The Mental Status Exam (MSE) is an assessment of the individual’s current state of mind. It assesses the range, quality, and depth of perception, thought processes, feelings, and psychomotor actions. Direct observation of the individual is required for the completion of the MSE. The observation occurs before, during and after the formal clinical interview while the clinician is in direct view of the individual. Specific questions to assess certain domains of the MSE are also required. The following information is included as a guide only. Clinical judgment regarding a MSE is paramount in completing this exam.
MENTAL STATUS EXAMINATION DEFINITIONS

I. LEVEL OF COOPERATION

Pleasant: Agreeable manners, behavior
Cooperative: Willingness and ability to work with others in a common effort.
Attentive: Ability to sustain focus on one activity.
Disturbance: difficulty finishing tasks, easily distracted or having difficulty in concentration.

II. GENERAL APPEARANCE

Appears to be Stated Age
General State of Physical Health
Dress: Neat, clean or disheveled
Hygiene: Bathed, groomed, shaved or not.

III. ATTITUDE

The position or posture that an individual presents to others.
Sensitivity: Easily hurt or damaged, delicate, susceptible
Passive: Inactive submissive, no opposition.
Dependent: Requires assistance from others.
Dramatic: Vivid, emotional, with flair.
Entitlement: Exaggerated sense of importance.
Perfectionist: Demands higher quality of performance from self and others more than is required by the situation.
Anti-authority: Hostile to or opposes social establishments, legal authorities, etc.
Eccentric: Odd, deviation from established norms.
Manipulative: Self-serving, controlling for own advantage.
Suspicious: Distrustful, guarded.
Impulsive: Prone to act spontaneously.
Aggressive: Forceful, ready, pushy.

IV. FACIAL EXPRESSIONS

Normal: In rate, tone, volume
Slow: Rate less than average
Fast pressured: Rate greater than average
Soft: Decreased volume
Loud: Increased volume
Monotone: No fluctuation in tone
Shurred: omission, reduction or substitution of sounds
Stuttering: Involuntary disruption or blocking of speech
Mutilism: Inability to speak
Poverty of Speech: Restricted amount of speech, monosyllables
Logorrhea: copious, logical speech
Echolalia: repetition of one’s words by another.
Motor Aphasia: Ability to speak is lost but understanding remains

V. Speech

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VI. BEHAVIOR AND PSYCHOMOTOR ACTIVITY

Normal:
Increased Amount: Excessive body movement.
A. Hyperactivity: Supranormal amount of purposeful, goal directed activity.
B. Agitation: Increased purposeless, goalless behavior
Decreased Amount: (Psychomotor Retardation)
Diminution or poverty of movement, lethargic
Tic: Twitching or spasmodic movement
Tremor: Trembling, shaking
Trichotillomania: The unnatural impulse to pull out one’s own hair
Pacing: Walking back and forth
Alexia: failure of muscle coordination; Irregularity of muscle action
Akathisia: Motor restlessness, inability to sit still
Dystonia: Involuntary, irregular chronic contortions of the muscles of trunk and extremities
Dyskinesia: Involuntary bucco-facial movements
Catatonia: motor anomalies
A. Mannerisms: Odd, repetitive movements, goal-directed
B. Stereotype: Odd repetitive movements. Not goal directed.
C. Echopraxia: Automatic copying of examiner’s movements or posture
D. Cataplexy: Awkward posture or position for prolonged period
E. Flexibilities (Waxy Flexibility)
Encountering resistance when moving extremity which is maintained in an odd position.

VII. AFFECT (Objective)

The children’s observation/evaluation of the patient’s feelings state (during the interview)
Appropriate: Emotional tone consistent with content of speech, thought and ideas.
Inappropriate: Emotional tone inconsistent with content of speech, thought of ideas
Expanded: Excess of joy or sadness, a wide range
Labile: Rapid, abrupt changes in feeling tone
Constricted: impoverished, inhibited, a spectrum of feelings not elicited
Blunted: A severe reduction in the intensity of feeling tone
Ambivalence: Contradictory feelings present at the same time.

