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46 Chapter 2 Psychiatric assessment The clinical interview In most branches of clinical medicine, diagnoses are made largely on the basis of the patient’s history, with physical examination and investigation playing important, but subordinate, roles. In psychiatry, physical examin ation and investigations are of lesser diagnostic value and diagnosis is based on the clinical interview and, to a lesser extent, the later course of the patient’s illness. Clinical interviewing is thus the central skill of the psych iatrist, and development of clinical interviewing skills is the main aim of basic psychiatric training. The clinical interview includes both history-taking and mental state exam ination (MSE). The MSE is a systematic record of the patient’s current psy chopathology. In addition to its role in diagnosis, the clinical interview begins the development of a therapeutic relationship and is, in many cases, the beginning of treatment. Clinical interview skills cannot be learnt from a textbook. This chapter is intended as a guide to the doctor developing skills in interviewing psychiatric patients. As a trainee psychiatrist, you should also take the opportunity to observe experienced clinicians, as they interview patients, to review your own videotaped consultations with a tutor, and, most importantly, to carry out many clinical interviews and present the results to your seniors. Skills in this area, as with all others, come with experience and practice. This chapter describes a model for the assessment of general adult and old age psychiatry patients on the wards or in the outpatient clinic. For special patient populations, modifications or extensions to the standard interview are described in the appropriate chapter: alcohol and drug problems (E Assessment of the patient with alcohol problems, p. 584; E Assessment of the drug user, p. 630); forensic (E Assessing risk of violence, p. 748; E Suggested format for criminal court report, p. 770); child and adolescent (E Assessment 1: principles, p. 648; E Assessment 2: considerations, p. 650; E

Assessment 3: practice points, p. 652); intel lectual disability (E The process of assessment, p. 798); and psychotherapy (E Assessment for psychotherapy, p. 884). The student or doctor coming to psychiatric interviewing for the first time is likely to be apprehensive. The symptoms which the patient describes may seem bizarre or incomprehensible, and the examiner may struggle for understanding and knowledge of which further questions to ask. Remember that the interviewer is not like a lawyer or policeman trying to 'get at the truth', but rather an aid to the patient telling the story in their own words. Start by listening, prompting only when necessary, and aim to feel at the end of the interview that you really understand the patient's problems and their perception of them. The following pages describe the standard structure for a routine his tory, MSE, and case summary; there are then pages devoted to the different symptom areas in adult psychiatry, with suggested probe questions. These are intended as guides to the sort of questions to ask the patient (or to ask yourself about the patient) and may be rephrased in your own words. See Box 2.1 for advice on personal safety.

The clinical interview Box 2.1 Always consider your personal safety when interviewing There is a risk of aggression or violence in only a small minority of psy chiatric patients. In the vast majority of patients, the only risk of violence is towards themselves. However, the fact that violence is rare can lead to doctors putting themselves at risk due to thoughtlessness. To combat this, it is important to think about the risk of violence before every consult ation with a new patient or with a familiar patient with new symptoms. Before interviewing a patient, particularly for the first time, con sider: who you are interviewing, where you are interviewing, and with whom. Ensure that the nursing staff have this information. • If possible, review the patient's records, noting previous symptomatology and episodes of previous violence (the best predictor of future violence). • A number of factors will increase the risk of violence, including: a previous history of violence, psychotic illness, intoxication with alcohol or drugs, frustration, feeling of threat (which may be delusional or relate to real-world concerns). • The ideal interview room has two doors, one for you and one for the patient. If this is not available, sit so that the patient is not between you and the door. Remove all potential weapons from the interview room. • Familiarize yourself with the ward's panic alarm system before you first need to use it. • If your hospital organizes break-away or aggression management training courses, attend these regularly to keep your skills up-to-date.

48 Chapter 2 Psychiatric assessment Setting the scene Introductions Observe the normal social forms when meeting someone for the first time. Introduce yourself and any accompanying staff members by name and status. Ensure that you know the names and relationships of any people accompanying the patient (and ask the patient if they wish these persons to be present during the interview). It is best to introduce yourself by title and surname and refer to the patient by title and surname. Do not use the patient's first name, except at their request. Seating The traditional consultation room, with the patient facing the doctor across a desk, is inappropriate in psychiatry. Use two or more comfortable chairs, of the same height, orientated to each other at an angle. This is less con frontational but allows direct eye contact, as necessary. A clipboard will allow you to write notes as you go along. Explanation Inform the patient of your status and specialty, and explain the purpose of the interview. Explain the reasons for referral as you understand them, and inform the patient of the information you have been told by the referrer. Patients often imagine you know more about them than you do. It is helpful to indicate to the patient how long the interview will last; this will allow both of you to plan your time, so as not to omit vital topics. Advise them that you may wish to obtain further information after the interview from other sources, and obtain their

consent to talk to any informants accompanying them if this would add to your assessment. Documentation For all episodes of clinical contact, a handwritten or electronic record is crucial, both as a way of recording and communicating information and as a medico-legal record. It is best to write or type the account at the time, or very shortly afterwards. The record should be legible, dated, and signed and ordered in a standard fashion. Initially, you may find it helpful to write out the standard assessment headings on sheets of paper beforehand. Interviewing non-English-speaking patients Where the doctor and the patient do not speak a common language, an interpreter is essential. Even in situations where the patient appears to speak some English, sufficient for day-to-day conversation, an interpreter is still highly desirable because idiomatic language and culturally specific interpretations of psychological phenomena may confuse understanding. Where possible, the interpreter should share not only a language, but also a cultural background with the patient, as many descriptions of psychiatric symptoms are culture-specific. Do not use members of a patient's family as interpreters, except where unavoidable (e.g. in emergency situations). It is unethical to use children as interpreters.

 Interviewing psychiatric patients Interview structure The exact internal structure of the interview will be decided by the na ture of the presenting complaint. However, the interview will generally go through a number of more or less discrete phases: Initiation Introduce yourself, and explain the nature and purpose of the interview. Describe how long the interview will last and what you know about the patient already. Patient-led history Invite the patient to tell you about their presenting com plaint. Use general opening questions, and prompt for further elaboration. Let the patient do most of the talking—your role is to help them to tell the story in their own words. During this phase, you should note down the major observations in the MSE. Having completed the history of the pre senting complaint and the MSE, you will be able to be more focused when taking the other aspects of the history. Doctor-led history Clarify the details in the history thus far with appropriate questions. Clarify the nature of diagnostic symptoms (e.g. are these true hallucinations? Is there diurnal mood variation?). Explore significant areas not mentioned spontaneously by the patient. Background history Complete the history by direct enquiry. This is similar to standard medical history-taking, with the addition of a closer enquiry into the patient's personal history. Summing-up Recount the history, as you have understood it, back to the patient. Ensure there are no omissions or important areas uncovered. Indicate if you would like to obtain other third-party information, empha sizing that this would add to your understanding of the patient's problems and help you in your diagnosis. Questioning techniques Open vs closed questions An open question does not suggest the possible an swers; a closed question expects a limited range of replies (cf. 'can you tell me how you are feeling?' and 'is your mood up or down at the moment?'). In general, begin the interview with open questions, turning to more closed questions to clarify details or factual points. Non-directive vs leading questions A leading question directs a patient to wards a suggested answer (e.g. 'is your mood usually worse in the morn ings?', rather than 'is your mood better or worse at any time of day?'). Just as lawyers are reprimanded for 'leading a witness', we should, in general, avoid leading our patients to certain replies, as the desire to please the doctor can be a very powerful one. Giving advice Aim to leave at least the last quarter of the available interview time for discussion of the diagnosis, your explanation to the patient of your under standing of the nature and cause of their symptoms, and your detailing of your plans for treatment or further investigation or referral, as indicated. The patient's confidence

in your diagnosis will be improved by their belief

Interviewing psychiatric patients that you really understand ‘what is going on’, and spending time detailing exactly what you want them to do will pay dividends in i compliance. As a junior trainee, you may have to break at the end of the history-taking segment, in order to present the case to your senior and get advice on management. After the interview The process of assessment does not, of course, end with the initial clin ical interview. In psychiatry, all diagnoses are, to some extent, provisional. You should follow your initial interview by gathering information from rela tives, the general practitioner (GP), and previous case records and clarifying symptoms observed by nursing staff. In an emergency situation, a modifica tion of this technique, focusing mainly on the acute problem, is more appro priate, with re-interviewing later to fill in the blanks, if required.

52 Chapter 2 Psychiatric assessment Discussing management In psychiatry, more than any other specialty, it is essential for successful management that the patient has a good understanding of their disorder and its treatment. There is no equivalent in psychiatry of the simple frac ture where all that is required of the patient is to ‘lie back and take the medicine’. The treatment of any psychiatric disorder begins at the initial interview where, in addition to the assessment, the doctor should aim to establish a therapeutic alliance, effectively communicate the management plan, instil a sense of hope in the patient, and encourage self-help strategies. Establish a therapeutic relationship • Aim to listen more than you speak (especially initially). • Show respect for the patient as an individual (e.g. establish their preferred mode of address; ask permission for anyone else to be present at the interview). • Explicitly make your actions for the benefit of the patient. • Do not argue; agree to disagree if consensus cannot be reached. • Accept that, in some patients, trust may take time to develop. Communicate effectively • Be specific—explain what you think the diagnosis is and what the management should be. • Avoid jargon—use layman’s language, or explain specialist terms which you use. • Avoid ambiguity—clarify precisely what you mean and what your plans are. Be explicit in your statements to patients (e.g. say ‘I will ask one of our nurses to visit you at home on Monday morning’, rather than ‘I’ll arrange some community support for you’). • Connect the advice to the patient—explain why you think what you do and what it is about the patient’s symptoms that suggest the diagnosis to you. • Use repetition and recapitulation—use the ‘primacy/recency’ effect to your advantage. Restate the important information first, and repeat it at the end. • Break up/write down—most of what is said to patients in medical interviews is rapidly forgotten or distorted. Make the information easier to remember by breaking it up into a numbered list. Consider providing personalized written information, in addition to any advice leaflets, etc. that you give the patient. This is imperative if the advice is complex and specific (e.g. dosage regimes for medication).

