

**PRACTICE GUIDELINE FOR THE
Psychiatric Evaluation
of Adults
Second Edition**

WORK GROUP ON PSYCHIATRIC EVALUATION

Michael J. Vergare, M.D., Chair

Renée L. Binder, M.D.

Ian A. Cook, M.D.

Marc Galanter, M.D.

Francis G. Lu, M.D.

AMERICAN PSYCHIATRIC ASSOCIATION STEERING COMMITTEE ON PRACTICE GUIDELINES

John S. McIntyre, M.D.,

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Molly T. Finnerty, M.D.

Sherwyn M. Woods, M.D., Ph.D.

Bradley R. Johnson, M.D.

Joel Yager, M.D.

AREA AND COMPONENT LIAISONS

Robert Pyles, M.D. (Area I)

C. Deborah Cross, M.D. (Area II)

Roger Peele, M.D. (Area III)

Daniel J. Anzia, M.D. (Area IV)

John P. D. Shemo, M.D. (Area V)

Lawrence Lurie, M.D. (Area VI)

R. Dale Walker, M.D. (Area VII)

Mary Ann Barnovitz, M.D.

Sheila Hafter Gray, M.D.

Sunil Saxena, M.D.

Tina Tonnu, M.D.

STAFF

Robert Kunkle, M.A., *Senior Program Manager*

Amy B. Albert, B.A., *Assistant Project Manager*

Laura J. Fochtman, M.D., *Medical Editor*

Claudia Hart, *Director, Department of Quality Improvement and Psychiatric Services*

Darrel A. Regier, M.D., M.P.H., *Director, Division of Research*

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STATEMENT OF INTENT

The APA Practice Guidelines are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual patient and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome for every individual, nor should they be interpreted as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities some contributors, including work group members and reviewers, have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. Work group members are selected on the basis of their expertise and integrity. Any work group member or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work is asked to disclose this to the Steering Committee on Practice Guidelines and the work group. Iterative guideline drafts are reviewed by the Steering Committee, other experts, allied organizations, APA members, and the APA Assembly and Board of Trustees; substantial revisions address or integrate the comments of these multiple reviewers. The development of the APA practice guidelines is not financially supported by any commercial organization.

More detail about mechanisms in place to minimize bias is provided in a document available from the APA Department of Quality Improvement and Psychiatric Services, "APA Guideline Development Process."

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DEVELOPMENT PROCESS

This practice guideline was developed under the auspices of the Steering Committee on Practice Guidelines. The development process is detailed in a document available from the APA Department of Quality Improvement and Psychiatric Services, the “APA Guideline Development Process.” Key features of this process include the following:

- A comprehensive literature review
- Development of evidence tables
- Initial drafting of the guideline by a work group that included psychiatrists with clinical and research expertise in psychiatric evaluation
- Production of multiple revised drafts with widespread review (14 organizations and 64 individuals submitted significant comments)
- Approval by the APA Assembly and Board of Trustees
- Planned revisions at regular intervals

Relevant literature was identified through a computerized search of MEDLINE, using PubMed, for the period from 1994 to 2005. The search strategy (psychiatric assessment OR psychiatric assessments OR psychiatric emergencies OR psychiatric emergency OR psychiatric evaluation OR psychiatric evaluations OR psychiatric histories OR psychiatric history OR psychiatric interview OR psychiatric interviewing OR psychiatric interviews OR psychological assessment OR psychological assessments OR psychological evaluation OR psychological interview OR mental status examination OR mental status examinations OR psychiatric rating) OR (mental disorders/diagnosis AND [laboratory findings OR laboratory techniques OR laboratory test OR laboratory tests OR radiograph OR radiographic OR radiography OR x ray OR imaging OR MRI OR tomography OR physical exam OR physical examination OR interview OR interviewing OR history taking OR evaluation OR assessment]) yielded 19,429 references, of which 7,894 were published between 1994 and 2005 in English and had associated abstracts. An additional search on history taking AND (psychiatric OR sexual OR occupational OR social OR psychosocial) yielded 1,927 references, with 731 of these published with abstracts in English between the years 1994 and 2005.

Additional, more limited searches were conducted by APA staff and individual members of the Work Group on Psychiatric Evaluation to address discrete issues outside of the primary guideline topic.

This document represents a synthesis of current scientific knowledge and rational clinical practice on the psychiatric evaluation of adults. It strives to be as free as possible of bias toward any theoretical approach.

INTRODUCTION

Psychiatric evaluations vary according to their purpose. This guideline is intended primarily for general, emergency, and consultation evaluations for clinical purposes. It is applicable to evaluations conducted by a psychiatrist with adult patients (age 18 or older), although sections may be applicable to younger patients. Other types of psychiatric evaluations (including forensic, child custody, and disability evaluations) are not the focus of this guideline; however, the general recommendations of this guideline may be applicable to other, more specialized evaluations.

The guideline presumes familiarity with basic principles of psychiatric diagnosis and treatment planning as outlined in standard, contemporary psychiatric textbooks (1–6) and taught in psychiatry residency training programs. It was developed following a review of contemporary references, and it emphasizes areas of consensus in the field.

Recommendations of this guideline are intended to be consistent with the care model endorsed in the Institute of Medicine report *Crossing the Quality Chasm* (7). This report notes that with advancements in medical science, the emphasis of health care delivery must shift to ongoing management of chronic conditions. The initial psychiatric evaluation may set the stage for such ongoing care by establishing initial treatment goals, gathering relevant baseline data, establishing a plan for systematic follow-up assessment using formal but practical and relevant measures, and ensuring longitudinal follow-up.

While there is broad agreement that each element of the extensive general evaluation described in this guideline may be relevant or even crucial in a particular patient, the specific emphasis of an evaluation will vary according to its purpose and the patient's presenting problem. Consideration of the domains outlined in this guideline is part of a general psychiatric evaluation, but the content, process, and documentation must be determined by applying the professional skill and judgment of the psychiatrist. The performance of a particular set of clinical procedures does not ensure the adequacy of a psychiatric evaluation, nor does their omission imply that the evaluation is deficient. The particular emphasis or modifications applied by the psychiatrist to the generic evaluation offered in this guideline should be consonant with the aims of the evaluation, the setting of practice, the patient's presenting problem, and the ever-evolving knowledge base concerning clinical assessment and clinical inference. Although documentation is an integral part of an evaluation, it is important to emphasize that the scope and detail of clinically appropriate documentation also will vary with the patient, setting, clinical situation, and confidentiality issues. Because of the wide variation in these factors, this guideline does not include recommendations regarding the content or frequency of documentation. Such determinations must be based on the specific circumstances of the evaluation.

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I. PURPOSE OF EVALUATION

The purpose and conduct of a psychiatric evaluation depend on who requests the evaluation, why it is requested, and the expected future role of the psychiatrist in the patient's care. The outcome of the evaluation may or may not lead to a specific psychiatric diagnosis. Three types of clinical psychiatric evaluations are discussed: 1) general psychiatric evaluation, 2) emergency evaluation, and 3) clinical consultation. In addition, general principles to guide the conduct of evaluations for administrative or legal purposes are reviewed. At times there may be a conflict between the need to establish an effective working relationship with the patient and the need to obtain comprehensive information efficiently. If the psychiatrist expects to provide care directly to the patient, the establishment of an effective working relationship with the patient may take precedence over the comprehensiveness of the initial interview or interviews (8). In such a case, emphasis may be placed on obtaining information needed for immediate clinical recommendations and decisions (9).

▶ A. GENERAL PSYCHIATRIC EVALUATION

A general psychiatric evaluation has as its central component an interview with the patient. The interview-based data are integrated with information that may be obtained through other components of the evaluation, such as a review of medical records, a physical examination, diagnostic tests, and history from collateral sources. A general evaluation usually is time intensive. The amount of time necessary generally depends on the complexity of the problem and the patient's ability and willingness to work cooperatively with the psychiatrist. Language competence needs to be assessed early in the evaluation so that the need for an interpreter can be determined. Several meetings with the patient, and in many cases appropriate family or relational network members, may be necessary. More focused evaluations of lesser scope may be appropriate when the psychiatrist is called on to address a specific, limited diagnostic or therapeutic issue.

The aims of a general psychiatric evaluation are 1) to establish whether a mental disorder or other condition requiring the attention of a psychiatrist is present; 2) to collect data sufficient to support differential diagnosis and a comprehensive clinical formulation; 3) to collaborate with the patient to develop an initial treatment plan that will foster treatment adherence, with particular consideration of any immediate interventions that may be needed to address the safety of the patient and others—or, if the evaluation is a reassessment of a patient in long-term treatment, to revise the plan of treatment in accordance with new perspectives gained from the evaluation; and 4) to identify longer-term issues (e.g., premorbid personality) that need to be considered in follow-up care.

In the course of any evaluation, it may be necessary to obtain history from other individuals (e.g., family or others with whom the patient resides; individuals referring the patient for assessment, including other clinicians). Although the default position is to maintain confidentiality unless the patient gives consent to a specific intervention or communication, the psychiatrist is justified in attenuating confidentiality to the extent needed to address the safety of the patient and others (10, 11). In addition, the psychiatrist can elicit and listen to information provided by friends or family without disclosing information about the patient to the informant.

More detailed recommendations for performing a general psychiatric evaluation are provided in Section III.

▶ **B. EMERGENCY EVALUATION**

The emergency psychiatric evaluation generally occurs in response to thoughts, feelings, or urges to act that are intolerable to the patient, or to behavior that prompts urgent action by others, such as violent or self-injurious behavior, threats of harm to self or others, failure to care for oneself, bizarre or confused behavior, or intense expressions of distress. The aims and specific approaches to the emergency evaluation have been reviewed elsewhere in detail (11–15) and include the following:

1. Assess and enhance the safety of the patient and others.
2. Establish a provisional diagnosis (or diagnoses) of the mental disorder(s) most likely to be responsible for the current emergency, including identification of any general medical condition(s) or substance use that is causing or contributing to the patient's mental condition.
3. Identify family or other involved persons who can give information that will help the psychiatrist determine the accuracy of reported history, particularly if the patient is cognitively impaired, agitated, or psychotic and has difficulty communicating a history of events. If the patient is to be discharged back to family members or other caretaking persons, their ability to care for the patient and their understanding of the patient's needs must be addressed.
4. Identify any current treatment providers who can give information relevant to the evaluation.
5. Identify social, environmental, and cultural factors relevant to immediate treatment decisions.
6. Determine whether the patient is able and willing to form an alliance that will support further assessment and treatment, what precautions are needed if there is a substantial risk of harm to self or others, and whether involuntary treatment is necessary.
7. Develop a specific plan for follow-up, including immediate treatment and disposition; determine whether the patient requires treatment in a hospital or other supervised setting and what follow-up will be required if the patient is not placed in a supervised setting.

The emergency evaluation varies greatly in length and may on occasion exceed several hours. Patients who will be discharged to the community after an emergency evaluation may require more extensive evaluation in the emergency setting than those who will be hospitalized. For example, patients who have presented with intoxication or who have received medications in the emergency department may require additional observation to verify their stability for discharge. In other individuals with significant symptoms but without apparent acute risk to self or others, additional time may be needed to obtain more detailed input from family, other involved caretaking persons, and treatment providers; to verify that the proposed plan of follow-up is viable; and to communicate with follow-up caregivers about interventions or recommendations resulting from the emergency assessment.

When patients are agitated, psychotic, or uncooperative with assessment, and when their clinical presentation appears to differ from the stated factors prompting assessment, it may be especially important to obtain history from other individuals (e.g., family members, other professionals, police), keeping in mind principles of confidentiality, as described in Section I.A above and in Section V.A.

Patients presenting for emergency psychiatric evaluation have a high prevalence of combined general medical and psychiatric illness, recent trauma, substance use and substance-related conditions, and cognitive impairment (16–27). These diagnostic possibilities deserve careful consideration. General medical and psychiatric evaluations should be coordinated so that additional medical evaluation can be requested or initiated by the psychiatrist on the basis of diagnostic or therapeutic considerations arising from the psychiatric history and interview. Although issues of confidentiality are sometimes raised, in an emergency situation necessary information about the patient can be communicated with the emergency medicine department

staff. In many emergency settings, patients initially are examined by a nonpsychiatric physician to exclude acute general medical problems. Such examinations usually are limited in scope and rarely are definitive (18, 19, 28–30). Furthermore, psychiatrists and emergency physicians sometimes have different viewpoints on the utility of laboratory screening for substance use or medical disorders in psychiatric emergency department patients (31, 32). Therefore, on the basis of clinical judgment and the specific circumstances of the evaluation, the psychiatrist may need to request or initiate further general medical evaluation to address diagnostic concerns that emerge from the psychiatric evaluation (12, 16, 18–27, 33–35).

► **C. CLINICAL CONSULTATION**

Clinical consultations are evaluations requested by other physicians or health care professionals, patients, families, or others for the purpose of assisting in the diagnosis, treatment, or management of an individual with a suspected mental disorder or behavioral problem. These evaluations may be comprehensive or may be focused on a relatively narrow question, such as the preferred medication for treatment of a known mental disorder in a patient with a particular general medical condition. Psychiatric evaluations for consultative purposes use the same data sources as general evaluations. Consideration is given to information from the referring source on the specific problem leading to the consultation, the referring source's aims for the consultation, information that the psychiatrist may be able to obtain regarding the patient's relationship with the primary clinician, and the resources and constraints of those currently treating the patient. Also, in the case of a consultation regarding a mental or behavioral problem in a patient with a general medical illness, information about that illness, its treatment, and its prognosis is relevant. The patient should be informed that the purpose of the consultation is to advise the party who requested it. Permission to report findings to others, including family, needs to be clarified with the patient and other concerned parties before the evaluation begins.

The aim of the consultative psychiatric evaluation is to provide clear and specific answers to the questions posed by the party requesting the consultation (36, 37). For example, the psychiatrist may be asked to determine the patient's capacity to give consent for treatment decisions. On other occasions, the psychiatrist may be asked to assess a particular sign, symptom, or syndrome; provide a diagnosis; and recommend evaluation, treatment, or disposition at a level of specificity appropriate to the needs of the treating clinician.

