



# History Taking

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# What are they looking for

- **Formulation and Diagnosis:**

to explain it in understandable language to the patient, including differential diagnoses if applicable. Your knowledge base is crucial for this.

- **Comprehensive History Taking:**

Eliciting and exploring relevant symptoms and details in sufficient depth.

- **Risk Assessment Skills:**

Adequately identifying potential risks and integrating them into the consultation.

- **Patient-Centered Approach:**

ensuring the interaction does not cause undue emotional or physical distress. This includes showing empathy.

- **Attention to Physical Health**



# General Structure

## Introduction:

- Introduce yourself and your role clearly. (*Dr-Mr/ First name- First Name*)
- Rapport first, then agenda-setting

## Initial Exploration (Open Questions):

- Begin by listening to the patient
- Allow the patient to freely share their *thoughts and expectations.*

## Focused Inquiry (Closed Questions) – Funnel Shape (Open- Close- Super closed!):

- Once initial features are explored, signal to the patient that you will ask more specific questions- ASKING CONSENT (e.g., "Would it be OK if I ask you some specific questions now?").
- Then, focus on specific details with targeted closed questions, if appropriate.

**Ensure to explore all components of the TASK instructions thoroughly.**



# General Structure

## Demonstrate Systematic Approach:

- Explain what you are doing and why
- Summarise aspects of the information collected to show you are collating and processing information, and to check understanding with the patient. Use mini-summaries for active listening.

## • Formulation and Diagnosis:

- Commit to a diagnosis or formulate the problem based on available information, stating it clearly and explaining it to the patient in understandable language.
- If unsure, explain your plan to reach a definite diagnosis.

## • Risk Assessment:

- Demonstrate adequate skills in risk assessment throughout the history taking.

## • Patient Engagement and Rapport:

- Be mindful of language, ensuring it is empathetic and does not cause distress.
- Build rapport by checking on their emotional state and showing curiosity

# Biggest Mistakes in History Stations

## Poor Listening Skills and Not Responding to Cues:

- fail to use verbal or non-verbal cues to increase understanding.
- asking questions but not listening or acting upon answers

Echo/rephrase important points

Respond to emotion ("That sounds really tough...")

Special weapon: *linking!*

## Formulaic or Disorganised Consultation Style:

- The consultation may appear disjointed or erratic, without a clear logical structure.
- Repetitive or multiple closed questions
- Using pre-prepared phrases that sound *insincere or not tailored to the patient* (e.g., "How does that make you feel?")

## Insufficient Depth or Significance of Findings:

## Poor Language Use:

- Using jargon or technical terms without explaining them fully to the patient

## Time Management Issues: Running out of time before completing all tasks or formulating a comprehensive plan

## General Structure

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**1. Chief Complaint** - “Tell me more about what’s brought you in today.”

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**2. Presenting Illness** - Timeline, triggers, progression (“How did it start?”)

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**3. Associated Features** - Risk, mood, sleep, appetite, functioning, psych symptoms

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**4. Relevant Past History** - Medical, psychiatric, family, social, substance

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**5. Impact & Context** - Life impact, supports/relationships, stressors

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*Signpost each domain as you approach it, e.g., “Now I’d like to ask about your health in general...”*

# General Structure- Start :

**Introduction and Rapport:** 3C Framework –

**Clarify (OQ), Connect (A,V,E), Collaborate**

**Chief and Presenting Complaint:**  
4-5 points of main diagnosis + Timeline (OPD)

**History of Comorbid Illness:**  
3 points of comorbid diagnosis (eg. depression, anxiety etc)

**Impact (Work/Stud/ Relationships/ Daily Activities/ Social Life/ Self-Care) or/and Coping or and Risk Assessment**

# General Structure- Background Hx :

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**Past Psychiatric History**

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**Medical/ Physical History –Sleep and appetite**

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**Medication and Treatment History**

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**Forensic History**

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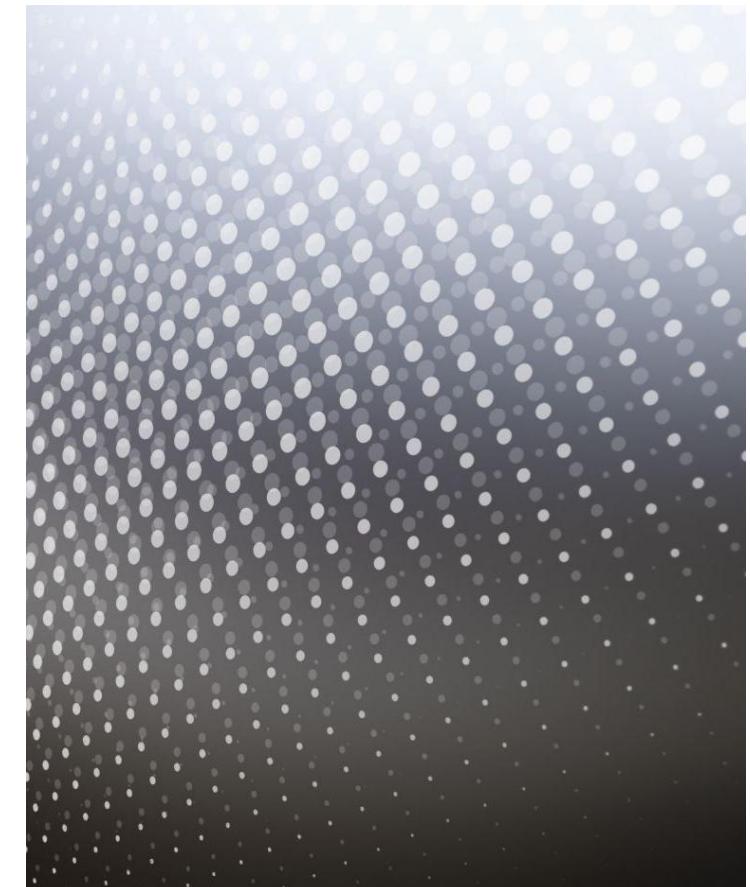
**Substance Use History**

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**Family History**

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**Social History/ Support systems**



# General Structure -End:

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- Insight and Understanding (Collaborative approach again): **ICE (If theres time)**
- Diagnosis (If asked to give diagnosis)
  - Formulate (**3 areas**) + *Invite patient to hear diagnosis*+ Diagnosis

or

*Invite patient to hear diagnosis* + Diagnosis + Formulate (**3 areas**) why you gave the diagnosis

- Give either Diagnosis / Differentials / How you will you further investigate to find probable diagnosis (eg dementia, autism, adhd etc)
- Plan Next Steps (**JUST 1 LINE IF POSSIBLE**)- investigations/ treatments/ referrals.

