MENTAL HEALTH HISTORY

AND

MENTAL STATUS EXAMINATION

MENTAL HEALTH ASSESSMENT

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Assessment should include the following steps:

- History taking
  - Review of the presenting complaint
  - A detailed biological, psychological and social history
- An attempt to understand the patient's personality
- Assessment of current social situation
- A mental status examination
- A physical examination
- A formulation
- Making a specific diagnosis and differential diagnosis
- Quantifying the severity of the disorder (including use of outcome tool)
- Identifying any specific risk to the patient or others
- Organising any special tests or investigations

1. History Taking

History taking has two main aims:

(i) to detail the main complaints

(ii) to obtain a biographical understanding of the patient as a person

THE PRESENTING COMPLAINT

Obtain a brief description of the principal complaint and the time frame of the problem in the individual's own words. The individual's concerns need to be taken seriously. Respect and empathy will enhance trust. The individual's description of the problem will also enable the clinician to assess the individual's insight or perception into his or her situation. Specifically, find out:

- What is the nature of the problem?
- Why and precisely how has the individual presented at this time?
- Identify specific symptoms that are present and their duration.
- Note time relationships between the onset or exacerbation of symptoms and the presence of social stressors/physical illness.
- Note also any disturbance in mood, appetite, sexual drive and sleep.
- Obtain information about any treatments given by other doctors or specialists for this problem, and the individual's response to treatment

A DETAILED BIOLOGICAL, PSYCHOLOGICAL AND SOCIAL HISTORY

A comprehensive bio-psycho-social history includes the history of the presenting illness together with the following: personal history; family history; past medical history; past psychiatric history; details of past and current alcohol and illicit drug use; and eliciting information to enable assessment of personality.

It will be important for the clinician to identify information that is relevant and useful and to bypass information that is not as useful. However, remember adequate time and following the patient's lead facilitate recognition of the problem. An important part of history taking involves probing for useful information that the individual does not mention spontaneously.

Some individuals (e.g. those who are brought to see you by others) may deny the existence of a problem. In these circumstances it may be necessary to obtain a history of the illness from a family member or close friend. In any event, additional history from another who knows the patient well is invaluable.

History of Presenting illness or problem

This section covers information related to the presenting complaint that predates the current episode such as:

- Events that led up to the current presentation
- Information about previous episodes
- Treatment for previous episodes

Phase of illness -many mental disorders (e.g. anxiety and depressive disorders) are chronic or relapsing. So, when taking a history take special note of the time course of symptoms

- Are they of recent onset or chronic in nature?
- What factors increase or decrease the severity of symptoms?
- Is this an acute episode of illness, partial remission, relapse or recurrence?

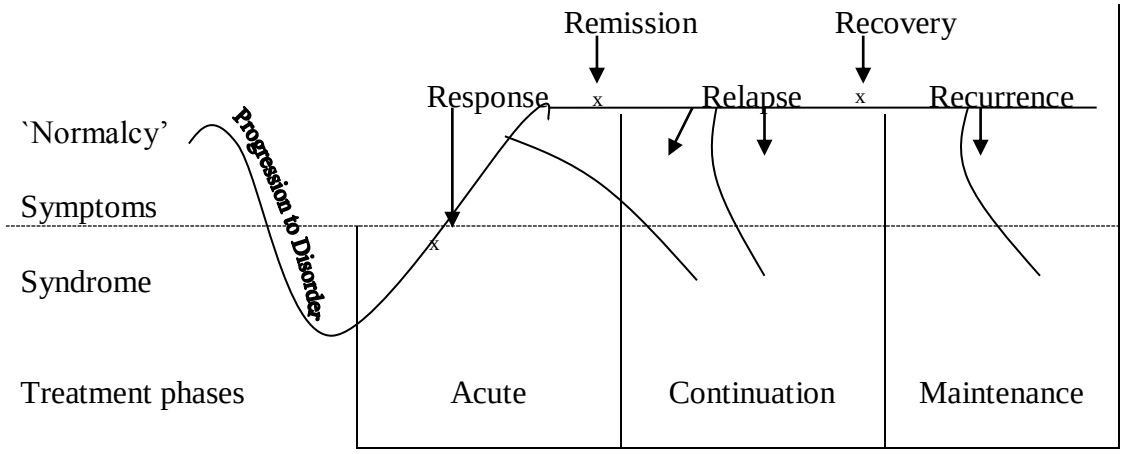


Figure: Response, remission, recovery, relapse, recurrence

Adapted from The Journal of Clinical Psychiatry 1991, S2 (2 suppl) 12 - 16

THE PERSONAL HISTORY

The personal history covers many aspects of the individual's life, from childhood through to adulthood. If you do not already know, obtain information about:

