CHAPTER 3
Assessment

Introduction

Psychiatric assessment has three main goals:

- *To make a diagnosis*. Despite its limitations (see Chapter 2), diagnosis is central to the practice of psychiatry, since it provides the basis for rational, evidence-based approaches to treatment and prognosis (Craddock and Mynors-Wallis, 2014). A major goal of most assessments, especially those of new patients, is therefore to allow a diagnosis or differential diagnosis to be made. This in turn requires that the symptoms and signs of psychiatric disorder (see Chapter 1) can be elicited, and their diagnostic significance appreciated.
- *To understand the context of the diagnosis*. The psychiatrist needs to have sufficient information about the patient's life history, current circumstances, and personality. This is necessary to try and understand why the disorder has occurred in this person at this time; it also has a major bearing on decisions about management and prognosis.
- *To establish a therapeutic relationship*. The psychiatrist must ensure that the patient feels able and willing to give an accurate and full history. Without this skill, the necessary diagnostic information is unlikely to be obtained. Thus, establishment of a therapeutic relationship is essential if the patient is to engage fully in discussions about management, and to adhere to any treatment decisions which are agreed upon.

The *process* of psychiatric assessment, also known as the *psychiatric interview*, can be broken down into the following stages:

- *Preparation*. This includes having the interviewing skills necessary to achieve the above goals, acquiring as much background information as possible (e.g. the reason for referral, and whether informants are available) to help guide the assessment and identify areas for particular focus, and anticipating whether the interview may need to be adapted (e.g. owing to language difficulties, or a shortage of time).
- *Collecting the information*. This is usually addressed by means of a series of headings covering the psychiatric history, mental state examination, and other components, as described below.
- *Evaluating the information* to arrive at a diagnosis or differential diagnosis. This is the hardest part of the process to describe to readers new to psychiatry, as it requires knowledge of the diagnostic significance of particular symptoms and symptom combinations. It is therefore suggested that this chapter should be returned to at regular intervals, to refine how

assessments are conducted to match one's developing knowledge and skills.

- *Using the information* to make treatment decisions and form prognostic opinions.
- *Recording and communicating the information collected, and the conclusions drawn*. The information must be shared with other health professionals involved with the care of the patient both now and in the future, and with the patient and their significant others. Various modes of communication are necessary (e.g. with regard to its nature and level of detail) depending on the circumstances of the assessment and the needs of the recipient.

This chapter covers these areas in turn, concentrating on the full initial assessment of a patient by a general adult psychiatrist. It also discusses how this process should be adapted in other circumstances. First, however, the basic process of psychiatric interviewing will be outlined. At the outset, it is worth emphasizing that the description of assessment in textbooks tends to make the process appear to be a passive, even predetermined, one of extensive data collection. In practice, however, assessment is an active, selective process, in which diagnostic clues are pursued, hypotheses tested, and the focus of questioning adapted to the particular circumstances. This 'dynamic' aspect of assessment can only be learned from practical experience. It also requires a working knowledge of the main psychiatric syndromes for the significance of specific symptoms or history items that emerge during the assessment to be appreciated. It was for this reason that the preceding chapter covered psychiatric classification.

It is assumed that the reader is already competent in medical history-taking and physical examination, and these topics are considered only briefly.

Psychiatric interviewing

Preparing for the assessment

Psychiatric assessments are conducted in many settings. The following recommendations should be followed as far as is practicable, but they cannot always be achieved in their entirety. In some locations, such as an Accident and Emergency department, the setting may be far from ideal. Nevertheless, it is important to do what is possible to ensure safety and confidentiality, and to put the patient at ease.

Before starting the interview, it is always worth finding out what is already known about the patient and the circumstances in which the assessment has come about. This will often be in the form of a referral letter from another doctor, or there may be notes available from previous assessments. This information will reveal areas of enquiry that may require particular emphasis, and may modify the diagnosis that is subsequently made. Equally, every assessment should, of course, begin with an open mind (not least since prior diagnoses may be incorrect, or the present presentation may be different).

Only a small minority of patients are potentially dangerous, but the need for precautions should be considered before every interview. The interviewer should always:

- make sure that another person knows where and when the interview is taking place and how long it is expected to last. This is especially relevant to interviews in the community;
- ensure that help can be called if it is needed. In hospital, check for an emergency call button and its position, and otherwise try to arrange for another person to be within earshot;
- ensure that neither the patient nor any obstruction is between you and the exit;
- remove from sight any objects that could be used as weapons.

If the risk is thought to be high, or if these requirements cannot be met, it may be necessary to defer the interview.

Starting the assessment

The psychiatrist should welcome the patient by name, give their own name and status, and explain in a few words the reason for and purpose of the assessment. If the patient is being seen at the request of another doctor, the interviewer should indicate this. If the patient is accompanied, the interviewer should greet the companion(s) and explain how long they should expect to wait and whether they will be interviewed. It is usually better to see the patient alone first, provided that he is able to provide an adequate history. The interviewer should explain that notes will be taken, and that these

will be confidential. If the interview is for the purposes of a report to an outside agency (e.g. a medicolegal report), this should be made clear. The general structure of the interview should be explained, and the time available stated; the latter is not only a matter of courtesy but is also valuable if the psychiatrist later needs to interrupt the patient, or ask him to give more concise answers, to ensure the assessment can be completed.

The patient should be comfortable and the interviewer should not face the patient directly but arrange his chair at an angle. If possible, the interviewer should also avoid sitting at a much higher level. Whenever possible, the interviewer should make notes (whether on paper or electronically) during the interview, as writing up an assessment afterwards is time-consuming and not always wholly accurate. However, it is usually better to delay note-taking for some minutes until the patient feels that he has the interviewer's undivided attention. The patient should be placed at the left side of a right-handed interviewer. With this arrangement, the interviewer can attend to the patient and maintain an informal atmosphere while writing.

The following techniques have been shown to improve the results of the interview (Goldberg *et al.*, 1980). The interviewer should:

- adopt a relaxed posture and appear unhurried—even when time is short;
- maintain appropriate eye contact with the patient and not appear engrossed in note-taking;
- be alert to verbal and non-verbal cues of distress as well as to the factual content of the interview;
- maintain control of the interview if the patient is over-talkative or discursive.

Continuing and completing the assessment

The interview should begin with an open question (one that cannot be answered with a simple 'yes' or 'no'), such as 'Tell me about your problems or difficulties'. The patient should be allowed to talk freely for several minutes before further questions are asked. As the patient describes their problems, the interviewer should observe their responses and manner—for example, whether they are reticent or unduly circumstantial.

The first step is to obtain a clear account of the patient's problems. It is important to separate symptoms from their consequences, and from other life problems that the patient may want to discuss. For example, a patient may have low mood, sexual difficulties, or financial worries as the presenting complaint. In each case the common denominator may prove to be depression, but it will require your assessment to discover this. Your priority at the start is to focus upon the symptoms and signs of psychiatric disorder, leaving the other kinds of problem until later.

