

Psychological Assessment in Acute Psychiatric Settings: From a Narrative Review to a Decision-Making Framework

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Abstract: Psychological assessment in acute psychiatric settings plays a critical role in establishing accurate diagnoses, informing treatment planning, and improving clinical outcomes. Clinicians working in these high-intensity environments must evaluate patients presenting with severe psychiatric symptoms while navigating substantial challenges, including time pressure, fluctuating clinical presentations, and limited patient cooperation. This narrative review examines existing literature on psychodiagnostics assessment in psychiatric inpatients units and identifies key factors that influence decision-making. Building on this evidence, the review proposes a rapid decision-making framework designed to support clinicians in selecting and implementing appropriate assessment strategies. By integrating structured instruments, clinical judgement, and contextual information this framework aims to standardize assessment practices, enhance diagnostic accuracy, and facilitate treatment adherence and continuity of care. A clear decision-making framework is necessary to propose unambiguous psychotherapeutic treatments that clarify treatment paths and facilitate achievement of objectives in the short and long term.

Keywords: Psychological assessment, Acute psychiatric settings, Decision-making framework, Psychodiagnostic assessment, Psychiatric inpatients.

INTRODUCTION

Hospitalization in a psychiatric diagnosis and care unit - SPDC, according to Italian legislation - represents an extremely sensitive and critical moment for patients and clinicians alike (Sangiorgio *et al*, 2011; Vyas *et al*, 2023). In Italy, hospitalization in a SPDC begins at age 18. A significant proportion of individuals are admitted for the first time without any prior psychiatric diagnosis or treatment - for example, following a suicide attempt (Della *et al*, 2023), or due to first-episode psychosis (Galderisi *et al*, 2020). Others are hospitalized because of acute exacerbations of existing psychiatric disorders (Marcus *et al*, 2017). Before admission, the evaluating psychiatrist formulates a preliminary or "admission" diagnosis during the emergency department assessment based on presenting signs and symptoms (Kraft *et al*, 2021). However, a comprehensive and definitive diagnosis can only be formulated during hospitalization, enabling the initiation of an appropriate treatment plan (Galderisi *et al*, 2020).

The complexity of psychological distress among adults requiring acute psychiatric hospitalization reflects the multifactorial nature of mental health disorders. While patients often present with severe symptoms requiring rapid intervention, the underlying contributors are rarely singular or straightforward (Maercker *et al*, 2022). The severity of symptoms, time pressure, and heterogeneity of clinical presentations underscore the need for structured decision-making

strategies in acute settings (Hamann *et al*, 2020; Johnson *et al*, 2022), including the use of psychological tests where feasible (Stukenberg *et al*, 2000; Cukrowicz *et al*, 2004).

Developing a flowchart to support clinicians in selecting appropriate psychological assessment tools may enhance the efficiency and accuracy of psychodiagnostics profile.

A comprehensive understanding of the interaction between biological, psychological, and social factors is essential for accurate diagnosis, effective treatment planning, and reducing the risk of future readmissions.

AIM

Different approaches are used in acute psychiatric setting to assess the psychopathology of inpatients (Hamann *et al*, 2020; Maercker *et al*, 2022; Marcus *et al*, 2017). Much of the literature focuses on suicide attempt, impulsive and aggressive behavior, substance use, and medical comorbidities associated with psychiatric hospitalization (Rufino *et al*, 2018). Despite numerous clinical studies addressing assessment practices in psychiatric ward, there is no overarching framework for psychological assessment in acute psychiatric wards.

This narrative review therefore aims to propose a rapid decision-making framework for psychodiagnostics assessment in acute psychiatric wards.

METHODS

To conduct this narrative review, the author followed the SANRA (Scale for the quality Assessment

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of Narrative Review Articles) guidelines (Baethge *et al.*, 2019) and supplemented them with the SWiM checklist (Campbell *et al.*, 2020) to enhance transparency in the synthesis process and improve the overall quality of reporting.

The review question was structured using the PICO framework: (i) *Population (P)*: psychiatric patients aged 18 or older admitted to acute psychiatric wards, and mental health clinicians involved in psychodiagnostics assessment; (ii) *Intervention (I)*: implementation or conceptualization of a rapid decision-making framework for psychodiagnostic assessment; (iii) *Comparison (C)*: standard practice or absence of structured assessment procedures; (iv) *Outcomes (O)*: improved diagnostic efficiency (e.g. reduced assessment time), enhanced diagnostic accuracy and consistency, better integration of psychological and clinical perspectives in acute care, and development of operational guidelines for rapid psychodiagnostics decision-making.

