

REVIEW ARTICLE

Mental Status Examination: A Comprehensive Guide for Nursing Assessment in Psychiatric Practice

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ABSTRACT

Introduction: The Mental Status Examination (MSE) is a structured and systematic method of assessing an individual's current psychological functioning. It serves as an essential component of psychiatric evaluation by providing objective information regarding appearance, behavior, cognition, emotions, thought processes, perception, insight, and judgment.

Objective: Objective of this articles To provide a comprehensive, academically structured overview of the Mental Status Examination, including its major domains, methods of assessment, clinical interpretation, and relevance to psychiatric nursing practice.

Methods: This narrative review was developed using standard psychiatric and mental health nursing literature, contemporary psychiatric diagnostic frameworks, and authoritative resources on the assessment of mental and behavioral disorders. The major domains of the MSE—including general appearance and behavior, psychomotor activity, speech, mood and affect, thought, perception, cognition, insight, and judgment—were reviewed and organized into a systematic nursing assessment framework.

Conclusion: Competence in performing, interpreting, and documenting the MSE is an essential skill for psychiatric and general nurses. A systematic MSE promotes early recognition of mental and behavioral abnormalities, supports individualized nursing care, facilitates continuity of care, and strengthens patient safety and multidisciplinary communication.

KEYWORDS:

• Mental Status Examination • Psychiatric nursing • Mental health assessment
• Cognition • Thought disorder • Perception • Insight • Judgment • Psychiatric assessment

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INTRODUCTION

The **Mental Status Examination (MSE)** is a systematic clinical assessment of an individual's current mental, emotional, behavioral, and cognitive functioning. It is often described as the psychiatric equivalent of the physical examination because it provides a structured description of the patient's observable and elicited mental functioning at a particular point in time.^{1,2}

The MSE is not a single diagnostic test. Rather, it is an organized method of collecting and documenting clinical observations obtained during interaction with the patient. It generally encompasses appearance, behavior, psychomotor activity, speech, mood, affect, thought processes and content, perception, cognition, insight, and judgment.^{1,2}

The findings of the MSE must be interpreted in relation to the patient's age, developmental level, educational and cultural background, language, medical condition, medications, substance use, and presenting clinical problem.^{1,3} Cultural and contextual factors are particularly important because behaviors, emotional expressions, beliefs, communication patterns, and interpretations of experiences may vary across individuals and cultures. The WHO's current clinical guidance for ICD-11 emphasizes the importance of clinically appropriate and culturally informed assessment of mental and behavioral disorders.⁴

The MSE is used in psychiatric hospitals, emergency departments, general hospitals, outpatient clinics, community mental health services, and other healthcare settings.^{1,2} For nurses, systematic MSE assessment is particularly important because nurses frequently have prolonged and repeated contact with patients and may therefore identify subtle changes in mental status that are not apparent during a brief medical consultation. The uploaded manuscript appropriately emphasizes the role of nurses in ongoing observation, documentation, safety assessment, and communication with the healthcare team.

CLINICAL IMPORTANCE OF THE MENTAL STATUS EXAMINATION

The MSE serves several important clinical purposes.

Establishing a baseline mental status: An initial MSE provides a baseline against which subsequent assessments can be compared. Repeated assessments can demonstrate improvement, deterioration, fluctuation, or lack of response to treatment.^{1,2}

Identification of acute changes: Changes in consciousness, attention, orientation, cognition, perception, behavior, or psychomotor activity may indicate an acute clinical problem such as delirium, intoxication, withdrawal, neurological illness, severe mood disorder, or psychosis.^{1,2}

Assessment of patient safety: Mental status findings may identify concerns related to suicidal ideation, self-harm, aggression, impulsivity, severe disorganization, impaired judgment, wandering, or inability to care for oneself. However, a comprehensive risk assessment should not be replaced by the MSE alone. Risk assessment should include specific questions about suicidal and homicidal thoughts, intent, plans, means, previous behavior, protective factors, and relevant contextual factors.

Monitoring treatment response: Repeated MSEs allow clinicians to document changes following pharmacological, psychological, behavioral, or other interventions. For example, changes in psychomotor activity, speech, thought organization, hallucinations, mood, affect, insight, or judgment may provide clinically meaningful information about response to treatment.

