Assessment in Mental Health and Psychiatric Nursing
Applying the Nursing Process in MHPN
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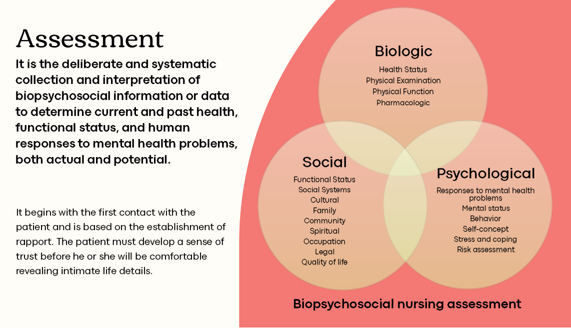
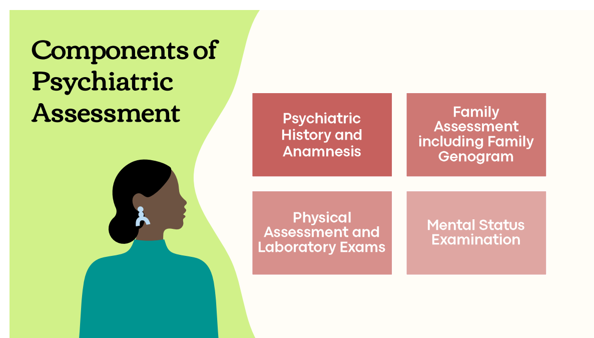
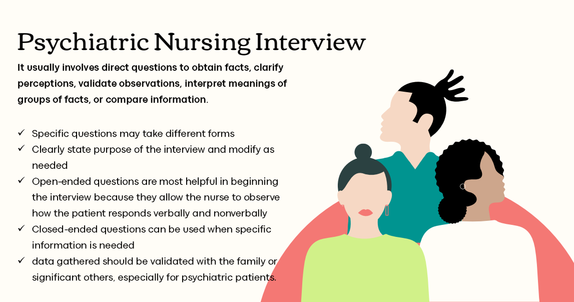
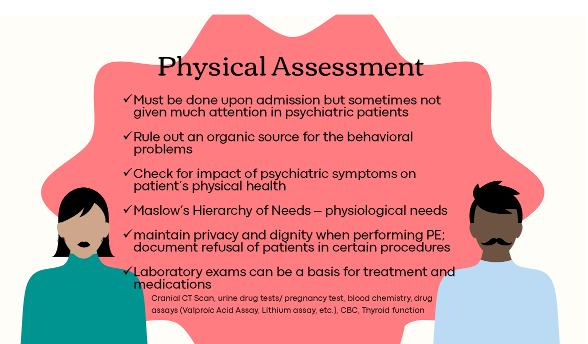
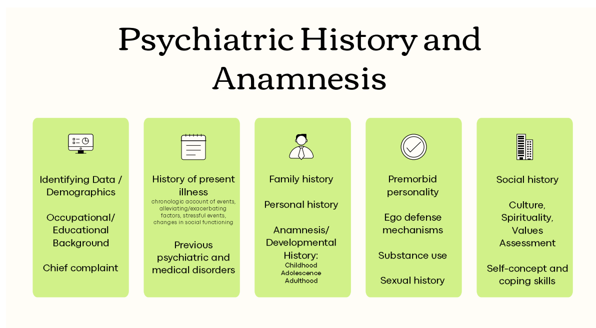
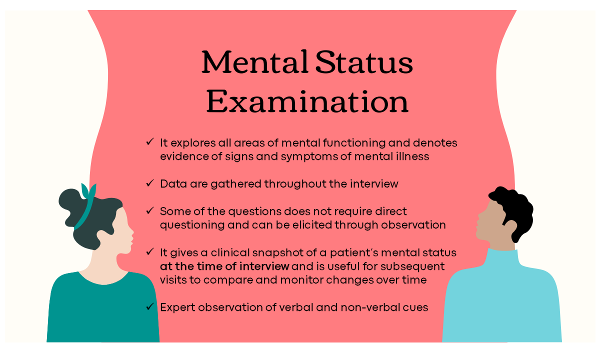