A comprehensive literature search was conducted in PubMed/MEDLINE, EBSCO, and APA PsycINFO. The keywords “Psychological assessment” and “psychiatric inpatients” were used in combination, for studies published from 1st January 2000 to 31st August 2025. The initial search yielded 6,116 records (PubMed *n*= 1089; EBSCO *n*= 4004; PsycINFO *n*=1023). After removing duplicates and applying inclusion/exclusion criteria, 12 studies were retained and included in the final narrative synthesis.

Psychological Assessment in Acute Psychiatric Setting

Psychological assessment in acute psychiatric units typically integrates clinical interviews, standardized assessment tools, and collateral information from family or caregivers. The process can be conceptualized into three key stages: *Initial Evaluation* (Step I). Upon admission, clinicians conduct a comprehensive intake assessment, including a mental status examination (MSE). This step identifies presenting symptoms, risk factors (e.g., suicidality), and immediate medical needs. Instruments such as the Brief Psychiatric Rating Scale (BPRS) (Hopko *et al.*, 2001), the Positive and Negative Syndrome Scale (PANSS) (Amore *et al.*, 2008), and the Columbia-Severity Rating Scale (C-SSR) (Simpson *et al.*, 2023; Kyron *et al.*, 2018), may be used. This first evaluation is typically conducted by the psychiatrist, who must initiate pharmacological therapy treatment if needed.

Intermediate Evaluation (Step II). Once the patient is stabilized, further psychodiagnostic testing may be performed to clarify underlying conditions. Tools such

as the Minnesota Multiphasic Personality Inventory (MMPI) in its different forms (Marquardt *et al.*, 2024), the Beck Depression Inventory (BDI), the Montgomery-Asberg Depression Rating Scale (MADRS-S), or the Personality Inventory for DSM-5 (PID-5) offer insight into mood disorders (Svanborg et Ekselius, 2003), personality traits (Rodriguez-Seijas *et al.*, 2020), or psychotic symptoms. Neuropsychological testing may be administered to evaluate cognitive functioning (Wood *et al.*, 2019a), especially when neurodegenerative conditions or substance-related disorders are suspected. Before conducting any cognitive evaluation, clinicians must ensure that the clinical information supports a clearly defined diagnostic question. Since acutely ill patients may have impaired insight or communication difficulties, collateral information from relatives or outpatient providers is essential to reconstruct symptom timelines and premorbid functioning.

Another relevant issue concerns IQ and the diagnosis of Intellectual Disability (ID). The presence of acute psychotic episodes, confusion, and impairments in cognitive functioning associated with the psychopathological condition may, at times, give rise to the suspicion of an underlying intellectual disability. However, confirming ID requires a structured assessment including developmental history and evaluation of lifelong adaptive functioning (Kumar *et al.*, 2025).

Final Evaluation (Step III). In the final stage, patients receive a psychiatric diagnosis or psychological profile to guide post-discharge treatment planning. This process is crucial for preventing readmissions and promoting adherence to care.

Despite the availability of best-practice guidelines for inpatient psychiatric care setting (Chaplin *et al.*, 2022; Svanborg et Ekselius, 2003; Marquardt *et al.*, 2024), no structured decision-making framework currently exists for psychodiagnostic assessment in acute psychiatric wards.

Factors Involved in the Psychodiagnostics Process

Several factors influence psychological assessment in acute settings.

- i) *Patient Cooperation*. Acute symptoms - such as agitation or disorganized thinking - may limit engagement. Observations and brief structured interviews may be more practical than lengthy assessments (Walker *et al.*, 2019).
- ii) *Age-Related Factors*. Psychological distress manifests differently across adulthood: a)