In the course of the evaluation, the consultant may also identify a diagnostic or therapeutic issue that was not raised in the request for consultation but that is of concern to the patient or of relevance to treatment outcome. For example, treatment adherence may be affected by personality and countertransference issues that compromise the patient's therapeutic alliance with the referring clinician. If any conflicts between the patient and the primary clinician do emerge as an issue, positive resolution of them should be encouraged in a manner that respects the patient's relationship with the primary clinician.

If agreed to by the patient, discussion of findings and recommendations with the family or involved persons can assist with appropriate follow-up and adherence with recommendations.

► **D. OTHER CONSULTATIONS**

Other psychiatric consultations are directed toward the resolution of specific legal, administrative, or other nonclinical questions. While the details of these evaluations, such as forensic evaluations, child custody evaluations, and disability evaluations, are beyond the scope of this guideline, several general principles apply. First, the evaluatee usually is not the psychiatrist's patient, and there are limits to confidentiality implicit in the aims of the evaluation; accordingly, the aims of the evaluation and the scope of disclosure should be addressed with the evaluatee at the start of the interview (38, 39). Second, questions about the evaluatee's legal status and legal

representation should be resolved before the assessment begins, if possible. Third, many such consultations rely heavily, or even entirely, on documentary evidence or data from collateral sources. The quality and potential biases of such data should be taken into account.

The aims of these psychiatric consultations are 1) to answer the requester's question to the extent possible with the data obtainable and 2) to make a psychiatric diagnosis if it is relevant to the question.

II. SITE OF THE CLINICAL EVALUATION

▶ A. INPATIENT SETTINGS

The scope, pace, and depth of inpatient evaluation depend on the patient population served by the inpatient service, the goals of the hospitalization, and the role of the inpatient unit within the overall system of mental health services available to the patient (40, 41).

In addition to providing a highly structured and contained setting in which patient safety can be monitored and optimized, the inpatient setting permits intensive and continuous observation of signs and symptoms while the patient is being treated for psychiatric and general medical conditions through the collaborative efforts of the multidisciplinary treatment team (see also Section IV.A.5). Particularly for individuals with complex psychiatric presentations or multiple co-occurring disorders, the enhanced level of observation in the inpatient environment may facilitate assessment of co-occurring general medical conditions or evaluation for procedures such as electroconvulsive therapy, may aid in resolving diagnostic dilemmas, and may help in determining a patient's ability to function safely and independently in a less restrictive setting (41, 42).

Inpatient settings provide enhanced opportunity to corroborate clinical judgment and decision making, including discharge planning, through access to information from multiple sources. These include the multidisciplinary treatment team, family, friends, and individuals involved in the care of the patient outside the hospital, as well as prior hospitalization records.

From the outset, the inpatient evaluation should include assessment of the patient's access to appropriate treatment following hospitalization. The patient's living arrangements should also be assessed to determine whether they will continue to be suitable after discharge. If the posthospitalization disposition is not apparent, the evaluation should identify both patient factors and community resources that would be relevant to a viable disposition plan and should identify the problems that could impede a suitable disposition. Family involvement, when appropriate, can also be initiated, and goals for inpatient family work can be identified.

▶ B. OUTPATIENT SETTINGS

Outpatient settings differ widely, from office-based practices to community mental health centers to intensive outpatient or partial hospital programs, among others. Nevertheless, evaluation in the outpatient setting usually differs in intensity from inpatient evaluation because of less frequent interviews and less immediate availability of laboratory services and consultants from other medical specialties. Also, the psychiatrist in the outpatient setting has substantially less opportunity to directly observe the patient's behavior and to implement protective interventions when necessary. For this reason, during the period of evaluation it is important for the psychiatrist to reassess whether the patient requires hospitalization or more intensive outpatient care (e.g., greater visit frequency, intensive outpatient or partial hospital programs, programs of assertive community treatment). Unresolved questions about the patient's general medical status

may also require more rapid assessment in a more structured setting. If the patient's presentation is atypical (e.g., with respect to symptoms, symptom severity, or age at onset), a more thorough medical workup may be required or coordinated with the patient's primary care physician. Patients who do not have a primary care physician may need assistance in obtaining appropriate referrals. A decision to change the setting for evaluation will depend on the patient's current mental status and behavior as well as the patient's history of psychiatric symptoms and treatment, the status of co-occurring general medical conditions or substance use, and the availability of diagnostic resources, therapeutic resources, and sociocultural supports.

Advantages of the outpatient setting include greater patient autonomy and the potential for a more longitudinal perspective on the patient's symptoms. However, the lack of continuous direct observation of behavior limits the obtainable data on how the patient's behavior appears to others. Consequently, extended evaluation of the patient in the context of psychoeducational or time-limited groups can complement and augment observations from one-to-one interviews. With the patient's permission, involvement of family or significant others as collateral sources in the evaluation process also deserves consideration. It is also useful to be aware that family and significant others may not be supportive of the patient or of psychiatric treatment. If the patient states that family systems issues, especially marital or partner issues, are a problem, an evaluation session with the partner can provide valuable information and clarify the systems issues. When substance use is suspected, obtaining data from other involved persons (e.g., family, close friends, staff), determining blood alcohol levels, or screening for substances of abuse may be especially important.

► **C. GENERAL MEDICAL SETTINGS**

Evaluations are also conducted in hospital emergency departments (see Section I.B) and general medical (i.e., nonpsychiatric) settings, such as inpatient units. The latter allow for some direct behavioral observation by staff and for some safeguards against self-injurious or other violent behavior by patients. However, the level of behavioral observation and potential intervention against risky behavior in these settings tends to be less than on psychiatric inpatient units. In addition, psychiatric interviews on general medical-surgical units are often compromised by interruptions and lack of privacy. These problems sometimes can be mitigated by using a space on the unit where the patient and the psychiatrist can meet privately.

Developing an ongoing relationship with staff on medical inpatient units will increase the likelihood of obtaining accurate behavioral data as well as of ensuring that staff implement recommendations. If there is prominent hostility or anxiety in interactions between the patient and hospital staff, the evaluating physician must consider interfacing with others in the hospital system to determine its contributors.

If the patient has an unclear sensorium or other cognitive impairments, it is critical to interview people in the patient's relational network to see if these symptoms were present before hospitalization or have developed since treatment was begun. In interviewing family members, it is very useful to discuss their beliefs about the patient's illness and prior treatment, the patient's record of adherence to medication treatment, and concerns about discharge planning. If family members do not perceive themselves as allies in treatment, the patient's treatment is likely to be compromised once he or she leaves the hospital (43).

Documentation of psychiatric evaluations in general medical charts should be sensitive to the standards of confidentiality of the nonpsychiatric medical sector and the possibility that charts may be read by persons who are not well informed about psychiatric issues. Information written in general medical charts should be confined to that necessary for the general medical team and should be conveyed with a level of detail and specificity that will be most helpful to the overall management of the patient. It is also important that documentation be of sufficient detail to establish a diagnosis and treatment plan.

▶ **D. OTHER SETTINGS**

Evaluations conducted in other settings, such as residential treatment facilities, home care services, nursing homes, long-term care facilities, schools, and prisons, are affected by a number of factors: 1) the level of behavioral observations available and the quality of those observations, 2) the availability of privacy for conducting interviews, 3) the availability of general medical evaluations and diagnostic tests, 4) resources to conduct the evaluation safely, and 5) the degree of likelihood that information written in facility records will be understood and kept confidential.

In light of these factors, it is necessary to consider whether a particular setting permits an evaluation of adequate speed, safety, accuracy, and confidentiality to meet the needs of the patient. Factors of the setting that compromise the evaluation merit documentation.

III. DOMAINS OF THE CLINICAL EVALUATION

General psychiatric evaluations involve a systematic consideration of the broad domains described in this guideline and vary in scope and intensity. Table 1 summarizes the domains. The intensity with which each domain is assessed depends on the purpose of the evaluation and the clinical situation. An evaluation of lesser scope may be appropriate when its purpose is to answer a circumscribed question. Such an evaluation may involve a particularly intense assessment of one or more domains especially relevant to the reason for the evaluation.

Across all domains, evaluations are generally based on three sources of information: 1) observation and interview of the patient; 2) information from others (e.g., family, significant others, case managers, other clinicians [including the patient's primary care physician]) that corroborates, refutes, or elaborates on the patient's report; and 3) medical records. An awareness of how people report current symptoms and events is important to the clinical assessment process. In considering the information obtained, the patient's current mental state is relevant. Mistakes in comprehension, recall, and expression may also lead to erroneous reporting of information (44).

▶ **A. REASON FOR THE EVALUATION**

The purpose of the evaluation influences the focus of the examination and the form of documentation. The reason for the evaluation usually includes (but may not be limited to) the chief complaint of the patient. It should be elicited in sufficient detail, including the patient's words, to permit an understanding of the duration of the complaint and the patient's specific goals for the evaluation. If the symptoms are of long standing, the reason for seeking treatment at this specific time is relevant; if the evaluation was occasioned by a hospitalization, the reason for the hospitalization is also relevant. If the patient did not initiate the evaluation, the reason another individual or entity may have requested or required it should be noted. The opinions of other parties, including family, can also assist in establishing a reason for evaluation. Under some circumstances (e.g., with psychotic or uncommunicative patients), input from others may be crucial.

▶ **B. HISTORY OF THE PRESENT ILLNESS**

The history of the present problem or illness is a chronologically organized history of recent exacerbations or remissions and current symptoms or syndromes. These may involve descriptions of worries, changes in mood, suspicions, preoccupations, delusions, or hallucinatory ex-

TABLE 1. Domains of the Clinical Evaluation

Domain	Questions to Consider
Reason for the evaluation	<p>What is the patient's chief complaint and its duration?</p> <p>What reason does the patient give for seeking evaluation at this specific time?</p> <p>What reasons are given by other involved parties (e.g., family, other health professionals) for seeking evaluation at this specific time?</p>
History of the present illness	<p>What symptoms is the patient experiencing (e.g., worries; preoccupations; changes in mood; suspicions; delusions or hallucinatory experiences; recent changes in sleep, appetite, libido, concentration, memory, or behavior, including suicidal or aggressive behaviors)?</p> <p>What is the severity of the patient's symptoms?</p> <p>Over what time course have these symptoms developed or fluctuated?</p> <p>Are associated features of specific psychiatric syndromes (i.e., pertinent positive or negative factors) present or absent during the present illness?</p> <p>What factors does the patient believe are precipitating, aggravating, or otherwise modifying the illness or are temporally related to its course?</p> <p>Did the patient receive prior treatment for this episode of illness?</p> <p>Are other clinicians who care for the patient available to comment?</p>
Past psychiatric history	<p>What is the chronology of past episodes of mental illness, regardless of whether such episodes were diagnosed or treated?</p> <p>What are the patient's previous sources of treatment, and what diagnoses were given?</p> <p>With respect to somatic therapies (e.g., medications, electroconvulsive therapy), what were the dose or treatment parameters, efficacy, side effects, treatment duration, and adherence?</p> <p>With respect to psychotherapy, what were the type, frequency, duration, adherence, and patient's perception of the therapeutic alliance and helpfulness of the psychotherapy?</p> <p>Is there a history of psychiatric hospitalization?</p> <p>Is there a history of suicide attempts or aggressive behaviors?</p> <p>Are past medical records available to consult?</p>
History of alcohol and other substance use	<p>What licit and illicit substances have been used, in what quantity, how frequently, and with what pattern and route of use?</p> <p>What functional, social, occupational, or legal consequences or self-perceived benefits of use have occurred?</p> <p>Has tolerance or withdrawal symptoms been noted?</p> <p>Has substance use been associated with psychiatric symptoms?</p> <p>Are family members available who could provide corroborating information about the patient's substance use and its consequences?</p>

TABLE 1. Domains of the Clinical Evaluation (continued)

Domain	Questions to Consider
General medical history	<p>What general medical illnesses are known, including hospitalizations, procedures, treatments, and medications?</p> <p>Are undiagnosed illnesses causing major distress or functional impairment?</p> <p>Does the patient engage in high-risk behaviors that would predispose him or her to a medical illness?</p> <p>Is the patient taking any prescribed or over-the-counter medications, herbal products, supplements, and/or vitamins?</p> <p>Has the patient experienced allergic reactions to or severe adverse effects of medications?</p>
Developmental, psychosocial, and sociocultural history	<p>What have been the most important events in the patient's life, and what were the patient's responses to them?</p> <p>What is the patient's history of formal education?</p> <p>What are the patient's cultural, religious, and spiritual beliefs, and how have these developed or changed over time?</p> <p>Is there a history of parental loss or divorce; physical, emotional, or sexual abuse; or exposure to other traumatic experiences?</p> <p>What strategies for coping has the patient used successfully during times of stress or adversity?</p> <p>During childhood or adolescence, did the patient have risk factors for any mental disorders?</p> <p>What has been the patient's capacity to maintain interpersonal relationships, and what is the patient's history of marital and other significant relationships?</p> <p>What is the patient's sexual history, including sexual orientation, beliefs, and practices?</p> <p>Does the patient have children?</p> <p>What past or current psychosocial stressors have affected the patient (including primary support group, social environment, education, occupation, housing, economic status, and access to health care)?</p> <p>What is the patient's capacity for self-care?</p> <p>What are the patient's sociocultural supports (e.g., family, friends, work, and religious and other community groups)?</p> <p>What are the patient's own interests, preferences, and values with respect to health care?</p>
Occupational and military history	<p>What is the patient's occupation, and what jobs has the patient held?</p> <p>What is the quality of the patient's work relationships?</p> <p>What work skills and strengths does the patient have?</p> <p>Is the patient unable to work due to disability?</p> <p>Regarding military service, what was the patient's status (volunteer, recruit, or draftee), did the patient experience combat, and did the patient suffer injury or trauma?</p> <p>Is the patient preparing for or adjusting to retirement?</p>

TABLE 1. Domains of the Clinical Evaluation (continued)

