Psychiatry

CLINICAL CASES UNCOVERED

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Introduction

Psychiatry is the ultimate clinical speciality. No other branch of medicine relies so much on empathic listening skill and the integration of biological, psychological and sociological theory to unravel a patient's story into a coherent aetiological formulation. Whether you hope to call yourself a psychiatrist or are just passing through, be aware that this is a golden opportunity to acquire competencies that will serve as foundations for your working life (e.g. understanding reactions to illness and adversity, the relationships between physical and mental health, working with 'difficult' patients and relatives, and keeping your cool in unpredictable situations).

The focus throughout the book is on developing your clinical reasoning and core competencies up to a standard of passing undergraduate examinations, workplace-based assessments of your early years as a doctor, and beyond. Part 1 is a guide to psychiatric assessment and introduces the range of treatment options, Part 2 is a collection of case studies covering the range of mental disorders, and Part 3 is for self-assessment. Ultimately, clinical judgement comes from experience, and the more patients you encounter, the more skilled you will become. Some clinical dilemmas have no 'textbook' right answer. Medical professionalism is based on working within our shared ethical framework (Box A); whenever the rights and wrongs of a situation are opaque, it can be helpful to return to these first principles to determine your action.

You will get the most from the case studies by stopping to answer every question posed as the responsible doctor. The cases vary in complexity, beginning with easier ones. An index of cases by diagnosis is provided on p. 223 – useful for revision or if you want to select a case for peer group learning or tutorials. All cases are amalgams of patients and situations we have come across, and none describe identifiable individuals.

In relation to diagnoses, we have used the World Health Organization's categorization of mental disorder, the ICD-10 (International Classification of Diseases). The terms here are used to describe disorders, not people: people with borderline personality disorders or schizophrenia are not 'borderlines' or 'schizophrenics'.

Box A The duties of a doctor

Patients must be able to trust doctors with their lives and health (General Medical Council: www.gmc-uk.org). To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
- Keep your professional knowledge and skills up to date
- Recognize and work within the limits of your competence
- Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
- Treat patients politely and considerately
- Respect patients' right to confidentiality
- Work in partnership with patients
- Listen to patients and respond to their concerns and preferences
- Give patients the information they want or need in a way they can understand
- Respect patients' right to reach decisions with you about their treatment and care
- Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
- Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
- Never discriminate unfairly against patients or colleagues
- Never abuse your patients' trust in you or the public's trust in the profession

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Diagnoses do not define identity, and they need to be used sensitively in mental health.

We have both been lucky enough to learn through great clinicians we have been taught by and worked with, and from the generosity of our patients. None of us can fully understand what something is like until we experience it ourselves, and first-hand accounts of mental disorders that we have found valuable are listed in Further reading below. You will not need them to pass exams, but they are worth reading to balance your clinical experience and reading with the realities of mental illness and its consequences.

Peter and Nicola Byrne
2008

Further reading

Sunbathing in the Rain: A Cheerful Book about Depression. Gwyneth Lewis (2007) HarperCollins. The author is a poet, and her experience of a severe depressive episode is charted as her investigation into the mystery of how she came to arrive at the point of psychological collapse. She re-evaluates assumptions about depression as simply a problem, exploring its meaning for her and its potential role as a signal that her life needed to change. Comprising a series of short sections which can be dipped into, she speaks to those involved in caring for depressed people, and those currently depressed themselves and unable to digest long tracts of text.

An Unquiet Mind. Kay Redfield Jamison (1995) Vintage. A psychiatric 'classic', the author is an eminent American professor of psychiatry who describes her experience of bipolar affective disorder. With frequent intersections between the personal and the scientific, it is widely read by professionals and patients.

Smashed: Growing Up a Drunk Girl. Koren Zailckas (2005) Ebury Press, London. A young woman's experience of using alcohol to avoid social anxiety and uncomfortable emotions in the transition into adulthood. Gives a good – albeit retrospective – account of her innate predisposition to becoming addicted, illustrating how some people might powerfully 'take' to a substance after only limited exposure, which can seem bewildering to people with no such inclination. The collateral damage of substance misuse to her close relationships and the striking descriptions of her physical and sexual vulnerability when drunk are complicated by the blank horror of her alcohol-induced amnesia.

Drinking: A Love Story. Caroline Knapp (1999) Quartet Books, London. An account of alcohol addiction from the perspective of a highly functioning journalist from a 'respectable' middle-class background, who goes on to seek help from Alcoholics Anonymous (AA). Provocative reading for those who drink to excess socially or to relieve stress, and for whom the line between harmless and harmful drinking may not always be clear.

Beyond Crazy: Journeys Through Mental Illness. Julia Nunes and Scott Simmie (2002) McClelland and Stewart, Toronto. Compiled by two successful Canadian journalists, the whole range of mental disorders is presented, written in different styles and from many perspectives, but the book ends with clear explanations and useful advice. Almost every account moves logically from setting out painful, real experiences to discovering universalities that promote understanding and recovery.

Speaking Our Minds: An Anthology. Jim Read and Jill Reynolds (1996) MacMillan, London. An anthology of writing from over 50 individuals, from diverse perspectives and backgrounds, who have experienced mental distress and have had various forms of treatment. Useful to understand the nature of their difficulties and what authors did and (frequently) did *not* find useful from mental health services.

Is That Me? My Life With Schizophrenia. Anthony Scott (2002) A. & A. Farmer, Dublin. A deeply personal account of a life punctuated by schizophrenia. Written in an honest and direct style, the author is generous to the people who helped him along the way and reflective about the obstacles to his full recovery.

Born on a Blue Day. Daniel Tammet (2006) Hodder. A unique account of how a man with Asperger's syndrome experiences reality, filtered through his relationship with words and colours. Unusually, he is able to explain the nature of his 'savant' mathematical abilities and to describe the mutual incomprehension between him and those around him growing up. It is also an impressive account of someone transcending their own limitations.

Stuart: A Life Backwards. Alexander Masters (2005) Fourth Estate, London. Strictly speaking a biography, this is a life story traced backwards, starting from Stuart's adult position as a chaotic, homeless, 'personality-disordered' and at times violent drug-user existing in a social underclass. The author is one of his care-workers and (like most doctors) hails from a

background of relative advantage and security that is in marked contrast to Stuart's. The book is simultaneously an account of his relationship with Stuart, often characterized by mutual irritation and exasperation. Stuart's behaviour initially appears bewildering, but increasingly makes sense as we are led backwards to its origins. In turns hilarious and terrifying, his story is a challenge to instinctive reactions to reject this type of 'difficult' patient.

Telling is Risky Business: Mental Health Consumers Confront Stigma. Otto Wahl (1999) Rutger's University Press, New Brunswick. This is a catalogue of people's experiences of isolation and misunderstanding by others as a result of their mental illness. Drawing on first-hand accounts of stigma, it demonstrates how negative stereotypes have invaded every aspect of Western culture to make discrimination against 'those people' the norm, not the exception.

