ADULTS with psychiatric conditions who are admitted as inpatients need to be assessed carefully to ensure they receive the best possible care. Although staff nurses don’t make the diagnosis, your assessment can help the psychiatrist and other treatment team members understand the patient’s struggle. This is particularly important as many inpatients are hospitalized involuntarily and timely intervention is essential. (See Involuntary psychiatric admissions.) This article provides an overview of selected psychiatric conditions and their signs and symptoms.

**Schizophrenia and schizoaffective disorder**
Clinicians consider five domains when assessing patients for schizophrenia or schizoaffective disorder—delusions, hallucinations, disorganized thinking and speech, grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms.

- **Delusions** are fixed beliefs not amenable to change even in light of conflicting evidence (excluding religious beliefs commonly held in the community). Examples include:
  - delusions of persecution ("someone is out to get me")
  - nihilistic delusions ("something bad is going to happen")
  - somatic delusions ("something is terribly wrong with me")
  - control delusions ("someone is making me do something")
  - thought-withdrawal delusions ("aliens are stealing my thoughts")
  - thought-insertion delusions ("aliens are putting thoughts into my head")
  - thought-broadcasting delusions ("everyone can hear my thoughts")
  - referential delusions ("people are talking about me")
  - delusions of grandeur (for instance, a patient thinks she’s royalty and should be treated as such)
  - erotomania (a false belief that others are in love with the patient).

- **Hallucinations** are perception-like experiences that occur without an external stimulus. In schizophrenics, auditory hallucinations (AHs) are more common than visual or other hallucinations. Visual hallucinations (VHs) may be illusions (misin-
Involuntary psychiatric admissions

Typically, patients in inpatient psychiatric settings are admitted involuntarily under a legal hold for assessment and treatment. They’re deemed either dangerous to themselves or others or unable to feed, clothe, or shelter themselves. Their signs and symptoms stem from an acute phase of mental illness and aren’t related to brain injury, organic brain changes, cognitive disabilities, medical problems, intoxication, or criminal behavior. Some also have substance abuse issues. Generally, they’re expected to respond to treatment. Length of stay averages 5 to 14 days.

Examples of events and conditions that can lead to involuntary admission include:
- deliberate self-harm with significant injury
- acute suicidal ideation with or without an actual suicide attempt
- psychosis leading to risky behavior (for instance, hearing voices commanding the patient to kill himself or others)
- grossly disorganized behavior and inability to take care of self
- refusal to eat in the belief that food is poisoned.

Interpretation of visual stimuli; for instance, a shadow becomes a menacing black dog. VHs can occur with other medical conditions, such as alcohol withdrawal, or may manifest as an aura with a seizure or brain injury. AHs and VHs rarely occur at the same time.

• **Disorganized thinking and speech** may include:
  - circumstantiality (verbalization of concrete details that’s slow in getting to the point)
  - concrete thinking (making literal rather than figurative interpretations; for instance, the patient answers “I took the bus” when asked how he or she ended up in the hospital)
  - clang associations (rhyming words and not completing sentences)
  - loose associations (sentences or phrases not logically connected to those coming before or after)
  - tangentiality (going from topic to topic without making a point)
  - neologisms (making up words that have meaning only to the patient)
  - “word salad” (a stream of unconnected words).

• **Grossly disorganized and abnormal motor behavior** may manifest as:
  - unpredictable behavior that interferes with task completion or causes agitation
  - failure to follow instructions to move
  - holding a fixed bizarre position
  - lack of verbal or physical response
  - purposeless or repetitive movements
  - staring at staff
  - catatonic stupor not caused by a physical problem.

• **Negative symptoms** refer to lack of something, including:
  - lack of emotional expressions
  - avolition (lack of motivation for goal-oriented tasks)
  - alogia (decreased speech)
  - anhedonia (lack of pleasure from activities previously enjoyed)
  - asociality (lack of interest in others).

A schizophrenic patient with negative symptoms seems to lack personality.