Domain	Questions to Consider
Legal history	<p>Does the patient have any past or current involvement with the legal system (e.g., warrants, arrests, detentions, convictions, probation, parole)?</p> <p>Do past or current legal problems relate to aggressive behaviors or substance intoxication?</p> <p>Has the patient had other significant interactions with the court system (e.g., family court, workers' compensation dispute, civil litigation, court-ordered psychiatric treatment)?</p> <p>Is past or current legal involvement a significant social stressor for the patient?</p>
Family history	<p>What information is available about general medical and psychiatric illnesses, including substance use disorders, in close relatives?</p> <p>Is there a family history of suicide or violent behavior?</p> <p>Are heritable illnesses present in family members that relate to the patient's presenting symptoms?</p>
Review of systems	<p>Is the patient having difficulty with sleep, appetite, eating patterns, or other vegetative symptoms, or with pain, neurological symptoms, or other systemic symptoms?</p> <p>Does the patient have symptoms that suggest an undiagnosed medical illness that may be causing or contributing to psychiatric symptoms?</p> <p>Is the patient experiencing side effects from medications or other treatments?</p>
Physical examination	<p>What is the appropriate timing, scope, and intensity of the exam for this patient, and who is the most appropriate examiner?</p> <p>Upon examination, are there abnormalities in the patient's general appearance, vital signs, neurological status, skin, or organ systems?</p> <p>Is more detailed physical examination necessary to assess the patient for specific diseases?</p>
Mental status examination	<p>What symptoms and signs of a mental disorder is the patient currently exhibiting?</p> <p>What are the patient's general appearance and behavior?</p> <p>What are the characteristics of the patient's speech?</p> <p>What are the patient's mood and affect, including the stability, range, congruence, and appropriateness of affect?</p> <p>Are the patient's thought processes coherent?</p> <p>Are there recurrent or persistent themes in the patient's thought processes?</p> <p>Are there any abnormalities of the patient's thought content (e.g., delusions, ideas of reference, overvalued ideas, ruminations, obsessions, compulsions, phobias)?</p> <p>Is the patient having thoughts, plans, or intentions of harming self or others?</p> <p>Is the patient experiencing perceptual disturbances (e.g., hallucinations, illusions, derealization, depersonalization)?</p>

TABLE 1. Domains of the Clinical Evaluation (continued)

Domain	Questions to Consider
Mental status examination (continued)	<p>What are the patient's sensorium and level of cognitive function (e.g., orientation, attention, concentration, registration, short- and long-term memory, fund of knowledge, level of intelligence, drawing, abstract reasoning, language, and executive functions)?</p> <p>What are the patient's level of insight, judgment, and capacity for abstract reasoning?</p> <p>What is the patient's motivation to change his or her health risk behaviors?</p>
Functional assessment	<p>What are the patient's functional strengths, and what is the disease severity?</p> <p>To what degree can the patient perform physical activities of daily living (e.g., eating, toileting, transferring, bathing, dressing)?</p> <p>To what degree can the patient perform instrumental activities of daily living (e.g., driving, using public transportation, taking medications as prescribed, shopping, managing finances, keeping house, communicating by mail or telephone, caring for dependents)?</p> <p>Would a formal assessment of functioning be useful (e.g., to document deficits or aid continued monitoring)?</p>
Diagnostic tests	<p>What diagnostic tests are necessary to establish or exclude a diagnosis, aid in the choice of treatment, or monitor treatment effects or side effects?</p>
Information derived from the interview process	<p>Are symptoms minimized or exaggerated by the patient or others?</p> <p>Does the patient appear to provide accurate information?</p> <p>Do particular questions evoke hesitation or signs of discomfort?</p> <p>Is the patient able to communicate about emotional issues?</p> <p>How does the patient respond to the psychiatrist's comments and behaviors?</p>

periences as well as recent changes in sleep, appetite, libido, concentration, memory, or behavior, including suicidal or aggressive behaviors. Information gathered on the pertinent positive and pertinent negative features of the history of present illness will vary with the patient's presenting symptoms or syndrome. Temporal features relating to the onset or exacerbation of symptoms may also be relevant (e.g., onset after use of exogenous hormones, herbal products, or licit or illicit substances; variation in symptoms with the menstrual cycle; postpartum onset). Also pertinent are factors that the patient and other informants believe to be precipitating, aggravating, or otherwise modifying the illness. Available details of previous treatments and the patient's response to those treatments will be delineated as part of the history of present illness. If the patient was or is in treatment with another clinician, the effects of that relationship on the current illness, including transference and countertransference issues, are considered. Input from members of a clinical team who care for the patient can be very helpful (Section IV.A.6). For patients seen on medical-surgical units, it is important to consider the history of both the present medical-surgical illness and the present psychiatric illness (45).

▶ **C. PAST PSYCHIATRIC HISTORY**

The past psychiatric history includes a chronological summary of all past episodes of mental illness, including substance use disorders, and treatment. The summary includes prior hospitalizations; suicide attempts, aborted suicide attempts, or other self-destructive behavior; psychiatric syndromes not formally diagnosed at the time; previously established diagnoses; treatments offered; and responses to and satisfaction with treatment. With respect to psychotherapy, it is important to ascertain the type (e.g., psychodynamic, cognitive, behavioral, supportive), format (e.g., group, individual, couple), frequency, duration, patient's perception of the alliance, and adherence. With respect to medications, the dose, efficacy, side effects, treatment duration, and adherence are important to ascertain while understanding that reporting errors are more likely to occur when treatment involved more than one medication (46). With respect to other somatic therapies such as electroconvulsive therapy, information on the number of treatment sessions, treatment course duration, technical parameters, efficacy, and side effects is similarly useful to obtain. When past medical records are available and readily accessible, it is important that they be consulted for ancillary information.

The chronological summary also delineates the most recent periods of stability as well as episodes when the patient was functionally impaired or seriously distressed by mental or behavioral symptoms, even if no formal treatment occurred. Such episodes frequently can be identified by asking the patient about the past use of psychotropic medications prescribed by other clinicians and otherwise unexplained episodes of social or occupational disability.

▶ **D. HISTORY OF SUBSTANCE USE**

The psychoactive substance use history includes past and present use of both licit and illicit psychoactive substances, including but not limited to alcohol, caffeine, nicotine, marijuana, cocaine, opiates, sedative-hypnotic agents, stimulants, solvents, MDMA (methylenedioxy-methamphetamine), androgenic steroids, and hallucinogens (47). Relevant information includes the quantity and frequency of use and route of administration; the pattern of use (e.g., episodic versus continual, solitary versus social); functional, interpersonal, or legal consequences of use; tolerance and withdrawal phenomena; any temporal association between substance use and other present psychiatric illnesses; and any self-perceived benefits of use. It is also important to inquire about prior treatments for substance use disorders as well as about periods of abstinence, including their duration, recentness, and factors that aided in sobriety or contributed to relapse. Obtaining an accurate substance use history often involves a gradual, nonconfrontational approach to inquiry that involves asking multiple questions to seek the same information in different ways and using slang terms for drugs, patterns of use, and drug effects. Patients are particularly likely to underestimate their level of substance abuse and their related functional impairments; corroboration by other family members is useful when possible. It is also helpful to inquire about patterns of substance use by others within the family or living constellation. For more extensive discussion of the assessment of substance use, abuse, and dependence, the reader is referred to the Center for Substance Abuse Treatment's *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (48) and APA's *Practice Guideline for the Treatment of Patients With Substance Use Disorders* (49).

▶ **E. GENERAL MEDICAL HISTORY**

The general medical history includes available information on known general medical illnesses (e.g., hospitalizations, procedures, treatments, and medications), allergies or drug sensitivities, and undiagnosed health problems that have caused the patient major distress or functional impairment. This includes history of any episodes of important physical injury or trauma; sexual and reproductive history; and any history of endocrinological, infectious (including but not

limited to HIV, tuberculosis, and hepatitis C) (50), neurological disorders, sleep disorders (including sleep apnea), and conditions causing pain and discomfort. Of particular importance is a specific history regarding diseases and symptoms of diseases that have a high prevalence among individuals with the patient's demographic characteristics and background—for example, infectious diseases in users of intravenous drugs or pulmonary and cardiovascular disease in people who smoke. Information regarding all current and recent medications, including hormones (e.g., birth control pills, androgens), over-the-counter medications, herbal supplements, vitamins, complementary and alternative medical treatments, and medication side effects, is part of the general medical history. With all aspects of the general medical history, obtaining corroborating information (e.g., from medical records, treating clinicians, family) can be helpful, since ordinary errors in comprehension, recall, and expression can lead to errors in patient reports (51).

► **F. DEVELOPMENTAL, PSYCHOSOCIAL, AND SOCIOCULTURAL HISTORY**

The personal history reviews the stages of the patient's life, with special attention to perinatal events, delays in physical or psychological development, formal educational history, academic performance, and patterns of response to normal life transitions and major life events, including parental loss or divorce; physical, emotional, or sexual abuse; and other trauma such as exposure to political repression, war, or a natural disaster (52–55). The childhood and adolescent history of risk factors for later psychiatric disorders (Table 2) may also be relevant. History of adaptive skills and strengths to overcome challenges is also relevant.

The patient's capacity to maintain stable and gratifying interpersonal relationships should be noted, including the patient's capacities for attachment, trust, and intimacy. A sexual history is obtained and includes consideration of sexual orientation and practices, past sexual experiences (including unwanted experiences), and cultural beliefs about sex (54). The psychosocial history also determines the patient's past and present levels of interpersonal functioning in family and social roles (e.g., marriage, parenting) (56–58). This includes a delineation of the patient's history of marital and other significant relationships. For patients with children (including biological, foster, adopted, or stepchildren), the psychosocial history will include information about these individuals and their relationship to the patient.

As part of the psychosocial history, past or current stressors are assessed and include the categories on axis IV of DSM-IV-TR: primary support group, social environment (e.g., discrimination and acculturation), education, occupation, housing, economic status, and access to health care. Specific information obtained in evaluating psychosocial stressors may include details about patients' living arrangements, access to transportation, sources of income, insurance or prescription coverage, and past or current involvement with social agencies. Assessment of the patient's self-care functioning may also include consideration of exercise behavior and money management skills, including gambling behavior.

The sociocultural history delineates the patient's migration history and past and current sociocultural context of supports and stressors as well as other important cultural and religious influences on the patient's life (59). Emphasis is given to relationships, both familial and non-familial, and to religion and spirituality that may give meaning and purpose to the patient's life and provide support, as described in the DSM-IV-TR Outline for Cultural Formulation (described in more detail in Section IV.B.1.a).

Patients present for a psychiatric evaluation with their own interests, preferences, and value systems pertaining to health care practice, and these are another important part of the sociocultural history. They may involve cultural factors and explanatory models of illness that affect attitudes, expectations, and preferences for professional and popular treatments, as described in the DSM-IV-TR Outline for Cultural Formulation and the 2004 Core Competencies of the American Board of Psychiatry and Neurology (60). Also important to the assessment and treatment process are other domains such as existential, moral, and interpersonal values and social

TABLE 2. Questions About Childhood Developmental History for Which Affirmative Answers May Indicate Increased Risk for Psychiatric Illness

Did the patient lose a parent at an early age?
Was there unusual or excessive separation anxiety during childhood or adolescence?
Were there significant problems with sleep?
Were there eating disturbances?
Were there problems making or keeping friends?
Was severe shyness a problem, including when interacting in peer groups?
Were there problems with being bullied or bullying?
Were there frequent disciplinary problems in school?
Were there serious difficulties with temper?
Were there many school absences for medical problems or any other problems?
Were there any delays in learning to read, write, or do math?
Were there serious problems paying attention, finishing school work, or completing homework?
Did the above problems lead to grade retention or special education intervention?

influences such as school, church, work, and community or other agencies. Attending to these factors plays a crucial role in developing a therapeutic alliance, negotiating a treatment plan, determining the outcome criteria for successful treatment, and enhancing treatment adherence. Belief systems may also influence the handling of privacy and confidentiality during the evaluation as well as influence the type and amount of information disclosed as part of any informed consent process. In addition, patients' value systems are relevant to clinical considerations at important life transitions (e.g., job and career transitions, marital transitions, genetic counseling before or during pregnancy, end-of-life planning).

▶ **G. OCCUPATIONAL AND MILITARY HISTORY**

The occupational history describes the sequence and duration of jobs held by the patient, reasons for job changes, and the patient's current or most recent employment, including quality of work relationships and whether current or recent jobs have involved shift work, a noxious or perilous environment, exposure to hazardous materials, unusual physical or psychological stress, or injury or exposure to trauma while in the military or hazardous occupations (e.g., fire and rescue, law enforcement). Work skills and strengths are noted, as well as the quality of the patient's relationships with co-workers and work supervisors. Past or current experience with the workers' compensation system and patterns of recovery or disability following episodes of illness are also determined (61–64). When appropriate, a history of preparation for and adjustment to retirement is included.

Relevant data about military experience include volunteer, recruited, or draftee status; reasons for rejection at time of enlistment (if relevant); combat exposure (if any); awards; disciplinary actions; and discharge status.

▶ **H. LEGAL HISTORY**

The legal history includes a description of past or current involvement with the legal system (65). This may include interactions with the police without formal arrest as well as involvement with the juvenile or criminal justice system (e.g., arrests, detentions including jail or prison confinement). Individuals may be on probation or parole or may have pending court appearances or active warrants for arrest that will influence treatment planning. A history of legal

problems relating to aggressive behaviors or occurring in the context of substance intoxication is similarly relevant. Other past or current interactions with the court system (e.g., family court, workers' compensation, civil litigation, court-ordered psychiatric treatment) may serve as significant stressors for the patient and are also important to address (55, 66).

▶ **I. FAMILY HISTORY**

The family history includes available information about the patient's family constellation and the strength of relationships with family members. Information obtained about close family members, including parents and, if applicable, siblings, spouse, and children, will include general information (e.g., current age or age at time of death, position in sibship, occupation), quality of relationship to the patient, and health status. General medical and psychiatric illness in close relatives is noted, including disorders that may be familial or may strongly affect the family environment. A history of adoption or foster care or disruptions in the family environment because of divorce, remarriage, prolonged absences of family members (e.g., occupational absences, hospitalization, incarceration), or deaths may be useful to elicit. Family history information will also consist of any history of psychiatric hospitalizations, illness, or significant symptoms, including suicide and attempted suicide in first- and second-degree relatives. More specific questions are important to ask depending on the patient's clinical presentation, given the heritability of psychosis; mood disorders; anxiety disorders; cognitive disorders; learning disabilities; developmental disabilities, including autism, hyperactivity, or attention deficit disorder; substance use disorders; and antisocial behavior. For family members who have experienced psychiatric symptoms, it is helpful to learn the treatment received and their response to treatment. It is also important to determine first- and second-degree relatives' history of medical disorders (67), particularly those with relevance to psychiatric illness and treatment, such as cardiac, neurological, and endocrine disorders. If family health problems are current, this may contribute psychological or financial stresses for the patient.