How to use this book

Clinical Cases Uncovered (CCU) books are carefully designed to help supplement your clinical experience and assist with refreshing your memory when revising. Each book is divided into three sections: Part 1, Basics; Part 2, Cases; and Part 3, Self-Assessment.

Part 1 gives a precis of history and examination, and key treatments based on best evidence. Part 2 contains many of the clinical presentations you would expect to see on the wards or crop up in exams, with questions and answers leading you through each case. New information, such as test results, is revealed as events unfold and each case concludes with a handy case summary explaining the key points. Part 3 allows you to test your learning with several question styles (MCQs, EMQs and SAQs), each with a strong clinical focus.

Whether reading individually or working as part of a group, we hope you will enjoy using your CCU book. If you have any recommendations on how we could improve the series, please do let us know by contacting us at: medstudentuk@oxon.blackwellpublishing.com.

Disclaimer

CCU patients are designed to reflect real life, with their own reports of symptoms and concerns. Please note that all names used are entirely fictitious and any similarity to patients, alive or dead, is coincidental.

Approach to the patient

Psychiatric histories are complex. The challenge is to cover a wide range of areas in a limited time, often with the patient at a time in their lives where they are least able to give a coherent account of themselves.

This section begins with the content of the assessment – the 'what': **history, mental state examination (MSE), physical examination** and **formulation**. You will come across different versions of the interview schedule in terms of the ordering and grouping of information – find a version that makes most sense to you and stick to it. We outline our preferred version here. The second part of this section looks at the process of conducting interviews, or the 'how'.

History

History-taking has been compared to shining a torch around a dark room. Initially, you need to use a systematic approach to find what you are looking for, using an established framework to structure your history (Table 1), until you know instinctively where to focus your attention. A comprehensive assessment will take about an hour depending on the patient. For example, when interviewing an adult in crisis in accident and emergency (A&E), focus on the presenting problem, role of substance misuse if any, medical and psychiatric history, pertinent current social circumstances and indicators of risk. By contrast, the planned psychiatric outpatient assessment of an adolescent will be a time-intensive process, covering detailed family, personal and developmental history, including collateral information from the parents and, if possible, their family doctor and school.

Table 1 details the content of the history. When presenting a history, verbally or in writing, introduce the case with a brief **background** to put the information that follows in a specific context (i.e. who the patient is; when, where and why you were interviewing them).

The **presenting complaint/history of presenting complaint** should use the patient's own words to describe their problems (e.g. 'I just feel numb') not the technical labels for them. These come later in the MSE ('affect was depressed'). The structure echoes that of any medical history, covering symptom onset, trajectory and relationship to other problems. Differentiate between the patient's report and that of others. *Relevant negative findings* are included as they help signpost towards your differential diagnoses later (e.g. if schizophrenia is the primary problem, list the lack of mood symptoms that exclude bipolar disorder).

Family history explores biological (e.g. genetic) vulnerability to illness as well as formative experiences (e.g. losses and dysfunctional relationships). In the **personal** history you are looking for evidence of developmental problems (normal development is summarized in Table 2), getting a sense of the family atmosphere in which they grew up, and exploring their capacity to form relationships and to direct the course of their lives (school, occupation). **Social circumstances** indicate level of current functioning, and the social network that supports this.

The **substance misuse** history may permeate all the other areas of the history, but needs to be addressed in its own right to clarify all the important information (for the worked example of alcohol see Box 1).

Under **medical**, specifically enquire about a history of epilepsy or head injury. Ask women about their obstetric history (e.g. number of pregnancies, miscarriages, terminations of pregnancy) and older patients about vascular risk factors.

If past **psychiatric** history indicates a relapsing recurring disorder, explore why things were better during periods of relative health.

Any **forensic** history may well link to **premorbid personality** in terms of social habits (e.g. binge drinking), impulse control and capacity for remorse/victim empathy. A history of violence not formerly prosecuted should also be included here: past violence is the best predictor of future violence.

Table 1 The psychiatric history.

Background to assessment

- Basic **demographics**: name, age, gender, ethnic background, marital status, children, type of employment and if currently unemployed, for how long?
- **Current treatment status**: any established diagnosis; nature of current involvement with psychiatric services; if an inpatient, voluntary or involuntary admission
- **Context of your interview**: who referred the patient, where you saw them

Presenting complaint

- In the patients **own words** (e.g. 'There's nothing wrong with me. I've no idea why I'm in hospital')

History of presenting complaint

- **What** is the problem? **When** did it start? **How** did it develop: onset/progress/severity/consequent impairment (e.g. unable to work, end of a relationship)
- What makes it **better** or **worse**; **relationship to other problems**
- **Relevant negative** findings
- **Collateral** history from informants (e.g. friends, family, GP, work colleagues). Note any contradictions

Family history

- **Family structure** describes biological/adoptive/step-parents and siblings: age, state of health or cause and age of death, occupations, quality of relationships. Currently, who supports the patient and who exacerbates their problems?
- **Family history of mental disorder** includes substance misuse, suicide

Personal history

- **Obstetric and birth**: conception planned/unplanned, wanted/unwanted; maternal physical and mental health during pregnancy and postnatally, any prescribed medication or substance misuse; birth full-term/premature, obstetric events and complications, low birth weight, congenital abnormalities, neonatal illness, maternal separation and bonding
- **Development and milestones** (Table 2): delays in interaction with others, speech; motor control, walking, toilet training; sleep difficulties; emotional or behavioural difficulties, hyperactivity; physical illness
- **Family atmosphere and stability**: e.g. warm and caring; abusive; emotionally impoverished or volatile; material circumstances; periods of separation from caregivers (e.g. in hospital due to childhood illness; in foster care due to parental difficulties)
- **Social development**: establishment of friendships, imaginative play, experience of bullying, any juvenile delinquency
- **Educational attainment**: specific learning difficulties, school refusal, age left education and qualifications
- **Occupation**: periods of employment, nature of work/skills
- **Psychosexual**: age of first sexual experience, sexual orientation, number, length and quality of significant relationships, marriage(s), children from all previous relationships

Social circumstances

- **Housing** situation (e.g. renting, numbers of people in the house), **employment**, **finances**, **benefits**, **debts**
- Daily **activities**
- Sources of family and social **support**

Substance misuse history

- **Alcohol** use, amounts (Box 1)
- **Illicit substance** use: type, pattern of use including frequency, dependency; associated problems – occupational, social, relationship, health and criminal activity
- Abuse of any **prescribed** or **over-the-counter** medications

Medical history

- Past and current **physical illness** and **treatment**, allergies
- Current **medication**, including any over-the-counter drugs taken regularly

Table 1 (*Continued*)

Past psychiatric history

- **Age** of onset of symptoms and first contact with services (there is always a time gap); nature and progression of difficulties; **diagnoses**
- **Hospital** admissions: when, length, voluntary or under section
- Past **treatment** – medication, psychological, ECT: what has helped in the past, what has not, medication type, doses prescribed and actual doses taken (i.e. concordance with prescription); history of side-effects

