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Letter to the Editor

'Masking' of the mental state: Unintended consequences of personal protective equipment (PPE) on psychiatric clinical practice

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"When your face says it all, your mouth waits its turn" – this quotation by Anthony T. Hincks applies as much to psychiatry as to life. The mental state examination (MSE) derives significantly from simple observation of someone's facial expressions and body language, in addition to clinical questions. But, the current COVID-19 pandemic has necessitated certain changes in the way MSE is conducted, e.g., face masks, alcohol hand-rubs, social distancing, etc., and these changes may be here to stay ("When and how to use masks," 2019). In this paper, we have highlighted some of the major issues which are likely to arise during MSE and psychiatric interviews with the pandemic-related precautions in place, and the need to find alternative strategies to deal with these problems.

1. Appearance and behaviour

The use of masks hampers the observation of facial expressions which is very important for any MSE. The fact that whether someone is smiling, frowning, has flat expressions, or is looking around out of suspicion or confusion, gives significant clues into their mental state (Martin, 1990). This may be even more difficult in settings where the use of other protective gears like face-shield and goggles is necessary (Mistry et al., 2009). Similar to problems in observing expressions, we are likely to miss orofacial movement disorders such as tics or tardive dyskinesias, subtle mumbling which may occur as a part of hallucinatory behaviour in psychosis andsubstance use-related signs e.g. tobacco (oral mucosal changes), opioids (pupillary constriction/dilation, lacrimation) or cannabis (conjunctival injection). Also, due to the smell of alcohol hand-rubs, psychiatrists may miss on subtle smell cues such as body odour arising out of poor self-hygiene and smell of substances like alcohol and cannabis which might suggest intoxication. Furthermore, making eye contact and establishing a rapport is challenging given the distraction of the PPE and the 'non-humanly' feeling it gives. E.g., PPE might accentuate the suspiciousness in patients who have paranoia, the new smells and appearances may be extremely difficult to cope with for patients with autism spectrum disorders, patients having depression might require a gentle human touch and support during an interview which becomes near impossible with PPE and social distancing, it might be very challenging to provide reorientation to patients having delirium, or memory cues to those having dementia when they cannot see the faces of those around them, etc.

2. Speech

Speaking through masks can muffle the speech, which hurdles the coherence and volume of speech. In disorders like severe depression and negative symptom schizophrenia, where the patient might be barely audible in usual circumstances, masks might make conversations near impossible (Priebe et al., 2011). Also, because of the difficult conversation, the therapist and patient might have to frequently ask each other to repeat what they are saying, thus making the conversations more tedious and time consuming.

3. Affect

As mentioned above, there can be hurdles in observing expressions in presence of PPE. This makes it extremely difficult to estimate the objective affect, range of emotion and presence of reactivity to stimuli, which are important markers for some mental health conditions.

4. Thought and perception

Eliciting thought and perceptual abnormalities often requires detailed phenomenological explorations. The difficulties in understanding speech, as mentioned above, make this task very challenging, e.g., muffled speech makes it difficult to pick formal thought disorders and ineffective conversations make it difficult to understand the phenomenological content of delusions and hallucinations.

Apart from the difficulties in conducting MSE, PPE may also pose a barrier to observe some clinical signs which are as important to psychiatry as for other medical disciplines, e.g., injuries, pallor, icterus, cyanosis, etc. Inability to pick up signs of potentially life-threatening conditions such as pupillary constriction in opioid overdose, tremors in lithium toxicity and dehydration in catatonia, can prove to be disastrous.

In such scenarios, psychiatrists might find themselves in ethical dilemmas where they might be tempted to remove their own PPEs or ask the patients to remove theirs, for unimpeded MSEs and clinical interviews, potentially putting their own or the patients' health and life at risk. There seems to be no easy answer to this (Mehta et al., 2020). Potential strategies to bypass some of these problems may include the creation of a transparent physical barrier between the psychiatrist and

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the patient or teleconsultations, but they may have their own shortcomings. Ultimately, it boils down to the quintessential comparison of risk vs benefit of such practices. It would be highly beneficial for psychiatrists and patients alike if the national or international psychiatric bodies can prepare guidelines while weighing all the pros and cons, to conduct interviews and MSEs during the current pandemic.

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