1 PSYCHIATRIC ASSESSMENT

Thomas Pollak, with Sarah Stringer and Maurice Lipsedge

Starry, starry night.
Paint your palette blue and grey,
Look out on a summer’s day,
With eyes that know the darkness in my soul.
Vincent (Starry, Starry Night)—Don McLean

The information contained in the following assessment is drawn from a number of sources, particularly The Illness of Vincent van Gogh (Blumer 2002) and The Yellow House (Gayford 2006). Vincent’s views on his alcohol consumption have been elaborated to show symptoms of alcohol dependence.

Your first patient

History

Name
Vincent Willem van Gogh

Date of birth
30 March 1853

Background information
Vincent van Gogh was brought to Hotel Dieu Hospital, Arles, by police on the morning of 24 December 1888. The police were contacted following an incident the previous night when Vincent threatened his friend, Paul Gauguin, with an open straight razor. He fled the scene and later reappeared at a brothel on Rue du Bout d’Arles, asking to see a prostitute named Rachel. He gave her his severed earlobe, saying, ‘Guard this object very carefully’. He then left. Police discovered blood-soaked towels near the bottom of the stairs in his house, and found Vincent unconscious in his bedroom, bleeding from his left ear.

Presenting complaint
‘I am having frightful ideas . . . I fear that God has abandoned me.’

History of presenting complaint
Vincent reports that for the past 4 weeks he has been aware of God punishing him. Although he denies hearing God speak to him, he says he receives divine ‘communications’ that only he can understand. He would not elaborate as to their nature.

He says that his thoughts have become more confused over the previous 3–4 weeks, their speed increasing to the point that ‘the noise inside has become unbearable’. He reports losing the need for food, sleeping only 2 or 3 hours a night, and having to work constantly ‘to regain God’s favour’ through his art.
Vincent does not report elevated mood but says that his mood changes as quickly as his thoughts and has been doing so for a month.

Vincent is unable to say what has caused the change in him, but referred to the ‘impending treachery’ of Mr Gauguin. He gave no explanation for cutting off his ear, stating that his reasons were ‘quite personal’.

**Past psychiatric history**

Vincent reports two previous episodes of depression, each lasting a few months. The first followed rejection by a girl in London during his early twenties. The second followed dismissal from his post as an evangelist in Belgium when he was 25. He never saw a doctor for these. Subsequent to both episodes, Vincent reports periods of immense energy and productivity where he pursued his goals of religion and art with great intensity and needed less for sleep.

**Past medical history**

Vincent has suffered from gastrointestinal irritability for most of his adult life; no cause has been identified. He claims to suffer from ‘seizures’ but did not elaborate on these. At 29 he was treated for gonorrhoea as an inpatient in The Hague.

**Drug history**

No prescribed medications.

No known drug allergies.

**Family history**

Vincent’s mother, Anna Cornelia, is still alive; his father was a preacher and died 3 years ago. Vincent is the eldest of six surviving siblings (Figure 1.2). Exactly one year before Vincent was born, his mother gave birth to a stillborn boy, also named Vincent Willem. Vincent believes that his name is cursed. There is no family history of mental illness.

**Personal history**

**Birth and early development**

Vincent was born in Groot-Zundert, in The Netherlands. His mother’s pregnancy and labour are believed to have been unremarkable. Developmental milestones were reached normally, although doctors had some concerns over apparent craniofacial asymmetries. Vincent’s parents told him that he was a clumsy boy.

**Family background and early childhood**

Vincent described himself as a moody child, often disobedient and with few friends. His early interests were

![Vincent van Gogh's genogram](image-url)

**FIGURE 1.2** Vincent van Gogh’s genogram
flowers, birds, and insects, but he preferred to play alone. His younger brother Theo was always his closest friend, although Vincent described himself as being distant from his parents and other siblings.

**Education**

Until the age of 12, Vincent was taught at home by a governess. He then went to boarding school until starting middle school in Tilburg, where he learnt to draw. His attendance and marks were satisfactory, although he neither worked particularly hard nor excelled in any subject; notably, he showed no special aptitude for art. At 25, Vincent began a theology degree, but dropped out within the first year.

**Occupation**

Vincent worked as an apprentice for an art dealer in his uncle’s company from the age of 16, travelling to Brixton, London, as part of his job. He returned to Britain at 23 to work as a supply teacher in Ramsgate. Two years later, having cut short his theology degree, Vincent became a preacher in Belgium. This was also short-lived, as he was dismissed by the church for failing to maintain a sufficiently tidy appearance. Aged 27, he took up art in Brussels.

For the past 8 years he has lived and worked as an artist in Antwerp, Neunen, Paris, and The Hague. He has had little financial success and is largely funded by his brother Theo.

