UNIT 2 STEPS IN MENTAL HEALTH (STATUS) ASSESSMENT

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2.0 INTRODUCTION
The mental health of an individual is often reflected in the mental status examination (MSE), which is an integral and most important aspect of the psychiatric assessment. It can be understood as an equivalent of the physical examination in the rest of medicine. The MSE attempts to assess all areas of an individual’s current mental functioning and forms the basis of identifying any signs and symptoms of mental illnesses. Sometimes, it may be the most significant determinant of establishing the diagnosis.

Information gathered as a part of the mental status examination can in fact begin prior to the actual verbal communication between the patient and the therapist and involves assessment of verbal, nonverbal and behaviour component of the interaction throughout the interview. Most of the information does not require direct questioning, and the information gathered from observation can guide the clinician to the in-depth picture of patient’s psychopathology. Direct questioning augments and rounds out the MSE. The MSE is also useful during subsequent visits to compare and monitor changes over time. The psychiatric mental status examination includes cognitive screening to understand the basic cognitive functioning of the individual. A good mental status examination usually takes 45 minutes to 1 hour or longer depending on the level of psychopathology and cognitive status.

The components of the mental status examination are presented in this Unit in the order one might include them in the written note for organizational purposes, but as noted above, the data is gathered throughout the interview. In this Unit, we shall restrict our discussion to the mental health assessment of adults.

2.1 LEARNING OBJECTIVES
After studying this Unit, you will be able to:

● Learn the appropriate observations to make in MSE;
Identification and Assessment of Mental Disorders

- Know how to note these observations in a concise and appropriate manner;
- Know the components of MSE and how to elicit them;
- Learn how to formulate a case and diagnosis; and
- Be aware of various diagnostic schedules and rating scales.

2.2 COMPONENTS OF MSE

The integral components of MSE are included in Text Box 1 and detailed below.

Text Box 1

Components of Mental Status Examination

- Appearance and behaviour
- Psycho-Motor activity
- Speech
- Mood
- Affect
- Form of thought
- Thought content
- Possession of thought
- Perceptual disturbances
- Cognitive functions
- Judgment
- Insight

Appearance and Behaviour

This includes a general description of how the patient looks, acts and behaves while entering the interview situation, during the interview and while he leaves the office of clinician after completion of the interview. With regard to the looks of the patient, the clinician should focus on key features like how is the patient groomed, is he tidy, is he kempt, what is the facial expression of the patient, does the patient have any abnormal movements and is there something typical/atypical about patient. For example, just observing that a patient entered the interview situation with a thumping gait, is dressed in bright colour dress and is having various religious threads around the neck, can provide significant lead for further evaluations for conditions like mania or psychosis depending on other associated features. Items to be noted include what the patient is wearing, and whether it is appropriate for the context. Distinguishing features, including disfigurations, scars, and tattoos are to be noted. Any unusual or sustained postures and pacing should be noted and described. The presence or absence of any tics should be noted, as should be jitteriness, tremor, apparent restlessness, lip-smacking, and tongue protrusions.

With regard to patient’s behaviour attention should be paid to facts like, how much importance does the patient give to the social norms of greeting to each other, whether he waits till he is asked to sit, does he still or is he fidgety, does the patient make eye contact are you able to emotionally connect with the patient, what is the affect of the
patient, does the patient exhibit any odd behaviour, does the patient appear to be interested in the interview, or appears angry and confrontative, etc. While describing the patient’s behaviour, a general statement about whether they are exhibiting acute distress and then a more specific statement about the patient’s approach to the interview should be recorded. The patient may be described as cooperative, agitated, disinhibited, disinterested, etc. Appropriateness should also be kept in mind in considering in the interpretation of the observation.

Psycho-Motor Activity

Motor activity may be described as normal, decreased (generalized slowing, bradykinesia), or increased (agitated, restless). This helps to understand the diagnoses (e.g., depression versus mania) as well as possible neurological or medical issues. Paying attention to psychomotor activity can also provide clues to adverse reactions or side effects of medications such as tardive dyskinesia, akathesia, or parkinsonian features.