Construction of a formal pedigree or genogram is often helpful in delineating family relationships and identifying a family history of illness. The web sites of the American Medical Association (68), the American Society of Human Genetics (69), and the March of Dimes (70) provide additional details on the drawing of pedigrees.

▶ **J. REVIEW OF SYSTEMS**

The review of systems includes current symptoms not already identified in the history of the present illness. If not already addressed in the history of present illness, sleep, appetite, eating patterns, vegetative symptoms of mood disorder, pain and discomfort, systemic symptoms such as fever and fatigue, and neurological symptoms are also relevant. In addition, common symptoms of diseases for which the patient is known to be at particular risk because of historical, genetic, environmental, or demographic factors are an important part of the review of systems. Special attention should be given to typical side effects observed with prescribed or over-the-counter medications and other treatments, including complementary or alternative therapies, that the patient is receiving.

▶ **K. PHYSICAL EXAMINATION**

Evaluation of the patient's general medical status necessitates that a physical examination be performed. Although the process of the physical examination is described more fully in Section IV.A.5, specific elements assessed as part of the physical examination may include the following:

1. General appearance, height, weight, body mass index (BMI), and nutritional status
2. Vital signs
3. Head and neck, heart, lungs, abdomen, and extremities
4. Neurological status, including cranial nerves, motor and sensory function, gait, coordination, muscle tone, reflexes, and involuntary movements
5. Skin, with special attention to any stigmata of trauma, self-injury, or drug use
6. Any body area or organ system that is specifically mentioned in the history of the present illness or review of systems or that is relevant to determining the current status of problems mentioned in the past medical history

Additional items may be added to the examination to address specific diagnostic concerns or to screen a member of a clinical population at risk for a specific disease. For example, an individual with mental retardation might be assessed for the physical characteristics of a recognized syndrome.

► L. MENTAL STATUS EXAMINATION

The purpose of the mental status examination is to obtain evidence of symptoms and signs of mental disorders, including dangerousness to self and others, that are present at the time of the interview. Further, evidence is obtained regarding the patient's insight, judgment, and capacity for abstract reasoning to inform decisions about treatment strategy and the choice of an appropriate treatment setting. Thus, the mental status examination is a systematic collection of data based on observation of the patient's behavior while the patient is in the psychiatrist's view during, before, and after the interview. During the mental status examination, the patient might also mention past symptoms and signs, but these should be recorded under the history of the present illness.

Responses to specific questions are an important part of the mental status examination (71, 72), particularly in the assessment of cognition. Consequently, in recording the findings of the mental status examination, it is useful to include examples that illustrate the clinical observations. For example, it would be preferable to note that the patient exhibited poor judgment in precipitously attempting to remove his intravenous line rather than simply describing the patient's judgment as impaired.

Although its precise organization may vary, the mental status examination typically contains the following elements:

1. *Appearance and general behavior.* In describing the patient's appearance, factors such as approximate age, body habitus, dress, grooming, hygiene, and distinguishing features (e.g., scars, tattoos) may be noted. The patient's general behavior, level of distress, degree of eye contact, and attitude toward the interviewer are also considered.
2. *Motor activity.* The patient's level of psychomotor activity is noted, as is the presence of any gait abnormalities or purposeless, repetitive, or unusual postures or movements (e.g., tremors, dyskinesias, akathisia, mannerisms, tics, stereotypies, catatonic posturing, echopraxia, apparent responses to hallucinations).
3. *Speech.* Characteristics of the patient's speech are described and may include consideration of rate, rhythm, volume, amount, accent, inflection, fluency, and articulation.
4. *Mood and affect.* The patient's expressions of mood and affect are noted. Although the use and definitions of the terms *mood* and *affect* vary, mood is typically viewed as referring to the patient's internal, subjective, and more sustained emotional state, whereas affect relates to the patient's externally observable and more changeable emotional state (71, 73). Affect is often described in terms of its range, intensity, stability, appropriateness, and congruence with the topic being discussed in the interview.

5. *Thought processes.* Features of the patient's associations and flow of ideas are described, such as vagueness, incoherence, circumstantiality, tangentiality, neologisms, perseveration, flight of ideas, loose or idiosyncratic associations, and self-contradictory statements.
6. *Thought content.* The patient's current thought content is assessed by noting the patient's spontaneously expressed worries, concerns, thoughts, and impulses, as well as through specific questioning about commonly observed symptoms of specific mental disorders. These symptoms include delusions (e.g., erotomania or delusions of persecution, passivity, grandeur, infidelity, infestation, poverty, somatic illness, guilt, worthlessness, thought insertion, thought withdrawal, or thought broadcasting), ideas of reference, overvalued ideas, ruminations, obsessions, compulsions, and phobias. Assessment of suicidal, homicidal, aggressive, or self-injurious thoughts, feelings, or impulses is essential for determining the patient's level of risk to self or others as part of the clinical formulation. If such features are present, details are elicited regarding their intensity and specificity, when they occur, and what prevents the patient from acting on them (11, 74–79).
7. *Perceptual disturbances.* Hallucinations (i.e., a perception in the absence of a stimulus) and illusions (i.e., an erroneous perception in the presence of a stimulus) may occur in any sensory modality (e.g., auditory, visual, tactile, olfactory, gustatory). Other perceptual disturbances that patients may experience include depersonalization and derealization.
8. *Sensorium and cognition.* Systematic assessment of cognitive functions is an essential part of the general psychiatric evaluation, although the level of detail necessary and the appropriateness of particular formal tests will depend on the purpose of the evaluation and the psychiatrist's clinical judgment. Evaluation of the patient's sensorium includes a description of the level of consciousness and its stability. Elements of the patient's cognitive status that may be assessed include orientation (e.g., person, place, time, situation), attention and concentration, and memory (e.g., registration, short-term, long-term). Arithmetic calculations may be used to assess concentration or knowledge; other aspects of the patient's fund of knowledge may also be assessed as appropriate to sociocultural and educational background. Additional aspects of the cognitive examination may include assessment of level of intelligence, language functions (e.g., naming, comprehension, repetition, reading, writing), drawing (e.g., copying a figure or drawing a clock face), abstract reasoning (e.g., explaining similarities or interpreting proverbs), and executive functions (e.g., list making, inhibiting impulsive answers, resisting distraction, recognizing contradictions).
9. *Insight.* The patient's insight into his or her current situation is typically assessed by inquiring about the patient's awareness of any problems and their implications. Patients may or may not recognize that psychosis or other symptoms may reflect an underlying illness or that their behavior affects their relationships with other individuals. They also may or may not recognize the potential benefits of treatment.

Another element of insight involves the patient's motivation to change his or her health risk behaviors. Such motivation often fluctuates over time from denial and resistance to ambivalence to commitment, a sequence that has been referred to as "stages of change" (80–82). The stages, which are not necessarily discrete, have been labeled *precontemplation* (denial, minimization); *contemplation* (musing or thinking about doing something); *preparation* (actually getting ready to do something); *action* (implementing concrete actions to deal with the problem); and *maintenance* (acting to ensure that the changes are maintained) (83). Patients who are not quite ready to change may vacillate about modifying their behaviors before actually committing to change and acting on it. Assessing stages of change as part of the evaluative process leads to stage-appropriate educational and therapeutic interventions that attempt to help patients move to more adaptive stages in a patient-centered manner (84–86).

10. *Judgment.* The quality of the patient's judgment has sometimes been assessed by asking for the patient's responses to hypothetical situations (e.g., smelling smoke in a theater). However, in assessing judgment, it is generally more helpful to learn about the patient's responses and decision making in terms of his or her own self-care, interactions, and other aspects of his or her recent or current situation and behavior. If poor judgment is present, a more detailed explication of the patient's decision-making processes may help differentiate the potential causes of this impairment.

IV. EVALUATION PROCESS

▶ A. METHODS OF OBTAINING INFORMATION

1. Patient interview

The psychiatrist's primary assessment tool is the direct face-to-face interview of the patient. Evaluations based solely on review of records and interviews of persons close to the patient are inherently limited by a lack of the patient's perspective. Furthermore, the clinical interview provides the psychiatrist with a sample of the patient's interpersonal behavior and emotional processes. It can either support or qualify diagnostic inferences from the history and can also aid in prognosis and treatment planning. Important information can be derived by observing the patient's general style of relating, the ways in which the patient minimizes or exaggerates certain aspects of his or her history, and whether particular questions appear to evoke hesitation or signs of discomfort. Additional observations concern the patient's ability to communicate about emotional issues, the defense mechanisms the patient uses when discussing emotionally important topics, and the patient's responses to the psychiatrist's comments and to other behavior, such as the psychiatrist's handling of interruptions or time limits.

The interview should be done in a manner that facilitates the patient's telling of his or her story, while simultaneously obtaining the necessary information. Time constraints need to be considered and adequate time allowed for the interview. High-priority tasks include an assessment of the patient's safety and the identification of signs, symptoms, or disorders requiring urgent treatment.

Opening with a discussion of the purpose of the interview offers the patient an understanding of the process. Empirical studies of the interview process suggest that the most comprehensive and accurate information emerges from a combination of 1) open-ended questioning with empathic listening and 2) structured inquiry about specific events and symptoms (87–92). When the purpose is a general evaluation, beginning with open-ended, empathic inquiry about the patient's concerns usually is best. Attention to the patient's most pressing concerns, whenever possible, will improve the therapeutic alliance and is likely to facilitate increased patient cooperation; other inquiries may be more limited initially in the service of the alliance. Patient satisfaction with open-ended inquiry is greatest when the psychiatrist provides feedback to the patient at multiple points during the interview. Structured, systematic questioning has been shown to be especially helpful in eliciting information about substance use and traumatic life events and in ascertaining the presence or absence of specific symptoms and signs of particular mental disorders (93–102) (Section IV.A.3).

Throughout the interview, useful clinical information is obtained by being sensitive to issues of development, culture, race, ethnicity, primary language, health literacy, disabilities, gender, sexual orientation, familial/genetic patterns, religious and spiritual beliefs, social class, and

physical and social environment influencing the patient's symptoms and behavior. Respectful evaluation involves an empathic, nonjudgmental attitude and appropriate responses concerning the patient's cultural identity, his or her own explanation of illness and treatment pathways, sociocultural stressors and supports, and modes of interpersonal communication, both verbal and nonverbal. An awareness of one's possible biases or prejudices about patients from different subcultures and an understanding of the limitations of one's knowledge and skills in working with such patients may help one determine when it is advisable to consult with a clinician who has expertise concerning a particular subculture (103–105).

a) Use of interpreters in the interview

When available, professionally trained interpreters with mental health experience should be used for encounters involving patients with limited English proficiency and those who are deaf or have severely limited hearing and who prefer to communicate using sign language (106, 107). Bilingual and bicultural staff may also be helpful (108). With cooperative patients, over-the-phone language interpretation services can be used when other professionally trained interpreters are unavailable, although establishing rapport with the patient may be more difficult. Family members, community members, or friends should not be used unless the patient refuses to use the professional interpreter or under emergency circumstances, in which case this should be noted in the patient record. The interpreter should be instructed to translate the patient's own words and to avoid paraphrasing except as needed to translate the correct meaning of idioms and other culture-specific expressions (109–111).

b) Interviews with agitated or aggressive individuals

When evaluating individuals who are agitated or aggressive, the psychiatrist needs to give consideration to the patient interview as well as to his or her own safety (13, 77, 112–116). Establishing the presence of backup personnel and choosing an appropriate space in which to conduct the interview are useful preparations before meeting with an agitated or aggressive patient. Because such individuals may become more agitated if they feel trapped within a small room or are too closely positioned to the interviewer, a distance of several arms' length from the patient, with both psychiatrist and patient having access to the door, is generally optimal. A safe office environment should not contain potentially dangerous objects (e.g., decorative items), and the clinician should avoid clothing that can be used against him or her (e.g., neckties, scarves, prominent dangling earrings). Depending on the configuration of the office or interview room and its proximity to other staff, a mechanism for summoning assistance (e.g., a panic button) may also be indicated.

During the interview, a nonconfrontational and straightforward approach is often most effective. Attending to the patient's comfort, using reflective or active listening techniques, and showing respect for the patient's feelings and stated concerns may aid in establishing rapport. The key to calming an aggressive patient is affect management. Patients who are affectively aroused will need to ventilate their feelings, and the clinician should allow the patient to tell his or her own story. Logical or rational responses to an affectively flooded individual may further inflame the patient. Affect management involves acknowledging the patient's affect, validating the affect when appropriate, and encouraging the patient to talk about his or her feelings (116).

In some circumstances, it may be appropriate to set limits (e.g., noting that aggressive behavior cannot be permitted) while simultaneously emphasizing the need to attend to the safety of the patient and others. Throughout the interview, the clinician needs to be alert for signs that the patient's agitation is escalating (e.g., increased body movements or pacing, clenched fists, verbal threats, or increasing verbal volume); such signs may indicate a need to adjust the interview style or timing. At times, it will be best to postpone in-depth history taking or discussion of distressing topics that are not germane to the patient's current presentation.

In some instances, administration of psychotropic medications or judicious use of seclusion or restraint may be necessary to enhance the safety of the patient and others (114) or to permit essential physical examination, laboratory studies, or other diagnostic assessment. Reliance on such measures should be justified by the urgency of obtaining the diagnostic information and should be in compliance with applicable laws and regulations. The psychiatrist should consider how any special circumstances of the interview or examination may influence clinical findings. When the patient is able to cooperate, parts of the examination that cannot be completed or that are significantly influenced by the use of medication, seclusion, or restraint should be repeated if possible.

Guidelines for reducing the use of seclusion and restraint while at the same time maintaining the safety of patients and staff are available in a report developed by the APA with the American Psychiatric Nurses Association and the National Association of Psychiatric Health Systems (117). Recommendations of the report include assessing for anger management problems, identifying risk factors (e.g., pregnancy, asthma, head or spinal injury) before using restraint, identifying triggers, involving patients in treatment planning, asking patients about past experiences of seclusion and restraint, involving family, and documenting interventions attempted before using seclusion or restraint.