- Adolescence and Early Adulthood (18-25 years): This developmental stage is marked by identity formation, increased autonomy, and vulnerability to mental health disorders such as mood disorders, anxiety, and emerging psychosis. Neurodevelopmental changes, combined with psychosocial stressors like academic pressure or relationship conflicts, often contribute to psychological distress (Esque *et al*, 2021).
- b) Middle Adulthood (26-59 years): Adults in this age group may experience distress stemming from occupational stress, financial pressures, or familial responsibilities. Disorders such as major depressive disorder (MDD), generalized anxiety disorder (GAD), and substance use disorders are prevalent. The cumulative effect of unresolved stressors or trauma from earlier stages may also surface during this period. c) Late Adulthood (60 years and above): Older adults may face unique challenges, including bereavement, physical illness, and social isolation, contributing to psychological distress (Dols *et al*, 2014). Neurodegenerative conditions like dementia often co-occur with psychiatric symptoms, complicating the clinical picture.
- iii) *Substance Use and Its Impact.* Substance use is a critical factor in the development and exacerbation of psychological distress in adults. *Cannabis.* While commonly perceived as a mild substance, cannabis use, particularly in high-potency forms, is linked to anxiety, depression, and psychosis, especially in individuals predisposed to mental illness. *Stimulants* (e.g., MDMA, cocaine). These substances can precipitate acute psychiatric crises, such as manic episodes or paranoia, and may lead to long-term neurochemical dysregulation affecting mood and cognition. *Unidentified Substances.* The increasing availability of synthetic drugs complicates diagnosis and treatment, as their effects are often unpredictable and not well-documented (Suntharalingam *et al*, 2022).
- iv) *The Role of Stressors.* Stressful life events, whether acute or chronic, are a common precipitant of psychological distress in hospitalized individuals, but also in the community staff (Richards *et al*, 2006). *Acute Stressors.* Events such as job loss, divorce, or a traumatic incident can act as triggers for psychiatric symptoms, particularly in vulnerable individuals (Whitney *et al*, 2004). *Chronic Stressors:* Long-term exposure to adversity, such as financial instability or domestic violence, contributes to the development of conditions like depression and PTSD (Gatov *et al*, 2020).
- v) *Comorbid Conditions.* Psychological distress in adults is often compounded by the presence of comorbid medical or psychiatric conditions. a) *Medical Comorbidities.* Chronic illnesses like diabetes, cardiovascular disease, or chronic pain conditions frequently co-occur with depression and anxiety, creating a bidirectional relationship that complicates treatment (Fowler and Jackson-Burns, 2024); b) *Psychiatric Comorbidities.* The co-occurrence of disorders such as depression with substance use or anxiety with PTSD requires a nuanced, integrative approach to care.
- vi) *Time Constraints.* Given the need for rapid stabilization, assessments must balance thoroughness with efficiency. (Chaplin *et al*, 2022).
- vii) *Ethical and Cultural Sensitivity.* Assessment must respect cultural differences. Tests must be normed in the patient's language; if not, administration is not appropriate (Berg, 2018).
- viii) *Multidisciplinary Collaboration.* Coordinated communication among psychiatrists, psychologists, nurses, and social workers ensures comprehensive care.
- ix) *Training of clinicians.* Training should emphasize psychological domains relevant to acute care and promote consistent use of appropriate tools (Wood *et al*, 2019b).
- The Importance of Developing Flowcharts for Guiding Clinicians in Psychological Profiling in Acute Psychiatric Wards**
- Psychological assessment in acute settings fulfills several essential functions. i) Standardization of practice, by delineating clear steps. In this way, a flowchart reduces variability in assessments across clinicians, promoting consistency in diagnostic approaches; ii) Time efficiency, by guiding clinicians in the selection of tools based on the patient's presenting symptoms, and reducing cognitive load during high-pressure situations; iii) Integration of multidimensional factors, by incorporating key variables such as symptom severity, comorbidities, and contextual factors (e.g., substance use, recent trauma), ensuring that no critical aspect of the patient's presentation is overlooked.
- Structured flowcharts provide an effective visual decision-support system, helping clinicians navigate

complex clinical processes through clear and logical pathways.

To maximize their utility, flowcharts should be carefully designed, evidence-based, and adaptable to diverse clinical scenarios (Figure 1). Key components include:

Initial Triage. The flowchart should begin with a triage step to determine the urgency and focus of the assessment. For instance, it might direct clinicians to prioritize tools for evaluating suicidality or risk of aggressive behavior (*single domain*), or to assess the

psychopathological determinants (*global psychological status*).

Symptom-Specific Pathways. Based on the patient's primary symptoms, the flowchart should guide the clinician to appropriate tools or to start specific treatments. For example, detect psychotic symptoms can help the whole staff to adopt behavioral strategies to facilitate "the environment reading" in the patient (Fowler *et al*, 2024; Gaudiano *et al*, 2023). CBT-based strategies are the most widely employed, as they help patients engage in more functional, here-and-now behaviors.