Speech

While describing the speech, one should consider the fluency, amount, rate, tone, and volume of the spoken speech. Fluency refer to whether the patient has full command of the language as well as to potentially more subtle fluency issues such as stuttering, word finding difficulties, or paraphasic errors. The evaluation of the amount of speech refers to whether it is normal, increased, or decreased. Decreased amount of speech may suggest anxiety or disinterest to thought blocking or psychosis. An increased amount of speech is frequently seen in mania or in agitated psychotics. Along with this, it is important to assess the rate of the speech. Is it slowed or rapid (pressured)? Finally, speech can be evaluated for its tone and volume. Tonal inflections (change of tone or speech) are exaggerated in demonstrative patients and may be decreased in patients with psychosis. The volume of spoken speech is also frequently increased in mania or agitated patients and decreased in depressed or anxious patients. However, while interpreting any of the above features, patients own premorbid level should be considered for comparison rather than the therapists own speech or features of speech noted in general.

Mood and Affect

Traditionally, mood is defined as the person’s internal and sustained emotional state. Its experience is subjective, and hence it is best to use the patient’s own words in describing their mood. Terms such as ‘sad’, ‘angry’, ‘guilty’, or ‘anxious’ are common descriptions of mood. Affect on the other hand represents the patient’s current state of emotional responsiveness. It should be assessed by observing the outward display of emotion by the patient. Affect is often described with the following elements: quality, range, reactivity and appropriateness. Terms used to describe the quality (or tone) of a patient’s affect include dysphoric, happy, euthymic, irritable, angry, agitated, tearful, sobbing, and flat. Speech is often an important clue to assessment of affect but not exclusive. Range of affect is important to evaluate and it represents the entire continuum of affective states seen during the interview. It may be described as “restricted” or “blunt”, indicating pathological state. The reactivity of the affect indicates the change in the affect in relation to environmental or internal stimuli (for e.g., if the patient smiles when the therapist makes a light hearted comment). It should also be noted if the affect of the patient is appropriate to the current circumstances, clinical situation and what he/she is thinking about (thought content).

Form of Thought

Form of thought or thought process differs from thought content in that it does not describe what the person is thinking rather how the thoughts are formulated, organized,
and expressed. A patient can have normal thought process with significantly delusional thought content. Conversely, there may be generally normal thought content but significantly impaired thought process. Normal thought process is typically described as linear, organized, and goal-directed.

The abnormal thought process is described as flight of idea, tangentiality, circumstantiality, perseveration, thought block, neologism, poverty of speech, etc. With flight of ideas, the patient rapidly moves from one thought to another, at a pace that is difficult for the listener to keep up with, but all of the ideas are logically connected. A circumstantial patient overincludes details and materials that is not directly relevant to the subject or answers of the question but does eventually returns the subject or answer of the question. Tangential thought process may at first appear similar, but the patient never returns to the original point or question. The tangential thoughts are seen as irrelevant and related in a minor, insignificant manner. Perseveration is the tendency to focus on a specific idea or content without the ability to move on to other topics. The perseverative patient will repeatedly come back to the same topic despite the interviewer’s attempts to change the subject. Thought blocking refers to a disordered thought process in which the patient appears to be unable to complete a thought. The patient may stop mid-sentence and leave the interviewer waiting for the completion. When asked about this patients will often remark that they do not know what happened and may not remember what was being discussed.

Neologisms refer to a new word or condensed combination of several words that is not a true word and is not readily understandable although sometimes the intended meaning or partial meaning may be apparent. Word salad is speech characterized by confused, and often repetitious, language with no apparent meaning or relationship attached to it. However, it is important to remember that eliciting the form of thought, especially when on subtle abnormalities may be present is slightly different from a normal interview process. The best way to elicit a thought process abnormality is to give an open ended question or give a specific topic to the patient and ask them to speak for some time on the same, for example, “tell me something about the school which you went to”. Further, it needs to be understood that at times it may be difficult for the therapist to follow the thought process closely because of various reasons and in such circumstances, recording the interview with the permission of the patient for later analysis may be useful.

