# The Power of Persuasion: Challenges in Claims Involving Mental Impairments

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1

## Evaluating Mental Impairments

- 20 C.F.R. 404.1520a & 416.920a
- "Special Technique" to evaluate mental impairments
  - Evaluate symptoms, signs and laboratory findings to determine if MDI
  - Rate degree of functional limitation
    - Degree to which impairment(s) interfere with ability to function independently , appropriately, effectively, and on a sustained basis
  - Broad functional areas
    - Understand, remember, apply information
    - Interact with others
    - Concentrate, persist, or maintain pace
    - Adapt or manage oneself
  - Rated on five-point scale: none, mild, moderate, marked, extreme

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2

2

# Evaluating Mental Impairments

- 20 C.F.R. 404.1520a & 416.920a, cont'd
- "Technique" used to evaluate impairments under Sequential Evaluation
  - See 20 C.F.R. 404.1520 & 416.920
- None or mild = not severe
- Meet or equal Listing of Impairments in appendix 1 to subpart P of part 404 ?
- If Listing is not met or equaled, what is RFC?
- Factors in Sections 12.00C – 12.00H of Listing 12.00 are considered in rating degree of functioning

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3

3

# Mental Impairment Listings

- Published September 26, 2016
- Federal Register, Vol. 81, No. 106
- https://www.federalregister.gov/documents/2016/09/26/2016-22908/revised-medical-criteria-for-evaluating-mental-disorders
- Helpful commentary in Federal Register and in Introduction to Listings at 12.00C-12.00H
- https://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm

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4

4

# "A" Criteria

- Each category – or listing – still contains "A" criteria
  - Diagnostic criteria pertaining to each listed impairment
  - In accordance with DSM-5 criteria

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5

5

# "B" Criteria

- Revised to better reflect functioning in work-related terms
  - B1 - Understand, remember, *or* apply information
  - B2 – Interact with others
  - B3 - Concentrate, persist, *or* maintain pace
  - B4 – Adapt or manage oneself
- B1 and B3 now "or" instead of "and"
  - Marked or extreme limitation in any part of B1 or B3 will constitute a marked limitation

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6

6

# "B" Criteria

- Focus of B criteria is on mental abilities used to perform work activities
  - Follow one-or-two step instructions
  - Handle conflicts with others
  - Respond to social cues
  - Interact without excessive hostility
  - Regulate emotions and control behavior
  - Maintain personal hygiene
- ADL removed
  - SSA will use evaluation of ADL as source of information rather than criterion

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7

7

# "B" Criteria

- Evaluation of B criteria will be more comparable to functional equivalency in children's claims
  - Need two marked limitations or one extreme
  - Five-point rating scale
    - None
    - Mild
    - Moderate
    - Marked
    - Extreme

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8

8

# "B" Criteria

- Definitions less than clear?
  - Mild – functioning is "slightly limited"
  - Moderate = fair
  - Marked = seriously limited
  - Extreme = inability to function on a sustained basis
  - BUT --- extreme does not mean a total lack or loss of ability to function
- SSA acknowledges that clinicians may not use the same definitions of descriptors

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9

9

# "C" Criteria

- Alternative severity criterion
- Claimant with marginal adjustment due to psychosocial supports of treatment
- Two-year documentation required
- "Serious and persistent" disorder
- "Decompensation" replaced by "deterioration"
  - Decompensation too extreme
- Minimal capacity to adapt to changed environment or changes, despite treatment

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10

10

# "C" Criteria

- C criteria not applicable to listings
  - 12.07 - Somatic symptom disorder
  - 12.08 - Personality and impulse control disorders
  - 12.10 - Autism Spectrum Disorder
  - 12.11 - Neurodevelopmental disorders
  - 12.13 - Eating disorders
- Per SSA, unique situations described in C criteria do not typically apply in above disorders

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11

11

# Intro Highlights

- Factors in Sections 12.00C – 12.00H of Listing 12.00 are considered in rating degree of functioning, per 20 C.F.R. 404.1520a & 416.920a
- Clinical mental health counselors
  - Recognition of role of LCSWs as therapists
  - But not "acceptable medical sources"
  - See also 20 C.F.R. 404.1502 & 416.902
- Social workers, shelter staff, and outreach workers acknowledged as examples of non-medical sources of evidence
- Unique challenges of obtaining longitudinal evidence for homeless claimants acknowledged

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12

12

# Intro Highlights

- Lack of treatment or noncompliance may be result of mental impairment
- Validity testing to identify malingering rejected
- Mental status exams added to list of evidence sought from medical sources
  - POMS DI 22511.005 rescinded
  - POMS had acknowledged that MSE done during an office visit may not be indicative of ability in a work setting
- Standardized testing references removed, except regarding Listing 12.05
- Psychiatric review technique retained

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13

13

# Intro Highlights

- Acknowledgment that evidence of functioning in an unfamiliar setting not necessarily indicative of ability to work
- Support and structure must be evaluated
- Complete picture of ADL necessary
  - But ability to perform some routine activities without help does not necessarily mean no mental disorder or not disabled
  - Routine activities include caring for personal needs, cooking, shopping, paying bills, living alone, or driving

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14

14

# SSR 16-3p

- Evaluation of Symptoms in Disability Claims
- Supersedes SSR 96-7p – Assessing Credibility of an Individual's Statements
  - Subjective symptom evaluation not an examination of claimant's character
- SSR 16-3p tracks two-step process for evaluating symptoms set forth in20 C.F.R. 404.1529 & 416.929:
  - MDI that could reasonably produce symptoms
  - Extent to which intensity and persistence of symptoms limit ability to perform work-related activities