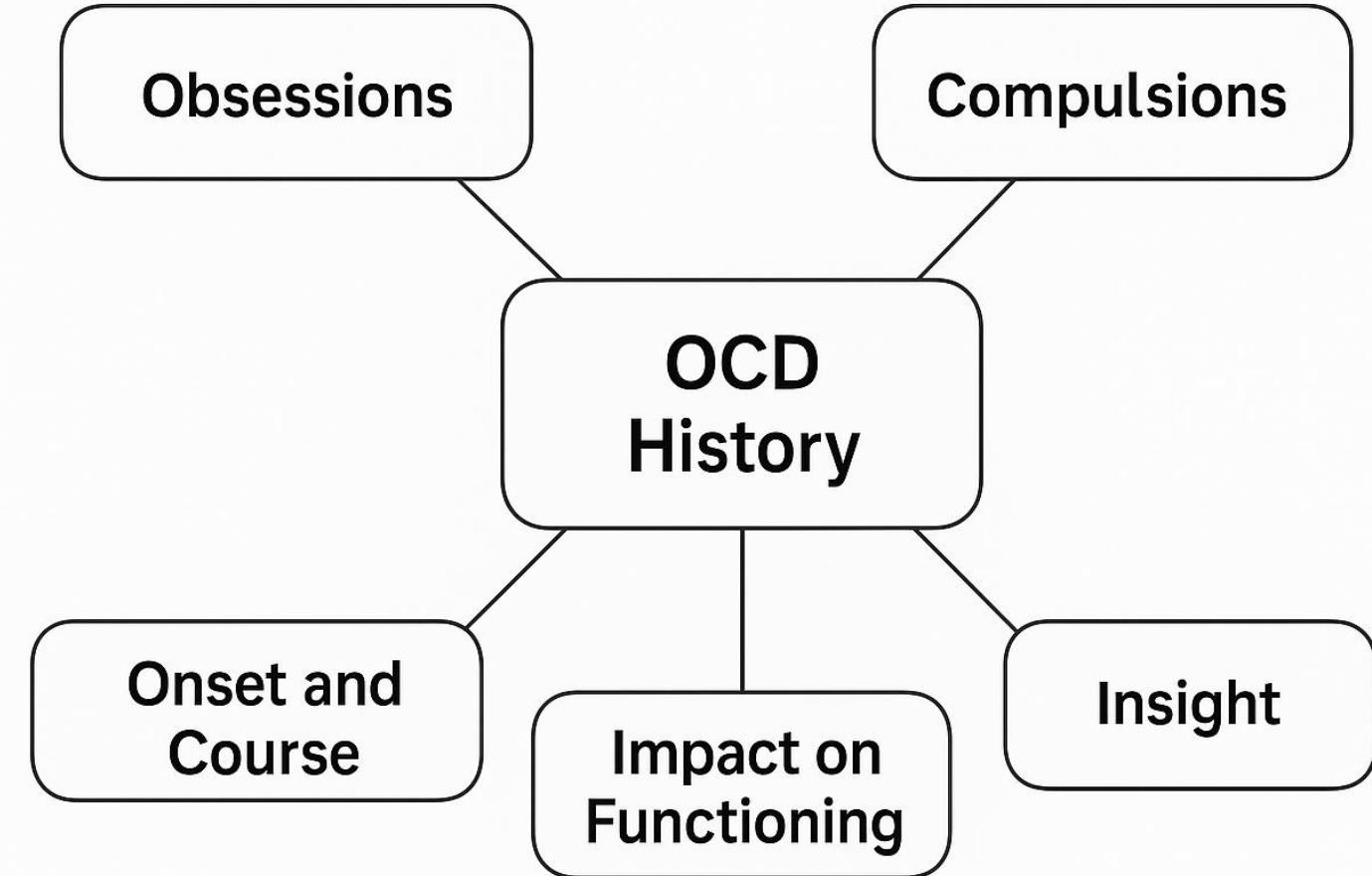


# Basic Psychiatric Hx Assessments

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# Obsessive- Compulsive Disorder (OCD)

- Thoughts of contamination—compulsions to wash hands excessively.
- Task:  
Take a history of her obsessions and compulsions as well as their impact on her functioning.



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## 1. Engagement & Rapport

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## 2. Obsession

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## 3. Compulsion

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## 4. Onset and Triggers/ Impact

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## 5. Formulation



# OCD

## Rapport

“How has things been since your baby was born 6 weeks ago? *Get the baby’s name!*”

"It takes courage to talk about these things"

"Many women experience changes in their thinking after having a baby"



## OCD Obsession

"What's the most upsetting thought that keeps popping up?"

"These thoughts about cleaning - how often do they come into your mind?"

"When you have these thoughts, how do they make you feel?"

"Do you find these thoughts difficult to stop or control?"

### Specific Postpartum questions TOWARDS BABY:

"Are these thoughts focused on protecting your baby from harm?"

"Do you worry about germs / contamination affecting your baby?"

**Look for ego-dystonic intrusive thoughts, distress about the thoughts themselves, and attempts at thought suppression**

## OCD Compulsion

"When you have these thoughts, is there anything you feel you must do?/ do to feel safe?"

"Can you walk me through what a typical cleaning routine looks like now?"

"How many times do you need to clean something before it feels 'right'?"

"If you try to stop cleaning, what happens?"

### Specific Postpartum questions TOWARDS BABY:

"Does this cleaning involve baby bottles, toys, or equipment?" (*Indirect harm to baby!*)

"Have you been avoiding certain activities with your baby because of these worries?"

"What does your husband say about cleanliness / your baby's safety?" (*Social circle*)

## OCD

### Functional impact & Comorbid – 100% have comorbid mood disorders

"How much time each day do you spend on cleaning routines?" – "must be exhausting" (*Energy*)

"Has this affected your ability to care for/ enjoy time with your baby?" (*Anhedonia*)

"How has this impacted your relationship with your partner?"

"When that thought appears, how do you feel in your body?" (*Panic Attacks*)

#### Specific Impact Areas:

Mood: "How's your mood been since baby was born? Was it similar before?" (*depression/ anxiety- which came first?*)

Sleep: "How are you sleeping - do the thoughts keep you awake?"

Social functioning: "Have you stopped seeing friends or family because of these worries?"

Self-care/ appetitie: "Are you able to look after yourself properly/ have meals regularly to get your strength/ What about me time?"

## OCD

### What about HARM TO SELF and BABY?!

1) normalise, 2) elicit the critical content, and 3) ego-dystonic intrusive thoughts vs genuine intent

#### **Self harm (*Elicit*):**

“On the hardest days, have you ever thought of ending your own life?”

#### **Baby harm (*Normalise*):**

“Some mums picture something awful happening to the baby and feel horrified. Any thoughts like that for you?”

#### **Ego dystonic vs ego syntonic (*Differentiate*):**

“Do those thoughts ever feel so strong you might act, or are they always unwanted and you try to resist?”

**Clinical reasoning-** So these thoughts are shocking to you, you always try to push them away, and you've never come close to acting on them / I'm asking because mums who are distressed by the thought rarely act on it

# □ OCD History Assessment

**⚠ What about HARM TO SELF and BABY?!**

## ⌚ Three-Step Approach Strategy

1) NORMALISE

2) ELICIT

3) DIFFERENTIATE



**Self Harm**

Elicit

DIRECT APPROACH

"On the hardest days, have you ever thought of ending your own life?"



**Baby Harm**

Normalise

NORMALISING APPROACH

"Some mums picture something awful happening to the baby and feel horrified. Any thoughts like that for you?"

## 🔍 Ego Dystonic vs Ego Syntonic (Differentiate)

"Do those thoughts ever feel so strong you might act, or are they always unwanted and you try to resist?"

Ego Dystonic = Unwanted, Resisted

VS

Ego Syntonic = Might Act On

## □ Clinical Reasoning

"So these thoughts are **shocking to you**, you **always try to push them away**, and you've **never come close to acting on them** / I'm asking because mums who are **distressed by the thought rarely act on it**"

# Obsessive-Compulsive Disorder (OCD)

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## **Ending Formulation:**

“You’ve been dealing with [Obsessions] and [Compulsions] for [Timeline].”

## **Impact:**

“These thoughts and behaviors are affecting your [e.g., work or social life].”

## **Any Relevant Risks:**

**“If those thoughts ever change / if they start to feel appealing / you feel you might act – please call us immediately or attend A&E.”**

**Task:** Take a history of her **obsessions and compulsions** as well as their **impact on her functioning**.



# Neurodevelopmental and Neurocognitive Disorders

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# Asperger Syndrome

- Challenges at work related to social interactions and routines.
- **Task:**  
Assess the nature and extent of his problems to arrive at a diagnosis.

