



***Mental
Status
Examination***

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The Mental Status Examination

The mental status examination is a clinical assessment of the individual which reflects both the individual's subjective report and experience, and the clinician's observations and impressions at the time of the interview. Assessment of mental status is a vital component of clinical care. It is used to establish a baseline, evaluate changes over time, facilitate diagnosis, plan effective care, and evaluate response to treatment. In addition, the information obtained facilitates the clinician's understanding of the individual's experience, and when performed skilfully, enhances the therapeutic alliance between the nurse and client. Like any clinical skill, the mental status examination is one which is enhanced through practice, clinical supervision, and feedback. It is hoped that this learning package will also be helpful to you as you acquire or refine the knowledge necessary to conduct this important clinical skill.

There is variation in how clinicians organize, conduct, and document assessments. However, the following content areas should be addressed in any comprehensive assessment of mental status:

<i>GENERAL OUTLINE OF A MENTAL STATUS EXAMINATION</i>
1. Appearance, Attitude, & Activity (Behaviour)
2. Mood & Affect
3. Speech & Language
4. Thought & Perception
5. Cognition
6. Insight & Judgement

APPEARANCE, ATTITUDE, AND ACTIVITY (BEHAVIOUR)

In this section of the mental status examination, the interviewer summarizes observations regarding the person's appearance, attitude toward the interview and interviewer, and behaviour. These observations begin as soon as the interviewer sees the client, and continue throughout the course of the interview. These descriptions are valuable because they paint a picture of the individual during the interview which may be helpful to others in achieving a greater understanding of both the individual and the interviewer's conclusions based on the interview. However, it is imperative that the interviewer documents in an objective and non-judgmental manner in order to avoid bias and ensure that the picture which is painted is both accurate and fair.

Describing Appearance

Appearance can provide valuable clues to a person's mood, cognitive state, self-awareness, presence of thought disorder, motor condition, and general physical health. Descriptions of appearance in a mental status examination should include any prominent or unusual physical characteristics (shaved head, tattoos, etc), approximate height and weight (obesity or thinness), posture, grooming and hygiene, level of eye contact, apparent age in relation to chronological age, facial expression in relation to thought content, and anything unusual such as clothing which is inconsistent with the time of day or season, or unusually applied clothing or make-up, etc.

Describing Attitude

In describing attitude, consider both the individual's attitude toward the interview and the interviewer. The individual's attitude may influence the validity and content of information obtained, and may pose special challenges to the interviewer. It is important to consider any effect of the client's attitude on you, on the development of the therapeutic relationship, and on your ability to objectively report on your findings. The client's attitude toward the interviewer may be described in terms such as cooperative or uncooperative, frank, deductive, defensive, evasive or guarded, hostile or threatening. Any changes in attitude throughout the interview, as well as the level of rapport established, should also be recorded.

Describing Activity or Behaviour

Description of activity and behaviour should provide a mental image of the person during the interview. Psychomotor behaviour includes all non-verbal behaviour evident during the interview, and can reveal information regarding a person's mood, energy level, muscle strength, co-ordination, general medical condition, and potential adverse effects of medication. The documentation of activity and behaviour in the mental status examination should include abnormalities in the level of activity, any abnormal or involuntary motor activity or behaviour, and any excessive, repeated, or distinctive activity or behaviour. It is important to describe the actual behaviour (e.g. constantly wringing hands, tapping foot repeatedly) rather than simply stating your interpretation of the behaviour (e.g. appears anxious).

MOOD AND AFFECT

Describing Mood

Mood is a pervasive and sustained emotion, subjectively experienced and reported by an individual and observed by others. Clients should be encouraged to describe their emotional state in their own words. If not spontaneously reported, the interviewer must explicitly ask about mood, progressively using more directive questioning if necessary. Clients should be encouraged to report on both the intensity of their emotion and whether it is typical for them. Mood is often described as euthymic, dysthymic, depressed/sad, happy, apathetic, anxious, angry, euphoric, manic, hypomanic. In describing mood, it is also important to report on any associated changes in vegetative functions: energy, appetite, libido, and sleep. The congruence of mood and thought content should also be noted.

Mood may be further characterized in terms of its stability, reactivity, and duration.