**Signs and symptoms of schizophrenia and schizoaffective disorder**

Signs and symptoms of schizophrenia include delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior.

Signs and symptoms of schizoaffective disorder include:
- a major mood episode of either major depression or mania for at least 1 month
- at least 2 weeks of delusions or hallucinations that don’t occur at the same time as a major mood episode.

**Assessment tips**

If your patient seems to be hearing voices, observe him or her to determine the following:
- Is the patient talking to a wall or an empty space?
- Is he or she mumbling or yelling? If so, can you make out words or themes?
- Are the patient’s eyes darting, staring, or frightened?
- Does the patient seem to be lost in thought?
- Is the patient thought blocking (stopping talking abruptly)?
- What is the patient’s affect (nonverbal expression of feelings, including posture, facial expression, and tone of voice)?

Try to determine if the patient seems internally preoccupied or is behaving in a way that’s consistent with AHs. Once you’ve formed general impressions, ask the patient questions such as the following:
- Are the voices frightening?
- What are they saying?
- Are they telling you to do something?
- Are they loud?
- Do you believe the voices?
- How often do you hear them?

Keep in mind that paranoid patients may not admit to hearing voices until they’ve developed trust in you or until antipsychotic medications start to take effect. Try to identify a theme to what the voices are saying; for example, are they worried something had will happen? Unfortunately, voices rarely go away completely even when the patient is well-managed on medications. (Download Nursing mental health assessment.)
Bipolar I disorder

Bipolar I disorder involves manic episodes that last at least 1 week or manic symptoms severe enough to require immediate hospital care. Mixed episodes (mania and depression at the same time) may occur as well. Some patients also experience episodes of hypomania (similar to mania but less intense). The episodes don’t stem from a medical condition or substance use.

Signs and symptoms

The following are examples of signs and symptoms of bipolar I disorder:

- persistent elevated mood, including high energy output, expansiveness, persistence, task and goal orientation, or marked irritability
- significant behavior changes, such as grandiose behavior, constantly moving without purpose, taking part in high-risk activities, such as sex with strangers, or incessant rapid speech.

In many cases, patients with bipolar disorder require hospitalization to protect themselves from their own behavior.

Assessment tips

When assessing the patient, ask yourself these questions:

- What is the patient’s mood? (Document this in the patient’s own words.)
- What is the patient’s affect? (How does the patient appear to be feeling?)
- What is the quality and content of the patient’s behavior and speech?

Documentation tips

Describe specific risks of the patient’s manic behavior, including sexual risks, antagonizing others, making intrusive phone calls, making life-defining decisions, or losing weight because the patient can’t sit long enough to eat a meal. Keep in mind that a patient with bipolar I disorder may be in the depressed phase of the condition, so be sure to assess for depression, suicide risk, and marked shifts in mood or affect. (See Assessing the patient’s violence and aggression risk.) When documenting the quality and content of the patient’s behavior and speech, be as specific as possible.

Major depressive disorder

Major depressive disorder causes severe symptoms that affect how the patient thinks and feels. It also may affect such activities as sleeping, eating, and working. The patient must have signs or symptoms for at least 2 weeks. In 2014, an estimated 15.7 million adults aged 18 or older in the United States had at least one major depressive episode in the past year, making it one of the most common mental health disorders.

Essential information to communicate during care transitions includes:

- pain management history
- pain assessment tools and scales used
- complementary and pharmacologic interventions tried and shown to be either effective or ineffective
- patient goals for pain outcomes.

Clinical decision-making tools, such as alerts in the electronic health record regarding inappropriate or high-alert medications, flag alerts for frail elders, and embedded standard communication and pain assessment tools, may promote effective communication and documentation.

