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When Paul Harrison, Mike Sharpe and I were offered the chance to take over the eighth edition of *Lecture Notes in Psychiatry* in 1997, we spent a great deal of time together thinking through the structure of a book that would portray psychiatry as the evidence-based, patient-oriented branch of medicine that we knew it could be. Our thinking was inspired by the advances in evidence-based medicine led in Oxford by David Sackett, Muir Gray and Iain Chalmers and the Cochrane Collaboration. We wanted to apply the principles of clinical epidemiology - not just in our recommendations around use of treatments but also to challenge traditional approaches to history and examination taking in psychiatry. For decades, students had been taught that the only way to do a proper psychiatric assessment was to do a ‘full’ history and examination – an approach that is both inefficient and incompatible with real-world clinical practice.

The Oxford University Department of Psychiatry is proud of its heritage of producing and updating its suite of textbooks, a process initiated by Michael Gelder when he was the first Head of Department. We are therefore delighted that Gautam Gulati, Mary-Ellen Lynall and Kate Saunders have taken on the task of updating and revising *Lecture Notes in Psychiatry*. To an extent, all textbooks are out of date as soon as they are published but even with the developments in information technology, a concise, portable, paper textbook containing an up-to-date synthesis of current knowledge occupies its own niche and still has a major role in training. Frequent revisions and updating are, however, critical to keep them accurate and useful. This is hard work of course and after three editions, Paul, Mike and I felt that we could not face revising the book again! It is marvellous to see that Gautam, Mary-Ellen and Kate have done so with such aplomb, keeping what remains useful from earlier editions but updating it with great skill.

*John Geddes*
The skills, attitudes and knowledge inherent in learning psychiatry are relevant to all doctors – and to all other health professionals. We have written this book with medical students and psychiatric trainees in mind, but anticipate it being a useful resource for any health professional interested in the subject.

We describe a practical approach towards psychiatry. Chapter 1 outlines the principles behind the practice of modern psychiatry and introduces the psychiatric assessment. Our guide to assessment comprises a basic psychiatric assessment (Chapter 2), followed by diagnosis-specific assessments (Chapter 3) and a guide to risk assessment (Chapter 4). Chapter 5 describes how to draw everything together and communicate the information to others. The recommendations in these chapters are summarized in a set of ‘quick guides,’ included at the front of the book for easy reference.

The middle chapters cover the principles of aetiology (Chapter 6), treatment (Chapter 7) and psychiatric services (Chapter 8). The main psychiatric disorders of adults are covered in Chapters 9–15, followed by childhood disorders (Chapter 16) and learning disability (Chapter 17). Chapter 18 discusses psychiatry in non-psychiatric medical settings – the place where most psychiatry actually happens. Chapter 19 (Mental health and the law) is a new addition to the book and one you are likely to find useful in whichever setting you work.

Given our illustrious predecessors, we were humbled to be asked to write the 11th edition of Lecture Notes. Indeed we aimed to build upon the last edition of the book written so eloquently by Paul Harrison, John Geddes and Michael Sharpe.

To facilitate learning, we have added learning objectives at the start of each chapter and highlighted key points towards the end. Multiple-choice questions have been added, along with detailed explanations of the answers, to allow the reader to consolidate key points. Links to key papers and guidelines have been added for readers keen to know more about a particular disorder.

We hope we have done justice to the work started by Paul, John and Michael in keeping this Lecture Series book both informative and enjoyable.

We thank Jonathan Price, who was instrumental in drawing our team together and in setting the direction in the early days of our writing. We are grateful to colleagues who have generously shared their expertise with us.

The book is dedicated to Annette Lynall, John Conway, Catherine Sage, and the memory of Graham (Matthew) Jay and Colonel S. Gulati.

Gautam Gulati
Mary-Ellen Lynall
Kate Saunders
We would like to thank the following people for their contribution to this book.

Professor Paul Harrison (University of Oxford), Professor John Geddes (University of Oxford) and Professor Michael Sharpe (University of Edinburgh) who edited the 10th edition of this book.

Dr Jonathan Price (University of Oxford) for bringing the author team together, and for helping set the direction in the early days of our work on this edition of the book.

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Dr Elizabeth Naomi Smith (Oxford Health NHS Foundation Trust) for her contribution to the chapter on Psychiatry in other settings.

Dr Charlotte Allan (Oxford Health NHS Foundation Trust) for her contribution to the chapter on Dementia, delirium and neuropsychiatry.