Risk history

- **Risk episodes**: deliberate self-harm (**DSH**) and **suicide attempts**; **self-neglect** and **exploitation** by others (financial, sexual), thoughts of and actual **harm to others**
- **Context** of episodes, **worst harm resulting**

Forensic history

- **Arrests, charges and convictions**: nature of offences, outcome (custodial sentence, community service, probation)
- Include criminal activities where patient was **not arrested, crime not detected**

Premorbid personality

- When did they last – or have they ever – felt 'normal': what is normal for them, how is that different to now?
- General: how would they describe themselves, how would friends/family describe them?
- Specific:
  - **Character** traits (e.g. anxious, sensitive, suspicious, dramatic): 'how would you describe yourself as a person?'
  - **Prevailing mood** and **stability of mood**
  - **Impulse control**
  - **Nature of relationships with others**: partners, friends, colleagues (e.g. close and confiding, casual only)
  - **Leisure** interests (hobbies)
  - **Spirituality** and religious affiliation
  - **Tolerance of stress** and coping style, including use of substances to manage stress, modify mood or facilitate social interaction

ECT, electroconvulsive therapy.

Mental state examination

The MSE describes the *here and now* at interview, analogous to a physical examination. If recent symptoms such as hearing voices or sleeping poorly are not present at interview, they should be mentioned in the presenting complaint rather than here. If current symptoms are discussed in the presenting complaint, do not repeat that detail here: the MSE is the place to summarize and classify. For example, if a presenting complaint describes an account of persecution from neighbours, the MSE would simply state 'evidence of persecutory delusional beliefs regarding neighbours, as described'.

Table 3 details the content of the MSE. **Appearance and behaviour** sketches a portrait of the patient. If you are presenting the patient's details over the telephone, the listener should be able to picture that patient. This description will be your main finding in patients who are unable or choose not to engage with the interview.

Speech can elucidate the more subtle cognitive deficits of schizophrenia or developmental disorders such as autism. If you are unable to access or clarify the subjective **mood**, **thought content** or **perceptual experiences** of a reluctant or incapacitated historian, this is not (hopefully) a failure of your examination, but a finding in itself: when presenting do not stumble over information not obtained, state clearly why that was the case (e.g. 'Unable to access thought content as the patient declined to answer questions' or 'Evidence of some poorly elaborated persecutory delusional thinking regarding staff, but the content of these beliefs unclear due to the degree of their thought disorder as previously described'). An essential part of the mood MSE is to clarify the degree of **suicidal ideation** and **intent** and/or any **thoughts of harming others**.

Cognition is often briefly described in terms of orientation in time, place or person. Asking patients to

Table 2 Normal development and developmental milestones.

Stage	Normal development	Milestones: at approximate ages
Up to 1 year **Infancy**	*Social:* formation of secure relationship with main carer/s *Motor:* balance, sitting, crawling, walking	*Smiling:* 3 weeks; selective smiling 6 months *Speech:* cooing 2 months, babbling 6 months, first words: 40 weeks to 1 year *Walking:* first steps 1 year
Up to 2 years **Year 2**	*Continued social:* keen to please parents, anxious if meets with disapproval	Short-lived temper tantrums: 'the terrible two's' *Speech:* 3-word sentences *Motor:* sphincter control, jumps, laterality
2–5 years **Preschool years**	Rapid language development and curiosity (questions++); learns place in the family, gender role	Tantrums subside, development of fantasy life/ imaginative play *Speech:* ↑↑vocabulary, subtle voice tones, end of 'baby talk' *Motor:* full postural control
5–10 years **Middle childhood**	Learns role at school and in wider community/ society	*Speech:* inflection, pronunciation and abstract talk. Reading and writing *Motor:* boys better gross motor skills than girls
11 years + **Adolescence**	Puberty 11–13 for girls, and 13–17 for boys; described as a period of emotional turmoil	Increased self-awareness and moves towards autonomy. Complex social interactions: peer groups become more important, intimate relationships begin

Box 1 The alcohol history

Screening

In general medicine, a commonly used screen is the **CAGE**: have you ever felt you needed to **C**ut down your drinking; felt **A**nnoyed by others criticizing your drinking; felt **G**uilty about your drinking and/or needed an **E**ye-opener in the morning to steady your nerves. Two or more suggest a significant problem, and merit full enquiry.

Alcohol history

- **Amount consumed weekly** in units: 1 unit = half a pint of regular strength beer, a small glass of wine (125 mL), a small (liqueur) glass of fortified wine (e.g. sherry) or a *single* measure of spirits. One bottle of wine is 7 units; fortified wines are higher. Many popular beers in the UK are stronger and wine is served in larger glasses. One bottle of spirits contains 30 units
- **Pattern of use**: binges, steady intake over the week, throughout the day
- **Features of dependency**: **compulsion**; **increased salience** of drinking; **difficulties controlling use** despite harm; **tolerance**; physiological **withdrawal** as blood alcohol levels fall. Withdrawal manifests as a range of symptoms:
  - *mild:* tremor, nausea or retching, mood disturbance, sleep disturbance
  - *moderate:* perceptual distortions and hallucinations
  - *severe and potentially life-threatening:* full-blown delirium tremens (confusion, terror, severe tremor, seizures, leading to coma and death)
- **Harm from use**: **physical, mental, relational, occupational, criminal** (Table 18, p. 62)

Table 3 The mental state examination (MSE).

Appearance and behaviour

General appearance, physical state, abnormal movements, behaviour and rapport

- Style and manner of **dress**, **hygiene**: self-neglect
- **Physical state**: signs of physical illness, drug/alcohol withdrawal, self-harm scars
- Manner of **engagement** during interview (e.g. suspicious/guarded/relaxed). Quality of **eye contact** (e.g. fixed stare, avoidant). **Distractibility** and preoccupation with internal world (e.g. appearing to respond to auditory hallucinations)
- **Motor** movements: involuntary **tics, chorea, tremor, tardive dyskinesia** (repetitive movements, typically orofacial, due to high-dose antipsychotics) and **akathisia** (external manifestation of internal sense of restlessness, again a side-effect of antipsychotics). **Motor stereotypies** are regular repetitive non-goal directed movements (e.g. rocking). **Mannerisms** are idiosyncratic goal-directed behaviours (e.g. style of walking). **Catatonic** symptoms include 'automatic behaviours' such as *echopraxia* and *echolalia* (imitation of interviewer's movements and speech, respectively), *perseveration* (repetition of a movement, words/syllables or maintenance of a posture once context has passed), *forced* (automatic) *grasping* of objects offered. Catatonia is a rare motor manifestation of schizophrenia or frontal lobe lesions
- **Hyper-/hypoactivity**: relevant in delirium and mood states