VIII. MOOD (Subjective)

The patient’s report of his/her feeling state over the past several weeks.
Euphoric: Normal, level range of mood, implying absence of depression or elation
Irritable: Easily annoyed and provoked to anger.
Dysphoria: An unpleasant, painful or anguished state
Euphoria: intense elevation with feelings of grandeur
Apathetic: Lack of feeling or emotion
Grief: Sadness appropriate to real loss
Depressed: Spirits low
Anhedonia: Loss of interest in and withdrawal from all regular and pleasurable activities.
Alexithymia: Inability or difficulty in describing or being aware of one’s moods or emotions
Diurnal Variation: Consistent shift in feeling during 24-hour period. Ex: Better morning, worse as day progresses
Mood-Congruent: Content of thoughts, feelings, mood appropriate
Mood-Incongruent: Content of thoughts, feelings has no association with mood.

X. THOUGHT CONTENT

The specific topics, details or matters presented during the interview.
Ego-syntonic: Ideas that are in harmony with an individual’s concept of self.
Guilt: Self-reproach, responsibility for imagined offenses
Anomia: Alienation, lack of direction
Unworthiness: Critical of one’s worth or ability
Helplessness: Incapable of assisting one’s self.
Hopelessness: utter despair, problems can’t be solved
Somatic Preoccupation: Overly concerned with body functions
Obsessions: Persistence of an unwanted thought that cannot be eliminated from consciousness
Compulsion: Pathological need to act on an
impulse which, if resisted anxiety
Ruminations: Excessive worry, repetitive or
continuous speculation
Doubting/Indecision: Uncertainty
Grandiosity: Exaggeration of one’s worth

Ideas of Reference: incorrect assumption that
real events or incidents have direct reference to
one’s self
Overvalued Ideas: Fanatically maintained
notions, such as the superiority of one’s sex,
nation, or race over others
Paranoid Ideation: Belief that one is singled out
for unfair treatment
Hyper-Religiosity: Excessive concern with
spiritual matters
Phobic Thoughts: Irrational, unrealistic fears.
A. Specific-Circumscribed dread of discreet object
or situation. (Ex-spiders, snakes); B. Social-
Dread of public humiliation(public speaking,
performing, eating in public)
Delusion: A fixed false belief
A. Persecution: false belief that one is being
harassed or cheated
B. Grandeur: false belief of one’s importance,
power, or identity
C. Reference: False belief that behavior of
others, events, or objects refers to one’s self.
D. Control: False belief that one’s will, thoughts
and feelings are controlled by external forces
1) Thought Withdrawal: Thoughts are being
removed by external forces
2) Thought Insertion: Thoughts are being
implanted by external forces.
3) Thought Broadcasting: thoughts can be heard
by others
Suicidal Ideation: Desire to harm oneself or end
one’s life
Homicidal Ideation: Desire to do serious harm to
or take the life of another person.

XL. DISORDER OF PERCEPTION

Perception: The mental registration or meaning
interpretation of the sensory stimulus.

Not Present
Illusion: Misinterpretation of a real, sensory
experience
Agnosia: Inability to recognize and interpret the
significance of sensory stimuli (auditory, visual,
olfactory, gustatory, facile)
Hysterical Anesthesia: Loss of sensory
modalities from internal conflicts.
Dysmegalopsia: Objects seem larger and closer
than they are
B. Micropsia: Objects seem smaller and receded
into space
Depersonalization: A subjective sense of being
unreal, strange, or unfamiliar to oneself
Derealization: A subjective sense that the
environment to strange or unreal
Jamais Vu: False feeling of unfamiliarity with a
real situation one has experienced
Hallucination: An incorrect sensory perception
in the absence of actual external stimulus
A. Auditory: False perception of sound
1) Elementary Noises
2) Complete: Voices or words
B. Visual: False perception of eight consisting of
formed and unformed images.
C. Olfactory: False perception of smell
D. Gustatory: False perception of taste
E. Tactile: False perception of touch or surface
sensation
F. Somatic: False perception of things occurring
to one’s body
G. Extracampine: Sees objects outside the
sensory field. Ex: Behind his back
H. Kaleidoscopic: Vivid colors with geometric
patterns

XII. SOMATIC COMPLAINTS

Sleep: Normal, Difficulty getting to sleep,
diminished amount of sleep, early morning
awakening(terminal insomnia)
Eating Habits: Appetite-normal, increased,
decreased. Unusual food cravings, binge eating,
self-induced vomiting.
Weight: Normal, increased, decreased
Crying Spells.
Decreased Energy
Loss of Interest
Diminished Libido
Tachycardia
Sweating
Shortness of Breath