## **Work-Related Issues**

Difficulties with social interaction  
Problems with routines and changes

## **Social Communication**

Difficulty with verbal and non-verbal communication  
Challenges with understanding social cues

# **Asperger Syndrome**

## **Repetitive Behaviors**

Preoccupation with specific interests  
Repetitive routines or rituals

## **Developmental History**

Early development and milestones  
History of social difficulties and rigidity

## Asperger

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- 1. Engagement – Workplace impact (Criterion B)**
- 2. Social communication (Criterion A)**
- 3. Special Interest**
- 4. Developmental and Family Hx**
- 5. Formulation**



# Autism

## DSM 5 Criteria

### Criterion A: Social Communication and Social Interaction Deficits

Must demonstrate all 3 of the following:

- Social-emotional reciprocity deficits
- Nonverbal communication difficulties
- Relationship development and maintenance challenges

### Criterion B: Restricted, Repetitive Behaviors/Interests

Must demonstrate at least 2 of the following:

- Stereotyped/repetitive behaviors
- Insistence on sameness/routines
- Highly restricted, fixated interests
- Sensory processing differences



## Autism

### Workplace impact – Criterion B

#### Criterion B Target Questions:

"How long had you been in your previous office?" (routine adherence)

"What specifically about the new office makes it difficult/ to concentrate?" (sensory/environmental factors)

"When your routine gets disrupted like this, how does it affect you?" (change tolerance)



## Autism

### Social Communication – Criterion A

**S/P:**

"I notice you mentioned you don't like your new employer ... can you tell me more about your relationships with colleagues and supervisors?"

#### **Criterion A Target Questions:**

"How do you typically interact with/ Did you tell your coworkers (or *friends*) at work?" (social-emotional reciprocity)

"Do you find it easy to pick up on what others are thinking or feeling?" (social communication)

"How comfortable do you feel in workplace meetings or informal chats?" (relationship maintenance)

Deliberate use of wording *friends* to see reaction.

## Autism

### Special Interest eg Colour fixation of your clothes

**When the role player begins discussing your clothing color, validate and explore rather than redirect:**

"I can see you're really interested in this color - tell me more about that"

"How long have you been interested in colors and painting?" (intensity and duration)

"Do you find yourself thinking about colors frequently throughout the day?" (preoccupation level)

"When you mentioned toys in this colour - can you tell me about that?" (age-appropriateness of interests)

If he apologises after talking a lot, don't just say its ok!

"Why did you feel you needed to apologize?" (social awareness)

"Did anyone tell you talk too much about your interests?" (social feedback history)



## Autism

### Special Interest eg Colour fixation of your clothes

#### Family History Assessment:

"You mentioned your uncle has autism - what do you know about that?"

"Are there other family members who might have similar traits?" (genetic risk factors)

"Looking back at your childhood, were there signs that might be similar to what you're experiencing now?" (early development)

#### Childhood Development:

"How were things for you socially in school?"

"How was friendship like then? Did they share your interests?"



### 1 "Permission-Seeking" Observation

*Non-confrontational awareness and accommodation*

EYE CONTACT APPROACH

#### Example Script

"Can I check something with you? I've noticed you seem **more comfortable looking away** rather than directly at me. Would you prefer we **keep talking like this**, or is there anything I could do to **make it easier**?"

### 2 Praise - Curiosity

*Reframe as positive characteristic before exploring*

SPEECH PATTERN APPROACH

#### Example Script

"You have a very **steady, even tone** when you talk. Is that something you've **cultivated**, or does it just feel **natural**?"

### 3 Quote His Language

*Use patient's own words to explore impact*

BULLYING EXPLORATION

#### Example Script

"You mentioned colleagues said your speech is '**different**'. What words did they use, and how did that **affect you**?"

Clinical Context:  
During bullying exploration

## Asperger Syndrome

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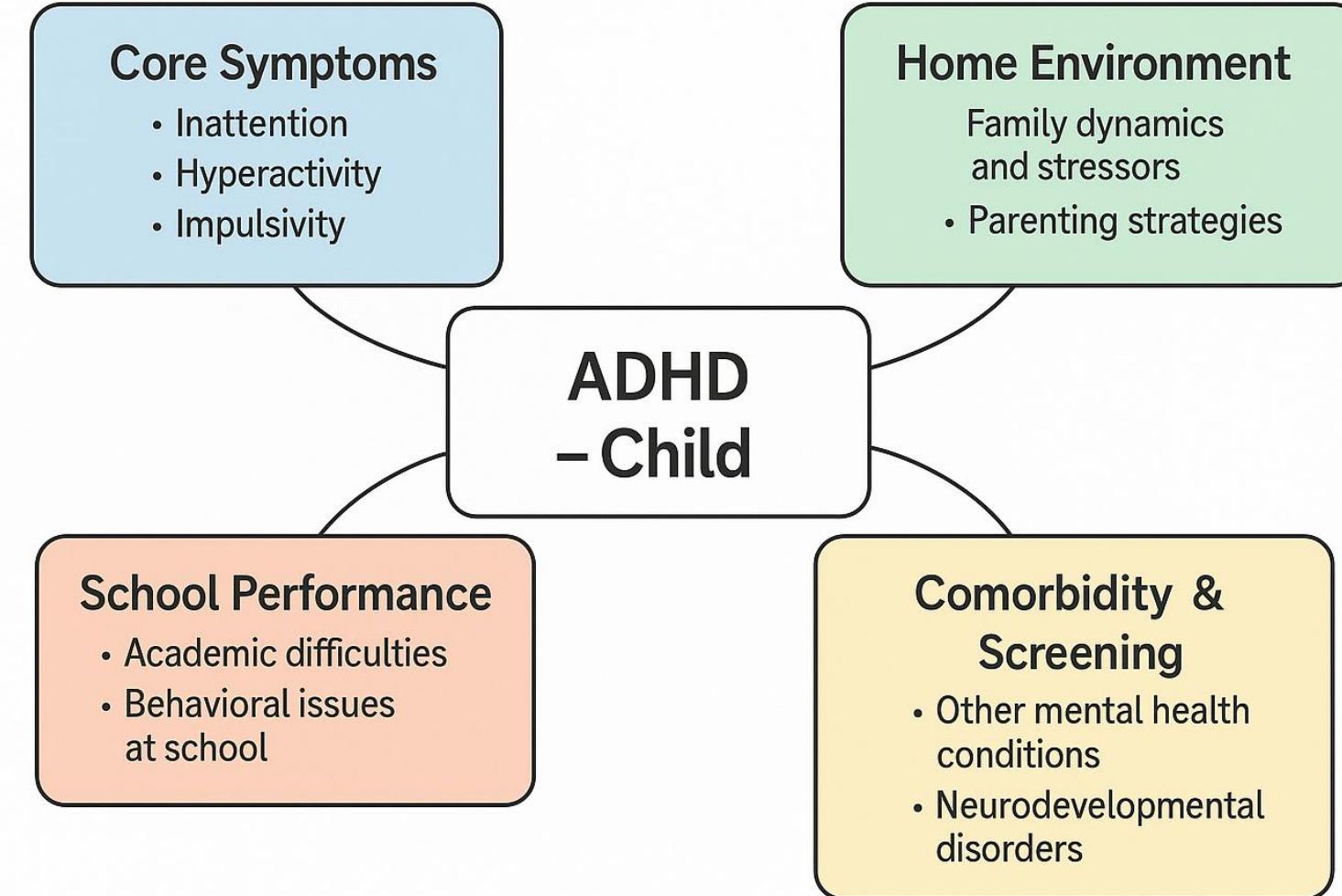
- **Summarise Symptoms:** "Based on our conversation, I can see several patterns that suggest you may indeed be on the autism spectrum, (*similar to your uncle*). You're showing difficulties with workplace transitions and routine changes, you have intense interests (in colors), and you're aware of differences in how you communicate socially."
- **Diagnosis:** more testing and possibly speaking with family about your early years. **(Can't give diagnosis after 7 min!)**

**Task:** Assess the **nature and extent** of his problems to arrive at a **diagnosis**.



# ADHD - Child

- Trouble focusing, hyperactivity, impulsivity at home and school.
- Task:  
Speak to Mum to elicit more information about David, looking for features suggestive of a childhood disorder. Please also consider other associated comorbidities.