Speech

Rate, amount, form and coherence

- Increased/decreased; fast/slow; loud/soft
- **Verbal stereotypy**: repetition of irrelevant words or phrases
- **Formal thought disorder** disruption to the continuity of thought. Answers may be initially appropriate but **circumstantial**, straying far from the topic before returning or **tangential**, where they do not return. The latter represents mild **derailment**, with more severe forms seeing the juxtaposition of completely irrelevant ideas, also known as **loosening of associations**. The most extreme form of thought disorder is known as **word salad** where meaning is indecipherable. **Flight of ideas** in hypomanic/manic states is the rapid transition between topics via internal links (connected words, themes, rhyming, alliteration e.g. 'Black cats scare me, I've a black bag'), or the inclusion of external distractions into the train of thought (e.g. subsequent comments on interviewer's black shoes)
- **Poverty of thought** describes insubstantial speech that conveys little meaning
- **Neologisms**: words or phrases invented or used idiosyncratically to denote new meaning ('I don't like my boss: he's a bosstard')

Mood

Subjective mood, objective affect; thoughts of self-harm and of harming others

- *Subjectively* patient description of their *current* mood: rated out of 10, with 0 lowest; it is useful to rate their 'usual' mood
- *Objectively* interviewer's appraisal of their **affect** (external manifestation of emotional state) and emotional range during interview, **euthymic** (within normal range) and normal reactivity/**incongruous** affect given context/**perplexed/blunted** emotional range
- **Presence or absence of thoughts of self-harm** or **harming others**, state any **plans** and **degree of intent** (e.g. passive death wish, suicidal ideation or suicidal intent)

Thought content

Morbid preoccupations (i.e. ruminations), obsessions, overvalued ideas, delusions

- **Obsessions**: repetitive, intrusive, unwanted, stereotyped thoughts or images
- **Overvalued ideas**: those held with a morbid intensity, but without fulfilling the criteria for a delusion. They are not argued beyond the bounds of reason (e.g. patients with anorexia nervosa are not deluded but have overvalued ideas about their weight)
- A **delusion**: a fixed (usually false) belief held without evidence that is out of keeping with an individual's sociocultural background. Delusions may be primary or secondary. **Primary** (delusional mood, perception and autochthonous delusions) occur out of the blue (i.e. without prior morbid experience). **Delusional mood** is an unpleasant sense that surrounding events refer to oneself. As the mind abhors a vacuum, delusional mood is usually resolved by the formation of an explanatory sudden delusional idea (an '**autochthonous**' delusion): delusional mood is unlikely in a current MSE but may be recalled retrospectively. **Delusional perception** is the sudden attribution of self-referential meaning to a normally perceived object (e.g. 'The position of that cup on the table means I will be famous'). **Secondary** delusions (usually) evolve from pre-existing morbid psychological processes (altered mood, hallucinations, other delusions). They include delusions of **persecution, grandiosity, reference, guilt, poverty, nihilism** (i.e. extreme negation of self or world; e.g. believing part of the body has died). **Passivity** describes the experience that one's mind (thought passivity), emotions, actions, will or body (somatic passivity) is not under one's control. They include **thought insertion**, **withdrawal** and **thought broadcast** (loss of the sense of barrier between one's mind and external world). Passivity is usually linked with a delusional explanation (e.g. thoughts removed by the government)

Table 3 (*Continued*)

Perception

Sensory distortions, sensory deceptions (illusions, hallucinations)

- **Distortions** are changes in *intensity* or *quality* of real sensory phenomena (e.g. micropsia in a temporal lobe seizure)
- **Deceptions** are either **illusions** (i.e. *misinterpretations of real stimuli*), often in altered mood states or consciousness (e.g. hearing an innocuous noise as a sinister footstep when anxious) or **hallucinations**, which are *internally generated* perceptions in the absence of an external stimulus. **Auditory** hallucinations include noises and voices. **Second person** auditory hallucinations talk to the patient, including giving **commands**. **Third person** auditory hallucinations discuss the patient, sometimes in a **running commentary** on their actions. **Thought echo** is hearing one's thoughts repeated aloud after one thinks them. Other hallucinations include **visual, somatic, olfactory, taste, sexual and touch**. 'Formication' describes hallucinations of touch where small animals/insects are felt to be crawling all over the body, classically seen in organic disorders such as cocaine psychosis. **Reflex** hallucinations are triggered by an external stimulus *in another modality* (e.g. seeing a bus triggering a somatic hallucination of electric shocks). **Functional** hallucinations are triggered by an external stimulus and are experienced at the same time as the stimulus (e.g. auditory hallucinations associated with the sound of running water). **Extracampine** hallucinations are experienced as outside of the sensory field (e.g. voices heard from another country). **Hypnagogic** and **hypnopompic** hallucinations occur with reduced levels of consciousness when drifting off to sleep and on waking, respectively
- **Pseudohallucinations** are experienced as arising from within the patient (e.g. 'voices in my head') rather than the external world, but they are beyond conscious control. In contrast to hallucinations, they are not experienced as having a material reality. They occur in normal grief (seeing or hearing the deceased) as well as a range of disorders including schizophrenia, post-traumatic stress ('flashbacks') and borderline personality disorder

Cognition

Global, dominant and non-dominant hemispheres, frontal lobe function

- **Global: level of consciousness** (if abnormal, use the Glasgow Coma Scale), **orientation** in time, place and person, **attention and concentration** (e.g. test naming months of the year backwards), **memory**: anterograde short-term ('working') memory tested by immediate recall of three given items; long-term tested by their recall 5 minutes later. Retrograde memory includes public (e.g. 'Who is the prime minister?') and personal ('Where were you born?') information, semantic (e.g. how to use a fork) and episodic memory (e.g. 'What happened yesterday?'). Global cognition includes **IQ** (usually estimated rather than formally tested; e.g. 'high', 'low normal')
- **Dominant** hemisphere tests: **language** (naming of objects, repetition of a phrase, comprehension of commands, reading and writing), **calculation** and **praxis** (limb apraxia, e.g. 'Show how you wave goodbye'; finger agnosia, e.g. put pen in their hand with eyes closed – 'what's this?'; conceptual apraxia, e.g. show toothbrush – 'what's this used for?') and awareness of **details.** Draw a clock at 3.45 (see text)
- **Non-dominant** hemisphere tests: **neglect** (hemispatial rather than sensory), **construction** and **visuospatial** ability
- **Frontal lobes** tests: **verbal fluency** (e.g. 'Name as many animals as you can in a minute': tests fluency plus strategy, e.g. listing farm animals first), **similarities and proverb interpretation** (i.e. conceptual thinking, e.g. 'What do a table and chair have in common?'; 'What is the difference between a mistake and a lie?'), **estimates** ('How fast can a leopard run?': frontal lobe lesions typically grossly overestimate) and **alternating sequences** (copying of alternating hand sequence, which tests sequential motor activity dependent on dorsolateral prefrontal cortex function)

Insight

Understanding of illness and its treatment

- Do they think there is anything wrong with them?
- If there is something wrong, do they think it is a physical or psychological problem, or both?
- How do they describe the problem and what caused it?
- Do they think they need treatment, if so what?
- What do they think of treatment offered?

draw a clock at 3.45 is a quick test of neglect (draw both sides?), construction (looks like a clock?) and details (all numbers correct?) as well as frontal lobe function in their strategic approach to the task. Systematic cognitive testing is carried out where there is any index of clinical suspicion regarding cognitive compromise and is performed routinely with older patients (Table 19, p. 68).