XIII. SENSORIUM
COGNITIVE FUNCTION
INSIGHT AND JUDGEMENT

Sensorium: The level of consciousness or mental
clarity
Alert: Quick to perceive and respond, ready
Delirium: Bewildered, restless, confused
Somnolence: Abnormal drowsiness; Lethargy,
obtunded.
Stupor: Lack of reaction to and unawareness of
surroundings. Aroused by intense stimuli only
Coma: prolonged degree of unconsciousness
Orientation: Time-Year, season, date, day of
week, month, approximate time of day
Place: Knows where he/she is: state, city,
county/(town)street, name of hospital
Person: Knows own name. Situation: Why
he/she is here, with whom he/she is interacting
Memory: Immediate Recall-3 items; recall in
120 seconds. Short Term: Events of past 5-10
minutes. Recent-Events or items of day, week,
or month. Past-Birthdate, anniversaries,
significant past experiences
A. Amnesia: Partial or total inability to recall
past experiences
B. Fugue: Amnesia, then assuming a new
identity
C. Confabulation: Unconscious filling of gaps in
memory with imagined or untrue experiences
Attention and Calculation
A. County by threes, 1, 4, 7,----(1-40)
B. County backwards from 21-1, 20-19, 18,
C. Process Digits: Forward-Three (6-35)
to eight (82673829) backwards-Three (183) to
eight (72485136)
D. Simple arithmetic: 6+8, 50-12, 8x9
E. Spell Words: World, State (Forward,
Backwards)
F. Sentence Learning: “No ifs, ands, or
butts”(Repeat)
G. Identity Objects: (Dystopia) Example: Pen,
watch, shoe.
H. Copy Design: Visual Motor Integrity(Draw
two triangles which must connect at one point)

Fund of Information: Who is the President?
Vice-President? County in which you reside?
State Capital? How many weeks are there in a
year? What direction are you traveling when
going from San Francisco to Boston?
Insight: Awareness of how one’s own
personality traits and behaviors contribute to
symptoms and problems. To understand cause
and meaning of a situation.
Judgement: Ability to access situation correctly,
choose among different options, and act
appropriately within that situation
Evaluate: Issues regarded in an upcoming
decision, or way past decisions handled.
<table>
<thead>
<tr>
<th>MSE AREA</th>
<th>ASSESSMENT TOOLS</th>
<th>CLINICAL PRESENTATION</th>
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<tbody>
<tr>
<td><strong>Appearance</strong>: how the client looks; the overall image projected by the client</td>
<td>observation of: hygiene; clothing; general observation of how the client looks; cosmetics/make-up; odors; hair grooming/style/adornment</td>
<td>bizarre make-up or clothing may alert you to the possibility of a manic illness; grooming may be a good indication of the person’s ability to function independently; depression and psychosis may prevent normally well-groomed individuals from attending to personal hygiene; manner of dress can provide clues to a client’s self image; any change in appearance should be explored with the client and family, documenting when the change occurred and under what circumstances; clothes are costumes—what people wear is what they choose to communicate; facial expression often mirrors the client’s mental state</td>
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<tr>
<td><strong>Affect</strong>: observable expression of emotion; “affect is to mood what weather is to climate”; the more immediate emotional tone</td>
<td>observation of the client during the interview to determine the client’s feelings state; observation of the client’s nonverbal expression of feelings; includes range, appropriateness, stability and intensity</td>
<td>increase reactivity is common among histrionic individuals; blunted and flat affect are often seen in schizophrenia; blunted affect may be seen with clients on anti-psychotic medications; depressed clients may be unable to control sudden tearful outbursts; manic individuals may experience uncontrollable bouts of rage or laughter; people with borderline personality disorder may display labile affect</td>
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<tr>
<td><strong>Mood</strong>: a pervasive and subjectively experienced feeling state; colors the person’s world view; mood is a more long-termed sustained emotion</td>
<td>client’s description of his/her own feeling state over the past few weeks or longer; “how would you describe your general mood recently?”; ask about usual mood level and how it has varied with life’s events; “how do you feel?”; note the duration of the mood states; can the moods be attributed to events or circumstances in the client’s life</td>
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<tr>
<td>Memory: the client’s ability to recall</td>
<td><strong>Immediate:</strong> digit span-ask client to repeat a series of random numbers, first forward and then backward. <strong>Recent:</strong> Say 3 emotionally neutral object words; ask the client to repeat the words; tell the client you will ask again for these words to be repeated; later in the interview, ask the client to repeat the name of the three objects. <strong>Remote:</strong> ask about the names and dates from the client’s earlier life; ask the client to name the US Presidents beginning with the current one and going backwards.</td>
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<tr>
<td>if a client can register the three words but not recall them this may indicate dementia; if the client can recall with cueing (e.g. “I’ll give you a hint...the first word is a color), then this may indicate dementia; sensing their failing memories, some clients may conceal it with confabulation, denial, and circumstantiality; when concentration is impaired the client may be unable to attend to tasks and will appear to have a memory deficit when none exists; clients who recognize their memory impairment may react to your questions with anxiety, depression or hostility.</td>
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<tr>
<td>Attention: the ability to sustain a focus on one task or activity</td>
<td>count by threes-1,4,7 (1-40)</td>
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<tr>
<td>count backwards from 21-1</td>
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<tr>
<td>spell word or state forward and backward</td>
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<tr>
<td>Concentration: the ability to focus and maintain attention to outside stimuli as well as to mental operations such as puzzle solving and calculations</td>
<td>serial 7’s (or 3’s)- ask client to subtract 7’s (or 3’s) in succession, starting from 100; count backward from 20</td>
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<tr>
<td>lack of concentration is another indicator of thought disturbance; many people with thought disorders cannot perform more than one or two calculations in the serial 7 test; the norm for persons under 65 on the serial 7 test is to reach 1 in 60 seconds with 4 or less errors; depression, anxiety, dementia, and psychosis are often associated with disturbance in concentration</td>
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<tr>
<td>Eye Contact</td>
<td>observation during interview</td>
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<tr>
<td>eye contact often decreases with increasing anxiety or paranoia; clients with psychosis or dementia who can not concentrate on the interview may not focus on you visually</td>
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</tbody>
</table>
### Motor Activity: the way the client moves

