Mental Status Exam for Children and Adolescents

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Agenda

Mental Status Exam

- What Is a Mental Status Exam?
- General Guidelines
- Who Does a Mental Status Exam?
- Elements of Mental Status Exam
- Tools
- Summary
Objectives

• Recognize the mental status exam (MSE) as both a psychiatric and neurologic evaluation.

• Identify elements of the pediatric MSE.

• Outline, assemble, refine and conduct the MSE in a systematic manner for individual clinician use.
Mental Status Exam
What Is a Mental Status Exam?

- Mental status examination in USA or mental state examination in the rest of the world, abbreviated MSE, is an important part of the clinical assessment process in psychiatric practice.
### What Is a Mental Status Exam? (cont’d)

A structured way of observing and describing a **patient's current state of mind**, under the domains of

<table>
<thead>
<tr>
<th><strong>Appearance</strong></th>
<th><strong>Thought Processes</strong></th>
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</thead>
<tbody>
<tr>
<td>(dress, cleanliness, slim, obese, posture, eye contact, quality)</td>
<td>(goal directed, circumstantial, concrete, derailed, disorganized)</td>
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<table>
<thead>
<tr>
<th><strong>Attitude</strong></th>
<th><strong>Thought Content</strong></th>
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<tbody>
<tr>
<td>(demeanor, friendly, hostile, agitated, relaxed)</td>
<td>(unremarkable, day’s events,)</td>
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<tr>
<th><strong>Behavior/Motoric</strong></th>
<th><strong>Perception</strong></th>
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<tbody>
<tr>
<td>(wnl, hyperactive, slow, vegetative, lethargic)</td>
<td>(hallucinations, odd perceptions, paranoia)</td>
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<tr>
<th><strong>Mood and Affect</strong></th>
<th><strong>Cognition</strong></th>
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<tbody>
<tr>
<td>(happy, anxious, sad, manic, bright, congruent, expansive)</td>
<td>(above, average, below, delays)</td>
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<tr>
<th><strong>Speech</strong></th>
<th><strong>Insight and Judgment</strong></th>
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<tr>
<td>(speed, rhythm, volume, prosody)</td>
<td>(limited, age appropriate, good, poor, nil)</td>
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What Is a Mental Status Exam? (cont’d)

• One component of a neurological or mental health/psychiatric assessment.

• A learned clinical skill, not an innate aptitude

• Requires effort to develop and practice to maintain
Origins and Definition

• The MSE originates from an approach to psychiatry known as descriptive psychopathology or descriptive phenomenology which developed from the work of the philosopher and psychiatrist Karl Jaspers.
• a German psychiatrist and philosopher who had a strong influence on modern theology, psychiatry and philosophy.
Karl Jaspers

the only way to comprehend a patient’s experience is through his or her own description (through an approach of empathic and non-theoretical enquiry), as distinct from an interpretive or psychoanalytic approach which assumes the analyst might understand experiences or processes of which the patient is unaware, such as defense mechanisms or unconscious drives.
• MSE is a blend of empathic descriptive phenomenology and empirical clinical observation.

MSE is too often overlooked these days, and is as essential to good clinical practice as auscultation, palpation, and percussion.
General Guidelines
Create the Setting
Establish Rapport

- Welcome The Child
- Have parent in room if soothing to child
- Privacy - close door
- Basic Human Comforts
- Calming and Respectful Demeanor
- Encourage Open Communication
- Acknowledge and Validate Child's Distress/Concerns
General Guidelines (cont’d)

• Ask Open Ended Questions

• Allow Client to Explain Things in His/Her Own Words

• Encourage to Elaborate, Explain

• Avoid Interrupting

• Guide Interview as necessary

• Avoid asking “why?” instead ask, “help me understand.”

• Listen and Observe for Cues from Client
General Guidelines (cont’d)

• MSE is more than simply a means of gathering information.

• It is also therapeutic, the first contact with patient.

• MSE sets the stage for your future relationship.