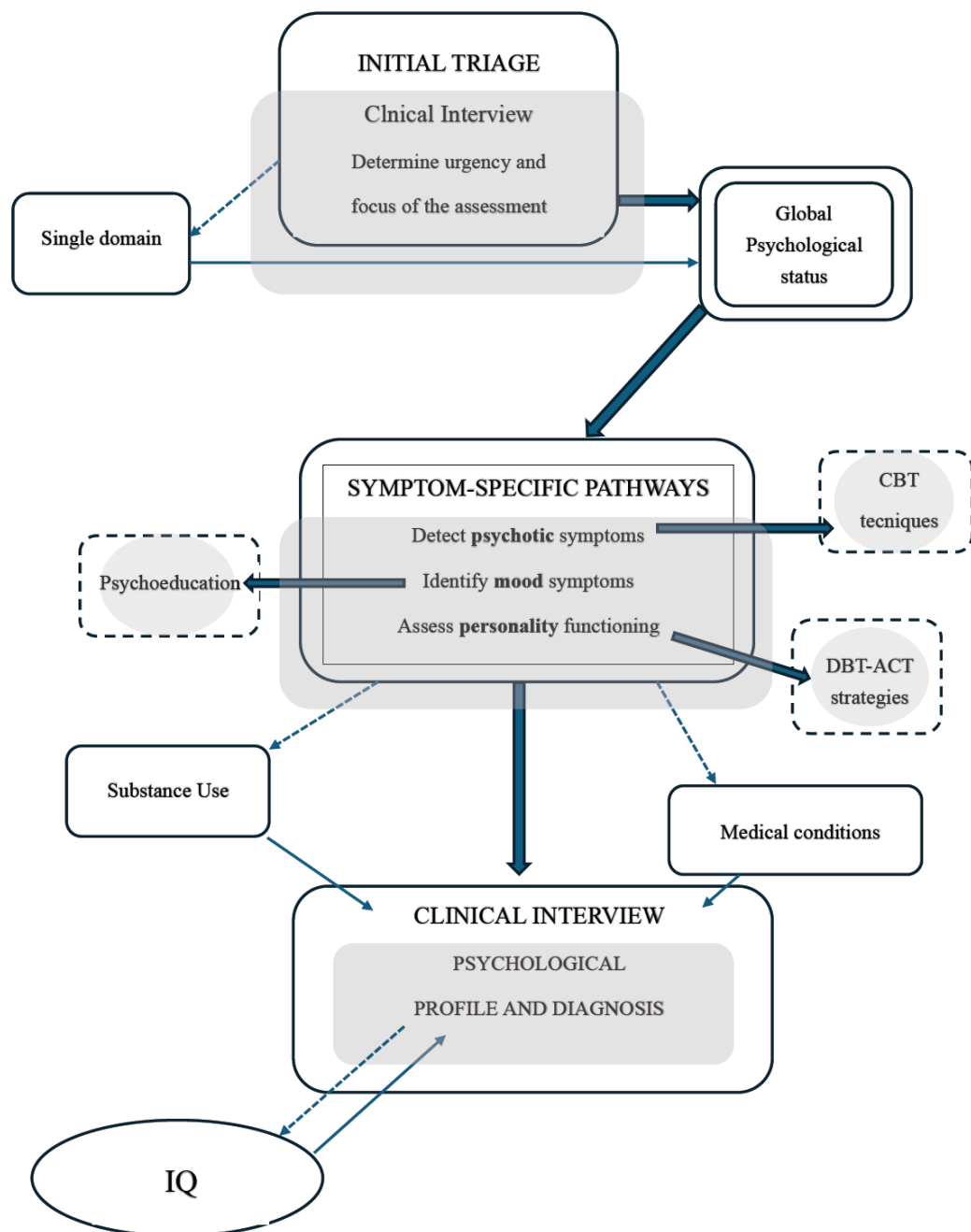


Figure 1: Flowchart. The flowchart outlines three key steps in psychodiagnostic assessment: 1) Initial Triage; 2) Symptom-specific Pathways; 3) Clinical Interview.

Bold arrows indicate mandatory pathways; solid lines indicate required steps; dashed arrows represent optional conditions to be assessed. The shaded boxes with dashed outlines indicate the psychotherapeutic interventions to be implemented based on the symptoms identified.