Facilitating multidisciplinary communication: Standardized documentation provides a common clinical language for communication among nurses, psychiatrists, psychologists, physicians, social workers, occupational therapists, and other members of the healthcare team.^{1,2}

Supporting nursing care planning: MSE findings contribute to comprehensive nursing assessment and help nurses identify appropriate nursing priorities, interventions, patient education needs, safety precautions, and monitoring requirements.

ROLE OF THE MENTAL STATUS EXAMINATION IN PSYCHIATRIC NURSING

The MSE has particular importance in psychiatric nursing because nurses frequently

observe patients across different times of the day and under different circumstances. This repeated contact allows nurses to identify changes that may not be evident during a single clinical interview.

The major contributions of MSE assessment to psychiatric nursing include:

1. **Comprehensive mental health assessment:** Provides systematic assessment of appearance, behavior, speech, mood, affect, thought, perception, cognition, insight, and judgment.
2. **Establishment of baseline status:** Provides a reference point for subsequent assessments.
3. **Early identification of abnormalities:** Helps identify clinically important changes associated with psychotic, mood, anxiety, substance-related, neurocognitive, and other mental disorders.
4. **Identification of safety concerns:** Supports recognition of behavioral and cognitive findings requiring further assessment of suicide, self-harm, aggression, violence, wandering, or impaired self-care.
5. **Nursing diagnosis and care planning:** Provides objective assessment findings that can contribute to formulation of nursing problems and individualized interventions.
6. **Monitoring of treatment:** Repeated assessments help determine whether the patient's mental status is improving, deteriorating, or fluctuating.
7. **Therapeutic communication:** The MSE requires appropriate rapport, active listening, observation, empathy, and nonjudgmental communication.
8. **Clinical documentation:** Clear documentation creates a clinically useful record of the patient's mental status.
9. **Continuity of care:** Consistent MSE documentation facilitates handover, referral, discharge planning, and follow-up.
10. **Education and professional development:** MSE assessment develops clinical observation, critical thinking, clinical reasoning, and psychiatric nursing competencies.

MAJOR COMPONENTS OF THE MENTAL STATUS EXAMINATION

Although the precise organization varies among clinicians, a comprehensive MSE generally includes:

- General appearance and behavior
- Level of consciousness and attitude toward the examiner
- Psychomotor activity
- Speech and language
- Mood and affect
- Thought process/form
- Thought content
- Perception
- Cognition
- Insight
- Judgment
- Risk assessment and clinically relevant observations
- Summary and clinical impression

Contemporary descriptions similarly identify appearance, behavior, motor activity, speech, mood, affect, thought process, thought content, perception, cognition, insight, and judgment as the principal domains of the MSE.^{1,2}

GENERAL APPEARANCE AND BEHAVIOR

General appearance and behavior are usually assessed from the moment the patient enters the clinical environment. The nurse should observe the patient before and during the interview and document clinically meaningful findings rather than simply assigning vague labels.

Apparent age

Document whether the patient appears approximately the stated age or significantly older or younger.

Examples:

- Appears stated age.
- Appears older than stated age.
- Appears younger than stated age.

Grooming and hygiene

Assess:

- Personal hygiene
- Hair

- Facial grooming
- Oral hygiene
- Clothing
- Odor
- Cleanliness
- Appropriateness of dress

Documentation should distinguish between **poor grooming** and deliberate cultural or personal choices.

Dress

Assess whether clothing is:

- Appropriate for age
- Appropriate for weather
- Appropriate for the clinical situation
- Clean or soiled
- Conventional or unusual
- Excessive or insufficient

Unusual or bizarre clothing can be clinically relevant, but interpretation should consider cultural and contextual factors.

Facial expression

Observe whether facial expression appears:

- Pleasant
- Anxious
- Sad
- Angry
- Fearful
- Blunted
- Flat
- Animated
- Incongruent with the reported emotional state

Posture

Possible observations include:

- Upright
- Relaxed
- Stooped
- Rigid
- Guarded
- Slumped
- Tense

Eye contact

Document whether eye contact is:

- Appropriate
- Reduced
- Avoidant
- Excessive
- Intermittent

Eye contact should never be interpreted in isolation because cultural norms, anxiety, trauma, neurodevelopmental characteristics, and social context may influence it.