• Empathic, warm, yet neutral can be very soothing even to a child who is very agitated, depressed, frightened, or angry.

• You may be rushed and distracted by other things, but your patient will often remember your first encounter even years later.
• Empathy
  - Not synonymous with liking the patient—Rather, it reflects our appreciation that another person is suffering and experiencing difficulty, and needs the full benefit of our care and expertise.”
Conducting the MSE

The routine MSE in 15-30 minutes,

Probes

• Cognition
• Emotions
• Behavior
• Motor Activity

Examination takes longer to teach and describe than it does to perform.
“The first MSE with a patient serves as reference point against which all subsequent exams—by the same clinician or others—will be compared,” Dr. Deutsch.

“An examiner needs to train herself/himself so that her/his examinations are consistent over time and as objective as possible.”

The Elements and Import of the Mental Status Examination, 2007, Deutsch
Purpose-

• obtain a comprehensive cross-sectional description of the patient's mental state, which, when combined with the biographical and historical information of the psychiatric history, allows the clinician to make an accurate diagnosis and formulation, which are required for coherent treatment planning.
Information

• collected through a combination of direct and indirect means:
  
  • unstructured observation

  • while obtaining the biographical and social information, focused questions about current symptoms

  • and psychological tests.
Who Does a Mental Status Exam?

Trained

• Nurses
• Counselors
• Therapists
• Physicians
• Psychiatrists
• Nurse Practitioners
Elements of MSE

I. Appearance, Attitude, Behavior, and Social Interaction

II. Motor Activity

III. Mood

IV. Affect
Elements of MSE (cont’d)

V. Speech

VI. Thought Processes

VII. Thought Content

VIII. Intellectual Functioning

XI. Judgment and Insight
I. Appearance, Attitude, Behavior, and Social Interactions

- **Dress** (age appropriate?)
- **Ease in Separation from Parent**
- **Manner In Relating** (regressed?)
- **Attention Span**
- **Speech and Language**
Appearance

• Does the child appear to be well-nourished and well-developed; is he overweight or too thin?

• Is the child well-groomed, well-dressed and attentive to personal hygiene?

• Who accompanies the child?

• Are they sitting, standing, lying down?

• Eye contact and relatedness?
II. Motoric Activity

- Hyperactive
- Still
- Fidgets
- Into **EVERY** toy
- **Gross** (large muscle groups) or
- **Fine** (small muscle groups) Motor Coordination
III Mood

• “How do you feel;” this is patient’s subjective self-report and is best presented as direct quotes in the patient’s own words (eg, “I feel angry.”).

• Fantasies, Feelings, and Inferred Conflicts

• Nonverbal Clues to Feelings

• Clues to Depression

• Anxiety
IV Affect

Does the patient display the normally expected range of facial expressiveness

-a narrowing or constriction of affect

-a "flattening" of affect?
IV  Affect (cont’d)

Does the facial expressivity show lability (rapidly changing mood, tearful, difficult to control); is the lability marked?

Is facial expressivity and affectual displays appropriate with respect to: prevailing mood, ideational content?
V Speech

• Think about music and describe the musical qualities of speech

• rate, rhythm, loudness and tonality. note unusual pauses or latencies, articulation problems, and stuttering and stammering ~prosody.
VI Thought Processes

• Listen!

• Flow and production
  - Paucity
  - Overproductive
  - Rapid
  - Coherent/Incoherent
  - Understandable?
Thought Processes (cont’d)

Do they:

~respond to questions in a logical, relevant coherent and goal-directed manner?

~give too much, unimportant detail (ie, circumstantial)?

~skip from topic to topic not elaborating fully on any one of them (ie, tangential)?
Thought Processes (cont’d)

~repeat words, phrases and thoughts and have difficulty switching topics (ie, perseverative)?

~use words idiosyncratically?

~use words in a way that doesn’t adequately serve the purpose of social communication?

Do they have receptive/expressive issues?
VII Thought Content

- Do they:
  - have overvalued ideas?

- express firmly held, fixed false beliefs that cannot be explained by the patient’s culture or religion?