| observe the clients physical activity during the interview | gives further indications of the client’s ability to maintain normal control; posture and body movements can be related to attitude, mannerisms particular to specific psychiatric disorders, mediation side effects, or physical disorders; rigid posture and gait may indicate a client’s anxiety or vigilance; seriously depressed clients may demonstrate slumped posture and slow gait; physical handicaps often are almost always of great emotional significance to the client and should be noted; constant restlessness (psychomotor agitation) and pacing may signal anxiety, agitated depression, or mania; slow movements and little reactivity (psychomotor retardation) may indicate depression, drug reactions, and catatonia; |

### Speech: speech is a hybrid of what one may observe and the thought processes of the client

| observation of client; the way the client speaks; the quality (relevance, appropriateness to topic, coherence, clarity, and voice volume) and quantity (amount and rate of speech, and any sense of pressure) of the client’s speech | provides information about the thought processes; pressured speech is often present in the manic phase of bipolar disorder; rapid speech is found in a variety of conditions, most commonly in acute anxiety states; slowed speech is common among depressed people; absence of speech occurs in some severely psychotic people; some psychotic clients can be inappropriately loud; extremely shy clients may whisper; garbled speech is found in some alcoholic clients; note any speech impediments or other speech abnormalities |

### Delusions: a false belief firmly held despite incontrovertible and obvious proof or evidence to the contrary; the belief is not one ordinarily accepted by other members of the client’s culture or subculture

| “do you feel you have special knowledge or powers?”; “do you think anyone wants to hurt you or has spread lies about you?”; “have you felt that your thoughts were influenced or controlled by some outside force?”; “do you feel that you can control the thoughts of others?”; “has anything unusual happened to your body?”; “do you have any particular worries about your body?”; “have you had any unusual spiritual experiences?”; “has anything unusual happened around your home lately | Delusions are hallmarks of psychotic illness, although they do not occur in all psychotic individuals; ask questions in a naturalistic conversational manner to avoid evoking paranoia or minimization |
**Intellect:** the client’s basic knowledge and awareness of social events

- Observation: client’s general fund of knowledge; affected by the client’s culture, education, performance anxiety, willingness to cooperate and psychopathology; evaluating the client’s fund of information involves questioning the client’s general knowledge and awareness of current events, geared to the client’s background; observation of clients diction and vocabulary

  - May be helpful in determining the level/type of treatment for the client

**Judgment:** the ability to make and carry out plans and to discriminate accurately and behave appropriately in social situations

- Observation: during the interview; ask what the client would do in a social situation that requires judgment; “what would you do if you smelled smoke in a crowded theater?”; “what would you do if you found a stamped, addressed envelope lying on the street?”; “what would you do if you were given a $1000?”; “what should you do if you are stopped for speeding?”; “what should you do if you lose a library book?”; “why are criminals put in prison?”