## ADHD- Child

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**1. Core ADHD**

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**2. Comorbid**

---

**3. Functional**

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**4. Developmental and Family Hx**

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**5. Formulation**

## ADHD- Child

**Sounds easy- why not many score well?**

### Common Pitfalls

#### Assessment mistakes

Accepting vague descriptions **without seeking specific examples**

**Missing comorbidity** screening

Failing to assess **functional impairment**

#### Communication

Rushing through symptoms **without validating parental concerns** (*You are speaking to a 3<sup>rd</sup> person!*)

Failing to **acknowledge parental expertise** and observations (*Collaborative Language*)

Sounding **check-listy/ too formulaic**



## ADHD- Child Rapport/ Engagement

"Hello .....I understand you've been concerned about David.

As his mother, you know him better than anyone, so I really want to understand what you've been seeing at home.

Can you start by telling me what's been most worrying you about David recently?"

### Validation and Normalisation

*"It sounds like you've been really observant about David's needs"*

"Many parents notice these patterns ... you're not alone in this" – when she is worried

*"It must be exhausting managing this at home"*

### Let her lead

“Looking back over his life, what stands out as the key patterns or turning points?”

“When you think back to pregnancy and those early days, what stands out?”



## ADHD- Child

### ADHD symptoms- Inattention

**S/P:**

"Let me ask about David's attention and concentration..."

**Target questions:**

"Does David have trouble paying attention to details in schoolwork? How's his grades"

"What does he often do when you talk to him or give him a task?"

**Instead of accepting yes/no answers, always follow up:**

"Can you give me a specific example ....of that happening this week?"

"What does that look like at home .....compared to what teachers say?"



## ADHD- Child

### ADHD symptoms- Hyperactivity-Impulsivity

**S/P:**

"Now let me ask about his energy levels and impulse control.../ Sounds like quite an energetic fellow"

**Target questions:**

"Does David fidget or... tap his hands or feet when he needs to sit still?"

"Is he often 'on the go' - like getting up and moving around when he should stay seated?"

**"How is he when it comes to play?"**

**Instead of accepting yes/no answers, always follow up:**

**"Can you give me a specific example ....of that happening this week?"**

**"What does that look like at home .....compared to what teachers say?"**



# ADHD- Child Comorbid

**The top 5 comorbidities in kids with ADHD:**

1. Autism Spectrum Disorder (24%)
2. Learning Disorders (22%)
3. Sleep Problems (15%)
4. Language Disorders (15%)
5. Anxiety Disorders (12%)



## ADHD- Child Comorbid

### Autism Spectrum Assessment

"How does David get along with the other kids?"

"Does he have any particular interests he's really focused on?"

"How does he handle changes in routine or surprises?"

"Does he make good eye contact during conversations?"

### Learning Disorders

"How is David doing academically compared to his classmates?"

"Any specific subjects he really struggles with?"



## ADHD- Child Comorbid

### Anxiety/Emotional Regulation

"Is David a worrier?"

"How does he handle frustration?"

"Any fears?"

### Oppositional Defiant Disorder

#### Present in 41% of ADHD cases:

"How does David respond to rules?"

"Has he ever refused to comply with requests?"

"Do you feel he is deliberately defiant / seems to enjoy annoying others?"



## ADHD- Child

**Developmental & Medical History - 25% of children with ADHD have early developmental concerns!!!!**

**Instead of :**"Any concerns during pregnancy/ birth/ milestones/ or David's early development?"

**Try:** "You've described how difficult things are with David now. I'm wondering when you first became a mum, how did those early months go with him? **There may be patterns early on (*Clinical Reasoning*).**"

"Has anyone in the family have had similar traits?"

**When she mentions:** "He's always been active"

**Your response:** "Always been active ....that's interesting. Can you help me understand what 'always' looks like? **Even as a toddler** when he was learning to walk and talk?"

## ADHD- Child

**Developmental & Medical History - 25% of children with ADHD have early developmental concerns!!!!**

**S/P:**

"With everything David's been through, I want to make sure we haven't missed anything medical that might explain his difficulties. Have there been any times you've worried about his physical health...."

**F/up:** "And his hearing and vision ... school would notice if there were problems there, but what's your sense of how he sees and hears?"

**Target questions** (*That you can ask closed with good S/P*):

Sleep problems: "How is David's sleep - any snoring, restless sleep?"

Hearing/vision: "Any concerns about his hearing or eyesight?"

Seizures: "Any episodes of staring spells or seizures?"

Head injuries: "Any significant head injuries or accidents?"

Medications: "Is he taking any medications currently?"



## ADHD- Child

**Developmental & Medical History - 25% of children with ADHD have early developmental concerns!!!!**

**Clinical Reasoning – Basically to say her son is not the devil!:**

"From what you're describing ....the early activity levels, the struggles with milestones, and the family history of similar patterns .... this helps me understand that David's difficulties **likely have neurodevelopmental roots rather than being purely behaviour to stress.**"



# ADHD- Child Functional Impact

## Home

"How are family relationships affected by David's behavior?"

"Can he do chores by himself?"

## School

"What do his teachers say about his classroom behavior?"

"Did he get in trouble in school?"

## Social Functioning

"Does David have friends? How do playdates typically go?"

"Is he invited to social activities?"

"Any issues with group activities?"



# ADHD- Child Risks

## Physical safety

"Has his impulsivity got him in danger?"

## Academic risk

"Is he behind academically?"

## Social risk

"Is he being bullied in school?"

KEY PRINCIPLE: Not sounding formulaic or checklist-y • Validate mum • Make her lead

### 1 Let Her Lead with Chief Complaint

*Open, collaborative start*

Start completely open-ended and let mum tell her story.

**Listen for whether concerns are primarily at SCHOOL or HOUSE** - this determines your next focus area.

"That sounds really challenging for both of you..." • "I can see why you're worried..."

**Key Actions:**

- Open-ended start
- Note setting mentioned
- Validate concerns
- Don't interrupt story
- Show empathy first

### 2 Explore Symptoms in HER Setting First

*Follow her lead, then systematically explore*

If she mentioned **school problems** → explore school symptoms first

If she mentioned **home problems** → explore home symptoms first

Naturally weave in: **Inattention, Hyperactivity, Impulsivity**

**Explore Naturally:**

- Attention/focus issues
- Hyperactive behaviors
- Impulsive actions
- Real-life examples
- Impact on daily life

### 3 Bridge to Other Setting (School/House)

*Natural transition, not abrupt switch*

**"What you're describing at home sounds familiar..."** → transition to school

**"I'm wondering if teachers notice similar things..."** → explore other setting  
Look for cross-setting consistency

**Bridge Phrases:**

- "Similar at school?"
- "Teachers mentioning...?"
- "Different settings?"
- "Consistent pattern?"
- "Various situations?"

4

#### Comorbidities & Functioning Impact

*Explore broader picture*

"How is this affecting his friendships/learning/confidence?"