2. Use of collateral sources

Family members, other important people in the patient's life, and records of prior medical and psychiatric treatment are frequently useful sources of information. Collateral information is particularly important when patients have impaired insight, including when patients have substance use disorders or cognitive impairment, and is essential for treatment planning when patients require a high level of assistance or supervision because of impaired function or unstable behavior. Family members and others who know the patient well may provide important information about the patient's personality before the onset of illness, since the patient's own account may be unduly influenced by his or her mental state. Collateral sources of information may also provide essential information about the illness course (Section III.C), the current symptoms and behavior (Section III.B), and the reasons for the evaluation (Section III.A). The extent of the collateral interviews and the extent of prior record review should be commensurate with the purpose of the evaluation, the complexity of the clinical presentation, and the diagnostic and therapeutic goals. For example, in an acute inpatient or emergency setting, collateral information may be crucial to developing an understanding of the patient's clinical condition, whereas in long-term outpatient psychotherapy the impact on the treatment process of obtaining collateral information from family or others needs to be considered. Except when immediate safety concerns are paramount, the confidentiality of the patient should be respected. At the same time, it is permissible for the psychiatrist to listen to information provided by family members and other important people in the patient's life, as long as confidential information is not provided to the informant (Sections I.A, I.B, II.C, and V.A).

3. Use of structured interviews and rating scales, including functional assessments

Structured interviews, standardized data forms, questionnaires, and rating scales can be useful tools for diagnostic assessment and evaluation of treatment outcome. Table 3, while not all-inclusive, lists many of the common structured instruments in use (see also the CD-ROM from APA's *Handbook of Psychiatric Measures* [118]). Such structured instruments may be used as components for establishing a diagnosis, measuring social or occupational function, or monitoring changes in symptom severity or side effects over time during treatment.

Although most commonly used in psychiatric research, rating scales may also help psychiatrists structure a thorough line of questioning. In addition, self-report scales may be valuable in opening communication with patients about their symptoms, feelings, or experiences. At the

TABLE 3. Examples of Clinical Rating Scales

Scale	Administration (Time)	Clinical Use	Reference	Availability
Quality of life				
Quality of Life Enjoyment & Satisfaction Questionnaire (Q-LES-Q)	Self-administered questionnaire; short (16-item; 5 min) or long (60-item; 15 min) format	Assessment of degree of enjoyment and satisfaction in various areas of daily life	Endicott J, Nee J, Harrison W, et al: <i>Quality of Life Enjoyment and Satisfaction Questionnaire: a new scale.</i> <i>Psychopharmacol Bull</i> 29:321-326, 1993	Jean Endicott, Ph.D.; Dept. of Research Assessment and Training, New York State Psychiatric Institute, Unit 123; 1051 Riverside Drive; New York, NY 10032; ph 212-543-5536
Mental health status and functioning				
Clinical Global Impression (CGI) Scale	Clinician-rated scale (1-2 min after clinical information is obtained)	Global assessment of response to medication treatment	Guy W, Bonato RR (eds): <i>Manual for the ECDEU Assessment Battery, revised 2nd ed.</i> Chevy Chase, Md, National Institute of Mental Health, 1970, pp 12.1-12.6	Guy W: <i>ECDEU Assessment Manual for Psychopharmacology, revised ed.</i> Washington, DC, US Department of Health, Education, and Welfare, 1976; APA (2000) <i>Handbook of Psychiatric Measures</i>
Global Assessment of Functioning (GAF) Scale	Clinician-rated scale, ranked 0-100 (1-2 min after clinical information is obtained)	Assessment of patient functioning, monitoring of change, and selection of patients suitable for short-term treatment	American Psychiatric Association: <i>DSM-IV-TR</i>	DSM-IV-TR
Social and Occupational Functioning Assessment Scale (SOFAS)	Clinician-rated scale, ranked 0-100 (1-2 min after clinical information is obtained)	Assessment of patient social and occupational functioning and monitoring of change	American Psychiatric Association: <i>DSM-IV-TR</i>	DSM-IV-TR

TABLE 3. Examples of Clinical Rating Scales (continued)

Scale	Administration (Time)	Clinical Use	Reference	Availability
Adverse effects				
Abnormal Involuntary Movement Scale (AIMS)	Observer-rated 12-item anchored scale (5–10 min)	Assessment of patients who may have involuntary movement disorders (from antipsychotic medications) and may have tardive dyskinesia	Guy W (ed): ECDEU Assessment Manual for Psychopharmacology, revised ed. DHEW Publ No ADM 76-338. Washington, DC; US Department of Health, Education, and Welfare, 1976	Guy 1976; APA (2000) <i>Handbook of Psychiatric Measures</i>
Rating Scale for Extrapyramidal Side Effects or Simpson-Angus Extrapyramidal Symptom Rating Scale	Observer-rated 10-item anchored scale (10 min)	Assessment of dose-limiting side effects when antipsychotic medications are initiated, titrated, and monitored and effectiveness of anticholinergic or other agents in the treatment of extrapyramidal side effects	Simpson GM, Angus JWS: A rating scale for extrapyramidal side effects. <i>Acta Psychiatr Scand Suppl</i> 1970; 212:11–19	APA (2000) <i>Handbook of Psychiatric Measures</i>
Cognitive disorders				
Delirium Rating Scale Revised–98 (DRS–R98)	Clinician-administered structured exam (15–30 min)	Assessment of a broad range of delirium symptoms: the 16-item scale can be used to diagnose delirium; the 13-item severity subscale can be used to rate symptom severity	Trzepacz PT et al: Validation of the Delirium Rating Scale—Revised–98: comparison with the Delirium Rating Scale and the Cognitive Test for Delirium. <i>J Neuropsychiatry Clin Neurosci</i> 2001; 13:229–242; erratum, 2001; 13:433	© Paula T. Trzepacz, M.D., Lilly Research Laboratories, Indianapolis, IN 46285; PTT@lilly.com
Mini-Mental State Examination (MMSE)	Clinician-administered 30-item structured scale (5–10 min)	Detecting and tracking the progression of cognitive impairment associated with neurodegenerative diseases	Folstein MF et al: “Mini-Mental State”: a practical method for grading the cognitive state of patients for the clinician. <i>J Psychiatr Res</i> 1975; 12:189–198	Administrator of the Mini-Mental LLC, 31 St. James Avenue, Suite 1, Boston, MA 02116; ph 617-587-4215; APA (2000) <i>Handbook of Psychiatric Measures</i>

TABLE 3. Examples of Clinical Rating Scales (continued)

Scale	Administration (Time)	Clinical Use	Reference	Availability
Alcohol use disorders				
CAGE Questionnaire	Self-report or observer-rated 4-item questionnaire (<1 min)	Screening for alcohol problems	Ewing JA: Detecting alcoholism: The CAGE questionnaire. <i>JAMA</i> 1984; 252: 1905–1907	APA (2000) <i>Handbook of Psychiatric Measures</i>
Mood disorders				
Beck Depression Inventory, 2nd Revision (BDI-II)	Self-report or observer-rated 21-item questionnaire, ranked on a 0–3 scale (5–10 min)	Assessment of severity of depressive symptoms in patients with diagnosed depressive illness and monitoring of treatment effects	Beck AT et al: An inventory for measuring depression. <i>Arch Gen Psychiatry</i> 1961; 4:561–571	Harcourt Assessment, Inc., 19500 Bulverde Road, San Antonio, TX 78259; ph 800-211-8378; http://harcourtassessment.com/haiweb/Cultures/en-US/default.htm
Hamilton Depression Rating Scale (Ham-D)	Observer-rated 21- or 17-item checklist, ranked on a 0–4 or 0–2 scale (15–20 min)	Assessment of severity of depressive symptoms in patients with primary depressive illness and monitoring changes with treatment	Hamilton M: A rating scale for depression. <i>J Neurol Neurosurg Psychiatry</i> 1960; 23:56–62	Guy W: ECDEU Assessment Manual for Psychopharmacology, revised ed. DHEW Publ No ADM 76-338. Washington, DC, US: Department of Health, Education, and Welfare, 1976
Quick Inventory of Depression Symptomatology—Self-Report (QIDS-SR)	Self-report 16-item scale including the nine domains of major depressive disorder (5–7 min)	Assessment of depressive symptom severity and symptomatic changes in a time efficient manner to gauge effects of treatment	Rush AJ et al: The 16-Item Quick Inventory of Depressive Symptomatology (QIDS), Clinician Rating (QIDS-C), and Self-Report (QIDS-SR): a psychometric evaluation in patients with chronic major depression. <i>Biol Psychiatry</i> 2003; 54:573–583; erratum, 2003; 54:585	Trivedi MH et al: The Inventory of Depressive Symptomatology, Clinician Rating (IDS-C) and Self-Report (IDS-SR), and the Quick Inventory of Depressive Symptomatology, Clinician Rating (QIDS-C) and Self-Report (QIDS-SR) in public sector patients with mood disorders, a psychometric evaluation. <i>Psychol Med</i> 2004; 34:73–82

TABLE 3. Examples of Clinical Rating Scales (continued)

Scale	Administration (Time)	Clinical Use	Reference	Availability
Mood disorders (continued)				
Patient Health Questionnaire (PHQ-9)	Self-report, clinician-scored 9-item questionnaire ranked on 0–3 scale and scored 0–27 (<2 min)	Assessment of DSM-IV depressive disorder diagnoses and grading of depressive symptom severity	http://www.pfizer.com/pfizer/phq-9/index.jsp	Copyright 1999 Pfizer, Inc. http://www.pfizer.com/pfizer/phq-9/index.jsp http://www.depressionprimarycare.org/clinicians/toolkits/materials/
Geriatric Depression Scale (GDS)	Self-report 30-item scale (10–15 min)	Screening for depressive illness in geriatric patients, assessment of severity, and monitoring change with treatment	Yesavage JA et al: Development and validation of a geriatric depression screening scale: a preliminary report. <i>J Psychiatr Res</i> 1982; 17:37–49	Yesavage et al. 1982; APA (2000) <i>Handbook of Psychiatric Measures</i>
Young Mania Rating Scale (YMRS)	Clinician-administered 11-item checklist, ranked on a 0–4 or 0–8 scale (15–30 min)	Assessment of the severity of mania and evaluation of changes in manic symptoms with treatment over time	Young RC et al: A rating scale for mania: reliability, validity and sensitivity. <i>Br J Psychiatry</i> 1978; 133:429–435	Young et al 1978; APA (2000) <i>Handbook of Psychiatric Measures</i>
Anxiety disorders				
Hamilton Anxiety Rating Scale (HARS)	Clinician-administered 14-item scale, with items ranked 0–5 (15–30 min)	Assessment of the severity of overall anxiety in patients with diagnosed anxiety or depressive disorders and monitoring outcome of treatment	Hamilton M: The assessment of anxiety states by rating. <i>Br J Med Psychol</i> 1959; 32:50–55	Hamilton 1959; Anxiety Disorders Prevention Program, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213
Yale-Brown Obsessive Compulsive Scale (Y-BOCS)	Clinician-administered semistructured interview (30 min initially)	Assessment of overall obsessive-compulsive disorder severity and monitoring change with treatment	Goodman WK et al: The Yale-Brown Obsessive Compulsive Scale, I: development, use, and reliability. <i>Arch Gen Psychiatry</i> 1989; 46:1006–1011	University of Florida, College of Medicine, Department of Psychiatry, P.O. Box 100256, 1600 SW Archer Road, Gainesville, FL 32610; APA (2000) <i>Handbook of Psychiatric Measures</i>

TABLE 3. Examples of Clinical Rating Scales (continued)

Scale	Administration (Time)	Clinical Use	Reference	Availability
Psychotic disorders				
Brief Psychiatric Rating Scale (BPRS)	Clinician-rated 18-item scale, ranked 1–7 (20–30 min)	Global assessment of response to treatment in patients with moderate to severe psychotic disorders	Overall JE, Gorham DR: The Brief Psychiatric Rating Scale: recent developments in ascertaining and scaling. <i>Psychopharmacol Bull</i> 1988; 24:97–99	Overall and Gorham, http://www.psychrehab.com ; APA (2000) <i>Handbook of Psychiatric Measures</i>
Positive and Negative Syndrome Scale (PANSS)	Clinician-rated 3-subscale, 5-factor, 30-item scale rated based on information from a structured interview (30–40 min) and informant information	Assessment of severity of common symptoms in patients with schizophrenia and other psychotic disorders, delineation of target symptoms, and monitoring of treatment response	Kay SR et al: Positive and Negative Syndrome Scale (PANSS) Rating Manual. Toronto, ON, Multi-Health Systems, 2000	Multi-Health Systems, Inc., P.O. Box 950, North Tonawanda, NY 14120-0950; ph 800-456-3003; fax 888-540-4484; http://www.mhs.com
Aggression and agitation				
Overt Aggression Scale—Modified (OAS-M)	Clinician-administered 25-item scale with 9 subscales and rating three areas, aggression, irritability, and suicidality (30 min)	Assessment of aggressive behaviors, delineation of target symptoms, and monitoring of change over time	Coccaro E et al: Development of neuropharmacologically based behavioral assessments of impulsive behavior. <i>J Neuropsychiatry Clin Neurosci</i> 1991; 3(suppl): S44–S51	Emil Coccaro, M.D., Department of Psychiatry, Medical College of Pennsylvania, Eastern Pennsylvania Psychiatric Institute, 3200 Henry Avenue, Philadelphia, PA 19129; APA (2000) <i>Handbook of Psychiatric Measures</i>

Source. Information in this table was derived from APA's *Handbook of Psychiatric Measures* (118).

same time, these tools vary considerably as to their reliability and validity. Potential cultural, ethnic, gender, social, and age biases are relevant to the selection of standardized interviews and rating scales and the interpretation of their results (119–125). Furthermore, clinical impressions of treatment response should consider the relative importance of specific symptoms to the patient's function and well-being and the relative impact of specific symptoms on the patient's social environment. Consequently, rating scales should never be used alone to establish a diagnosis or clinical treatment plan; they can augment but not supplant the clinician's evaluation, narrative, and clinical judgment (11, 126–129).