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15

15

# 16-3p- cont'd

- SSR 16-3p lists sources to consider when evaluating symptoms, including claimant's statements and medical and non-medical sources
- Seven factors to consider, including daily activities; location, duration, frequency, and intensity of pain or other symptoms; etc.
- Adjudicators look for consistency, including consistency of claimant's own statements
  - But inconsistencies may not mean statements are inaccurate as symptoms may vary
- Attempts to obtain relief, including changing medications, seeing specialists, different treatments, may support allegations

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16

16

# SSR 16-3p, cont'd

- Adjudicators may consider failure to follow treatment but must consider reasons, including inability to afford Tx, inability to recognize need for Tx due to mental or linguistic limits, etc.
  - Compare SSR 18-3p re failure to follow treatment as basis for denial of claim
- Adjudicator cannot simply make conclusory statement that claimant's statement are not supported or consistent
- Findings must be based on case record
  - Adjudicators are prohibited from soliciting non-medical evidence outside of record
  - May not assess claimant's overall character or truthfulness

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17

17

# Adaptive Skills Questionnaire

**This form is designed to gather information about how this client typically functions in their everyday life compared to non-disabled individuals who are the same age.**

Name of Client/Patient: _____ Client/Patient Age: _____

Name of Person Completing Form: _____

Background on Person Completing Form

1. Your Relationship to Client/Patient: _____

2. How long have you known them? _____

3. In what all contexts/areas have you observed this person's behavior? (Please check all that apply)

__ Classroom __ Professional Office __ Interacting peers their age

__ In the home ___ In the workplace ___ Other: (describe)_____

4. Are you familiar with what types of things non-disabled individuals (the same age as this client/patient) usually can and cannot do? _____ Yes _____ No

5. If yes, how do you know what types of things non-disabled individuals the same age as this client/patient usually can and can't do? (Please describe)

_____

_____

6. If you are a service provider, do you (or have you) work(ed) with clients the same as this client who are non-disabled? ___ Yes __No

**If you answered YES to Question #4, please answer the following questions. If you answered NO to Question #4, please skip to Question #19 now.**

7. Compared to non-disabled individuals of the same age, how would you rate this client's academic skills (e.g., reading level, understanding what they are reading, vocabulary level, writing skills, math skills)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

8. Compared to non-disabled individuals of the same age, how would you rate this client's academic achievement (e.g., class grades, yearly progression)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

9. Compared to non-disabled individuals of the same age, how would rate this client's social skills?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

10. Compared to non-disabled individuals of the same age, how would you rate this client's communication skills (e.g., ability to clearly express themselves, to follow conversations and understand them, etc.)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

11. Compared to non-disabled individuals of the same age, how would you rate this client's personal hygiene skills (e.g., maintaining a neat/clean appearance, bathing, toileting, dental care, etc.)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

12. Compared to non-disabled individuals of the same age, how would you rate this client's ability to get along with other people (e.g., classmates, coworkers, other customers in a store, etc.)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____

_____

13. Compared to non-disabled individuals of the same age, how would you rate this client's ability to cope with stress/frustration/disappointment?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____

_____

14. Compared to non-disabled individuals of the same age, how would you rate this client's ability to solve his/her own problems?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____

_____

15. Compared to non-disabled individuals of the same age, how would you rate this client's ability to use appropriate nonverbal communication to interact with other people (e.g., knowing not to laugh when someone is crying or seriously injured, able to use pointing or gestures to express themselves)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____

_____

16. Compared to non-disabled individuals of the same age, how would you rate this client's ability to recognize safety concerns and to respond appropriately (e.g.,

noticing that there is smoke in the room and knowing what to do, knowing to look both ways before crossing the street and actually doing it before crossing, etc.)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____

_____

_____

17. Compared to non-disabled individuals of the same age, how would you rate this client's ability to understand, remember, and follow a schedule or routine independently?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____

_____

18. Compared to non-disabled individuals of the same age, how would you rate this client's ability to recognize medical issues and take appropriate action (e.g., applying basic first aid to a cut, knowing when to call 911, knowing when to call the doctor versus going to the hospital, etc.)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____

_____

**Please answer the following questions based on your knowledge of and/or observation of the client.**

19. Does the client typically start a task or project independently and follow it through to completion without outside assistance/supervision (e.g., reminders, prompts)?

____ Yes ___ No ___Don't Know

If NO, please describe:

_____

_____

20. Does the client typically listen to, remember, and follow directions given to them without outside assistance or supervision (e.g., reminders, prompts)?

____ Yes ___ No ___Don't Know

If NO, please describe:
_____
_____

21. Is the client typically able to break larger tasks or goals into smaller more manageable steps without outside assistance/supervision?

____ Yes ___ No ___Don't Know

If NO, please describe:
_____
_____

22. Is the client typically able to sort through information, identify what is important and prioritize it (e.g., if they have 20 things to get done, are they typically able to determine what really needs to be done now and what can wait until a later time)?

____ Yes ___ No ___Don't Know

If NO, please describe:
_____
_____

23. Did the client have special education services in high school?

____ Yes ___ No ___Don't Know

23a. If yes:
Did they have their own aide?

____ Yes ___ No ___Don't Know

Did they have speech/language therapy?

____ Yes ___ No ___Don't Know

24. Does the client know all of the steps to do their own laundry (without outside assistance or supervision)?

____ Yes ___ No ___Don't Know

If NO, please describe:

_____

_____

25. Does the client know how to cook meals for themselves?

____ Yes ___ No ___Don't Know

25a. If yes:

Have they ever caught food (or the kitchen on fire)?