- Infancy (drug treatments during pregnancy; emotions and temperament; level of activity; nourishment; general development). This information is generally only important if the index individual is a child. You will need to obtain this information from the child's parents or guardians.
- Childhood and adolescence (emotional adjustment; relationships with peers, siblings and parents; play; trait anxiety; physical illnesses; sleeping behaviour; mental and motor development; early loss of close family members; sexual or physical abuse; belonging to a group; relating to peers and adults; school history; extent of sexual activity).
- Work history (jobs held; reasons for changing jobs; level of satisfaction with employment; ambitions).
- Social history (friends, peer group)
- Marital history (number of marriages; duration; quality of relationships; personality of spouse/s; reasons for break-up of relationship/s).
- Children (name; sex; age; mental and physical health)
- Relationships with others (intimate or sexual relationships; presence of someone in whom to confide).
- Forensic history including illegal activities/violence (ask about criminal record and any previous episodes of violence such as pub brawls, violence at home, or other acts of aggression).

THE FAMILY HISTORY

You may be familiar with the person's family history, but if not ask about the individual's close family (i.e., spouse, children, parents, siblings). For each member of the immediate family, obtain information about:

- Age
- Health
- Occupation
- Personality description
- Quality of relationship with that person
- Psychiatric and other illnesses (including alcoholism and other substance abuse)
- Treatment for these illnesses
- Response to treatment

It is also important to ask about the presence of psychiatric illness in grandparents, aunts, and uncles.

PAST MEDICAL HISTORY

The bio-psycho-social approach requires careful assessment of any possible organic contribution. Whilst it is likely the patients medical history is well known to you, it is important to review it at this time and carefully consider whether medical problems could be contributing to the current presentation (e.g. thyroid problems not uncommonly are associated with the onset of anxiety or depression). Obtain or record previously obtained information about any medical problems for which professional help has been obtained. Find out about the response to treatment.

Obtain information about previous episodes of illness, treatment of these and response to treatment.

PREVIOUS PSYCHIATRIC HISTORY

Obtain information about previous episodes of psychiatric illness, treatment of these and response to treatment.

DRUG AND ALCOHOL HISTORY

Find out about present and/or previous drug or alcohol use and abuse (prescribed medications, self-prescribed, or illegal) and responses to each of these drugs. Are there any adverse (including allergic) drug reactions?

2. Assessment of personality

An attempt should be made to understand the patient's personality. Often valuable information comes from the patient's relatives. In addition the patient should be asked, "Can you tell me what sort of person you were before you became ill"? Use information obtained in the biographical history to assist your assessment.

Personality can be defined as *a relatively stable and enduring set of characteristic behavioural and emotional traits*. Over time, a person will interact with others in a reasonably predictable way. Personality changes with experience, maturity, and external demands in a way that promotes adaptation to the environment.

Note:

- Overall mood or temperament
- Character traits
- Confidence
- Ways of coping with adversity or stress
- Religious and moral beliefs
- Ambitions and aspirations
- Social relationships with family, friends, workmates

3. Current social situation

What is the individual's current social situation? In particular look for factors which will act as "risk" for illness or those which are resilience factors. These include:

- social network
- family relationships
- home situation
- occupation – type, security, job satisfaction
- financial situation

Personality Disorders

In assessing patients we need to determine whether there maybe "personality pathology" or whether there is any evidence that the individual may have a personalty disorder. *A personality disorder is a variant, or an extreme set of characteristics that goes beyond the range found in most people.* The key features of a personality disorder are that it:

- Is deeply ingrained and has an inflexible nature
- Is maladaptive, especially in interpersonal circumstances
- Is relatively stable over time
- Significantly impairs the ability of the person to function
- Distresses those close to the person
- Is ego syntonic- i.e. the behaviours do not distress the person directly

To accurately diagnose a personality disorder requires an extensive and thorough longitudinal history from childhood right through to the current time. It furthermore requires corroborative information – a patient's own recollection may be biased and subjective and may be distorted for the patient's own ends. In clinical practice, failure to adequately obtain the longitudinal history or search for corroborative information accounts for why these disorders are either missed, or inadequate and inaccurate assessments of personality are made.

Single behaviours are insufficient to make a diagnosis of personality disorder. Instead, clusters of behaviours existing over a lengthy time period and interfering with a person's level of functioning are required.

Various classifications are used, but one common approach is that of DSM which puts personality disorders phenomenologically into similar clusters -

- CLUSTER A- Odd, eccentric or 'mad'- paranoid, schizoid, schizotypal
- CLUSTER B- Dramatic, emotional or erratic, 'bad'- antisocial, borderline, histrionic, narcissistic
- CLUSTER C- Anxious or fearful, 'sad'- avoidant, dependent, obsessive-compulsive

Of note,

- A current mental disorder (e.g. depression)may worsen personality problems, and vice versa, personality problems may worsen a coexisting mental disorder
- There is a worse prognosis for patients with comorbid mental disorder and personality disorder.
- A diagnosis of 'chronic' mental disorder e.g. chronic depression may be made by mistake rather than recognising a personality disorder. Remember, a key feature of personality disorder is a stable pattern of long duration, whose onset can be traced back at least to adolescence or early adulthood. So, beware when the history starts with *"I've been depressed as long as I can remember……"*

4. The mental status examination[1]

The mental status examination (MSE) is an integral part of any interview, not just one that takes place in a specific psychiatric assessment. *The MSE records only observed behaviour, cognitive abilities and inner experiences expressed during the interview.* The MSE is conducted to assess as completely as possible the factors necessary to arrive at a provisional diagnosis, formulate a treatment plan and follow the clinical course.