From the start, consider the possible diagnoses and, as the interview progresses, select questions to confirm or reject these diagnoses. For example, if the patient mentions hearing voices, this immediately raises the possibility of schizophrenia and requires that, at some stage in the assessment, the other cardinal features of the disorder are sought, and their presence or absence clearly noted. The interviewer also considers what information is relevant to prognosis and treatment. Thus, as noted earlier, interviewing is not simply the asking of a routine set of questions. It is an active and iterative process in which the focus of attention is directed by hypotheses formed from the information already elicited, and modified repeatedly as more information is collected. This active process of interviewing is particularly necessary when time is short and when immediate treatment decisions must be made. Obviously, as the interviewer gains confidence and acquires more psychiatric knowledge, he or she becomes better at thinking of possible diagnoses, and proceeding in a way that rules them in or out more rapidly and convincingly.

It is generally better to establish clearly the nature of the symptoms before asking how and when they developed. If there is any doubt about the nature of the symptoms, the patient should be asked to describe specific examples. When all of the presenting symptoms have been explored sufficiently, direct questions are asked about others that have not come to light but which may be relevant. In doing this, the interviewer uses his knowledge of psychiatric syndromes to decide what further questions to ask. For example, a person who complains of feeling depressed would be asked about thoughts concerning the future, and about suicidal ideas. If suicidal thoughts are acknowledged, further specific questions should be asked. Also ask about the impact that the symptoms have had on the patient's life, looking for evidence of functional impairment.

The onset and course of the symptoms are clarified next, together with their relationship to any stressful events or physical illness. Considerable persistence may be needed to date the onset or an exacerbation of symptoms accurately. It sometimes helps to ask how the onset related to an event that the patient is likely to remember, such as a birthday. The patient's attempts to cope with the symptoms are noted—for example, increased drinking of alcohol to relieve distress. If treatment has already

been given, its nature, timing, and effects are noted, together with the patient's concordance with it.

The interviewer completes the relevant parts of the full assessment schedule, which is described in later sections of this chapter. When time is adequate, the mental state is usually examined at the end of the interview, together with any relevant physical examination. If time is short, it may be better to examine the mental state after the presenting complaints have been clarified. This can make it easier to select the key points to be asked about in the rest of the history.

Throughout the interview, allow the patient, as far as possible, to describe their problems spontaneously. In this way, unexpected material may be volunteered that might not be revealed by the answers to questions. However, questions may be needed to bring the patient back to the point after a digression, and to elicit specific information—for example, about the relationship between symptoms and stressful events. Whenever possible, the interviewer should use open rather than leading or closed questions (a leading question suggests the answer, whereas a closed question allows only the answers 'yes' or 'no'). Thus, for example, instead of the closed question 'Are you happily married?' the interviewer might ask 'How do you and your wife get on?' When there is no alternative to a closed question, the answer should be followed by a request for an example.

Before ending the interview, it is good practice to ask a general question such as 'Is there anything that I have not asked you about, that you think I should know?' It is also useful to summarize for the patient what you consider to be the key points, to check for any errors of fact, and to see whether the patient agrees with your initial understanding of events.

Box 3.1 summarizes some techniques that promote effective interviewing.

Box 3.1 Some techniques for effective psychiatric assessments

- Help the patient to talk freely. This can be done using open questions, and by non-verbal cues such as nodding, or saying 'Go on' or 'Tell me more about that'
- Keep the patient to relevant topics. Again, non-verbal cues are useful, as well as specific interventions such as 'At this point I'd like to ask you more about how you've been feeling. We can return to your money worries later'
- Make systematic enquiries, but avoid asking so many questions that other, unanticipated issues are not volunteered
- Check your understanding, and that you have enquired about all of the areas the patient thinks are important, by summarizing the key points of the history back to the patient. This step also helps you to begin to formulate your views on the diagnosis and causes
- Be flexible in assessments, with regard to both their length and sequence. Select questions according to the emerging possibilities regarding diagnoses, causes, and plans of action

Interviewing informants

Whenever possible, the patient's history should be supplemented by information from a close relative or another person who knows them well. This is much more important in psychiatry than in the rest of medicine, for several reasons. Some psychiatric patients are unaware of the extent or significance of their symptoms. Others are aware of their problems but do not wish to reveal them—for example, people who misuse alcohol often conceal the extent of their drinking. Patients and relatives may also give quite different accounts of personality characteristics, or have contrasting interpretations of recent events and symptoms. Interviews with a partner or relative are used not only to obtain additional information about the patient's condition, but also to assess their attitudes to the patient and the illness, and often to involve them in the subsequent management plan. In addition, they provide an opportunity to learn what burdens the illness has placed on the partner or relative, and how they have tried to cope. A history from an informant is essential when the patient is unable to give an accurate account of his or her condition (e.g. because of impaired memory). Finally, when it is important to know about the patient's early development or childhood, an interview with a parent is usually the best way to discover the relevant information.

Informants can either be seen separately from the patient, or invited to join the interview. The choice depends on both the assessor's and the patient's preference, but in both instances the patient must give consent. If the patient refuses, explore the reasons for this and explain the difficulties that it will pose. There are a few situations in which the patient's permission is not required before interviewing a relative or other informant—for example, if the patient is a child, or when adult patients are mute or confused. In other cases, the doctor should explain to the patient the reasons for

interviewing the informant, while emphasizing that confidential information given by the patient will not be passed on. If any information needs to be given to a relative—for example, about treatment—the patient's permission should be obtained. Questions from relatives should be dealt with in the same way.

The psychiatrist begins by explaining the purpose of the interview, and may need to reassure the informant. For example, a relative may fear that they will be viewed as responsible in some way for the patient's problems. The interviewer should be sensitive to such ideas and, when appropriate, discuss them in a reassuring way, but without colluding or becoming involved in ways that might conflict with their primary duty to the patient. If the informant has been interviewed separately from the patient, the psychiatrist should not tell the patient what has been said unless the informant has given their permission. This is important even when the informant has revealed something that should be discussed with the patient—for example, an account of excessive drinking.

Sometimes it is necessary to speak to employers, educators, friends, police, or others to collect further information. This should be done only with the patient's permission, unless there are legal or safety issues which override this principle—for example, if the patient is in custody, or if there are grounds for concern that the patient may harm a third party.

The psychiatric history

The main parts of a psychiatric assessment are the *psychiatric history* and the *mental state examination*. The latter covers the symptoms and signs present during the interview, and the former deals with everything else. The assessment is then completed by the physical examination, and sometimes by further investigations. This section covers the psychiatric history, followed by the mental state examination, and then the other aspects of the assessment.

A commonly used scheme for history-taking is given below. For ease of reference, the scheme is presented as a list of headings and items. More details, and some background information to the questions, are provided in the subsequent notes. As noted above, much of the interview is designed to elicit diagnostic symptoms, but other questions are intended to obtain information about the patient's life and circumstances, while the interview as a whole must try to establish the rapport needed to achieve these goals and form the basis for a subsequent therapeutic relationship.

The following scheme is comprehensive and systematic, as an ability to conduct this form of assessment is essential before briefer interviews are attempted. Modification of the interview for use in briefer or specific settings is described later. Moreover, although it is neither possible nor necessary to take a full history on every occasion, the information that has been elicited should always be recorded systematically and in a standard order. This practice helps the interviewer to remember all of the potentially important topics and to add further information later. The practice also makes it easier for colleagues who need to refer to the notes in the future. This order can be followed in the written or electronic record, even when it was not possible to elicit the information in the desired sequence. This and all other entries in the notes should be dated and, whenever possible, signed.

A scheme for history-taking

Information is grouped under the headings shown in Box 3.2. For clarity, this section is written in the style of short notes and illustrative questions. The next section explains why these topics are relevant, and some of the problems that may occur when covering them.