Signs and symptoms

Patients with a major depressive disorder...
Suicide risk assessment

When assessing patients for suicide risk, your first priority is to observe for active suicidal behavior, such as hiding contraband to harm themselves. Also, be aware of factors that could increase suicide risk, including recent loss, suicide in the family, chronic pain, male gender, or suicide of a prominent person. Check for:

- recent suicide attempts, particularly in the last 6 months
- whether a recent suicide attempt was well-planned to escape rescue, or a poorly planned attempt from which the patient was easily rescued or called for help
- patient’s level of ambivalence; for instance, does the patient have hope for the future? Would he or she want to live if something changed?
- motivation for suicidality; for example, does the patient want to end pain and suffering? Does he or she feel like a burden to others? Does the patient feel self-loathing, anger, or rage?
- patient’s access to a suicide method, including what’s available outside the hospital (for instance, a stockpile of pills or access to a gun or a rope)
- patient’s intent to act on suicidal thoughts
- command auditory hallucinations telling the patient to commit suicide
- protective factors that may reduce risk; for instance, is suicide against the patient’s religion? Does the patient have family obligations, such as children?

Formulate an objective rating (high, medium, or low) of the lethality of the patient’s previous suicide attempts and current suicide plans. (Don’t share this information with the patient.)

Clinical formulation
Assess the patient’s risk level based on your opinion, regardless of whether you’ve used a suicide assessment tool with a score. Include your recommended level of observation (which may range from every 30 minutes to constant observation at arm’s length or with restraints) and precautions (such as room searches, supervised utensils, and mouth checks after receiving medication).

Clinical alerts
- Assess all patients for suicidality every shift, regardless of their diagnosis.
- Know that improvement in a patient’s mood and affect may indicate he or she has a clear suicide plan or sufficient energy to commit suicide.
- Always discuss the patient’s safety plan with the patient. This plan details what the patient can do to keep safe and what you will do to keep the patient safe. (Don’t refer to this as a contract for safety.)
- Assess the patient for pervasive hopelessness (a key element in suicide risk).

Alcohol withdrawal syndrome

Alcohol withdrawal syndrome occurs when a person reduces or stops consuming alcohol, especially after a period of heavy or prolonged drinking. Severe withdrawal symptoms require medical attention and possibly hospitalization for detoxification.

Signs and symptoms
The following may occur with alcohol withdrawal syndrome:

- autonomic hyperactivity (diaphoresis, increased pulse)
- tremor (usually of the hands)
- insomnia
- nausea and vomiting
- hallucinations or illusions, which typically start as sensitivity (for instance, the patient

disorder have a depressed mood or loss of pleasure or interest in activities that usually provide pleasure. Other signs and symptoms include:

- unintentional weight loss or gain (5% or more in 1 month)
- insomnia or hypersomnia
- psychomotor agitation
- fatigue
- feelings of worthlessness or excessive guilt
- decreased ability to concentrate
- suicidal thoughts or a suicide attempt.

Be aware that depression differs from dementia and delirium. Dementia is a gradual neurocognitive decline involving decreased logic and memory; for instance, patients try to answer questions but give the wrong answer. Delirium is marked by sudden onset of rapid fluctuations in behavior and level of consciousness; it stems from medication, substance use, or a medical condition. Delirium usually is a medical emergency.

Assessment tips
When assessing patients with a suspected major depressive disorder, start by evaluating their risk for suicidal ideation or behavior. (See Suicide risk assessment.) Ask the patient how he or she is feeling, and document the answer in the patient’s own words; for instance, “Patient states that mood is ________.”

Also ask the patient to rate his or her mood on a scale of 1 to 10, with 10 indicating the most severe feelings of depression. Note the patient’s affect (how he or she appears to be feeling) and determine if it matches the stated mood.

Next, assess the amount and pattern of the patient’s sleep, fluid and food intake, recent weight changes, activity and behavior level, and self-care (noting how much prompting or assistance the patient needs).

Keep in mind that depressed patients typically give brief answers or may say they don’t care or don’t know the answer. Also, patients with depression who have an unknown history of manic or hypomanic episodes may be tipped into a manic phase when they begin antidepressants without also taking mood-stabilizing medication.
Substance withdrawal assessment

You can use the assessment tools below to evaluate patients you think may be experiencing alcohol, opioid, or stimulant withdrawal.