Discussing management Instil hope • Patients with mental health problems often feel extremely isolated and cut off from others, and they may feel that they are the only people ever to experience their symptoms. Reassure them that you recognize their symptoms as part of a pattern representing a treatable illness. • Convey to the patient your belief that this illness is understandable and that there are prospects for recovery. • Counteract unrealistic beliefs (e.g. the fear of ‘losing my mind’ or of ‘being locked away forever’). • Where cure is not possible, emphasize that there is still much that can be done to manage the illness and ameliorate symptoms. Encourage self-help • Be clear to the patient what they can do to help themselves, e.g. maintain treatment adherence (E Medication adherence, p. 994), avoid exacerbating factors (e.g. drug or

alcohol misuse), consider lifestyle changes (e.g. house move, relationship counselling). • Provide written self-help materials appropriate to the current disorder (E Resources for patients, p. 1072). • Where appropriate, encourage contact/attendance at voluntary treatment organizations, self-help groups, or patient organizations (E Resources for patients, p. 1072). Develop knowledge of, and links with, local resources and aim to have their contact numbers and location information available at the consultation.

54 Chapter 2 Psychiatric assessment History The history should, as far as possible, be gathered in the standard order presented here. This provides structure and logical coherence to the ques tioning, both for the doctor and the patient, and it is less likely that items will be omitted. Basic information Name, age, and marital status. Current occupation. Route of referral. Current legal status (detained under the Mental Health Act?). Presenting complaints Number and brief description of presenting complaints. Which is the most troublesome symptom? History of presenting complaints For each individual complaint, record its nature (in the patient's own words as far as possible), chronology, severity, associated symptoms, and associ ated life events occurring at or about the same time. Note precipitating, aggravating, and relieving factors. Have these or similar symptoms occurred before? To what does the patient attribute their symptoms? Past psychiatric and medical history Previous psychiatric diagnoses. Chronological list of episodes of psychi atric inpatient, day hospital, and outpatient care. Current medical conditions. Chronological list of episodes of medical or surgical illness. Episodes of symp toms for which no treatment was sought. Any illnesses treated by the GP. Drug history List names and doses of current medication (have they been taking it?) Previous psychiatric drug treatments. History of adverse reactions or drug allergy. Any non-prescribed or alternative medications taken. Family history Family tree (see Fig. 2.1) detailing names, ages, relationships, and illnesses of first- and second-degree relatives. Are there any familial illnesses? Personal history Childhood Were there problems during their pregnancy or delivery? Did they reach development milestones normally? Was their childhood happy? In what sort of family were they raised? Education Which primary and secondary schools did they attend? If more than one of each, why was this? Did they attend mainstream or specialist schools? Did they enjoy school—if not, why? At what age did they leave school and with what qualifications? Type of further education and qualifications at tained. If they left higher education before completing the course, why was this? Employment Chronological list of jobs. Which job did they hold for the longest period? Which job did they enjoy most? If the patient has had a series of jobs—why did they leave each? Account for periods of unemployment in the patient's history. Is the type of job undertaken consistent with the patient's level of educational attainment?

History Relationships Sexual orientation. Chronological account of major relationships. Reasons for relationship breakdown. Are they currently in a relationship? Do they have any children from the current or previous relationships? With whom do the children live? What relationship does the patient have with them? Forensic (E Assessing risk of violence, p. 748; E Suggested format for criminal court report, p. 770). Have they been charged or convicted of any offences? What sentence did they receive? Do they have outstanding charges or con victions at the moment? Social background information Current occupation. Are they working at the moment? If not, how long have they been off work and why? Current family/relationship situation. Alcohol and illicit drug use (E Assessment of the patient with alcohol problems, p. 584; E Assessment of the drug user, p. 630). Main recre ational activities. Premorbid personality How would they describe themselves

before they became ill? How would others have described them? Key: Female Hypertension MI 27 26 9 (Twins)9 6 ?ADHD Male Age 32 years Deceased Affected Index case Fig. 2.1 A family tree diagram.

56 Chapter 2 Psychiatric assessment Mental state examination The MSE is an ordered summary of the examining doctor's observations as to the patient's mental experiences and behaviour at the time of interview. Its purpose is to suggest evidence for and against a diagnosis of mental dis order and, if a mental disorder is present, to record the current type and severity of symptoms. The information obtained should, together with the psychiatric history, enable a judgement to be made regarding the presence and severity of any mental disorder and the risk of harm to self or others. The required information can be obtained during the course of history- taking or in a systematic fashion afterwards. The MSE should be recorded and presented in a standardized format, although the information contained may derive from material gained in different ways. It is helpful to record the patient's description of significant symptoms, word for word. Appearance • Apparent age. • Racial origin. • Style of dress. • Level of cleanliness. • General physical condition. • Abnormal involuntary movements, including tics, grimaces, stereotypies, dyskinetic movements, tremors, etc. Behaviour • Appropriateness of behaviour. • Level of motor activity. • Apparent level of anxiety. • Eye contact. • Rapport. • Abnormal movement or posture. • Episodes of aggression. • Distractibility. Speech • Volume, rate, and tone. • Quantity and fluency. • Abnormal associations, clang, and punning. • Flight of ideas. Mood • Subjective and objective assessment of mood. • Mood evaluation should include the quality, range, depth, congruence, appropriateness, and communicability of the mood state. • Anxiety and panic symptoms. • Obsessions and compulsions. Perception • Hallucinations and pseudo-hallucinations. • Depersonalization and derealization. Illusions and imagery.

Mental state examination Thought form • Linearity. • Goal-directedness. • Associational quality. • Formal thought disorder. Thought content • Delusions. • Over-valued ideas. • Preoccupations. • Obsessive thoughts, ideas, and impulses. • Thoughts of suicide or deliberate self-harm. • Thoughts of harm to others. Assess intent, lethality of intent, plan, and inimicality. Does the patient show any urge to act upon the plan? Cognition • Attention and concentration. • Orientation to time, place, and person. • Level of comprehension. • Short-term memory. Insight • Does the patient feel his experiences are as a result of illness? • Will he accept medical advice and treatment?

58 Chapter 2 Psychiatric assessment Case summary The written and oral presentation of the results of a clinical interview should follow a standard format: history, MSE, results of physical examin ation, and case summary. The case summary can take a variety of forms, but the structure suggested here is suitable for most situations. You should in clude a brief synopsis of the case, a differential diagnosis with your favoured working diagnosis, and a comment on the aetiological factors in this patient. Synopsis This should be a short paragraph summarizing the salient points of the pre ceding information and covering: • Basic personal information. • Previous psychiatric diagnosis. • Description of the presentation. • Description of current symptoms. • Positive features on MSE. • Suicide risk. • Attitude to illness. Differential diagnosis This will usually be a short list of two or three possibilities. In an exam situ ation, mention other less likely possibilities you would consider in order to exclude. Your presentation should have directed you towards choosing one as your working diagnosis. Formulation For general psychiatric patients, the formulation should include comments on why the person has become ill and why now. You should identify the 'three

Ps’: predisposing, precipitating, and perpetuating factors for the cur rent illness. This information will be important in guiding a suitable manage ment plan. So, for example, in a patient with depressed mood following the birth of a baby, predisposing factors could be a family history of depressive illness, ♀ sex; precipitating factors could be the postnatal period, job loss, a change of role, and feelings of inadequacy; and prolonging factors could be disturbed sleep and an unsupportive partner. Management plan Following the presentation of history, MSE, physical examination, and for mulation, you would normally go on to present or to document your initial management plan, including recommended investigations, initial drug treat ment, comment on risk management, and advice to other healthcare pro fessionals involved with the patient’s care.

Case summary 59

60 Chapter 2 Psychiatric assessment Observations of appearance and behaviour The greater part of the MSE consists of empathic questioning about the patient’s internal experiences. Nonetheless, important information re garding the mental state can be obtained from careful observation of the patient’s appearance, behaviour, and manner, both during the interview and, in some cases, later on the ward. This is particularly important in some situations, e.g. with a patient who may be concealing the presence of psych otic symptoms or where there is reason to doubt the patient’s account. Take time to observe the patient during the interview, and ask yourself the following questions. If possible, ask nursing staff about behaviour on the ward (e.g. does he have any abnormal movements or mannerisms? How does he interact with other patients? Does he appear to be responding to unseen voices or commands?). What is the patient’s appearance? Describe the patient’s physical appearance and racial origin. Compare what age they appear with their actual age (i.e. biological vs chronological age). What is their manner of dress? Patients with manic illnesses may dress in an excessively formal, flamboyant, or sexually inappropriate manner. Patients with cognitive impairment may have mismatched or wrongly buttoned clothing. What is the patient’s behaviour during the interview? Are there episodes of tearfulness? Do they attend to the interview or do they appear distracted? Do they maintain an appropriate level of eye con tact? Do you feel that you have established rapport? What is the patient’s level of activity during the interview? Does the patient appear restless or fidgety? Do they settle to a chair or pace during interview? Is there a normal level of gesticulation during conversation? Is there any evidence of self-neglect? Does the patient have lower-than-normal standards of self-care and per sonal hygiene? Are they malodorous, unshaven, or dishevelled? Are their clothes clean? Are there cigarette burns or food stains on their clothes? Is the patient’s behaviour socially inappropriate? Is there embarrassing, overly familiar, or sexually forward behaviour? All are seen in manic illness or where there is cognitive impairment. Is the patient’s behaviour threatening, aggressive, or violent? In manner or in speech, does the patient appear hostile or threatening? Do you feel at risk? Is there aggressive or violent behaviour on display during the interview? What prompts it?

Observations of appearance and behaviour Are there any abnormal movements? Does the patient have repetitive or rocking movements or bizarre pos turing (stereotypies)? Do they perform voluntary, goal-directed activities in a bizarre way (mannerisms)? What is their explanation for this? For patients on neuroleptic medication, is there evidence of side effects (e.g. stiffness, rigidity, tremor, akathisia)? Is the patient distractible or appearing to be responding to hallucinations? Does the patient appear to be attending to a voice other than yours? Are they looking around the room as if for the source of a voice? Are they murmuring or mouthing

soundlessly to themselves? Are there episodes of giggling, verbal outbursts, or other unexplained actions?

