SOCM
Examining Behavior and Mental Status
PFN: SOMPYLOK

Hours: 1.5

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Terminal Learning Objective
- Action: Communicate knowledge of “Examining Behavior and Mental Status”
- Condition: Given a lecture in a classroom environment
- Standard: Received a minimum score of 75% IAW course standards on the formative quizzes and the Physical Exam Practical Test grade sheet

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References
- Bates’ Guide to Physical Examination and History Taking (11th ed.; 2013; Bickley)
Reason

As a SOF Medic, we cannot divide the mind and the body; every patient will have a physical and a mental component to their injury/illness. We must treat the patient as a whole, if we expect to maximize recovery.

Agenda

- Communicate the types of behavior and mental status symptoms of a patient
- Communicate medically unexplained symptoms as they pertain to behavior and mental status
- Communicate patient identifiers for selective mental health screenings

Agenda

- Identify the different types of character disorders and their respective behavioral patterns
- Communicate changes in attention, mood, or speech; insight, orientation, or memory
- Define anxiety, panic, ritualistic behavior, phobias, delirium, and dementia
Agenda

- Communicate the screenings for depression, suicidality and substance abuse
- Identify the methods and reasoning behind observing appearance, behavior, speech, language, and mood during an examination

Agenda

- Communicate the assessment and techniques of determining thought, perception, and cognition, to include: memory, attention, information and vocabulary, calculations, abstract thinking, and constructional ability

Agenda

- Identify the assessments and techniques of the mini-mental status examination and how to record behavior and mental status exam findings
The Types of Behavior and Mental Status Symptoms of a Patient

Behavior and Mental Status

- Prevalence in U.S.
  - 30% of U.S. population has a mental disorder
  - 20% of those patients receive treatment
  - 50% of the patients who do receive treatment, actually stick to the treatment guidelines
  - “Difficult patients”
    - Frequent the clinic and have multiple unexplained symptoms
    - Often has underlying psychiatric condition

Patient Symptoms

- Psychological
  - Mood and anxiety
- Physical
  - Pain, fatigue, or palpitations
  - Often termed somatic
Patient Symptoms

- Physical (cont’d)
  - Prompt >50% of U.S. office visits
    - 25% of those patients have persisting and recurrent problems that fail to improve regardless of treatment
    - 30% of all physical symptoms are medically unexplained

Patient Symptoms

- Medically unexplained symptoms
  - Single complaints – back pain, headache, or musculoskeletal problems
  - Functional syndromes or clusters – irritable bowel syndrome, chronic fatigue, or multiple chemical sensitivity

Medically Unexplained Symptoms as They Pertain to Behavior and Mental Status
Medically Unexplained Symptoms

- Aid Station - often the first stop
  - Is it a medical or psychiatric patient?
  - Be careful to treat the patient as a whole
  - Failure to recognize can decrease
    - The patient’s quality of life
    - Treatment outcomes

Medically Unexplained Symptoms

- Difficult patient or a malingerer?
  - Often have unexplained symptoms and unrecognized psychiatric problems
  - View these as general warning signs of underlying psychological distress
  - Mental health disorders
    - ~20% of outpatients
    - 50-70% are undetected and untreated

Patient Identifiers for Selective Mental Health Screenings
Selective Mental Health Screening

- Screening for depression and anxiety
  - Warranted for any patient having unexplained conditions that last beyond 6 weeks
  - Two-tier approach
    - Brief screening questions with high sensitivity for patients at risk
    - Detailed investigation when needed

Patient Identifiers

- Medically unexplained physical symptom
- Multiple physical or somatic symptoms
- High severity of the presenting symptom
- Chronic pain
- Symptoms > 6 weeks
- Physician rating as a difficult encounter
- Recent stress
- Low self-rating of health
- High use of healthcare services
- Substance abuse

Selective Mental Health Screening

- High-yield screening questions
  - Depression: Over the past 2 wks, have you felt:
    - Down, depressed, or hopeless?
    - Little interest or pleasure in doing things?
  - Anxiety
    - Generalized, social phobia, panic disorder, PTSD, or acute stress disorder
  - Hypochondriacal features
    - Whitely index
  - Multidimensional
The Different Types of Character Disorders and their Respective Behavioral Patterns