**Alcohol withdrawal: CIWA-Ar Scale**
The Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar), monitors patients for alcohol withdrawal symptoms. It takes about 5 minutes to administer and focuses on 10 common signs and symptoms of alcohol withdrawal. The maximum score is 67; patients scoring below 10 usually don’t need additional medication for withdrawal.

1. Ask the patient, “Do you feel sick to your stomach? Have you vomited?” (Assesses for nausea and vomiting)
2. Ask the patient to extend the arms and spread the fingers apart. Hold the patient’s hand to feel for moisture and tremors. Release and observe the hands. (Assesses for tremor)
3. Observe for moisture and diaphoresis. (Assesses for paroxysmal sweating)
4. Ask, “Do you feel nervous or anxious?” Include subjective answers. (Assesses for anxiety)
5. Observe the patient’s behavior for agitation. (Assesses for agitation)
6. Ask, “Do you have itching, burning, numbness, or odd sensations? Do you feel bugs crawling on or in your skin?” (Assesses for tactile disturbances)
7. Ask, “Do sounds seem harsh to you? Are you hearing anything that’s disturbing to you?” (Assesses for auditory disturbances)
8. Ask, “Is the light too bright? Are you seeing anything that’s disturbing to you?” (Assesses for visual disturbances)
9. Ask, “Do you have a headache? How would you rate it on a pain scale?” (Assesses for headache or fullness in the head)
10. Ask, “What day is this? Where are you? Who am I?” If the patient is confused, ask him or her to complete serial arithmetic additions. (Assesses for orientation and clouded sensorium)


**Opioid withdrawal: COWS tool**
To evaluate a patient for opioid withdrawal, you can use the Clinical Opiate Withdrawal Scale (COWS) to rate and monitor common signs and symptoms of opioid withdrawal over time. The score helps determine the severity of opioid withdrawal and assess the level of physical dependence on opioids. The 11 items in the tool include:
- resting pulse rate
- sweating
- restlessness
- pupil size
- bone or joint aches
- runny nose or tearing (not attributable to a cold or allergy)
- GI upset
- tremor (observation of outstretched hands)
- yawning
- anxiety or irritability
- goose bumps.

For more information, visit [www.mdcalc.com/cows-score-for-opiate-withdrawal](http://www.mdcalc.com/cows-score-for-opiate-withdrawal).

**Stimulant withdrawal**
Assess the patient for:
- dysphoric (depressed) mood, which can lead to suicidality
- psychomotor agitation, which can result in aggressive or violent behavior.

**Clinical alerts**
- Know that alcohol withdrawal can be life-threatening. Patients shouldn’t attempt to quit cold turkey.
- Be aware that benzodiazepine withdrawal can cause the same signs and symptoms as alcohol withdrawal.
- Recognize that visual and tactile hallucinations are the most common perceptual disturbances during alcohol withdrawal.
- Be familiar with the signs and symptoms of withdrawal unique to the specific substance you believe your patient is using.

complains that lights are too bright or sounds are too loud) and then develop into hallucinations (usually tactile or visual). Other signs and symptoms include anxiety, general tonic-clonic seizures, inability to sit still, and constant purposeless movement or fidgeting. (For more information on alcohol, opioid, and stimulant withdrawal, see Substance withdrawal assessment.)

**Opioid withdrawal**
Opioids include heroin, metha-
done, oxycodone, hydrocodone, and certain other substances. Heavy opioid use over several weeks changes brain chemistry. Opioid withdrawal occurs when the person stops using opioids.

**Signs and symptoms**
Patients with opioid withdrawal may have insomnia or a sad or depressed mood. Physiologic signs and symptoms may include:
- nausea and vomiting
- muscle ache
- lacrimation (tearing eyes)
- rhinorrhea (running nose)
- pupil dilation
- piloerection
- diaphoresis
- diarrhea
- yawning
- fever.