Karen Moore (Senior Development Editor at Wiley) for her help and advice with editorial aspects.
Quick guides

History-taking checklist

**Before you begin:**
- Information (referral letters, notes), location, safety
- Introduction, consent, establish expectations

**Basic details:**
- Method of referral, status under the Mental Health Act (where appropriate)
- Age, marital status, occupation, current living arrangements

**Presenting complaint(s):**
- Main symptom: ‘NOTEPAD’: Nature, Onset, Triggers, Exacerbating/relieving, Progression, Associated symptoms, Disability
- Other symptoms or problems, important negatives
- Impact of symptoms (biological, psychological, social)
- How others perceived symptoms/state
- Treatment received to date

**Past psychiatric history:**
- Formal care: community psychiatric care? In-patient treatment? Detention?
- Treatments and response
- Self-harm or harm to others

**Treatment/drug history:**
- Prescribed biological and psychological treatments
- Non-prescribed treatments
- Adherence, side effects
- Any recent changes?
- Allergies

**Family history:**
- Parents, siblings and children: age, occupation, health and quality of relationship with patient
- For children: name, DOB, school, any other professional involvement
- Family history of mental illness, suicide, self-harm or substance misuse
- Any recent family events

**Personal history and premorbid personality:**
- Pregnancy, birth and developmental milestones normal?
- Childhood: emotional problems, serious illnesses, parental separation
- Education: enjoyed school, bullying, finished school, special education classes?
- Occupational history: job changes, military service
- Intimate relationships (psychosexual history): partners, quality of relationships, sexual problems, abuse
- Traumatic events including exposure to self-harm/suicide
- Premorbid personality: character, interests, beliefs, habits

(continued)
**Social history** (current circumstances):
- Self-care
- Family and social support
- Caring responsibilities
- Living arrangements
- Finances: problems? benefits?
- Description of a typical day

**Substance use: smoking, alcohol, illicit drugs:**
- Which substances, quantity, how and when?
- Evidence of dependence? Periods of abstinence?
- Impact on life, esp. related offences

**Forensic history:**
- Contact with police, charges, convictions, imprisonment
- How do these relate to episodes of illness?

**Past medical history:**
- Current and past illnesses, surgery, admissions
- (Menstrual and obstetric history)

**Risk assessment:**
- Risks to self (self-harm, self-neglect…)
- Risks to others (staff, family, work…)
- Driving
- Child protection considerations

**Corroborative history** if appropriate
Proceed to **Mental State Examination**

---

**Mental State Examination checklist**

**Appearance and behaviour**
- Appearance
- Body language/abnormal movements
- Eye contact/rapport

**Speech**
- Quantity and spontaneity
- Volume and rate
- Tone, prosody
- Articulation and intelligibility

**Mood**
- Subjective
- Objective: mood, constancy, congruity

**Thoughts**
- Form/flow: any classic patterns? (formal thought disorder, flight of ideas)
- Content:
  - abnormal beliefs: delusions and over-valued ideas
  - preoccupations and obsessions
  - phobias
  - morbid thoughts: harm to self or others
Structure of a psychiatric case presentation

For an example of a case presented in both oral and written form, see pages 51–52.

Demographic details:
- Name, age, sex, occupation
- Dates of referral, assessment, admission, detention, discharge
- Current Mental Health Act status

Presenting complaint(s):
- Nature, onset, progression, treatments to date
- Mental state at presentation

Background history:
- Past psychiatric history and past medical history: diagnoses, admission and treatments
- Family history
- Personal and social history including job record, relationships, children, premorbid personality
- Use of alcohol and drugs
- Forensic history

Mental State Examination:
- Appearance and behaviour
- Speech
- Mood
- Thoughts
- Perceptions
- Cognition
- Insight

Risk assessment:
- Risks to self
- Risks to others

Physical examination

Investigations

Differential diagnosis: List the possible diagnoses, giving the most likely diagnosis first and citing evidence for and against the top differentials
Aetiology, divided into either or both of:
• Predisposing, precipitating, perpetuating and protective factors
• Biological, psychological and social factors

Management and progress:
• General aspects of management including setting of care
• Acute management: biological, psychological and social aspects
• Maintenance (long-term) management
• Current symptoms and problems

Prognosis:
• Short-term
• Long-term
Similarly, conditions such as dementia may move between psychiatry and neurology.

The conditions in which psychiatrists have developed expertise have tended to be those that either manifest with disordered psychological functioning (emotion, perception, thinking and memory) or those that have no clearly established biological basis. However, scientific developments are showing us that these so-called psychological disorders are associated with abnormalities of the brain, just as so-called medical disorders are profoundly affected by psychological factors. Consequently, the delineation between psychiatry and the rest of medicine can increasingly be seen as only a matter of convenience and convention.

Traditional assumptions, however, continue to influence both service organization (with psychiatric services usually being planned and often situated separate from other medical services) and terminology (see below).

Where is psychiatry going?