62 Chapter 2 Psychiatric assessment Speech The content of the patient's speech (i.e. what they say) will be our major source of information for their history and mental state. The form of their speech (i.e. how they say it) is abnormal in a number of mental disorders and should be observed and commented upon. Is there any speech at all? A small number of patients are mute during interview. Here the doctor should aim to comment on the apparent level of comprehension (does the patient appear to understand what is said, e.g. shakes or nods their head appropriately), the level of alternate communication (can they write an swers down, do they point or use gestures?), and the level of structural impairment of the organs of speech (a patient who can cough on demand is demonstrably able to oppose both vocal cords normally). What is the quantity of speech? Are answers unduly brief or monosyllabic? Conversely, are they inappropri ately prolonged? Does the speech appear pressured, i.e. is there copious, rapid speech, which is hard to interrupt? What is the rate of speech? There is a wide variation in normal rates of speech across even the re gions of the UK. Is the patient's speech unusually slow or unusually rapid, given the expected rate? This may reflect acceleration or deceleration in the speed of thought in affective illnesses. What is the volume and quality of speech? Does the patient whisper or speak inappropriately loudly? Is there stut tering or slurring of speech? What is the tone and rhythm of speech? Even in a non-tonal language like English, normal speech has a musical quality, with the intonation of the voice and rhythm of the sentences conveying meaning (i.e. the rise in tone at the end of a question). Loss of this range of intonation and rhythmic pattern is seen in chronic psychotic illnesses. How appropriate is the speech? Is the content of speech appropriate to the situation? Does the patient an swer questions appropriately? Are there inappropriate or pointless digres sions? Can the meaning of the speech always be followed? Is there abnormal use of language? Are there word-finding difficulties, which may suggest an expressive dys phasia? Are there neologisms (i.e. made-up words or normal words used in an idiosyncratic manner)?

Abnormal mood Abnormal mood In describing disorders of mood, we draw a distinction between affect (the emotional state prevailing at a given moment) and mood (the emotional state over a longer period). To use a meteorological analogy, affect rep resents the weather, whereas mood is the climate. Variations in affect— from happiness to sadness, irritability to enthusiasm—are within everyone's normal experience. Assessment of pathological abnormality of affect in volves assessing the severity, longevity, and ubiquity of the mood disturb ance and its association with other pathological features suggestive of a mood disorder. Depressed mood is the most common symptom of the mood disorders and, in its milder forms, has been experienced by most people at some point. Its experience is personal and is described in a variety of ways by dif ferent people—as a profound lowering of spirits, subjectively different from normal unhappiness; as an unpleasant absence of emotions or emotional range; and as a more physical symptom of 'weight' or 'blackness' weighing down on the head or chest. Increasingly, severe forms of depressed mood are indicated by the patient's rating of greater severity, as compared with previous experience, i pervasiveness of the low mood to all situations, and d reactivity of mood (i.e. d ability of the mood to be lightened by pleasur able or encouraging events). The two central clinical features of depressive illness are: (1) pervasively depressed and unreactive mood; and (2) anhedonia— the loss of pleasure in previously pleasurable activities. The clinical picture also includes the 'biological features of depression', thoughts of self-harm, and, in more severe cases, mood-congruent

psychotic features. The biological features include disturbance of sleep [particularly early morning wakening (EMW) and difficulty getting off to sleep], reduced appetite, loss of libido, reduced energy levels, and subjective impression of poorer concentration and memory. Many depressed patients will have thoughts of deliberate self-harm or ending their lives as a way of ending their suffering. With increasingly severe depressed mood, there are increasingly frequent and formed plans of suicide. The development of a sense of hopeless ness about the future is a worrying sign. Mania and depression are often thought of as two extremes of illness, with normality or euthymia in the middle. Morbid change in mood (either elevation or depression) can more accurately be considered as being on one side of a coin, with normality on the other. Some patients display both manic and depres sive features in the one episode—a mixed affective state. Manic and depres sive illnesses have, in common, i lability (i.e. susceptibility to change) of mood, i irritability, d sleep, and an increase in subjective anxiety. The core features of manic illnesses are sustained, inappropriate elevation in mood (often described as feeling on top of the world) and a distorted or inflated estimate of one's importance and abilities. The clinical picture also includes i lability of mood, i irritability, i activity levels, disturbed sleep pattern with a sense of diminished need for sleep, and subjectively improved memory and concentration despite an objective deterioration in these skills. With increasingly severe episodes of manic illness, there is loss of judgement, an increase in inappropriate and risky behaviour, and the de velopment of mood-congruent delusions.

64 Chapter 2 Psychiatric assessment Asking about depressed mood 'How has your mood been lately?' Patients vary in their ability to introspect and assess their mood. Beginning with general questioning allows a more unbiased account of mood prob lems. Report any description of depression in the patient's own words. Ask the patient to assess the depth of depression (e.g. 'on a scale of 1 to 10, where 10 is normal and 1 is as depressed as you have ever felt, how would you rate your mood now?'; how long has the mood been as low as this?). Note any discrepancy between the patient's report of mood and the ob jective signs of mood disturbance. 'Does your mood vary over the course of a day?' Clarify if the mood varies as the day goes on. If mood improves in the evening, does it return completely to normal? Does anything else change as the day goes on, to account for the mood change (e.g. more company in the evenings)? 'Can you still enjoy the things you used to enjoy?' By this point of the interview, you should have some idea about the activ ities the patient formerly enjoyed. Depressed patients describe a lack of interest in their previous pursuits, d participation in activities, and a sense of any participation being more of an effort. 'How are you sleeping?' Many patients will simply describe their sleep as 'terrible'. They should be asked further about time to bed, time falling asleep, wakefulness throughout the night, time of waking in the morning, quality of sleep (is it refreshing?), and any daytime napping. 'What is your appetite like at the moment?' Patients reporting a change in their appetite should be asked about the reasons for this (loss of interest in food, loss of motivation to prepare food, or swallowing difficulties?). Has there been recent weight loss? Do their clothes still fit? 'How is your concentration?' Clarify any reported decline by asking about the ability to perform standard tasks. Can they read a newspaper? Can they watch a TV show? Ask about work performance. 'What is your memory like at the moment?' Again, clarify any reported decline.

Asking about depressed mood 'How is the sexual side of your relationship?' Potentially embarrassing topics are best approached in a professional and matter-of-fact way. It is important to enquire about this directly, as the symptom of loss of libido can cause considerable suffering for the patient and partner and is less likely than other symptoms to be mentioned spon taneously.

During treatment, this symptom should again be asked about, as many psychotropic drugs negatively affect sexual performance. ‘Do you have any worries on your mind at the moment?’ Depressed patients tend to preferentially dwell on negative issues. ‘Do you feel guilty about anything at the moment?’ Patients with depres sive illnesses often report feelings of guilt or remorse about current or his torical events. In severe illnesses, these feelings can become delusional. Aim to assess the presence and nature of guilty thoughts.

66 Chapter 2 Psychiatric assessment Asking about thoughts of self-harm Completed suicide is an unfortunately common outcome in many psychi atric conditions. Thoughts of self-harm occur commonly and should always be enquired about. Many patients with a mental illness of any severity will have had such thoughts at some stage. It should be emphasized that asking about self-harm does not ‘put the idea in their head’, and patients may wel come the chance to discuss such worrying thoughts. The assessment is not only of the presence of suicidal thoughts, but also of their severity, frequency, and the likelihood of them being followed by suicidal action. One suggested method involves asking about behaviours and thoughts associated with increasing suicide risk. This tactful enquiry can be made, in addition to an estimate of risk. The aim is not to trap the patient into an unwanted disclosure, but to assess the severity of suicidal intent, and hence the attendant risk of completed suicide. ‘How do you feel about the future?’ Patients often remain optimistic of improvement despite severe symptoms. Hopelessness about the future and a feeling that things will never get better are worrying. ‘Have you ever thought that life was not worth living?’ A consequence of hopelessness is the feeling that anything, even nothing ness, would be better. ‘Have you ever wished you could go to bed and not wake up in the morning?’ Passive thoughts of death are common in mental illness and can also be found in normal elderly people towards the end of life, particularly after the deaths of spouses and peers. ‘Have you had thoughts of ending your life?’ If yes, enquire about the frequency of these thoughts—are they fleeting and rapidly dismissed, or more prolonged? Are they becoming more common? ‘Have you thought about how you would do it?’ Ask about methods of suicide the patient has considered. Particularly worrying are violent methods that are likely to succeed (e.g. shooting, hanging, or jumping from a height). ‘Have you made any preparations?’ Aim to establish how far the patient’s plans have progressed from ideas to action. Have they considered a place, bought pills, carried out a final act (e.g. suicide note, or begun putting their affairs in order)? ‘Have you tried to take your own life?’ Further assessment may be needed if there has been a recent concealed attempt (e.g. overdose).

Asking about thoughts of self-harm Self-injurious behaviours Some patients report causing harm to themselves, sometimes repeatedly, without reporting a desire to die (e.g. lacerate their arms, legs, or abdomen; burn themselves with cigarettes). In these cases, enquire about the reasons for this behaviour, which may be obscure, even to the person concerned. In what circumstances do they harm themselves? What do they feel and think before harming themselves? How do they feel afterwards?

68 Chapter 2 Psychiatric assessment Asking about elevated mood ‘How has your mood been lately?’ As for enquiries about depressed mood, begin with a very general question. Report the patient’s description of their mood in their own words. Clarify what the patient means by general statements such as ‘on top of the world’. ‘Do you find your mood is changeable at the moment?’ Besides general elevation in mood, patients with mania often report lability of mood, with

tearfulness and irritability, as well as elation. The pattern and type of mood variation should be noted, if present. ‘What is your thinking like at the moment?’ Patients with mania often report a subjective increase in the speed and ease of thinking, with many ideas occurring to them, each with a wider variety of associated thoughts than normal. This experience, together with the nature of their ideas, should be explored and described. ‘Do you have any special gifts or talents?’ A characteristic feature of frank mania is the belief that they have excep tional abilities of some kind (e.g. as great writers or painters) or that they have some particular insight to offer the world (e.g. the route to achieving world peace). These beliefs may become frankly delusional, with the patient believing they have special or magical powers. The nature of these beliefs and their implications and meaning for the patient should be described. ‘How are you sleeping?’ Manic patients describe finding sleep unnecessary or a distraction from their current plans. Enquire about the length and quality of sleep. ‘What is your appetite like at the moment?’ Appetite is variable in manic illnesses. Some patients describe having no time or patience for the preparation of food; others eat excessively and spend excessively on food and drink. Ask about recent weight gain or loss and about a recent typical day’s food intake. ‘How is your concentration?’ Typically, manic patients have impaired concentration and may report this; in this case, the complaint should be clarified by examples of impairment. Some manic patients overestimate their concentration, along with other subjective estimates of ability. Report on objective measures of concentra tion (e.g. attention to interview questioning or ability to retain interest in newspapers or TV while on the ward). ‘How is the sexual side of your relationship?’ Again, this topic should be broached directly and straightforwardly. Manic patients sometimes report i interest in sexual activity. Clarify the patient’s estimate of his or her own sexual attractiveness and recent increase in sexual activity or promiscuity.