**Psychosexual/relationships**

Vincent’s romantic life has been characterized by unrequited love and rejection. In particular, there were two unreciprocated infatuations during his twenties, one in London and the other in Etten. The second of these rejections led Vincent to deliberately harm himself, burning his hand with a lamp.

While living in The Hague, at 28, Vincent began a relationship with a prostitute named Sien, a single mother with a drinking problem. Vincent’s family disapproved and placed considerable pressure on him to end the relationship, which he eventually did.

In Arles, Vincent has made frequent use of prostitutes, whom he describes as his ‘sisters of mercy’, although he has recently reduced contact with them because of a loss of libido. Nevertheless, he enjoys a particularly close relationship with a prostitute named Rachel.

**Substance misuse**

**Alcohol**

Vincent admits to drinking alcohol daily to ‘stun’ himself when ‘the storm inside gets too loud’. He notes that without alcohol he becomes shaky and sweaty, and desperately craves a drink. Vincent reports that he needs increasing amounts of alcohol, and is currently drinking eight glasses of absinthe and 1.5 bottles of red wine a day. He has been drinking beer and wine in moderation since his late teens and started drinking absinthe 8 years ago. In the past 2 months Vincent has drunk in the mornings, causing Mr Gauguin to criticise his drinking and make Vincent feel both guilty and angry. He has never tried to give up drinking completely, but has thought about cutting down. Vincent recognizes a loss of control upon drinking and frequent blackouts when intoxicated. He has had fights with Mr Gauguin that he has not remembered subsequently, and has been barred from numerous inns in Arles for aggressive behaviour while drunk.

**Smoking**

Vincent has smoked a pipe since his teens, now using 15g of tobacco per day.

**Other substances**

Vincent also admits to occasionally chewing his lead-based paints, and sipping the turpentine that he uses to thin his paints. He did not offer reasons for this.

**Forensic history**

Nil formal, but note aggression when drunk.

**Premorbid personality**

Vincent reports that as an adolescent he was prone to lengthy periods of low mood but was ‘not quite miserable’. He describes himself as hard-working and a loner. He often feels overwhelmed by setbacks, struggling to get back on track afterwards. Vincent enjoys travel and frequently moves between cities.

Vincent has strong religious convictions. Politically and morally, he believes passionately in social justice, particularly for the poor. This has shaped his life to the extent that he gave up most of his possessions to work among the poor as an evangelist in Belgium. As an artist, he claims to be producing art ‘for the people’.

**Social history**

Vincent’s brother, Theo, is always on hand with emotional and financial support. Despite offering practical help, Vincent’s mother often makes disparaging remarks about his behaviour, which she regards as odd.

Vincent moved to Arles in February 1888, with the intention of establishing a ‘southern school’ of artists in the South of France. For the past 9 weeks he has lived with Paul Gauguin, an artist from Paris, in a shared house he refers to as ‘The Yellow House’. The citizens of Arles have not welcomed Vincent, viewing him as an eccentric.

**Collateral history**

Mr Gauguin reports that over the past 9 weeks, Vincent has become increasingly irritable, flying into unpredictable
rages and talking to himself. He has also been obsessed with religious issues, and speaks of profound meanings in his paintings, which are not obvious to others. He has been sleeping little, eating poorly, drinking heavily, and painting continuously. In the past month alone, Vincent has produced over 25 paintings, describing them as the best he has ever done. On one occasion Mr Gauguin noticed Vincent staring into space, his hand shaking. He dropped his paintbrush and seemed confused afterwards, unable to recall this event. Mr Gauguin believes that he may have triggered Vincent’s deterioration by expressing his intention to leave Arles; he suggests that the prospect of living alone terrifies Vincent.

Mr Gauguin thinks that Vincent may have cut off his ear and given it to Rachel in emulation of a common practice in the bullfighting arenas around Arles, where a victorious bullfighter cuts off a bull’s ear and presents it to his beloved.

**Mental state examination**

**Appearance and behaviour**

A gaunt 35-year-old white man with red hair and beard, his head bandaged, with blood seeping through on the left-hand side. He was appropriately dressed in a blue cap with a furry trim and matching winter coat. He appeared unwashed, with sallow skin and coal marks on his face. He smelled of alcohol and smoked his pipe nervously throughout the interview. He had difficulty maintaining eye contact and was frequently distracted by objects in the room, particularly the yellow sunflowers arranged in a vase. Vincent whispered to himself throughout the interview, apparently responding to someone or something. He looked tense, and at one point paced the room in an agitated manner for 10 minutes. Although he was not keen to engage, there was no evidence of aggression.