All psychiatric diagnoses are made clinically at interview situations. There is no blood test, X-ray or single identifying feature for any psychiatric condition. Thus, a thorough assessment, of which the MSE is an essential component, is necessary.

The MSE should begin as soon as the patient enters the room-observation will reveal important information such as grooming, hygiene, behaviour, gait, level of interest in and interaction with surroundings etc.

Much of the MSE is obtained "free" through observation and discussion from the initial parts of the interview.

"Free" parameters	**Parameters to ask about**
Level of consciousness	Orientation
Appearance	Cognitive functioning
Behaviour	Suicidal/homicidal thoughts
Co-operation	Knowledge base
Reliability	Perception
Affect	Mood
Thought form	Thought content

Key components of the MSE are:

APPEARANCE AND BEHAVIOUR

The aim of this section is to observe and describe the manner and appearance of the individual at the time of assessment.

Describe the individual's physical appearance (e.g., grooming; hygiene; clothing including shoes; hair; nails; build; tattoos; other significant features).

[1] The material in this section is sourced from the following:

- World Health Organisation Collaborative Centre for Mental Health and Substance Abuse: Treatment Protocol Project. Management of Mental Disorders, Vol I, Third edition 2000
- Hamilton M (ed) Fish's Clinical Psychopathology. John Wright & Sons Ltd, Bristol, 1974
- Robinson DJ. Brain Calipers: A guide to a successful mental status exam. Rapid Psychler Press, Canada 1997.
- Trzepacz PT, Baker RW. The Psychiatric Mental Status Examination, Oxford University Press., New York 1993

What is the individual's reaction to the present situation and the examiner? (e.g., hostile, friendly, withdrawn, guarded, co-operative, uncommunicative, seductive). Note the rapport developed – this is a summary of the relatedness between the patient and the clinician as revealed in how they interacted during the interview.

Describe the individual's motor behaviour (e.g., psychomotor retarded, restless, repetitive behaviours, hyperactive, tremors, hand-wringing, bizarre (include description)).

SPEECH

The physical aspects of speech can be described in terms of rate, volume and quantity of information (e.g., slow, rapid, monotonous, loud, quiet, slurred, whispered). Some particular characteristics of speech that you might consider are:

Mutism	Total absence of speech, often associated with depression or post-traumatic stress.
Poverty of speech	Restricted amount of spontaneous speech. Replies to questions are brief or monosyllabic. Allow time for individuals to elaborate their answers.
Pressured speech	Speech is extremely rapid, difficult to interrupt, loud, & hard to understand.

MOOD AND AFFECT

Mood (internal feeling or emotion which often influences behaviour and the individual's perception of the world) and affect (external emotional response) may both provide useful diagnostic information.

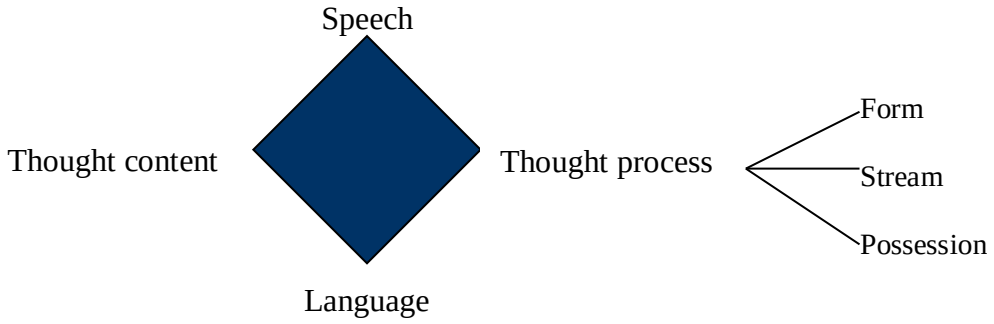
Describe the individual's mood (e.g., depressed, euphoric, childish, silly, labile (alternating between extremes), suspicious, fearful, hostile, anxious, irritable, self-contemptuous). This should be assessed taking into account what the patient has said about how they have felt and behaved recently, and at the current time.

Describe the individual's affect. Note whether the emotional response is appropriate given the subject matter being discussed. Some terms you may need to be familiar with are:

Normal affect	Variation in: facial expression, voice, use of hands, body movements
Restricted affect	Decrease in intensity and range of emotional expression
Blunted affect	Severe decrease in intensity and range of emotional expression
Flat affect	Total or near absence of emotional expression; face immobile, voice monotonous

DISORDERS OF THINKING

Disorders of thought include disorders of stream of thought, possession of thought, content of thought, and form of thought.