Psychiatry is evolving rapidly, and three themes permeate this book:

- **Psychiatry, like the rest of medicine, is becoming less hospital based.** Most psychiatric problems are seen and treated in primary care, with many others handled in the general hospital. Only a minority are managed by specialist psychiatric services. So psychiatry should be learned and practised in these other settings too.

- **Psychiatry is becoming more evidence-based.** Diagnostic, prognostic and therapeutic decisions should, of course, be based on the best available evidence. It may come as a surprise to discover that current psychiatric interventions are as evidence-based (and sometimes more so) as in other specialties.
• Psychiatry is becoming more neuroscience based. Developments in brain imaging and molecular genetics are beginning to make real progress in the neurobiological understanding of psychiatric disorders. These developments are expanding the knowledge base and range of skills that the next generation of doctors will need. These developments do not, however, make the other elements of psychiatry – psychology and sociology, for example – any less important, as we will see later.

Why study psychiatry?

Studying psychiatry is worthwhile for all trainee doctors, and other health practitioners, because the knowledge, skills and attitudes acquired are applicable to every branch of medicine. Specifically, studying psychiatry will give you:

• A basic knowledge of the common and the ‘classic’ psychiatric disorders.
• A working knowledge of psychiatric problems encountered in all medical settings.
• The ability to effectively assess someone with a ‘psychiatric problem’.
• Skills in the assessment of psychological aspects of medical conditions.
• A holistic or ‘biopsychosocial’ perspective from which to understand all illness.

Useful knowledge

Formerly, patients with severe psychiatric disorders were often institutionalized and their management was exclusively the domain of psychiatrists. The advent of community care means that other doctors, especially GPs, encounter and participate in the management of such patients, so all doctors need basic information about these ‘specialist’ psychiatric disorders. Equally, all doctors need to recognize and treat the more common psychiatric illnesses, such as anxiety and depressive disorders. These are extremely prevalent in all medical settings, yet they are all too often overlooked and ineffectively treated.

Useful skills

Most psychiatric disorders are diagnosed from the history, and many treatments are based on listening and talking. So, psychiatrists have had to acquire particular expertise in interviewing patients, in assessing their state of mind and in establishing a therapeutic doctor–patient relationship – with patients who may pose challenges in this respect because of the nature of their problems. These skills remain important in all medical practice. For example, all doctors should be able to:

• Make the patient feel comfortable enough to express their symptoms and feelings clearly.
• Use basic psychotherapeutic skills – for example, knowing how to help a distressed patient and how best to communicate bad news.
• Discuss and prescribe antidepressants and other common psychotropic drugs with confidence.

Without these ‘soft’ skills, the ‘hard’ skills of technological, evidence-based medicine cannot be fully effective. An impatient, non-empathic doctor is less likely to elicit the symptoms needed to make the correct diagnosis, and their patient is less likely to adhere to the treatment plan they prescribe.

Useful attitudes

Psychiatric diagnoses are still associated with stigma and misunderstanding. These stem largely from the misconception that illnesses that do not have established ‘physical’ (or ‘organic’) pathology are ‘mental’, and that such ‘mental’ illness is not real, represents inadequacies of character, or is the person’s own fault. Studying psychiatry will help you to challenge these attitudes. You will see many patients with severe symptoms in whom no ‘organic’ pathology has been established, but who have real symptoms and disability. You will be repeatedly reminded of the stigma that patients with psychiatric problems experience from the public, and sometimes from their relatives and even, sadly, from health professionals. Finally, you will be confronted with the reality of human frailty. Recognizing these issues and dealing with them appropriately – by developing positive, educated and effective attitudes – is another important consequence of studying psychiatry. You might conclude, as we have done that:

• Suffering is real even when there is no ‘test’ to prove it.
• Psychological and social factors are relevant to all illnesses and can be scientifically studied.
• Much harm is done by negative attitudes towards patients with psychiatric diagnoses.

Your own experience and personality will influence your relationship with patients – your positive attributes as well as your vulnerabilities and prejudices.
How to start psychiatry

The psychiatric interview

The first, key skill to learn is how to listen and talk to patients, in that order. The psychiatric interview has two functions:

- It forms the main part of the psychiatric assessment by which diagnoses are made.
- It can be used therapeutically – in the psychotherapies, the communication between patient and therapist is the currency of treatment (Chapter 7).

Psychiatric assessment

Because of its central importance, the principles of psychiatric assessment are outlined here. The practicalities are described in the next two chapters. Psychiatric assessment has three goals:

1. To elicit the information needed to make a diagnosis, since a diagnosis provides the best available framework for making clinical decisions. This may seem obvious, but it hasn’t always been so in psychiatry.
2. To understand the causes and context of the disorder.
3. To form a therapeutic relationship with the patient.