Informant(s)

- Usually the principal informant is the patient. If not, state the reason.
- The name(s), relationship to the patient, and length of acquaintance of any other person(s) interviewed.
- The name of the referrer and the reasons for referral.

History of present condition

Also known as the *history of presenting complaint,* this section is in many ways the core of the interview, usually providing most of the key diagnostic information.

- List the symptoms, with the onset, duration, severity, and fluctuation of each. Quantitative information is valuable. For example, a patient can rate their low mood on a 10-point scale.
- Ask about and record symptoms that might have been expected but which are *not* present (e.g. no

Box 3.2 Outline of the psychiatric history

Name, age, and address of the patient
Name(s) of informant(s) and their relationship to the patient
History of present condition
Family history
Personal history (expanded in Box 3.3)
Past illness
Personality (expanded in Box 3.4)

Box 3.3 Outline of the personal history

Mother's pregnancy and the birth
Early development
Childhood: separations, emotional problems, illnesses, education
Occupations
Relationships and sex
Children
Social circumstances
Substance use
Forensic history

suicidal ideation in a person with low mood; no first-rank symptoms of schizophrenia in a patient with delusions).

- The temporal relationship between symptoms and any physical disorder, or psychological or social problems.
- The nature and duration of any functional impairment caused by the symptoms.
- Any treatment received, and its effects and side-effects.

Family history

- Parents and siblings—age, current state of health or date and cause of death, occupation, personality, quality of relationship with patient. Psychiatric and medical family history.
- When the family history is complex and relevant, summarize it as a family tree.

Personal history

This is a particularly variable section of the history (see Box 3.3). In the case of a young person with a disorder suspected to have origins early in life, it will be important and extensive; for older patients or some other disorders, only limited questioning may be necessary.

- Pregnancy and birth abnormalities (e.g. infections, prematurity, problems with labour).
- Early developmental milestones—walking, talking, etc.
- Childhood—any prolonged separation from the parents, and the patient's reaction to it. Any emotional problems (age of onset, course, and treatment). Any serious illness in childhood.
- Schooling and higher education—type, courses, qualifications, extracurricular achievements, relationships with teachers and other students. Note any experience of bullying (nature, duration, and impact) or school exclusions.
- Occupations—present job (dates, duties, performance, and satisfaction), earlier jobs (list them, with reasons for changes).
- Significant relationships —identity and gender of current partner, duration and nature of relationship. Partner's health and attitude to the patient's illness. Nature and number of previous relationships.
- Sexual history—attitude to sex, any sexual difficulties and their relationship to current symptoms. Knowing how, and how far, to enquire about sexual matters is discussed further on page 42.
- Children—identities, date of any abortions or stillbirths, temperament, emotional development, mental and physical health. Who are the child carers.
- Social circumstances—accommodation, household composition, financial situation.
- Use of alcohol, tobacco, illicit drugs—which ones, when, and how much. Problems arising from substance use.
- Forensic history—arrests, convictions, imprisonment. Nature of the offences, especially with regard to dangerousness. For a few patients, the forensic history is a key part of the assessment (see Chapter 18.

Past psychiatric and medical history

- Past psychiatric illnesses—nature and duration, and their similarity to current episode. Include any

episodes of self-harm. Date, duration, nature, location, and outcome of any treatment.

- Past medical history—illnesses, operations, accidents, and drug treatments.
- Current medication, including over-the-counter medicines and alternative remedies. Any allergic or other adverse reactions.

Personality

By this stage in the interview, the patient's manner and description of their history will have provided some indication about their personality. However, a specific focus is also necessary, covering the domains noted in Box 3.4. Personality can be a relatively difficult area of the history, as outlined below in the section 'Notes on history-taking'.

- Relationships—friendships (few or many, superficial or close, with own or opposite sex), relationships with work colleagues and superiors.
- Use of leisure time—hobbies and interests.
- Predominant mood and emotional tone (e.g. anxious, despondent, optimistic, pessimistic, self-deprecating, overconfident, stable or fluctuating, controlled or demonstrative).
- Character traits (e.g. perfectionist, obsessional, isolated, impulsive, sensitive, controlling).
- Attitudes and standards (e.g. moral or religious; attitude towards health).
- 'Ultimate concern'—what or who matters most in their life?

Notes on history-taking

The scheme outlined above lists the items to be considered when a full history is taken, but has not indicated why these items are important or what sort of difficulties may arise when eliciting them. These issues are discussed in this section, which is written in the form of notes approximating to the headings used above.

Box 3.4 Assessment of personality

Relationships
Leisure activities
Prevailing mood and emotional tone
Character
Attitudes and standards
'Ultimate concern'

The reason for referral

Only a brief statement need be given—for example, 'severe depression with somatic symptoms'. The reason for referral usually, but not always, proves to be the main focus of the interview. Check that the patient has the same understanding as to why they have been referred. If not, this in itself is useful information. For example, the patient may disagree that they are depressed, believing that their somatic symptoms are due to cancer. This may affect their willingness to engage fully in the assessment or accept the treatment for depression that is subsequently recommended.

History of present condition

Because it is central to the assessment, it is always worth spending sufficient time on this part of the history to identify the key elements. There will often be several such symptoms, and each should be characterized fully to appreciate its diagnostic significance. Record the severity and duration of each symptom, how and when it began, what course it has taken (increasing or decreasing, constant or intermittent), and what factors affect it. Indicate which symptoms co-vary. As noted above, record any symptoms or features that would have diagnostic significance but which are not present (e.g. lack of anhedonia in a person complaining of low mood).

Note any treatments that have been given during this episode, the response, and any adverse effects. If a drug was ineffective, ask whether the patient took it regularly and at the required dosage.

Family history

A family history of psychiatric disorder may indicate genetic or environmental influences. A genetic contribution is more likely for some disorders than for others, and increases as more relatives are affected. Although family environment has, as a rule, proved to be less important than genes in explaining family history (see Chapter 5), knowledge about the family's circumstances remains part of the basic information required for understanding the origin and presentation of the patient's problems.

Recent events in the family may have been stressful to the patient—for example, the serious illness or divorce of a family member. Events in the family may throw light on the patient's concerns. For example,

the death of an older sibling from a brain tumour may partly explain a patient's extreme concern about headaches.

Personal history

Pregnancy and birth

Events in pregnancy and delivery are most likely to be relevant when the patient is learning disabled, although they are also risk factors for several psychiatric disorders which have their onset in childhood, adolescence, or early adulthood. An unwanted pregnancy may be followed by a poor relationship between mother and child.

Child development

Few patients know whether they have passed through developmental stages normally. Failure to do so may be a sign of learning disability and also a risk factor for later disorders such as schizophrenia. However, this information is usually more important if the patient is a child or adolescent, in which case the parents are likely to be available for interview. The effects of separation from the mother vary considerably, and depend in part on the age of the child, the duration, and the reason for separation. Questioning about the child's emotional development provides information about early temperament and emerging personality, and abnormalities or delays may serve as risk factors for, or early signs of, later problems. However, childhood behavioural characteristics as a rule are weak predictors of adult disorders, and only require detailed consideration when assessing children and adolescents. Assessment in child psychiatry is covered in Chapter 16.