Disorders of stream of thought

Disorders of tempo

Flight of ideas. Here the thoughts follow each other rapidly, there is no general direction of thinking and the connections between successive thoughts appear to be due to chance factors which however can be understood. Flight of ideas is typical of mania. Usually flight of ideas occurs together with pressure of speech. *Clanging*, in which words are chosen for sounds not meanings (e.g., I ate my food, mood, rude), and *punning* (using the same word with different meanings) are commonly seen in flight of ideas.

Inhibition or retardation of thinking. Here the train of thought is slowed down a number of ideas and mental images, which present themselves, is decreased. The poor performance in a person with retardation of thinking may lead to a mistaken diagnosis of dementia. Inhibition of thinking is typical of retarded depression.

Circumstantiality. Here thinking proceeds slowly with many unnecessary trivial details but finally the point is reached. The goal of thought is never completely lost and thinking proceeds towards it by an intricate and devious path.

Disorders of continuity of thinking

Perseveration. Here mental operations tend to persist beyond the point of what is relevant and thus prevent progress of thinking. Perseveration is common in organic brain disorders.

Thought blocking. Here there is a sudden arrest of the train of thought leading a blank and an entirely new thought may then begin. This is characteristic of psychosis, but also occurs when individuals are very anxious.

♦ Disorders of the possession of thought

Normally an individual experiences their thinking as being their own although this sense of personal possession is never in the foreground of ones consciousness. Individuals also feel that they are in control of their thinking. In some psychiatric disorders there is a loss of control or sense of the possession of thinking.

Obsessions

The essential feature of an obsession is that it appears against a patient's will, but is recognised as their own thoughts. Individuals may experience obsessional mental images, ideas, fears or impulses which are distressing to them. Obsessions are seen as part of an obsessive compulsive disorder or an individual with depression and less often in individuals with schizophrenia.

Thought alienation

Here the patient has the experience that his thoughts are under control of an outside agency or that others are participating in his thinking. Thought alienation is often seen as part of a schizophrenic illness and include:

Thought insertion. Thoughts are being inserted into one's mind and are recognized as being foreign and coming from without.

Thought withdrawal. The patient finds that as he is thinking his thoughts suddenly disappear and are withdrawn from his mind by a foreign influence

Thought broadcasting. The patient knows that as he is thinking everyone else is thinking in unison with him.

♦ Disorders of content of thinking

Thought content refers to what patients talk about in the substance of the interview. One of the key reasons the interview is left unstructured is to allow an assessment of thought content. Thought content is considered abnormal when it contains any of the following elements: delusions, overvalued ideas, suicidal or homicidal thoughts, preoccupation with various themes, obsessions, compulsions or phobias.

A delusion is a false unshakeable belief out of keeping with a patient's social, cultural and religious background.

An overvalued idea is a thought, which because of the associated feeling tone, takes precedence over all other ideas and preoccupies the patient's thinking and affects their behaviour.

The content of delusions is influenced by social and cultural background and include:

Delusions of persecution These can take many forms e.g., a patient knows that people are talking about him, spying on him, plan to kill him etc.

Q: Is anyone trying to harm, kill, poison or interfere with you?
Q: Do you ever feel uncomfortable as if people are watching you?

Delusions of jealousy	Commonly this takes the form of marital infidelity.
Delusions of love	These are also called the fantasy lover or erotomania. Here the person is convinced that some person is in love with them though often the alleged lover has never actually spoken to them.
Grandiose delusion	These are commonly seen in schizophrenia, drug induced states, organic brain syndromes and manic episodes.
Delusions of ill health	These are a characteristic feature of a depressive illness but may also be found in schizophrenia and other disorders.
Delusions of guilt	These are also commonly seen as part of depressive disorder

Look for:
Depressive Themes – helplessness, hopelessness, self-reproach, guilt, Hypochondriacal ideas, suicidal ideas.

Grandiose Themes – exaggerated belief of self-importance, power, knowledge, identity.

Suicidal Thoughts – the individual needs to be asked about suicidal thoughts, especially if there are symptoms of depression (even if mild). If suicidal thoughts or intentions are reported, further questioning will be required.

Other abnormalities of thought content include:
Obsessions, comparisons, anti-social urges, phobias, intentions, hypochondriacal symptoms and preoccupations (perhaps with illness). If any of these characteristics are prominent they are recorded in this section.

Disorders of the form of thinking

The term formal thought disorder is a synonym for disorders of conceptual or abstract thinking (i.e. of the way in which ideas are produced and organised) which occur in schizophrenia and in organic brain disorders. Various classifications of formal thought disorder have been developed.

Some important terms you may need to be familiar with are listed below.