Character Disorders

- Character/Personality disorders
  - Also labeled “difficult patients” and escape detection
  - Dysfunctional interpersonal skills that disrupt and destabilize relationships
    - Usually these traits are formed in early childhood
    - There is a high incidence of character disorders and alcohol or substance abuse

Character Disorders (cont’d)

- Character/Personality disorders (cont’d)
  - Interaction with patients who have character disorders can be especially challenging
  - 90% of patients also meet the criteria for other character disorders
  - The underlying diagnosis may go undetected
  - Impulsive - >50% attempt suicide and cut or injure themselves
Character Disorders

- Character/Personality disorders (cont’d)
  - These patients are more likely to report
    - Feeling unhappy, depressed, or despondent
    - Mood swings and emotions spiraling out of control
    - Extremes of rage, sadness, and anxiety
  - Your teammates will come to you with these feelings if they trust you. Don’t fail them! Early diagnosis can lead to early recovery!

Changes in Attention, Mood, Speech, Insight, Orientation, or Memory

Changes in Mental Status
Changes in Mental Status

- Common or concerning symptoms
  - Terminology
  - Changes in attention, mood, or speech
  - Changes in insight, orientation, or memory
  - Anxiety, panic, ritualistic behavior, and phobias
  - Delirium or dementia

Changes in Mental Status

- Terminology
  - Level of consciousness (LOC) - Alertness or state of awareness of the environment
  - Attention - The ability to focus or concentrate over time on one task or activity
  - Memory - The process of registering or recording information, tested by asking for immediate repetition of material, followed by storage or retention of information

Changes in Mental Status

- Terminology (cont’d)
  - Orientation - Awareness of personal identity, place, and time; requires both memory and attention
  - Perceptions - Sensory awareness of objects in the environment and their interrelationships (external stimuli); also refers to internal stimuli such as dreams or hallucinations
Changes in Mental Status

- Terminology (cont’d)
  - **Thought processes** - The logic, coherence, and relevance of the patient’s thought as it leads to selected goals, or how people think
  - **Thought content** - What the patient thinks about, including level of insight and judgment
  - **Insight** - Awareness that symptoms or disturbed behaviors are normal or abnormal

- **Judgment** - Process of comparing and evaluating alternatives when deciding on a course of action; reflects values that may or may not be based on reality and social conventions or norms

- **Affect** - An observable, usually episodic, feeling or tone expressed through voice, facial expression, and demeanor

- **Mood** - A more sustained emotion that may color a person’s view of the world

- **Language** - A complex symbolic system for expressing, receiving, and comprehending words

- **Higher cognitive functions** - Assessed by vocabulary, fund of information, abstract thinking, calculations, construction of objects that have two or three dimensions
Changes in Mental Status

- Attention, mood, speech; insight, orientation, and memory
  - Assess the patient’s:
    - Level of consciousness
    - General appearance
    - Mood
    - Ability to pay attention
    - Memory
    - Understanding
    - Speech
  - Conversation; not an interrogation

Anxiety, Panic, Ritualistic Behavior, Phobias, Delirium, and Dementia

Mental Disorders

- Anxiety, Panic, Ritualistic Behavior, and Phobias
  - If patient has unusual thoughts, beliefs, or perceptions, explore them as they arise
  - Anxiety disorder – Worries lasting over 6 months
  - Panic disorder – Recurrent panic attacks followed by anxiety about further attacks
Mental Disorders

- PTSD vs. acute anxiety reaction
  - Acute anxiety reaction is common in individuals following very high stress situations
  - PTSD cannot be diagnosed until symptoms have persisted for months after the event
    - Most common group - crime victims
    - Then disaster survivors, then high stress occupations
    - Most normal individuals will report some symptoms following acute or chronic stress experiences

Mental Disorders

- Post traumatic stress disorder
  - Occurs after a major life-changing event
  - Symptoms
    - Re-living the event (affecting day to day life)
    - Avoidance
    - Hyper-arousal
    - Survivor guilt

Mental Disorders

- Delirium or Dementia
  - All patients with documented or suspected brain lesions or psychiatric symptoms need further assessment
  - Patients may have
    - Subtle behavioral changes
    - Difficulty taking meds properly
    - Problems with household chores
Mental Disorders

- Delirium
  - Acute onset
  - Fluctuating, with lucid intervals
  - Worse at night
  - Lasts hours to weeks
  - Disturbed LOC
    - Less aware of their environment and less able to focus or sustain attention