Screen for: Anxiety, Depression, ODD, Learning difficulties, Social impact

**Areas to Cover:**

- Social relationships
- Academic performance
- Self-esteem
- Anxiety/mood
- Oppositional behavior



5

#### Neurodevelopment / Family / Medical History

*Systematic but conversational*

Early milestones, pregnancy, family ADHD history, medical conditions, medications, substances

**Key Areas:**

- Early development
- Family history ADHD
- Medical conditions
- Current medications
- Pregnancy/birth



6

#### Formulate & Reflect Back

*Collaborative summary*

"From what you're telling me, it sounds like..." → summarize key findings and validate her observations

**Include:**

- Cross-setting symptoms
- Functional impact
- Acknowledge challenges
- Next steps
- Validate her concerns

## Attention-Deficit/Hyperactivity Disorder (ADHD)

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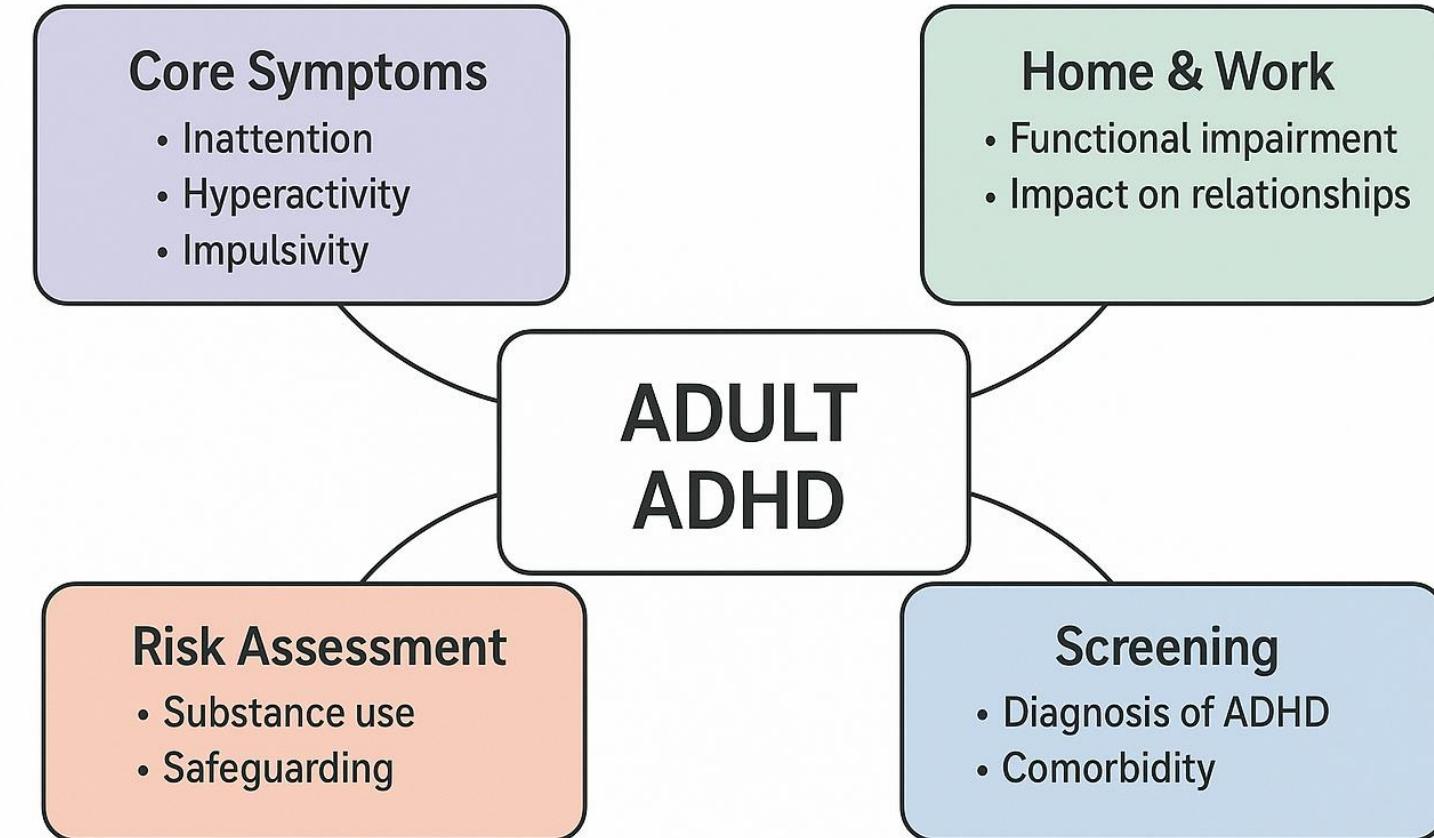
- "Based on our conversation, David appears to be showing symptoms of **[inattention/hyperactivity-impulsivity/combined]**, present since before **[age]**, occurring both at home and school. The pattern is **highly suggestive of ADHD**. The next steps would be [one line assessment plan]."

**Task:** Speak to Mum **to elicit more information** about David, looking for **features suggestive of a childhood disorder**. Please **also consider other associated comorbidities**.



# ADULT ADHD

- Trouble focusing, hyperactivity, impulsivity at home and school.
- Task:  
Take a **history** to assess for **symptoms of adult ADHD** and perform a **risk assessment**.



## ADHD- Adult

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**1. Core ADHD**

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**2. Comorbid**

---

**3. Functional**

---

**4. Developmental and Family Hx**

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**5. Formulation**



## ADHD- Adult Rapport/ Engagement

“Many adults discover later in life that certain difficulties are part of ADHD. (*empathy*)

I’d like to understand how these patterns have affected you then talk about ways forward..... that okay?  
(*Collaboration*)”

**To get him continuously engaged:**

**Instead of accepting yes/no answers, always follow up with specific examples.**

**Or**

**Example-First Queries:** “Tell me about a recent meeting where attention was difficult.”/ “Tell me about a time recently when something small got overlooked—how did that happen?”- **then take it from there.**



## ADHD- Adult

### ADHD symptoms- Inattention - Hyperactivity-Impulsivity

#### Inattention:

“How often do small errors slip into your work because of missed details?”

“Tell me about keeping track of deadlines or bills.”

“What happens when someone gives you multi-step instructions?”

#### Hyperactivity- Impulsivity:

“Do you feel restless inside, like you’re ‘driven by a motor’ even when seated?”

“How easy is it to wait in queues or meetings without blurting things out?”

**Childhood: “Growing up, were teachers or parents ever concerned about ....”/ "What did teachers have to say about how you were back then?"**



## ADHD- Adult Comorbid

**The top 5 comorbidities in kids with ADHD:**

1. Anxiety/Mood
2. Substance Use - 24% of adults with ADHD - “Alcohol or drugs in helping you focus / relax?”
3. Sleep Problems - affect 15%
4. Personality Traits – “difficulties managing emotions or relationships?”



# **ADHD- Adult Functional Impact**

## **Employment/Education**

“How’s work been?”

“What feedback from your colleagues/ employers?”

## **Relationships**

“How do friends / partners describe you?”

## **Daily Living**

“Walk me through paying bills/ keeping appointments/ or household chores.”

## **Finances**

“Have impulsive buys / missed payments / debt?”



# ADHD- Adult Risk

## Driving safety – ADHD doubles traffic violations

**S/P:** “We’ve talked about focus; can I ask about how this affects your driving?”

“How many speeding tickets or near-misses in the past year?”

## Occupational hazards

“Ever got into trouble at work?”

## Financial impulsivity

“Any purchases you regret?”

## Substance misuse

Quantity-frequency for alcohol, stimulants, cannabis.



## ADHD- Adult Risk

### **Self-harm & suicidality**

“At your lowest, any thoughts of ending life / self-harm?”

### **Aggression/legal**

“Ever acted on impulse - gotten into fights or legal trouble?”

### **Safeguarding dependents**

**If children present:** “Any accidents?”



# ADHD-Adult

1

## Let Patient Lead with Their Story

Start where they are - work vs. relationships vs. daily life. Note their primary concern setting.