Thought Content

Thought content is essentially what thoughts are occurring to the patient or the meaning of the words expressed by the patient during the interview. This is inferred by what the patient spontaneously expresses, as well as responses to specific, questions aimed at eliciting particular pathology. Some patients may persistently be repetition on specific content or thoughts. For example, a depressed patient may think that his future is bleak and constantly think about this, while the anxious patient may worry about more daily occurrences. Thought content also includes delusions which are false, fixed ideas that are held despite evidence to contrary and are not shared by others from the same socio-cultural and educational background. Questions that can be helpful include, “do you ever feel that people around are all looking at you/ like someone is following you/ want to harm you,” and “do you feel like the TV or radio has a special message for you?” Suicidality and homicidality also fall under the category of thought content. Simply asking if someone is suicidal or homicidal is not adequate. One must get a sense of ideation, intent, plan, and preparation. While completed suicide is extremely difficult to accurately predict, there are identified risk factors, and these can be used in conjunction with an evaluation of the patient’s intent and plan for acting on thoughts of suicide.
Other variables that can be useful in the assessment of both suicidal and homicidal thoughts and impulses include whether there is a contingency involved (‘if this happens then I will commit suicide’), whether the thoughts are new or chronic, and what prevents the patient from acting on them.

From completion point of view, it is important to remember that besides the psychopathology expressed by the patient as part of the thought content, the therapist should also actively question the patient to cover the whole range of psychopathology and document the presence and absence of various abnormalities.

**Possession of thought**

Most of us recognize our thoughts to be our own and under our control. However, in some clinical conditions, this possession of thought is lost. Obsessional thoughts are unwelcome and repetitive thoughts that repeatedly intrude into the patient’s consciousness. They are generally ego-alien, absurd, and resisted by the patient. Thought alienation is part of the First Rank Symptoms of Schneider. (First Rank Symptoms were initially proposed by Schneider as diagnostic criteria for Schizophrenia in 1959). These include thought insertion, thought withdrawal and thought broadcasting.

**Perceptual Disturbances**

Perceptual disturbances include hallucinations, illusions, depersonalization, and derealization. Hallucinations are perceptions that occur to an individual in the absence of stimuli to account for the same. Auditory hallucinations are the hallucinations most frequently encountered in the psychiatric setting. Other hallucinations can include visual, tactile, olfactory, and gustatory (taste). The interviewer should make a distinction between a true hallucination and a misperception of stimuli (illusion). Hearing the wind rustle through the trees outside one’s bedroom and thinking a name is being called is an illusion. Hypnagogic hallucinations (at the interface of wakefulness and sleep) may be normal phenomena. At times, patients without psychosis may hear their name called or see flashes or shadows out of the corner of their eyes. In describing hallucinations, the interviewer should include what the patient is experiencing, when it occurs, how often it occurs, and whether it is uncomfortable (ego dystonic) or not. In the case of auditory hallucinations, it can be useful to learn if the patient hears words, commands, or conversations and whether the voice is recognizable to the patient.

Depersonalization is a feeling that one is not oneself or that something has changed in oneself. Derealization is a feeling that one's environment has changed in some strange way that is difficult to describe.

**Cognition**

As part of the MSE, the interviewer should get an overall sense of the patient’s level of cognitive functioning. The elements of cognitive functioning that should be assessed are level of consciousness, attentiveness/alertness, orientation, concentration, memory (both short and long term), calculation, fund of knowledge, abstract reasoning, insight, and judgment. There are structured tests which can be used to assess all the above cognitive functions. However, it is important to remember that these tests can be applied universally and at time socio-cultural adaptation may be required. Another important aspect of cognitive function evaluation is that the therapist should tell the patient in advance that they may be administering certain simple tests to get an idea about the patient’s cognitive status. This is important because at times, patients may feel as to why such simple silly questions are asked to them and may consider that evaluation was demeaning to their status. For details of the cognitive functions, the readers are advised to refer the book *Steps in Mental Health (Status) Assessment*.
by Strub and Black (2000). Alternatively, simple test battery like mini mental status can be useful in providing about few of the cognitive functions.