Education

The school record gives an indication of intelligence, achievements, and social development. Ask whether the patient made friends and got on well with teachers, and about success at games and other activities. Bullying is a risk factor for later psychological difficulties, and other negative events such as exam failures may be important stressful memories. Similar questions are relevant to higher education.

Occupational history

Information about the present job helps the interviewer to understand the patient's current abilities, interests, and financial and social circumstances, and may be a potential source of stress. A list of previous jobs and reasons for leaving is relevant to the assessment of personality. If the status of jobs has declined, this may reflect chronic illness or substance misuse.

Marital history

This heading includes all enduring intimate relationships. Ask about the current and any previous lasting relationships, preferably phrased in a way that does not assume the gender of the partner(s). Frequent broken relationships may reflect abnormalities of personality. The partner's occupation, personality, and state of health are relevant to the patient's circumstances and, like the nature of the relationship itself, will affect the partner's role in the care and management of the patient.

Sexual history

The interviewer should use common sense when deciding how much to ask the individual patient, depending on the response to initial questions, demographic factors (such as age and relationship status), and the nature of the presenting complaint. Usually the interviewer is concerned to establish generally whether the patient's sexual life is in any way involved in their current difficulties, whether as a cause, a correlate, or a consequence. If so, then more detailed enquiry is appropriate.

Judgement must also be used about the optimal timing and amount of detail of questioning about childhood abuse, especially sexual abuse. Unfortunately, such past experiences are sufficiently common to merit enquiry. However, often it may not be appropriate to raise the matter in a first interview, unless prompted by the patient or in the light of background information available to the interviewer. The decision to raise the topic also depends on the clinical suspicion, and the time and expertise available to the interviewer. Sensitivity is also necessary when deciding what information to record and with whom it should be shared.

Assessment of sexual history and sexual disorders is considered further in Chapter 13.

Children

Pregnancy, childbirth, miscarriages, and terminations are events that are sometimes associated with adverse psychological reactions. Information about the patient's children is relevant to present worries and the pattern and characteristics of family life.

Consideration of the welfare and needs of any children is always integral to an assessment, as their health and care may be adversely affected by the parent's illness or its treatment. For example, if a seriously depressed woman has a young baby, due steps to ensure the baby's wellbeing are essential, and the situation may influence decisions about the mother's care (e.g. about medication if she is breastfeeding, and about hospital admission). In turn, any concerns about the care or welfare of children

should be clearly recorded, and followed by appropriate discussions and, if necessary, interventions. Such considerations are increasingly covered by guidelines, protocols, and legislation (which differ from country to country), and the reader is advised to keep up to date in this respect.

Social circumstances

Questions about housing, finances, and the composition of the household help the interviewer to understand the patient's circumstances. Assets and resources (including potential carers) are assessed, as well as problems and sources of stress. There can be no general rule about the amount of detail to elicit, and this must be guided by common sense.

Substance use and misuse

This includes past as well as present consumption of alcohol and other substances, and the impact of their use on the patient's health and life. Misuse of prescribed drugs should also be considered. The patient's answers may be evasive or misleading, and may need to be checked with other informants and sources of information (e.g. urine screens, blood tests). See Chapter 20 for further information about interviewing in this area.

Past psychiatric and medical history

In many instances, a patient being assessed will have a past psychiatric history. A previous diagnosis increases the probability that the current diagnosis will prove to be similar, but it is important always to keep an open mind, as the diagnosis may have changed, or the previous diagnosis may have been incorrect. Patients or relatives may be able to recall the general nature of the illness and treatment, but it is nearly always appropriate to request information from others who have treated the patient.

The medical history is also important (Phelan and Blair, 2008). A medical disorder or its treatment may be directly related to the presentation (e.g. a recurrence of hypothyroidism presenting with lethargy, or mania induced by corticosteroids), but may also be indirectly relevant (e.g. via the psychosocial effects of chronic ill health, or as a sign of somatoform disorder).

Assessment of personality

This is important because:

- it helps the interviewer to understand the patient as a person, and to put their current difficulties into context;
- personality traits can be a risk factor for psychiatric disorders (e.g. obsessionality increases the risk of developing a depressive disorder);
- personality traits can colour the presentation of psychiatric disorder;
- personality can be disordered, and personality disorder may be a differential or comorbid diagnosis.

Aspects of personality can be assessed by asking for a self-assessment, by asking others who know the patient well, and by observing behaviour. Good indications of personality can often be obtained by asking how the patient has behaved in particular circumstances, especially at times when social roles are changing, such as when starting work, or becoming a parent. However, mistakes can arise from paying too much attention to the patient's own assessment of their personality, especially during a single interview. Some people give an unduly favourable or unfavourable account. For example, antisocial people may conceal the extent of their aggressive behaviour or dishonesty and, conversely, depressed patients often judge themselves negatively and critically. When assessing personality from behaviour at interview, take into account the artificiality of the situation and the anxiety that it may provoke. These factors mean that it is essential to interview other informants whenever possible, and to avoid drawing premature or unjustified conclusions about personality. Personality tests are now rarely used in clinical practice, but interview schedules for diagnosis of personality disorder are widely used in forensic and other settings (see Chapters 15 and 18).

Relationships

Is the patient shy or do they make friends easily? Are their friendships close and are they lasting? Leisure activities can throw light on personality, by reflecting the patient's interests and preference for company or solitude, as well as their levels of energy and resourcefulness.

Mood and emotional tone

Ask whether the patient is generally cheerful or gloomy and whether they experience marked changes of mood, and, if so, how quickly these moods appear, how long they last, and whether they follow life events. Information about prevailing mood and mood swings may also reveal evidence suggestive of mood disorder, which can be enquired about further.

Character

Common sense and experience will indicate the depth and focus of character assessment that are needed for

each patient. If the patient (or informant) has difficulty describing their character with an open question, offer them options—for example, 'Would you call yourself an optimist or a pessimist? A loner or a socialite?' Do not focus entirely on negative attributes, but ask about positive ones, including resilience in the face of adversity. This is important not just to gain a balanced impression, but because strengths are usually better targets for intervention if personality proves to be therapeutically relevant.

For details on the assessment of personality, see Cloninger (2009). The assessment of personality disorder has been described by Tyrer *et al.* (2015), and is discussed further in Chapter 15.

The mental state examination

The history records symptoms up to the time of the interview. The mental state examination is concerned with symptoms, signs, and behaviour during the interview, and is usually conducted after the history. Although the distinction is traditional, and conceptually useful, in practice the boundary between the history and the mental state examination is somewhat blurred. In particular, very recent symptoms and signs are often recorded in the mental state examination, even if the phenomena are not experienced or elicited during the interview. The mental state examination is also sometimes used to elicit and record symptoms and signs which, for whatever reason, have not been covered previously in the interview (e.g. whether the patient is suicidal). For a history of the mental state examination, see Huline-Dickens (2013).

The mental state examination uses a standard series of headings under which the relevant phenomena, or their absence, are recorded (see Box 3.5). The symptoms and signs referred to in the following account are described in Chapter 1 and, with a few exceptions, are not repeated. Mental state examination is a skill that should be learned by watching experienced interviewers and by practising repeatedly under supervision, as well as by reading. The mental state examination provides, in conjunction with the history of the present condition, most of the key diagnostic information. The ability to carry out and record an accurate and comprehensive mental state examination is therefore a core skill required by all psychiatrists and other mental health professionals. It is also specified by the United Kingdom General Medical Council as a requirement for all newly qualified doctors (General Medical Council, 2009).