Though these goals are the same in all of medicine, the balance of psychiatric assessment differs in several ways. Firstly, the interview provides a greater proportion of diagnostic information. Physical examination and laboratory investigations usually play a lesser, though occasionally crucial, role. Secondly, the interview includes a detailed examination of the patient’s current thoughts, feelings, experiences and behaviour (the mental state examination), in addition to the standard questioning about the presenting complaint and past history (the psychiatric history). Thirdly, a greater wealth of background information about the person is collected than in other specialties (the context).

Psychiatric assessments have a reputation for being excessively long. We take a pragmatic approach to the process of assessment. A basic psychiatric assessment is used to collect the essential diagnostic and contextual information (Chapter 2). Then, more detailed diagnosis-specific assessments are used if anything has led you to hypothesize that the patient has a particular disorder (Chapter 3). This two-stage basic and diagnosis-specific approach considerably shortens most assessments – to 45 minutes or less. It also happens to be what psychiatrists actually do – as opposed to what they tell their students to do.

Diagnostic categories

Solving a problem is always easier when you know the range of possible answers. Similarly, before embarking on your first assessment, it helps to know the major psychiatric diagnoses and their cardinal features. Table 1.1 is a simplified guide. As you gain experience, aim for more specific diagnoses that correspond to those listed in the International...
Classification of Diseases, 10th revision (ICD-10), which are used in this book (see Appendix 1). There is an alternative to ICD-10, published by the American Psychiatric Association, called the Diagnostic and Statistical Manual of Mental Disorders. It is widely used in research, and the controversial 5th edition (DSM-5) was published in 2013. The two systems are broadly similar. Whatever the classification, remember the underused category of ‘no psychiatric disorder’. A term such as ‘nervous breakdown’ has no useful psychiatric meaning – it may describe almost any of the categories in Table 1.1.

Psychiatric classification

The classification of psychiatric disorders has several problems that you should be aware of before you start:

- **Most diagnoses are syndromes, defined by combinations of symptoms, but some are based on aetiology or pathology.** For example, depression can be caused by a brain tumour (diagnosis: organic mood disorder), or after bereavement (diagnosis: abnormal grief reaction) or without clear cause (diagnosis: depressive disorder). This combination of different sorts of category leads to some conceptual and practical difficulties, which will become apparent later.

- **Comorbidity: many patients suffer from more than one psychiatric disorder** (or a psychiatric disorder and a medical disorder). The comorbid disorders may or may not be causally related, and may or may not both require treatment. As a rule, comorbidity complicates management and worsens prognosis.

- **Hierarchy: not all diagnoses carry equal weight.** Traditionally, organic disorder trumps everything (i.e. if it is present, coexisting disorders are not diagnosed), and psychosis trumps neurosis. This principle is no longer applied consistently, partly because it is hard to reconcile with the frequency and clinical importance of comorbidity.

- **Categories versus dimensions.** The current system assumes there are distinctions between one disorder and another, and between disorder and health. However, such cut-offs are notoriously difficult to demonstrate, either aetologically or clinically, whereas there is good evidence that there are continuums – for example, between bipolar disorder and schizophrenia, and for the occurrence of psychotic symptoms in ‘normal’ people. However, clinical practice requires ‘yes/no’ decisions to be made (e.g. as to what treatment to recommend) and so a categorical approach persists.

- **Psychiatric classification is not an exact science.** All classifications have drawbacks, and psychiatry has more than its share, as illustrated by the above points. Nevertheless, despite the imperfections, rational clinical practice requires a degree of order to be created, and most of the current diagnostic categories at least have good reliability, and utility in predicting treatment response and prognosis.

After the assessment: summarizing and communicating the information

Completion of the psychiatric assessment is followed by several steps:

- **Make a (differential) diagnosis**, according to ICD-10 categories (Appendix 1), using your knowledge of the key features of each psychiatric disorder.

- **Attempt to understand how and why the disorder has arisen** (Chapter 6).

- **Develop a management plan**, based on an awareness of the best available treatment (Chapter 7), how psychiatric services are organized (Chapter 8) and the patient’s characteristics, including their risk of harm to self or others (Chapter 4).

- **Communicate your understanding of the case** (Chapter 5).

KEYPOINTS

- Psychiatry is a medical specialty. It mostly deals with conditions in which the symptoms and signs predominantly relate to emotions, perception, thinking or memory. It also encompasses learning disability and the psychological aspects of the rest of medicine.

- Knowledge, skills and attitudes learned in psychiatry are relevant and valuable in all medical specialties.

- Be alert to the possibility of psychiatric disorder in all patients, and be able to recognize and elicit the key features.