Rapport

Assess whether rapport is:

- Easily established
- Established with difficulty
- Superficial
- Guarded
- Difficult to establish
- Not established

Behavior and attitude

Observe whether the patient is:

- Co-operative
- Guarded
- Suspicious
- Hostile
- Friendly
- Withdrawn
- Overfamiliar
- Disinhibited
- Aggressive
- Negativistic
- Appropriate

The uploaded manuscript appropriately includes facial expression, posture, mannerisms, eye contact, rapport, consciousness, behavior, dress, grooming, and physical appearance within general observation.

LEVEL OF CONSCIOUSNESS AND ALERTNESS

Level of consciousness should be assessed and documented because impaired consciousness can have important medical and psychiatric implications.

Possible descriptions include:

- Alert
- Drowsy
- Lethargic
- Obtunded
- Stuporous
- Unresponsive

A reduced level of consciousness should prompt consideration of medical, neurological, toxicological, metabolic, medication-related, or other causes rather than being automatically attributed to psychiatric illness.

PSYCHOMOTOR ACTIVITY

Psychomotor activity refers to the quantity, quality, and organization of motor behavior.

The nurse should assess for:

- Normal activity
- Psychomotor agitation
- Restlessness
- Psychomotor retardation
- Hyperactivity
- Tremor
- Tics
- Mannerisms
- Stereotyped movements
- Abnormal involuntary movements
- Akathisia
- Catatonic features
- Echopraxia
- Negativism
- Ataxia

The original manuscript identifies these observations, including agitation, restlessness, hypoactivity, tics, tremors, akathisia, stereotypy, echopraxia, and negativism.

Clinical significance

Psychomotor agitation may occur in anxiety, mania, substance intoxication or withdrawal, severe depression, psychosis, or other conditions. Psychomotor slowing may occur in depression, medication effects, neurological disorders, or other medical conditions. Therefore, interpretation should always be made in clinical context.

SPEECH AND LANGUAGE

Speech should be assessed systematically because abnormalities may provide important information regarding mood, thought organization, neurological functioning, and psychiatric illness.

The assessment should include:

Quantity

- Normal
- Increased
- Decreased
- Poverty of speech
- Paucity of speech
- Excessive or expansive

Rate

- Normal
- Slow
- Rapid
- Pressured

Volume

- Normal
- Loud
- Soft
- Whispered

Tone and prosody

- Normal
- Monotonous
- Animated
- Tremulous

Fluency and articulation

Assess for:

- Clear speech
- Slurring
- Hesitation
- Dysarthria
- Aphasia
- Neologistic language
- Word-finding difficulty

Coherence and relevance

Determine whether responses are:

- Logical

- Coherent
- Relevant
- Circumstantial
- Tangential
- Disorganized

Reaction time

Document whether the patient responds:

- Promptly
- After a prolonged delay
- Inconsistently

Whenever possible, documenting a brief verbatim sample of the patient's speech can improve the objectivity of the assessment. The uploaded manuscript specifically recommends recording a short sample of speech and assessing quantity, rate, coherence, relevance, volume, tone, manner, and reaction time.

MOOD AND AFFECT

Mood and affect are related but distinct concepts.

Mood

Mood is the patient's subjectively experienced and reported emotional state. It should preferably be documented using the patient's own words.

Useful questions include:

- "How have you been feeling recently?"
- "How would you describe your mood?"
- "Have you been feeling sad or depressed?"
- "Have you been unusually energetic or elevated?"
- "Have you been feeling anxious or worried?"
- "Have you been unusually irritable or angry?"

Examples include:

- "I feel sad."
- "I feel anxious."
- "I feel fine."
- "I feel very energetic."

Affect

Affect refers to the emotional expression observed by the clinician during the interaction.

Assess:

Range

- Full
- Restricted
- Blunted
- Flat

Intensity

- Normal
- Reduced
- Increased

Stability

- Stable
- Labile

Congruence

Determine whether affect is congruent with the reported mood and thought content.