- Stability: refers to the consistency of the mood, particularly within the course of the day
- Reactivity: refers to whether or not mood changes in response to external events or circumstances
- Duration: refers to the persistence of the mood, measured in hours, days, weeks, months, or even years

Describing Affect

Affect is the observed expression of emotion. A person's affective state consists of several components, which are objectively observed and cannot be elicited by direct questioning. It should be monitored throughout the interview, and its congruence with thought content should be noted. Written description of affect in the mental status examination should be characterized in terms of its range, change pattern, intensity, and appropriateness:

- Range: refers to the variation in emotional expression observed throughout the interview; it is characterized as full (normal variation in emotional expression) or constricted (limited variation in emotional expression)
- Change pattern: refers to the rate of change of emotional expression; it is characterized as stable (normal rate of change) or labile (rapid change in emotional expression, without external stimuli)
- Intensity: refers to the strength of emotional expression; it is characterized as average, flat (complete lack of emotional expression) or blunted (reduced intensity of emotional expression)
- Appropriateness: refers to congruence of affect and thought content; characterized as appropriate when congruent, inappropriate when not

SPEECH AND LANGUAGE

Describing Speech

In this portion of the mental status examination, the interviewer evaluates and documents the physical characteristics of speech and the individual's use and comprehension of language. The relationship between thought process and speech is unclear, however, in practical terms, comprehensive assessment of thought process is dependent upon intact speech and language comprehension abilities. Evaluation of speech and language can provide important clues to an individual's physical and mental state, thought processes and cognitive organization, and intellectual capacity.

Evaluation of formal speech disorder is not possible through mental status examination alone, however the mental status exam may provide data to support further testing. The interviewer should note any evidence of speech impairment, such as stuttering, unusual rhythms in speech, and comment on the individual's use and comprehension of language. In addition, specific characteristics of speech should be described:

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| Rate: | refers to the speed of speech, and is further characterized as pressured (very rapid and difficult to interrupt), slowed, or appropriate |
| Volume: | especially important to comment if unusually loud or hushed |
| Quality: | describe as spontaneously verbal/non-verbal/fluctuations in tone |

THOUGHT AND PERCEPTION

In evaluation of thought and perception, the interviewer assesses how well a person formulates, organizes, and expresses their thoughts (i.e. thought process), as well as any abnormalities in thought content or perception. A formal thought disorder is characterized by disturbance in the process or form of thought.

Evaluation of Thought Process

Evaluation of thought involves assessment of process (the way a person thinks) and content (what a person thinks). Comprehensive evaluation of thought process involves attention to the following:

- | | |
|----------------------|--|
| <i>Thought Rate:</i> | may be revealed through direct questioning, or inferred based on the rate of speech. It is characterized as rapid, slowed, or appropriate. |
| <i>Thought Flow:</i> | refers to the organization, or “connectedness” of thinking. It is characterized as logical when there are clear and easily understood connections between thoughts, and as disjointed when these connections are unclear and difficult to follow. |
| <i>Thought Form:</i> | refers to the way (form) in which thoughts are expressed; characterized as concrete (inability to think beyond the most overt meaning), impoverished (little meaningful information contained in the conversation), or overly inclusive (excessive, irrelevant detail) |

Abnormalities in Thought Process

It is important to assess and document the presence, or absence, of significant abnormalities in thought process, as this is fundamental to the determination of a psychosis. This assessment is inferred from the communication, and/or from direct questioning of the client regarding what their thoughts are like. The overall goal is to document an assessment of the individual’s organization, flow, and production of thought. Common abnormalities of thought process are listed below. It is understood that there is variation in the style of thought process in all individuals, thus a determination of an abnormality in thought process is based on the presence and frequency of specific phenomena. Such a judgement should be made carefully, based on as much information as possible, and supported by specific examples in documentation. It is helpful to consider some of the following questions when evaluating thought process:

- Was the conversation direct and informative, or confusing and vague?
- Did questions need to be repeated/rephrased?
- Did ideas flow smoothly from one to another?
- Was redirection frequently required?
- Was there evidence of shared meaning?

Abnormalities of thought process include:

- Tangentiality
- Circumstantiality
- Flight of ideas
- Loosening of associations
- Word salad
- Perseveration
- Clang associations
- Echolalia
- Non-sequiturs
- Neologisms
- Thought blocking

These terms are defined at the end of this document.