Anxiety symptoms Anxiety symptoms Anxiety symptoms are the most common type of symptoms seen in pa tients with psychiatric disorders. They are the core clinical features of the ICD-10 neurotic disorders (which are indeed called anxiety disorders in DSM-5) and are also prominent clinical features in psychotic illnesses, af fective illness, organic disorders, and drug and alcohol use and withdrawal. Anxiety has two components: psychic anxiety—an unpleasant effect in which there is subjective tension, i arousal, and fearful apprehension; and somatic anxiety—bodily sensations of palpitations, sweating, dyspnoea, pallor, and abdominal discomfort. The sensations of anxiety are related to autonomic arousal and cognitive appraisal of threat, which were adaptive primitive survival reactions. Anxiety symptoms are part of normal healthy experience, particularly be fore novel, stressful, or potentially dangerous situations. Moderate amounts of anxiety can optimize performance (the so-called ‘Yerkes–Dobson’ curve—plotting performance level against anxiety shows an inverse U shape). They become pathological when they are abnormally severe or ab normally prolonged, or if they are present at a level out of keeping with the real threat of the situation. Anxiety symptoms may be present at a more or less constant level— generalized anxiety; or they may occur only episodically—panic attacks. Anxiety symptoms may or may not have an identifiable stimulus. Where a stimulus can be identified, it may be very specific, as in a simple phobia (e.g. fear of cats or spiders), or it may be more generalized, as in social phobia and agoraphobia. In phobias of all kinds, there is avoidance of the feared situation. Because this avoidance is followed by a reduction in unpleasant symptoms, it is reinforced and is liable to be repeated. Breaking of this cycle is the basis of desensitization methods of treating phobias (E Behaviour therapy, p. 908). The repetition of behaviours in order to achieve reduction in the ex perience of anxiety is also seen in the symptoms of obsessions and compul sions. Here, the patient

regards the thoughts (obsessions) and/or actions (compulsions) as purposeless but is unable to resist thinking about them or carrying them out. Resistance to their performance produces rising anxiety levels, which are diminished by repeating the resisted behaviour.

70 Chapter 2 Psychiatric assessment Asking about anxiety symptoms In enquiring about anxiety symptoms, aside from the nature, severity, and precipitants of the symptoms, it is important to establish in all cases the impact they are having on the person's life. Record what particular activities or situations are avoided because of their symptoms and, in the case of obsessional symptoms, note how much time the patient spends on them. 'Would you say you were an anxious person?' There is a wide variation in the normal level of arousal and anxiety. Some people are inveterate 'worriers', while others appear relaxed at all times. 'Recently, have you been feeling particularly anxious or on edge?' Ask the patient to describe when the symptoms began. Was there any particular precipitating event or trauma? 'Do any particular situations make you more anxious than others?' Establish whether the symptoms are constant or fluctuating. If the latter, enquire about those situations that cause worsening or improvement. 'Have you ever had a panic attack?' Ask the patient to describe to you what they mean by this. A classical panic attack is described as sudden in onset, with gradual resolution over 30–60min. There are physical symp toms of dyspnoea, tachycardia, sweating, chest tightness/chest pain, and paraesthesiae (related to over-breathing); coupled with psychological symp toms of subjective tension and apprehension that 'something terrible is going to happen'. 'Do any thoughts or worries keep coming back to your mind, even though you try to push them away?' 'Do you ever find yourself spending a lot of time doing the same thing over and over—like checking things or cleaning—even though you've already done it well enough?' Besides identifying the type of repetitive thought or action involved, it is important to establish that the thoughts or impulses are rec ognized as the person's own (in contrast with thought insertion in psychotic illness) and that they are associated with resistance (although active resist ance may diminish in chronic OCD). Patients with obsessional thoughts often worry that they are 'losing their mind' or that they will act on a par ticular thought (e.g. a mother with an obsessional image of smothering her baby). Where the symptom is definitively that of an obsession, the patient can be reassured that they will not carry it out.

Asking about anxiety symptoms 71

72 Chapter 2 Psychiatric assessment Abnormal perceptions Abnormal perceptual experiences form part of the clinical picture of many mental disorders. Equally, the range of normal perceptual experience is very wide. Patients vary in their ability to explain their subjective perceptual experiences. The brain constantly receives large amounts of perceptual information via the five special senses—vision, hearing, touch, taste, and smell; the muscle, joint, and internal organ proprioceptors, and the vestibular appar atus. The majority of this information is processed unconsciously, and only a minority reaches conscious awareness at any one time. An external object is represented internally by a sensory percept that combines with memory and experience to produce a meaningful internal percept in the conscious mind. In health, we can clearly distinguish between percepts which represent real objects and those which are the result of internal imagery or fantasy, which may be vividly experienced in the mind but are recognized as not real. Abnormal perceptual experiences may be divided into two types: • Altered perceptions—including sensory distortions and illusions—in which there is a distorted internal perception of a real external object. • False perceptions—including hallucinations and pseudo-

hallucinations— in which there is an internal perception without an external object. Sensory distortions are changes in the perceived intensity or quality of a real external stimulus. They are associated with organic conditions and with drug ingestion or withdrawal. Hyperacusis (experiencing sounds as abnor mally loud) and micropsia (perceiving objects as smaller and further away, as if looking through the wrong end of a telescope) are examples of sensory distortions. Illusions are altered perceptions in which a real external object is com bined with mental imagery to produce a false internal percept. Both lowered attention and heightened affect will predispose to experiencing illusions. Affect illusions occur at times of heightened emotion (e.g. while walking through a dangerous area late at night, a person may see a tree blowing in the wind as an attacker lunging at them). Completion illusions rely on our brain's tendency to 'fill in' presumed missing parts of an object to produce a meaningful percept and are the basis for many types of optical illusion. Both these types of illusions resolve on closer attention. Pareidolic illusions are meaningful percepts produced when experiencing a poorly defined stimulus (e.g. seeing faces in a fire or in clouds). Hallucinations A hallucination is defined as 'a percept without an object' (Esquirol, 1838). As symptoms of major mental disorders, hallucinations are the most significant type of abnormal perception. It is important to appre ciate that the subjective experience of hallucination is that of experiencing a normal percept in that modality of sensation. A true hallucination will be perceived as being in external space, distinct from imagined images, out side conscious control, and as possessing relative permanence. A pseudo- hallucination will lack one or all of these characteristics and be subjectively

Abnormal perceptions experienced as internal or 'in my head'. The only characteristic of true per ceptions which true hallucinations lack is publicness; hallucinating patients may accept that their experiences are not shared by others around them in the same way as a normal sensory experience. Auditory hallucinations are most frequently seen in functional psychoses. Three experiences of auditory hallucinations are first-rank symptoms in schizophrenia. These are: • Hearing a voice speak one's thoughts aloud. • Hearing a voice narrating one's actions. • Hearing two or more voices arguing. Visual hallucinations are associated with organic disorders of the brain and with drug and alcohol intoxication and withdrawal. They are very rarely seen in psychotic illness alone but are reported in association with dementias, cortical tumours, and stimulant and hallucinogen ingestion, and, most commonly, in delirium tremens. The visual hallucinations seen in de lirium tremens are characteristically 'Lilliputian hallucinations' of miniature animals or people. Olfactory and gustatory hallucinations may be difficult to distinguish and occur in a wide range of mental disorders. Olfactory hallucinations occur in epileptic auras, in depressive illnesses (where the smell is described as un pleasant or repulsive to others), and in schizophrenia. They may also occur in association with a persistent delusion of malodorousness. Hypnagogic/hypnopompic hallucinations are transient false perceptions which occur on falling asleep (hypnagogic) or on waking (hypnopompic). They may have the characteristics of true or pseudo-hallucinations and are most commonly visual or auditory. While they are sometimes seen in nar colepsy and affective illnesses, they are not indicative of ill health and are frequently reported by healthy people. Elemental hallucinations are the hallucinatory experience of simple sen sory elements such as flashes of light or unstructured noises. They are as sociated with organic states. Extracampine hallucinations are those false perceptions where the hallu cination is of an external object beyond the normal range of perception of the sensory organs. Functional hallucinations are hallucinations of any modality that are ex perienced simultaneously with a normal stimulus in that modality (e.g. a patient who only experiences auditory hallucinations when he hears the sound of the ward's air

conditioning). Reflex hallucinations are hallucinations in one modality of sensation experienced after experiencing a normal stimulus in another modality of sensation.