____ Yes ___ No ___Don't Know

Have they ever forgotten that they had food on the stove or in the oven?

____ Yes ___ No ___Don't Know

25b. If NO to Question #25, please describe:

_____

_____

26. Does the client know if they have enough money to make purchases at a store (e.g., Can they estimate what their purchases cost before they are given the total by the cashier?)?

____ Yes ___ No ___Don't Know

27. Have they ever had to put items back in the store because they did not have enough money to pay for what they brought to the checkout?

____ Yes ___ No ___Don't Know

28. Are they able to calculate change on purchases (e.g., Do they know if they are getting the right amount of money back)?

____ Yes ___ No ___Don't Know

If NO, please describe:

_____

_____

29. Do they understand the value of money (e.g., that $100 is more valuable than $5)?

____ Yes ___ No ___Don't Know

If NO, please describe:

_____

_____

30. In an unfamiliar store/location, do they know how to get assistance in finding an item that they are looking for (e.g., a restroom, a certain item to purchase, etc.)?

____ Yes ___ No ___Don't Know

If NO, please describe:

_____

_____

31. Is the client aware of safety issues in crowded public locations (e.g., the possibility of theft, knowing to stay alert)?

____ Yes ___ No ___Don't Know

If NO, please describe:

_____

_____

32. Is the client easily manipulated or taken advantage of?

____ Yes ___ No ___Don't Know

If yes, please describe:

_____

_____

_____

33. Are there any other ways in which you think the client may lack the mental, academic, social, personal, conceptual, or practical skills that non-disabled individuals of the same age have? If so, please describe:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

# PSYCHIATRIC FUNCTIONAL ASSESSMENT[1]

**NAME OF PATIENT:**
**SSN:**

Please answer each of the following questions about the patient. The answers will be used in support of your patient's claim for Social Security disability benefits.

1. Date treatment began: _____

2. Frequency of treatment: _____

3. Diagnoses: _____
_____
_____
_____

4. Describe the clinical findings that indicate the severity of your patient's mental impairment and symptoms:
_____
_____
_____
_____

5. Treatment type and response: _____
_____
_____

   a. Prognosis: _____

   b. Side effects of medications or other treatment that may affect the ability to work (e.g., fatigue, nausea, dizziness, lethargy, stomach upset, etc.):
   _____
   _____

6. Has your patient's condition lasted or can it be expected to last at least 12 months? ☐ Yes ☐ No

7. Does your patient have a low I.Q. or reduced intellectual functioning? ☐ Yes ☐ No ☐ Unknown

   If yes, please explain (with reference to any test results): _____
   _____
   _____
   _____

[1] Blank form provided by the Empire Justice Center for completion by provider(s).

8. Using the following scale, please estimate how your patient's condition affects the ability to perform the following work-related activities ***independently (without accommodations, extra help, structure, or supervision), appropriately, effectively, and on a sustained, full-time (40-hour workweek) basis in a regular, competitive work setting***:

- **None** – no limitation in functioning;
- **Mild limitation** – approximately **less than 5%** of the workday or workweek;
- **Moderate limitation** – approximately **5-10%** of the workday or workweek;
- **Marked or serious limitation** – approximately **11-20%** of the workday or workweek; or
- **Extreme limitation or inability to function** – approximately **more than 20%** of the workday or workweek.

In providing your opinion, you may consider patient's functioning in a treatment or services setting, such as patient's ability to follow through with prescribed treatment, stay on task during evaluation or treatment, manage difficult situations or changes, or interact adequately with providers and staff.

| **UNDERSTANDING, REMEMBERING OR APPLYING INFORMATION** | None | Mild (less than 5%) | Moderate (5-10%) | Marked or serious (11-20%) | Extreme or inability to function (> 20%) |
|---|---|---|---|---|---|
| Understand and learn terms, instructions, and procedures | | | | | |
| Describe work activity to someone else | | | | | |
| Ask simple questions or request assistance | | | | | |
| Answer questions and providing explanations | | | | | |
| Recognize a mistake and correct it | | | | | |
| Identify and solve problems | | | | | |
| Use reason and judgment to make work-related decisions | | | | | |
| Remember locations and work-like procedures | | | | | |
| Understand and remember short and simple instructions | | | | | |
| Carry out very short and simple oral instructions (1-2 steps) | | | | | |
| Sequence multi-step activities | | | | | |
| Other (please specify): | | | | | |
| | | | | | |

Please explain, or provide examples:

_____

_____

| INTERACTING WITH OTHERS | None | Mild (less than 5%) | Moderate (5-10%) | Marked or serious (11-20%) | Extreme or inability to function (> 20%) |
|---|---|---|---|---|---|
| State own point of view | | | | | |
| Initiate or sustain conversation | | | | | |
| Understand and respond to social cues (physical, verbal, emotional) | | | | | |
| Respond appropriately to requests, suggestions, criticism, correction, and challenges from co-workers or supervisors | | | | | |
| Cooperate and handle conflict with others | | | | | |
| Keep social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness | | | | | |
| Get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes | | | | | |
| Other (please specify): | | | | | |
| | | | | | |

Please explain or provide examples:

_____

_____

| CONCENTRATION, PERSISTENCE OR MAINTAINING PACE | None | Mild (less than 5%) | Moderate (5-10%) | Marked or serious (11-20%) | Extreme or inability to function (> 20%) |
|---|---|---|---|---|---|
| Initiate and perform a task they understand and know how to do | | | | | |
| Complete tasks in a timely manner | | | | | |
| Maintain attention for two-hour segment | | | | | |
| Ignore or avoid distractions while working | | | | | |
| Sustain an ordinary routine without special supervision | | | | | |
| Perform at a consistent pace without interruption from symptoms or an unreasonable number and length of breaks | | | | | |
| Work in coordination with or proximity to others without being unduly distracted | | | | | |
| Stay on task | | | | | |
| Other (please specify): | | | | | |
| | | | | | |

Please explain or provide examples:

_____

_____

Please estimate, on average, how many days per month your patient is **likely to be <u>absent</u> from work** as a result of symptoms or treatment.