**Opening:** "What's brought you here today? What's been the biggest struggle for you?"

*Validation: "That sounds really frustrating - struggling to keep up at work despite working so hard."*



2

## Deep Dive into THEIR Priority Setting

Explore ADHD symptoms thoroughly in the setting they mentioned first (work, relationships, home).

**Focus:** Specific examples, impact on functioning, coping strategies they've tried.

*Validation: "It makes sense that you'd feel overwhelmed when meetings keep shifting focus."*



3

## Natural Bridge to Other Life Areas

Smoothly transition to explore ADHD symptoms in relationships, home, social settings.

**Cross-setting assessment:** Consistency of symptoms across contexts.

*Bridge: "You mentioned struggling with focus at work - do you notice similar patterns in your relationships or at home?"*



4

#### Comorbidities & Functional Impact

Screen for anxiety, depression, substance use. Assess impact on work performance, relationships, self-esteem.

**Key areas:** Sleep, mood, substance use, self-medication patterns.

**Bridge:** "When things get overwhelming like this, how do you typically cope? Do you find yourself feeling down or anxious?"



5

#### Developmental & Background History

Childhood ADHD symptoms, school performance, family history, medical history, substance use history.

**Focus:** Evidence of early onset, persistence, family patterns.

**Bridge:** "Looking back, were there signs of this in childhood? How was school for you?"



6

#### Collaborative Formulation

Summarize findings, share clinical thinking, involve patient in formulation.

**Approach:** "Based on what you've shared, here's what I'm thinking... Does this fit with your understanding?"

**Collaboration:** "What parts of this discussion have resonated most with you? What questions do you have?"

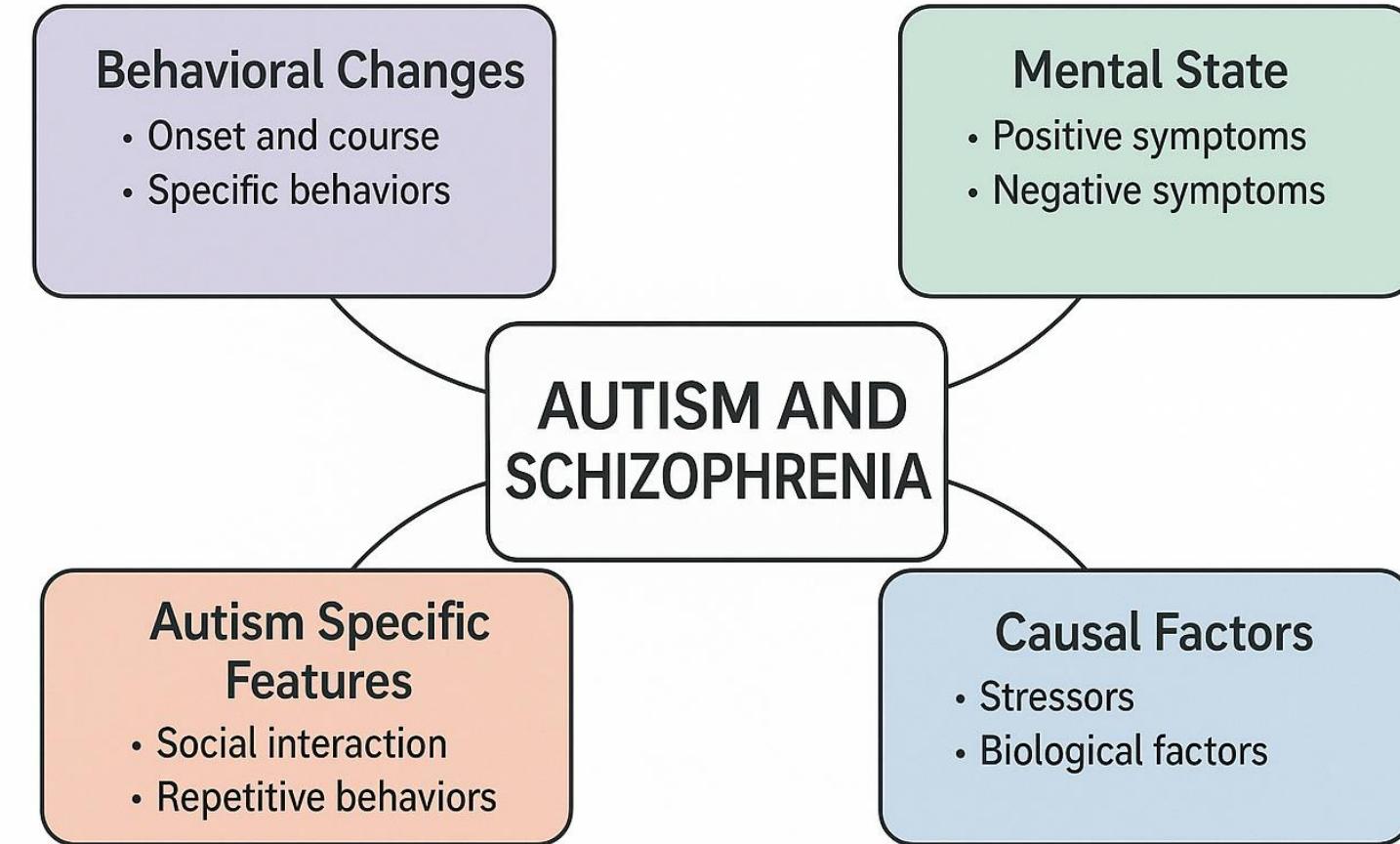
## ADULT ADHD

- **Summarise Symptoms:** “You’ve described difficulties with [A / I / H] since childhood.”
- **Highlight Behavioral Impact:** “These are affecting your [work performance, relationships, daily routines] particularly [Additional Risks].”
- **Next Steps:** “We’ll conduct further assessments to see how we can support you.”

**Task:** Take a **history** to assess for **symptoms of adult ADHD** and perform a **risk assessment**.

# Autism and Schizophrenia

- Behavioral changes and concerns about mental health in a patient with autism and mild intellectual disability.
- **Task:**  
Take a **relevant history** to explore the nature of the current presentation, **including causal factors**. You are **not required to formulate a management plan**.





## Autism and Schizophrenia

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**1. Rapport- Engagement**

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**2. ABC**

---

**3. Functional**

---

**4. Background Hx**

---

**5. Formulation**

# Autism and Schizophrenia

## Rapport/ Engagement

Let him talk for a few seconds enough to get the gist of what he is saying – then interrupt by calling his name and saying-

"I understand you've been through something really difficult with your [dog passing away]. I can see you've been talking to yourself"

### Attachment Assessment:

"Tell me about your dog - what was he like for you?"

"What did you and your dog do together every day?"

"How long did you have this special routine with him?"

**Clinical rationale: Establishes routine disruption - core autism stressor and attachment bond strength - predictor of grief intensity**



## Autism and Schizophrenia

### ABC Analysis of adverse event – Model used in LD- Show temporal relationship

#### A - Antecedents (Before dog's death)

"What was your morning like before you found your dog?"

"How was your dog the night before?"

"What was your routine supposed to be that day?"

#### B - Behavior (The discovery and immediate response)

"What happened when you found your dog?"

"What did you see when you looked out the window?"

"Tell me about the person in the red shirt" (for example!)

**For those who are very autistic with concrete thinking: Avoid "How did that make you feel?" - use "What happened next?"**



## Autism and Schizophrenia

### ABC Analysis of adverse event – Model used in LD

#### C - Consequences (Current state and beliefs)

##### Psychosis?:

"What do you think about the person in the red shirt now?"

"Do you see or hear things that others don't notice?"

"Are you having conversations when no one else is there?"

##### Acute or chronic?:

"When did you first start thinking about the red shirt person?"

"Before your dog died, did you ever worry about people trying to hurt you?"