Derailment (Loosening of associations)
A disorder in the logical progression of thoughts where unrelated and unconnected (or loosely connected) ideas shift from one subject to another. The language disturbance occurs *between* clauses. There is no meaningful relationship between the ideas which are being expressed, e.g. "The dogs are running in the field. They are going into their neighbours. The cars are making a lot of noise."

Incoherence (word salad)
Communication is disorganised and senseless and the main idea cannot be understood (e.g., "All is nothing and under nothing twists."). The language disturbance occurs *within* clauses, as opposed to derailment in which the disturbance occurs *between* clauses.

Neologisms The creation of completely new words or expressions that have no meaning to anyone other than the individual (e.g., "I have a helopantic under my foot.")

Tangentiality Replies to questions are irrelevant or oblique. The reply usually refers to the appropriate topic but fails to give a complete answer. (e.g., when asked about the type of medication taken today; "Yes, I take medication but I exercise as well."

Word approximation Stringing words together in new and unconventional ways to represent a specific meaning (e.g., 'handcoat; to mean glove). Often associated with organic brain disease.

PERCEPTION

Perception is the process of experiencing the environment, and recognising or making sense of the stimuli received via sensing input. An object in the environment causes a sensation, upon interpretation by the brain, it becomes a perception. Disorders of perception involved false associations or the de novo arrival of a precept without a stimulus.

Hallucinations

A hallucination is a false sensory perception in which the individual sees, hears, smells, feels or tastes something that other people do not see, hear, smell, feel, or taste. The hallucination occurs in the absence of an appropriate external stimulus. Hallucinations are not necessarily associated with a psychotic disturbance and can occur when falling asleep (hypnagogic hallucinations), when waking up (hypnopompic hallucinations), or in the course of an intense religious experience. Note, hallucinations commonly occur in people with an acute organic brain syndrome (delirium). The type of hallucination and the content should be described. Some types of hallucinations clinicians may need to be familiar with are:

Auditory hallucinations May be non-verbal (e.g., tapping, humming, music, laughing, etc.) or verbal (conversation, accusatory {often associated with depression}, etc.). An auditory hallucination is probably the most common type of hallucination.

Q: Do you hear sounds such as muttering, whispering, music, etc.?
Q: Do you hear voices talking about you or to you? Do these voices give orders? What do the voices say?
(Note whether the content is depressive, grandiose, and appropriate for the individual's mood).
Q: Can you carry on a two-way conversation with the voice/s?

Visual hallucinations Being able to see objects, people or images that others cannot see. Most commonly occurs in organic mental disorders.

Q*: While fully awake, have you had visions or seen things that other people couldn't see**?*

Olfactory hallucinations Smelling things that do not exist. Most commonly occurs in organic mental disorders.

Gustatory hallucinations Relation to sense of taste. Most commonly occurs in organic mental disorders.

Tactile hallucinations The false perception of touch or surface sensation, such as from an amputated (phantom) limb, or crawling sensations on or under the skin.

Somatic hallucinations The false perception that things are occurring *in* or *to* the body.

Other perceptual disturbances

Derealisation The external world appears different and unfamiliar. The individual feels distanced from the world and things may seem colourless or dead. Derealisation may be associated with extreme anxiety, stress, fatigue, an affective disorder, or with hyperventilation, which is a symptom of panic disorder.

Q: Have you had the feeling that everything around you is unreal?
Q: Have you felt that everything is an imitation of reality, with people acting instead of being themselves?

Depersonalisation The perception or experience of the self seems different or unfamiliar. The individual may feel unreal, or that his body is somehow distorted, or may have the sense of perceiving himself from a distance. In its severe form, the individual may feel as if he were actually dead. May be associated with extreme anxiety, stress, or fatigue.

Q: Have you felt as if you were outside yourself, looking at yourself from the outside?
Q: Have you felt as if some part of your body did not belong to you?

Dissociation Unconscious defence mechanism involving the segregation of any group of mental or behavioural processes from the rest of the person's psychic activity: may entail the separation of an idea from its accompanying emotional tone, as seen in dissociative and conversion disorders

COGNITION

Cognition, in a general sense, refers to information processing. Cognitive function draws on both thinking and memory. The storage, retrieval, and ability to manipulate information are assessed in this part of the MSE. Whilst it is not essential to test completely the cognitive functions of every patient in every interview, remember that when cognitive decline is suspected, these tests should be administered early and often.

Orientation

Obvious disturbances in orientation are usually indicative of organic brain disease. The commonly used categories for assessment of orientation are time, place and person. Impairments usually develop in this order, and, if treatable, usually clear in the reverse order.

Time

Ask the individual to tell you today's date. Remember, however, that even non-impaired people do not always know the correct date and may be one or two days out!

Place

The individual should be able to identify where he or she is and should behave accordingly. If there is any doubt, ask the individual to describe the route or means by which he or she would travel home.

