Course Title

**Evaluation of Anabelle through a Mental Status Examination**

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**Question 1 – Thought Form/Process and Thought Content**

Synderman and Rovner (2009) mentioned that in order to describe the form of thinking of a patient and in order to categorise how the ideas of a patient are expressed during the Mental Status Examination (MSE), psychiatrists use the thought process – one of the factors assessed during the MSE. The flow and rate of thought are noted by the physicians (Hales, Yudofsky and Gabbard, 2008). Generally, the thought form of a patient is described in regards to the continuum exists between disconnected and goal-directed thoughts. Relating to this the case study of Anabelle, the thought rate of the patient is **rapid** as she screams, shouts and talk very fast (rapidly) (Evans et al. 2016). On the same hand, the thought flow – refers to the connectedness and organisation of thoughts – of Anabelle is **disjointed** because the connections between her thoughts are difficult to follow and are unclear. Lastly, the thought form of Anabelle can be broadly characterised as **impoverished** as her thoughts contain very little meaningful information (relating to a specific scenario she has observed). Specifically, the thought process of Anabelle contains the abnormality of **flight of ideas** as she was producing continous and rapid verbalizations which were shifting from one idea to another, however, each idea was connected.

On the other hand, thought content tends to describe what the patient is thinking and whether the patient’s thoughts includes the absence or presence of obsessional or delusional, and homicidal and suicidal ideas (Synderman and Rovner, 2009; Coombs, Curtis and Crookes, 2011). The thought content of Anabelle can be broadly regarded as **delusional** as the content she if verbalising is not consistent with the cultural, religious and social context. Specifically, the thought content of Anabelle can be categorised as **persecutory delusion** –such a delusional belief that one is being watched, harmed, discriminated, manipulated and ridiculed by another person or group,and **nihilistic delusion** – such a delusional belief that self, others and/or the word is going to end or are non-existent. The abnormality in the thought content of Anabelle can also be regarded as **thought broadcasting** as she thinks that her thoughts can be heard by others as such they are broadcasted through air – evident from Anabelle statement to the nurse, “*You know, don’t you? You know it’s in my veins!*”

**Question 2 - Perception**

Cummings (2015) mentioned patients can also experience perceptual disturbances with regards to the environment or the self. Synderman and Rovner (2009) that perceptual disturbances are classified as hallucinations and these occur because of the absence of a sensory stimulus. Hales, Yudofsky and Gabbard (2008) mentioned that different sensory systems can experience hallucinations including visceral, auditory, tactile, visual, gustatory and olfactory. Evans et al. (2016) highlighted that a person is experiencing perceptual disturbances if the patient is consistently responding to the internal stimuli – the patient is hearing someone’s voice and then speaking with him/her while remaining in the internal stimuli. Williams (2009) further highlighted that hallucinations, or more specifically perceptual disturbances, can either be directly endorsed by the client or the physician has to reveal it through careful observations of the content the patient is speaking in conjunction with the evaluation of the thought form and thought content.

It is evident from Anabelle’s case study that she is experiencing **hallucinations** and specifically she is experiencing **auditory hallucinations** – false perceptions of sounds which usually includes noise and other voices; evident from Anabelle’s statement, “*Can’t you hear what they’re saying?!*”, and **visual hallucinations** – false visual perceptions consisting of formed and unformed images; evident from Anabelle’s statement, “*They’re everywhere. Everywhere…under my skin! Every one of us is falling – the whole planet is falling!*” This statement evidence that Anabelle is seeing some formed images in her surrounding which may be classified as human or non-human images. The abnormality of Anabelle can also be regarded as **derealisation** because she is having a subjective sense that her surrounding environment is strange and covered with bizarre beings speaking, rather threatening, her.

**Question 3 – Affect and Mood**

Burgess (2013) mentioned that a sustained and pervasive emotion is “mood” which is subjectively reported and experienced by an individual and on the other hand observed by other persons. The emotional state can either be investigated through directly asking the patient but in most of the cases, the patient will not explicitly disclose his/her emotional state and then the physician must use directive questioning. Evans et al. (2016) mentioned that thought content and the congruence of mood should also be noted when defining the emotional state of a patient along with any changes associated with various vegetative functions including sleep, appetite and libido. The mood of Anabelle can be classified as **dysphoric** – a state of dissatisfaction and unease also accompanying agitation and depression; Anabelle is observed to be dissatisfied with her environment whether it be in the hospital or her home, and **anxious** – which is an unpleasant state of the inner turmoil and is accompanied with nervous behaviour currently shown by Anabelle. The stability of the current mood of Anabelle is very high during the course of the day; her dysphoric and anxious mood almost remain for most of the time as evident from the facts told by her mother. The reactivity of the mood of Anabelle is very less because it is not changing to external circumstances and/or events – it is not dependent on the latter.

Burgess (2013) defines “affect” as the observed expressions of motions. An affective state of an individual is comprised of numerous components which cannot be comprehended through direct questioning rather through objectively observing the individual. Affect is described through four main components namely, range, change pattern, intensity and appropriateness. Range – variation in the emotional expression of an individual and the range of Anabelle’s affect is **constricted** throughout the interview as very limited variations in the emotional expressions were observed. The intensity of Anabelle’s mood can be classified as **exaggerated** as she is self-dramatizing some unrealistic scenarios – exaggerated expressions of the motion. The affect of Anabelle’s mood can be categorised as **inappropriate** to the situation and is also **congruent** with the thought content.

**Question 4 – Appearance and Behaviour**

Evans et al. (2016) highlighted that the appearance of a person has the tendency of providing valuable clues about the patients’ cognitive state, mood, the presence of thought disorder, self-awareness, general physical health and motor condition. The physical characteristic of Anabelle was wearing dirty jeans along with a T-shirt and came barefoot. Her hairs were dyed pink and blue but were unkempt and matted. She also has piercings in her lip, nose and eyebrow. The pupils of Anabelle were extremely dilated and also has lost her weight during the past three months. Though she has just entered early adulthood, through her appearance it seems that the apparent age is more than the chronological age. She has not taken care of her grooming and hygiene. The appearance of Anabelle can simply be regarded as **dishevelled**.

The description of behaviour and activity tends to provide the mental image of the patient. All of the non-verbal behaviour is classified through the psychomotor behaviour having the tendency of revealing information regarding the patient’s energy, mood, general medical condition, coordination, muscle strength, and the adverse effects of medication (if provided) (Evans et al. 2016). There exist various abnormalities in the level of activity shown by Anabelle as she was consistently wringing her hands, was pacing up and down in the Emergency Department (ED) corridor and was constantly staring at the ceiling or at the staff members. Though she was physically present in the hospital, mentally she was seeing herself in another world, “*The young woman hesitates before entering the cubicle like she is about to enter a trap*”. Her behaviour was showing that she was feeling danger from someone – an **excessive and repetitive behaviour**.

**References**

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