**Speech**

Pressure of speech: volume varied from a whisper to a shout when agitated. Tone switched between irritable, gloomy, and excited. Vincent complained that he ‘could not keep up’ with his thoughts and found the speed of them distressing. He showed flight of ideas, with rapid changes in topic.

**Mood**

Subjectively: ‘Black, black as the night!’

Objectively: Labile: switching rapidly between euphoria, tearfulness, and irritability.

**Thought**

Religious themes predominated, although it was difficult to establish specific beliefs. He stated on a number of occasions that God had forsaken him and had been communicating to him through everyday objects. At one point he said, ‘I am in the Garden of Gethsemane’.

He expressed persecutory delusions regarding Mr Gauguin, whom he accused of conspiring against him with other artists from Paris. Vincent would not elaborate on their alleged plans but could not be convinced of their innocence.

Vincent reported no thoughts of self-harm. When asked about his ear, he replied, ‘That affair is over now’. He denied thoughts of harm to others, including Mr Gauguin.

**Perception**

Vincent denied illusions or hallucinations in all modalities. However, it seems likely that he was experiencing auditory hallucinations as he whispered to himself as though talking to someone. He was also probably experiencing visual hallucinations since his eyes repeatedly tracked something unseen as if it moved around the room.

**Cognition**

Vincent scored 29 out of 30 on the Mini Mental State Examination. He lost one point for not knowing which floor of the building he was on.

**Insight**

Vincent showed partial insight into his condition. Although he admitted that he was ill, he insisted that the illness was a ‘malady of the soul’ inflicted upon him by God. He agreed to admission and to taking medication, but suggested that medicines were unlikely to work as ‘they could not undo God’s doing’.

**Psychiatric assessment**

Psychiatric assessments can seem overwhelming; they are longer, more detailed, and have more subsections than in other medical specialties. Vincent’s assessment should give you a vivid example of how to structure a history and mental state examination (MSE), demonstrating where to place the information you gather during an assessment. This section will now take you through the principles of the history and MSE, explaining relevant terms and ending with Vincent’s formulation.

Before starting, be aware that the exact division of information in the history and MSE is controversial, reflecting the difficulty of summarizing a whole life into neat categories. The most important thing is that you listen to your patient’s story and present it in a way that helps others understand why this person is suffering this problem at this time. Your assessment should lead people through the information so that your preferred diagnosis doesn’t ambush them. To do this, include all the information needed to make a confident diagnosis...
and exclude competing diagnoses—as well as the details that bring your patient to life.

**Psychiatric history**

*Background information*

Set the scene with the patient’s name, age, sex, and ethnicity. Explain how they came to present to the hospital or clinic and whether admission was informal (voluntary) or under a section of the Mental Health Act.

**Presenting complaint**

‘Always use the patient’s own words’—this keeps their story fresh and stops you from misinterpreting their problem from the start. Useful starting questions might be:

- What led up to you coming into hospital?
- Have you been having any problems recently? Can you tell me about them?

*History of presenting complaint*

Describing the period leading up to admission, assess the presenting complaint as you would in any history. Use NOTEPAD to ensure that you include:

- **Nature of problem**
- **Onset**
- **Triggers**
- **Exacerbating/relieving factors**
- **Progression** (improving, worsening or staying the same; intermittent or continuous)
- **Associated symptoms**
- **Disability** (effect on life)

The nature of the presenting complaint is the form the problem takes, e.g. a worry, mood, delusion, hallucination, physical ailment, social problem.

Before finishing, summarize the patient’s problem and ask them:

- Is there anything else you think I should know?

Associated symptoms are guided by your knowledge. Patients may not know that depression is associated with insomnia and hopelessness, so ask specific questions.

**Past psychiatric history**

Ask about previous contact with psychiatric services, problems treated by the GP, and times of severe stress or depression which the patient handled alone.

- Has anything like this ever happened before?
- Have you had any stress-related or mental health problems before?

Find out when past episodes occurred, how long they lasted, and whether they required admission to hospital or use of the Mental Health Act. Note past diagnoses and treatments, highlighting treatments that helped. Always check for previous risky behaviour while unwell (self-harm, suicide attempts, or violence).

**Past medical history**

List past and present physical problems; not only can physical problems relate to the presentation (e.g. multiple sclerosis can cause depression), but awareness of them is vital in arranging treatment.

**Drug history**

List the patient’s current medications, both prescribed and over-the-counter. Always note drug allergies and side effects.

**Family history**

Drawing a genogram with the patient is the clearest way to present their family. For each relative, include:

- Name, age, occupation
- Mental illness
  - Has anyone in your family suffered from stress or had to see a doctor for mental health problems?
- Physical illness
- Age and cause of death, if applicable.

Genograms are tricky at first, but quickly become easier—practice with every patient you see.