Box 3.5 Mental state examination headings

Appearance and behaviour
Speech
Mood
Thoughts
Perceptions
Cognitive function
Insight

Appearance and behaviour

General appearance

Much diagnostically useful information can be obtained from the patient's appearance and behaviour. Indeed, as discussed later, experienced clinicians often make provisional diagnoses within minutes of meeting a patient, relying heavily on this information. The process of observation starts from the first moment you see the patient. For example, what is their manner and behaviour in the waiting room? Are they sitting quietly, pacing around, or laughing to themselves? When greeted, what is their response? As they walk towards the interview room, is there evidence of parkinsonism or ataxia? Note their general attire. A dirty, unkempt appearance may indicate self-neglect. Manic patients often dress brightly or incongruously. Occasionally an oddity of dress may provide the clue to diagnosis—for example, a rainhood worn on a dry day may be the first evidence of a patient's belief that rays are being shone on their head by persecutors. An appearance suggesting recent weight loss should alert the observer to the possibility of depressive disorder, anorexia nervosa, or physical illness.

Facial appearance and emotional expression

The facial appearance provides information about mood. In depression, the corners of the mouth are turned down, and there are vertical furrows on the brow. Anxious patients have horizontal creases on

the forehead, widened palpebral fissures, and dilated pupils. Facial expression may reflect elation, irritability, or anger, or the fixed 'wooden' expression due to drugs with parkinsonian side-effects. The facial appearance may also suggest physical disorders (e.g. thyrotoxicosis).

Posture and movement

Posture and movement also reflect mood. A depressed patient characteristically sits with hunched shoulders, with the head and gaze inclined downwards. An anxious patient may sit on the edge of their chair, with their hands gripping its sides. Anxious people and patients with agitated depression may be tremulous and restless—for example, touching their jewellery or picking at their fingernails. Manic patients are overactive and restless. Other abnormalities of movement include tardive dyskinesia (see page 729) and the motor signs seen mainly in catatonic schizophrenia (see page 256).

Social behaviour

The patient's social behaviour and interactions with the interviewer are influenced by their personality and by their attitude to the assessment, as outlined above. However, their behaviour can also be influenced by psychiatric disorder, so it provides another potential source of diagnostic information. Manic patients tend to be unduly familiar or disinhibited, whereas those with dementia may behave as if they were somewhere other than in a medical interview. A person with schizophrenia may be withdrawn and preoccupied, whilst a person with antisocial personality disorder may behave aggressively. If the patient's social behaviour is highly unusual, note what exactly is unusual, rather than simply using imprecise terms such as 'bizarre'.

Speech

Speech and thoughts are recorded in different parts of the mental state examination, even though it is only through speech that thoughts become known to the interviewer. By convention, the 'speech' section covers the rate, quantity, volume, and flow of speech, and any delays in responding to questions or apparent difficulties producing or articulating speech. The content of speech, in the sense that it reveals the patient's thoughts (e.g. preoccupations about death, grandiose delusions) is deferred until the 'Thoughts' section.

Rate and quantity

Speech may be unusually fast and increased in amount, as in mania ('*pressure of speech*'), or slow, sparse, and monotonous, as in depression. Depressed or demented patients may pause for a long time before replying to questions, and then give short answers, producing little spontaneous speech. The same may be observed among shy people or those of low intelligence.

Difficulties with speaking

If the patient is having problems finding or articulating words, consider the possibility of dysphasia or dysarthria. For further details, see Box 3.6 and consult a neurology textbook (e.g. Kaufman and Milstein, 2017).

Neologisms

Neologisms are private words invented by the patient, often to describe morbid experiences. If the interviewer is uncertain whether a word is a neologism, ask the patient to repeat and spell the word, and explain its meaning.

Flow of speech

Abnormalities in the flow of speech may simply reflect an anxious, distracted patient, or one of low intelligence. More significantly, such abnormalities may be evidence of disturbances in the stream or form of thoughts. For example, sudden interruptions may indicate thought blocking, and rapid shifts from one topic to another suggest flight of ideas. For a description of these features, see Chapter 1. It can be difficult to be certain about these abnormalities; if possible, write down a representative example.

Mood

Conventionally, the mood section includes recording of other emotions such as anxiety, and also related phenomena, including suicidal thoughts. The phenomenology of mood and its disorders are discussed in more detail in Chapters 9 and 10.

Depression and mania

The assessment of mood begins with the observations of behaviour described already, and continues with direct questions such as 'What is your mood like?' or 'How are you in your spirits?' To assess depression, questions should be asked about a feeling of being about to cry (actual tearfulness is often denied), pessimistic thoughts about the present, hopelessness about the future, and guilt about the past. Suitable questions are 'What do you

Box 3.6 The neuropsychiatric examination

Language abilities

Dysarthria is difficulty in the production of speech by the speech organs. **Dysphasia** is partial failure of language function of cortical origin; it can be receptive or expressive. Testing for dysarthria can be done by giving difficult phrases such as 'West Register Street' or a tongue twister.

Receptive dysphasia can be detected by asking the patient to read a passage of appropriate difficulty or, if they fail in this, individual words or letters. If they can read the passage, they are asked to explain it. Comprehension of spoken language is tested by asking the patient to listen to a spoken passage and explain it (first checking that memory is intact) or to respond to simple commands (e.g. to point at named objects).

Expressive dysphasia is detected by asking the patient to name common objects such as a watch, key, and pen, and some of their parts (e.g. the face of a watch), and parts of the body. The patient is also asked to talk spontaneously (e.g. about hobbies) and to write a brief passage, first to dictation, and then spontaneously, on a familiar topic (e.g. the members of the family). A patient who cannot do these tests should be asked to copy a short passage.

Language disorders point to the left hemisphere in right-handed people. In left-handed patients localization is less certain, but in many it is still the left hemisphere. The type of language disorder gives some further guide to localization. Expressive dysphasia suggests an anterior lesion, receptive dysphasia suggests a posterior lesion, mainly auditory dysphasia suggests a lesion towards the temporal region, and mainly visual dysphasia suggests a more posterior lesion.

Construction abilities

Apraxia is inability to perform a volitional act even though the motor system and sensorium are sufficiently intact for the person to do so. Apraxia can be tested in several ways.

- **Constructional apraxia** is tested by asking the patient to draw simple figures (e.g. a bicycle, house, or clock face).
- **Dressing apraxia** is tested by asking the patient to put on some of their clothes.
- **Ideomotor apraxia** is tested by asking the patient to perform increasingly complicated tasks to command, usually ending with a three-stage sequence such as: (1) touch the right ear with (2) the left middle finger while (3) placing the right thumb on the table.

Apraxia, especially if the patient fails to complete the left side of figures or dressing on the left side, suggests a right-sided lesion in the posterior parietal region. It may be associated with other disorders related to this region, namely sensory inattention and anosognosia.

Agnosia is the inability to understand the significance of sensory stimuli even though the sensory pathways and sensorium are sufficiently intact for the patient to be able to do so. Agnosia cannot be diagnosed until there is good evidence that the sensory pathways are intact and consciousness is not impaired.