Assessment
It is the deliberate and systematic collection and interpretation of biopsychosocial information or data to determine current and past health, functional status, and human responses to mental health problems, both actual and potential.
It begins with the first contact with the patient and is based on the establishment of rapport. The patient must develop a sense of trust before he or she will be comfortable revealing intimate life details.
Biologic
Health Status
Physical Examination
Physical Function
Pharmacologic
Social
Functional Status
Social Systems
Cultural
Family
Community
Spiritual
Occupation
Legal
Quality of life
Psychological
Responses to mental health problems
Mental status
Behavior
Self-concept
Stress and coping
Risk assessment
Biopsychosocial nursing assessment

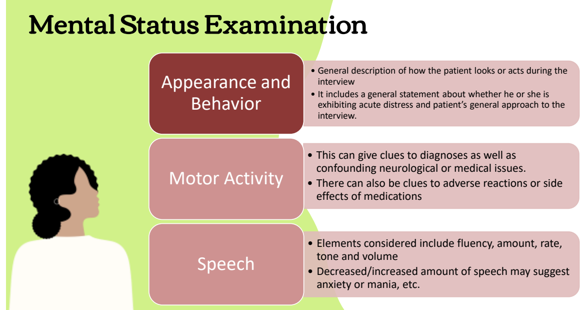

Components of Psychiatric Assessment
Psychiatric History and Anamnesis
Family Assessment including Family Genogram
Physical Assessment and Laboratory Exams
Mental Status Examination

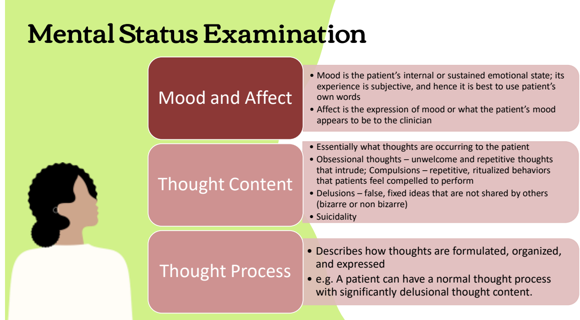

Psychiatric Nursing Interview
It usually involves direct questions to obtain facts, clarify perceptions, validate observations, interpret meanings of groups of facts, or compare information.
✓ Specific questions may take different forms
✓ Clearly state purpose of the interview and modify as needed
✓ Open-ended questions are most helpful in beginning the interview because they allow the nurse to observe how the patient responds verbally and nonverbally
✓ Closed-ended questions can be used when specific information is needed
✓ data gathered should be validated with the family or significant others, especially for psychiatric patients.

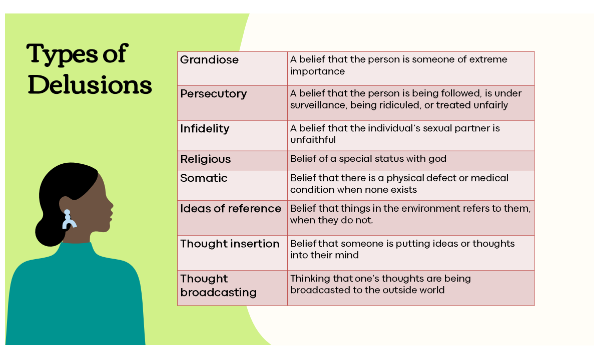

Physical Assessment
✓Must be done upon admission but sometimes not given much attention in psychiatric patients
✓Rule out an organic source for the behavioral problems
✓Check for impact of psychiatric symptoms on patient's physical health
✓Maslow's Hierarchy of Needs – physiological needs
✓maintain privacy and dignity when performing PE; document refusal of patients in certain procedures
✓Laboratory exams can be a basis for treatment and medications
Cranial CT Scan, urine drug tests/ pregnancy test, blood chemistry, drug assays (Valproic Acid Assay, Lithium assay, etc.), CBC, Thyroid function