See the Online Resource Centre (ORC) for genogram advice.

**Personal history**

This is the patient’s life story. At first, include as much detail as possible in each section, learning how to ask questions and order information. With experience, you can act more like a film-maker or biographer, focusing on the headline events that created this person or relate in some way to their problem.

**Birth and early development**

Unless you are assessing a child or someone with a learning disability or neurological problems, it is usually enough to ask two questions:

- Do you know if there were any problems with your mother’s pregnancy and your birth?
- As far as you know, did you walk and talk at the normal ages?

As a general rule of thumb, if someone doesn’t know much about these things, they were probably ‘normal’ (i.e. a full-term spontaneous vaginal delivery with normal milestones). If there were any problems, find out details, including:
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- Prematurity
- Labour complications/birth trauma/interventions, e.g. Caesarean section
- Time in special care/being unable to go home immediately
- Need for paediatric follow-up

Family background and early childhood

Record periods of serious or lengthy illness, separation from parents, and neglect or abuse.
- What was it like growing up in your family?
- What were your parents and siblings like? How did you get on with them?
- Was early childhood a happy or a difficult time?

Education

This section gives a lot of information about personality and social abilities, and some idea about intelligence. Note age and level of achievement on leaving education, e.g. three A-levels (grades BBD).
- What was school like for you?
- Did you have any problems at school?

Also explore more specific issues:
- What were your friendships like?
- Were you shy or outgoing?
- Were you bullied or did anything traumatic happen?
- Were you ever in trouble for things like bullying or truanting?
- Did you get on with teachers?
- Were you near the top, middle, or bottom of the class?

Occupation

Chronologically list your patient’s jobs, including durations and reasons for leaving jobs (e.g. promotion/resignation/dismissal). Did they enjoy working? Look for trends, e.g. numerous brief jobs that ended due to arguments with employers. This may say something important about their interpersonal relationships or response to authority.

Psychosexual/relationships

List relationships chronologically, using common sense to decide how detailed this should be. Which was the longest relationship and what happened? What were the characteristics and can your patient see any recurring patterns?
- Age of first intercourse and number of sexual partners
- Long-term/brief

- Monogamous/not
- Heterosexual/homosexual/bisexual
- Quality of relationships (e.g. abusive, supportive)
- Marriages or civil partnerships

If currently in a relationship, ask about duration, partner’s name and occupation, and whether they are content. Ask if there are any sexual problems.

Substance misuse

This should cover past and present use of drugs, alcohol, and cigarettes. The easiest method is to take each drug individually and ask when it was first used, tracking forward from that point. Look specifically for route and amount used, including changes over time (increased amounts suggest tolerance). Note attempts at abstinence and formal detoxifications. Also note specific problems due to drug misuse (e.g. hepatitis, withdrawal fits).

Forensic history

This covers criminal behaviour.
- Have you ever been in trouble with the police?

List offences, noting seriousness, convictions, and sentences. Clearly record details of any violent or sexual offences in the notes. Find out whether offences were committed while unwell, and think about symptoms that might increase risk, e.g. paranoia may cause someone to lash out for perceived self-protection. Consider possible forensic issues relating to your patient’s disorder, e.g. theft to afford a drug habit.

It’s often worth asking people if they ever broke the law without being caught.

Premorbid personality

This tries to understand what the person was like before they became unwell. A lot of information is reflected in the rest of the personal history, e.g. someone who bullied others at school, physically abused their partner, and lost multiple jobs after arguing with managers might be reasonably viewed as somewhat volatile.
- Before all this happened, what kind of person were you?
- How would your friends describe you?
- How do you cope under pressure?
- Do you have any strong religious or moral views?

Social history

The social history is the patient’s current day-to-day situation. It should cover:
- Housing (type, rented/owned, flatmates)
- Finances, including benefits

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• Current employment/training
• Activities or interests
• Carer’s duties
• Social network

Always check for final points:

• You’ve told me a lot today. Is there anything we’ve not covered that you think I should know?

Collateral history
A history from someone who knows the patient well is useful—especially if the patient can’t or won’t talk to you. Other people may be better placed than the patient to say whether behaviour or personality have changed. You need your patient’s consent to actively contact their family or friends, since the act itself indicates that there is something medically or psychiatrically wrong with them. If a relative approaches you (e.g. while on the ward), there is no breach of confidentiality in listening to them, although you must explain that you cannot reveal your patient’s information without permission. If collateral historians do not want the patient to know what they have said, document this and write the information on a separate (removable) page in the notes—consider the potential impact upon interpersonal relationships if the patient chooses to access their notes.

Don’t assume that collateral historians are good witnesses. People may give misleading or deliberately false information!