A note should be made of the patient’s level of consciousness. Orientation can be assessed by asking the patient to tell about the time, name the place and name the accompanying person. Patient’s attention can be assessed by serial 7s subtraction with the patient starting at 100 and counting back by 7s up to five times, alternatively having the patient spell ‘world’ backwards. Immediate, recent and remote memory need to be separately evaluated. Immediate memory is tested by registration and recall. Registration of the patient tested by asking the patient to repeat three words (for example, ‘school, purple, honesty’) after the interviewer. Recall is tested by asking the patient to recollect the three words given 3 minutes earlier. Remote memory is tested by asking questions about previous events (e.g. birthdates of children) and seeking corroboration about the same from the informant.

Patient’s intelligence should be tested in the fields of general fund of knowledge (that assesses general awareness of the world e.g. who is the Prime Minister of the country?), calculation ability (by giving the patient simple and complex calculations, starting from single digit to double digits and then more complex calculations, starting from addition and then moving to subtraction, multiplication and division) and comprehension (by narrating simple stories which have a moral and asking the patient to tell the moral of the story). Abstract reasoning is the ability to shift back and forth between general concepts and specific examples. Having the patient identify similarities between like objects or concepts (apple and pear, bus and airplane, or a poem and a painting) as well as interpreting proverbs can be useful in assessing one’s ability to abstract. Cultural and educational factors and limitations should be kept in mind when assessing ability to abstract. Judgment refers to 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. A patient may have no insight into their illness but have good judgment. It has been traditional to use hypothetical examples to test judgment. For example, “What would you do if you found a stamped envelope on the sidewalk?” However, it is better to use real situations from the patient’s own experience to test judgment. The important issues in assessing judgment include whether a patient is doing things that are dangerous or going to get them into trouble and whether the patient is able to effectively participate in their own care. Significantly impaired judgment may be cause for considering a higher level of care or more restrictive setting such as inpatient hospitalization.

**Insight**

Insight, in psychiatric evaluation, refers to the patient’s understanding of whether they have an illness, whether this illness is physical or psychological, what is the cause of the illness and whether they need treatment, what would be their role in treatment, etc. Depending on the assessment, the patient may have no insight, partial insight, or full insight. Insight is generally lost in psychosis. The amount of insight is not an indicator of the severity of the illness.

**Physical Examination an important supplement to mental state examination**

The physical examination should not be forgotten and it remains important in every patient. The inclusion and extent of physical examination will depend on the nature and setting of the psychiatric interview. Vital signs, weight, waist circumference, body mass index, and height may be important measurements to follow particularly given the potential effects of psychiatric medications or illnesses on these parameters. A focused neurological evaluation is an important part of the psychiatric assessment.
Check Your Progress 1

**Note:**
1) Read the following questions carefully and answer in the space provided below.
2) Check your answer with that provided at the end of this unit.

1) Enumerate the various components of MSE.

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2) Enumerate the various elements of cognition that need to be assessed.

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2.3 MENTAL STATUS ASSESSMENT OF AN UNCOOPERATIVE PATIENT

Many a times, the clinicians are faced with non-cooperative patients. However, non-cooperativeness should not be equated with non-informativeness. When faced with such a patient, the clinicians should rely more on observations. A simple guide to evaluate the mental status of an un-cooperative patient is given by Kirby (1921) and assessment covers the following areas:

**General reaction and posture:** A note should be made of attitude and posture, whether it is voluntary comfortable, natural, how the patient does reacts when he is placed in an uncomfortable position. Further a note should be made of reaction (resistive, evasive, irritable, apathetic, complaint) of the patient towards the clinicians and other staff, spontaneous acts (like playfulness, mischievousness or assaultativeness), eating and dressing, bowel and bladder control. A note of change in the attitude of the patient through out the interview should also be kept.

**Facial expression:** Whether the patient appears alert, attentive, placid, vacant, stolid, sulk, scowling, averse, perplexed, distressed, etc. Any signs of emotions: tears, smiles, flushing, perspiration. On what occasions?

**Eyes:** Open or closed, movements of the eyes, reaction to sudden approach of threat to stick pin in the eye, papillary reaction. Does the patient resist when the therapist attempts to open the eyes? Does the patient has any movements of the eyes or has a fixed gaze?