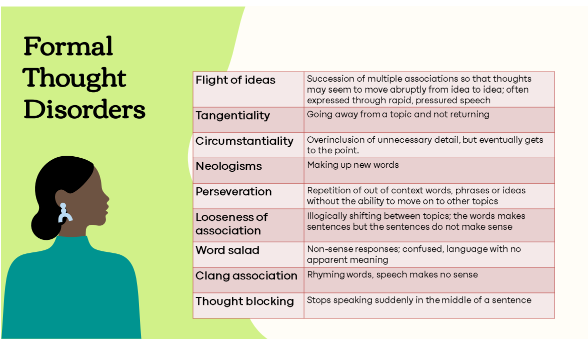

Psychiatric History and Anamnesis
Identifying Data / Demographics
Occupational/ Educational Background
Chief complaint
History of present illness
chronologic account of events, alleviating/exacerbating factors, stressful events, changes in social functioning
Previous psychiatric and medical disorders
Family history
Personal history
Anamnesis/ Developmental History:
Childhood
Adolescence
Adulthood
Premorbid personality
Ego defense mechanisms
Substance use
Sexual history
Social history
Culture, Spirituality, Values Assessment
Self-concept and coping skills

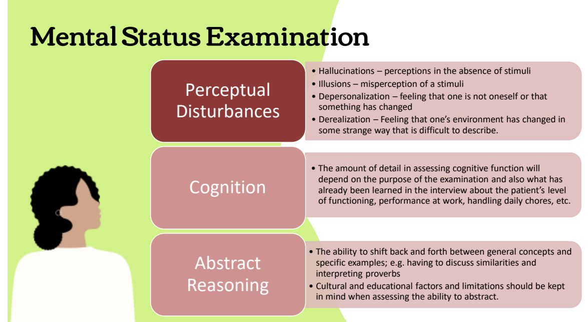

Mental Status Examination
It explores all areas of mental functioning and denotes evidence of signs and symptoms of mental illness
Data are gathered throughout the interview
Some of the questions does not require direct questioning and can be elicited through observation
It gives a clinical snapshot of a patient's mental status at the time of interview and is useful for subsequent visits to compare and monitor changes over time
Expert observation of verbal and non-verbal cues

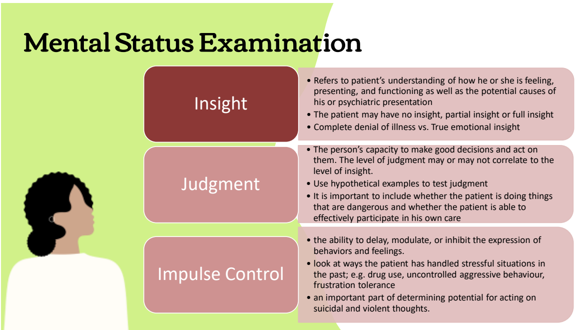

Mental Status Examination
Appearance and Behavior
General description of how the patient looks or acts during the interview
It includes a general statement about whether he or she is exhibiting acute distress and patient's general approach to the interview.
Motor Activity
This can give clues to diagnoses as well as confounding neurological or medical issues.
There can also be clues to adverse reactions or side effects of medications
Speech
Elements considered include fluency, amount, rate, tone and volume
Decreased/increased amount of speech may suggest anxiety or mania, etc.


Mental Status Examination
Mood and Affect
Mood is the patient's internal or sustained emotional state; its experience is subjective, and hence it is best to use patient's own words
Affect is the expression of mood or what the patient's mood appears to be to the clinician
Thought Content
Essentially what thoughts are occurring to the patient
Obsessional thoughts – unwelcome and repetitive thoughts that intrude; Compulsions – repetitive, ritualized behaviors that patients feel compelled to perform
Delusions – false, fixed ideas that are not shared by others (bizarre or non bizarre)
Suicidality
Thought Process
Describes how thoughts are formulated, organized, and expressed
e.g. A patient can have a normal thought process with significantly delusional thought content.