Insight is multidimensional and should not be stated as simply being 'present' or 'absent'; delineate insight as described and avoid the presumption that having insight means simply agreeing with your doctor.

Physical examination

Systematic cardiac, respiratory, gastrointestinal and neurological examinations must always be performed for a first psychiatric assessment, and revisited whenever new physical symptoms arise or if there is an unanticipated change in someone's mental state. Physical and mental symptoms are related in complex ways (Box 2).

Physical examination has several aims: it ensures **organic aetiology** is not missed, the **physical impact** of mental disorder is established (e.g. malnutrition in anorexia) and it records **physical side-effects** of current treatment. It also establishes a **physical baseline** before any treatment is started (e.g. antipsychotic medication causing weight gain).

Who performs the physical will depend on context (e.g. it **should** already have been carried out for GP or A&E referrals). On admission to a psychiatric ward, all patients must have a physical repeated by the ward doctor and, if not yet performed, investigations on admission should include a routine blood screen (full blood count [FBC], urea and electrolytes [U&Es], liver function tests [LFTs], lipids, glucose, thyroid). Whatever the context, it is essential to make sure comprehensive physical assessment has not been missed. If a patient declines to cooperate, it is your responsibility to record that refusal, and flag up the fact it is an outstanding component of their assessment.

Box 2 Types of association between physical and mental illness

1. Physical illness presenting with psychological symptoms (i.e. organic psychiatry)
2. Physical illness associated with secondary psychological symptoms as a reaction to illness
3. Mental illness predisposing to physical illness (e.g. depression as an independent risk factor for coronary heart disease)
4. Physical symptoms as the sole presentation of a psychological disorder (e.g. somatization)
5. Medication for mental or physical illness causing psychological side-effects (iatrogenic illness)
6. Chance association (two disorders occur by coincidence): comorbidity of psychiatric and medical illnesses

Formulation

Structure your formulation as below:

Summary statement

Salient features of the case in a few sentences.

Differential diagnoses

Starting with most likely, give evidence for and against, with each differential. Use the diagnostic hierarchy in Fig. 1 as a prompt for possibilities and a reminder of comorbidity (e.g. 'Depression as the primary diagnosis, comorbid with a secondary diagnosis of anxious-avoidant personality disorder').

Note that classifying mental disorder as 'organic' denotes a presumed or identified gross physical cause (e.g. endocrine disorder or alcohol intoxication). Non-organic mental disorders (i.e. the rest) are sometimes referred to as 'functional'; the disorder arises at the level of the higher mental functions governing cognition, perception, emotion and behaviour. Unlike physical illness, most psychiatric disorders do not therefore map onto measurable material realities; they are best understood as

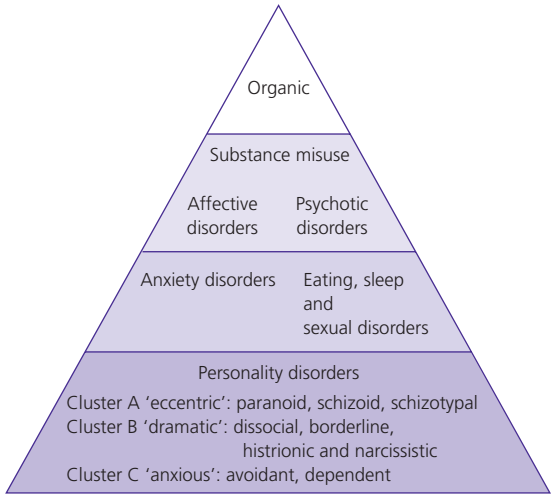

Figure 1 Hierarchy of psychiatric disorders.

end-point presentations of a variety of biopsychosocial processes. Formulate your diagnoses within an aetiological framework (see below), otherwise terms such as 'depression' convey little meaning.

Aetiology

Divide this into **predisposing**, **precipitating** and **maintaining** factors, further subdivided by **biological**, **social** and **psychological** type. A 3 × 3 grid with these headings serves as a framework for collating findings. Avoid rigid iteration of the 'biopsychosocial' model; focus on what is important, give a sense of the relative weight of contributing factors and if, for instance, social factors do not appear relevant, say so. For example, the aetiology of a depressive episode could be described thus: *predisposing* strong family history of depression (bio) compounded by an emotionally (psycho) and materially (social) deprived childhood, this episode *precipitated* by a recent relationship break-up (social) and *maintained* by alcohol abuse (bio) in the context of a personality characterized by limited emotional resources for tolerating stress (psycho).

Aetiological formulation can also be focused along **cognitive**, **behavioural** or **psychodynamic** lines:

- A **cognitive assessment** would make a current problem list and link these to any associated: (a) *negative dysfunctional beliefs*; (b) *systematic cognitive bias* in information processing about self, others and the world; or (c) *cognitive distortions* (e.g. a tendency to overgeneralize or take an 'all or nothing' view).
- A **behavioural assessment** would consider early faulty learning experience leading to current problematic behaviours, which would then be analysed in terms of how they were currently being rewarded and thereby maintained.
- A **psychodynamic** assessment would look at early childhood experience and the development of psychological defences, associated patterns of interpersonal relating and the relationship of these to current symptoms.

Summary of active risks

Risk to **self**, including **self-harm**, **suicide**, **self-neglect**, and risk to **others**, both **general** and to **specific** individuals. State factors likely to increase or decrease risk. For risk to others, note any suggestion that they believe the integrity of their world is under threat (e.g. persecutory delusions and delusions of jealousy may be acted on) and any psychotic experiences that lower their sense of control (e.g. somatic passivity, command auditory hallucinations), alongside any personality traits such as impulsivity and potentially disinhibiting factors such as alcohol use.

Initial management

Detail your plan for **investigations, treatment** and **risk management**, listing interventions in descending order or priority. Investigations include obtaining physical **tests** (e.g. bloods, electroencephalography [EEG], magnetic resonance imaging [MRI]) as well as **collateral information** and **past records**. Identify treatments (see Mental health treatments) and include specific measures required to reduce risk.

How to conduct a psychiatric interview

Anyone can ask a list of questions. Most patients can talk for an hour. Skilful history taking combines information gathering with a potential therapeutic opportunity. You aim to provide the patient with the relief of being understood and to further develop their own understanding. Where possible, help them to clarify what their thoughts and feelings are, and to make links between their past and current behaviours and their presenting problems. This is an opportunity to reinforce adaptive attitudes and behaviours, encouraging their capacity to manage their situation.

To be effective, clinical interviewing must be like a dance. You are both leading and responding to the patient. Good timing is key: when to let the patient talk, when to interrupt, when to ask something sensitive, when to make a challenging comment or suggestion, and when to stay silent if the patient is not ready to hear it. Throughout this process, you are under observation by the patient, who is gauging what kind of doctor you are, how much to tell you, and whether you are trustworthy. Do not underestimate the importance of first impressions: looking and acting professional reassures people that you are.