- ☐ Never
- ☐ About 1 day per month
- ☐ About 2 days per month
- ☐ About 3 days per month
- ☐ About 4 days per month
- ☐ More than 4 days per month

Please estimate, on average, how many days per month your patient is **likely to be <u>late</u> to work** as a result of symptoms or treatment.

- ☐ Never
- ☐ About 1 day per month
- ☐ About 2 days per month
- ☐ About 3 days per month
- ☐ About 4 days per month
- ☐ More than 4 days per month

| **ADAPTING OR MANAGING ONESELF** | None | Mild (less than 5%) | Moderate (5-10%) | Marked or serious (11-20%) | Extreme or inability to function (> 20%) |
|---|---|---|---|---|---|
| Manage psychologically based symptoms | | | | | |
| Change activities or work settings without being disruptive | | | | | |
| Distinguish between acceptable and unacceptable work performance | | | | | |
| Set realistic goals | | | | | |
| Respond to demands | | | | | |
| Make plans independently of others | | | | | |
| Maintain personal hygiene and attire appropriate to work | | | | | |
| Respond appropriately to changes in a routine work setting | | | | | |
| Deal with normal work stress | | | | | |
| Be aware of normal hazards and take appropriate precautions | | | | | |
| Other (please specify): | | | | | |
| | | | | | |

Please explain or provide examples:

_____

_____

9. Does the patient have a "serious and persistent" mental disorder of at least 2 years?

☐ Yes ☐ No ***(If <u>no</u>, please skip to Question 10)***

Is there ongoing medical treatment, medication, mental health therapy, psychosocial support, or a highly-structured setting that diminishes signs or symptoms? ☐ Yes ☐ No

Particularly with chronic disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, halfway house, board and care facility, or other environment that provides similar structure, including the home. ***<u>Please check all that apply</u>:***

☐ Receiving help from family members or others who monitor the individual's daily activities and help them to function.

☐ Participating in a sheltered, supported, or transitional work program.

☐ Receiving assistance from a crisis response team, social workers, case managers, day treatment programs, or other community-based mental health care providers who help to meet the individual's needs.

☐ Living alone, but creating a highly-structured environment by eliminating all but minimally necessary contact with the outside world.

☐ Living alone, but receives a high level of outpatient care or social services.

Is there minimal capacity to adapt to the following without an exacerbation of signs/symptoms and deterioration in functioning:

Changes in environment?

☐ Yes ☐ No

Increased mental or stress-related demands, not already a part of daily life?

☐ Yes ☐ No

10. Does your patient have difficulty performing activities of daily living (ADLs) such as getting out of bed, grooming, dressing, shopping, cleaning, laundry, and taking medications independently as the result of his or her psychiatric condition?

☐ Yes ☐ No

If yes, please explain: _____

_____

11. Are there physical factors (e.g. pain, lack of sleep, fatigue), that exacerbate the psychiatric condition?

☐ Yes ☐ No

If yes, please explain: _____

_____

12. Does the psychiatric condition exacerbate patient's experience of pain or any other physical symptom? ☐ Yes ☐ No

If yes, please explain: _____

_____

13. Are patient's symptoms intermittent or marked by fluctuations? ☐ Yes ☐ No

If yes, please explain: _____

_____

14. Is your patient compliant with prescribed treatment? ☐ Yes ☐ No

If no, please indicate any reasons or factors affecting the patient's compliance: _____

_____

15. Please describe patient's level of insight into his or her impairment: _____

_____

16. Are your patient's diagnoses and clinical findings reasonably consistent with the symptoms and functional limitations described in this evaluation ☐ Yes ☐ No

Please explain: _____

_____

17. Does patient's condition include maladaptive patterns of alcohol or substance use? ☐ Yes ☐ No

If yes, would the limitations set forth above remain in the absence of such use? ☐ Yes ☐ No

Please explain what changes you would make to your description of your patient's limitations if your patient were not using alcohol or drugs:

_____

_____

_____

_____

Signature: _____ Date: _____

Printed Name: _____ Phone: _____

***If form is not completed by psychiatrist or psychologist, please have supervising psychiatrist or psychologist review and co-sign below.***

**Co-signed by:**

Signature: _____ Date: _____

Printed Name: _____ Title: _____

# Mental Status Examination

Andrea Faulkner

2021

## OVERVIEW

What is it? is MSE the observations of the functional capacities of an individual. Typically, it is an organized reporting of observations and is usually written.

The MSE is reported along with a history of signs and symptoms which have lead an individual to ask for help or to be taken for evaluation.

*Symptoms* are complaints of the individual.

*Signs* are indicators which can be independently corroborated or measured, such as weight loss or sleep disturbance.

MSE was originally a part of a neurological exam of cognitive function, but has been developed by psychiatry, psychology and other disciplines also to report affective and thinking states as well as issues of psychological adaptation.

MSE typically includes *observations of* and *judgments about* behavior and relatedness during less formal aspects of an interaction (e.g. history taking) as well as *observations of* and *judgments about* behavior observed as a result of cognitive testing, typically used as a screen for neurological impairment.