Evaluation of Thought Content

Thought content refers to what the person is thinking about. Assessment of thought content is possible through careful listening and directive questioning. Exploration of thought content conveys to the individual a willingness and desire to understand them better, an interest in their thoughts and experiences, and permission to discuss potentially sensitive issues. Certain areas tend to be avoided by both the interviewer and the client due to their distressing, embarrassing, or threatening nature. As a clinical, rather than a social interaction, the conduct of the mental status examination requires that the interviewer explore all aspects of thought content, regardless of the sensitive nature of the topic. Failure to do so may result in incomplete or inaccurate risk assessment, and impair the ability of the interviewer to effectively intervene.

There are specific areas about which the interviewer must inquire if they are not introduced by the client. These include:

- **Suicidal or homicidal ideation, intent, and plan**
- **Delusional thought content, and the manner in which delusional beliefs impact on the person's life or behaviour**
- **The content of auditory hallucinations, if present**
- **The presence of command hallucinations**

Abnormalities of thought content include:

- Obsessions
- Compulsions
- Phobias
- Delusions (content and impact on behaviour must be described)
- Ideas of reference
- Ideas of influence
- Thought insertion/thought broadcasting/thought withdrawal
- Suicidal ideation, intent, and plan (document fully)
- Homicidal ideation, intent, and plan (document fully)

Exploring Delusional Thought Content

It is not sufficient to rely upon spontaneous expression of delusional thought content within the interview. Specific questions to assess for delusional thought content should be included in the interview. Further exploration should include the content of any delusional system(s), and the impact of delusional beliefs upon behaviour. In documentation, specific examples of apparently delusional thought content should be cited.

Exploring Suicidal/Homicidal Ideation

The presence or absence of suicidal and homicidal ideation, as well as its severity or urgency, must be specifically assessed and documented as part of every mental status examination. At a minimum, the interviewer should specifically inquire re:

- the presence of suicidal/homicidal thinking
- the duration, frequency, persistence and intensity of these thoughts
- the ability of the individual to control them
- the desire and intention of the individual to act upon them
- their likely actions in the event of increasing intensity of suicidal/homicidal ideation or decreasing control over these thoughts, and
- the existence and nature of any developed suicide or homicide plan

The presence of suicidal or homicidal ideation, or concerns re their presence if denied, should prompt further intensive assessment, direct questioning, and immediate action, if necessary, to prevent harm to self or others.

Evaluation of Perceptions

Perceptual disturbances may be experienced in reference to the self or the environment. Perceptual abnormalities include:

- Hallucinations (auditory/visual/gustatory/tactile/olfactory)
- Illusions
- Depersonalization
- Derealization

These terms are further defined at the end of this document. Hallucinations may be readily endorsed by the client, or they may be revealed only through careful observation (person pauses during interview, appears preoccupied, is observed responding either verbally or physically in absence of external stimulus) or direct questioning. The presence of hallucinations should **always** prompt further inquiry into the nature and content of the hallucinations, and assessment of risk to self or others. In addition, the circumstances in which hallucinations occur, their persistence, frequency, and effects on the person, and the person's use of coping mechanisms and their effectiveness should be explored and documented. The presence of command hallucinations is associated with increased risk, and should prompt further intensive assessment.

COGNITION

Cognition is the ability to know and think, using intellect, logic, reasoning, memory, and all of the higher cortical functions. Appropriate communication and comprehension depend upon intact speech and language abilities, the absence of thought disorder, and on brain functions that relate to cognition and intellect. Consequently, these functions should be directly and indirectly assessed during the mental status examination. In contrast to other aspects of the mental status exam, cognition is tested in a structured way. One of the most widely used screening tests is the Mini-Mental State Exam (Folstein, Folstein, and McHugh, 1975), which assesses orientation, memory, calculations, reading and writing capacity, visuospatial ability, and language. It may be useful to consider a standardized test of cognition in instances in which impaired cognitive capacity is known or suspected.

In assessing cognition, the interviewer evaluates the individual across a number of parameters: orientation, level of consciousness, attention and concentration, memory, visuospatial and constructional ability, reading and writing ability, abstract thinking ability, and intellectual ability.

Evaluating Orientation

Orientation to person, place, and time is a basic cognitive function. Essentially, this means that the person knows who they are, where they are, and the date/day of the week. A hospitalized person may/may not have had access to a calendar, and subsequently may not know the exact date, but should remain clear on the month, season, and year, and be close to the day of the week and beginning, middle, or end of the month.