If new to psychiatry, start by simply listening to patients as fellow human beings. Be respectful, thanking them for their time in helping you develop your interview skills. They might be bored of being asked the same questions, especially as an inpatient. Stop to **think aloud** about their answers rather than racing on to the next question, and you will both get more out of the process. It is not unusual for students to obtain useful information previously unknown to a busy clinical team, with whom the patient may feel more reserved. Take a systematic approach to one particular area (e.g. taking a careful

MSE or past psychiatric history) before attempting to cover everything.

Throughout the interview be curious and ask yourself – *what would that be like?* Develop your capacity for empathy, which differs from sympathy (pity) as it is an active process. With empathy one accurately identifies with another's situation and is therefore able to have a mirroring emotional response to it that resonates with theirs. Empathy is therefore an essential clinical skill for understanding your patients.

Before starting, clarify

- Why you are seeing the patient – what are the goals of your assessment? What do you need to establish today and what can wait?
- Where you will be seeing the patient? Is there adequate privacy and security? Staff should be nearby for support if needed. Familiarize yourself with the local alarm system (e.g. wall-mounted; 'hand-held'), **and sit nearest the door**.
- How much time do you have? If possible have a clock in view so you can keep track of time, without making the patient feel uncomfortable.
- Who is going to be in the room? If patients are wary of the interview process you might suggest they are joined by a friend or family member, but if possible start an assessment of an adult with them unaccompanied, as others' presence may influence or inhibit their responses. If an adult patient is unquestioningly accompanied by another adult into the interview, ask yourself why. For some families it reflects the fact that the patient became unwell in early life and has never managed to individuate as an independent adult who would normally see a doctor alone. As a rule, encourage patient autonomy where possible – while acknowledging the (possibly central) importance of another person's role and the information they might provide; suggest the patient is seen alone initially, with the other person brought into the interview towards the end.

How do you start?

The interview process starts from when you call the patient's name. Most people feel uncomfortable seeing a psychiatrist, anxious they might be seen as 'crazy'. Put them at ease as you bring them into the room by a comment on the setting or their journey for example: the content is unimportant – you are making a connection with them as a human being rather than as a 'case'. The tone *they* set is often informative.

- Check how they like to be addressed: amongst older people and in some cultures, automatic use of their first name may irritate.
- Explain why you are seeing them, who referred them and why, and orientate them to what to expect. Advise them about confidentiality and what will happen to the information they give you.
- Clarify the time allowed and what you need to achieve in that time (e.g. 'I need to ask you questions about your current situation and past history so we can understand what's been happening and agree a plan about where to go from here'). Warn them there is a considerable amount of information to cover so you may need to interrupt at points to move on, and apologize in advance for having to do so. Suggest there will be future opportunities to return to important topics.
- Start your enquiry with an open question such as 'How are you?' Then listen. A common trap is to interrupt too early. Let them talk in an unhurried way initially as doing so is time well spent. It builds rapport as the patient knows they are being listened to and it orientates you to their perspective. When you move on to specific enquiry, pursue positive responses to their logical conclusion: make sure you have understood what the patient is saying before you move on.
- If the patient is unforthcoming, switch tack to asking why they think they were referred, or why others might be concerned. Consider also whether you need to change your approach (see below).
- As a rule, you need to make notes as there will be too much to remember. Explain this clearly.

How do you clarify the nature of the presenting complaint?

Start **broad** with **open-ended questions** about a topic (e.g. 'What's your mood been like recently?'), gradually refining your understanding with increasingly focused questions, eventually clarifying details by moving to **closed** questions that invite a yes or no answer (e.g. 'So if I've understood right, you only sleep around 4 hours most nights?').

Use **reflective listening** and **summarize** at regular points throughout the interview: this gives the patient feedback of what you have understood in a form that helps them make more sense of it themselves, while also inviting their comment or correction. This technique of active listening is a skill not to be confused with simply repeating what the patient has just said.

Formulate hypotheses to test your assumptions with the patient. Assist the patient to reflect on what the nature of their emotional experience has been, especially if they find this difficult and struggle to make connections between how they feel and how they behave.

If a patient is resistant to a certain line of questioning, move on. Change to a less anxiety-provoking area, and return later taking a different approach: **push where it moves**. For example, if during family history, the patient speaks of hearing his late father's voice, explore this now. Interviewing schedules (Tables 1 and 3) need to be flexible to respond to the patient, not the other way round.

If you are struggling to engage the patient in the interview, try modifying your approach. Everyone has a preferred clinical style depending on personality: the skill is to know when to adapt it, and how. Do not persist with a casual informal approach if that individual might feel more comfortable with a reserved business-like manner. Gain a sense of what is right for that individual at that time.

Once you have established the nature of the presenting problem, stop to consider how it might relate to other perhaps more fundamental difficulties for that individual: how might it function as a solution to these, however maladaptive and unconscious this process may be. This perspective may explain why resolution of the presenting problem has proved impossible to date (e.g. alcohol misuse following bereavement).

How do you ask about delusions and hallucinations?

Advise the patient you need to ask some questions that may sound strange, but they are 'routine questions' everybody gets asked. Introduce each topic with open questions (e.g. for persecutory delusions, ask 'How are other people treating you generally at the moment?'). Depending on the answer, pursue this downstream with more specific closed questions (Box 3).

Box 3 Asking about delusions and hallucinations

Delusions

- *Persecutory:* are you currently under threat from any individuals or organizations?
- *Reference:* are things happening around you that seem to have a special significance just for you? Prompt: like seeing things about yourself on television or in the newspapers or perhaps in songs or being talked about on the radio?
- *Grandiose:* do you have any special powers or mission?
- *Guilty:* do you feel you have committed a terrible crime or sin that deserves punishment?
- *Hypochondriacal:* are strange things happening to your body that you can't explain?
- *Nihilistic:* do you have a sense something terrible is about to happen? Does something feel wrong inside you?
- *Thought passivity:* start broad – are you able to think clearly at the moment? Then, is there any interference with your thoughts? Have you been a victim of telepathy? Once described, clarify:
  - **thought insertion**: are thoughts put into your head that you know are not your own?
  - **thought withdrawal**: do you ever have the experience thoughts are taken out of your head by some external power?
  - **thought broadcast**: do you ever have the experience your thoughts are leaking or being transmitted from your head in some way, so that others can hear them?
  - **thought echo**: do you ever have a thought and then hear it being spoken afterwards?
- *Somatic passivity* (i.e. made actions, body functions, emotions or will): e.g. is your body ever controlled by another force or agency?

When delusions are present, enquire how the patient understands that experience (e.g. by the elaboration of more delusional ideas) and summarize: (i) **type** e.g. paranoid; (ii) **complexity** e.g. part of a complex delusional system involving many people; (iii) **mood congruity** e.g. none (threatening idea has no impact on patient emotionally) or congruous (a hypochondriacal delusion coincides with low mood); (iv) **influence on behaviour** e.g. none, patient does not act in accordance with his belief that he is the prime minister

Hallucinations

- When on edge or under stress some people hear or see things that are not there: has anything like that happened to you? Have you heard voices, mutterings or noises when there is no-one there or nothing else to explain it? Repeat for visual, etc.