- The major diagnostic categories are: neurosis, mood disorder, psychosis, organic disorder, substance misuse and personality disorder.
The basic psychiatric assessment

Learning objectives
✓ To understand the structure of a typical psychiatric assessment, including the history and mental state examination
✓ To develop a practical approach to the initial assessment of patients who present to psychiatric services, and to patients in other settings in whom you suspect a psychiatric problem
✓ To learn basic psychiatric terminology

Approaching a psychiatric assessment

The principles and goals of psychiatric assessment were outlined in Chapter 1. A ‘traditional’ first assessment interview includes an extensive search for symptoms and detailed, wide-ranging questions about the patient’s life history. Though comprehensive, this approach can take over an hour, which in many situations is unrealistic. We suggest a more flexible approach to assessment in which screening questions and other basic information (the basic psychiatric assessment; this chapter) are used to identify possible diagnoses, which are then confirmed or excluded by more focused assessment (diagnosis-specific assessments; Chapter 3). For a checklist of the areas to cover in a fuller psychiatric assessment, see Quick Guides.

The basic assessment described in this chapter is designed to obtain a clear account of the patient’s main problem(s) and screen rapidly but systematically for evidence of common psychiatric disorders. If your basic assessment or other sources of information make you suspect a particular diagnosis, you should use the appropriate diagnosis-specific assessment(s) from Chapter 3, which cover cognitive function, psychosis, mood disorders, anxiety disorders, eating disorders, substance misuse, somatic symptoms and the unresponsive patient. Each assessment guide is designed to determine whether a disorder in that category is present and, if so, to establish the specific diagnosis and elicit the appropriate contextual information. Box 2.1 gives examples of how an assessment might proceed. Assessment of childhood disorders, learning disability, sleep and sexual functioning are covered in their respective chapters. Risk assessment is described in Chapter 4.

Box 2.1 Using the basic assessment and diagnosis-specific assessments

Three examples show how an assessment may develop:
1 A woman complains of tiredness and feeling fed up. The basic assessment described in this chapter reveals evidence of depression and a recent increase in alcohol intake, but not of suicidal intent, psychosis or cognitive impairment. You proceed to the diagnosis-specific assessments for mood and substance misuse (Chapter 3). These assessments confirm the presence of a depressive disorder, but no significant alcohol problem.
A wife reports her 70-year-old husband is getting confused. Your initial suspicions are of dementia, so you do a diagnosis-specific assessment of his cognitive function. However, although his concentration is poor, he does not have typical memory loss or other symptoms of dementia. You decide to do a basic psychiatric assessment and you find evidence of depression, so you assess his mood, which leads you to a diagnosis of major depressive disorder.

A man is brought in having been found standing in the road naked, screaming at passers-by to stop irradiating him. You do not elicit any psychotic symptoms on the basic psychiatric assessment. Nonetheless, his presenting behaviour prompts you to do a diagnosis-specific assessment for psychosis. He may initially deny symptoms in case you are part of a conspiracy! Given that illicit drugs can produce this kind of behaviour, you also assess for substance misuse.

What is the mental state examination (MSE)?

All psychiatric assessments include a mental state examination (MSE) as well as the history. The scope of the MSE is a source of some confusion. Classically, the MSE is limited to those features present at the time of the interview, with everything else being in the history. Put another way, the MSE represents an objective cross-sectional description of the patient’s presentation. Is the MSE the psychiatric equivalent of the physical examination? This is partly true: the MSE is the occasion for the interviewer to note any signs of psychiatric disorder: for example, ‘The patient keeps looking anxiously around’. However, the MSE also includes formal descriptions of symptoms reported by the patient, for example, ‘he described third party auditory hallucinations which were command in nature’, and in this respect it overlaps with the history (Figure 2.1).

Components of the basic psychiatric assessment

The basic psychiatric assessment covers the areas shown in Table 2.1 and is outlined below. It consists of some pre-interview preparation, a history, a mental state examination, and possibly a physical examination. Variations on the structure presented here are common and often desirable: by responding flexibly to the direction the patient takes, rather than slavishly following a preconceived order of topics, you are likely to improve the history you obtain.

Before the interview

- Location: You will be discussing intimate, and sometimes distressing, topics. The room should be comfortable, and as soundproof as possible. This can be challenging, especially on medical wards.
- Safety: Occasionally patients may become disturbed or violent. Discuss with a senior member of staff – should you have a chaperone? Check local procedures – for example, are there panic buttons?

Figure 2.1 A comparison of medical and psychiatric assessments, showing the relationship of history, functional enquiry, mental state examination (MSE) and physical examination. Note the overlap between the components of the psychiatric assessment. For example, recent suicidal thoughts might be detected in the history or MSE; akathisia (restlessness) may be elicited as a symptom in the history or MSE or as a sign in the physical examination.
Arrange seating so you are closer to the door than the patient. Safety is a particular issue for home visits.