Evaluating Level of Consciousness

The overall level of consciousness should be documented. This is typically characterized as along a continuum from alert to drowsy, delirious, stuporous, or comatose.

Evaluating Attention and Concentration

Attention is the ability to focus and direct cognitive processes. Simple tests of attention include asking the person to name 5 things that start with the same letter or to repeat a number of digits, beginning with a 2 digit series, and continuing until a mistake is made; normal forward spans are

6 +/- 1 digit. Another test of attention is to ask the person to spell “world” backwards, and give 1 point for each correctly placed letter.

Concentration is the ability to focus and sustain attention over a period of time. A simple test of concentration is to ask the person to “count backward starting at 65 and stopping at 49”. The person could also be asked to calculate serial seven subtractions by “starting at 100, then subtract 7, and then keep subtracting 7 from each answer”. Alternatively, the person could be asked to recite the days of the week or months of the year backwards.

Evaluating Memory

Memory impairment can be symptomatic of a number of conditions, including depression and cognitive disorders. It is important to assess both short-term and long-term memory, since they may be differentially affected. It is also important to note the person’s response to memory loss, if present. The following aspects of memory should be assessed:

- Recall: the capacity for immediate retention and recall of new information; may be tested by asking the person to repeat a list of 3 words immediately after hearing them
- Recent: the ability to recount information/events from the recent past; may be tested by asking the person to repeat the above list after a 5 minute interval; person could also be asked to recall the interviewer’s name or a significant recent news event
- Remote: the ability to recount events from the distant past; may be tested by asking the person to recount verifiable historical events such as their date of birth or marriage, or significant events from their childhood

Evaluating Visuospatial and Constructional Ability

These abilities are essential to performing many everyday activities, such as driving, using a computer, and successfully navigating within the environment without becoming lost. Impairment in these tests may indicate a lack of integration of motor and visuospatial functions, and offer clues to the affected area of the brain. Asking the person to copy a figure such as a 3-dimensional square or interlocking pentagons, or to draw a clock indicating a certain time may assess these abilities. Any difficulties with these tasks should be noted, and the person’s work should be retained for clarity and for future comparisons.

Evaluating Reading and Writing Ability

This may be evaluated by asking the person to read a sentence and then do what the sentence says. For instance “close your eyes”. The person should also be asked to write a simple but complete sentence.

Evaluating Abstract Thinking Ability

Abstract thinking is the capacity to conceptualize meanings of words beyond the most literal (concrete) interpretation. This includes the ability to analyze information according to themes, to generalize according to categories, to appreciate double meanings, to make comparisons, to hypothesize, and to reason. Education, intelligence, and cultural factors, as well as physical or

psychiatric disorders may affect abstract thinking ability. It may be tested during the mental status examination by asking the person to interpret a proverb or to identify similarities between objects.

Sample Proverbs:

1. The grass is greener on the other side of the fence.
Concrete interpretation: “his lawn is greener than mine”
Abstract interpretation: “things that seem better elsewhere, aren’t necessarily”
2. Don’t count your chickens before they hatch.
Concrete interpretation: “you won’t know how many chickens will be born just by counting the eggs”
Abstract interpretation: “don’t make plans based on something that might never happen”
3. A stitch in time saves nine.
Concrete interpretation: “sewing prevents more rips”
Abstract interpretation: “take action today to prevent problems tomorrow”

Sample Similarities:

1. How are an apple and an orange similar?
Concrete interpretation: “they’re both round”
Abstract interpretation: “they’re both fruit”
2. How are a table and chair similar?
Concrete interpretation: “they both have legs”
Abstract interpretation: “they’re both items of furniture”
3. How are a dog and a tree similar?
Concrete interpretation: “they both have bark”
Abstract interpretation: “they’re both living things”

Evaluating Intellectual Ability

In clinical interviews such as the mental status examination, intelligence is not tested directly, but is inferred based on the person’s educational attainment, occupational functioning, use of vocabulary, fund of general knowledge, and ability to engage in abstract thinking. When specific information regarding intellectual ability is needed, the person may be referred for formal IQ testing, and a standardized IQ test, such as the Wechsler Adult Intelligence Scale (WAIS) may be administered.

INSIGHT AND JUDGEMENT

Insight and judgement are complex cognitive tasks which require the utilization and integration of several mental functions, especially higher level conceptualization ability. They are inter-related constructs: the ability to make a sound judgement requires an adequate level of insight, and insight requires the ability to critically evaluate the potential repercussions of one's situation or behaviour. Evaluation of both insight and judgement is based on both the content and the process of the interview.