Mental state examination
Past psychopathology belongs in the history; if it is present it goes in the mental state examination (MSE). The MSE, like any other medical examination, describes your findings when you examine the patient. In a physical examination you would not report jaundice if the patient was not yellow—even if you knew that they had liver disease, or were jaundiced yesterday. Likewise, don’t mention hallucinations in a patient’s MSE unless they are hallucinating when you see them. Patients often present ‘normally’ and reporting this is as crucial as reporting pathology in accurately depicting their mental health, and monitoring deterioration or recovery. If your MSE does not show the psychopathology of the recent history, note this clearly to draw attention back to the history and ensure that it isn’t overlooked (e.g. ‘no hallucinations elicited in any modality, in contrast to the history obtained’).

The MSE comprises:
• Appearance and behaviour
• Speech
• Mood
• Thought
• Perception
• Cognition
• Insight

Most of the MSE is covered during the history; if your patient has spent the last hour emphatically explaining the conspiracy against them, don’t repeat this simply because you are ‘now doing’ the MSE.

Appearance and behaviour
Imagine watching a film with the sound off: Everything you could describe would be included in appearance and behaviour (although you may want to add smells). A good description should highlight diagnostic clues and enable anyone to walk onto the ward and easily identify your patient.

General appearance
Start with age, sex, build, and ethnicity. Then note:
• Hair, make-up, clothing
• Physical problems (e.g. hemiparesis, hearing aid, dehydration)
• Scars, piercings, tattoos
• Self-care: well-kempt or self-neglecting (e.g. dishevelled, stained clothing, malodorous)

Clothing deserves a special mention if inappropriate (e.g. a bikini in the winter) or striking in some way. Sometimes it reflects the underlying mood (e.g. dark clothes in depression; bright garish clothes in mania). Very loose or tight clothing may indicate recent weight loss or gain.

Body language
• Facial expression, e.g. smiling, scowling, fearful
• Eye contact, e.g. responsive and appropriate/staring/downcast/avoidant/distracted
• Posture, e.g. hunched shoulders in depression
• Activity level: overactive or underactive?
• Describe what they are doing, e.g. ‘Pacing restlessly around the room’
• Movements may seem slowed (motor retardation) in depression, or speeded up in mania

Other movements
• Extrapyramidal side effects are caused by antipsychotics (see p.80 for more), e.g.
  – Akathisia: unpleasant restlessness causing agitation
  – Parkinsonism: shuffling gait, ‘pill rolling’ tremor, slowed movements, and rigidity
  – Tardive dyskinesia: rhythmic involuntary movements of the face, limbs, and trunk, e.g. grimacing, chewing

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• Repeated movements
  – Mannerisms: appear goal-directed (e.g. sweeping hair from face)
  – Stereotypies: not goal-directed (e.g. flicking fingers at air)
  – Tics: purposeless, involuntary movements involving a group of muscles (e.g. blinking)
  – Compulsions: rituals the patient feels compelled to undertake (e.g. hand-washing)

• Catatonic symptoms: these are rare, e.g. waxy flexibility (see p.78 for more)

Rapport

Are they withdrawn and cold; polite and friendly; rude or guarded (suspicious or deliberately withholding information); disinhibited (e.g. removing their clothing)?

Other

• Responding to hallucinations, e.g. watching ‘nothing’, talking to an unseen companion
• Smells, e.g. body odour, urine, alcohol

Speech

Because of the overlap between them, speech and thought are difficult to separate: speech is our window to the patient’s thoughts. Think of speech as a train, and the patient’s thoughts as the passengers.

• Speed is the rate of speech.
• The number of passengers is the abundance of thoughts.
• The route is the way that thoughts progress, linking from one idea (station) to the next.

Therefore normal speech and thought would be a train travelling at normal speed, while reasonably full of passengers. The train would travel a logical route from Station A to Station B.

The train can obviously drive too quickly or too slowly (increased or decreased rate of speech and underlying thoughts). It can also:

• Drive too quickly, whilst overcrowded with passengers. This is pressure of speech, reflecting underlying pressure of thought. It feels like machine-gun fire and is hard to interrupt. It is usually seen in mania.
• Drive slowly with few passengers. This is poverty of speech, reflecting underlying poverty of thought, and is usually seen in depression.
• Stop without warning and throw all the passengers off. This is thought block: the complete emptying of the mind of thoughts, shown in speech by a sudden halt. It is sometimes seen in schizophrenia.

With normal speed and passengers, the train can make an unnecessary lengthy detour via lots of minor peripheral stations, finally reaching Station B. This is circumstantial speech, reflecting underlying over-inclusive thinking which adds excessive details and subclauses to every sentence.