Person

It is rare that an individual would not know his or her own identity. (Do not confuse orientation-of-self with religious delusions, such as believing oneself to be God). Ask if the individual knows the names and relationships of any family, friends, or professionals who are in the room or in the waiting room outside.

Attention and Concentration

Attention: the ability to focus and direct cognitive processes.
Test by: digit span - forwards and backwards - most adults have a digit span of 5-7 numbers forward and 4-6 numbers backward without errors.

Concentration: the ability to focus and sustain attention for a period of time. Concentration may be assessed by asking the individual to subtract serial 7s from 100. This task is only necessary if you suspect that there is some degree of impairment. Performance anxiety, mood disturbance, an alteration of consciousness, or an extreme lack of education may interfere with the task. An alternative is to spell WORLD backwards, or to subtract serial 3s starting from 20

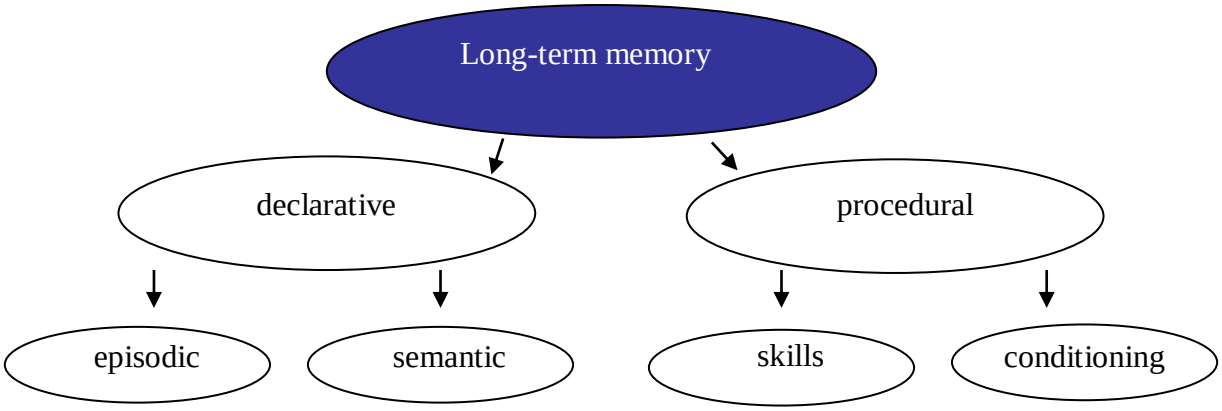
Memory

Immediate memory
Registration – the capacity for immediate recall of new learning: it lasts only a few seconds. Ask the individual to repeat 4 items – dog, hat, green, peach.

Short term memory
Temporary – lasting few seconds to a few minutes. Also called recent memory.

Ask the individual to repeat the 4 items after3 minutes. For words not recalled prompt with semantic cue: animal (dog), piece of clothing (hat), colour (green), fruit (peach).

Long term memory
Long term memory has no demonstrable limits of storage and provides the fund of knowledge for the patient. It remains stable over time and is the type most affected by forms of amnesia. Long term memory has two subtypes - declarative and procedural.



Procedural – involves remembering how to perform a set of skills e.g. driving. This form of memory evolves after many trials and remains largely intact in various forms of amnesia.
Declarative – involves data or facts that can be verbal or non verbal, as opposed to skills or procedures. This type of memory can be acquired in a short time and is the form most impaired in amnesia.
Test – Episodic memory – time-tagged, personalised (or autobiographical) and experiential knowledge e.g. date of wedding etc.
Test - Semantic memory – recall of general information a person could reasonably be expected to have learned e.g. date of WWII.

Visuospatial ability

The ability to perform visuospatial functions is an essential part of performing daily activities. The ability to navigate, use machinery and perceive the environment all depend on intact visuospatial functions. This is tested in the MSE by assessing constructional ability. Commonly used tests are:

Draw a 3D figure, e.g. cube

Draw a clock face showing a specified time

Abstract thoughts

Abstract thinking involves the ability to: deal with concepts; extract common characteristics from groups of objects; juggle more than one idea at a time; and interpret information. Abstract thinking may be assessed by asking the individual to interpret the meanings of common proverbs (e.g., a bird in the hand is worth two in the bush), or by the similarities test in which patients are asked to compare two objects and list as many common qualities as they can (e.g., chair and desk). Care needs to be taken when using proverbs with different cultural groups. A lack of abstract ability is often associated with organic brain disease or thought disorder.

INTELLIGENCE

Assessment of intelligence can be done by the clinician using level of functioning and vocabulary use to estimate whether the individual is of normal or above IQ. The mean intelligence of the population is an IQ of 100 (IQ = mental age over chronological age by 100). Persons with mental retardation (intellectual disability) have IQ scores < 70 combined with significant adaptive deficits which have developed during the developmental period (up to 18 years of age).