Evaluating Insight

Insight is the ability to be self-aware. It involves the capacity to examine many aspects, viewpoints, and consequences of an issue before forming an opinion or making a decision. Insight may be affected by a person's intellectual ability, cognitive function, defence mechanisms, personality style, presence or absence of a thought disorder and cultural context. In the context of the mental status examination, assessment of insight focuses on both the person's self-awareness that there is a problem or illness, and to the non-delusional understanding of its cause or meaning. Insight can range along a continuum from complete denial of illness to an admission of symptoms and need for treatment, which is translated into behaviour. Sample questions to elicit degree of insight include direct questions such as "what has brought you here today"; "what do you think is the problem"; and "do you think there is anything that will help you to feel better?".

Evaluating Judgement

Judgement is a process of forming an opinion or conclusion based on information about a situation that can lead to a decision or action. The greater the degree of insight, the greater the potential for sound judgement. In addition to insight, sound judgement is also dependent upon intact cognitive function, capacity to conceptualize, and ability to consider long-term effects and possible adverse outcomes. In a clinical interview, assessments about judgement are based on whether the person understands the likely outcome of his/her behaviour, and what action they might take in a hypothetical situation. A sample question might be "what would you do if you saw a train coming toward you on the track?". Additionally, the interviewer could assess judgement regarding current difficulties by asking the person how they think their hallucinations/mood difficulties etc, should be handled.

KEY POINTS TO REMEMBER:

- Use an outline to ensure a comprehensive evaluation
- Listen to what is said and what is not said
- Specifically explore all areas
- Document all assessment findings, not just atypical findings
- Provide corroborating data to support your conclusions
- Retain raw data for clarity and future comparisons
- Seek clinical supervision and feedback to refine your skills

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DEFINITION OF TERMS

Affect

Definition: the observed expression of emotion

Affect can be further described in terms of its range (full/constricted), change pattern (stable/labile), intensity (flat/blunted) and appropriateness (congruence with thought content).

Full range of affect:	a variety of emotions are appropriately expressed
Constricted affect:	little variation in emotional expression
Flat affect:	absence or near absence of any externally expressed emotion
Blunted affect:	externally expressed emotion is present, but of muted intensity
Labile affect:	rapid and abrupt changes in emotional expression, unrelated to external stimuli
Stable affect:	absence of rapid and abrupt changes in emotional expression
Appropriate affect:	emotional expression is consistent with the accompanying idea, thought, or speech
Inappropriate affect:	emotional expression is inconsistent with the accompanying idea, thought, or speech

Akathisia

Subjective feeling of muscular tension secondary to antipsychotic or other medication, which can cause restlessness, pacing, repeated sitting and standing

Catatonia

A severe disturbance of motor function, usually manifested by markedly decreased activity, but may involve hyperactivity, with alternation between these states; in the hypoactive state, the person is immobile and maintains peculiar postures for lengthy periods

Circumstantiality

Talking at length around a point before finally getting to it, usually in an overly detailed fashion

Clang association

A form of loose associations in which statements are connected by sound and not meaning

Compulsion

Repetitive and ritualized behaviour which the person feels compelled to perform

Delusion

Definition: false, fixed belief which is not consistent with the person's social, cultural, or religious background

Grandiose delusion

Delusional belief that one possesses special wealth, powers, skill, influence, or destiny

Persecutory delusion

Delusional belief that one is being harmed, watched, ridiculed, manipulated, discriminated against, or plotted against, by another individual or group

Nihilistic delusion

Delusional belief that self, others, or the world is non-existent or coming to an end

Somatic delusion

Delusional belief involving functioning of the body (e.g. that one's brain is rotting or internal organs are being eaten by snakes)

Depersonalization

A subjective sense of being unreal, strange, or unfamiliar

Derealization

A subjective sense that the environment is strange or unreal

Dysphoria

An unpleasant and negative mood that is perceived as being uncomfortable and characterized by unhappiness, dissatisfaction with life or self, and a sense of uneasiness

Dysthymia

Depressed mood of less intensity than that experienced with a clinical depression

Echolalia

Pathological repeating of words or phrases of one person by another; tends to be repetitive and persistent