- **Setting:** Chairs are best arranged at ninety degrees to each other. If a desk is required for making notes, this should not be directly between the patient and the interviewer. Sit in a relaxed and slightly forward posture. Arrange not to be interrupted – turn off mobile phones and pagers whenever possible.

- **Information:** Read any referral letter and previous notes. These may provide a preliminary diagnostic hypothesis, clarify the reason for the referral and suggest lines of questioning. The notes can also help you to identify a possible ‘informant’ from whom to gain a corroborative history.

- **Approach the patient:**
  - Introduce yourself, check the identity of the patient, describe what you are suggesting and obtain consent. For example: ‘Hello, I’m a medical student and my name is X. Can I check that you are Y? … Thank you. Would you mind if I ask you some questions about what has happened to you? … Thank you. If it’s okay with you, we’ll go into an interview room to talk. This shouldn’t take more than 20 minutes, and if you want to stop at any point, you can just say.’
  - Emphasize confidentiality. If notes are to be taken, explain why.
  - Establish the patient’s expectations for the interview.

### The basic history

As in the rest of medicine, the history focuses on the problems the patient complains of. However, in the psychiatric history, there is a greater emphasis on the person’s personality, life experiences, current circumstances and other contextual information. This ‘background history’ is a crucial part of the psychiatric assessment. It can enhance the therapeutic relationship by demonstrating an interest in the patient as a person. It can help to identify causes or precipitants for

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**Table 2.1 The basic psychiatric assessment. See Appendices 1 and 2 for a fuller checklist of points to cover during the history and MSE**

<table>
<thead>
<tr>
<th>Before you begin</th>
<th>• Information (referral letters, notes), location, safety</th>
<th>• Introduction, consent, establish expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic details</strong></td>
<td>• Method of referral</td>
<td>• Age, marital status, occupation, current living arrangements</td>
</tr>
<tr>
<td><strong>Basic history: current problems and background history</strong></td>
<td>• Presenting complaint(s), and their history</td>
<td>• Past psychiatric history</td>
</tr>
<tr>
<td></td>
<td>• Past history and premorbid personality</td>
<td>• Family history</td>
</tr>
<tr>
<td></td>
<td>• Social history (current circumstances)</td>
<td>• Personal history</td>
</tr>
<tr>
<td></td>
<td>• Substance use: smoking, alcohol and illicit drugs</td>
<td>• Forensic history</td>
</tr>
<tr>
<td></td>
<td>• Forensic history</td>
<td>• Past medical history and drug history</td>
</tr>
<tr>
<td><strong>Basic mental state examination</strong></td>
<td>• Appearance and behaviour</td>
<td>• Speech</td>
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<td></td>
<td>• Mood</td>
<td>• Thoughts</td>
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<td><strong>Risk assessment</strong></td>
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<td><strong>Physical examination</strong> if necessary</td>
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<td><strong>Corroborative history</strong> if possible</td>
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<td><strong>Investigations</strong> as necessary</td>
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mental health problems such as bereavement, childhood abuse or financial worries. It may also reveal personal factors that affect management, such as the presence of a supportive partner to supervise medication.

How much background information you should seek depends on the nature of the patient’s problems, and what is already known. For example, in general practice the patient’s circumstances may be well known; for a woman newly referred to your out-patient clinic, more detailed questioning might be needed.

Some of the questions may feel invasive, to you or to the patient. Some tips …

- **Signpost:** ‘I’d like to ask about topics which are a bit more personal. Is that okay?’
- **Acknowledge embarrassment:** ‘I know these things are difficult to talk about …’
- **Normalize:** ‘You’ve told me how ..., some people when they feel like that can ... Is that something you’ve felt?/Have you had any problems like that?’
- **Are you the right person at the right time to be asking these questions?**

It can be hard to strike a balance between keeping control of the interview and allowing the patient sufficient time to answer questions fully and in their own way. As well as responding to what the patient says, be sensitive to non-verbal clues such as facial expression, posture and tone of voice.

**Basic details**

- Clarify the method of referral, if unclear from the notes.
- Clarify the patient’s age, marital status, occupation and living arrangements.

**Presenting complaint(s) and their history**

- Start with open questions: ‘What do you think is the main problem? How have you been feeling?’
- Closed (but not leading) questions are used to clarify the responses: ‘You say you’re not sleeping well: can you tell me a bit more about that? What time do you wake?’
- Encourage the patient to list their main problems and describe each in their own words. ‘Do you have any other problems?’
- Assess the nature, duration and progression of each of the symptom(s).
- Are there any precipitating and relieving factors?
- Assess the degree of functional impairment: effect on relationships, work, sleep, etc.
- How have others perceived the problems: ‘What did your friends say about you when you were feeling like that?’
- Treatments tried for the current problem.