For persons with chronic diseases, and particularly those with multiple comorbid conditions, structured assessment of physical and instrumental function may be useful in assessing strengths and disease severity (130). Functional assessments include assessment of physical activities of daily living (e.g., eating, using the toilet, transferring, bathing, and dressing) and instrumental activities of daily living (e.g., driving or using public transportation, taking medication as prescribed, shopping, managing one's own money, keeping house, communicating by mail or telephone, and caring for a child or other dependent) (131, 132). Impairments in these activities can be due to physical or cognitive impairment or to the disruption of purposeful activity by the symptoms of mental illness.

Formal assessment of physical and instrumental activities of daily living may be appropriate for patients who are disabled by old age or by chronic mental illness or general medical conditions. Such assessments facilitate the delineation of the combined effects of multiple illnesses and chronic conditions on patient's lives, and such assessments provide a severity measure that is congruent with patients' and families' experience of disability. In addition, functional assessment facilitates the monitoring of treatment by assessing important beneficial and adverse effects of treatment.

4. Use of diagnostic tests, including psychological and neuropsychological tests

Laboratory tests are included in a psychiatric evaluation when they are necessary to establish or exclude a diagnosis, to aid in the choice of treatment, or to monitor treatment effects or side effects (16, 133–144). When laboratory tests are obtained, relevant test results are documented in the evaluation, with their importance for diagnosis and treatment indicated in the clinical formulation or treatment plan.

Diagnostic tests used during a psychiatric evaluation include those that do the following:

1. Detect or rule out the presence of a disorder or condition that has treatment consequences. Examples include urine screens for substance use disorders, neuropsychological tests to ascertain the presence of a learning disability, and brain imaging tests to ascertain the presence of a structural neurological abnormality.
2. Determine the relative safety and appropriate dose of potential alternative treatments. For example, tests of hematological, thyroid, renal, and cardiac function in a patient with bipolar disorder may be needed to help the clinician choose among available mood-stabilizing medications (145), or evaluation of cardiac or pulmonary function may be important in determining a patient's medical status prior to electroconvulsive therapy (146).
3. Provide baseline measurements before instituting treatment, with subsequent measurements used to assess effects of treatment. For example, baseline and follow-up electrocardiograms may be required to identify effects of antipsychotic or tricyclic antidepressant medications on cardiac conduction, whereas baseline and follow-up glucose levels and lipid panels may be required to identify effects of second-generation antipsychotic agents.
4. Monitor blood levels of medications when indicated (e.g., for effectiveness, toxicity, or adherence).

Under each of these circumstances, the potential utility of a test will be determined by multiple interrelated factors, including the following:

1. The likelihood that an individual from a population of similar patients (e.g., of similar age, gender, treatment setting) would have the condition. This probability is also referred to as the *prevalence* of the condition in that population. In general, conditions that are more prevalent in the population are more likely to be correctly identified by use of a diagnostic test. In the context of obtaining baseline measurements, the likely prevalence of the condition at a later date may also be relevant.
2. The probabilities that the test will correctly detect a condition that is present (true positive), incorrectly identify a condition as present when it is not (false positive), correctly identify a condition as absent (true negative), or incorrectly identify a condition as absent when it is actually present (false negative). Although information about these probabilities is available for many tests, the key point to consider in clinical practice is that false negative and false positive test results do occur. Furthermore, incorrect identification of a condition can result in unnecessary and potentially detrimental evaluations and interventions; incorrectly viewing a condition as absent can lead to other crucial signs and symptoms of the condition being ignored.
3. The treatment implications of the test results. Obviously, a test will be of benefit if it correctly detects a previously unidentified and treatable condition. However, the treatment implications may be nil if the test correctly detects a condition that is already known to be present on the basis of clinical examination or history or if it correctly detects a benign or incidental condition that leads to further unnecessary testing with no beneficial effect on treatment.

Given the wide range of clinical situations evaluated by psychiatrists, there are no specific guidelines about which tests should be “routinely” done. It is important to have a clear rationale for the ordering of tests (12, 23, 26), and each patient should be considered individually. Nevertheless, some general principles may aid in deciding on particular diagnostic assessments. For example, tests may be ordered on the basis of the setting (e.g., some patients seen in emergency departments may be at increased risk for certain conditions that warrant diagnostic tests), the clinical presentation (e.g., certain tests are warranted for patients with new onset of delirium), or the potential treatments (e.g., patients may need certain tests before initiation of lithium therapy). For tests that require the patient’s participation, factors such as language, education level, intelligence, culture, and level of alertness can affect the testing process and may influence the choice of diagnostic approaches. Patient preferences are also important to consider. Furthermore, the potential benefits of identifying and treating a particular condition need to be weighed against the costs (e.g., time, money, physical pain, emotional stress) of indiscriminate testing.

More detail on the use of laboratory testing to aid in diagnosis and to guide treatment is provided in APA practice guidelines for specific disorders. Table 4 provides examples of and general indications for tests that may be indicated depending on the status of the patient.

Neuropsychological testing has a broad range of application, but the decision to order neuropsychological testing for an individual patient remains a matter of clinical judgment (147). Neuropsychological testing may be requested when cognitive deficits are suspected or there is a need to grade for severity or progression of deficits over time. In addition, neuropsychological testing can be helpful in distinguishing between cognitive disorders and malingering or factitious disorders. When patients present later in life with the new onset of psychosis or mood disorder accompanied by cognitive deficits, neuropsychological testing may also be helpful in distinguishing dementia from other psychiatric syndromes. In research studies, typical patterns of cognitive deficits have been identified in a variety of psychiatric disorders, including Alzheimer’s disease (148), schizophrenia (149–151), bipolar disorder (152–156), major depressive disorder (157–160), and autism (161, 162). Findings have highlighted the fact that cognitive deficits and associated impairment of social and occupational functioning may persist despite successful treatment of other core symptoms of an illness. For example, executive dysfunction may

TABLE 4. Tests That May Be Indicated as Part of a Psychiatric Evaluation

Test	Notes
Basic laboratory tests (e.g., complete blood count; blood chemistries, including lipid profile, B ₁₂ , folate; urinalysis)	Used to screen for general medical conditions or provide baseline measures prior to treatment. Recommended frequency of screening may vary with health status and with specific ongoing treatments (e.g., second-generation antipsychotics, lithium).
Medication levels	Used to monitor therapeutic levels of medications.
Pregnancy test	Some psychiatric conditions and treatments may entail risks to a pregnant woman or her fetus.
Fasting blood glucose or hemoglobin A1c	Used to diagnose diabetes or help determine risk. Patients prescribed second-generation antipsychotics may be at increased risk of developing diabetes.
Lyme serology, syphilis serology, HIV test	May assist in evaluation of cognitive and behavioral changes. Individuals with behavioral problems such as impulsivity or drug use may be at increased risk for HIV infection.
Thyroid function tests	May be important for patients with suspected mood disorder, anxiety disorder, or dementia. Used to monitor lithium effects.
Toxicology screen, blood alcohol level	Used to screen for substance use or abuse. Individuals with a mental disorder are at increased risk for substance abuse.
Electrocardiogram	Used to assess effects of medications that may influence cardiac conduction (e.g., tricyclic antidepressants, some antipsychotics). May also be indicated depending on age and health status.
Chest X ray	Used to diagnose cardiopulmonary disorders (e.g., pneumonia, tuberculosis) that may contribute to delirium. May also be part of a pre-ECT evaluation depending on age and health status.
Imaging studies	Structural (e.g., computed tomography [CT], magnetic resonance imaging [MRI]) and functional (e.g., positron emission tomography [PET], single photon emission computed tomography [SPECT], electroencephalogram [EEG], functional magnetic resonance imaging [fMRI]) studies may indicate regional brain abnormalities related to a psychiatric illness and its management.
Lumbar puncture	Used to diagnose central nervous system infection (e.g., meningitis, herpes, toxoplasmosis, syphilis, Lyme disease). May be important for differential diagnosis of delirium.
Polysomnography	Used to diagnose sleep disorders, including sleep apnea. May be important for differential diagnosis of depression, psychosis, or other cognitive or behavioral changes.
Psychological testing	May be requested when cognitive deficits are suspected or there is need to grade for severity or progression of symptoms over time. May also be helpful in establishing a diagnosis (e.g., dementia, mental retardation) or in delineating specific deficits that affect thought processes, treatment, or vocational planning.

persist in otherwise responsive depression (163), and working memory may remain impaired in schizophrenia independent of response of positive and negative symptoms (149, 164). Thus, for some patients, a better understanding of persistent neuropsychological impairments can aid in treatment and vocational planning.

5. Physical examination

An understanding of the patient's general medical condition is important in order to 1) properly assess the patient's psychiatric symptoms and their potential cause, 2) determine the patient's need for general medical care, and 3) choose among psychiatric treatments that can be affected by the patient's general medical status (16, 22, 25, 26, 34, 144, 165, 166). The psychiatrist also ensures that a recent medical workup with appropriate laboratory tests and monitoring is performed. The psychiatrist should be informed about the results of the medical workup and incorporate this information into the evaluation. The psychiatrist's close involvement in the patient's general medical evaluation and ongoing care can also improve the patient's care by promoting cooperation, facilitating follow-up, and permitting prompt reexamination of symptomatic areas when symptoms change.

The physical examination may be performed by the psychiatrist, another physician, or a medically trained clinician. Considerations influencing the decision of whether the psychiatrist will personally perform the physical examination include potential effects on the psychiatrist-patient relationship, the purposes of the evaluation, and the complexity of the medical condition of the patient. The timing, scope, and intensity will vary according to clinical circumstances. For example, the physical examination of an otherwise healthy patient with paranoia, or the genital-rectal examination of a patient with a history of sexual abuse, may be deferred to a more appropriate time and setting.

In most circumstances, the physical examination should be chaperoned. Particular caution is warranted in the physical examination of persons with histories of physical or sexual abuse or with other features that could increase the possibility of the patient's being distressed as a result of the examination (e.g., a patient with an erotic or paranoid transference to the psychiatrist). All but limited examinations of such patients should be chaperoned.

6. Work with multidisciplinary teams

In many settings, it has become commonplace for the care of psychiatric patients to draw on the expertise of multidisciplinary teams. In the evaluation phase of care, other members of the clinical team (e.g., nurses, psychologists, occupational therapists, social workers, case managers, peer counselors, chaplains) may gather data or perform discipline-specific assessments. The psychiatrist responsible for the patient's care reviews and integrates these assessments into the psychiatric evaluation of the patient and works with other members of the multidisciplinary team in developing and implementing a plan of care.

The opportunity to improve systematic observations of patients' behavior by staff is an advantage of controlled settings such as hospitals, partial hospital settings, residential treatment facilities, and other institutions. Several types of observations may be gathered, according to the patient's specific situation:

1. *General observations.* These are relevant to all patients in all settings and include notes on patients' behavior, statements and expressed concerns, cooperativeness with or resistance to staff, sleep/wake patterns, and self-care.
2. *Diagnosis-specific observations.* These are observations relevant to confirming a diagnosis or assessing the severity, complications, or subtype of a disorder. Examples include recording signs of withdrawal in an alcohol-dependent patient and observations during meals for patients with eating disorders.

3. *Patient-specific observations.* These are observations aimed at assessing a clinical hypothesis. An example is observation of behavior following a family meeting for a patient in whom family conflicts are suspected of having contributed to a psychotic relapse.
4. *Observations of response to treatment interventions.* Examples include systematic recording of a target behavior in a trial of behavior therapy, observations of the effects of newly prescribed medications, and nurse-completed rating scales to measure changes after behavioral or psychotherapeutic interventions.

► **B. THE PROCESS OF ASSESSMENT**

The actual assessment process during a psychiatric evaluation usually involves the development of initial impressions and hypotheses during the interview and their continual testing and refinement on the basis of information obtained throughout the interview and from mental status examination, diagnostic testing, and other sources (167).

1. Clinical formulation

The integrative formulation aids in understanding the patient as a unique human being and allows the psychiatrist to appreciate the patient's environment, strengths, challenges, and coping skills. The formulation includes information specific to the patient that goes beyond what is conveyed in the diagnosis; it will vary in scope and depth with the purpose of the evaluation. Components of the formulation include phenomenological, neurobiological, psychological, and sociocultural issues involved in diagnosis and management (60, 168–179). As relevant to each domain, the formulation will typically include a concise synthesis of what is known about the patient (e.g., individual characteristics, genetic predispositions, general medical conditions or laboratory abnormalities, past life experiences and developmental history, extent and quality of interpersonal relationships, central conflicts and defense mechanisms) and the patient's past and current symptomatology (including childhood or subsyndromal illness and predisposing, precipitating, perpetuating, or protecting factors) as well as the responses of symptoms to treatment. Variations in phenomenology with factors such as a patient's age or gender can be relevant in determining whether or not a behavior is indicative of psychopathology (180). Thus, the formulation may also include a discussion of the diagnostic, therapeutic, and prognostic implications of the evaluation findings.

a) Cultural formulation

The DSM-IV-TR Outline for Cultural Formulation (Table 5) provides a systematic method of considering and incorporating sociocultural issues into the clinical formulation (181–185). Depending on the focus and extent of the evaluation, it may not be possible to do a complete cultural formulation based on the findings of the initial interview. However, when cultural issues emerge, they may be explored further during subsequent meetings with the patient. In addition, the information contained within the cultural formulation may be integrated with the other aspects of the clinical formulation or recorded as a separate element.

The cultural formulation begins with a review of the individual's cultural identity and includes the patient's self-construal of identity over time (186). Cultural identity involves not only ethnicity, acculturation/biculturalism, and language but also age, gender, socioeconomic status, sexual orientation, religious and spiritual beliefs, disabilities, political orientation, and health literacy, among other factors.

Next, the formulation explores the role of the cultural context in the expression and evaluation of symptoms and dysfunction, including the patient's explanatory models or idioms of distress through which symptoms or needs may be communicated. These are assessed against the norms of the cultural reference group. Treatment experiences and preferences (including complementary and alternative medicine and indigenous approaches) are also identified. Cul-

TABLE 5. Components of a Cultural Formulation

Cultural identity of the individual
Cultural explanations of the individual's illness
Cultural factors related to psychosocial environment and levels of functioning
Cultural elements of the relationship between the individual and the clinician
Overall cultural assessment for diagnosis and care

Source. From DSM-IV-TR, pp. 897–898.

tural factors related to psychosocial stressors, available social supports, and levels of function or disability are also assessed; during this process, the roles of family/kin systems and religion and spirituality in providing emotional, instrumental, and informational support are highlighted.