When auditory hallucinations are present, clarify: (i) **content** (if clear); (ii) from **where** the patient hears them; (iii) **second or third** person quality; (iv) **mood congruity**; (v) **timing** and **frequency**; (vi) **effect on the patient**

How do you cover large amounts of information?

Avoid getting bogged down in detail. You are taking an overview, not a life story. Focus on establishing the **best and worst** of important parameters. For example, with employment, establish their highest level of past functioning in comparison to now, so ask about their most senior past position and their longest time in one job. For their risk history, establish the most serious harm to self or others caused. With multiple hospital admissions, clarify dates of the first and most recent, how long was the longest, and how many were under section?

Where possible, **link topics** (e.g. 'When you have been drinking like that have you ever got in trouble with the police?') When an abrupt change in direction is required, explain this by making **linking statements** (e.g. 'What you're telling me is clearly important and will need to be thought about more. For today, we need to cover some more basic information, so I have to change topic now and ask about medication'). Keep orientating the patient to where you need to take them.

How do you assess someone from a culture unfamiliar to you?

No-one expects you to be an expert on all world cultures, but be aware of your own ignorance and ask questions to avoid making culturally biased assumptions. For example, when a patient hears God, it can sometimes be difficult to differentiate illness from normal religious experience: check with family, friends or church members to confirm what is culturally normative.

Avoid assuming that a patient shares the dominant beliefs and values of their culture. Think of the subcultures within your own culture.

Beyond ethnicity, be sensitive to other factors such as socioeconomic circumstances. Most doctors have backgrounds of reasonable emotional and material security; the impact of adverse events or the difficulty of change will be underestimated if a doctor unthinkingly applies their own emotional, social and financial resources as a benchmark.

How do you ask about sensitive topics?

Normalize the question, again by prefacing it with a statement that it is a routine question you ask everybody. Have a **straightforward manner** that conveys professionalism and makes the patient feel you have asked this question hundreds of times before, and have heard a range of answers. Shame is a powerfully aversive emotion and a patient may avoid disclosure if they fear either feeling stupid or exposed by your reaction to what they say.

Normalize potentially undesirable answers concerning generally or culturally prohibited behaviour (e.g. sex, substance misuse or aggression) by putting the behaviour into context. For example, do not ask 'Do you hit your partner?' but rather 'It sounds like you've been at your wits' end. Have you ever reached the point where you felt you had no option but to hit her to get through to her?' With a patient experiencing persecutory delusions, you might say 'It sounds as if you have serious concerns about your safety. Have you got to the point you feel you need to take matters into your own hands to protect yourself?' These are leading questions, but you have established basic facts first. You are not pretending to condone such behaviour, but demonstrating you can understand it.

Deliberate assumption is sometimes useful, in particular with substance misuse. For example, with young adults, do not ask if they smoke cannabis or use cocaine, ask how much or how often. They will tell you if they do not. With alcohol, most people underestimate how much they drink. If alcohol is or might be a problem, deliberately **overestimate** an amount for that patient (e.g. 'So would you drink a bottle of spirits most days?') Patients usually correct you with a more accurate figure as if freed to do so by an exaggerated one.

Do not avoid topics that make you feel uncomfortable. Asking about suicide, for example, will never make someone suicidal. That said, excessive attention to suicide method is unhelpful. Use stepped questions, becoming more specific (e.g. 'What's been happening sounds very stressful. Have you got to the point where you felt you couldn't go on? Have you got to the stage of thinking about taking your own life? What did you think you might do? Did you make any plans?').

Remember medication may be a **sensitive topic**. Around half of all patients do not take it as prescribed – regardless of type – but may not disclose this to avoid doctors' disapproval or disappointment. Never assume they take it at the prescribed dose and frequency: start by asking how often they manage to take it and at what dose, and take it from there.

It can be useful to revisit the issue of **confidentiality**: patients are often concerned about this, but reluctant to ask.

Be explicit with what it is you are asking, otherwise both you and the patient will be confused as to what they have said yes to.

What is your last assessment question?

'Is there anything else you'd like to tell me?'

Mental health treatments

Core interventions

Mental health interventions are divided into biological (typically, medication and electroconvulsive therapy [ECT]), psychological (psychotherapy) and social (financial advice, vocational interventions). This assumes treatments fit neatly into these boxes, but several (e.g. cognitive–behavioural therapy [CBT] and group therapy) are both psychological *and* social. Our approach presents nine essential treatments (Table 4), listing another 17 options later (Table 5). Two core interventions, assessment and home treatment/admission, are examples of biopsychosocial treatments. No treatment will achieve its full potential if given in isolation or without proper negotiation with the *individual* who receives it. Concordance is a two-way process between an informed patient and a flexible doctor. It is the best way of maximising patients' taking medication regularly (compliance).

A for assessment

During your assessment, it is not enough to set out the sequence of events from no symptoms to symptoms, with indications of symptoms' severity over the time course. You must place these in the context of the person's situation (relationships, job, housing, lifestyle) and *precipitants* (p. 8). A high-quality assessment, where a patient begins to see his/her difficulties in a context amenable to interventions, is in itself therapeutic.

KEY POINT

The first statement of the Hippocratic oath is 'First do no harm'. Stop and think before you rush into interventions, perhaps under pressure to do something, *anything*. Balance any potential benefits with the negative consequences of the treatment.

B for behavioural therapy

A broad definition of mental disorders is that they are abnormalities of thinking, feeling and behaving. We know that disturbances of thinking (confusion, holding paranoid beliefs about strangers) and feeling (low mood, episodes of anxiety) invariably manifest as abnormal behaviours. Consider these in reverse: how we behave impacts on our thoughts and our mood. Identifying unhelpful behaviours (withdrawal, aggression) will guide patients into evaluating the costs (in symptoms and consequences) of continuing to act in a way that makes their life more difficult. A cost–benefit analysis contrasts how things are now with how they could be *if* changes were initiated. Box 4 gives the most common behavioural intervention, a **slow breathing exercise** to reduce anxiety, especially panics. Analysis of behaviours is complex; it is good to advise someone with dependency traits (Table 31, p. 105) not to volunteer for every new task at work, but telling someone with social phobia (p. 59) to avoid new people would perpetuate their symptoms. A standard behavioural approach is to examine ABCs (Table 4) with the patient. Each of antecedents and consequences will list a mixture of thoughts and feelings, many of which cause distress – but interventions target all three to teach ('condition') the patient new ways of thinking and acting.