- **Astereognosia** is failure to identify three-dimensional form; it is tested by asking the patient to identify objects placed in their hand while their eyes are closed. Suitable items are keys, coins of different sizes, and paper clips.
- **Atopognosia** is inability to locate the position of an object on the skin.
- In **finger agnosia** the patient cannot identify which of their fingers has been touched when their eyes are closed. Right–left confusion is tested by touching one hand or ear and asking the patient which side of the body has been touched.
- **Agraphognosia** is failure to identify letters or numbers 'written' on the skin. It is tested by tracing numbers on the palms with a closed fountain pen or similar object.
- **Anosognosia** is failure to identify functional deficits caused by disease. It is seen most often as unawareness of left-sided weakness and sensory inattention.
- **Agnosias** point to lesions of the parietal association cortex posterior to the primary somatosensory cortex. Lesions of either parietal lobe can cause contralateral astereognosia, agraphognosia, and atopognosia. Sensory inattention and anosognosia are more common with right parietal lesions. Finger agnosia and right–left disorientation are said to be more common with lesions of the dominant parietal region.

think will happen to you in the future?' or 'Have you been blaming yourself for anything?' Questions about elevated mood correspond to those about depression—for example, 'How are you in your spirits?' followed, if necessary, by direct questions such as 'Do you feel in unusually good spirits?' Note that the mood in mania can be irritable as well as cheerful. It can be useful to ask the patient to rate their current mood on a numerical or other scale.

A distinction is sometimes drawn between 'objective' and 'subjective' mood. The latter is the patient's view of their own mood; the former refers to the interviewer's conclusion based upon their observation of the patient during the interview and the responses to their questions. On occasion the two may differ—for example, a severely depressed person may deny low mood. It is important therefore to record the presence of the various symptoms and signs of depression (or mania) during the mental state examination.

Both depressed and elevated mood, if clinically significant, are accompanied by other features of depression and mania, respectively—for example, anhedonia, tiredness, or poor concentration in depression. In practice, therefore, it is common to extend this part of the mental state examination to include questioning about other diagnostic features of mood disorder, if these have not been asked about already. Whether the interviewer chooses to record them in the notes under this heading or to insert them into the relevant part of the history is a matter of personal preference and convenience.

Fluctuating and incongruous mood

As well as assessing the prevailing mood, the interviewer should ascertain how mood varies. When mood varies excessively, it is said to be *labile*—for example, the patient appears dejected at one point in the interview but quickly changes to a normal or unduly cheerful mood. Any lack of emotional response, sometimes called blunting or flattening of affect (see page 5), should also be noted.

Normally, mood varies during an interview in parallel with the topics that are being discussed. The patient appears sad while talking about unhappy events, angry while describing things that have irritated them, and so on. When the mood is not suited to the context, it is recorded as *incongruent*—for example, if the patient giggles when describing the death of their mother. Before concluding that such behaviour reflects an incongruous mood, consider whether it could be a sign of embarrassment or an effort to conceal distress.

Suicidal ideation

Some inexperienced interviewers are wary of asking about suicide due to fear that they may suggest it to the patient. There is no evidence to warrant this caution, and an explicit assessment of suicide risk should be part of every mental state examination. Nevertheless, questioning should be handled sensitively and in stages, starting with open questions such as 'Have you ever thought that life is not worth living?' and, if appropriate, going on to ask 'Have you ever wished that you could die?' or 'Have you ever considered any way in which you might end your life?' and then leading on to direct questioning about current suicidal intent or plans. The interviewer may also be concerned that they will not be able to cope if the patient does admit to being suicidal. A basic training in this topic, and knowledge of self-harm and suicide, should preclude these worries. Questions about suicide are considered further on page 000.

Anxiety

Anxiety is assessed both by asking about subjective feelings and by enquiring about the physical symptoms and cognitions associated with anxiety, as well as by observation. For example, the interviewer should start with a general question such as 'Have you noticed any changes in your body when you feel upset?' and then go on to enquire specifically about palpitations, dry mouth, sweating, trembling, and the various other symptoms of autonomic activity and muscle tension. Such features may also be apparent during the interview. To detect anxious thoughts, the interviewer can ask 'What goes through your mind when you are feeling anxious?' Possible replies include thoughts of fainting or losing control. Many of these questions overlap with enquiries about the history of the disorder.

Depersonalization and derealization

These are usually symptoms of anxiety disorders, but occasionally they are diagnosed as a separate disorder (see page 656). Their importance in the mental state examination is largely due to the fact that they are easily mistaken for psychotic symptoms and must be distinguished from them. Patients who have experienced depersonalization and derealization find them difficult to describe, and patients who have not experienced them may say that they have done so because they have misunderstood the questions. Try to obtain specific examples of the patient's experiences. It is useful to begin by asking 'Do you ever feel that things around you are unreal?' and 'Do you ever feel unreal or that part of your body is unreal?' Patients with derealization often

describe things in the environment as seeming artificial and lifeless. Patients with depersonalization may say that they feel detached, unable to feel emotion, or as if they are acting a part.

Thoughts

In this section, any predominant *content* of the person's thoughts can first be noted. For example, there may be a preoccupation with persecutory themes, negative or self-deprecating responses to questions, or a repeated return of the conversation to diet and body shape. This information may signify a delusional disorder, depression, and an eating disorder, respectively, and indicate areas for further questioning. However, the main purpose of this section is to determine the *nature* of the patient's thoughts, and in particular to identify obsessions and delusions.

Thinking can also be abnormal in terms of the flow of thoughts, and the links from one topic to another, called *formal thought disorder*. This was introduced in Chapter 1 (see page 15).

Obsessions

Obsessions were described on page 13. An appropriate question is 'Do any thoughts keep coming into your mind, even though you try hard to stop them?' If the patient says 'Yes', they should be asked for an example. Patients may be ashamed of obsessional thoughts, especially those about violence or sexual themes, so persistent but sympathetic questioning may be required. Before recording thoughts as obsessional, the interviewer should be certain that the patient accepts them as their own (and not implanted by an outside agency).

Compulsions

Many obsessional thoughts are accompanied by compulsive acts (see page 14). Some of these can be observed directly (although rarely during the interview), but others are private events (e.g. repeating phrases silently), and are detected only because they interrupt the patient's conversation. Appropriate questions are 'Do you have to keep checking activities that you know you have completed?', 'Do you have to do things over and over again when most people would have done them only once?', and 'Do you have to repeat exactly the same action many times?' If the patient answers 'Yes' to any of these questions, the interviewer should ask for specific examples.

Delusions

A delusion cannot be asked about directly, because the patient does not recognize it as differing from other beliefs. Because of the difficulty that this poses for the interviewer, and the diagnostic significance of delusions, these were described in detail in Chapter 1.

The interviewer may be alerted to the possibility of delusions by information from other people or by events in the history. When searching for delusional ideas, it is useful to begin by asking what might be the reason for other symptoms or unpleasant experiences that the patient has described. For example, a patient who says that life is no longer worth living may be convinced that he is thoroughly evil and that his internal organs are already rotting away. Some patients hide delusions skilfully, and the interviewer needs to be alert to evasions, changes of topic, or other hints that information is being withheld. However, once the delusion has been uncovered, patients often elaborate on it without much prompting.