Appropriateness

Determine whether the emotional expression is appropriate to the conversational context.

The source document appropriately identifies mood descriptors such as euthymic, dysphoric, euphoric, and anxious and describes affect in terms of range, intensity, stability, and congruence.

THOUGHT

Thought assessment is conventionally divided into **thought process/form** and **thought content**.^{1,2}

Thought process or form

Thought process refers to the organization and flow of ideas.

Assess for:

- Logical and goal-directed thinking
- Circumstantiality
- Tangentiality
- Flight of ideas
- Loose associations
- Thought blocking
- Perseveration
- Clang associations
- Neologisms
- Disorganized thinking

- Poverty of thought

Circumstantiality

The patient provides excessive detail but eventually returns to the original point.

Tangentiality

The patient moves away from the question and does not return to the original point.

Flight of ideas

Rapid movement from one idea to another with understandable but accelerated associations, classically associated with manic states.

Thought blocking

A sudden interruption in the flow of thought, with the patient appearing unable to continue.

Loose associations

A significant weakening or absence of understandable logical connections between ideas.

Neologism

A newly created word or idiosyncratic expression that is not conventionally recognized.

Perseveration

Persistent repetition of a word, phrase, response, or idea despite a change in the question or context.

The uploaded manuscript identifies abnormalities including circumstantiality, tangentiality, neologisms, word salad, perseveration, ambivalence, flight of ideas, thought retardation, mutism, thought blocking, and clang associations.

THOUGHT CONTENT

Thought content concerns **what the patient is thinking about**.

Assessment should include:

- Delusions
- Obsessions
- Phobias
- Preoccupations
- Overvalued ideas
- Suicidal thoughts
- Self-harm thoughts

- Homicidal or aggressive thoughts
- Guilt
- Hopelessness
- Ideas of reference
- Other clinically significant beliefs

Delusions

A delusion is a fixed belief that is not consistent with available evidence and is not explained by the individual's cultural or religious context.

When assessing unusual beliefs, questions should be neutral and non-confrontational.

Examples:

- "Do you feel that anyone is trying to harm you?"
- "Do you feel that other people are talking specifically about you?"
- "Do you have beliefs that other people find difficult to understand?"

The clinician should document the patient's response rather than attempting to argue with the belief during the assessment.

Obsessions

Assess for recurrent, intrusive, unwanted thoughts, images, or urges that cause distress and are difficult to control.

A suitable question is:

"Do you experience unwanted thoughts or images that repeatedly come into your mind even though you do not want them?"

Phobias and excessive fears

Explore specific situations, objects, or circumstances that provoke disproportionate fear or anxiety and lead to avoidance.

Preoccupations

Assess whether the patient's thinking is excessively focused on a particular subject, concern, illness, relationship, event, or perceived problem.

PERCEPTION

Perception refers to the way sensory information is experienced and interpreted.

The assessment should include:

- Illusions
- Hallucinations

- Depersonalization
- Derealization
- Other perceptual disturbances

Illusion

An illusion is a misinterpretation or distortion of an actual external stimulus.

For example, a patient may misinterpret a shadow as a person.

Hallucination

A hallucination is a perception occurring without an appropriate external sensory stimulus.

Hallucinations may be:

- Auditory
- Visual
- Tactile
- Olfactory
- Gustatory
- Somatic

A useful neutral question is:

“Have you experienced hearing, seeing, smelling, tasting, or feeling something that other people do not seem to experience?”

The original manuscript appropriately identifies illusion as misinterpretation of an external stimulus and hallucination as perception in the absence of an appropriate stimulus.

Hypnagogic and hypnopompic experiences

Perceptual experiences occurring during the transition into sleep are described as **hypnagogic**, whereas those occurring during awakening are described as **hypnopompic**. These experiences should not automatically be interpreted as evidence of a psychotic disorder.

Depersonalization

A subjective experience of unreality or detachment from oneself.

Derealization

A subjective experience in which the external environment feels unreal, unfamiliar, dreamlike, or detached.

The original document also discusses micropsia and macropsia; these are visual perceptual distortions in which objects may appear abnormally small or large, respectively.

