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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 To an extent, all textbooks are out of date as soon as they are published but even with the developments in information technology, a concise, portable, paper textbook containing an up-to-date synthesis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*
Preface

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
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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
Perceptions
• Illusions and hallucinations (esp. visual, auditory)
• Derealization and depersonalization

Cognition
• Orientation (time, place, person)
• Conscious level
• Specific domains: attention, memory, language, visuo-spatial

Insight
• That they are unwell
• That they recognize their symptoms to be those of illness
• That the illness needs treatment
• Willingness to comply with treatment plan
• Capacity to consent to treatment plan

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
Getting started

Psychiatry can seem disconcertingly different from other specialties, especially if your first experience is on a psychiatric in-patient unit. How do I approach a patient? What am I trying to achieve? Is he or she dangerous? How does psychiatry relate to the rest of medicine? This chapter is meant to help orientate anyone facing this situation. Like the rest of the book, it is based on three principles:

- Psychiatry is part of medicine.
- Psychiatric knowledge, skills and attitudes are relevant to all doctors.
- Psychiatry should be as effective, pragmatic and evidence-based as every other medical specialty.

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).

What is psychiatry?

‘Psychiatry is ... weird doctors in Victorian asylums using bizarre therapies on people who are either untreatably mad or who are not really ill at all.’ Although remnants of such ill-informed stereotypes persist, the reality of modern psychiatry is very different and rather more mundane! Psychiatry is, in fact, fundamentally similar to the rest of medicine: the treatments used are primarily evidence-based, with success rates comparable with those in other specialties. Psychiatric patients are not a breed apart – psychiatric diagnoses are common in medical patients, and most patients with psychiatric disorders are treated in primary care. And psychiatrists are no stranger than other doctors, probably.

Psychiatric disorders may be defined as illnesses that are conventionally treated with treatments used by psychiatrists, just as surgical conditions are those thought best treated by surgery. The specialty designation does not indicate a profound difference in the illness or type of patient. In fact it can change as new treatments are developed; peptic ulcer moved from being a predominantly surgical to a medical condition once effective drug treatments were developed.

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.