In intellectual disability the IQ level determines the level of disability:

IQ 50 to 70 mild

IQ 35 to 50 moderate

IQ 20 to 35 severe

IQ less than 20 profound

The vast majority of persons with intellectual disability fall into the mild category and live in the community with little utilisation of services. Those with more severe levels of disability usually fall under the care of disability services within the various states and territories. In intellectual disability it is especially important for GPs to remember that the level of comorbid psychiatric and physical disorders is very high. The rate of epilepsy is overall 30% (severe and profound 50%) and comorbid psychiatric disorders are present in up to 50% of intellectually disabled patients.

JUDGEMENT

Judgement involves weighing and comparing the relative values of different aspects of an issue. Determining whether a particular judgement is sound is situation dependent.

INSIGHT

Insight refers to the individual's awareness of his or her situation and illness. There are varying degrees of insight. For example, an individual may be aware of his or her problem but may believe that someone else is to blame for the problem. Alternatively, the individual may deny that a problem exists at all. The assessment of insight has clinical significance since lack of insight generally means that it will be difficult to encourage the individual to accept treatment.

5. The physical examination

Physical examination is a necessary part of the psychiatric assessment. Organic factors need to be excluded as the cause of symptoms or as contributory to them. Furthermore, comorbid illnesses which affect presentation and management, or impede development of judgement, insight and compliance need to be dealt with.

A competent systems examination, and especially central and peripheral nervous system examination, must be performed. Acute and chronic physical effects of illicit drug taking and alcohol use, including associated infections, must always be sought, even if the patient denies use of such agents.

6. The formulation

The Summary
Information collected on history, mental status examination, and physical examination must be brought together into a summary, from which flows the diagnostic and differential diagnosis, prognosis and treatment plan.

The summary should sift the information obtained to produce a brief outline of:

- Who the person is
- What their problems are
- What effects these problems are having on the person (physical, psychological, social, work, financial)

Psychiatric diagnosis is essentially a way of grouping symptoms and signs into certain groups of "illness". The exercise of applying these labels is important but has less relevance than in medicine and surgery where treatment and prognosis are often simply related to the diagnosis. In psychiatry, there are many important variables

which need to be considered as well as diagnosis, and these should be assembled as a psychiatric formulation

The Formulation
In the formulation, relevant facts are drawn together and discussed from the point of view of diagnosis, aetiology, further investigations, treatment and prognosis. The formulation describes how and why the problems arose in terms of predisposing, precipitating, maintaining (+ protective) factors and lays the framework for planning of treatment. The bio-psycho-social approach is essential to the formulation.

Table 1 : Factors determining illness+

	Predisposing	**Precipitating**	**Maintaining**	**Protective**
Biological	Family history of medical and psychiatric illness	Physical illness Medication SE's Alcohol/drug use	Physical illness Medication SE's Alcohol/drug use	Treatment of illness
Psychological	Personality traits: Defence/coping Mechanism Past psychiatric history	Life events Stressors	Stressors Personality traits	Personality traits Defence/coping mechanism Treatment of illness
Social	Family environment Early relationships	Social circumstances Occupational circumstances	Relationship Problems Occupational Problems Financial problems	Supportive environment Faith

+Adapted from: Bloch S, Singh BS. Foundations of Clinical Psychiatry, 1994, Melbourne University Press

7. Diagnosis and differential diagnosis

A useful way of acknowledging the relevance and potential interaction of biological, psychological, sociocultural and spiritual factors is use of the multiaxial approach to diagnosis.

- Axis I - Mental disorder –a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability. Key groupings include:
  - Organic/cognitive disorders
  - Mood disorders
  - Anxiety disorders
  - Psychotic disorders
  - Somatoform disorders
  - Eating disorders
  - Substance use disorders

- Axis II - Personality traits/disorder-an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's

culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. Maladaptive personality traits which do not meet the threshold for a personality disorder should be noted here.

- Axis III - Medical conditions –any medical conditions which are potentially relevant to the understanding or management of the individual's mental disorder should be noted here.

- Axis IV – Psychosocial and environmental stresses-any psychosocial or environmental problems or stressors can be noted here

- Axis V - Level of social and occupational functioning-this is a summary of the clinicians judgement of the individual's overall level of functioning. This is useful in planning treatment and in measuring it's impact. Commonly a GAF score (Global Assessment of Functioning) is given here (see Tools for Diagnostic Screening and Outcome Measurement)

8. Severity of disorder

This will be determined by history, mental status signs and level of functional impairment/disability. Examples of severity assessment made this way are shown in Tables 2 and 3 below.

