

KATHERINE GORDY LEVINE'S SHRINKS THINK LECTURE NOTES

I taught various graduate level Human Development Courses for many years at Columbia University's School of Social Work. I was one of the first social workers allowed to teach one of those courses; for years they had been taught only by psychiatrists. I always gave my students extensive Lecture Notes. Those lectures notes are part of part of my *narcissistic* need to share my "intellectual" property. I spent lots of years learning, hope what I give back is valuable to someone and my need to share healthy narcissism.

THE MENTAL STATUS EXAMINATION

NORMAL OR NOT: PART TWO

WHEN IT COMES TO ASSESSING WHETHER SOME IS NORMAL OR NOT NORMAL ACCORDING TO THE MEDICAL MODEL, THE TOOL NEMTAL HEALTH PROFESSIONALS ARE TAUGHT TO USE IS USE IS THE MENTAL STATUS EXAM.

WARNING: The poet Bobby Burns had a poem titled, To A Louse, On Seeing One on a Lady's Bonnet. The lines "O wad some Pow'r the giftie gie us/To see oursels as others see us! /It wad frae monie a blunder free us," You can't really do an objective mental status on yourself or a friend, so if you try to and most of you will, be warned.

There is an old joke about the rabbis—get three in a room and get seven interpretations of the law. Get three mental health professionals in a room deciding on a diagnosis and get ten idagnoses.

**Be warned. DON'T PRACTICE MEDICINE WITHOUT A LICENSE.
Be warned: DON'T PRACTICE MEDICINE WITH A LICENSE ON FRIENDS,
FAMILIES, LOVERS, ENEMIES.**

WHY A MENTAL STATUS EXAMS? The purpose of a mental status examination is to look at and record in an orderly fashion the current emotional state and mental functioning of an individual as perceived by the professional trained to diagnose mental disorders. Psychiatrists, nurses, psychologists, social workers and a host of others are so licensed.

A carefully completed mental status examine takes at least an hour and some insurance companies understand that it can take three hours to gather a history and do a careful assessment.

That being said, you have probably all been subjected to a mental status without your knowledge, and very briefly. Indeed, every time you visit a doctor, you are given the once over briefly and if not too bizarre, oriented to time and place, and not too difficult, you are generally judged as normal.

Come to that examination talking about being wired by aliens so you caN read people's minds, and you will mostly get a referral to a psychiatrist. Say you are depressed and a

competent physician will do a brief risk assessment. Come in stinking of drinking or with puncture lines up your arms and expect to be referred for drug treatment. Come in grossly underweight and asking for a diet and you hopefully will be referred for help. You get the picture.

HERE'S A QUICK ONCE OVER OF THE EXAM AND BOOKS HAVE BEEN WRITTEN ON HOW TO DO ONE. SO THIS IS JUST AN INTRODUCTION AND MAINLY TO HELP CONSUMERS KNOW WHAT TO EXPECT.

1. **General Appearance:** Just describe how the person generally looks. First do they look their age. Adequately nourished? Clean, over clean, neat, dirty, unkempt, Describe facial expression--sad, expressionless, angry, worried, elated. Avoids eye contact, stares into space.. Note, posture, odd movements. Note any scars, bruises or other unusual physical characteristics. How are they dressed? Note any bizarre tendencies. In thin teenage girls, long loose flowing clothes and several layers of clothes hint at anorexia. Long sleeves also hint at hiding needle marks or self-mutilation, or in younger children bruises from child abuse.
2. **Attitude:** Generally refers to attitude during interview or toward interviewer. Cooperative, evasive, shy, argumentative, outgoing, aggressive, seductive submissive, suspicious. Open about feelings, guarded about feelings or just shy? There is a difference.
3. **Motor Behavior:** General level of activity. Note anything unusual such as extreme restlessness, hyperactivity, under-activity, tics, unusual posture, way of walking or other mannerisms. Note pacing, hand wringing, repetitive acts, tremors, fidgeting, tics.