74 Chapter 2 Psychiatric assessment Asking about abnormal perceptions Asking patients about their experience of abnormal perceptions and ab normal beliefs (e.g. hallucinations and delusions) presents a number of problems for the examiner. Unlike symptoms such as anxiety, these symp toms are not part of normal experience, and so the examiner will not have the same degree of empathic understanding. Patients will often fear the reaction of others to the revelation of psychotic symptoms (fear of being thought 'mad') and so conceal them. When such symptoms are not present, patients may resent such questioning or regard it as strange or insulting. As with most potentially embarrassing topics, the best approach is frank ness, lack of embarrassment, and straightforwardness. If the interview thus far has not led to report of psychotic symptoms, the examiner should begin by saying something like the following. 'Now I want to ask you about some experiences which sometimes people have but find difficult to talk about. These are questions I ask everyone.' This makes clear that these questions are not as a result of suspicion in the examiner's mind or an indicator of how seriously they regard the patient's problems. 'Have you ever had the sensation that you were unreal—or that the world had become unreal?' The symptoms of depersonalization and derealization are non-specific symptoms in a variety of affective and psychotic conditions. Many patients find them difficult or impossible to explain clearly, commonly describing the experience as 'like being in a play'. Patients often worry about these experiences, fearing they presage 'going mad'. They may therefore be reluctant to mention them spontaneously. 'Have you ever had the experience of hearing noises or voices when there was no one about to explain it?' If the patient agrees, then this experience should be further clarified: When did this occur? Was the patient fully awake? How often? Where did the sound appear to come from? If a voice was heard, what did it say? Did the patient recognize the voice? Was there more than one? How did the voice refer to the patient (e.g. as 'you' or 'him')? Can the patient give examples of the sort of things the voice said? 'Have you seen any visions?' Again, clarify when and how often the experi ence occurred. What were the circumstances? Was the vision seen with the 'mind's eye' or perceived as being in external space? Was it distinct from the surroundings or seen as part of the wallpaper or curtain pattern? 'Do you ever notice smells or tastes that other people aren't bothered by?' Again, clarify the details surrounding any positive response. Aim to distin guish olfactory hallucinations (where there is the experience of an abnormal odour) from a patient who has a delusion that he is malodorous.

Abnormal beliefs Abnormal beliefs Examination of the patient's ideas and beliefs will form an important part of the MSE. Abnormal or false beliefs include primary and secondary delusions and over-valued ideas. More so than other symptoms of mental ill health, a patient with delusions fits the common preconceptions of 'madness'. Delusions are important symptoms in the diagnosis of the major psychoses. Delusions A delusion is a pathological belief which has the following characteristics: • It is held with absolute subjective certainty and cannot be rationalized away. • It requires no external proof and may be held in the face of contradictory evidence. • It has personal significance and importance to the individual concerned. • It is not a belief which can be understood as part of the subject's cultural or religious background. Note: although the content of the delusion is usually demonstrably false and bizarre in nature, this is not invariably so. A secondary delusion is one whose development can be understood in the light of another abnormality in the mental state (e.g. the development of delusions of poverty in a severely

depressed patient). A primary delusion cannot be understood in this way and must be pre sumed as arising directly from the pathological process. Delusions can be categorized by their content or by the manner in which they are perceived as having arisen. Over-valued ideas An over-valued idea is a non-delusional, non-obsessional abnormal belief. Here, the patient has a belief which is, in itself, acceptable and comprehen sible but which is preoccupying and comes to dominate their thinking and behaviour. The idea is not perceived as external or senseless but will gen erally have great significance to the patient. Over-valued ideas may have a variety of contents in different disorders (e.g. concern over physical appear ance in dysmorphophobia; concern over weight and body shape in anorexia nervosa; concern over personal rights in paranoid personality disorder).

76 Chapter 2 Psychiatric assessment Asking about abnormal beliefs Both at the initial interview and during subsequent treatment, pro fessional staff dealing with a deluded patient should avoid colluding in the delusional belief system. The doctor should not be drawn into arguments about the truth of the delusion—by their nature, delusions cannot be argued or rationalized away, and arguments of this type can damage rapport. Nonetheless, the doctor should always make clear to the patient that he regards the delusional symptom as a symptom of mental ill health, albeit one which is very real and important to the pa tient concerned. Delusional ideas vary in their degree of detail and in their intensity over the course of an illness episode. In evolving psychotic illness, there will often be a perplexing sense of ‘something not being right’ and ill-formed symp toms such as a vague sense that they are being spied upon or persecuted in some way. As the delusion becomes more fully formed, it comes to dom inate the person’s thinking and becomes more elaborated—more detailed and with more ‘evidence’ produced to support the belief. With treatment, the delusion will hopefully fade in importance and the person may come to appreciate the belief as false or, despite holding to its initial truth, will regard it as no longer important. ‘Do you have any particular worries preying on your mind at the moment?’ Beginning with a very general question like this offers the patient an oppor tunity to broach a topic which may have been concerning them but which they have been putting off mentioning. ‘Do you ever feel that people are watching you or paying attention to what you are doing?’ Ask the patient to describe this sensation and an episode of its occurrence. Distinguish normal self-consciousness or a patient’s awareness of a genuinely notable abnormality from referential delusions. A delusion will generally have further elaboration of the belief—there will be some ‘reason’ why the reported events are happening. Elaboration may take the form of other beliefs about cameras, bugs, etc. ‘When you watch television or read the newspapers, do you ever feel that the stories refer to you directly or to things that you have been doing?’ Invite the patient to elaborate further on a positive response. Again, probe for fur ther elaboration of the belief and seek examples of when it has occurred. ‘Do you ever feel that people are trying to harm you in any way?’ Persecutory delusions are among the most common features of psychotic illness. There is potential for diagnostic confusion with paranoid personality traits, with suspicion and resentfulness towards medical and nursing staff and with genuine fears, understandable in the context of the patient’s lifestyle (e.g. of retribution from drug dealers or money lenders). Explore the nature and basis of the beliefs and the supporting evidence that the patient advances for them.

Asking about abnormal beliefs ‘Do you feel that you are to blame for anything, that you are responsible for anything going wrong?’ Delusions of guilt are seen in psychotic depression, in addition to the psychotic disorders. The affected individual may believe that they are responsible for a crime, occasionally one which has been promin ently reported. On occasions, these

individuals may ‘turn themselves in’ to the police, rather than seeking medical help. ‘Do you worry that there is anything wrong with your body or that you have a serious illness?’ Hypochondriacal delusions show diagnostic overlap with normal health concerns, hypochondriacal over-valued ideas, and somatiza tion disorder. Clarify this symptom by examining the patient’s evidence for this belief and the firmness with which it is held.

78 Chapter 2 Psychiatric assessment Asking about the first-rank symptoms of schizophrenia The first-rank symptoms are a group of symptoms which have special sig nificance in the diagnosis of schizophrenia. There is no symptom that is pathognomonic of schizophrenia. The first-rank symptoms are useful be cause they occur reasonably often in schizophrenia and more rarely in other disorders, and it is not too difficult to tell whether they are present or not. They can all be reported in other conditions (e.g. organic psych oses, manic illnesses). They do not give a guide to severity or prognosis of illness (i.e. a patient with many first-rank symptoms is not ‘worse’ than one with few), and they may not occur at all in a patient who undoubtedly has schizophrenia. There are eleven first-rank symptoms, organized into four categories according to type.
Auditory hallucinations • ‘Voices heard arguing’. • Thought echo. • ‘Running commentary’. Delusions of thought interference • Thought insertion. • Thought withdrawal. • Thought broadcasting. Delusions of control • Passivity of affect. • Passivity of impulse. • Passivity of volitions. • Somatic passivity. Delusional perception • A primary delusion of any content that is reported by the patient as having arisen, following the experience of a normal perception. ‘Do you ever hear voices commenting on what you are doing? Or discussing you between themselves? Or repeating your own thoughts back to you?’ For this symptom to be considered first-rank, the experience must be that of a true auditory hallucination where the hallucinatory voice refers to the patient in the third person (i.e. as ‘him’ or ‘her’, rather than ‘you’). Distinguish these experiences from internal monologues. ‘Do you ever get the feeling that someone is interfering with your thoughts— that they are putting thoughts into your head or taking them away? Or that your thoughts can be transmitted to others in some way?’ It is the experience itself that renders this symptom first-rank. The patient may describe add itional delusional elaboration (e.g. involving implanted transmitters or radio waves). The important point to clarify with the patient is that the experi ence is really that of thoughts being affected by an external agency and that it is not simple distraction or absent-mindedness. For thought broadcasting, ensure that the patient is not simply referring to the fact that they are ‘easily read’ or that they give away their emotions or thoughts by their actions.

Asking about the first-rank symptoms of schizophrenia ‘Do you ever get the feeling that you are being controlled? That your thoughts or moods or actions are being forced on you by someone else?’ Again, there may be delusional elaboration of this symptom, but it is the experience itself of an external controller affecting things which are normally experienced as to tally under one’s own control which makes this symptom first-rank. Clarify that the actions are truly perceived as controlled by an outside agency, ra ther than, for example, being directed by auditory hallucinations.

80 Chapter 2 Psychiatric assessment Disorders of the form of thought In describing psychopathology, we draw a distinction between the content and the form of thought. Content and form Content describes the meaning and experience of belief, perception, and memory as described by patients, while form describes the struc ture and process of thought. In addition to

abnormalities of percep tion and belief, mental disorders can produce abnormality in the normal form of thought processes. This may be suggested by abnormalities in the form of speech, the only objective representation of the thoughts, or may be revealed by empathic questioning designed to elicit the patient's subjective experiences. When patients mutter to themselves, listen closely to see if it is comprehensible or not. The latter is usually indicative of a disorder of form of thinking. See Box 2.2 for methods of assessing symptoms of thought disorder. Thought disorder Among the psychiatric symptoms that are outside normal experience, thought disorder is challenging to understand and perhaps the most diffi cult for the clinician to have empathy with. Consider a model of normal thought processes, and use this to simplify discussions of abnormalities. In this model, we visualize each thought, giving rise to a constellation of associations (i.e. a series of related thoughts). One of these is pursued, which gives rise to a further constellation and so on. This sequence may proceed towards a specific goal driven by a determining tendency (col loquially the 'train of thought') or may be undirected as in daydreaming. Disturbances in the form of thought may affect the rate or internal as sociations of thought. Box 2.2 Assessing symptoms of thought disorder Patients will rarely directly complain of the symptoms of thought dis order. In assessing the first-rank symptoms of schizophrenia, the doctor will have enquired about delusions of control of thought and about pas sivity delusions. Both these symptom areas require the patient to intro spect their thought processes; however, more rarely, they will be aware of disorders which affect the form, as opposed to the content, of their thoughts. They can be asked directly about the symptoms of acceleration and deceleration of thought, and these symptoms may be directly observ able in acceleration or deceleration of speech. Observation and recording of examples of abnormal speech is the method by which a formal thought disorder is assessed. Record examples of the patient's speech as verbatim quotes, particularly sentences where the meaning or the connection be tween ideas is not clear to you during the interview. Following recovery, patients can sometimes explain the underlying meaning behind examples of schizophrenic speech.