  - Note the client’s response to family situations, jobs, school, use of money, and interpersonal conflicts. Note whether decisions and actions are based on reality or are based on impulse, wish fulfillment, or disordered thought content; what values seem to underlie the client’s decisions and behaviors; allow for cultural variations; how do these compare to the norm for others in the same age bracket?

**Hallucinations:** perceptions the client believes to be real despite evidence to the contrary; the client perceives something that does not exist; may involve any of the five senses

- Observation: “do you ever hear voices or see things other people do not hear or see?”; “does your mind ever play tricks on you?”; note the circumstances in which the hallucinations occur, with an eye to possible precipitating factors; note the content of the hallucination; evaluate whether hallucinations are drug/alcohol related; be alert to unreported hallucinatory experiences during the interview

  - Visual hallucinations alone may suggest an organic psychosis or delirium; in schizophrenia auditory hallucinations are prominent; in stimulant induced psychosis, tactile hallucinations may be seen; tactile hallucinations may be associated with delirium; visual may indicate drug use; clients may be hallucinating when their eyes dart from side to side, when they stare at nothing, or when they seem preoccupied as if they are listening to voices; some clients may refer to their thoughts as voices if the voices come from inside or outside of the persons head; hallucinations may be seen in all types of psychotic illness but may also be induced by such factors as drugs, alcohol, and stress
<table>
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<tr>
<th><strong>Insight into Problems:</strong> client’s awareness and understanding of their illness</th>
<th>“what are your reasons for seeking help?”; “do you feel you have emotional/substance abuse problems right now?”; “how serious are these problems?”; “do you feel you need help in understanding and learning to cope with these problems?”</th>
<th>Assesses the client’s ability to identify the existence of a problem (does not refer to etiology or psychodynamics aspects of the illness) and to have an understanding of its nature; this is an important factor in assessing the client’s potential for compliance with treatment; insight into illness is particularly impaired in psychotic illnesses and later stage dementias.</th>
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<tr>
<td><strong>Orientation:</strong> awareness of time, place, person, situation</td>
<td>“what is today’s date?”; “what is the day of the week?”; “what is the name of this place?”; “what is your full name?”; “do you know who I am?”; “Why are you here?”</td>
<td>Determines the presence of confusion or clouding of consciousness; is an important information for determining whether a client has organic mental impairment; orientation to self is usually retained with early stages of confusion or disorientation; with increasing impairment, the client will tend to have more difficulty with these questions; disturbances in orientation may be an indicator of substance misuse or toxicity from medication, especially antidepressants</td>
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<tr>
<td><strong>Thought Content:</strong> ideas the client communicates; clients’ ideas about themselves and the world</td>
<td>always ask for clarification when you do not understand something the client said; begin with general questions and move to specific ones; “have you had any unusual or troublesome experiences?”; “have you had thoughts you feel other people would not understand?”; “have you had any strange or disturbing thoughts?”</td>
<td>Depersonalization and derealization are common in anxiety states as well as in borderline personality disorder; morbid preoccupations are often found in depressed people</td>
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## Suicidal Ideation:
desire to harm oneself or end one's life

<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
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<tbody>
<tr>
<td>actively raise questions related to suicidal thoughts; assess thoughts, plans, potential for action, deterrents to action, and the client's feelings about these suicidal ideas</td>
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- "Do you ever feel that life is not worth living?"; "have you ever had thoughts of harming yourself?"; "have you ever wanted to kill yourself?"; "do you wish that you were dead, even if you would not do harm to yourself?"; "have you ever tried to kill or harm yourself?"; "has anyone in your family or a close friend tried to harm themselves?"; "are you having feelings or thoughts now about harming yourself?"; "do you have a plan for harming yourself?"; note whether the client makes reference to future events

- someone who hears voices commanding or suggesting that they kill themselves is at extreme high risk for suicide

- assess specificity, lethality and availability of means; the person with a very specific plan, for a highly lethal and not easily reversed plan, who also has ready access to the means to harm themselves is at high risk.