**Reaction to what is said or done:** A note should be made of patient's react to simple commands like show the tongue, move the limbs, grasp the hands. Similarly reaction to pin pricks, imitation of actions of others, automatic obedience, whether the motion of movement is slow or sudden should be evaluated.
Muscular reactions: Test for rigidity, catalepsy, waxy flexibility, negativism, etc.

Emotional responsiveness: Emotional responsiveness is the feeling shown by the patient while talking to the family or children or while describing sensitive issues of the history.

Speech: Efforts to talk, lip movements, whispers, movements of head.

Writing: Patient must be offered a paper and a pencil. Some of the un-cooperative patients may write while they fail to talk.

## 2.4 CASE FORMULATION AND DIAGNOSIS

### Formulation

At the end of the data gathering, it is important to develop a formulation and diagnosis (diagnoses) as well as recommendations and treatment planning. In this part of the evaluation process, the data gathering is supplanted by data processing where the various themes contribute to a biopsychosocial understanding of the patient’s illness. The formulation should include a brief summary of the patient’s history, presentation, and current status. It should include discussion of biological factors (medical, family, and medication history) as well as psychological factors such as childhood circumstances, upbringing, and past interpersonal interactions and social factors including stressors, and contextual circumstances such as finances, school, work, home, and interpersonal relationships. These elements should lead to a differential diagnosis of the patient’s illness (if any) as well as a provisional diagnosis.

### Diagnosis

The diagnosis of the patient has multifold implications. First, it is an attempt to understand in a few standardized words what is wrong with him/her. It has significant impact on the clinician's understanding of the patient’s treatment (in terms of pharmacological/non pharmacological measures, duration of treatment, etc.) and prognosis. Hence, a diagnosis must be made with caution and after complete and adequate evaluation. Even after making a diagnosis, a good clinician is always ready to continue observing the patient, exploring the psychopathology in greater detail and revising the diagnosis if so required.

In addition to their psychological symptoms, patients often have multiple other problems (physical co-morbidity, psychosocial issues, etc.). Hence, both current diagnostic systems, the DSM-IV-TR and the ICD-10 use the multiaxial diagnostic systems. The DSM-IV-TR classification a multiaxial diagnostic assessment that includes:

- **Axis I**: Major psychiatric diagnoses such as major depression, schizophrenia, and generalized anxiety disorder
- **Axis II**: Personality disorders and mental subnormality or pervasive developmental disorders
- **Axis III**: Medical conditions
- **Axis IV**: Stressors
- **Axis V**: Global assessment of functioning (GAF) on a 100-point scale referring to the patient's overall functioning based on symptoms, activities of daily living, and social and work interactions. Higher numbers indicate a higher level of functioning and lower numbers indicate various levels of impairment of functioning.
Check Your Progress 2

Note:  
1) Read the following questions carefully and answer in the space provided below.
2) Check your answer with that provided at the end of this unit.

1) Enumerate the various axes of the DSM-IV-TR multiaxial diagnostic system.

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2.5 SPECIAL METHODS TO ASSESS MENTAL HEALTH

1) Interviewing Schedules

These include structured/semi-structured interviews for diagnosing mental health disorders. They are infrequently used in clinical practice and are more commonly used for research practices. These include:

- The Mini-International Neuropsychiatric Interview (MINI) is a short structured clinical interview which enables researchers to make diagnoses of psychiatric disorders according to DSM-IV. The administration time of the interview is approximately 20 minutes.

- The Schedule for Affective Disorders and Schizophrenia (SADS) is a collection of psychiatric diagnostic criteria and symptom rating scales published in 1978. The diagnoses covered by the interview include schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, anxiety disorders and a limited number of other diagnoses.

- Schedules for Clinical Assessment in Neuropsychiatry (SCAN) is a set of tools created by WHO aimed at diagnosing and measuring mental illness that may occur in adult life. It can be used with both ICD-10 or DSM-IV systems. The entire SCAN interview consists of 1,872 items, spread out over 28 sections. Most patients, however, will only need parts of the interview, and it is assessed in the beginning of each section if the section is actually relevant.

- The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) is a diagnostic exam used to determine DSM-IV Axis I disorders (major mental disorders) and Axis II disorders (personality disorders). The instrument was designed to be administered by a clinician or trained mental health professional, for example a psychologist or social worker. Ideally, this would be someone who has had experience performing unstructured, open-ended question, diagnostic evaluations.

