The following pages contain a study guide to learning to conduct a mental status examination. Although this element of the physical exam is one of the more difficult to teach, the acquisition of this tool is undeniably one of the most important ones you develop as a physician. Being highly skilled in this area of patient examination will separate you from many of your colleagues and will often determine your success in treating patients.

Since we are engaging in the examination of the brain through behavioral expression, we must attune ourselves to being astute observers of our patients and carefully considering deficits and how they may impact treatment. This is required of us as Osteopathic physicians and will serve you well as you progress through training. We trust that this guide will help you in developing your skills in patient care.

Please feel free ask questions or comment on the guide.
Mental Status Examination
A Clinical Study Guide

The Mental Status Exam is a part of the Physical Exam of any patient. It should be thought of in context with the rest of the physical exam.

Mental Status Exam
- Observation of brain functioning is the goal
- Complications/limitations
  - Attempting to derive information about brain functioning through observation of behavior and responses to tasks, etc.
  - Looking at brain functioning through overlay of learned responses, behavior, dynamics, etc.
- Examination remains science with art
  - Not unlike any other medical examination (ex. Auscultation)

Every patient examination should contain elements of the mental status exam; however, the content may be contracted or expanded to address the overall needs of patient assessment.

General Description:
The physician observes the patient’s general appearance from his/her first encounter (perhaps in the waiting room). It is important that the physician pays close attention to any indicators of abnormalities in the patient’s functioning. Although general appearance is diffuse in terms of physiology, it represents very ingrained social functions and does often reveals pathology. A brief description of the patient’s behavior and interaction with the examiner, including eye contact is also important.
**Mood:**

Mood is usually described by the patient with some qualification. It can be described as both an internal state of the patient and a prevailing condition of the patient over the recent past. The mood is usually described subjectively; however, characteristic terms exist including “depressed”, “expansive”, etc. Mood and affect are dynamic processes (like all functions of the human body). They can therefore be thought of as occurring as a continuously changing process as a function of time. Direct questioning of the patient concerning his/her mood in addition to observation is necessary to fully assess a patient’s mood.

**Affect:**

In contrast to mood, affect is generally considered to be the outward representation of the mood. In other words, it is what we see when we interact with our patient that communicates his/her mood. The components of affect that are usually described include range, stability and congruence to mood. Mood and affect are often considered as related findings in the mental status exam. If the two are reflective of each other, they are said to be “Congruent”.

![Mood and Affect Graphs](image-url)
Thought can be described as the processes in the brain that allow us to incorporate bits and pieces of information into conceptual thought (ideas) that, in part, make us all human. Although some other animals “think” and associate some concepts, they lack the complexity of human thought. The normal brain should “think” in characteristic ways.

Thought starts with the small “pieces” (thought content) that are collected from internal sources such as memories and external sources such as sensory information. These pieces are later incorporated into more complex thought through associations (the way components of thought content are linked together). This linking or incorporation of thought content should occur in a logical fashion and provides for higher level CNS functions including many forms of learning. The linking of thought is called thought process. In abnormal conditions such as psychotic disorders, characteristic errors in thought are often seen. These may include delusions (invalid or inaccurate thought content) and looseness of associations (pieces of thought content that, although incorporated together seem to be unrelated).

1. Assessment of thought content is accomplished by observing the patient’s interaction with the physician and listening carefully for evidence of the presence of delusional thought (thought content that does not reflect reality).
2. The physician also needs to directly assess for the presence of Suicidal or homicidal ideation. This assessment is accomplished through direct questioning (ie have you had thoughts of harming yourself or others?)
3. Thought process is assessed by asking the patient an open ended question (tell me a bit about yourself) and listen carefully. Close ended questions (yes or no questions) will often not reveal abnormalities in this area if the deficits are subtle. All patients should be assessed by asking open ended question at some time during the course of their examination.
**Perception:**

Perception is the sensory input to the brain. Perception is assessed both by observation or looking for evidence of the patient experiencing *hallucinations* (sensory stimuli deriving denovo) or *illusions* (misinterpretation of existing stimuli) and by directly questioning the patient. Questions designed to elicit abnormalities in perception include “Do you ever hear or see things that others do not” or “Do you ever see things that aren’t there”, etc.

**Memory:**

Memory is a complex function of the brain that occurs in a diffuse pattern across cortical structures. It is temporally organized from recent memory to remote memory. Testing of memory is dependent on intact mechanisms for *memory encoding, storage, retention and retrieval*.

Memory is assessed by:

1. corroborating historical facts (remote memory)
2. Asking the patient to remember 3 unrelated items, then asking them to immediately recite them (encoding and storage) then asking them to recall the three items after 5 minutes have passed while you move on with other history and testing (retention and retrieval).

**Other Cognitive Functions:**

Concentration and Attention Span:

Concentration and attention span is assessed by observing patients’ ability to attend to the interview process. Concentration can also be directly assessed by asking the patient to serially subtract 7’s from 100 or have the patient attempt to spell “world” backwards.
General assessment of Intellect:

Although objective intelligence cannot be assessed without formal testing, a general assessment of intellect serves as contextual information for other cognitive functions, especially abstract thinking.

Abstraction ability:

Abstract thinking is generally assessed by asking the patient to interpret common proverbs (Don’t cry over spilled milk, etc.) and/or by asking the patient to list similarities between common objects (apple/orange, airplane, car). The patient should interpret these tasks with answers that indicate abstract thinking although abstract thinking is somewhat dependent on education and intellect.

Insight:

The patient’s ability to understand current circumstances and needs is called insight. Presence or lack of this function is usually apparent during the interview process as the patient discusses history, understanding of deficits and understanding of proposed treatment.

Judgment:

This function is traditionally assessed by presenting the patient with a scenario requiring a decision making process then asking what they would do (ex. If you found an addressed, stamped envelope on the ground, what would you do with it? If you were in a crowded theater and smelled smoke what would you do?) Listening carefully to the recent history and speaking with family members is often more revealing of functional judgment.