The organization of reporting varies some depending on the angle of the observer. For instance a psychiatrist or psychologist interested in neurology may organize reporting around neuropsychiatric indicators, such as certain types of speech and language problems, whereas a report of psychotic process may focus on speech and language problems reflective of disorders of thinking, and a report with emphasis on dynamics may focus on issues of relatedness.

The following is a general outline for reporting which can be adapted for specific uses.

## General Observations

**Appearance**: clothing, personal style, and grooming

This is a presentation of self. One should evaluate the meaning of the presentation in a cultural context. Often people are dressed and groomed in a way which is well within cultural or subgroup norms, and there is not much which can be inferred. For instance, college students are often dressed in jeans or casual slacks, shirt and a sweater, and wear athletic or other casual shoes. In an MSE one may describe the college student as "casually and conventionally dressed in jeans and a sweater."

Other styles of dress may indicate allegiance to another subgroup, such as big jeans falling off at the hips and sweatshirts typical of many teenage boys.

Individuals who are quite disorganized in their thinking or social function often present as disorganized in their clothing style, and may be disheveled, poorly groomed and malodorous, or may be dressed inappropriately for the weather.

Individuals with manic depressive illness in a manic phase may present with a flamboyant dress style with many adornments or in a manner which suggests heightened sexual sensitivity.

If a particular style is remarkable, the evaluator may provide a more detailed description, such as the following for an adolescent girl:

> *She had very short, straight pale blond hair. She wore heavy pale makeup on her face with ample dark eye makeup and very deep red lipstick. She wore a large, tattered man's wool overcoat over a tight black sweater and flowing printed skirt. She wore fingerless black lace gloves, black lace tights and shiny black work boots.*

Her presentation was carefully put together. It was designed to draw attention, but also announced an affiliation with a particular adolescent subgroup.

This is another example of a description of a 22-year man who was alcohol dependent and had mild developmental delays. His greatest cognitive strengths were his verbal abilities, and his greatest level of function was in social realms.

> *John is a thin man who has a stylish haircut. He wore sunglasses in the waiting room; during our meeting he put his sunglasses on top of his head. His western style shirt was neatly coordinated with black jeans and cowboy boots.*

This description portrays an appearance that is not so characteristic of a man with developmental delays; his appearance gave a lot of information about his self-concept and suggested that he had good social function.

When giving a general description of the individual it is typical to describe body habitus, "short and slender," " moderately obese," or "average height and weight," and any physical or sensory abnormalities or deficiencies. If the individual came to the interview with an interpreter one would say this early in the MSE and explain the difficulty with communication.

**Movement and Posture:**

Posture may reflect self-view, e.g., stooped posture may reflect poor self-esteem or rigidly straight posture may suggest an interpersonal style.

One should note mannerisms, such habits which may reflect anxiety (picking at nails), unusual movements, such as facial or body tics.

One should note rate of spontaneous movement. In depression this is often slowed, and in attention deficit disorder, anxiety states, or manic phase of bipolar disorder the rate may be increased ("psychomotor slowing or retardation, and acceleration"). Often the rate of spontaneous movement is also correlated with rate of verbal output.

It is helpful note how close or distant a person chooses to sit from the examiner if s/he/they has a choice, and note whether the person pulls the chair closer or pushes away to increase distance.

Individuals may assume postures which suggest defensiveness or aggressivity, for instance mother of a child patient which suggested aggressivity and defensiveness simultaneously by holding her hands in front of her face with clenched fists

Paranoid persons may scan the room frequently, even get up and look out the window in vigilance.

Psychotic people may have very bizarre movements of body or limb.

Some individuals who have taken anti-psychotic medication chronically may have movement typical of tardive dyskinesia. Another condition associated with anti-psychotic medication is a subjective sense of restlessness which is sometimes expressed with increased movement in the extremities; this is called akathisia. Frequently persons taking anti-psychotic medication have movement disorder like that seen in Parkinson Disease: flat facial expression ("masked facies"), drooling, shuffling gait, diminished spontaneous movement and axial stiffness, especially in neck and shoulders.

Catatonia is rare and individuals would not likely present with this at a routine outpatient evaluation. It is a condition in which there is essentially no spontaneous movement. The condition is typically associated with thought and affective disorders. Persons with this sometimes have "waxy flexibility."

**Eye Contact**

Eye contact upon first meeting with a therapist typically is intermittent, with increase in frequency and duration as the person becomes more comfortable; there's a fairly wide range of socially normal eye contact. Use of eye contact is culturally embedded; in some cultures, direct eye contact is considered impolite or may have other meaning.

Persons for whom direct eye contact is culturally endorsed but are depressed or who have poor self-esteem for other reasons may have diminished eye contact. If this is severe the person may not increase eye contact over time. In part this may represent psychomotor slowing.

Other affective states which may result in longer periods of downcast or turned gaze include anger, shame or embarrassment.

Prolonged eye contact and angry facial expression may be used to express anger or hostility and personal challenge. Eye contact and other facial expression may imply a flirtatious stance toward the interviewer.

**Speech**

Descriptions of speech are often included in general descriptions. Because speech is also an expression of the process of thinking it is often included it with that information. If thought process is fundamentally sound, then a brief description of speech is often included under general description.

**Mood and Affect**

What is the difference?
Some say: mood is subjective and affect is objective
Others say: mood is overall feeling and affect is immediate presentation

One can use parts of both concepts:

Affect is what the evaluator can observe in the room (therefore immediate and objective)
Mood is how a person would describe an internal feeling and is often a description which considers the last several days, at least.