While overcrowded and speeding, the train can make a series of sudden detours, quickly passing through a number of unexpected stations. This is flight of ideas. The route is understandable, because there is always a reason for each detour. Ideas may be linked normally, or through rhymes or puns; sometimes new ideas arise from distractions in the room. Although the original plan was to reach station B, this was lost along the way and the destination changed; this keeps happening, and so the goal of thinking is never maintained for long.

Derailment may occur. The train can leave the tracks, ending up at a new destination completely unrelated to the original route. This may happen in schizophrenia and is very difficult to follow, since the patient’s speech is muddled and illogical, with no understandable connections between thoughts. This is also called loosening of associations or knight’s move thinking—the latter because of the indirect movement of the knight in chess.

Although the train would usually progress from Station B to Station C, in perseveration it becomes stuck at Station B. Answers to questions are repeated inappropriately, e.g.

**You:** What’s your name?
**Elvis:** Elvis.
**Y:** How old are you?
**E:** Elvis.

This usually occurs in organic states (e.g. dementia).

The above terms will not always be relevant, but every patient’s speech can be described in terms of:

• **Rate:** fast, slow, or normal.
• **Volume:** loud, soft, or normal, e.g. shouting, whispering.
• **Tone:** the emotional quality of speech, e.g. sarcastic, angry, glum, calm, neutral. Loss of the natural lilt and stresses in sentences produces monotonous speech.
• **Flow:** speech may be spontaneous, or only when prompted; hesitant, or with long pauses before answers; garrulous and uninterruptible.

Also note:

• Dysarthria—impaired articulation
• Dysphasia—impaired ability to comprehend or generate speech
Mood and affect are sometimes used synonymously, although they are a little different. Overall, mood is like a lake, into which you throw a stone—the ripples you then see are the affect. In other words, mood is the pervasive experience of the patient; affect is the momentary changing state we observe from the outside. Mood divides into:

- **Subjective:** how the patient says they are feeling, recorded in their own words.
- **Objective:** what you think about the patient’s emotional state, e.g. low, elated, irritable, anxious, perplexed, etc. As well as naming the mood, you can comment on its variability:
  - Labile—very changable mood, e.g. flitting quickly between anger, tears, and laughter (like getting unexpected waves rather than ripples from the lake analogy).
  - Flat/blunted—lack of normal variability (as if the stone has no effect on the surface of the lake).

Mood is incongruent if your patient’s report of their mood does not match their presentation, e.g. they giggle as they say they feel deeply depressed.

If the patient’s mood shifts appropriately with the conversation and is neither particularly ‘up’ nor ‘down’ you can write, ‘Reactive and neither elated nor depressed’.

Don’t list symptoms of depression (e.g. appetite, sleep) under Mood in the MSE; save them for the history.

Thought
The content of thought is the patient’s beliefs and ideas. Simply writing persecutory delusions gives very little information, so give verbatim examples or fully describe content.

Even if there is nothing ‘abnormal’ you need to record something! What is your patient thinking about?

Preoccupations and worries
Preoccupations are recurrent thoughts that can be put aside by the patient. Worries are similar, but cause a feeling of anxiety or tension.

- What kinds of things do you worry about?
- What’s on your mind!

**Delusions**
A delusion is a fixed belief, held despite rational argument or evidence to the contrary. It cannot be fully explained by the patient’s cultural, religious, or educational background. Occasionally the belief is true, but this is coincidental, since the reasoning behind it is illogical and faulty, e.g. a patient might rightly believe that his wife is cheating on him, but the belief began only because she burned his dinner.

Delusions feel as real as any other thought. If you were deluded that you were a medical student, this belief would feel as real as the belief you currently have that you are a medical student. No-one could convince you otherwise because you would know it was true and other people’s disbelief would annoy you. This can make it difficult to ask about delusions! Fortunately, delusions generally relate to things that are important to the patient, and so are often referred to while talking. Your job is to listen sensitively and explore anything unusual.

Be alert to the evasive replies of the guarded patient.

>> See Schizophrenia Reality (p.83) for tips on asking about delusions.

True primary delusions are rare. These arise completely ‘out of the blue’ in someone without prior mental health problems. You are much more likely to discover secondary delusions, which follow another abnormal experience, such as an abnormal mood or a hallucination (e.g. on hearing a disembodied voice, a patient then believes they are being stalked). Systematized delusions occur when delusions grow and build on each other, connecting into a delusional system. Delusions can be categorized by theme.