Euthymia

A normal range of mood, implying absence of either depressed or elevated mood

Flight of ideas

Rapid, continuous verbalizations producing constant shifting from one idea to another; ideas tend to be connected

Hallucination

Definition: False sensory perception, occurring in the absence of external stimuli; may involve any sensory modality

Auditory hallucination

False perception of sound, usually voices but may include other noises, such as music; the most common type of hallucination in psychiatric disorders

Command hallucination

An auditory hallucination in which a voice instructs the individual's behaviour; these instructions may be difficult or impossible to resist, and may be acted upon, with potentially catastrophic consequences

Visual hallucination

False perception involving sight, consisting of both formed images (e.g. a person) and unformed images (e.g. flashes of light)

Gustatory hallucination

False perception of taste, usually unpleasant, without an external stimulus

Tactile hallucination

False perception of touch or surface sensation (e.g. crawling sensation under the skin)

Olfactory hallucination

False perception of smell, without an external stimulus

Hypnagogic hallucination

False sensory perception occurring while falling asleep; generally considered a nonpathological phenomenon

Hypnopompic hallucination

False perception occurring while awakening from sleep; generally considered a nonpathological phenomenon

Ideas of influence

False belief that another person or external power has control over one's thoughts, behaviours, and/or feelings

Ideas of reference

False personalized interpretations of actual events; person believes that the behaviour or events refer specifically to them, when in fact they do not

Illusion

Misperception or misinterpretation of actual external sensory stimuli

Insight

Refers to both the individual's awareness of a problem or illness and to the nondelusional understanding of its cause or meaning

Judgement

The process of forming an opinion or conclusion based on information about a situation and, ideally, reaching a conclusion that appropriately weighs and recognizes the important elements of an issue

Loosening of associations

Flow of thought in which the conventional connections (associations) between expressed thoughts are reduced or lost

Mood

A pervasive and sustained emotion, subjectively experienced and reported by the individual and observed by others

Neologism

Word or words created by the individual, but used as if they had a specific and mutually understood meaning

Non-sequitur

Verbal response which is totally unrelated to the question which was asked

Obsessions

Intrusive and unwanted ideas which intrude into consciousness despite efforts to suppress them

Overvalued idea

An illogical or false idea that is held relatively firmly, though not with delusional intensity

Overly inclusive

Inability to preserve conceptual boundaries, such that irrelevant or distantly associated elements become incorporated into concepts; speech is characterized by excessive detail

Perseveration

Involuntary continuation or recurrence of an experience or activity, most typically verbal

Phobia

Persistent, irrational, exaggerated, and invariably pathological dread of a specific stimulus or situation, which typically results in a compelling desire to avoid the feared stimulus

Poverty of thought

Thought that gives little information because of vagueness, empty repetitions, or obscure phrases; most commonly manifested by the absence or near absence of spontaneous comment and lack of elaboration on ideas

Pressured Speech

Rapid speech that is increased in amount and difficult to interrupt

Psychomotor agitation

Excessive motor and cognitive activity, usually nonproductive and in response to inner tension

Psychomotor retardation

Decreased motor and cognitive activity, characterized by visible slowing of thought, speech, movements

Sensorium

The hypothetical “sense center” of the brain; when a person is clearly aware of the nature of his/her surroundings, and is fully oriented, the person’s sensorium is described as intact

Suicidal ideation

Thoughts about killing oneself; ranges from passive thoughts of death (“I wish I were dead”) to active thoughts involving intent to kill self and development of a suicide plan

Tangentiality

A disturbance in association characterized by the individual becoming side-tracked through a chain of readily understandable associations, but never returning to the point of the question

Thought blocking

Abrupt interruption in train of thought before a thought or idea is finished; after a brief pause, the person indicates no recall of what was being said or was going to be said

Thought broadcasting

Delusional belief that a person’s thoughts can be heard by others, as though they were being broadcast over the air

Thought insertion

Delusional belief that thoughts are being implanted in a person’s mind by other people or forces

Thought withdrawal

Delusional belief that thoughts are being removed from a person’s mind by other people or forces

Tic

Sudden, repetitive, stereotyped jerky movements of eyes, vocal organs, face, extremities, or trunk

Waxy flexibility

Condition of a person who can be molded into a position that is then maintained for a prolonged period of time

Word salad

An extreme form of loosening of associations, characterized by speech consisting of a series of unconnected words and neologisms, the content of which is incomprehensible