Mental Disorders

- Dementia
  - Slow onset
  - Progressive
  - Lasts months, years, or forever
  - Normal LOC until late in the course of illness

Mental Disorders

The Assaultive/Combative Patient
Mental Disorders

- Assaultive/Combative Patient
  - Pre-Assault Phase
    - Anxious
    - Breathlessness
    - Rigid posture
    - Clenching jaws or fists
    - Pacing
    - Profanity
    - Rapid/loud speech
    - Threats

Mental Disorders

- Think "prevention" first
  - Control the environment; evaluate hazards of situation first
  - Know your own buttons
  - Give him space
  - Control without flaunt
  - Don't allow time pressures to put you or patient at risk

Mental Disorders

- Early intervention-management
  - Remove weapons or potential weapons from patient and medic*
  - Give him and yourself an "out"
  - Talk him down
  - Try to get them into a safe area
  - Establish expectations
  - Acknowledge feelings
  - Offer opportunity for additional care
Mental Disorders

- Controlling violent situations
  - Patients that pose a threat need restraints*
  - Local protocols-medical control
  - Medico-legal aspects
  - Only reasonable force
  - Utilize law enforcement if available
  - Carefully record details of incident
  - Frequently check on the patient

Mental Disorders

- Restraint Guidelines
  - Humanely & professionally applied
  - Use least restrictive means as necessary
  - Plan restraint with back-up plan
  - Ensure adequate manpower is available*
  - Protect from personal injury/legal liability
  - Explain why you’re using restraints - don’t negotiate

Mental Disorders

- Restraint Techniques
  - Physical restraint
    - Use folded blankets or a mattress to absorb strikes or thrown objects
    - Take control of the patient without causing unnecessary harm
  - Chemical restraint
    - Diazepam (Valium) 10mg IM or Midazolam (Versed) 5mg IM
Mental Disorders

- Personal Safety
  - Remain at safe distance from patient
  - Don't allow patient to block exit
  - Use large furniture as safety buffer
  - Never leave medic alone with patient
  - Avoid threatening statements
  - Use folded blankets/cushions to absorb impact of thrown objects

Most Important!

You can not provide the patient the required medical attention he needs if you become a patient yourself

The Screenings for Depression, Suicidality, and Substance Abuse
Depression, Suicide, and Substance Abuse

- Depression
  - Often missed early signs
    - Low self-esteem
    - Loss of pleasure in daily living
    - Sleep disorders
    - Difficulty concentrating
  - Watch for patients with prior or family history of depression

- Suicide
  - 434 active duty personnel committed suicide in 2010
  - > 50% of patients contemplating suicide sought medical attention a month prior
  - 90% of people who committed suicide suffered from
    - Depression or other mental illness
    - Substance abuse

- Alcohol and Substance Abuse
  - Extensive comorbidity between alcohol/substance abuse and mental disorders/suicide
  - Screening should be a part of every patient history
The Methods and Reasoning Behind Observing Appearance, Behavior, Speech, Language, and Mood During an Examination

Observational Reasoning

- Components of Mental Status Exam
  - Appearance and behavior
  - Speech and language
  - Mood
  - Thoughts and perceptions
  - Cognitive function
  - Higher cognitive function

Observational Reasoning

- Appearance and Behavior
  - Level of consciousness
    - Is the patient awake and alert?
    - Understand your questions?
    - Respond appropriately?
  - Posture and Motor Behavior
    - Patient prefer to lay in bed or walk around?
    - Do posture and activity change with topics under discussion?
Observational Reasoning

- Dress, grooming, and personal hygiene
  - Appropriate to weather and temperature
  - Clean, properly buttoned/zipped

- Facial expression
  - Eye contact
  - Appropriate changes in facial expression

Observational Reasoning

- Patient’s affect – external expression of internal emotion
  - Does it vary appropriately with topics
  - Do emotions vary spontaneously (labile) or are they flat
  - Note patient’s openness and reactions to others

Observational Reasoning

- Speech and Language
  - Quantity – Talkative or relatively silent?
  - Rate – Fast or slow?
  - Loudness – Loud or soft spoken?
  - Articulation of Words
    - Are words spoken clearly?
    - Is there a nasal quality?
Observational Reasoning