Types of Delusions
Grandiose
A belief that the person is someone of extreme importance
Persecutory
A belief that the person is being followed, is under surveillance, being ridiculed, or treated unfairly
Infidelity
A belief that the individual's sexual partner is unfaithful
Religious
Belief of a special status with god
Somatic
Belief that there is a physical defect or medical condition when none exists
Ideas of reference
Belief that things in the environment refers to them, when they do not.
Thought insertion
Belief that someone is putting ideas or thoughts into their mind
Thought broadcasting
Thinking that one's thoughts are being broadcasted to the outside world


Formal Thought Disorders
Flight of ideas
Succession of multiple associations so that thoughts may seem to move abruptly from idea to idea; often expressed through rapid, pressured speech
Tangentiality
Going away from a topic and not returning
Circumstantiality
Overinclusion of unnecessary detail, but eventually gets to the point.
Neologisms
Making up new words
Perseveration
Repetition of out of context words, phrases or ideas without the ability to move on to other topics
Looseness of association
Illogically shifting between topics; the words makes sentences but the sentences do not make sense
Word salad
Non-sense responses; confused, language with no apparent meaning
Clang association
Rhyming words, speech makes no sense
Thought blocking
Stops speaking suddenly in the middle of a sentence

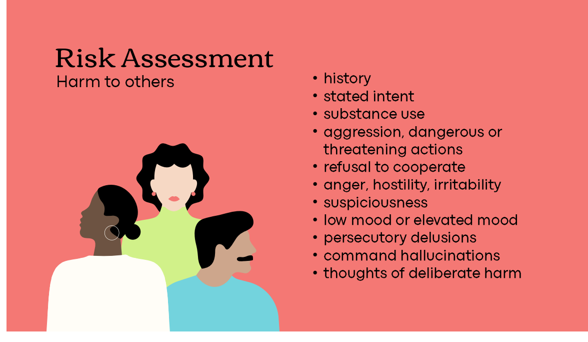

Mental Status Examination
Perceptual Disturbances
Hallucinations – perceptions in the absence of stimuli
Illusions – misperception of a stimuli
Depersonalization – feeling that one is not oneself or that something has changed
Derealization – Feeling that one's environment has changed in some strange way that is difficult to describe.
Cognition
The amount of detail in assessing cognitive function will depend on the purpose of the examination and also what has already been learned in the interview about the patient's level of functioning, performance at work, handling daily chores, etc.
Abstract Reasoning
The ability to shift back and forth between general concepts and specific examples; e.g. having to discuss similarities and interpreting proverbs
Cultural and educational factors and limitations should be kept in mind when assessing the ability to abstract.

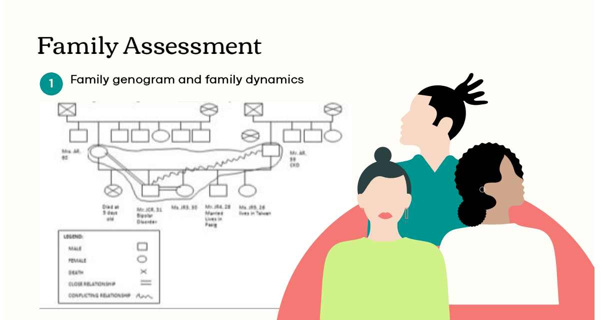

Mental Status Examination
Insight
• Refers to patient's understanding of how he or she is feeling, presenting, and functioning as well as the potential causes of his or psychiatric presentation
• The patient may have no insight, partial insight or full insight
• Complete denial of illness vs. True emotional insight
Judgment
• The person's capacity to make good decisions and act on them. The level of judgment may or may not correlate to the level of insight.
• Use hypothetical examples to test judgment
• It is important to include whether the patient is doing things that are dangerous and whether the patient is able to effectively participate in his own care
Impulse Control
• the ability to delay, modulate, or inhibit the expression of behaviors and feelings.
• look at ways the patient has handled stressful situations in the past; e.g. drug use, uncontrolled aggressive behaviour, frustration tolerance
• an important part of determining potential for acting on suicidal and violent thoughts.