In trying to determine how much control someone has of his motor behavior, with a child you can ask to play a game. "Let's pretend you are in the army and you have to obey orders. The first order is that you sit still for two minutes." Hyperactive children cannot tolerate this. Differentiate from nervous anxiety--child will ask how doing, want to know how long interview will last. Hyperactive child will more likely squirm and squirm. But, that little word with big pretensions, just being in a doctor's office can quiet hyperactivity for a while.

With adults can simply ask if the person finds it hard to sit still. Do others think you are hyper?

For under-active kids, try to coax into behavior,

Look for both context and trait. Trait refers to a behavior that may be inborn, but minimally is constant in most situations.

Note coordination, motor skills. Ask to write. A 4 year old child should be able to copy a circle, a 6 year old should be able to copy a cross, a school age

child should be able to copy a diamond. An adolescent should be able to copy two connecting pentagrams.

4. **Speech:** Tone of voice, rate, pitch. The way someone speaks rather than what is said. Slow, rapid, excessive, loud, soft, monotone. Note lisps, stuttering, mutism, whining.
5. **Affect:** What the client is feeling at the moment both by self report and observation. When affect is depressed, angry, hostile, or manic, or extremely flat, be thorough in completing the risk assessment.

Words that describe affect include: blunted or constricted, flat, excited, angry, ecstatic, happy, nervous, fearful, manic, calm. Note if affect seems appropriate or inappropriate to what is going on at the time or what is being talked about.

Mood should also be noted. Affect is weather, mood is climate. Mood refers to an emotional state across time. Ask the client about his or her usual feelings.

6. **Thought processes:** Level of intelligence: 3 year old should be able to identify facial parts and limbs. 5 year old should be able to identify wrist, ankle, elbow, knee. 7 year old should be able to identify jaw, temple, shin. 12 or 13 year old should be able to describe body as composed of bones, muscles, blood, nerves, should know the major organs.

Warning: Negativism, withdrawal, anxiety and other conditions mask intelligence.

Try to assess general cognitive levels. Look for magical thinking, concrete reasoning, or abstract thought. Note if capable of abstract thought. Also look at the structure and rate of connections in the thought patterns, i.e. loose, free flowing, blocked and constricted.

7. **Thought content:** What the client elects to talk about and admits to thinking about including perceptions. Is there a logical pattern evident? Common signs of disturbances include:
 - a. **Delusions**--a false belief about external reality that is held to despite the fact that what almost everyone else believes and despite obvious proof that the belief is false (not religious in nature). Believing you are fat when the rest of the world sees you as a skeleton. Believing the FBI has taped your phones by implanting a microphone in your pet gold fish.
 - b. **Hallucinations**--a sensory perception that feels real but occurs without stimulation of the relevant sensory organ. Common types: auditory, gustatory or taste, olfactory or smell, somatic, tactile, visual.

- c. **Illusions** are mis-perceptions of what is there--shadows on the wall seem as Stormtroopers. Must be unrelated to falling asleep or waking up.
 - d. **Loosening of associations**--repeated shifting from one frame of reference to another. Examples: "I'm tired. All people have eyes."
 - e. **Illogical thinking** other than delusions or hallucinations--facts obscured, distorted, contradictory, one premise does not follow another.
 - f. **Obsessions**--persistent ideas, thoughts, impulses or images that are experienced as intrusive and inappropriate and that cause distress. Often accompanied by compulsions--repetitive behaviors or mental acts designed to reduce anxiety may include washing, cleaning, counting, demanding assurances.
 - g. **Poverty of content**--speech does not convey any information.
 - h. **Thought broadcasting**--belief others hear your thoughts.
 - i. **Thought insertion**--belief thoughts are being placed in your head by radar or some other unusual process.
8. **Orientation:** Three areas generally tested: person, place, and time. Again, must be judged against expectations for age. Most children know their own name by the age of two. Three or four year old children should know where they are i.e. home, my aunt's house and possibly the name of the city they live in. Knowing time and date is harder and youngsters may not know exact date. Try day of week first.
 9. **Memory:** Grownups can ask and test somewhat formally. Not easily assessed in young children.
 10. **Judgment:** Judgment refers to the ability to make reasonable decisions. Take age into account. Children under the age of six or seven generally do not have good judgment. Poor judgment is evidenced by impulsivity, risk-taking behaviors. Ability to realistically weigh pros and cons is a sign of good judgment. Context and culture must be taken into account when determining judgment.
 11. **Insight:** Generally refers to awareness that have an illness. Someone with good insight recognizes they are ill and what they contribute to the illness: the younger child or more impaired the person, the less insight.
 12. **Risk assessments** mental status exams assess risk for suicide, substance abuse, harm to others. Some also assess for sexual risk taking. Risk assessments will be discussed specifically in another lecture.