**Stimulant withdrawal**
Stimulants include amphetamine, methylphenidate (Ritalin), amphetamine with dextroamphetamine (Adderall), cocaine, and certain other substances. They cause changes in brain chemistry after short periods of use and have a short half-life. Withdrawal occurs after the person stops using stimulants.

**Signs and symptoms**
Patients with stimulant withdrawal may have a dysphoric mood along with:
- vivid and scary dreams
- insomnia or hypersomnia
- increased appetite
- psychomotor retardation
- inability to sit still
- constant purposeless movement or fidgeting.

**Key points to remember**
When assessing patients for mental illness or substance withdrawal, always assess the risk for suicidal and aggressive behavior, regardless of the patient’s specific diagnosis. Also, be aware that a patient may not admit to experiencing certain symptoms until he or she trusts you. Finally, be sure to fully document your observations in the health record so psychiatric physicians and nurse practitioners can more easily diagnose the patient’s specific problem using the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5).

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**Selected references**


Jacobsen F. Type II workplace violence in an urban acute hospital: how do we know if we are creating a safer environment for patients and staff? *J Safe Manag Disrup Assault Beh*. 2012;20(2):4-8.


Please mark the correct answer online.

1. Fixed beliefs not amenable to change even in light of conflicting evidence are called:
   a. hallucinations.
   b. neologisms.
   c. catatonia states.
   d. delusions.

2. Perception-like experiences that occur without an external stimulus are called:
   a. hallucinations.
   b. neologisms.
   c. catatonic states.
   d. delusions.

3. Which statement about patients who seem to be hearing voices is correct?
   a. Patients with bipolar I disorder usually admit to hearing voices.
   b. Patients with a major depressive disorder usually admit to hearing voices.
   c. An appropriate question to ask a patient who may be hearing voices is, “Are the voices frightening?”
   d. An appropriate response to a patient who may be hearing voices is, “There is no one speaking to you.”

4. A patient who is engaged in high-risk or grandiose behavior may be suffering from:
   a. schizophrenia.
   b. bipolar I disorder.
   c. major depressive disorder.
   d. schizoaffective disorder.

5. Which statement about conducting a psychiatric assessment and documenting the findings is correct?
   a. Use the patient’s exact words.
   b. Summarize what the patient says.
   c. Omit assessment of memory.
   d. Describe patterns of speech in general terms.

6. Which of the following may indicate your patient is depressed?
   a. Rapid change in level of consciousness
   b. Sudden onset of rapid fluctuations in behavior
   c. Gradual neurocognitive decline that includes decreased logic
   d. Decreased ability to concentrate

7. When assessing patients for suicide risk, you should:
   a. Avoid directly asking them if they plan to harm themselves.
   b. Ask them if they intend to act on their suicidal thoughts.
   c. Check for suicide attempts, particularly in the last month.
   d. Assess them for risk once a day while they are hospitalized.

8. Patients with a major depressive disorder have symptoms for at least:
   a. 1 week.
   b. 2 weeks.
   c. 1 month.
   d. 2 months.

9. Which of the following findings indicate your patient may be experiencing opioid withdrawal?
   a. Tangentiality
   b. Delirium
   c. Lacrimation and rhinorrhea
   d. Tonic-clonic seizures

10. Which statement about alcohol withdrawal is correct?
    a. Insomnia rarely occurs with alcohol withdrawal.
    b. The best strategy to stop drinking is to go “cold turkey.”
    c. Patients may experience sensitivity that develops into hallucinations.
    d. Visual hallucinations are rare in patients experiencing alcohol withdrawal.