- Fluency – Involves rate, flow, melody of speech, and content
- Be alert for abnormalities
  - Gaps in the flow and rhythm of words
  - Disturbed inflections
  - Circumlocutions – using a phrase for a word they can’t remember “what you write with” for “pen”
  - Paraphasias – words are malformed, wrong, or invented

Observational Reasoning

- Mood
  - How is the patient’s overall mood?
  - Does it change quickly or mostly stay the same?
  - How long has it lasted?
  - Can be an indicator for depression or bipolar disorder
  - Reports from friends or relatives can be a great help

The Assessment and Techniques of Determining Thought, Perception, and Cognition, to Include: Memory, Attention, Information and Vocabulary, Calculations, Abstract Thinking, and Constructional Ability
Thoughts and Perceptions

- Thought processes
  - Assess the logic, relevance, organization, and coherence of the patient’s thought process
  - Patient’s speech is a window into their mind
  - Listen for patterns that suggest disorders of thought process

- Thought content
  - Follow leads as they occur
  - Example – “You mentioned that your neighbor is responsible for your entire illness. Can you tell me more?”
  - You may need to ask more specific questions, be tactful, again it’s not an interrogation

- Perceptions
  - Illusions – Misinterpretations of real stimuli
  - Hallucinations – Sensory perceptions in the absence of relevant stimuli
  - Example – “When you heard the voice, what did it say? How did it make you feel?”
Thoughts and Perceptions

- **Insight**
  - "What brings you to the hospital?"
  - Note if the patient is aware that a particular mood, thought, or perception is abnormal

- **Judgment**
  - Note if decisions or actions are based on reality, impulse, or wish fulfillment
  - Keep in mind the age and culture of the patient

Cognitive Function

- **Orientation**
  - Person – Patient’s name or the names of friends/relatives
  - Place – Where are they right now
  - Time – Time of day or date and year

Cognitive Function

- **Attention**
  - Spelling backward
    - Say a 5 letter word, then spell it for them
    - e.g., say “W-O-R-L-D”
    - Ask the patient to spell it backwards
  - Serial 7
    - “Start from 100 and count backwards by 7”
    - Stop them after 6 subtractions
Cognitive Function

- Remote memory – Ask about:
  - Birthdays
  - Social security numbers
  - Names of schools
  - Bank account numbers/ pin number

- Recent memory
  - Ask about things that happened today
  - Make sure you confirm the answer

Cognitive Function

- New learning ability
  - Ask the patient to remember 3 or 4 words
    - e.g., ball, diamond, tree
    - Have the patient to repeat them back to you to make sure they understand
  - Go on to next part of the exam
  - 3 to 5 min later ask the patient to repeat the words back to you
  - Note the speed and accuracy of the response

Higher Cognitive Functions

- Information and learning
  - Gives a rough estimate of intelligence level
  - Ask about work, hobbies, books, current events, anything they are interested in
  - Ask simple questions first, then more difficult ones
  - Note patient’s vocabulary, grasp of knowledge, and complexity
Higher Cognitive Functions

- Calculating ability
  - Test patient’s ability to do arithmetic (math)
  - Starting at simple math (4+7), and going on to more complex (25x6)

- Abstract thinking
  - Proverbs — “what does it mean when people say, A stitch in time saves nine?”
  - Similarities — “How are an apple and an orange alike?”

Higher Cognitive Functions

- Constructional ability
  - Have the patient copy each figure in order of complexity
  - These diamond would be rated as poor, fair, and go

The Assessments and Techniques of the Mini-Mental Status Examination and How to Record Behavior and Mental Status Exam Findings
Mini-Mental Status Examination

- Test for cognitive dysfunction or dementia
  - Orientation to time
    - “What is the date”
  - Registration
    - “I am going to say three words; you say them back after I stop; ball, diamond, tree”
  - Reading
    - “Please read this and do what it says”
    - Hand them a sheet that says, “close your eyes”

Record your Findings

- Example:
  - “The patient is alert, well-groomed, and cheerful. Speech is fluent and words are clear. Thought processes are coherent, insight is good. The patient is oriented to person, place, and time. Serial 7s accurate; recent and remote memory intact. Calculations intact.”

Questions?
Terminal Learning Objective

- Action: Communicate knowledge of “Examining Behavior and Mental Status”
- Condition: Given a lecture in a classroom environment
- Standard: Received a minimum score of 75% on the written exam IAW course standards

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