When ideas are revealed that could be delusional, the interviewer needs to determine whether they meet the criteria for a delusion (see page 9). First, ascertain how strongly they are held. Achieving this without antagonizing the patient requires patience and tact. The patient should feel that they are having a fair hearing. If the interviewer expresses contrary opinions to test the strength of the patient's beliefs, their manner should be enquiring rather than argumentative. The next step is to decide whether the beliefs are culturally determined convictions rather than delusions. This judgement may be difficult if the patient comes from a culture or religious group whose attitudes and beliefs are not known to the interviewer. In such cases any doubt can usually be resolved by finding an informant from the same country or religion, and by asking this person whether others from the same background share the patient's beliefs.

Some types of delusion, which are characteristic of schizophrenia and included in the list of *first rank symptoms* (see page 255), present particular problems of recognition:

- *Delusions of thought broadcasting* must be distinguished from the belief that other people can infer a person's thoughts from his expression or behaviour. When eliciting such delusions an appropriate question is 'Do you ever feel that other people know what you are thinking, even though you have not spoken your thoughts aloud?' If the patient says 'Yes', the interviewer should ask how other people know this. (Some patients answer 'Yes' when they mean that others can infer their thoughts from their facial expression.)

- *Delusions of thought insertion*. A suitable question is 'Have you ever felt that some of the thoughts in your mind were not your own but were put there from outside?' A corresponding question about *delusions of thought withdrawal* is 'Do you ever feel that thoughts are being taken out of your head?' In each case, if the patient answers 'Yes', detailed examples should be sought.
- *Delusions of control* (passivity of thought) present similar difficulties. It is appropriate to ask 'Do you ever feel that some outside force is trying to take control of you?' or 'Do you ever feel that your actions are controlled by some person or thing outside you?' Some patients misunderstand the question and answer 'Yes' when they mean that they have a religious or philosophical conviction that man is controlled by God or some other agency. Others think that the questions refer to the experience of being 'out of control' during extreme anxiety, while some say 'Yes' when in fact they have experienced auditory hallucinations commanding them to do things. Therefore positive answers should be followed by further questions to eliminate these possibilities.

Finally, the reader is reminded of the various categories of delusion described in Chapter 1 (see page 10). The interviewer should also distinguish between primary and secondary delusions, and be alert for the (rare) experiences of delusional perception and delusional mood. These issues only need to be addressed when there is already clear evidence of a psychosis, when they are useful in distinguishing schizophrenia from other psychotic disorders.

Perceptions

When asking about hallucinations, as with delusions, enquiries should be made tactfully to avoid distressing the patient and to encourage them to elaborate on their experiences without being ridiculed. Questions can be introduced by saying 'Some people find that, when their nerves are upset, they have unusual experiences.' This can be followed by enquiries about hearing sounds or voices when no one else is within earshot. Whenever the history makes it relevant, corresponding questions should be asked about visual hallucinations and those in other modalities. Conversely, in assessments where there has been no previous evidence of psychosis at all, it may be appropriate to omit assessment of them altogether.

Auditory hallucinations

If the patient describes auditory hallucinations, certain further questions are required depending on the type of experience, because of their diagnostic significance. Has the patient heard a single voice or several? If there were several voices, did they appear to talk to the patient or to each other about the patient in the third person? The latter experience must be distinguished from that of hearing actual people talking and believing that they are discussing the patient (an idea or delusion of reference). If the patient says that the voices are speaking to them, the interviewer should find out what the voices say and, if the words are experienced as commands, whether the patient feels that they must be obeyed. Note down examples of the words spoken by hallucinatory voices.

Visual hallucinations

Visual hallucinations must be distinguished from visual illusions. Unless the hallucination is experienced at the time of the interview, this distinction may be difficult because it depends on the presence or absence of a visual stimulus which has been misinterpreted. Ascertaining whether there is an 'as if' quality to the image, or asking if it is seen 'out there, or in your mind's eye' may aid the distinction. The interviewer should also distinguish hallucinations from dissociative experiences. The latter are described by the patient as the feeling of being in the presence of another person or a spirit with whom they can converse. Such experiences are reported by people with histrionic personality, although they are not confined to them, and are encouraged by some religious groups. They have little diagnostic significance.

Cognitive function

Early on in the interview, any significant cognitive difficulties will have already become apparent from the patient's interactions with the interviewer and their responses to questions. If so, the assessment of cognitive function should be brought forward, as the result may lead the interviewer to curtail the rest of the interview or to postpone it until an informant is available. The Mini-Mental State Examination (Folstein *et al.*, 1975) is a widely used cognitive screen in the elderly or where dementia or other organic disorder is suspected; see Chapter 14 for discussion of cognitive assessment in these contexts. Conversely, if the interview is nearing completion and no evidence or suspicion of any

difficulties with memory or attention has arisen, cognition can be assessed very briefly.

Orientation

This is assessed by asking about the patient's awareness of time, place, and person. Specific questions begin with the day, month, and year. When assessing the replies, remember that many healthy people do not know the exact date and that, understandably, patients in hospital may be uncertain about the day of the week or their precise location. If the patient cannot answer these basic questions correctly, they should be asked about their own identity; this is preserved except in severe dementia, dissociative disorders, or malingering.

Attention and concentration

While taking the history the interviewer should look out for evidence of attention and concentration. In this way an opinion will already have been formed about these abilities before reaching the mental state examination. Formal tests add to this information, and can provide a semi-quantitative indication of changes between occasions. A useful first test is '*serial sevens*': the patient is asked to subtract 7 from 100 and then to keep subtracting 7 from the remainder until the resulting number is less than 7. The time taken to do this is recorded, together with the number of errors. If poor performance seems to be due to lack of skill in arithmetic, the patient should be asked to do a simpler subtraction, or to state the months of the year in reverse order.

Memory

While taking the history the interviewer should compare the patient's account of past events with those of any other informants, and be alert for gaps or inconsistencies. If memory is impaired, any evidence of confabulation (see page 355) should be noted. During the mental state examination, tests are given of short-term, recent, and remote memory. Since none of these is wholly satisfactory, the results should be assessed alongside other information about memory and, if there is any doubt, supplemented by standardized psychological tests. Objective evidence of memory impairment and its impact on normal activities (e.g. shopping, dressing) is also essential.

Short-term memory can be assessed by asking the patient to memorize a name and a simple address, to repeat it immediately (to make sure that it has been registered correctly), and to retain it. The interview continues on other topics for 5 minutes before recall is tested. A healthy person of average intelligence should make only minor errors. If recall is imperfect, memory can be prompted (e.g. by saying '35, Juniper …' and the patient may then recall 'Street').

Memory for recent events can be assessed by asking about news items from the last few days.

Remote memory can be assessed by asking the patient to recall personal events or well-known items of news from former years. Personal items could be the birth dates of children or the names of grandchildren (provided these are known to the interviewer), and news items could be the names of well-known former political leaders. Awareness of the sequence of events is as important as the recall of individual items.

The reader is again referred to Chapter 14 for detailed assessment of cognitive functioning.

Insight

A note that merely records 'insight present' or 'no insight' is of little value. Instead the interviewer should enquire about the different aspects of insight discussed on page 20. This includes the patient's appraisal of their difficulties and prospects, and whether they ascribe them to illness or to some other cause (e.g. persecution). If the patient recognizes that they are ill, do they think that the illness is physical or mental, and do they think that they need any treatment? If so, what are their views on medication, psychotherapy, or admission, as appropriate? The interviewer should also find out whether the patient thinks that stressful life experiences or their own actions have played a part in causing their illness. The patient's views on these matters are a guide to their likely collaboration with treatment.