Box 4 Behavioural techniques: slow breathing exercise

Teaching a **slow breathing technique** is part of a programme to reduce sudden bursts of anxiety:

- *Stop*, sit down or lean against something
- *Hold* your breath for a slow count to 10: try saying to yourself 'one – one hundred, two – two hundred . . .'
- At the count of 10, breathe out slowly, thinking 'breathe out' or 'slow breaths'
- Then, breathe in over 3 seconds: 'in – two – three'
- Now, breathe out in 5 seconds: 'out – two – three'
- At the end of 1 minute (7 breaths in and 7 out), *hold* your breath again for a slow count to 10

Table 4 Nine core psychiatric treatments: A to I.

Intervention	Outcomes	Other examples
Assessment Full history + mental state exam + investigate For each of biological, social and psychological, what are the **predisposing**, **precipitating** and **maintaining** factors that led *this patient* to present *at this time*?	Give a context and initial approach to understanding symptoms and behaviours; integrate your knowledge of the profile of people who develop a particular disorder (epidemiology) with your clinical findings, supporting diagnosis and indicating severity	Consider extending your assessments: • Blood tests/imaging studies • Neuropsychological testing (IQ, personality) • Would admission clarify symptoms and behaviours?
Behavioural therapy (the B of CBT) Identifies behaviours that trigger or maintain unwanted symptoms; encourages behaviours that will reduce symptoms and break cycles of behaviour → symptoms → behaviour	For each patient, what are the Antecedents, Behaviours and Consequences (ABCs) of distressing symptoms? Even without behavioural analysis of all symptoms, generic behavioural measures will help (Table 6)	Homework: exercises to reduce antecedents and change behaviours; scheduling (planning a diary) to structure activities and reduce boredom; social skills training for the negative symptoms of schizophrenia
Cognitive therapy (the C of CBT) Identifies thoughts that drive symptoms and behaviours. Cognitive therapy changes a patient's mindset – the way he/she sees the world	Mood diary to identify how ways of thinking are associated with periods of low mood; using a formulation to change thoughts and ways of thinking in anxiety, psychosis, etc.	Albert Ellis' three cognitive distortions: 1 'I must do well'; 2 'You must treat me well'; and 3 'The world must be easy'. Change these musts to reduce distress in everyone
Drugs *The* biological treatment, but psychosocial aspects (e.g. concordance with medication, combination with other treatments) have a key role in achieving the best results	See text and individual cases, Box 2 & Tables 2, 5–7. Drug prescription is symptom-based: symptoms, function and side-effects are the main outcome measures	Added to four major groups in this section: anti-Alzheimer's drugs (p. 160), attention deficit disorder (p. 100), and preventing withdrawal of illegal drugs (Table 42)
Electroconvulsive therapy ECT improves low mood quickly in vulnerable patients: older people, severe depression – including postnatal	ECT should not be seen as a treatment of last resort and is therefore included here: risks for these patient groups when severely unwell increases with delay	ECT has a poor evidence base for its routine use in psychosis; for severe depression, it should be administered only in approved centres
Family interventions From contact with family, family as co-therapists to formal therapy	Family intervention reduces both symptoms and relapse rates in psychosis	Essential in treating young people and eating disorders; marital/couples therapy
Groups Psychological therapies delivered in group settings are time and cost effective	Open (e.g. AA) or closed groups (see text). Specific groups for common mental disorders	Psychoeducation usually takes place in groups: for psychosis, bipolar disorder and bulimia
Hospital admission and home treatment These are principally driven by risk assessment, less often by high levels of distress in a patient	Risks (suicide, harm to others) must be shown to be related to symptoms; both interventions provide intensive treatment to people in crisis	Most models of home treatment are assertive community treatment; there are many inpatient settings based on patients' needs
Individual psychotherapy One-to-one psychotherapy: many different approaches	Similar to flying, the greatest dangers of therapy are at the start and at the end (see text)	Psychotherapy is best considered by school (theory) and by problem (e.g. for addictions)

AA, Alcoholics Anonymous; CBT, cognitive–behavioural therapy; ECT, electroconvulsive therapy.

Table 5 The J to Z of other mental health interventions.

Treatment	Details	Who carries out these tasks?
J Job	Facilitating meaningful work; *place then train* (see text)	Vocational rehabilitation worker; careers' advisor
K Kids (children)	Consequences of illness in an adult on children. Paramount principle: the welfare of the child overrides that of the parent	You and your team; social services; child and family and social services; police and other state agencies
L Legal aspects	Any intervention with legal or forensic services' aspects. Confidentiality, conflicts of interest, consent, capacity	Every doctor should be capable of assessing capacity, specialist forensic psychiatric teams, police, lawyers
M Multidisciplinary	Use your team's experience, different approaches and skills: includes interagency working	Nurses, social workers, psychologists, speech and language therapists, support workers, etc. (see J & O)
N Nidotherapy	Environmental manipulation to reduce symptoms/relapses	Varies: general hospital staff, housing agencies, etc.
O Occupational therapy	OT assessments of all support needs. Ward interventions, social outings, treating phobias, pet/art/music therapy	Occupational therapists carry out the assessments working within the MDT and with others
P Prejudice	Stigma as the second illness: to reduce discrimination	This is everyone's job: users, carers and you
Q Quality of life	What gives meaning to patients' lives? Includes relationships, befriending, spirituality, religion, the Arts and more	Social function (GAF) can be measured by any staff member; focus of interventions determined by the patient
R Rehabilitation	Treating enduring disability: severe mood and psychotic disorders	Many treatment settings and staff involved (see text)
S Surgery	Gender reassignment surgery; last resort in treating people with treatment-resistant OCD	Many psychiatrists ensure independent scrutiny of its use; surgeons in designated centres
T TMS	TMS is not (yet) a proven alternative to ECT in treating depression or pain	Specialist centres: will probably become available in the same settings that currently deliver ECT
U User groups	Promoting recovery, resilience, and empowerment	Peer, advocacy, local and national users' groups
V Voluntary sector	Raising awareness of mental health and funding for specific projects (housing, activities, social networks; see text)	Carer groups, charities, Trusts, other non-statutory services, local and voluntary groups.
W Weight loss	Weight changes in anorexia, depression, dementia, psychosis.	Dietitians and physicians: essential, safe advice
X eXercise	Helping patients maximize exercise and lifestyle changes. Anxiety, mood disorders, reversing drug-induced weight gain	Patients, professionals in primary and specialist care settings, staff in sports and other facilities
Y Yoyo	EMDR. A proven adjunctive treatment (with CBT + drugs) of PTSD	Training in EMDR is brief, and any mental health professional can deliver this treatment
Z Z list (e.g. hypnosis)	Hypnosis (some proven efficacy in *physical* illnesses), aromatherapy, yoga, herbs, meditation, reiki, light boxes	All non-medical/alternative/complementary 'therapists': their independence may be problematic

CBT, cognitive–behavioural therapy; ECT, electroconvulsive therapy; EMDR, eye movement desensitization and reprocessing; GAF, Global Assessment of Functioning; MDT, multidisciplinary team; OCD, obsessive–compulsive disorder; OT, occupational therapy; PTSD, post-traumatic stress disorder; TMS, transcranial magnetic stimulation.