COGNITIVE FUNCTIONS

Cognitive assessment examines selected aspects of mental functioning, particularly when impairment is suspected.

Important domains include:

- Attention
- Concentration
- Orientation
- Memory
- Language
- Calculation
- Abstraction
- General knowledge
- Executive functioning

The specific cognitive domains assessed should be selected according to the patient's age, education, clinical presentation, and purpose of assessment.^{1,2}

Attention and concentration

Attention can be assessed through:

- Digit span
- Repeating numbers forward and backward
- Spelling a familiar word forward and backward
- Serial subtraction
- Other age and education-appropriate tasks

For example:

“Please repeat these numbers after me: 4-7-2-9.”

More complex tasks can assess concentration.

The uploaded manuscript includes digit span, spelling backward, serial subtraction, and simple calculations.

MEMORY

Memory assessment can be divided into:

Immediate memory

Assesses the ability to register and immediately reproduce information.

Example:

“I will give you three words. Please repeat them after me.”

Recent memory

Assesses recall of recent events.

Examples:

- “What did you have for breakfast today?”
- “What did you do earlier this morning?”

Remote memory

Assesses recall of events from the distant past.

Examples:

- “Where were you born?”
- “When did you complete high school?”
- “What is your date of birth?”

The source document similarly divides memory into immediate, recent, and remote memory and provides examples of questions for each domain.

Important: Memory testing should consider educational level, language, hearing or visual impairment, cultural background, and the possibility of delirium or other medical conditions.

ORIENTATION

Orientation is commonly assessed in relation to:

Time

- Date
- Day
- Month
- Year
- Approximate time

Place

- Hospital/clinic
- City
- Ward or location

Person

- Own identity
- Recognition of relevant people

The original manuscript specifically identifies orientation to time, place, and person.

Orientation findings should be documented carefully because disorientation may occur in delirium, major neurocognitive disorders, intoxication, withdrawal, severe medical illness, and other conditions.

ABSTRACTION

Abstract thinking evaluates the ability to identify relationships, similarities, meanings, and broader concepts.

Examples include:

“How are an apple and an orange alike?”

“What does the saying ‘A bird in the hand is worth two in the bush’ mean?”

The interpretation of proverb-based questions must account for language, culture, educational background, and familiarity with the proverb. The uploaded material appropriately notes that questions should be adapted to the patient’s regional language where necessary.

GENERAL KNOWLEDGE AND INTELLECTUAL FUNCTIONING

General knowledge can provide limited information regarding intellectual functioning, but it should **not be equated directly with intelligence**.

Possible areas include:

- General factual knowledge
- Vocabulary
- Similarities
- Educational attainment
- Ability to understand questions
- Ability to provide appropriate information

The original document includes questions about national leaders, major cities, vocabulary, and similarities.

However, questions regarding current political officeholders should be periodically updated and should not be used as the sole measure of intelligence or cognitive capacity.

JUDGMENT

Judgment refers to the ability to make appropriate decisions in personal and social situations.

Assessment may include:

Personal judgment

“What would you do if you found that you had accidentally taken the wrong medication?”

Social judgment

“What would you do if you found a wallet or addressed envelope on the street?”

“What would you do if you smelled smoke in a crowded cinema?”

Responses should be interpreted in relation to the patient’s developmental stage, education, culture, and clinical circumstances.

The source document includes both personal and social judgment questions.

INSIGHT

Insight refers to the patient’s understanding and awareness of their illness, symptoms, circumstances, and need for treatment.

A structured assessment may explore:

1. Whether the patient recognizes that a problem exists.
2. Whether the patient recognizes that symptoms may represent illness.
3. What the patient believes is causing the symptoms.
4. Whether the patient recognizes the need for treatment.
5. Whether the patient can integrate this understanding into behavior.

Questions may include:

“What brought you to the hospital?”

“What do you think is causing these difficulties?”

“Do you think you need treatment?”

“What do you think would help you recover?”

The original document describes a continuum ranging from denial of illness through increasing awareness and ultimately deeper emotional understanding.

Rather than simply documenting “good” or “poor” insight, it is preferable to describe **what the patient understands and does not understand.**

RISK ASSESSMENT

Although risk assessment is not synonymous with the MSE, it should be integrated into psychiatric nursing assessment when clinically indicated.