To describe mood, it is useful to use the patient's own words, particularly when she/he/they states the information spontaneously. Sometimes the description is vague, for instance, "okay" or "depressed." It is likely that a fuller description of self-report of mood is included in the history, especially if mood disorder is a prominent complaint.

Affect is another dimension which describes the individual, but is one which describes her or him in relation to the interviewer: it can impart much information about relationship dimensions of the individual.

Therefore, it's appropriate to describe what one sees about the individual, and to describe aspects of the interview which may account for change in affect. One also typically describes lability of affect, range of affect (full, flat, blunted), and appropriateness of affect to thought content.

These are examples of mood and affect descriptions:

*DB described herself as sad and irritable for the past several weeks. She presented with affect that rapidly changed from irritable and angry, often expressed with smiling and chuckling and self-harming ideas, to elated, and then to sad and withdrawn, particularly when I expressed empathy.*

*CG described herself as "I'm okay, in fact I'm pretty happy, despite all the things going on with me." She initially presented as smiling but sad and distant; as she talked about the burdens of her everyday life she wept quietly while facing me.*

*JJ described herself as severely depressed and anxious. She presented as sad, angry, and irritable initially. Questions about her internal state resulted in angry accusations about her ex-husband and current husband, and an increased interpersonal distance with me, although by the end of the interview she talked about her own feelings with much sadness and faced me directly.*

## Thought Content

### Themes

Usually one would describe areas of conflict from the patient's point of view, by summarizing the types of conflict that may come up repeatedly in her/his/their story. Occasionally patients will summarize this for you: "the trouble with me is that I keep getting in relationships that are hurtful, but I never anticipate this before it hurts." Typically, when someone is asking for help she/he/they may not see a pattern of repeated conflict. One can start to make inferences about defensive style from the patient's presentation of conflicts.

Frequent themes include shame, loss, inadequacy, and ineffectiveness. Control, omnipotence, universality, hyper sexuality, and religiosity are frequent themes with people who are psychotic or in a manic phase of bipolar illness.

**Suicidal Ideation and Homicidal Ideation** is usually noted along with other aspects of thought content. Generally, details of the history of suicidal ideation or homicidal ideation are noted in the history. If the individual has suicidal ideation it is typical to make a note in MSE about chronic versus acute suicidal feelings. When an individual has a history of suicide gestures or attempts details about these and how they have been managed are documented in the history section of the psychiatric note.

**Unusual Beliefs**

Delusions: are fixed, false beliefs.

Delusions can be bizarre or non-bizarre. Bizarre delusions are those that are implausible, not understandable, and do not derive from experiences of ordinary life. Bizarre delusions are usually found when the individual suffers from schizophrenia or bipolar disorder (manic phase). There can be lots of variations on some common themes, usually about special powers of the individual over aspects of her or his environment. Some delusions of grandeur include belief's that one is Jesus Christ, or the Anti-Christ, or Hitler and can save the world or can bring mass destruction to the world. Typical variations include having special technology given by some special friend or foe, such as a microchip in a tooth which allows eavesdropping on other's thoughts or the power to blow up the world by just willing it. Another typical theme is that the TV may have special messages just for the individual. There is jargon for particular types of delusional thinking, for instance the belief that others can read one's thoughts is called thought broadcasting and the belief that others can cause thoughts to be put in one's head is called thought insertion. Knowing some of the typical themes allows the interviewer to inquire about these thoughts; good descriptions of the beliefs is at least as good as jargon for describing them. DSM-V has a Glossary of Technical Terms which includes names of different types of delusions.

Paranoia is a form of delusion. It is the clear fixed belief that others conspire to harm, exploit, or deceive the individual. Sometimes it is associated with bizarre beliefs (e.g. in schizophrenia) and sometimes is not (in Delusional Disorder and Paranoid Personality Disorder).

If the paranoid idea is not bizarre, concluding that a person is paranoid is not always easy. Sometimes individuals may have a general feeling that they have no luck in the world and it seems as if someone has it in for them. This is not paranoia but may be self-referential feeling (see below). Also, there is always the possibility that someone *is* plotting against the person, in which case it is not a false belief.

## Unusual perceptions

**Hallucinations** involve the compelling sense that a particular sensory receptor is being stimulated when there is no stimulus. Typical hallucinations are auditory and range from the hearing muffled sounds or music to hearing clearly distinguishable voices. Hallucinations of schizophrenic people are typically voices which say disparaging things or argue about the person or other people, and which may command him or her to act in a particular way (command hallucinations). These commands are often very compelling, and can result in dangerous behavior, such as harm to self or others. Psychotic people do not necessarily tell interviewers about command hallucinations; often they are ashamed or frightened of them.

Other types of hallucinations occur with people who suffer from schizophrenia but are not as common. Visual hallucinations occur with schizophrenia but occur more often with people who have acute and serious medical disorders which has affected level of consciousness and cognition ("delirium"). Often these take the form of little people or animals and are not frightening to the person. Other times in medical illness and in psychotic illness the hallucinations are bizarre and frightening, such as experienced by a patient with schizophrenia who had multisensory hallucinations that he was falling into a vortex and was about to be sucked into another dimension. It was terrifying for him.

Tactile hallucinations are also associated with delirium. A specific type is the sensation that ants or bugs are crawling on one is seen in alcohol withdrawal.

Olfactory hallucinations involve a sense of smelling something for which there is no stimulus.