The cultural formulation also includes specific consideration of cultural elements influencing the relationship between the individual and the clinician. In this regard, it is important for clinicians to cultivate an attitude of “cultural humility” (187) in knowing their limits of knowledge and skills rather than reinforcing potentially damaging stereotypes and overgeneralizations. Differences in language, culture, or social status, as well as difficulties in identifying and understanding the cultural significance of behaviors or symptoms, may add to the complexities of the clinical encounter. Transference and countertransference may also be influenced by cultural considerations and may either aid or interfere with the treatment relationship. Further, the potential effect of the psychiatrist’s sociocultural identity on the attitude and behavior of the patient should be taken into account in the subsequent formulation of a diagnostic opinion.

The cultural formulation concludes with an overall assessment of the ways in which these varied cultural considerations will specifically apply to differential diagnosis and treatment planning.

b) Risk assessment

An additional component of the formulation involves an assessment of the patient’s risk of harm to self or others. This may include consideration of suicide or homicide risk as well as other forms of self-injury (e.g., cutting behaviors, accidents), aggressive behaviors, neglect of self-care, or neglect of the care of dependents. The risk assessment is intended to identify specific factors that may increase or decrease a patient’s degree of risk, thereby suggesting specific interventions that may modify particular risk factors or address the safety of the patient or others. Specific risk factors may include demographic parameters (e.g., age, gender), past behavior (e.g., suicide attempts, self-injury, aggression), psychiatric diagnoses, psychiatric symptoms (e.g., anxiety, hopelessness), co-occurring general medical conditions, sociocultural factors, psychosocial stressors, or individual strengths and vulnerabilities. For patients with suicidal behaviors, this risk assessment process is described in detail in APA’s *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors* (11). Although standardized rating scales of suicidal or aggressive behaviors are often used in research and may suggest helpful lines of clinical inquiry, their utility in clinical risk assessment is limited by their low predictive value (11).

For individuals with dependent children, the risk assessment also includes an evaluation of the patient’s capacity to parent. In addition to considering the number and ages of any children, the assessment reviews the patient’s capacity to meet the needs of dependent children, both in general and during psychiatric crises if these are likely to occur. The overall health, including mental health, of the children is also relevant, especially when the patient’s psychiatric condition is likely to affect the children through genetic or psychosocial mechanisms or to impede the patient’s ability to recognize and attend to the needs of a child.

2. Diagnosis

On the basis of information obtained in the evaluation, a differential diagnosis is developed. The differential diagnosis comprises conditions (including personality disorders or personality

traits) described in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR) (188), APA's current edition of DSM. A multiaxial system of diagnosis provides a convenient format for organizing and communicating the patient's current clinical status, other factors affecting the clinical situation, the patient's highest level of past functioning, and the patient's quality of life (188, pp. 27–33). General medical conditions are established through history, examination, diagnostic tests, medical records, and consultation.

The DSM classification and the specific diagnostic criteria are meant to serve as guidelines to be informed by clinical judgment in the categorization of the patient's condition(s) and are not meant to be applied in a rote fashion. (Other issues in the use of DSM and its application in developing a psychiatric diagnosis are discussed in DSM-IV-TR, pp. xxiii–xxxv and 1–12.) To augment the DSM multiaxial approach, some clinicians also find it helpful to identify the patient's level of defensive functioning or incorporate dimensional or other approaches into their diagnostic assessments (188, pp. 807–813; 189, 190).

3. Initial treatment plan

The initial treatment plan addresses any specific diagnoses and psychiatric needs of the patient that have been identified during evaluation. If diagnostic or other questions have been posed or additional information is necessary, these issues should be addressed in the treatment plan.

The initial treatment plan begins with a determination of the appropriate treatment setting and includes an explicit statement of the diagnostic, therapeutic, and rehabilitative goals for treatment that includes short-term as well as longer-term goals. In the case of patients who initially will be treated in an inpatient or partial hospital setting, this implies apportioning the therapeutic task between a hospital phase and a posthospital phase. Within the acute care setting, some goals may be targeted for achievement within several days, whereas other goals will be targeted for completion by the time of discharge. On the basis of the goals, the plan specifies further diagnostic tests and procedures, further systematic observations or additional information to be obtained, and specific therapeutic modalities to be applied.

A comprehensive treatment plan addresses biological, psychological, and sociocultural domains. The psychiatrist can select from a range of individual, group, and family therapies to create an integrated multimodal treatment that includes biological and sociocultural interventions (60).

Quality care involves treatment plans that are safe, timely, effective, efficient, equitable (i.e., not influenced in quality by personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status), and person-centered (7). Such treatment plans encourage recovery from illness through community integration and empower patients to make choices that improve their quality of life (191). Thus, the treatment plan is ideally the result of collaboration between the patient, the psychiatrist, and other members of the treatment team as well as the primary care practitioner for patients who have an established source of primary care.

A range of potentially effective treatments is initially considered. More detailed consideration and documentation of the risks and benefits of treatment options may be needed in the following circumstances: when a relatively risky, costly, or unusual treatment is under consideration; when involved parties disagree about the optimal course of treatment; when the patient's motivation or capacity to benefit from potential treatment alternatives is in question; when the treatment would be involuntary or when other legal or administrative issues are involved; or when available treatment options are limited by external constraints (e.g., financial barriers, insurance restrictions, geographic barriers, service availability, the patient's capacity to participate in the proposed treatment). Such considerations are also relevant when considering the level of care needed to provide an individual patient with appropriate treatment. In addition, level-of-care determinations will vary with the diagnosis, the presence of co-occurring general medical or psychiatric disorders (including substance use disorders), the assessment of the patient's risk to self or others, the current severity of symptoms, the patient's prior illness course and complications, his or her psychosocial supports, his or her treatment adherence, and the strength of the thera-

peutic alliance, among other factors. In some circumstances, it is also important for the psychiatrist to be able to recognize the limitation of health care resources and demonstrate the ability to act as an advocate for patients within their sociocultural and financial constraints (60).

4. Decisions regarding treatment-related legal and administrative issues

Although the consideration of forensic evaluations is outside the scope of this practice guideline, there are times when the general psychiatric evaluation may need to address legal or administrative concerns (Section V.C). Examples include deciding between voluntary and involuntary admission, determining whether legally mandated treatment should be pursued in objecting patients, determining whether there is a duty to protect (e.g., by modifying the patient's treatment, increasing outpatient visit frequency, initiating hospitalization, warning the victim) if the patient is deemed a potential risk to others, and deciding on the level of observation needed to address the patient's safety (11). In situations such as these, the psychiatrist's decision making will depend on the risk assessment (Section IV.B.1.b) as well as other relevant aspects of the history, examination, symptoms, diagnosis, and clinical formulation. Assessment of the patient's decision-making capacity may also be needed as part of the informed consent process. When a patient's capacity to consent to treatment is uncertain, questioning to determine mental status should be extended to include items that test the patient's decision-making capacity (192). As with other aspects of the evaluation, it is important to document the rationales for making a particular treatment decision, including a discussion of supporting evidence from the evaluation findings.

5. Systems issues

An assessment of family, peer networks, and other support systems is an important part of the psychiatric evaluation because of the potential role of these systems in ameliorating or augmenting the patient's signs and symptoms of illness. This is particularly true when evaluating individuals with complex biopsychosocial challenges or serious psychiatric or general medical conditions. If the initial evaluation indicates that aspects of the care system have an important role in the patient's illness and treatment, goals are developed in response to these findings. Systems may be more open to considering change at times of crisis. Consequently, as well as generating goals for the patient's diagnosis and individual treatment, the evaluation may lead to goals for intervening with the family, other important people in the patient's life, other professionals (e.g., therapists), general medical providers, and governmental or social agencies (e.g., community mental health centers or family service agencies). Specific plans may be needed for addressing problems in the care system that are seen as important to the patient's illness, symptoms, function, or well-being and that appear amenable to modification. For example, a parent may be unable to attend follow-up appointments unless issues relating to care of dependents are addressed; financial issues or formulary restrictions may preclude patients from obtaining their medications; or geographic constraints may limit access to a full range of treatment options. Plans to address such systems issues should consider feasibility, the patient's wishes, and the willingness of other people to be involved.

V. SPECIAL CONSIDERATIONS

▶ A. PRIVACY AND CONFIDENTIALITY

Considerations of privacy and confidentiality are an integral component of any psychiatric encounter. Aspects of privacy and confidentiality relating to communication with other medical

professionals and with sources of collateral information have been discussed above (Sections I.A, I.B, II.C, and IV.A.2). In general, the default position is to maintain confidentiality unless the patient gives consent to a specific intervention or communication. However, the psychiatrist is justified in attenuating confidentiality to the extent needed to address the safety of the patient and others (10, 11). This includes the ability to communicate necessary information about the patient to medical personnel in the context of an emergency situation. It is also permissible for the psychiatrist to listen to information provided by family members and other important people in the patient's life, as long as confidential information is not provided to the informant.

The Health Insurance Portability and Accountability Act (HIPAA) contains guidelines for release of the results of psychiatric evaluations. State laws may be more restrictive, and if so, state laws take precedence over HIPAA. According to HIPAA, information can be released without a specific consent form for purposes of "treatment, payment, and health care operations." Otherwise, patients must sign an authorization form that indicates the information to be used or disclosed, the purposes to which it will be put, the recipient of the information, and an expiration date. HIPAA gives special protection to psychotherapy notes if they are kept in a separate part of the medical chart (193, 194). The interpretation of HIPAA and other federal and state laws about confidentiality continues to evolve, and legal or risk management consultation should be sought if there are questions about the regulations related to release of information and protection of psychiatric records (195).

For individuals in treatment for substance use disorders, the provisions of 42 CFR §2.11 will apply (196) and will generally be more strict and supersede the provisions of HIPAA (197). As with HIPAA, necessary information may be disclosed to medical personnel in the context of treating a condition that poses an immediate threat to the health of any individual and that requires immediate medical intervention. Under such circumstances, documentation in the medical record needs to include "the name of the medical personnel to whom disclosure was made and their affiliation with any health care facility; the name of the individual making the disclosure; the date and time of the disclosure; and the nature of the emergency" (42 CFR §2.51 [196]).

Medical records may also be viewed by others in addition to the clinician writing the note (198) or other members of an interdisciplinary treatment team. These include third-party payers, quality assurance/peer review evaluators, the patient, and, in certain jurisdictions, the executor of an estate after a patient's death. Furthermore, records may be part of future or current legal or administrative hearings, including disability litigation, divorce and custody adjudication, competency determinations, and actions of medical licensing boards. Such accessing of patient's medical records needs to be taken into consideration when documenting the evaluation, formulation, diagnosis, and plan of treatment.

► **B. INTERACTIONS WITH THIRD-PARTY PAYERS AND THEIR AGENTS**

Third-party payers and their agents frequently request data from psychiatric evaluations to make determinations about whether a hospital admission or a specific treatment modality will be covered by a particular insurance plan. Despite the blanket consents to release information to payers that most patients must sign to obtain insurance benefits, it is useful for the psychiatrist to obtain, whenever feasible, contemporaneous consent for such communications. In some instances, it may be necessary to inform the patient what specific information has been requested and obtain specific consent for the release of that information. With valid consent, the psychiatrist may release information to a third-party reviewer, supplying the third-party reviewer with sufficient information to understand the rationale for the treatment and why it was selected over potential alternatives. However, the psychiatrist may also withhold information about the patient not directly relevant to the utilization review or preauthorization decision (199, 200).

▶ **C. LEGAL AND ADMINISTRATIVE ISSUES IN INSTITUTIONS**

When a patient is admitted to a hospital or other residential setting, the patient's legal status should be promptly clarified to establish whether the admission is voluntary or involuntary, whether the patient gives or withholds consent to evaluation and recommended treatment, whether the patient appears able to make treatment-related decisions, and whether an advance directive is in place. If there is a potential legal impediment to necessary treatment, action should be taken to resolve the issue.

The decision to hospitalize a patient involuntarily will depend on multiple factors, including the estimated level of risk to the patient and others, the patient's level of insight and willingness to seek care, and the legal criteria in that jurisdiction. In general, patients at risk for causing harm to themselves or others will satisfy the criteria for involuntary admission; however, the specific requirements vary from state to state (201), and in some states, willingness to enter a hospital voluntarily may preclude involuntary admission. To that end, psychiatrists need to be familiar with their specific state statutes regarding involuntary hospitalization.

Advance directives are attempts to ensure that individuals' wishes about treatment will be honored. Such directives may relate to wishes about treatment at the end of life (202) but may also relate to wishes about psychiatric treatment (203) or assignment of a durable power of attorney or health care proxy to make decisions in the event that the individual lacks capacity to do so (204). Although the specifics of advance directive regulations vary by jurisdiction, psychiatrists should include in their evaluation whether the patient has executed an advance directive—and, if so, the nature of the advance directive should be determined.

In every institution, whether public or private, fiscal and administrative considerations limit treatment options. Usually there are constraints on length of stay and on the intensity of services available. Further constraints can arise from the absence or inadequate funding of after-care services or of a full continuum of care. The initial assessment of treatment needs should not be confounded unduly with concerns about financing or availability of services, although the actual treatment may represent a balancing of optimal treatment and external constraints. A common example is the situation in which a patient's safety requires a level of supervision not available in a given facility. Another example is when a patient requires a general medical evaluation that cannot be carried out in a free-standing psychiatric facility and requires the patient's transfer to a general hospital. If such issues result in a major negative effect on patient care, efforts should be made to find alternatives, and the patient, family, and/or third-party payer should be informed of the limitations of the current treatment setting and/or resources.

▶ **D. SPECIAL POPULATIONS**

1. Elderly patients and patients with medical conditions

While advanced chronological age alone does not necessitate a change in the approach to the psychiatric evaluation, the strong association of old age with chronic disease and related impairments may increase the need for emphasis on certain aspects of the evaluation. The general medical history and evaluation, cognitive mental status examination, and functional assessment may need to be especially detailed because of the high prevalence of disease-related disability, use of multiple medications, cognitive impairment, and functional impairment in older people. The psychiatrist should attempt to identify all of the general medical and personal care clinicians involved with the patient and to obtain relevant information from them if the patient consents. It is also helpful to obtain information from the family.