"Do you think your thoughts about this might be connected to missing your dog?"



# Autism and Schizophrenia

## Function- Risk – Violence/Self/Vulnerability

### Learning disability-adapted questions:

"Who helps you with things at home now?"

"Are you eating and sleeping?"

"How are things with your siblings?"/ "Do they believe you? (*sibling conflict over beliefs*)

"*What would your dog want you to do right now?*"

### Risk assessment integration:

"Have you thought about hurting the person in the red shirt?"

"Are you having thoughts about hurting yourself?"

"Do you feel safe at home?"

## Autism and Schizophrenia

Bg Hx- Don't have to ask all of this if not enough time!

### Learning Disability History:

"Who normally helps you understand difficult things?"

### Autism History:

"How do you usually cope when your routine changes?"

### Previous Psychiatric Episodes:

"Have you ever felt this “confused” (*If he uses this word that you can use it too*) before?"

### Medication History:

"Are you taking any regular medicines?"

"Has anything changed with your tablets recently?"

## 💡 SURPRISE: Patient Experiencing Active Psychotic Symptoms

### ⌚ Scenario A: Auditory Hallucinations

You enter the station. The patient is sitting alone, talking animatedly to someone who isn't there, responding to voices, not making eye contact with you.

### 👁 Scenario B: Visual Hallucinations

Mid-conversation, the patient suddenly looks terrified, stares at the corner of the room, and says "Can't you see them? They're right there!"

## 🏆 100% SCORING RESPONSE FRAMEWORK

**1**

### REMAIN CALM & APPROACH GENTLY

Don't look startled or confused. Maintain professional composure and approach slowly.

✓ What to Say:

"Hello, I'm Dr. Smith. I can see you're having an intense experience right now."

### ACKNOWLEDGE THEIR REALITY

Validate their experience without agreeing or disagreeing with the content.

✓ Validation Examples:

"I can see this is very real and distressing for you."  
"That sounds very frightening."

**2**

### GENTLY EXPLORE THE EXPERIENCE

Ask about their current experience without challenging or reinforcing the hallucinations.

✓ Gentle Exploration:

"Can you tell me what you're experiencing right now?"  
"What are you hearing/seeing?"  
"How are you feeling about this?"

### ASSESS SAFETY & DISTRESS

Determine if they feel threatened or if the content is commanding/dangerous.

✓ Safety Assessment:

"Are the voices telling you to do anything?"  
"Do you feel safe right now?"

**3**

### OFFER YOUR PERSPECTIVE GENTLY

Share that you don't experience the same thing, without being confrontational.

✓ **Gentle Reality Testing:**

"I can see this is very real for you. I'm not hearing the same voices you are."  
 "I'm not seeing what you're seeing, but I can see how distressing this is."

### PROVIDE REASSURANCE

Offer support and let them know they're safe in this moment.

✓ **Reassurance:**

"You're safe here with me right now."  
 "We can work together to help you feel more comfortable."

**4**

### TRANSITION TO ASSESSMENT

Once they're more settled, gently move toward your clinical assessment.

✓ **Smooth Transition:**

"When you feel ready, I'd like to ask you some questions to better understand what's been happening."  
 "Can we talk about when these experiences started?"

### Ø WHAT NOT TO DO (Will Lose Marks)

✗ "There's no one there" / "You're imagining things"

✗ Looking shocked or unprofessional

✗ Agreeing with or reinforcing the hallucinations

✗ Ignoring the symptoms and jumping into questions

✗ "Calm down" / "It's not real"

✗ Speaking loudly or moving too quickly

## Autism and Schizophrenia

- 
- **Summarise Symptoms:** “You’ve described changes like [specific symptoms or behaviors].”
  - **Impact:** “These changes are affecting your [Impact].”
  - **Causes:** “All these happened after... [e.g., What happened or changed?].”

**Task:** Take a **relevant history** to explore the nature of the current presentation, **including causal factors**. You are **not required to formulate a management plan**.

# Old Age Depression- *Weight Loss*

- 72 years old, has been **losing weight over the past two months**. His **wife believes he may be depressed**. You are asked to see him in the outpatient clinic.- **retired 6 months/DRINKING/ ?Delusions?**
- **Task:**  
Take a **history** from the **husband** to **explore the reasons behind the weight loss**.

## Old Age Depression

---

**1. Current Presentation**

---

**2. Baseline Functioning**

---

**3. Timeline, Onset & Depressive Symptoms**

---

**4. Function/Cope- Impact - Risk**

---

**5. Formulation**



# Old Age Depression

## Current Presentation

### Open with:

“Mr ..., I understand you’ve lost some weight recently and your wife is worried. I’d like to ask some questions to understand what’s going on, including your appetite, mood, and general health. Is that okay?”

### Clarify the weight loss

“Roughly how much weight do you think you’ve lost?”

“Over what period of time?”

“Have your clothes or belt size changed?”

“Was this planned or unplanned?”



# Old Age Depression

## Baseline

### Appetite, eating and physical causes (must do)

“How is your appetite at the moment?”

“Do you feel hungry but don’t bother to eat, or do you just not feel like eating at all?”

“Do you ever miss meals? Who cooks? Any problems with chewing, swallowing, teeth, dentures?”

“Any sickness, diarrhoea, tummy pain, problems going to the toilet, coughing, breathlessness, fevers, night sweats?”

“Any new medications or changes to tablets in the last few months?”



## Old Age Depression Timeline and Mood

**Mood and depression link- “As you were speaking, I cant help but notice [sadness]...”**

“You mentioned feeling low. How have you been feeling in yourself over the last few months?”

“Any loss of interest or pleasure in things you used to enjoy?”

“How is your sleep?”

“Energy levels?”

“Are you worrying a lot or feeling anxious?”

“Any thoughts that life isn’t worth living, or that people would be better off without you?”



# Old Age Depression

## Cope

### Alcohol history (COPE-important for weight loss and mood)

“I understand you’ve been drinking more since you retired. Can you tell me what you drink in a typical day or week?”  
PATTERN

“Has the amount changed in the last two months?”

“Do you ever drink instead of eating meals?” CONNECT TO MEALS

“Any morning shakes, needing a drink to steady yourself, or memory gaps?” PHYSICAL/PSYCHO IMPACT

## Old Age Depression

?Delusion??- They just had to put it in there =/

**Money, retirement and possible delusion of poverty**

**You don't need to label it as a delusion in the station, but you should explore how realistic the belief is and how it affects eating.**

“You’ve been retired about six months now – how has that change been for you?”

“You mentioned worries about money. Can you tell me more about that?”

“Do you feel you genuinely don’t have enough money for food, or is it more a feeling of guilt about spending?”

“Have you ever skipped meals or bought less food because you feel you ‘can’t afford it’?”

**If he gives clear, fixed, unrealistic beliefs (“we are bankrupt” despite adequate income):**

“Has anyone (like your wife, bank, or pension office) told you anything different about your finances?”

“Even when they tell you that, do you still feel sure you are ruined financially?”



# Old Age Depression

## REMEMBER- WHY MOST FAIL!

You **don't need to chase every other possible delusion**; with an elderly, slow patient and limited time, focus on:

***whether his money belief is driving poor intake***, and

***whether it sounds fixed, unrealistic, and out of keeping with the facts (i.e. delusional guilt/poverty).***



## Old Age Depression

End

**Summarise Symptoms:** “From what you’ve told me, it sounds like **since [you retired]** you’ve been feeling low, drinking more, worrying a lot about money, and eating much less.

**Connect to Weight:** All of that together may be why you’ve lost weight.

**One line management:** We’ll need to do some physical checks and also think about ways to help your mood, your drinking, and your worries about money.”

