Conducting mental health assessments
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Overview of today’s lecture
- What information do we need to gather in a mental health assessment?
- How do we get that information?
  - Interview structure and skills needed
    - Assessment tools
- How do we organize the information and make sense of it?
- Where does diagnosis fit in?

Purpose of a mental health assessment
- Identify the primary problem
- Establish rapport
- Make a tentative DSM diagnosis
- Make a tentative case formulation
- Form a tentative treatment plan
What information do we need to gather in a mental health assessment?

- Referral source and identifying info- (may review old records)
  - Voluntary vs. involuntary
  - Presenting problem or chief complaint
  - History of presenting problem
    - What is happening in this episode of illness- symptoms, duration, time of onset
    - Precipitating event- Why now?
    - Does the client have a theory? What are they looking for from you?

- Medical history
  - Their current and past medical problems and treatments received
  - Family medical history if it seems relevant

- Psychiatric history
  - Previous episodes of illness
  - History of treatment – success and failures (inpatient and outpatient)
  - Substance use history
  - Family history of mental illness and treatment (history of medication can be very important)

Topics to cover

- Psychosocial history
  - Childhood issues and information about family of origin
  - Developmental milestones
  - Trauma history
  - Educational and vocational history
  - History of adult relationships and current family constellation
  - Spiritual history
  - Legal history

- Mental Status- (see handouts)
  - including lethality assessment
  - Tentative diagnosis/formulation and treatment plan
    - This includes DSM diagnosis as well as your initial formulation of what is wrong
    - Consider developmental stage
    - Remember strengths!
Biopsychosocial assessment

- The social work perspective is sometimes referred to as "person in environment", meaning that we cannot separate the individual from context including:
  - Social context - family, social class, geographic region
  - Cultural context - race, ethnicity, acculturation, language, dominant vs. targeted group
  - Spiritual context - beliefs about what causes problems and what heals
- Social work also stresses finding and building on client strengths

Strengths and Assets

- Take time in an assessment to focus on what is going well in their life rather than just focusing on the problems
- If nothing seems to be going well - then how are they coping?
- Coping and resilience means dealing well with bad situations
- How do these strengths fit with their culture vs. the dominant culture?
- Areas to consider:
  - What is their ability to perceive, analyze and comprehend their problems?
  - How do they manage stress?
  - What temperamental and dispositional factors help this person? What is their world view?
  - What is their support system?
It’s a balancing act

- The challenge of an initial interview is that you must be kind, gentle, build rapport and make the person feel comfortable
- AND you must gather an enormous amount of very specific information and fill out the requisite forms
- I think of this as the artist vs. the detective!

The artist

- “We receive a new patient with a mental wide-eyedness, taking in and recording the human data with freshness and clarity, minimizing prejudicial impression, remaining open for surprise... We want to find a way to allow the patient to tell his or her story as the patient understands it... we want to appreciate the patient’s experience. Just as we like to abandon ourselves to a powerful musical performance, eager to be swept up by the essence of the art, so too we must find a way of giving ourselves over to the experiential point of view of the patient”
  
  Roth 1987

The detective

- “I do not believe that I have had an interview with anybody in 25 years in which the person to whom I was talking was not annoyed by my asking stupid questions... A patient tells me the obvious and I wonder what he means and ask further questions. But after the first half hour or so, he begins to see that there is a reasonable uncertainty as to what he meant, and that statements which seem obvious to him may be remarkably uncommunicative to the other person.”
  
  Sullivan 1954
General interviewing guidelines

- Gather all possible sources of information ahead of time
- Start interview open ended, let them tell story and EMPATHIZE
- If they are very clear in their presentation you will not need to structure the interview as much
- Generally you will need a mixture of open and closed questions
- As you listen you will decide which issues need further exploration and then ask for specifics
- Use client’s words to reflect back but make sure that you understand their idiosyncratic meanings
- Signal to client when you are switching gears to detective mode
- Don’t be afraid to ask about sensitive topics– let them know that these are standard assessment questions

Guidelines (cont.)

- You must keep the interview on track and keep track of time
- Take notes! (but be willing to show them to client)
- If client is an unreliable source, seek out collateral contacts
- Don’t forget about strengths
- Reconcile yourself to idea that you will not get all the information in one session
- At end give them an idea of your view of things and next steps– convey a sense of hope, thank them for providing all this info and being patient with a million questions
- Leave time for them to ask questions

Diagnosis and Formulation
What is a mental disorder?