- have any unusual sensory experiences or perceptions; if so, in which sensory modality? hallucinations?

- have active suicidal or homicidal ideation, intent and plan; e latter must be thorough and tailed.
VII Thought Content (cont’d)

- Hallucinations
  - Auditory Hallucinations
  - Visual hallucinations
  - Obsessions and Compulsions
  - Imaginary Companions
VIII Intellectual Functioning

- Orientation to Time, Place, Person and Situational Context

**Cognition:** Assess domains of cognition.
- **Attention and working memory** -
  ~have child spell short words forwards and backwards
  ~days of week and then backward
  ~months of year and then backward
VIII Intellectual Functioning (cont’d)

- **Registration and short-term memory** ask child to repeat a list of three items presented earlier in the interview—always keep same 3.

- **Long-term memory** ask where they went to school previously and currently, **calculations** (serial subtraction of 3’s or 7’s), and **visuospatial ability** (ask the patient to draw a geometric figure from a sample and later from memory).
Abstraction

Evaluate with similarities/differences of apple and orange and

proverbs – “what does ‘you can lead a horse to water but you can’t make him drink’ or ‘even monkeys fall out of trees’ mean?”

Estimated Intelligence “average”, “above”, “below”, “unable to determine”
XI. Judgment and Insight

• Judgment regarding day to day behaviors

• Insight into why they are here, having behavior problems, anxiety, depression, anger

• Rate or Specify: Excellent, good, impaired, poor
Multicultural and Special Populations in Brief

• Developmental Disabilities

• Cultural Diversity

• Preschool Children
Developmental Disabilities

• Interventions should be tailored to each child, however...

• Must look for sensory issues

• Some children have a hyper arousal and others hypo arousal

• Must adjust your MSE to the child’s needs and abilities... language, activities and expectations
As with any people be **careful of your own assumptions**

Self assessment of **own bias and prejudice**

Be willing to **examine** what you “think to be true”

MSE makes **assumptions “so called normal behaviors and processes”** despite cultural considerations **NOT SO!**

Can lead to **misdiagnosis**

Affect, eye contact, thought processes

Family involvement **may be preferred, or not... assess, ask, seek individual assessment of person**
Cultural Diversity (con’td)

• Acculturation and its variability within the same family or different contexts

• Impt to learn about cultures but realize the broad diversity within each culture, tribe, country, location... even within one state or region

• Problems with assessment occurs when clinicians ignore ethnic variables because of narrow definitions, political and economic factors that help distinguish culture
Cultural Diversity (cont.)

• Limited eye contact may be sign of respect and not necessarily pathological
• Family involvement essential
• Cultural norms for child and family important to identify
• Longer term therapies may be important
• Therapists’ investment in the family and child critical
• If tx lives on a reservation – observed for behavior that is congruent to tribal values
Preschool Children

- Be spontaneous, willing to be silly - helps determine child’s ability to connect and be in relationship
- Regulation of emotions/activity
- Self soothing capacity
- Sensory Integration - Alert Program
- Transitions
Preschool Children (cont’d)

- Speech
- Play/Fantasy
- Unusual Behaviors
- Sleep Patterns
- Interpersonal Behaviors- with caregiver, with clinician
Summary

• **MSE** is an **important aspect** of psychiatric and neurologic assessment of children.

• **Clinical skill** that **must be learned and individually refined** by the clinician

• Importance of **assessing children** and adolescents in a systematic way
Tools

- Sent Folder of Assessment Tools
- Will send these to conference planners
Thank You!
References

• Interview with Stephen Deutsch, MD, April 2, 2007, The Elements and Import of the Mental Status Examination Associate Chief of Staff, Mental Health Service Line, Department of Veteran Affairs Medical Center; Professor of Psychiatry, Georgetown University School of Medicine

• Dennis, Jerry L Medical Director, ADHS/DBHS, Psychiatric Mental Status Exam.

• Centers for American Indian and Alaska Native Health Colorado School of Public Health.