Table 2 : Classification of severity of depressive illness, based on clinical features+*

	Mild	Moderate	Severe
Affective	lowered mood crying anxious irritable	Inability to experience pleasure pessimistic re future social withdrawal self-reproach, feel worthless feel like a failure hypochondriasis paranoid ideas	Apathy and social withdrawal see no future poor self-care ideas of guilt illness as punishment paranoid, hypochondriacal or nihilistic delusions
Cognitive	impulsive loss of confidence impaired concentration loss of interest/ enjoyment	work impairment indecisiveness forgetful	marked work impairment unable to make decisions slow mentation, impression of cognitive impairment
Somatic	low energy restless lowered libido loss of interest in food mild initial insomnia wake one or two times a night	no energy eat with encouragement loss of libido mild weight loss initial insomnia wake several times/night	agitation or psychomotor retardation unable to eat marked weight loss sleep only a few hours
Suicidality	life not worth living	thoughts of suicide	plans or attempted suicide

* not all clinical features are necessarily present in every patient

+From: Crowe S, Hoy J, Mills J. (eds) Management of the HIV Infected Patient 1996, Cambridge University Press

*Table 3: Classification of severity of mania based on clinical features *+*

	Mild (hypomania)	Moderate	Severe (manic Psychosis)
Mood	Cheerful or mild irritability	Unusually good or marked irritability	Euphoric or irritable and aggressive
Thought	Pressure of thought and speech	Racing thoughts, accelerated speech-loud, rapid, difficult to interrupt Flight of ideas - changes topic based on understandable associations, distracting, stimuli, plays on words	Jokes, puns, frequent irrelevancies Clanging – sounds rather than meaningful connections govern word choice Speech may be disorganised and incoherent
	Increased self-confidence and self-esteem	Grandiose ideas, Unrealistic over-estimation of abilities	Grandiose delusions Paranoid delusions
Cognitive	Poor concentration	Distractible	Distractible, disorganised
Somatic	Mild insomnia Mild overactivity	Reduced need for sleep Awake early full of energy	Minimal sleep without resulting fatigue
	Increased libido	Increased sexuality or promiscuity	Indiscriminate sexual promiscuity Self-neglect Exhaustion
Social	Overly familiar Increased social confidence and interaction	Increased sociability – telephone calls, letter writing, visits to friends Fiscal irresponsibility Unwarranted optimism Increased sexual activity	Intrusive, domineering, demanding social interactions Poor judgement – reckless spending, poor business decisions, reckless driving Activities disorganised, flamboyant, bizarre

* Not all clinical features are necessarily present in every patient

+From: Crowe S, Hoy J, Mills J. (eds) Management of the HIV Infected Patient 1996, Cambridge University Press

In addition, severity can be quantified using a disorder specific symptom rating scales. Useful scales, together with instructions for their administration are contained in the booklet Tools for Diagnostic Screening and Outcome Measurement.

9. Assessment of risk

Consideration of risk should encompass a range of areas including:

- Self harm risk
- Suicide risk – the factors associated with increased risk of suicide and other factors which should be reviewed during the interview to assess current risk are shown below
- Dangerousness to others
- Likelihood of substance abuse
- Vulnerability to exploitation by others
- Likelihood of deterioration of mental state
- Non compliance with treatment
- Homelessness
- Risk of self neglect

Factors associated with increased risk of suicide

- Age – rate rises steadily with age
- Sex – male > female
  *particularly high rate for males 15-30 years old, especially rural areas
- Marital status – single, widow (er)
- Socioeconomic status – rate increased for lower SE class
- Unemployment – rate increased for unemployed
- Physical illness – especially chronic and/or painful conditions
- Psychiatric illness – especially depression, schizophrenia
- Alcohol or drug abuse/dependence
- Distressing life events

Assessing suicide risk at interview

In addition to the general risk factors, assessment of risk in patients who report suicidal ideation requires consideration of:

- Level of wish/intent to die
- Level of wish/intent to live
- Fixed v ambivalent suicidal ideation
- Preparation for attempt e.g. collecting of tablets, bought a gun
- Final acts in anticipation of death e.g. making a will, sorting out insurance
- Presence of a plan
- Lethality of chosen means for self harm
- Access to and knowledge of how to use those means
- Presence or absence of supports
- Presence or absence of `protective' individual
- Presence of deterrents e.g. family, religion
- Purpose/reason for attempt

10. Investigations and Special tests

Once the differential diagnosis has been made, further tests may be needed to exclude or confirm the presence of suspected organic factors.

CT, MRI, functional imaging, EEG etc. may form part of the psychiatric examination, especially where organic cerebral pathology is suspected. With a patient presenting for the first time, apart from the general physical examination, a full blood examination, tests for renal, liver and thyroid function, calcium and phosphate estimation should be performed. Cerebral CT scanning, folate and B12, and syphilis serology should be performed as a routine in older patients especially if cognitive deficits are present. In younger patients where there is a history of drug abuse (either known or suspected), routine testing for Hep B, Hep C and HIV (with informed consent) should be undertaken. Remember that comorbid rate of substance abuse and unprotected sexual practice is high in both mania and schizophrenia (in the order of 50 to 60%).

Figure: Summary flowchart of the Psychiatric Assessment