- **Grandiose delusions:** exaggerated beliefs of being special or important
  - e.g. being rich and famous.
- **Persecutory (paranoid) delusions:** beliefs that others are trying to persecute or cause harm
  - e.g. people are spying on the patient.
- **Nihilistic delusions:** beliefs regarding the absence of something vitally important
  - e.g. the patient is dead, homeless, or their organs are rotting.
- **Delusions of reference:** beliefs that ordinary objects, events, or other people’s actions have a special meaning or significance for the patient
  - e.g. news reports relate to them, objects are arranged as ‘signs’.
- **Delusions of control:** beliefs that outside forces control the patient in some way.
- **Passivity**: the belief that movement, sensation, emotion, or impulse are controlled by an outside force, e.g. as if someone has a remote control for the patient’s actions.

- **Delusions of thought interference**: these occur against the person’s will and feel like an invasion of privacy.
  - Thought withdrawal: the belief that someone/something is removing thoughts from the patient’s head.
  - Thought insertion: the belief that thoughts are being placed into the patient’s mind, so that they are thinking someone else’s thoughts.
  - Thought broadcasting: the belief that thoughts are broadcast to others. This is different from people guessing someone’s thoughts by reading body language.

- **Delusions of jealousy**: despite the name, these are actually delusions of infidelity. The patient believes their partner is cheating; it usually affects men.

- **Amorous (erotomanic) delusions**: the belief that someone is in love with the patient. This is more common in women.

- **Delusions of guilt**: the belief of having committed an awful sin or crime.

- **Hypochondriacal delusions**: the patient believes that they have an illness.

  Partial delusions are like delusions but not held quite as firmly—there is a little doubt (partial conviction). These include beliefs that are ‘nearly’ delusional on the way into a psychotic episode and delusions that are weakening with recovery. Under close questioning, someone with a partial delusion would agree that it was possible their belief _could_ be wrong, e.g. due to their imagination playing tricks on them.

**Overvalued ideas**

These are reasonable ideas pursued beyond the bounds of reason. The patient’s life revolves around the idea to the point that it causes distress to them or others. For example, a man might become reasonably annoyed when his neighbour fills her front garden with unsightly garden gnomes, believing that they ‘make the neighbourhood look cheap’. It is _not_ reasonable to be preoccupied to the point of giving up work to take the neighbour to court and finally destroying the gnomes with a hammer! The overvalued idea here is that the gnomes make the neighbourhood look cheap.

**Obsessions**

These are recurrent, unwanted, intrusive thoughts, images, or impulses which enter the patient’s mind, despite attempts to resist them. Deep down, the patient knows that the thought is irrational, unlike a delusion where the patient absolutely believes it to be true. They also recognize the thought as their own—it isn’t placed into their head by some outside force, unlike thought insertion.

Obsessions are unpleasant and make the patient feel acutely uncomfortable or anxious, with themes such as contamination, aggression, sex, religion, or infection, e.g. ‘I’ve got AIDS’. This discomfort is often ‘undone’ by a compulsion. Compulsions are repeated, stereotyped, and seemingly purposeful rituals that the patient feels compelled to carry out. They may also be resisted, since the patient again feels that they are senseless. Compulsions can be actions (e.g. hand-washing) or thoughts (e.g. counting), but are included under Thought because of their close association with obsessions. If they are observed during the interview, they belong under Appearance and Behaviour.

- Do you have thoughts that keep coming into your head even though you try to block them out?
- Some people have rituals that they feel they need to do in a very exact way. Do you do anything like that?

**Thoughts of harm**

Everyone must be assessed for thoughts of harm to self or others. Document all thoughts with full details of any plans, e.g. any preparations, intended method and timing, victim’s details, etc. (See p.57 for more information on self-harm and suicide, and p.82 for harm to others.)

**Perception**

Perception relates to the patient’s sensory world. All five modalities should be explored; if they are normal, you can simply state ‘No illusions or hallucinations in any modality’.

**Illusions**

An illusion is the _misperception_ of a stimulus. People are more likely to make perceptual mistakes when they are drowsy, unable to attend to the stimulus, extremely emotional, or can’t see or hear clearly (e.g. someone who is scared of spiders mistakes a patch of dirt for a spider while cleaning a poorly lit shed).

Illusions are common in healthy people but also occur in mental illness, particularly delirium (where consciousness is clouded).

**Hallucinations**

A hallucination is a perception in the _absence_ of a stimulus, e.g. hearing a voice when no-one has spoken. Hallucinations feel as real as any other perception, so you can’t ask ‘Do you have hallucinations?’

>> See Schizophrenia Reality (p.85) for tips on asking about hallucinations.
Check all modalities.

- **Auditory**, e.g. music, voices.
- **Visual**, e.g. flashes, animals.
- **Touch**
  - **Tactile**: superficial feelings on or just below the skin, e.g. feeling of being scratched.
  - **Deep sensation**: internal feelings, e.g. feeling of the heart being twisted.
- **Olfactory**, e.g. smelling smoke.
- **Gustatory**, e.g. tasting ‘poison’ in food.