The nurse should assess for:

- Suicidal thoughts
- Suicidal intent
- Suicidal plan
- Access to means
- Previous suicide attempts
- Self-harm
- Homicidal or violent thoughts
- Aggression
- Severe impulsivity
- Vulnerability
- Neglect of basic needs
- Wandering
- Severe cognitive impairment

A patient who reports suicidal ideation should receive an appropriate, immediate and comprehensive suicide risk assessment according to institutional policy and clinical protocols.

SLEEP AND OTHER GENERAL OBSERVATIONS

Sleep may provide clinically relevant information, particularly in mood disorders, anxiety disorders, psychosis, substance-related disorders, and other psychiatric conditions.

Assessment may include:

- Difficulty initiating sleep
- Difficulty maintaining sleep
- Early morning awakening
- Excessive sleep
- Altered sleep-wake cycle
- Daytime sleepiness

The source document includes sleep disturbances and episodic behavioral changes within its general observation section.

CLINICAL INTERPRETATION OF MSE FINDINGS

MSE findings should not be interpreted as isolated diagnostic markers. The same finding may occur in several psychiatric, neurological, medical, medication-related, or substance-related conditions.

For example:

MSE Domain	Possible Clinical Significance
Poor grooming	Depression, psychosis, cognitive impairment, severe functional impairment, or social deprivation
Psychomotor agitation	Anxiety, mania, psychosis, substance-related states, severe distress
Psychomotor retardation	Depression, medication effects, neurological or medical disorders
Pressured speech	Commonly associated with manic states
Thought blocking	May occur in psychotic disorders
Disorganized thought	May occur in psychotic, neurological, toxicological, or severe medical conditions
Hallucinations	May occur in psychotic disorders, delirium, substance-related states, neurological disorders, and other conditions
Impaired attention	Particularly important in delirium and other acute medical states
Impaired memory	May occur in neurocognitive disorders, delirium, depression, substance-related states, and other conditions
Poor insight	May occur in psychotic and other psychiatric disorders
Impaired judgment	May increase vulnerability and safety risks

Therefore, an MSE finding should be interpreted together with history, physical examination, medication and substance history, collateral information, and relevant investigations.^{1,2}

DOCUMENTATION OF THE MENTAL STATUS EXAMINATION

Documentation should be:

- Objective
- Specific
- Concise but sufficiently detailed
- Clinically relevant
- Free from judgmental language
- Based on observed behavior and patient responses

Example of an academically appropriate MSE documentation

General appearance and behavior: Patient appears stated age, appropriately dressed for the setting, with adequate grooming and hygiene. Cooperative during the interview. Eye contact is appropriate, and rapport is readily established.

Psychomotor activity: No psychomotor agitation or retardation observed.

Speech: Speech is spontaneous, coherent, relevant, and goal-directed, with normal rate, volume, and tone.

Mood: Patient reports, "I have been feeling worried."

Affect: Anxious, mildly restricted, and congruent with reported mood.

Thought process: Linear, logical, and goal-directed. No flight of ideas, thought blocking, or loosening of associations observed.

Thought content: No delusions or overvalued ideas elicited. Suicidal and homicidal ideation denied.

Perception: No hallucinations or other perceptual disturbances reported or observed.

Cognition: Alert and attentive. Oriented to person, place, and time. Immediate and recent memory grossly intact.

Insight: Fair; patient recognizes the presence of emotional difficulties and the need for professional help.

Judgment: Appears intact based on responses to relevant hypothetical and real-life situations.

Clinical impression: Findings indicate an alert and cooperative patient with anxious mood and congruent affect, without overt evidence of psychosis or gross cognitive impairment during the assessment.

ROLE OF THE NURSE IN CONDUCTING THE MSE

Psychiatric and mental health nurses have an important role in continuous assessment of patients because they frequently interact with patients during medication administration, therapeutic communication, routine care, crisis situations, and daily activities.