**Box 2.2 Screening for alcohol problems**

**The FAST questions**

1. How often do you have eight or more drinks on one occasion?
2. How often during the past year have you failed to do what was normally expected of you because of drinking?
3. How often during the past year have you been unable to remember what happened the night before because you had been drinking?  
   [For these questions, score 0 for never, 1 for less than monthly, 2 for monthly, 3 for weekly and 4 for daily or almost daily.]
4. Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?  
   [For this question, score 0 for never, 2 for yes but not in past year, 4 for yes, in the past year.]

The maximum score is 16, and a score of 3 or more indicates hazardous drinking. You may not need to ask all four questions: if you find out on Q1 that the patient drinks eight or more drinks at least weekly, she or he has already reached the threshold for hazardous drinking, so move straight to a full assessment of substance misuse (p. 35) and consider administering the AUDIT questionnaire (p. 36). Note that the FAST questions do not screen for alcohol dependency, which is better picked up by the CAGE questions.

**The CAGE questions**

The CAGE is an alternative and widely used alcohol screening tool. Its four questions are:

1. Have you ever felt you ought to Cut down on your drinking?
2. Have people Annoyed you by criticizing your drinking?
3. Have you ever felt Guilty about your drinking?
4. Have you ever had a drink first thing in the morning (an ‘Eye-opener’)?

If three or more yes answers are given, the likelihood ratio for problem drinking is 250.

Getting a list of the patient’s problems allows you to start generating diagnostic hypotheses. Some problems will be symptoms (e.g. agitation); others will represent the patient’s predicament (e.g. homelessness). The diagnostic importance of a particular symptom is affected by its characteristics (intensity, fluctuation, duration, etc.), associated features and
functional impact. Knowing the relevant information to elicit comes rapidly with increasing knowledge and experience. A useful acronym is ‘NOTEPAD’: Nature, Onset, Triggers, Exacerbating/relieving, Progression, Associated symptoms, Disability. Get answers that are as precise as possible – for example, estimates of symptom duration. Finally, don’t ignore ‘medical’ symptoms. A brief functional enquiry to elicit these should be included.

Past psychiatric history

- Nature of any previous psychiatric contact: ‘Have you ever been an inpatient in a psychiatric hospital? Have you ever been in contact with the community mental health team? Were you given a diagnosis?’
- Treatments used for previous episodes of psychiatric illness and their effects.
- Self-harm and harm to others: ‘Have you ever harmed yourself or tried to kill yourself? Have you ever hurt anyone else?’

About 50% of psychiatry referrals have had prior psychiatric contact. A previous diagnosis is best seen as a strong hypothesis to be tested. Keep an open mind – the new problem may be different, or the previous diagnosis might be wrong. Past history may also provide useful information about prognosis and the patient’s attitude to their disorder and its management.

Family history

- Family tree - ask the ages, occupations and health of, at a minimum, parents, siblings and children. Draw out the tree.
- Quality of the family relationships: ‘How do you get on with your family?’ Problems in family relationships are commonly associated with psychiatric disorder.
- Family psychiatric history: ‘Has anyone in your family had problems like you’re having now?’ Also ask about suicide, self-harm or substance misuse. A positive family psychiatric history is a risk factor for most psychiatric disorders, for both genetic and environmental reasons.
- Brief family medical history.
- Any recent events in the family.

Personal history and premorbid personality

- Pregnancy, birth and childhood – ‘Are you aware of any problems around your birth or during your mother’s pregnancy with you? Did you walk and talk at the right age, as far as you know?’, childhood health problems, maltreatment.
- Education – did the patient enjoy school? bullying? finish school? special education classes?
- Occupations and reasons for changes, military service, job satisfaction.
- Relationships – number, duration, type, gender.
- Traumatic events – ‘In your life, have you ever had a particularly horrible or frightening experience?’ Exposure to suicide or self-harm is worth exploring specifically as it is a risk factor for those behaviours in the patient.
- Premorbid personality’ – the patient’s usual character, interests, belief and habits. ‘How would your friends describe you? How do you cope in a difficult situation? Would you describe yourself as a loner or very sociable?’ (offering alternatives can be helpful) ‘Do you believe there is something beyond us, like God? Is religion important to you?’