An **illusion** is the misperception or misinterpretation of a real stimulus, such as seeing a light or object peripherally and thinking that it is a small animal. Illusions are not necessarily pathological; they are more likely to be experienced by anyone who is stressed or tired. Illusions are not associated with a specific diagnosis. Illusions are fleeting and are easily reinterpreted. Hallucinations are persistent, and it is usually difficult for the person experiencing them to maintain a belief that they are not related to external stimuli.

**Dissociation** is an interruption in the integrated functions of consciousness, memory, identity, or perception in the environment. This can be sudden, gradual, transient, or chronic. Dissociation is not necessarily a pathological process, although prolonged dissociation or repeated severe dissociation is frequently associated with severe trauma

and is clearly disruptive to social and interpersonal functioning. Vivid reliving of traumatic events is a type of dissociation and is common in post-traumatic stress disorder.

Intact **reality testing** means that one knows that misperceptions are not part of external reality. Many people with schizophrenia have ongoing hallucinations. Although they are very compelling, some individuals can maintain an observing stance and believe that the experience does not represent external reality. This is difficult; most people cannot maintain this observing stance continuously.

**Thought Process**

Traditionally descriptions of speech process and thought process were somewhat arbitrarily separated. Comments about speech were lumped with other aspects of general observations, and comments about the form of thought (also called formal thought and thought process) were described later in the MSE. More recently there has been a push within psychiatry to standardize descriptions of thought disorders. Nancy Andreasen, MD pioneered this work about 50 years ago. She worked out definitions which characterized speech patterns, which are used to reflect difficulties of thought that are particularly characteristic in schizophrenia. There can be many reasons for speech and communication difficulties in addition to schizophrenia, including other psychiatric disorders, neurologic disorders, and learning disorders. Andreasen tries to include in her definitions aberrations due to psychiatric disorders and to exclude neurologic and learning disorders, with the exception of descriptions of aphasias. The following descriptions are derived from Andreasen's article, Thought, Language, and Communication Disorder, Archives of General Psychiatry, Vol 36, 1315, 1979.

**Poverty of Speech** is a restriction in the amount of spontaneous speech. Little is volunteered and answers to questions are brief and unelaborated. In addition to schizophrenia, a common disorder which may result in poverty of speech is severe depression.

**Poverty of Content of Speech** (poverty of thought, empty speech, alogia, verbigeration, negative formal thought disorder). Plenty of words are supplied, but little information is given. "Language tends to be vague, often overly abstract or concrete, repetitive and stereotyped." Sometimes the information requested is provided but using a lot more words than are necessary. One may find this pattern in schizophrenia, certain personality disorders, particularly if they are severe (e.g., hysterical personality disorder), in delirious or intoxicated states, and in mild to moderate developmental disabilities.

**Pressure of Speech** refers to the rate of speech production. It is greater than that which is ordinary or socially customary. The individual may be difficult to interrupt and when interrupted may not stop talking. Speech is

loud and emphatic. Some sentences may be left uncompleted because of eagerness to get to a new idea. If rate is measured, a rate of 150 words per minute is considered pressured. Often this type of speech is accompanied with derailment, tangentiality or incoherence. Other than schizophrenia, disorders or states which are associated with this pattern are attention deficit disorder with hyperactivity, anxiety, and bipolar disorder.

**Blocking** is the interruption of the train of speech before a thought is completed. Blocking is only judged to be present if the individual volunteers that train of thought is lost, or if she/he/they endorses this when questioned. This occurs commonly in schizophrenia, sometimes apparently when the individual is quite preoccupied with her or his own thoughts. Sometimes the preoccupation can be such that the individual may not be able to attend well to the question about blocking. Losing one's train of thought in the face of high anxiety is common in non-patients.

**Tangentiality** is a reply to a question which is oblique or irrelevant (tangential!). The answer may be related to the question in some way or may be totally irrelevant. In the past this has been used to be roughly equivalent to loose associations or derailment. Derailment refers to a similar process in spontaneous speech; loose associations is not included in Andreasen's lexicon. Although this idea was developed to label verbal behavior in schizophrenia, and in that context is an unconscious process, one can see tangential patterns or replies with someone trying to evade answering a question, for instance in antisocial personality disorder. In that context one may also observe poverty of content of speech.

**Derailment** (Loose Associations, Flight of Ideas) is a pattern in spontaneous speech in which ideas "slip off the track." Sometimes there may be a vague connection between the ideas, and at other times there may be none apparent, as the individual shifts from one frame of reference to another. The speech may sound disjointed. Usually there are a series of small slips, although gradually the person is far afield of the original topic. This is quite common is schizophrenia, but is also apparent with people who are preoccupied, for instance in states of severe anxiety or dissociation, in severe depression (particularly with elderly people with mild dementia), and with some people with severe personality disorders.

**Circumstantiality** "is a pattern of speech that is indirect and delayed in reaching its goal idea." The person has many details and sometimes parenthetical remarks but does reach the goal. This differs from derailment insofar as the goal is reached, and the ideas are closely connected on the way. This is a pattern of speech which is common in non-patients.

**Loss of Goal** In this pattern of speech the individual starts a subject, wanders away from the original topic, and never returns. She/he/they may or may not be aware that of the loss of goal. This often occurs in association with derailment.

**Self-reference** is a pattern where the individual repeatedly refers the topic of a conversation back to oneself or refers neutral topics to her or himself. In an interview situation this is best evaluated during parts of the interview where the subject is not asked to talk about her or himself, for instance during cognitive testing.

**Stilted speech** is excessively formal. Typically, excessively polite phraseology and formal syntax is used, along with multisyllabic words when simpler words are available and appropriate. A stereotype of the type of people who use this type of speech is the English butler of the early 20th Century, such as P.G. Wodehouse's Jeeves. "If I might make the suggestion, sir, I should not jerk the steering-wheel with such suddenness. We very nearly collided with that omnibus."