Disorders of the form of thought Accelerated tempo of thought Accelerated tempo of thought is called flight of ideas. It may be reflected in the speech as pressure of speech or may be described by the patient. The sensation is of the thoughts proceeding more rapidly than can be articulated and of each thought giving rise to more associations than can be followed up. Flight of ideas can be a feature of a manic episode. In the majority of cases of flight of ideas, some form of association of each thought can be discerned. For example, it could be a superficial clang association, alliter ation, and punning that proceeds like a game of dominoes where the last move determines the next move. In milder forms, called prolixity, the rate is slow and eventually reaches the goal if allowed adequate time. Decelerated tempo of thought Decelerated tempo of thought, or psychic retardation, occurs in depressive illnesses. Here the subjective speed of thought and the range of associations are d. There may be d rate of speech and absence of spontaneous speech. In addition, the remaining thoughts tend towards gloomy themes. In both accelerated and decelerated thought, there may be an i tendency for the determining tendency of thought to be lost (referred to as i distractibility). Schizophrenic thought disorder Disturbances of the associations between the thoughts are closely associ ated with schizophrenia and may be referred to as schizophrenic thought dis order. Four disturbances are classically described: snapping off (entgleiten), fusion (verschmelzung), muddling (faseln), and derailment (entgleisen). • Snapping off or thought blocking describes the subjective experience of the sudden and unintentional stop in a chain of thought. This may be unexplained by the patient or there may be delusional elaboration (e.g. explained as thought withdrawal). • Derailment or knight's move thinking describes a total break in

the chain of association between the meanings of thoughts. • Fusion is when two or more related ideas from a group of associations come together to form one idea. • Muddling is a mixture of elements of fusion and derailment. Drivelling refers to the resulting speech. • In mild forms, the determining tendency in the thoughts can be followed (i follow-up of side associations is referred to as circumstantiality).

82 Chapter 2 Psychiatric assessment Abnormal cognitive function All mental disorders affect cognition as expressed in affect, beliefs, and per ceptions. The organic mental illnesses directly affect the higher cognitive functions of conscious level, clarity of thought, memory, and intelligence. Level of consciousness This can range from full alertness through to clouding of consciousness, sopor, and coma (pathological unconsciousness), or from full alertness through to drowsiness, shallow sleep, and deep sleep (physiological unconsciousness). Confusion Milder forms of brain insult are characterized by a combination of dis orientation, misinterpretation of sensory input, impairment in memory, and loss of the normal clarity of thought—together referred to as con fusion. It is the main clinical feature of delirium (E Acute confusional state (delirium), p. 854) and is also present during intoxication with psy chotropic substances and occasionally as part of the clinical picture of acute psychotic illnesses. • Disorientation—an unimpaired individual is aware of who he is and has a constantly updated record of where he is and when it is. With increasing impairment, there is disorientation for time, then place, and lastly, with more severe confusion, for person. • Misinterpretation—with confusion, there is impairment of the normal ability to perceive and attach meaning to sensory stimuli. In frank delirium, there may be hallucinations, particularly visual, and secondary delusions, particularly of a persecutory nature. • Memory impairment—with confusion, there is impairment in both the registration of new memories (anterograde amnesia) and recall of established memories (retrograde amnesia). Events occurring during the period of confusion may be unable to be recalled or may be recalled in a distorted fashion, indicating a failure of registration. • Impaired clarity of thought—the layman’s ‘confusion’. A variable degree of impairment in the normal process of thought with disturbed linkages between meaning, subjective and objective slowing of thought, impaired comprehension, and bizarre content. Memory Beyond the ephemeral contents of our minds, containing our current thoughts and current sensorium, our memory contains all records of our experience and personality. • Working memory—synonymous with short-term memory, which is responsible for the immediate recall of small amounts of verbal (as in digit span) or visuospatial information. Used for such purposes as holding a telephone number while dialling it. Most people have between 5 and 9 ‘spaces’ available, with an average of 7 (the ‘magic number’). New information will enter at the expense of the old. It has been traditionally held that storage of information in long-term memory is dependent on short-term memory. This is now no longer thought

Abnormal cognitive function to be true; rather, these two memory components are thought to function independently of each other. For example, patients with even severe impairment of episodic memory (e.g. persons with Korsakoff’s syndrome) can present with normal short-term memory. • Long-term memory—system for storage of permanent memories, with apparently unlimited capacity. There appear to be separate storage systems for different types of information: memory for events (episodic memory), learnt skills (procedural memory), and memory of concepts and ideas unrelated to personal experience (semantic memory), which can be differentially affected by disease process. Intelligence A person’s intelligence refers to their ability to reason, solve problems, apply previous knowledge to new situations, learn new skills, think in an

abstract way, and formulate solutions to problems by internal planning. It is stable through adult life, unless affected by a disease process. Intelligence is measured by the IQ, a unitary measure with a population mean of 100 and a normal distribution. There is a ‘hump’ on the left-hand side of the popula tion curve for IQ representing those individuals with congenital or acquired lowered IQ. No pathological process produces heightened IQ. Acute vs chronic brain failure Despite its great complexity, the brain tends to respond to insults, what ever their source, in a variety of stereotyped ways (e.g. delirium, seizure, coma, dementia). These present as clinically similar or identical, whatever their underlying cause. Acute brain failure (delirium) and chronic brain failure (dementia) are two characteristic and stereotyped responses of the brain to injury. In common with other organ failure syndromes, there is an ‘acute-on-chronic’ effect where patients with established chronic impair ment are susceptible to developing acute impairment, following an insult which would not cause impairment in a normal brain [e.g. the development of florid delirium in a woman with mild dementia who develops a urinary tract infection (UTI)].

84 Chapter 2 Psychiatric assessment Assessing cognitive function 1 Assessing level of consciousness The Glasgow Coma Scale (GCS) is a rapid clinical measure of the conscious level (see Box 2.3). In delirium, both the conscious level and the level of confusion may vary rapidly on an hour-by-hour basis and may present as apparently ‘normal’ on occasions. Patients with symptoms suggestive of de lirium should therefore be re-examined regularly. Assessing confusion Assess orientation by direct questioning. Some degree of uncertainty as to the date and time can be expected in the hospitalized individual who is away from their normal routine. Directly enquire about episodes of perceptual disturbance and their nature. Document examples of confused speech, and comment on the accompanying affect. Assessing memory Working memory can be assessed by giving the patient a fictitious address containing six components, asking them to repeat it back, or by testing digit span, spelling of WORLD backwards, etc. Clinicians traditionally used the term ‘short-term memory’ to reflect material held over a short period (e.g. 5–30mins) or some time to refer to retention over the ensuing days or week. There is no evidence, however, from a neuropsychological perspec tive of a memory system with these characteristics, and one is better oc cupied in thinking of memory as defined here, and thereafter considering anterograde and retrograde aspects of the same. Level of intelligence In most cases, formal IQ testing will not be used and the IQ is assessed clinically. Clinical assessment of IQ is by consideration of the highest level of educational achievement reached and by assessment of the patient’s comprehension, vocabulary, and level of understanding in the course of the clinical interview. To some extent, this technique relies upon experience, giving the doctor a suitable cohort of previous patients for comparison, and allowance should be made for apparent impairment that may be sec ondary to other abnormalities of the mental state. In any case, if there is significant doubt about the presence of mental impairment, more formal neuropsychological testing should be carried out.

Assessing cognitive function 1 Box 2.3 Glasgow coma scale (GCS) The GCS is scored between 3 and 15, 3 being the worst (you cannot score 0) and 15 the best. It is composed of three parameters: [E] Best eye response (maximum score = 4)

1. No eye opening.
2. Eye opening to pain.
3. Eye opening to verbal command.
4. Eyes open spontaneously. [V] Best verbal response (maximum score = 5)

5. No verbal response.
6. Incomprehensible sounds.
7. Inappropriate words.
8. Confused but converses.
9. Orientated and converses. [M] Best motor response (maximum score = 6)
10. No motor response.
11. Extension to pain.
12. Flexion to pain.
13. Withdrawal from pain.
14. Localizing pain.
15. Obeys commands. Notes: • The phrase ‘GCS score of 11’ is essentially meaningless; the figure should be broken down into its components (e.g. quadraplegia + tracheostomy = E4 V1 M1 = GCS score 5, fully conscious). • A GCS score of 13 or more correlates with mild brain injury, 9–12 with moderate injury, and 8 or less with severe brain injury. Reproduced from Teasdale G, Jennett B (1974) Assessment of coma and impaired conscious ness. A practical scale. Lancet 304(7872): 81–4, with kind permission from Elsevier.

86 Chapter 2 Psychiatric assessment Assessing cognitive function 2 A wide range of standardized instruments are available for use in screening for cognitive impairment and for measuring severity and progression in established cases of dementia. There is currently no clear consensus on the best screening instrument, but in general, shorter screening tests are favoured in primary care or general medical settings. Bedside cognitive testing Six-item Cognitive Impairment Test (6CIT) (Katzman, 1983) A 6-question, ab breviated form of the older Blessed Information Memory Concentration Scale (BIMC) (1968), which examines orientation, memory, and concentra tion. Its usage is increasing, following its use as one component in a stand ardized assessment (Easycare©) recognized by the Royal College of General Practitioners. A computerized version is also available (Kingshill Version 2000). It is inversely scored and weighted, so that a score of 8 or more out of 28 is suggestive of significant cognitive impairment (sensitivity 78–90%, specificity 100%). Abbreviated Mental Test (AMT) (Hodkinson, 1972) A 10-item question naire testing orientation, memory, and concentration, originally developed by geriatricians as an abbreviated form of the mental test score from the BIMC. Useful for rapid screening for cognitive impairment—indicated by a score of 7 or less out of 10 (sensitivity 70–80%, specificity 71–90%). Mini Mental State Examination (MMSE) (Folstein, 1975) A 30-item ques tionnaire frequently used in psychiatric settings to screen for, and measure, cognitive impairment. It is included in many guidelines for dementia diag nosis, and there is a large body of research providing reference ranges for a variety of clinical situations and premorbid levels of functioning. A low sensitivity makes it less suitable as a screening test in primary care, but it is often used as a relatively short test to monitor changes in cognitive function over time, particularly in response to treatment. It should be remembered that the MMSE is based almost entirely on verbal assessment of memory and attention. It is insensitive to frontal executive dysfunction and visuo spatial deficits. A score of 23–25 or less out of 30 is considered impaired; however, note the low sensitivity and clinical experience which finds, not uncommonly, cognitive impairment in individuals with scores of 30/30 (sensitivity 30–60%, specificity 92–100%). Montreal Cognitive Assessment (MoCA) (Nasreddine, 2005) A 30-item questionnaire, increasingly used in preference to the MMSE, due to its as sessment of a broader range of cognitive domains and its greater sensitivity and specificity for mild cognitive impairment.