Key nursing responsibilities include:

1. Establishing a therapeutic relationship.
2. Ensuring privacy and a safe environment.

3. Introducing oneself and explaining the purpose of assessment.
4. Obtaining relevant subjective information.
5. Observing nonverbal behavior.
6. Assessing the major MSE domains systematically.
7. Identifying abnormal or changing findings.
8. Assessing immediate safety concerns.
9. Documenting findings objectively.
10. Reporting clinically significant changes promptly.
11. Reassessing the patient when clinically indicated.
12. Communicating findings during handover.
13. Participating in multidisciplinary care planning.
14. Providing appropriate patient and family education.

The nurse should also recognize that an abnormal mental state may have a medical or neurological cause. Acute confusion, altered consciousness, sudden behavioral change, new hallucinations, severe agitation, or rapidly changing cognition should therefore prompt consideration of conditions such as delirium, intoxication, withdrawal, infection, metabolic disturbances, medication effects, or neurological disease.

IMPORTANT CONSIDERATIONS WHILE PERFORMING AN MSE

Establish rapport

A respectful, nonjudgmental approach improves cooperation and the quality of information obtained.

Use clear and simple language

Questions should be adapted to the patient's educational, linguistic, developmental, and cognitive level.

Consider culture

Beliefs and behaviors should not be considered pathological solely because they differ from the examiner's cultural expectations. Contemporary WHO guidance emphasizes culturally informed assessment in mental and behavioral disorders.⁴

Consider physical illness

Psychiatric symptoms may be caused or influenced by medical conditions, medications, neurological disorders, intoxication, withdrawal, or metabolic disturbances.

Avoid premature diagnosis

The MSE describes the current mental state; it does not independently establish a psychiatric diagnosis.

Document both positive and negative findings

Important absent findings should be documented when clinically relevant, particularly concerning hallucinations, delusions, suicidal ideation, homicidal ideation, severe cognitive impairment, or altered consciousness.

CONCLUSION

The Mental Status Examination is a fundamental component of psychiatric and mental health nursing assessment. It provides a structured description of the patient's current appearance, behavior, psychomotor activity, speech, mood, affect, thought, perception, cognition, insight, and judgment. The MSE is particularly valuable because it provides a baseline for subsequent assessment and allows healthcare professionals to recognize changes in mental functioning over time. For nurses, systematic MSE assessment contributes to early recognition of clinical deterioration, identification of safety concerns, individualized nursing care, treatment monitoring, therapeutic communication, and effective multidisciplinary collaboration. However, the MSE should not be interpreted as an independent diagnostic instrument. Its findings must be integrated with psychiatric and medical history, physical examination, collateral information, medication and substance history, cultural context, and appropriate investigations. Developing competence in MSE assessment is therefore essential for psychiatric nursing students and practicing nurses. Accurate observation, appropriate questioning, objective documentation, culturally sensitive communication, and timely reporting of clinically significant findings are central to safe, evidence-informed, and patient-centred mental healthcare.

REFERENCES

1. Voss RM, Das JM. Mental Status Examination. In: StatPearls [Internet]. StatPearls Publishing; updated 2024. Accessed September 15, 2026. (NCBI)
2. Martin DC. The Mental Status Examination. In: Walker HK, Hall WD, Hurst JW, eds. *Clinical Methods: The History, Physical, and Laboratory Examinations*. 3rd ed. Butterworths; 1990. Chapter 207. (PubMed)
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed, text rev. American Psychiatric Association Publishing; 2022. (American Psychiatric Association)
4. World Health Organization. *Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders*. World Health Organization; 2024. doi:10.1177/00207640241234847. (World Health Organization)
5. Townsend MC, Morgan KI. *Psychiatric Mental Health Nursing: Concepts of Care in Evidence-Based Practice*. FA Davis.
6. Varcarolis EM. *Essentials of Psychiatric Mental Health Nursing: A Communication Approach to Evidence-Based Care*. Elsevier.
7. Boland R, Verduin ML, Ruiz P, eds. *Kaplan & Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry*. 12th ed. Wolters Kluwer; 2021.
8. Stuart GW. *Principles and Practice of Psychiatric Nursing*. 10th ed. Elsevier; 2013.
9. Carpenito-Moyet LJ. *Handbook of Nursing Diagnosis*. 16th ed. Wolters Kluwer; 2021.