Voices may be in the second person (addressing the patient directly as ‘you’) or the third person (as ‘he/she’). Those particularly suggesting schizophrenia discuss or argue about the patient, give a running commentary of the patient’s actions, or say the patient’s thoughts aloud (thought echo). Always describe what the patient is experiencing, e.g. second-person auditory hallucinations of an unfamiliar male voice shouting, ‘Your mother is a prostitute!’.

Healthy people do experience hallucinations, although these are usually brief, e.g. on waking (hypnopompic hallucinations), on falling asleep (hypnagogic hallucinations), or following a bereavement (e.g. hearing the dead person speaking). Hallucinations can signify severe mental illness. Auditory hallucinations are the most common; visual hallucinations suggest organic illness (e.g. brain tumour).

**Depersonalization and derealization**
Both experiences are an unnerving feeling of unreality and you may have experienced one or both when tired or anxious. They occur in many disorders, especially anxiety states.

- **Depersonalization**: the person feels unreal: detached, numb, or emotionally distant.
  - Do you ever feel as if you aren’t quite real?
- **Derealization**: the world feels unreal, e.g. ‘like a film set’.
  - Do you ever feel as if the world around you is not quite real?

Insight
Insight is never simply present or absent; there are different levels of awareness that something is wrong.

- Awareness that behaviour or symptoms are seen as abnormal by others.
  - Do you think your friends would say that you’re different to usual?
- Agreement that the behaviour or symptoms are abnormal.
  - Do you think there’s anything wrong with you at the moment?
  - Is this normal for you? How are you different to usual?
- Understanding that problems are due to mental illness (not, e.g. physical illness).
  - What do you think is causing X? Could it be stress or mental illness?
- Agreement that this illness requires treatment.
  - Do you think that the doctor’s treatment will help?
  - Would you be happy to try the treatment?

Insight can be patchy, e.g. a patient may not think that they are ill, but takes medication because they believe it satisfies the Mafia, stopping their persecution.

**Final thought**
A full assessment includes a physical examination. Always take a chaperone when examining patients, but remember that many people don’t want repeated physical examinations by students.

**Formulation**
The formulation presents the most important points from the history and examination before outlining further management and prognosis.

**Case synopsis**
- Background information: name, age, occupation, ethnicity, marital status.
- Brief summary of current episode.
- Relevant past history.
• Examination
  – Salient features of MSE.
  – Important physical findings, e.g. hemiparesis, jaundice.

**Differential diagnosis**

Start with your *preferred diagnosis* and then list other differentials, from most to least likely. For each, add reasons for and against the diagnosis. Keep the list short and don’t show off by naming rare or eponymous conditions unless certain you are right! Remember that organic states ‘trump’ all other conditions (see p.27 for diagnostic hierarchy).

**Risk**

Risk to self and others must be mentioned, e.g. suicide, self-harm, violence, neglect. Risk is graded as low, moderate, or high.

**Aetiology**

From the information gathered in the history and examination, consider the causes of your patient’s illness. *Predisposing* factors make people vulnerable to a disorder; *precipitating* factors trigger it; and *perpetuating* factors prevent recovery. Use a grid to help you to organize this material (Table 1.1).

**Formulation: Vincent van Gogh**

**Case synopsis**

Vincent van Gogh is a 35-year-old single Dutch artist. The police brought him to hospital on 24 December 1888 after he threatened a friend with a razor, and then cut off his own ear and gave it to a prostitute. He has not explained his actions but has mentioned ‘frightful ideas’ and being forsaken by God. Over the past 9 weeks he has become increasingly irritable, and has painted incessantly. There is a 4-week history of divine ‘communications’ and the feeling of being punished by God. During this time, his thoughts have been confused and fast, his mood labile, and his appetite and libido low, and he has been sleeping only 2–3 hours a night. Relationship problems with his friend, Mr Gauguin, could have triggered this episode, and substance misuse may have exacerbated his symptoms.

He suffered two episodes of depression in his twenties, neither of which was formally treated; both followed losses. Each episode gave way to a period of immense energy and creativity. He has self-harmed once before, burning his hand when he was 28. Vincent has had relationships with prostitutes since his twenties. He contracted gonorrhoea when he was 29 and has a possible history of seizures.

**Prognosis**

Give your opinion on the patient’s prognosis, both for their current episode of illness and long term. Include positive and negative prognostic factors to support your view.

**Management**

Management is holistic, since medication alone cures very little. Think about immediate, medium-term, and long-term care—again, a grid helps (Table 1.2).

**Investigations**

Investigations exclude physical causes of the problem (e.g. hypothyroidism in depression); check general physical health and provide baseline measures before starting medications.