obsession perceived as being senseless? Is it accompanied by compulsive acts? Good screening questions for obsessions and compulsions include: "do certain things keep coming into your mind, even though you try hard to keep them out?" or "do you ever find yourself spending a lot of time doing the same thing over and over again, even though most people would say you've already done it well enough?"

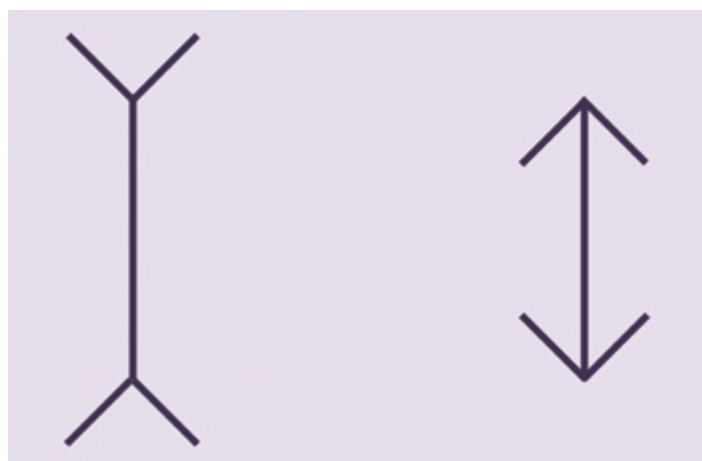
Table 2: Enquiring about delusions

| Type of delusion | Example questions |
|--|---|
| Delusions of persecution | <i>How are you getting on with other people? Is anyone deliberately trying to harm you or to make your life miserable?</i> |
| Delusions of control and passivity experiences | <i>Is someone or something controlling you? Is someone forcing you to think / say / do certain things?</i> |
| Delusions of thought control | <i>Are you able to think clearly? Are your thoughts being interfered with? Are thoughts which are not your own being put into your head? Are your own thoughts being removed from your head? Are your thoughts being heard or otherwise accessed by other people?</i> |
| Delusions of reference | <i>Do people talk about you behind your back? Do people drop hints about you / say things that have a special meaning for you?</i> |
| Delusions of grandeur | <i>How do you see yourself relative to other people? Do you feel you have a special mission? Do you feel that you have any special abilities or powers?</i> |
| Religious delusions | <i>Are you a very religious person? Are you especially close to God?</i> |
| Delusions of guilt | <i>Do you have any regrets? Do you feel you as though you have committed a crime / sinned greatly / deserve punishment?</i> |
| Nihilistic delusions | <i>Do you feel that something terrible has happened or is about to happen? Do you feel that a part of your body has stopped functioning / been removed? Do you feel as though you have died?</i> |
| Somatic delusions | <i>Are you concerned that you might have a serious illness?</i> |
| Delusions of jealousy | <i>How are you getting on with your partner? Does he or she reciprocate your loyalty?</i> |

Perception

Assess for any hallucinations and be sure to distinguish them from illusions. A hallucination is defined as a percept that arises in the absence of a stimulus. In contrast, an illusion is defined as a percept that arises as a misinterpretation of a stimulus, for example, hearing voices in the rustling of leaves (Figure 2).

Figure 2: The Müller-Lyer illusion arises from the misinterpretation of a stimulus; both lines are in actual fact the same length. In contrast, a hallucination arises in the absence of a stimulus.



It is not easy to ask about hallucinations; begin by an introductory statement followed by general questions, for example: “I gather that you have been under quite some pressure recently. When people are under pressure they sometimes find that their imagination plays tricks on them. Does that sound true for you?” and “have you seen or heard things which are unusual?” and “have you seen things which other people cannot see?” and “have you heard voices when there was no one around?”

If hallucinations are present, record their modality, content and mood congruency. Exclude hypnopompic and hypnogogic hallucinations and also pseudo-hallucinations, which can all occur in the absence of a mental illness. Hypnopompic hallucinations are visual or auditory hallucinations that occur only upon awakening, whereas hypnogogic hallucinations are visual or auditory hallucinations that occur only upon falling asleep.

Pseudo-hallucinations differ from true hallucinations in that (1) they are perceived to arise from the mind (inner space) rather than from the sense organs (outer space); (2) they are less vivid; (3) they are less distressing; and (4) the patient may have some degree of control or insight into them.

For auditory hallucinations of voices, determine if there is more than one voice and if the voices talk to the patient (second person) or about the patient (third person). Third person auditory hallucinations are a first rank symptom of schizophrenia, whereas second person auditory hallucinations can involve potentially dangerous command hallucinations; that is, hallucinations of voices that command the patient to do dangerous things such as harm himself or others. In such cases, it is important to establish whether the patient is likely to act on these commands.

Check also for the presence of depersonalisation (an alteration in the perception or experience of the self, leading to a sense of detachment from one's mental processes or body) and derealisation (an alteration in the perception or experience of

the environment, leading to a sense that it is strange or unreal). For example, you might ask: “have you ever felt distant or unreal?” or “have you ever felt that things around you are unreal?”

Cognition

Cognition can be assessed quickly and effectively by testing along three domains: (1) orientation in time and place; (2) attention and concentration; and (3) short-term and recent memory.

Ask the patient to name the time of day, day of the week and date of the year. If he has trouble with these, ask him to name the building that you are sitting in. Then ask the patient to repeat the name of three objects, such as pen, watch and table (short-term memory), and to commit these three objects to memory. Distract him with a test of attention and concentration, such as the serial sevens test: “subtract 7 from 100 and to keep on going”. Then ask him to recall the three named objects (recent memory). If you suspect cognitive impairment, you can carry out the 30-point Mini-Mental State Examination (MMSE), also known as the Folstein Test.

Insight

Finally, to determine the degree of insight (which is the degree of understanding that a person has of his illness and of the impact that it is having) ask the patient: “do you think there is anything wrong with you?” If he replies no, then go onto ask “why did you come to hospital?” however, if he replied yes then you can ask questions such as: “what do you think is wrong with you?” and “what do you think the cause of it is?” or “do you think you need treatment?” or “what are you hoping treatment will do for you?” A patient with a poor understanding of his illness, and the impact that it is having, is referred to as having ‘poor insight’ which is characteristic of certain mental disorders such as dementias, schizophrenia, mania and other psychotic disorders.

Conclusion

In conclusion, the mental state examination is an important and integral part of the psychiatric assessment. It is a structured appraisal of the patient’s behaviour and mental experiences over seven key domains, namely, appearance and behaviour, speech, mood, thought, perceptions, cognition and insight. Its role is to ensure that all important signs and symptoms of mental disorder are screened for and fully explored, and to construct a cross-sectional description of the patient’s mental state at or around that time. This is achieved through a combination of direct and indirect means: observation, focused questions about current symptoms, and formalised psychological tests. A fully proficient mental state examination calls upon knowledge, skill, experience and a high degree of sensitivity to different social and cultural norms and values. It plays a vital role in establishing the correct psychiatric diagnosis and in formulating an effective management plan.

Declarations

Dr Neel Burton is editor of “Clinical Skills for OSCEs” and author of “Psychiatry”.

Further reading

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The Clinical Skills Lab database will comprise information on over 200 clinical skills, broadly separated into:

- History taking skills
- Communication skills
- Clinical examination/interpretation skills
- Practical skills

Not only will this valuable resource provide material to students as a learning tool and revision aid, for example, OSCEs, it will also offer educational materials for teachers from all disciplines, allowing some standardisation of practice. The Clinical Skills community will also be encouraged to contribute, making this database interactive.

CSL is a free not for profit database. Visit www.ijocs.org for access