Identify mood symptoms can promote an immediate psychoeducation treatment to aim to enhance symptoms insight and treatments adherence. Numerous psychoeducational strategies include an informational component on mood symptoms and their normalization, both of which are key elements in helping patients understand what they are experiencing (Lucattelli *et al*, 2023).

Moreover, assessing personality functioning can assist patients in managing self-harm and aggressive behaviors (Banjo *et al*, 2023). The use of Dialectical Behaviour Therapy, DBT-oriented strategies, can facilitate the development of a strong therapeutic alliance, partly through the shared practice of effective techniques for managing emotional distress. Moreover, implementing Acceptance and Commitment Therapy (ACT) strategy within the team may also contribute to improving the emotional climate on the wards.

The early implementation of targeted psychotherapeutic strategies during the hospitalization promotes greater illness insight and supports sustained treatment adherence throughout the post-discharge period.

In such cases, the observed symptoms are not better explained by a psychiatric diagnosis. Thus, can be helpful to proceed with a cognitive screening that can highlight a cognitive impairment and promote specific care pathways (*i.e.* neurological disorders) (Marawi *et al*, 2023). In rare cases, the patient's clinical history may provide a better explanation of their overall functioning, thereby warranting an assessment of intellectual quotient (IQ).

Consideration of Comorbidities and Contextual Factors. The flowchart should include nodes that address common comorbidities (*e.g.*, substance use, medical conditions) and guide clinicians to tools that account for these complexities, with the overarching goal of guiding the patient toward the most suitable treatment pathway, both during hospitalization (*e.g.*, focused clinical interventions) and upon discharge (*e.g.*, assertive community treatments, stress management abilities, *etc.*).

Integration of Clinical Judgment. Although structured, flowcharts must allow flexibility and prevent diagnostic overshadowing. Decision points should include prompts that encourage clinicians to apply their professional judgement, particularly in cases of atypical presentations. Nevertheless, a structured approach helps minimize the risk of diagnostic overshadowing or the neglect of relevant factors. By providing clear and easily accessible information, flowcharts can standardize communication across the psychiatric team, ensure that all members adhere to a unified

diagnostic framework, and serve as valuable educational tools for new clinicians, facilitating skill acquisition in high-stakes environments.

LIMITS

Several limitations can be identified in this manuscript. First, acute psychiatric wards are managed differently across countries, making it difficult to generalize clinical practices. Not all units employ psychologists. The length of hospitalization also varies considerably across settings, depending on clinical, organizational, and cultural factors.

Another significant limitation is inherent to the nature of an acute psychiatric ward. Such a setting may restrict the use of structured observations as well as the administration of psychometric assessments. A further constraint concerns the reason for admission—for example, a first episode, a relapse, a suicide attempt, or poor treatment adherence. In all these circumstances, it may be advisable to consider alternative assessment strategies, grounded in the development of a therapeutic alliance supported by clinical and motivational interviewing. Moreover, patients may be admitted without being aware of the need for treatment and may therefore refuse to undergo evaluation. Another issue concerns test availability: not all assessment tools are freely accessible or translated into the most common languages.

CONCLUSION

Understanding psychological distress in adults admitted to acute psychiatric wards requires a multidimensional approach, that considers numerous variables as age-specific challenges, substance use, stressors, and comorbid conditions. A failure to account for these factors risks oversimplifying the diagnostic process and misguiding treatment efforts (Walker *et al*, 2019). By adopting a holistic perspective, clinicians can better address the complex needs of this vulnerable population, ultimately improving outcomes and quality of care (Marcó-García *et al*, 2024).

Psychodiagnostics assessment in acute psychiatric wards is a nuanced process requiring flexibility, clinical expertise, and collaboration (Wood *et al*, 2019b). While challenges such as time pressure and patient instability are inherent, a structured approach to assessment can yield valuable insights into the patient's condition, guiding treatment and long-term care planning. Investing in training and resources to support this critical function can significantly enhance patient outcomes and the overall effectiveness of acute psychiatric care.

Flowcharts represent an effective tool for structuring assessment in high-stakes environments. (Stukenberg *et al*, 2000). By guiding clinicians through the selection of assessment tools based on evidence-based pathways, flowcharts enhance diagnostic precision, improve efficiency, and ensure comprehensive evaluations. Their development and integration into clinical practice represent a significant step toward optimizing care for individuals in psychiatric crises. Future research should focus on validating these frameworks to ensure their effectiveness and adaptability in different psychiatric clinical contexts.

CONFLICTS OF INTEREST

The author declares no conflicts of interest.

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