A score of below 26 suggests impairment. It is available in a range of languages and in electronic form. Addenbrooke's Cognitive Examination, third edition (ACE-III) (Mathuranath, 2000) When time permits, or the clinical presentation is more complex, the ACE-III provides a more detailed, 100-item, clinician-administered bedside test of cognitive function. Questions cover five areas of function: attention and orientation, memory, verbal fluency, language, and visuospatial aware ness. Detailed data are available to allow interpretation of scoring, and spe cific training on administration of the test is recommended. The ACE-III has a reported sensitivity of 94% and a specificity of 89% for dementia, with a cut-off score of 88/100.

Assessing cognitive function 2 Collateral information It is always useful to have third-party information when assessing cognitive function—usually from a spouse, partner, family member, or carer. Third- party information can be more formally assessed using standardized instru ments, e.g. the Informant Questionnaire on Cognitive Decline (IQCODE). Further reading Hodges JR (2007) Cognitive Assessment for Clinicians, 2nd edn. Oxford: Oxford University Press.

88 Chapter 2 Psychiatric assessment Supplementary tests of cerebral functioning Where there is clinical suspicion of specific functional impairment, it is often useful to directly test the functioning of the different cerebral lobes. This provides more detailed supplementary information to the MMSE (which is essentially a screening test). More formal neuropsychological assessment may be required with additional, well-established psychological tests, al though these will usually be administered by psychologists. Frontal lobe functioning Frontal assessment battery (FAB) A brief (10-min) test of executive function, which essentially regroups tests often used when testing executive function at the bedside. These tests are associated with specific areas of the frontal lobes (i.e. conceptualization with dorsolateral areas; word generation with medial areas) and inhibitory control with orbital or medial areas. The max imum score is 18, and a cut-off score of 12 in patients with dementia has been shown to have a sensitivity of 79% for frontotemporal dementia vs Alzheimer's disease. However, any performance below 17 may indicate frontal lobe impairment. The Wisconsin card sorting task The patient has to determine the rule for card allocation and allocate cards accordingly. When the rule changes, a patient with frontal lobe dysfunction is likely to make more errors (tests response inhibition and set shifting). Digit span Short-term verbal memory is tested with progressively longer number sequences, first forwards (normal maximum digit span 6 ± 1) and subsequently in reverse order (normal maximum 5 ± 1). Trail-making test A 'join the dots' test of visuomotor tracing, testing con ceptualization and set shifting. Test A is a simple number sequence; Test B is of alternating numbers and letters (more sensitive for frontal lobe dysfunction). Cognitive estimate testing The patient is asked a question that requires ab stract reasoning and cannot be answered by general knowledge alone (e.g. 'how many camels are there in the UK?'). Testing of interpretation of proverbs can be helpful in uncovering con creteness of thought, e.g. 'People in glass house shouldn't throw stones'— asking the patient 'Are you aware of this proverb?', 'Can you tell me what this means?', and 'Give me a life scenario in which this would apply?' It is im portant to note that persons with more orbito-medial frontal lobe damage may present with completely normal neurocognitive assessment, but clin ically with histories that are consistent with frontotemporal dementia– behavioural variant. Parietal lobe functioning Tests for dominant lesions Finger agnosia Patient cannot state which finger is being touched, with their eyes closed. Astereoagnosia Patient unable to recognize the feel of common objects (e.g. coin, pen), with their eyes closed.

Supplementary tests of cerebral functioning Dysgraphaesthesia Inability to recognize letters or numbers written on the hand. Note: although of disputed clinical value, Gerstmann syndrome is clas sically described as right–left disorientation, finger agnosia, dysgraphia, and dyscalculia, due to a lesion of the dominant (usually left) parietal lobe. Tests for non-dominant lesions Asomatognosia Patient does not recognize parts of their body (e.g. hand, fingers). Constructional dyspraxia Inability to draw shapes or construct geometrical patterns. Other problem areas • Visual fields (as optic tracts run through the parietal lobe to reach the occipital lobe). • Speech—alexia, receptive dysphasia (Wernicke's area); conduction aphasia (cannot repeat a phrase but does understand the meaning). • Reading/writing (angular gyrus lesions).

90 Chapter 2 Psychiatric assessment Insight The question of whether the patient has insight into the nature of their symptoms tends only to arise in psychiatric illnesses. In general, a patient with physical illness knows that their symptoms represent abnormality and seeks their diagnosis and appropriate treatment. In contrast, a variety of psychiatric illnesses are associated with impairment of insight and the devel opment of alternative explanations by the patient as to the cause of their symptoms, e.g.: • An elderly man with early dementia who is unable to recall where he leaves objects and attributes this to someone stealing them. He angrily accuses his son of the 'crime'. • An adolescent, with developing schizophrenia, who believes his auditory hallucinations and sense of being watched are caused by a neighbour who has planted cameras and loudspeakers in his flat. He repeatedly calls the police and asks them to intervene. • A middle-aged woman with worsening depression who develops the delusion that she is bankrupt and is shortly to be evicted from her home in disgrace. Impairment of insight is not specific to any one psychiatric condition and is not generally a diagnostically important symptom. It tends to occur in psychotic and organic illnesses and the more severe forms of depressive illness. Neurotic illnesses and personality disorders are generally not asso ciated with impairment of insight. Impairment of insight can give a crude measure of severity of psychotic symptoms. Regaining of insight into the pathological nature of psychotic beliefs can give a similarly crude measure of improvement with treatment. Insight can be defined succinctly as 'the correct attitude to morbid change in oneself'. It is a deceptively simple concept that includes a number of beliefs about the nature of the symptoms, their causation, and the most appropriate way of dealing with them. Insight is sometimes reported as an all-or-nothing measure—as something an individual patient either does or does not have. In fact, insight is most usefully inquired about and reported as a series of health beliefs: • Does the patient believe that their abnormal experiences are symptoms? • Does the patient believe their symptoms are attributable to illness? • Do they believe that the illness is psychiatric? • Do they believe that psychiatric treatment might benefit them? • Would they be willing to accept advice from a doctor regarding their treatment? Beyond the simple question of whether the patient has impairment of in sight or not, it is vital to understand how the patient views their symptoms, as this will tend to influence their compliance and future help-seeking be haviour. It is important to emphasize that disagreement with the doctor as to the correct course of action does not necessarily indicate lack of insight. A patient may very well not agree to be admitted to hospital or to take a particular medication, despite having full insight into the nature of their symptoms. In these cases, the doctor should be sure to clarify that the pa tient has all the necessary information to make a suitable decision before considering the possible need for compulsory treatment.

Insight 91

92 Chapter 2 Psychiatric assessment Physical examination Examination of the patient's physical condition is an integral part of a comprehensive psychiatric assessment. There are five main reasons why this is so: • Physical symptoms may be a direct result of psychiatric illness [e.g. alcohol dependency (E Medical complications of alcohol misuse, p. 608); eating disorders (E Anorexia nervosa 3: assessment, p. 414); physical neglect in severe depression, schizophrenia, etc.]. • Psychiatric drugs may have physical side effects [e.g. extra-pyramidal side effects (EPSEs) and antipsychotics, hypothyroidism, and lithium, withdrawal syndromes]. • Physical illnesses can cause or exacerbate mental symptoms. • Occult physical illness may be present. • In the case of later development of illness (or, more rarely, medico-legal issues), it is helpful to have baseline physical findings documented. Physical examination is all too often deferred and then not done, or not done as thoroughly as is indicated. It may well be acceptable to defer full examination on occasions (e.g. a distressed and paranoid man seen in the Emergency Department), but a minimal investigation can be done and com pleted as the situation allows. A routine physical examination has the aim of documenting the patient's baseline physical state, noting the presence or absence of abnormal signs which could be associated with mental or physical illness and highlighting areas requiring further examination or investigation (see Table 2.1). General condition Note the height and weight. Does the patient look well or unwell? Are they underweight or are there signs of recent weight loss? Note bruising or other injuries, and estimate their age. Cardiovascular Radial pulse—rate, rhythm, and character. Blood pressure. Carotid bruits? Heart sounds. Pedal oedema. Respiratory Respiratory rate. Expansion. Percussion note. Breath sounds to auscultation. Abdominal Swelling or ascites. Masses. Bowel sounds. Hernias. Neurological Pupillary response and other cranial nerves. Wasting. Tone. Power. Sensation. Reflexes. Gait. Involuntary movements.