**Illogicity** is a pattern in which conclusions made are not logically warranted by preceding thinking. This may take the form of non-sequiturs or may be shown with faulty inductive references. This is common among non-patients as well as those psychiatrically disturbed. If the faulty reasoning is due to developmental delay or particular religious or cultural beliefs it is not given this label. If the difficulty with reasoning is due to delusional beliefs, delusions would be identified instead of illogicity.

**Clanging** is a way of speaking in which the sounds of words instead of the semantics are related in speech. One typically hears a series of rhyming or alliterative words, or words related by punning relationships. This pattern is sometimes similar to that observed in preschoolers who are enchanted with the sounds or words (silly, Billy, dilly, Millie, Willie you!). Clanging is unusual; it is typically observed in psychotic reactions due to psychiatric disorders or medical illness.

**Word Approximations** are words that are used in a novel or unconventional way. The meaning may be apparent even when the word is novel. Examples: paperskate for pen, handshoes for gloves. This is a pattern one can see in schizophrenia, and in aphasia, in which there is a specific neurological explanation for speech problems. (One can test for different aspects aphasia, as is typically done during cognitive testing of the MSE.) Very frequent word approximations lead to speech which is incoherent; this is typical for word approximations and substitutions due to aphasia, but also occurs in schizophrenia. Word approximations that are infrequent are found more commonly in schizophrenia than is incoherence.

**Incoherence** (Word Salad, Jargon Aphasia) This is speech which is incompressible at times. This may be due to not using rules of syntax or grammar which are normally used to link words together, or may be due to semantic substitutions or deletions, so that any meaning is lost. Sometimes "cementing" words are deleted, so that it is hard to make sense of the words given.

Sometimes a coherent phrase will occur in the midst of incoherent language. Although the language may resemble aphasia, incoherence is reserved to describe the deficiency in psychiatric disorders. The primary psychiatric disorders in which this occurs is schizophrenia and bipolar disorder.

**Neologisms** are words or phrases that are formed when the derivations are not apparent. This is quite uncommon, but not rare. These words sometimes have an onomatopoeic quality to them.

**Perseveration** is a pattern in which the same word, phrase or idea is repeated frequently while speaking. Andreasen's examples include: I think I'll put on my hat, my hat, my hat, my hat, in which a word is repeated; she gives another example in which the idea of geographical origin in repeated.

**Echolalia** is a pattern in which the individual echos words or phrase of the interviewer. The echo is often done in a flat and staccato manner, or less commonly with mumbling or mocking inflection. This pattern is more common in children than in adults and is more typical with neurologic disorders or psychiatric disorders closely associated with neurological impairments (e.g., autism, Tourette's, and some seizure disorders).

**Phonemic Paraphasia** is mispronunciations due to sounds or syllables which have slipped out of place. Milder forms are typical of non-pathological slips, e.g. "The rat can down the street" for "the cat ran down the street." More severe forms are common in aphasia.

**Semantic Paraphasia** is the substitution of an inappropriate word when trying to say something specific. The deficiency may or may not be apparent to the speaker. This can be found in fluent and non-fluent aphasias and can be quite similar to incoherence due to psychiatric disorder.

**Cognitive Testing** is used to screen for particular neurologic deficits. It is useful to assess people with altered states of consciousness, delirium, or dementia. Most clinicians do not routinely do cognitive testing unless there is an indication from earlier parts of the

MSE, or the clinician is working with a population in which such deficits are common, for instance, on a psychiatry consultation service on medical wards.

Historically, ability to think abstractly was "tested" during cognitive testing part of MSE and intellectual ability was inferred, based on information that was culturally and educationally bound, and from sources that have not been well-tested or validated.

More useful information about abstract ability and intelligence can be gleaned through careful observation of the individual during history taking. A typical scenario is of a person coming to talk about a problem for the first time and being anxious about coming. Early in the interview there may be many indicators of anxiety, including those which involve abstract ability and other cognitive functions. Through the interview the person becomes less anxious, and shows this, with posture, movement, eye contact and ability to share more intimate detail. One would expect to see more integrated and smoothly operating cognition, including better ability to make connections between feelings and behavior and antecedent events, or with descriptions of other events or thinking. This would be a more valid but rough measure of the person's abstract ability and intelligence. The estimation is at least as valid as that derived from interpreting culturally bound proverbs or defining arcane English words. The ability to step back and evaluate one's behavior involves insight; this requires a certain amount of intelligence and interpersonal maturity. If estimates of cognitive potential are inadequate, it would be appropriate to refer the patient to a clinician trained to do well-validated IQ testing.

At the end of the MSE report it is typical to make a comment about **intellectual function, insight** and **judgment**. Insight with regard to MSE refers to insight into one's illness. This may include psychological insight, or in some cases may not. It would be appropriate to comment about both. Traditionally judgment has been "tested" with a series of questions different social situations. This approach may be appropriate with those who are intellectually impaired by developmental delays, dementia, delirium or thought disorder. Instead of asking questions like "What would you do if you found a stamped and addressed letter?" it may be more appropriate to ask about situations in the person's life, or to make assessments from historical information. For instance, sometimes demented people with some insight into their limitations get lost while driving. Instead of asking for help the person may drive around for several days, perhaps sleeping in the car, instead of asking for help. This reflects poor judgment. People without intellectual compromise may show poor judgment, for instance, may put themselves in dangerous situations. Information from historical data and from the persons plans to handle distress in the future would best characterize good or limited judgment.