The personal and social history includes coverage of common late-life issues, including the loss of a spouse or partner, the loss of friends or close relatives, residential moves, the new onset of disabilities, financial concerns related to illness or disability, and intergenerational issues,

such as informal caregiving or financial transfers between members of different generations. It is important to evaluate intergenerational strains such as midlife couples with young children who cannot care for elderly relatives or, increasingly, patients in their 90s whose children are now in their 70s and ill themselves.

The psychiatrist may need to accommodate the evaluation to patients who cannot hear adequately. Use of sign language interpreters, amplification, a quieter interview room, and enabling lip reading are possible means to do this. When an elderly patient is brought for psychiatric evaluation by a family member, special effort may be necessary to ensure that both patient and family member have an opportunity to talk to the psychiatrist alone.

2. Incarcerated Persons

Increasing numbers of individuals with mental illness are incarcerated in jails, prisons, and other correctional facilities and require psychiatric evaluation (205–208). In addition, suicide is one of the leading causes of death in correctional settings, and urgent suicide assessments may be needed for individuals at risk (11, 209, 210).

The psychiatric evaluation of incarcerated individuals will include the general elements common to any psychiatric evaluation (211–213) but will place additional emphasis on aspects of the individual's alcohol and substance use history and legal history, including previous episodes of incarceration and associated behavioral changes. Psychosocial stressors, including new legal complications (e.g., denial of parole), receiving bad news about loved ones at home, and experiencing sexual assault or other trauma, are also important to assess, as these may increase the likelihood of suicidal behaviors (214). Similarly, the recentness of the incarceration (210, 214, 215) or placement in isolation (216–219) may be relevant to determination of suicide risk. Depending on the likely duration of incarceration, options for care following transfer between correctional institutions or for aftercare following release may also need to be explored as part of the evaluation.

Access to space that allows for auditory privacy and physical safety is necessary to adequately perform psychiatric evaluations in correctional settings (212).

3. Homeless persons

Evaluations of persons who are homeless may require both modifications of the evaluation process and unique interviewing skills. The disengaged lifestyle and mistrust often encountered in homeless persons may make a classically direct approach difficult if not impossible (220). As a result, the first step toward psychiatric evaluation is engagement. This process can take from days to years in nonclinical settings (e.g., on the street, under bridges, in shelters). Evaluation becomes possible when the homeless person believes that engaging with the psychiatrist will not recapitulate previous negative experiences, lost opportunities within the health care system, and encounters in jail and prison that heighten a fear of consequences from talking honestly. By necessity, then, the full psychiatric evaluation of homeless persons typically unfolds over numerous, often brief, and seemingly casual interactions.

4. Persons with mental retardation

The evaluation of individuals with mental retardation presents a number of clinical challenges. Although psychiatric illnesses occur at increased rates in those with mental retardation (221, 222), it is not always possible to establish a definitive axis I diagnosis as a cause for behavioral symptoms (223). Depending on the extent of the patient's intellectual limitations, the diagnosis of mental retardation may have been unrecognized before the behavioral symptoms began.

In interviewing individuals with mental retardation, particular attention needs to be given to the phrasing of questions so that they will be understandable to the patient. The use of general psychiatric self-report scales or other structured interview formats may be problematic in this

regard (221, 224). Behavioral observations or functional measures will often carry a greater weight in the assessment process, and patients with more severe mental retardation may be unable to report on their own mental experiences (225, 226). Thus, obtaining a comprehensive description of symptoms, signs, and aspects of history from family members, caretakers, and other professionals is often crucial. This is particularly true when persons with mental retardation present for evaluation in the context of a behavioral crisis, because otherwise minor events (e.g., changes in routine, upsetting interpersonal interactions) may be quite distressing and result in catastrophic reactions. Similar issues with evaluation may be observed in individuals with other developmental disabilities.

Evaluation for co-occurring general medical conditions is particularly important in adults with mental retardation, given higher rates of undetected medical illnesses (222, 227) as well as the tendency for atypical clinical presentations of medical illnesses (140, 227).

VI. FUTURE RESEARCH NEEDS

Psychiatric evaluation is, by necessity, highly individualized to the patient and to the treatment setting, making the development of rigorous research designs challenging. Nonetheless, a number of aspects of psychiatric interviewing and assessment may lend themselves to formal study and are discussed in further detail below. In addition, the research agenda for DSM-V (228) provides suggestions for research relating to psychiatric diagnosis, which has many areas of overlap with research on psychiatric assessment.

▶ A. INTERVIEWING APPROACHES

Some research, predominantly conducted in primary care settings, has examined the differences between specific interviewing approaches. For example, approaches to enhancing reporting and recall of historical information have been evaluated (229, 230). Additional studies have assessed the effects of communication style and vocabulary on outcomes such as patient satisfaction (231–236). The development of new evaluation strategies could help strengthen psychiatric interviewing approaches. In addition, it will be important to expand such research across different patient subgroups (e.g., according to age, gender, sexual orientation, race, ethnicity, cultural background), to individuals with psychiatric disorders, and to collaborative models of assessment and care. Measures of outcomes will also need to be expanded to include factors such as treatment adherence and the strength of the therapeutic alliance. Furthermore, studies will need to assess whether guideline-concordant approaches to assessment are associated with improved outcomes in community-based patient samples (237).

Research has also focused on the impact of technology on information gathering and the physician-patient encounter. For example, some studies have examined differences in the information elicited by face-to-face interviews as compared with computer-aided assessments or telephone interviews (238, 239). Other studies have assessed computerized documentation by physicians at the time of evaluation and its effect on patient perceptions (240–242). Patients and family members are increasingly learning about possible diagnoses and treatments through direct-to-consumer advertising and through Internet-based educational resources, which they sometimes bring to the evaluation. Systematic study of the influences of these information sources on the assessment and treatment planning processes would be useful. It also remains unclear whether use of template-based electronic health records as compared with narrative-based health records will influence the evaluation process, the physician-patient relationship, or communi-

cation with other members of the health care team. Thus, with the increasing use of technology in medicine, including computer-based interviews and telepsychiatry, the influence of such technologies is worthy of additional study in the full range of psychiatric settings.

▶ **B. RATING SCALES**

Although rating scales have been widely used in clinical research for assessment by the clinician and self-assessment, they are less often incorporated into psychiatric evaluations in clinical practice. To be most useful, rating scales need to be valid and reliable as well as demonstrate practical utility in typical clinical settings. Further study of clinical rating scales is required in clinical samples including patients with potentially confounding co-occurring disorders (243). Development and testing of rating scales also need to consider the different requirements for rating scales that are used in initial diagnostic assessments as compared with those used in monitoring of signs and symptoms over time or with treatment. The ability to use rating scales to detect prodromal or subsyndromal disorders as part of the psychiatric evaluation would be an important step in the design and testing of preventive approaches to psychiatric disorders. Ideally, research on rating scales could lead to the development of a limited set of formal systematic measures for screening and monitoring, with resulting benefits in identification and treatment of common psychiatric disorders, including substance use disorders.

▶ **C. DIAGNOSIS AND FORMULATION**

An integral part of the psychiatric evaluation is the process by which the information gathered as part of the psychiatric evaluation is synthesized and integrated into the development of a multi-axial diagnosis and biopsychosocial formulation. In addition to research on the validity and reliability of specific diagnoses, further research is needed on variations in both clinical and community presentations across different patient subgroups (e.g., according to age, gender, sexual orientation, race, ethnicity, cultural background) and in the presence of co-occurring general medical and psychiatric conditions. It is anticipated that the development of DSM-V will stimulate such research across many diagnostic areas, guided by APA's systematic efforts to review existing data and provide agendas for new research (228). With the advent of electronic health records and the increasing availability of decision-support tools, computerized approaches that may permit development of differential diagnoses or formulations will need to be compared to clinician-generated assessments. Longitudinal research on the reliability and validity of approaches to the clinical formulation may aid in fine-tuning this aspect of assessment.

▶ **D. DIAGNOSTIC TESTING**

With regard to diagnostic testing, neurogenetics and structural and functional neuroimaging techniques are areas of active and promising research. A burgeoning body of literature has reported associations between genetic markers (e.g., apolipoprotein E ϵ 4 allele, dopamine D₄ allele, catechol-*O*-methyltransferase polymorphisms, promoter polymorphisms of the serotonin transporter gene) and the presence of psychiatric illnesses or symptoms (244–251). Neurogenetic approaches may ultimately be useful in distinguishing between genetic and environmental etiologies of psychiatric disorders as part of the psychiatric evaluation (252), thereby permitting greater specificity in treatment planning and outcome measurement. While some have speculated that characterization of the particular genotype of a patient will lead to “personalized medicine” by guiding treatment choices, significant support for such therapeutic guidance in psychiatric disorders is not yet substantiated by the literature. The potential for progress in this area merits continued vigilance for reports of its impact on the practice of psychiatry.

Neuroimaging techniques are currently used in identifying central nervous system processes such as infection, malformations, cerebrovascular events, and malignancy. Accumulating evidence also suggests other applications of neuroimaging in psychiatric evaluation. In cognitive disorders of late life, such as Alzheimer's disease, neuroimaging techniques have been evaluated for use as surrogate markers for the microscopic neuropathologies that characterize the illness (253–256). Functional neuroimaging with positron emission tomography or single-photon emission computed tomography has demonstrated an association between reduced regional activity (metabolism or perfusion) in temporoparietal regions and the presence and severity of Alzheimer's disease (257–264), whereas other dementing illnesses do not show this temporoparietal feature. The reproducibility of these findings has enhanced the differentiation between Alzheimer's disease and other dementing illnesses (265). Ongoing work aims to confirm the clinical utility of such information.

In patients with schizophrenia and mood and anxiety disorders, structural and functional neuroimaging studies have reported differences between patients and healthy control persons (266–288) as well as differences in some patient subgroups (289–292) and in responders and nonresponders to some treatments (293–302). Nevertheless, the clinical utility of neuroimaging techniques for planning of individualized treatment has not yet been shown. Further research is needed to demonstrate a clinical role for structural and functional neuroimaging in establishing psychiatric diagnoses, monitoring illness progression, and predicting prognoses.

INDIVIDUALS AND ORGANIZATIONS THAT SUBMITTED COMMENTS

Norman Abeles, Ph.D.	Paul Jay Fink, M.D.
Renato D. Alarcon, M.D., M.P.H.	Peter Forster, M.D.
Mark A. Amdur, M.D.	K.W.M. Fulford, D.Phil., F.R.C.P., F.R.C.Psych.
Kamal Artin, M.D.	Paulette Marie Gillig, M.D., Ph.D.
David Baron, M.S.Ed., D.O.	Leslie H. Gise, M.D.
Carl C. Bell, M.D.	Sir David Goldberg, M.D.
David W. Brook, M.D.	Lawrence S. Gross, M.D.
Beth Ann Brooks, M.D.	Douglas G. Jacobs, M.D.
Karen Broquet, M.D.	Douglas A. Kalunian, M.D.
R.W. Burgoyne, M.D., Ph.D.	Elisabeth J.S. Kunkel, M.D.
Gabrielle A. Carlson, M.D.	Ira Lesser, M.D.
Mitchell J.M. Cohen, M.D.	James W. Lomax, M.D.
Paul D. Cox, M.D., C.G.P.	Henry Mallard, M.D.
Larry Culpepper, M.D., M.P.H.	David Mallott, M.D.
Glenn Currier, M.D., M.P.H.	Marlin R. Mattson, M.D.
David L. Cutler, M.D.	Peter McGeorge, M.D. M.B.Ch.B., F.R.A.N.Z.C.P.
Sarah DeMichele, M.D.	Hunter L. McQuiston, M.D.
William R. Dubin, M.D.	Jeffrey L. Metzner, M.D.
Michael A. Fauman, M.D., Ph.D.	Kenneth Minkoff, M.D.
Joel Feiner, M.D.	Mark Munetz, M.D.

Marvin Nierenberg, M.D.	Warren Seides, M.D.
Ann E. Norwood, M.D.	Michael Serby, M.D.
Lewis A. Opler, M.D., Ph.D.	Joel J. Silverman, M.D.
John Peteet, M.D.	Robert Stern, M.D., Ph.D.
Herbert S. Peyser, M.D.	Nada Stotland, M.D., M.P.H.
Harold Alan Pincus, M.D.	Jeffrey Stovall, M.D.
Henry Pinsker, M.D.	Paula T. Trzepacz, M.D.
Brian Robertson, M.D.	Mitchell G. Weiss, M.D., Ph.D.
Barbara R. Rosenfeld, M.D.	Cindy Wigg, M.D.
Barry W. Rovner, M.D.	Bonnie Zima, M.D., M.P.H.
M. David Rudd, Ph.D., A.B.P.P.	Mark Zimmerman, M.D.
John Z. Sadler, M.D.	Sidney Zisook, M.D.

Academy of Psychosomatic Medicine
 American Academy of Addiction Psychiatry
 American Academy of Clinical Psychiatrists
 American Academy of Family Physicians
 American Association for Emergency Psychiatry
 American Association of Directors of Psychiatric Residency Training
 American Association of Suicidology
 American Group Psychotherapy Association
 Association for Academic Psychiatry
 Association for Behavioral and Cognitive Therapies
 Group for the Advancement of Psychiatry
 National Institute of Mental Health
 Royal College of Psychiatrists
 World Federation for Mental Health

REFERENCES

The following coding system is used to indicate the nature of the supporting evidence in the summary recommendations and references:

- [A] *Double-blind, randomized clinical trial.* A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are blind to the assignments.
- [A-] *Randomized clinical trial.* Same as above but not double-blind.
- [B] *Clinical trial.* A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial.
- [C] *Cohort or longitudinal study.* A study in which subjects are prospectively followed over time without any specific intervention.
- [D] *Control study.* A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.

- [E] *Review with secondary data analysis.* A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.
- [F] *Review.* A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.
- [G] *Other.* Textbooks, expert opinion, case reports, and other reports not included above.

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