Other components of psychiatric assessment

Although the psychiatric history and mental state examination are the main parts of the psychiatric assessment, several other elements may also be necessary as part of the 'work-up' of a patient. This section does not cover more specialized aspects of assessment (e.g. the use of rating scales; see below) or those not directly linked to diagnosis or initial management (e.g. assessment for psychotherapy).

Physical examination

Physical examination provides three kinds of information in the assessment.

- It may reveal diagnostically useful signs (e.g. a goitre or absent reflexes), and it is therefore particularly important in the diagnosis or exclusion of organic disorders (see Chapter 14). Neurological (including cerebrovascular) and endocrine systems most commonly require detailed examination, although other systems should not be neglected. The reader should consult a relevant textbook (e.g. Kaufman and Milstein, 2017) if instruction is required in these aspects of clinical practice.
- Psychotropic drugs may produce physical side-effects, which need to be identified or measured (e.g. hypertension, parkinsonism, or a rash).
- The patient's general health, nutritional status, and self-care may all be affected by psychiatric disorders.

For these reasons, a physical examination is an integral part of the psychiatric assessment. In practice, however, the extent of the physical examination, and the medical responsibility for it, vary. For example, in the United Kingdom, the general practitioner may have recently carried out an appropriate physical examination, and hence the latter is unnecessary for most patients seen in outpatient clinic or the community. In the case of inpatients, the psychiatrist is generally responsible for their physical as well as their mental health, and every newly admitted patient should have a full physical examination. Whatever the circumstances, the psychiatrist should decide what physical examination is relevant, and either carry it out themselves or ensure that this is or has been done by another doctor. Discussion with a neurologist or other physician is appropriate if the initial examination reveals equivocal or complex findings, or if a second opinion is sought. In some cases, more detailed assessment of higher neurological functions is required, as in the neuropsychiatric examination, which is summarized in Box 3.6. This may be a prelude to formal neuropsychological or neurological assessment.

Laboratory and other investigations

These vary according to the nature of the differential diagnosis, the treatments that are being given, the patient's general health, and the resources available. At one extreme, no investigations may be necessary. At the other, extensive brain imaging, genetic testing, and biochemical screening may be needed—for example, if there is a strong suspicion of a treatable organic disorder, a familial dementia, or learning disability. There is no one set of routine investigations that is applicable to every case although, by convention, routine blood tests (full blood count, renal, liver, and thyroid function) are usually carried out on admission to hospital.

Investigations are discussed further in the chapters on individual syndromes and drug treatments.

Psychological assessment

Clinical psychologists and psychological testing can contribute to psychiatric assessment in several ways. However, they are not required in most cases, and their availability is increasingly limited in many settings. We therefore only introduce the topic briefly here, illustrating the main forms and roles of psychological assessment. For further information, see Powell (2009).

Neuropsychological assessment

There are many psychometric tests available that measure different aspects of neuropsychological performance, ranging from overall intelligence to specific domains of memory, speed of processing, or tests that putatively assess functioning of a particular part of the brain (Lezak *et al.*, 2012). Neuropsychological testing in psychiatry is primarily used in the following areas (Adams and Grant, 2009):

- In learning disability, where IQ defines the severity of the condition.
- In dementia, where tests measure the severity and domains of cognitive impairment.
- If a decline in performance from premorbid abilities is suspected. In this instance, a discrepancy may be seen between verbal and performance IQ.
- To monitor the progress of neuropsychological deficits during the course of illness, by repeated administration of tests.
- To reveal deficits that may be subtle and neglected clinically, but which may be functionally important. For example, in schizophrenia there are persistent impairments in specific domains of memory and attention, and these predict poor outcome (see Chapter 11).
- If an organic cause of psychiatric disorder is suspected, he profile of test results may suggest the location of the lesion. However, this use of neuropsychological testing to localize brain lesions has largely been replaced by neuroimaging.

Cognitive assessment

The term 'cognitive' is sometimes used interchangeably with the term 'neuropsychological'. In the present context, however, cognitive assessment refers to the assessment of a patient's cognitions (thoughts), assumptions, and patterns of thinking. It is used to determine the suitability for, and focus of, cognitive therapy (see Chapter 24).

Behavioural assessment

Observations and ratings of behaviour are useful in everyday clinical practice, especially for inpatients. When no ready-made rating scale is available, ad hoc ratings can be devised. For example, a scale could be devised for the nurses to show how much of the time a patient with depression was active and occupied. This could be a five-point scale, in which the criteria for each rating refer to behaviour (e.g. playing cards or talking to other people) relevant to the individual patient. As well as providing baseline information, the scale could also help to monitor progress and response to treatment.

Behavioural assessment is also used to evaluate the components of a patient's disorder—for example, in a phobia, the elements of anticipatory anxiety, avoidance, and coping strategies, and their relationship to stimuli in the environment (e.g. heights), more general circumstances (e.g. crowded places), or internal cues (e.g. awareness of heart action). Behavioural assessment is a necessary preliminary to behaviour therapy (see page 683).

Personality assessment

In the past, detailed personality testing, including the use of 'projective' tests such as the Rorschach test, was often part of psychiatric assessment. These tests are now rarely used in psychiatry, as they do not measure aspects of personality that are most relevant to psychiatric disorder, and they have not been shown to be valid predictors of diagnosis or outcome. Instead, personality is assessed descriptively as part of the history (described above), supplemented for research purposes with schedules for diagnosing personality disorders (see Chapter 15).

Risk assessment

Risk assessment is an essential part of psychiatric assessment. Risk in this context refers to risk of harm to others (through violence or neglect) and risk to self (through suicide, deliberate self-harm, or neglect). A failure to carry out and clearly document a risk assessment, and the resulting risk management plan, is a common criticism of enquiries that follow homicides and suicides involving psychiatric patients. All assessments, however brief, should include assessment of risk, and include a statement about the presence and magnitude of any acute risks in the record of the assessment.

Risk to self is covered in Chapter 21. Here we consider assessment of the risk of violence to others. Three kinds of information are used to assess such risks—personal factors, factors related to illness, and factors in the mental state. These factors are summarized in Box 3.7, with the most important ones in each category indicated by means of an asterisk. Further information on risk assessment, in the context of forensic psychiatry, can be found in Chapter 18.

A history of violence is the best predictor of future violence. Therefore it is important to seek full information on this not only by questioning the patient but, in appropriate cases, from additional sources, including relatives and close acquaintances, previous medical and social services records, and in certain cases the police. Antisocial, impulsive, or irritable features in the personality are a further risk factor. Social circumstances at the time of any previous episodes of violence may reveal provoking factors, and should be compared with the patient's current situation (see below). A parental history of violence, social isolation, and a recent life crisis also increase the risk. Among the illness factors, psychotic disorder and drug or alcohol misuse are important, and the combination of psychosis, substance misuse, and personality disorder is associated with the highest risk of violence.

The mental state factors in Box 3.7 require careful consideration. Thoughts of violence to others are very important, especially if they are concerned with a specific person to whom the patient has access. The entry concerning suicidal ideas refers to the occasional killing, usually of family members, by a patient with severe (usually psychotic) depression. Features of morbid jealousy and other delusional disorders may pose specific risks of harm against a perceived aggressor or rival (see page 307).

Situational factors are extremely important. Actual or perceived confrontational behaviour towards the patient by others may trigger violence, as may a return to situations in which violence has been expressed in the past.