- The World Health Organisation Composite International Diagnostic Interview (CIDI) is a structured interview for psychiatric disorders. As the interview is designed for epidemiological studies, it can be administered by those who are not clinically trained and can be completed in a short amount of time.
2) Psychological Tests

Psychological tests have a unique role in the assessment of mental health. While these are supplementary to a good mental state examination, these often provide valuable insights into the psychopathology of the patient. Psychological tests are particularly useful in certain clinician situations like:

- When patient is guarded with regards to his/her inner experiences/stressors
- In cases of differential diagnosis
- When detailed assessment of cognitive functions or personality is required

Further details on psychological assessments and tests shall be covered in another Unit of this Block.

3) Rating Scales: Tools which may be useful in monitoring mental health longitudinally

The term psychiatric rating scales encompasses a variety of questionnaires, interviews, checklists, outcome assessments, and other instruments that are available to inform psychiatric practice, research, and administration. Many such scales are useful in psychiatric practice to grade the severity of psychopathology and for monitoring patients over time or for providing information that is more comprehensive than what is generally obtained in a routine clinical interview. One advantage these scales have is that they assess a wide range of psychopathology, which may at times be missed in a clinical interview. Nevertheless, it must be remembered that these are only supplementary and cannot replace a good mental state examination. Rating scales may measure:

- Functional status, impairment, and general symptom severity (e.g. Global Assessment of Functioning Scale [GAF])
- Psychotic symptoms (e.g. Brief Psychiatric Rating Scale [BPRS], The Positive and Negative Syndrome Scale (PANSS) for Schizophrenia)
- Mood symptoms, e.g. Beck Depression Inventory (BDI), Hamilton Depression Rating Scale (HDRS), Young Mania Rating Scale (YMRS)
- Abnormal movements and medication induced side effects, e.g. Abnormal Involuntary Movement Scale (AIMS), Simpson-Angus Rating Scale for Extrapyramidal Side Effects
- Cognitive disorders, e.g. Mini Mental State Examination (MMSE)

Check Your Progress 3

Note:  
i) Read the following question carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What are the uses of rating scales in practice?

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2.6 LET US SUM UP

The mental state assessment is a crucial component of a psychiatric evaluation and the ability to perform a comprehensive MSE is an essential skill for a mental health professional. Although, the MSE is recorded in a structured form, there are no fixed steps for evaluation of the patient. Depending on the comfort of the patient and the therapist, questioning can be done for any of the aspect to begin with. By the end, the therapist should make sure that they have covered assessment of all the aspects of MSE. An important component of MSE is the direct observations made by the therapist of the patient. An assessment of patient’s physical and cognitive status is also part of assessment and should be meticulously performed. Un-cooperativeness on the part of the patient due to illness should not deter the therapist from carrying out the assessment. Once, the history taking and MSE is complete, it is important to put together all the information into a case formulation that leads to a provisional diagnosis or differential diagnoses. Besides the routine MSE, various diagnostic and phenomenological aids can be used as supplements to the clinical observations and rating scales can be used to grade the severity of psychopathology and monitor the patients psychopathology longitudinally.

2.7 ANSWERS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress 1

1) Appearance and behaviour, psychomotor activity, speech, mood and affect, form of thought, thought content, possession of thought, perception, cognitive functions, judgment, insight.

2) Level of consciousness, attention, orientation, attention, memory, intelligence (general knowledge, calculation, comprehension), abstraction.

Check Your Progress 2

- Axis I: Major psychiatric diagnoses
- Axis II: Personality disorders and mental subnormality or pervasive developmental disorders
- Axis III: Medical conditions
- Axis IV: Stressors
- Axis V: Global assessment of functioning (GAF)

Check Your Progress 3

Comprehensive assessment of psychopathology, monitoring a patient over time and research.

2.8 UNIT END QUESTIONS

1) Describe in detail the various components of mental status examination.

2) Describe the components of mental status examination in an un-cooperative patient.
2.9 REFERENCES AND SUGGESTED READINGS