<table>
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<tr>
<th>Follow-up Questions</th>
<th>Notes</th>
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<tr>
<td>Can the person guarantee that they will contact you or some other person if they feel like acting on their suicidal or self harm ideas?; be specific in contracting with the client; does the client need supervision of family/friends?; does the client need screening for hospitalization</td>
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</table>

- Some studies suggest that contracting for no self harm with clients has little if any efficacy

- individuals lacking resources/a significant support system as well as individuals facing seemingly dire circumstances have an increased risk for acting on their ideations
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<tr>
<th>Homicidal Ideation: desire to do serious harm to or to take the life of another person</th>
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<tr>
<td>actively raise questions related to homicidal thoughts; assess thoughts, plans, potential for action, deterrents to action, and the client’s feelings about these homicidal ideas</td>
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<tr>
<td>“Is there anyone that you are angry with?”; “have you ever had thoughts of harming others?”; “have you ever wanted to kill another person?”; “do you wish someone else were dead, even if you would not directly cause them harm?”; “have you ever tried to kill or harm another?”; “has anyone in your family or a close friend tried to harm another?”; “are you having feelings or thoughts now about harming another?”; “do you have a plan for harming another?”</td>
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<td>someone who hears voices commanding or suggesting that they harm or kill another is at extreme high risk for homicide</td>
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individuals lacking resources/a significant support system as well as individuals facing seeming dire circumstances have an increased risk for acting on their ideations.
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<tr>
<th>Thought Process: the way the client puts ideas together; the association between ideas and to the form and flow of thoughts in conversation</th>
<th>inferred from client's speech and behavior; evaluate rate and flow of ideas and association of ideas (the relationship between ideas)</th>
<th>racing thoughts often seen in clients with anxiety, mania or schizophrenia; depression may cause clients to have slowed or retarded thoughts; obsessional or schizophrenic clients be circumstantial; Blocking is seen in the client with severe anxiety and schizophrenia; loose associations are often seen in clients in psychotic states; flight of ideas is common in clients who are manic; clanging is sometimes present in mania; punning is seen in mania; neologisms are seen in schizophrenia, word salad is characteristic of schizophrenia; echolalia is observed in mania</th>
</tr>
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<tr>
<td>Interview Behavior: the client’s response to you the interviewer</td>
<td>in what ways does the client engage or distance you; does the client become more or less comfortable as the interview proceeds; does the client show an ability to form an alliance and work with you</td>
<td>provides an indication of the client’s motivation for treatment; clients may adopt surface attitudes to compensate for deeper problems (a frightened person acts angry or hostile); attitudes provide important clues as to how people defend themselves against unpleasant feelings; paranoid individuals are typically suspicious, evasive, and arrogant; a manic person may be inpatient and uncooperative; schizophrenics may be reserved, remote, and seemingly unfeeling; a depressed person may appear apathetic, hopeless, and helpless; people with dementia may demonstrate distractibility and apparent indifference to their condition</td>
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<tr>
<td>Other</td>
<td>assess for self mutilation and risk taking behaviors</td>
<td>ask questions related to self mutilation to include type of mutilation, frequency, any medical attention needed as a result</td>
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<td>assess for potential for violence</td>
<td>this is difficult to assess with any degree of accuracy; the assessment is based on known history for violent behavior, collateral information from others about the person’s behavior previous to the assessment, and upon the words and behavior of the person during the interview (e.g. anger, swearing, threats, agitation); substance abuse increases the risk for violent behavior as does irrational fear arising from states of delirium, dementia or psychosis</td>
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<td></td>
<td>individuals lacking resources/a significant support system as well as individuals facing seemingly dire circumstances have an increased risk for acting on their ideations</td>
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<td>note any repetitive gestures such as tics or grimacing; agitated behaviors such as hand wringing, hair pulling may be seen in clients with</td>
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<tr>
<td>Specific mannerisms</td>
<td>depression or anxiety; people taking anti-psychotic medications should be observed for involuntary movements of the tongue, mouth or extremities.</td>
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