Formulation documents the basis for a diagnosis and treatment plan. This is what you write up. The formulation should contain the following:

1. **Identifying data.** A fairly long initial sentence that sets the stage for the rest of the evaluation. Identifying information minimally includes age, sex, marital status and source of and reason for referral.
2. **Chief complaint** which is a verbatim sentence in response to the question: “Why are you seeking help?”
3. **History of the situation leading to referral.**
4. **Pertinent psychiatric history** including psychiatric hospitalizations or previous treatment efforts including medication trials and should include a statement about the patient's view of treatment results.
5. **Substance abuse history** including tobacco, caffeine as well as alcohol and other illegal drugs or abuse of legal drugs. Lots of people either purposely distort information or are in denial about how much they drink or use a drug.
6. **Review of symptoms** which is generally a review and rule out of various disorders and inclusion of the ones under consideration.
7. **Family, social and medical histories.**

Following the formulation, the Mental Status is completed with a focus on descriptive language for parts of the examination that point to the diagnosis. The general format for this part of the examination includes:

1. **Assessment or a brief recapitulation** of the overall clinical picture and a mention of differential diagnosis.
2. **DSM-IV DIAGNOSIS** List all five axes. Include codes. Codes are found in the DSM.

Axis I codes the main psychiatric diagnosis and symptom disorders.

Axis II codes personality disorders and mental retardation. Usually safest to use R/O until patient has been seen over a long enough period of time to validate the presence of a personality disorder.

Axis III is for noting general medical conditions that are significant to the psychiatric condition or affecting the patient's current functioning. This is often overlooked by the psychologically minded despite the fact that many mental disorders originate as a response to medical disorders. Depression is a prime example. Concussions and brain injuries another.

Axis VI note psychosocial stressors. This and the next Axis are often overlooked and should not be as they provide a fuller picture of the person.

Axis V indicates the degree to which functioning is impaired through the use of the Global Assessment of Functioning..

3. **Treatment plan** including any planned diagnostic tests, therapy, referrals to other professionals and the time you next plan to see the client.

THE MENTAL STATUS IS A STORY AND AN IMPORTANT ONE TO BE FAMILIAR WITH IF YOU ARE WORKING IN THE HELPING PROFESSIONS OR PARTNERING WITH A MENTAL HEALTH PROFESSIONAL FOR YOUR OWN NEEDS.

HOLD IT AS YOU HOLD TO ALL STORIES LIGHTLY AND AS POTENTIALLY PART OF A PICTURE BUT NOT THE TRUTH, THE WHOLE TRUTH AND NOTHING BUT THE TRUTH.

ALSO REMEMBER

We are all crazy in one way or another. What matters most is whether we are kind or cruel to ourselves or others. It also helps to keep in mind that someone might be certifiable, that does not mean he or she is wrong about all things.

STIGMA KEEPS PEOPLE FROM GETTING THE HELP THAT COULD CHANGE THEIR LIVES. STIGMA IS THE PROBLEM, NOT AN ILLNESS.

While it is expected parents, family, and friends might not be alert to the presence of a major mental illness, many mental health professionals over-look major problems. Some problems are silent problems—Learning Disabilities are one example of a hidden disorder. Trauma reactions are another. For years I have brokered to have doctors, nurses, and psychiatrists consider trauma reactions as part of the mix for children suffering from severe asthma. Not every child rushed to the hospital unable to breathe is traumatized, but many are and become super cautious, fearful, depressed or hyperactive as a result. I think I am a lone voice crying in the wilderness on that one. Still I cry out and hope you will also.

SHARE, CARE, GROW STRONG Knowledge is power.