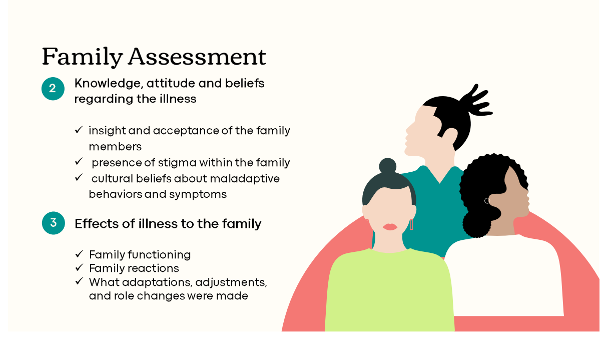
Common Questions for Psychiatric History and Mental Status
Psychiatric Report

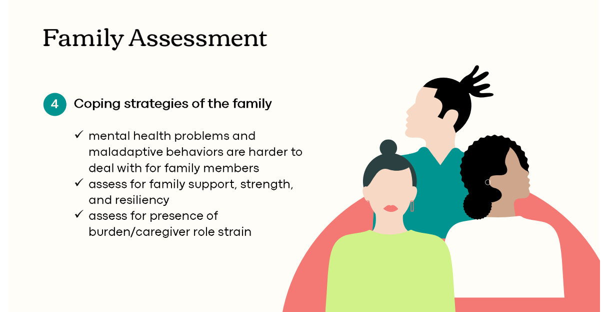
Risk Assessment
Always assess patients for patient safety and potential violence and danger to self or others

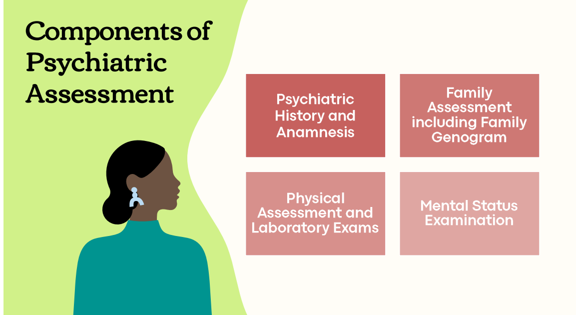
✓ Assess the specificity, lethality, availability, proximity of the suicide plan.
Risk Assessment
Harm to self
• history
• stated intent
• psychosocial risk factors
• specific suicide inquiry
• depressed mood
• isolation and lack of social support
• hopelessness
• worthlessness

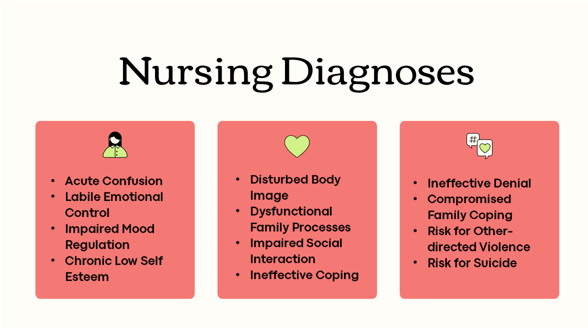

Risk Assessment
Harm to others
• history
• stated intent
• substance use
• aggression, dangerous or threatening actions
• refusal to cooperate
• anger, hostility, irritability
• suspiciousness
• low mood or elevated mood
• persecutory delusions
• command hallucinations
• thoughts of deliberate harm


Family Assessment
1 Family genogram and family dynamics

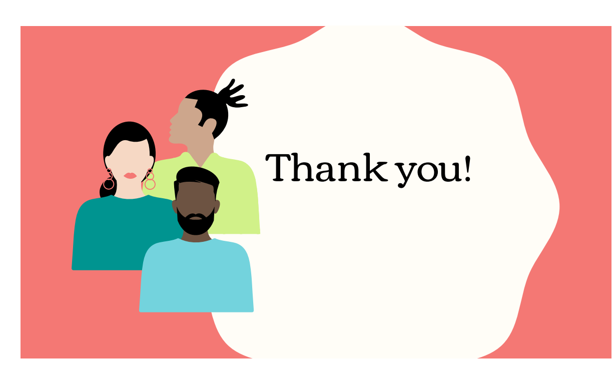








There is no health without mental health



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