Aspects of childhood can be associated with subsequent psychiatric disorder; for example, conduct disorder is associated with dissocial personality disorder, and childhood abuse is associated with all psychiatric disorders. The pattern of past relationships can give diagnostic clues, such as an absence of close relationships in schizoid personality disorder, or many turbulent ones in borderline personality disorder. The nature of employment may give clues to the patient’s level of functioning. A deteriorating or disrupted work record may reflect a psychiatric disorder or a personality trait, respectively. The premorbid personality shapes the risk, type and prognosis of psychiatric disorder. Note that a patient’s view of their personality and life may be distorted during psychiatric illness; for example, a depressed person will report themselves in an unduly negative light. Third party information may be useful in such cases. Questions on sexual history and functioning may be necessary at this stage, but detailed or especially sensitive discussion on this topic may better be deferred until a later stage.

Social history (current circumstances)

- Current relationships: ‘Do you have a partner at the moment? Are they a man or a woman?’ (never assume gender).
- Self-care and support: ‘Do you feel able to look after yourself at the moment?’ Who is there to support the patient, and who is dependent on the patient?
- Current employment.
- Current worries – finances, housing, relationship, etc.
- It can be helpful to ask the patient to describe a typical day.
Current relationships are important: they may contribute to the present disorder or have been damaged by it. Having a supportive partner improves outcome and assists management. Ongoing worries and stresses can perpetuate psychiatric disorder; their resolution is often part of management – for example, helping the patient sort out a housing problem. All patients with severe psychiatric disorder should have an assessment of needs (p. 84). Detailed information about the current circumstances is an essential component of this.

**Alcohol and drug use**

- ‘*Do you drink alcohol?*’ Record the amount per week in units. If the patient drinks alcohol regularly, ask the four FAST or CAGE questions (Box 2.2). They take about 20 seconds.
- ‘*Have you ever used recreational drugs?*’ If so, quantify the amount used: ‘*How much do you spend on X per week?*’ can give a good guide and is often more accurate than asking the patient to estimate weights consumed. You can ask the CAGE questions for each recreational drug used.
- Impact on the patient’s life: ‘*Has your drinking/drug use ever got you into trouble in your relationships? At work? With the law?*’

Alcohol and other drugs may be a cause, a component or a consequence of many psychiatric disorders, so should always be asked about. The recommended limits for alcohol intake are 21 units per week for men and 14 for women. One unit is half a pint of beer, a single measure of spirits, or a small glass of wine. Try out the NHS Choices Drinks Tracker free desktop and mobile app to calculate units per week.

**Forensic history**

- ‘*Have you ever had contact with the police? Were you charged? What happened?*’
- If there were incidents, did these relate to previous episodes of mental illness?

Having a ‘forensic history’ (i.e. a criminal record) may be directly related to a psychiatric disorder or be a coincidence. A history of violence will affect management regardless.

**Past medical history and drug history**

- ‘*Have you had any medical illnesses or operations?*’
- Current medication and adherence: ‘*Which ones do you usually take? Do they give you any side effects?*’
- Complementary therapies used.
- Allergies (important for the management plan).

Medical disorders can cause and be caused by psychiatric disorder, and the drugs used to treat psychiatric disorder may also cause medical problems. This co-dependence of mental and physical morbidity means that physical illness is common in people with psychiatric disorders, but it is often undiagnosed. Some patients forget that they have depot medication as it is administered by a nurse every few weeks. It is always worth asking specifically about injections.

**The basic mental state examination (MSE)**

The basic MSE described here concentrates on aspects of the recent mental state that are commonly affected by psychiatric disorder and that have diagnostic weight. Much of the MSE will have been covered in the history or from observations made in passing. However, the MSE is still useful to ensure (and to document) that you have checked for all important recent phenomena and provides a point of comparison over time. When you present your findings, you should clearly separate the history from the MSE. The headings of the basic MSE are:

1. **Appearance and behaviour** – an underestimated source of diagnostic information.
2. **Speech** – abnormal speech may be present in neurological, psychotic and mood disorders.
3. **Mood** – subjective and objective accounts of mood and its reactivity and congruency (terms explained below).
4. **Thoughts** – thought content, and the way thoughts flow, are affected in many psychiatric disorders. The nature of the abnormalities gives important diagnostic clues.
5. **Perceptions** – mainly affected in psychotic and organic disorders. Less florid alterations in sensory experiences also occur in anxiety disorders.
6. **Cognition** – cognitive impairment is characteristic of dementia and delirium, but can also occur in other disorders such as depression. If severe, it may make history-taking very difficult.
7. **Insight** – lack of awareness of illness is classically a sign of psychosis or ‘organic’ disorder. In all disorders, the patient’s views as to the nature and significance of their problems are important, not least since they may affect their views about the need for (and choice of) treatment.

1. **Level of consciousness:** alert/hypervigilant/sleepy.
2. **Appearance:** dress, posture, self-care, apparent body mass index (BMI), self-harm/intravenous drug use, smell.