> “They (mental disorders) all represent interactions among biological potentialities, individual vulnerabilities, environmental conditions, social stressors, social networks and supports, psychological orientations and learned behavior.”

  Mechanic, 1999

DSM-5 Definition

> “A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.”

  DSM-5, 2013

Furthermore...

> A mental disorder is:

  - Categorized while acknowledging differences among individuals with a particular disorder
  - Without sharp boundaries between different disorders and between disorder and no disorder
  - A description of an illness, not a person
Symptoms, Signs and Syndromes

- Symptoms: Subjective, reported by the client, cannot be observed (examples- chest pain, paranoid thinking, depressed mood, anxiety)
- Signs: Objective, observed by the clinician, can be documented (example- heart failure, paranoid speech, crying, restlessness)
- Signs are documented in your mental status exam section
- Syndromes: A collection of signs and symptoms
- These syndromes constitute mental disorders which have a characteristic course, prognosis and response to treatment

Mental Status Exam

- Part of any mental health assessment
- Provides a “snapshot” of the individual
- Based purely on observations during an interview
- Depending on setting and purpose of interview, MSE may be more or less detailed

Components of Mental Status Exam

- Appearance and general behavior
- Expression of mood and affect
  - Mood is internal state reported by client
  - Affect is what is seen externally by others
- Characteristics of speech and language
- Motor activity
- Current thoughts and perceptions
- Client’s understanding of current situation (insight)
- Attitude toward examiner
**MSE: Cognitive Status**

- Level of consciousness
- Orientation (×4)
- Attention and concentration
- Language functions (reading, comprehension)
- Memory (short and long term)
- General knowledge
- Calculations
- Drawing (clock face, a person)
- Executive functions (list making, resisting distractions)
- Quality of judgment and insight.

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**Diagnosis: Brief History of DSM**

- DSM-I 1952 – 106 diagnoses
- DSM-II 1968 – 182 diagnoses
- DSM-III 1980 – 265 diagnoses
  - Major change to previous manuals, used descriptive atheoretical approach to classification
- DSM-III-R – 1987 – 292 diagnoses
  - Introduced hierarchical exclusion rules and severity specifiers
- DSM-IV – 1994 – 365 diagnoses
  - Based on updated research, larger number of contributors, introduced “clinical significance” criteria
- DSM-IV-TR – 2000 – No change in number of diagnoses or criteria, just changes in descriptive text

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**DSM-5**

- Just published in May of 2013
- Approximately the same number of disorders
- Some expanded criteria and lowered thresholds for qualifying for a disorder
- Is NOT a dramatic departure from previous versions
What is a formulation?

- A formulation is a synthesis of the information gathered about the client and their presenting problems/symptoms into a working hypothesis about the client’s situation
- It should include predisposing, precipitating, perpetuating and protective factors involved in the person’s problems
- The formulation is shared with the client who can give feedback about its accuracy and this leads to cooperative treatment planning

Diagnosis vs. Formulation

- Descriptive label
  - What does this person have in common with others?
- Theory neutral
  - Predicts course of illness
  - Identifies treatment

- Explanatory Summary
  - What is unique about this person?
  - Informed by theory
  - Predicts responses to illness
  - Informs treatment

Formal assessment tools

- There are numerous standardized instruments that can be administered by any clinician which can aid with assessment
- Most are self-report instruments but others are administered by a clinician
- Commonly used:
  - Beck Depression Inventory (BDI-II)
  - Symptom Checklist 90 (SCL-90)
  - Hamilton Depression Inventory
  - Zung Self Rating Anxiety Scale
  - Positive and Negative Syndrome Scale (PANSS)
  - Geriatric Depression Scale
Formal assessment tools - Should you use them?

Pros
- Can be more exact than an interview
- Have been tested for validity and reliability
- Can fill in gaps you may have missed in an interview
- Can save time if it is a client self-report measure

Cons
- People can be just as untruthful on a form as in an interview - can exaggerate or minimize symptoms
- Are they measuring what is essential to that particular client?
- Can cost money for the agency
- Can be overwhelming for the client