11. Which assessment tool is used for patients experiencing alcohol withdrawal?
    a. CIDA-Dr
    b. LOC
    c. COWS
    d. CIWA-Ar

12. The average length of stay for a patient who has been involuntarily admitted to an inpatient psychiatric setting is:
    a. 24 hours.
    b. 2 days.
    c. 5 to 14 days.
    d. 21 days.
### Level of consciousness (LOC)
- Lethargic
- Stupor
- Delirious
- Comatose
- Alert
- Drowsy
- Acute changes in LOC

### Orientation
- Oriented or disoriented to time (date, day of week, month, season), place, self/others, situation
- Ability to perform serial additions in 3's or 7's, forward or backward
- Poor concentration

### Memory
- Intact
- Short-term memory loss
- Long-term memory loss
- Recall loss for new learning

### Perceptions and thought content
- Delusion theme
- Hallucination type
- For both: Assess content, frequency, how disturbing, how believable, whether patient can distract self, and what helps or worsens hallucinations
- Obsessions (ruminating or repetitive thoughts)

### Speech and thought
- Childlike tone
- Circumstantial
- Clang associations
- Concrete
- Controlled and measured
- Echolalia
- Flight of ideas
- Garbled
- Goal directed
- Incoherent
- Inductive
- Internal preoccupation
- Logical or illogical
- Loose associations
- Loud speech
- Mute
- Neologisms
- Non sequiturs
- Organized or disorganized
- Paucity of speech
- Perseveration (persistent repetition of a word, phrase, or gesture)
- Plasitve
- Preoccupied
- Pressured
- Profanity
- Racing thoughts
- Slurring
- Soft spoken
- Tangential
- Thought blocking
- "Word salad"
- Yelling

### Behavior and attitude
- Agitated
- Anxious
- Apathetic
- Appropriate
- Attentive
- Avolitional (lacks drive)
- Bizarre
- Braggadocio (brags about self)
- Calm
- Childlike
- Compulsive
- Contemplous
- Cooperative
- Difficult to redirect
- Dismissive
- Disorganized
- Dissociated
- Distant or aloof
- Elated
- Entitled
- Evasive
- Excitable
- Grossly disorganized
- Guarded
- Hoarding
- Hostile
- Hypersensitive
- Hypervigilant, easily startled
- Hypomanic
- Impaired interpersonal relationships
- Impulsive
- Inappropriate touching
- Ingratilating
- Irritable
- Isolative
- Malingerer (describe)
- Negative goal orientation
- Racing

### Mood
- Patient states, "I feel ____________ ."
- (Document patient's words.)

### Affect
- A lethymic (can't describe feelings)
- Angry
- Appropriate or inappropriate for situation
- Blunted
- Bright
- Calm
- Congruent or incongruent with stated mood
- Constricted
- Elated
- Fearful
- Flat
- Euthymic (having a moderate mood, neither depressed nor manic)
- Full range
- Guarded
- Happy or euphoric
- Irritated
- Labile (experiencing a constantly changing mood)
- Mixed
- Sad or dysphoric
- Silly
- Superficial
- Worried

### Sleep
- Decreased need for sleep
- Difficulty falling asleep
- Difficulty staying asleep
- Early awakening
- Feels tired or lethargic

### Somatic symptoms and motor movements
- Akathisia (inability to stay still)
- Catatonic
- Chest pain
- Chills
- Choking sensation
- Cogwheeling (palpable ratcheting movement)
- Dizzy
- Excessive sweating
- Headache
- Heart racing
- Hot flashes
- Light-headedness
- Muscle tension
- Nausea
- Pain
- Psychomotor agitation
- Psychomotor retardation
- Poor appetite
- Rigidity
- Tardive dyskinesia (repetitive involuntary movement)
- Shortness of breath
- Tics
- Tremors
- Unusual facial movements
- Unusual movements

### Insight (patient's understanding of situation or illness) and judgment (patient's plans for how he or she will manage)
- Good
- Fair
- Poor
- None
- Grossly impaired
- Ask patient about his or her plans for obtaining food, shelter, and clothing.

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This chart helps you structure your assessment of patients with psychiatric conditions. In each cell, the left column lists assessment elements; the bullets are specifics or prompts. Start by assessing the patient's risk of suicide and violence. Next, assess the category most relevant to the reason for your patient's admission. Then proceed with the rest of the categories below.