Physical examination Table 2.1 Some physical signs in psychiatric illness and possible causes General examination Parkinsonian facies Abnormal pupil size Argyll–Robertson pupil Enlarged parotids ('hamster face') Hypersalivation Goitre Multiple forearm scars Multiple tattoos Needle tracks/phlebitis Gynaecomastia Russell's sign (knuckle callus) Lanugo hair Piloerection ('goose flesh') Excessive thinness Antipsychotic drug treatment Psychomotor retardation (depression) Opiate use Neurosyphilis Bulimia nervosa (secondary to vomiting) Clozapine treatment Thyroid disease Borderline personality disorder Dissocial personality disorder Intravenous drug use Antipsychotic drug treatment Alcoholic liver disease Bulimia nervosa (secondary to inducing vomiting) Anorexia nervosa Opiate withdrawal Anorexia nervosa Cardiovascular Rapid/irregular pulse Slow pulse Anxiety disorder Drug/alcohol withdrawal Hyperthyroidism Hypothyroidism Abdominal Enlarged liver Multiple surgical scars ('chequerboard' abdomen) Multiple self-inflicted scars Alcoholic liver disease Hepatitis Somatization disorder Borderline personality disorder Neurological Resting tremor Involuntary movements Abnormal posturing Festinant (shuffling) gait Broad-based gait i sympathetic drive (anxiety, drug/alcohol misuse) Antipsychotic drug treatment Lithium treatment Antipsychotic drug treatment Tic disorder Huntingtons's/Sydenham's chorea Antipsychotic-induced dystonia Catatonia Antipsychotic drug treatment Cerebellar disease (alcohol, lithium toxicity)

94 Chapter 2 Psychiatric assessment Clinical investigation Clinical investigations, including blood testing, imaging techniques, and karyotyping, play a smaller role in psychiatry than in other medical special ties. They are mainly carried out to exclude medical conditions which may be part of the differential diagnosis (such as hypothyroidism as a cause of lethargy and low mood) or which

may be comorbid. They should generally be carried out as a result of positive findings in the history or physical exam ination or in order to exclude serious and reversible occult disorders (such as syphilis as a cause of dementia). Routine investigations may be carried out to assess general physical health and to provide a baseline measure prior to commencing medication known to have possible adverse effects, e.g. full blood count (FBC), liver function tests (LFTs), and antipsychotic medication; and urea and electro lytes (U&Es), creatinine clearance, and thyroid function tests (TFTs) prior to lithium therapy. Specific screening and monitoring tests are detailed in specific sections. It is good practice to screen new patients with some standard tests, and the usual test battery will include: FBC (and differen tial), U&Es, LFTs, TFTs, and glucose. Where there is suspicion of drug or alcohol misuse/dependency, mean corpuscular volume (MCV), B12/folate, and toxicology screening may be added. Other physical investigations are rarely requested (with perhaps the ex ception of ECG for patients on specific or high-dose antipsychotics), unless clinical examination indicates the possibility of an underlying (undiagnosed) physical disorder. Performance of an LP, for example, is reserved for situ ations where there is clear evidence to suggest a neurological disorder presenting with psychiatric symptoms (e.g. suspected meningitis or enceph alitis; multiple sclerosis) and, more often than not, in these circumstances, a referral will be made for a medical review. Use of other tools, such as EEG, CT, or MRI (and SPECT or PET where available) requires justification on the grounds of diagnostic need. EEG is frequently overused by psychiatrists and may be difficult to interpret, as psy chotropic medications may ‘muddy the waters’. EEG may be useful where epilepsy is suspected (on clinical grounds), to monitor some acute (toxic) confusional states, to assess atypical patterns of cognitive impairment, to aid the diagnosis in certain dementias [e.g. HIV, variant Creutzfeldt–Jakob disease (vCJD)], to evaluate particular sleep disorders, or as the gold standard for seizure monitoring during ECT. EEG should not be used as a general screening tool. Similarly, brain imaging adds little to the diagnosis of primary psychi atric disorders and should only be used where there is good evidence for possible neurological problems (e.g. history of significant head in jury, epilepsy, multiple sclerosis, previous neurosurgery) or where his tory and clinical examination indicate the possibility of a space-occupying lesion (e.g. localizing neurological signs, unexplained fluctuating level

Clinical investigation of consciousness, severe headache, marked and unexplained acute be havioural change). With the exception of organic disorders (e.g. the dementias where diagnostic imaging techniques may add useful informa tion to inform diagnosis, management, and prognosis), the sensitivity and specificity of imaging findings for most psychiatric conditions have yet to be established. As a general rule, comorbid or causative disorders will be suspected due to other symptoms and signs or by the atypical nature of the psychi atric picture, and the likelihood of revealing a totally unexpected diagnosis is small.

96 Chapter 2 Psychiatric assessment Common assessment instruments 1 The diagnosis of psychiatric disorders is largely clinical, although assessment tools are increasingly used for both clinical and research purposes. A huge variety of assessment tools is available for the diagnosis and assessment of severity of individual disorders and for the monitoring of progress and treatment response in established cases. Their primary use is as an aid in diagnosis and to provide an objective measurement of treatment response. They should not be considered as a primary means of diagnosis. A secondary use is in research, in order to ensure heterogenous patient groupings and reliably standardized diagnosis. Scales are often available in several versions, are either clinician- or patient-administered, and vary in required skill and experience of the ad

ministrator. Some are available for free by searching on the Internet, while others are copyrighted and available from purchase from the manufac turer. Examples of the more commonly found general and specific tests are given here. General General Health Questionnaire (GHQ) Self-rated questionnaire used as a screening instrument for the presence of psychiatric illness. The patient is asked to report the presence of a list of symptoms in the preceding weeks. Four versions are available, using 12, 28, 30, and 60 items. Diagnostic Interview Schedule (DIS) Can be used by non-clinicians to ad minister a fully structured interview, to diagnose the major psychiatric illnesses for research purposes. Global Assessment of Functioning Scale (GAF) A 100-item, self-report rating scale measuring overall psychosocial functioning. Minnesota Multiphasic Personality Inventory (MMPI) Self-report question naire consisting of 567 questions covering eight areas of psychopathology and two additional areas of personality type, and three scales assessing truthfulness. Results are compared with normative data from non-clinical populations. Results generate information useful for a broad range of clin ical applications. Primary Care Evaluation of Mental Disorders (PRIME-MD) One-page patient- completed questionnaire focusing on psychiatric illness commonly encoun tered in primary care. Has a corresponding Clinician Evaluation Guide. Quality of Life Interview (QOLI) Non-clinician-administered, fully struc tured interview, available in full and brief versions with 158 and 78 items, respectively. Suitable for assessment of quality of life in those with enduring and severe mental illnesses. Structured Clinical Interview for DSM-IV (SCID-I/SCID-II) Clinician- administered semi-structured interview for use in patients in whom a psychiatric diagnosis is suspected. Primarily used in research with trained interviewers, to inform the operationalized diagnosis of Axis I and II dis orders. The Research Version of the SCID-I for DSM-5 was released in November 2014 (SCID-5-RV).

Common assessment instruments 1 Mood disorders Beck Depression Inventory (BDI) Self-rated questionnaire containing 21 state ments, with four possible responses for each. The total score is quoted, with >17 indicating moderate and >30 indicating severe depression. Hospital Anxiety and Depression Scale (HADS) A 14-item, self-rated ques tionnaire, producing an anxiety and a depression subscore. Hamilton Rating Scale for Depression (HAM-D) An interviewer-rated, 17- item rating scale for depressive illness. Not a diagnostic instrument; used to measure changes (e.g. as a result of drug treatment); 17 items scored according to severity, producing the total score. Montgomery-Asberg Depression Rating Scale (MADRaS) A 10-item observer-rated scale. Each item rated 0–6, with a total score obtained. Mood Disorders Questionnaire (MDQ) A self-rated screen for bipolar dis order. 13 yes/no questions, and two others. Positive screen is ‘yes’ 7/13, and ‘yes’ to question 2, moderate/serious to question 3. Young Mania Rating Scale (YMRS) Assesses mania symptoms and weighted severity over the past 48hr. Anxiety spectrum Hamilton Anxiety Rating scale (HAM-A) A clinician-administered rating scale for generalized anxiety disorder; 14 items rated on a 5-point scale. Yale–Brown Obsessive–Compulsive Scale (Y-BOCS) A clinician-administered semi-structured interview allowing the rating of severity in patients with a pre-existing diagnosis of OCD. Schizophrenia Brief Psychiatric Rating Scale (BPRS) Measures major psychotic and non-psychotic symptoms, primarily used for schizophrenia patients. Clinician- rated, based on observation. Positive and Negative Symptom Scale (PANSS) A clinician-administered rating scale for the assessment of severity and monitoring of change of symptoms in patients with a diagnosis of schizophrenia. Items covering posi tive symptoms, negative symptoms, and general psychopathology. Scale for the Assessment of Positive/Negative Symptoms (SAPS/SANS) Administered together and completed from history and clinician observa tion. It breaks down into three divisions: psychoticism, negative symptoms, and disorganization. Abnormal Involuntary

Movement Scale (AIMS) A clinician-administered scale for assessing the severity of antipsychotic side effects; 12 items rated 0–4.

98 Chapter 2 Psychiatric assessment Common assessment instruments 2 Substance use Cut down? Annoyed? Guilty? Eye opener? (CAGE) A brief screening test for alcohol problems, consisting of four yes/no questions, with a score of 2 or more indicating the need for further assessment. Alcohol Use Disorders Identification Test (AUDIT) Completed by a skilled clinician to reveal if there is a need for further evaluation. Questions cover the quantity and frequency of alcohol use, drinking behaviours, adverse psy chological symptoms, and alcohol-related problems. Assessment instruments specific to children Attention-deficit/hyperactivity disorder (ADHD) (SNAP, Vanderbilt, Conners' Rating Scale) Used to assess the presence and severity of ADHD symptoms in multiple settings. Completed by adults who know the child well (parents, teachers). Also have subscales to measure other symptoms such as disrup tive behaviour. Anxiety Screen for Child Anxiety-Related Emotional Disorders (SCARED) A self-report instrument designed to measure anxiety symptoms in children. Autism Spectrum Childhood Autism Rating Scale (CARS) Ages 2 and up, scored by clinicians based on observation. Gilliam Autism Rating Scale (GARS) Ages 3–22, scored by teachers and parents, as well as clinicians. Autism Diagnostic Observation Schedule (ADOS) A semi-structured and lengthy diag nostic interview given by specially trained clinicians. It uses standardized data to aid in the diagnosis of pervasive developmental disorders. Children's Depression Inventory (CDI) A self-report of depression symp toms for ages 7–17 (first-grade reading level). Structured interviews (such as KSADS-PL) Semi-structured diagnostic interviews covering the spectrum of psychiatric illness in children and ad ministered by trained clinicians only. Older adults Geriatric Depression Scale (GDS) A self-reported screen for depression, using a series of yes/no questions. Instrumental Activities of Daily Living (IADL) Used to evaluate the day-to- day living skills in an older population. It can be used to evaluate treatment effectiveness or help identify placement needs of the individual. Further reading Sajatovic M, Ramirez L, Ramirez LF (2003) Rating Scales in Mental Health, 2nd edn. Hudson, OH: Lexicomp.