**Task:** Take a **history** from the **husband** to explore the **reasons behind the weight loss**.



# Down Syndrome with Low Mood and Memory Issues

- Changes in mood and memory in a patient with Down Syndrome.
- Task:  
Take a **collateral history** from mum with a view to **forming a diagnosis**.

## Down Syndrome with Low Mood and Memory Issues

---

**1. Current Presentation**

---

**2. Baseline Functioning**

---

**3. Timeline, Onset & Medical Factors**

---

**4. Function- Impact - Risk**

---

**5. Formulation**



# Down Syndrome with Low Mood and Memory Issues

## Current Presentation

### Mood Changes:

"Can you describe what changes you've seen in his mood / behavior?"

"Is he more withdrawn/ irritable/ sad than usual for him?"

"Has he lost interest in activities he normally enjoys?"

"How is he sleeping / eating compared to normal?"

Clinical reasoning: "I am asking this because low mood in Down syndrome often **presents as behavioral changes rather than verbalised symptoms.**"



# Down Syndrome with Low Mood and Memory Issues

## Current Presentation

### Memory & Cognitive Changes Assessment

"What memory problems have you noticed - is he forgetting familiar people, places, or routines?"

"Is he getting confused about time, day of the week, or where he is?"

"Has he been getting lost in familiar places / forgetting how to do things he could do before?"

"Any changes in his speech / ability to understand you?"



## Down Syndrome with Low Mood and Memory Issues

### Baseline/ Pre Morbid Functioning – (CAMDEX-DS)

"Before these changes started, what was he able to do by himself?"

"Could he dress himself/ manage his medications/ use money/ travel alone?"

"What was his usual personality like .....was he generally happy/ social/ routine-oriented?"

"Has he always needed prompting for daily tasks..... or is this new?"

# Down Syndrome with Low Mood and Memory Issues

## Timeline, onset and medical factors

"When did you first notice these changes - weeks, months, or years ago?"

"Did they start suddenly or gradually get worse over time?"

"Has it been a steady decline?" (*Step-wise changes*)

"Any triggers – illness/ medication changes / life events/ bereavement?"

### Medical Screening (Essential for Down Syndrome)

**Thyroid function:** ".....seems more tired than usual?"

**Sleep disorders**

**Infections:** ".....especially chest or urine infections?"

**Medications:** changes?

**Sensory/ Seizures**



# Down Syndrome with Low Mood and Memory Issues

## Functional- Impact & Risk

### ADL

"What help does he need now with washing/ dressing/ toileting?"

"Can he still prepare simple meals .....or has that changed?"

"How is he managing money/ shopping/ or using transport?"

"Any safety concerns ....eg leaving gas on/ getting lost/ wandering?"

### Behavioral & Risk Assessment

"Any aggressive behavior, / is he more passive than usual?"

"Has he talked about hurting himself / seemed hopeless?"

"Any new behaviors like repetitive actions / collecting things?"

"How is he coping with changes?"



# Down Syndrome with Low Mood and Memory Issues

## Functional- Impact & Risk

### Social circle:

"Are other family members or carers seeing the same changes?"

"What do day centre staff or support workers say?"

"Has his GP or other doctors noticed anything?"

## Down Syndrome with Low Mood and Memory Issues

---

- **Summarise Symptoms:** [name] is showing [specific changes mentioned] that represent a change from his usual functioning. The [timeline/pattern] you've described, combined with [specific symptoms], suggests we need to investigate this thoroughly.
- **Impact:** “These changes are affecting his [impsct].”

**Diagnosis/ Differentials/ Further investigations to find Diagnosis**

**Task:** Take a collateral history from mum with a view to forming a diagnosis.

# Dementia and Delirium- Cognitive Impairment

- Increasing confusion and memory difficulties over some months.
- **Task:**  
Take a [collateral history](#) from Miss .., considering [any possible relevant diagnoses](#).
- Take a [collateral history](#) from Mrs. .... to [arrive at a diagnosis](#).  
Do not provide a treatment plan or prognosis.

## Dementia and Delirium-Cognitive Impairment

---

**1. Current Presentation**

---

**2. Baseline Functioning**

---

**3. Timeline, Onset & Medical Factors**

---

**4. Function- Impact - Risk**

---

**5. Risk - Formulation**

# Dementia and Delirium-Cognitive Impairment

---

**1. Baseline Functioning (After acknowledging current worries that she first says!)**

---

**2. Changes now**

---

**3. Timeline, Onset & Medical Factors**

---

**4. Function- Impact - Risk**

---

**5. Risk - Formulation**

## Dementia vs Delirium Assessment

### ⌚ BASELINE-FIRST STRATEGY: Listen First, Then Target Your Questions

1

#### ACKNOWLEDGE & VALIDATE

Start by acknowledging the presenting concern with empathy before diving into questions.

✓ Opening Acknowledgments:

- | "I understand you've been concerned about the memory difficulties."
- | "This must be really worrying for you, seeing these changes in confusion."
- | "Thank you for bringing this to my attention - behavioral changes can be very distressing."



2

#### ESTABLISH BASELINE FUNCTIONING

Let them tell their story about what the person was like before these changes. This is crucial for differentiating acute from chronic changes.

✓ Focus on Their Story:

### ⌚ MAXIMUM LISTENING: Understand baseline before targeting symptoms

## 3

## TARGETED SYMPTOM EXPLORATION

Now that you understand the baseline, use focused questions to explore specific symptom domains based on your clinical suspicion.

### CLINICAL DECISION POINT

Based on the baseline story, target your questions toward either **DELIRIUM** or **DEMENTIA** domains

#### DELIRIUM PATHWAY

*When baseline suggests recent/acute changes*

1. Acute Onset & Fluctuating Course
2. Inattention
3. Disorganized Thinking
4. Altered Level of Consciousness

#### DEMENTIA PATHWAY

*When baseline suggests gradual/progressive changes*

- Memory & Learning
- Language
- Executive Planning
- Attention
- Perceptual-Motor
- Social Cognition

### KEY TEACHING PRINCIPLE

#### BASELINE FIRST = BETTER RAPPORT CLEARER DIAGNOSIS

By establishing what "normal" looked like, you can better differentiate **acute delirium** from **progressive dementia** while showing the family you're truly listening to their concerns.



## Dementia -Cognitive Impairment Baseline

"Before this illness started, what was [name] like on a normal day?"

"Could they manage their own finances/ cooking/ shopping/ driving independently?" (*Executive Functioning*)

"How was their memory and concentration normally?"

"Were they socially engaged, / had you noticed any gradual decline?"

### **Dementia specific (Needs more baseline exploration):**

"What was their personality like normally?" (*socially outgoing, organized, independent?*)

"When you think back a few years ago, how different were they from now?"



# Delirium-Cognitive Impairment

## Current Presentation

### 1: Acute Onset and Fluctuating Course

"When did you first notice these changes - was it sudden?"

"Does their confusion come and go throughout the day/ constant?"

"Are there times when they seem more like themselves?"

### 2: Inattention

"Are they easily distracted or have trouble focusing on conversations?"

"Do they seem to drift off when you're talking to them?"



# Delirium-Cognitive Impairment

## Current Presentation

### 3: Disorganised Thinking

"Is their speech confused/ jumping from topic to topic?"

"Are they saying things that don't make sense?"

### 4: Altered Level of Consciousness

"How alert are they - more sleepy than usual/ restless?"

"Are they more difficult to wake up / seem different?"



# Dementia -Cognitive Impairment

## Current Presentation

### **Memory & Learning:**

"Does [name] repeat questions or stories?"

"Do they forget recent events but remember things from long ago?"

### **Language:**

"Any trouble finding words or understanding conversations?"

### **Attention:**

"Can they focus on tasks or do they get easily distracted?"

### **Perceptual-Motor:**

"Any trouble recognising familiar objects or people?"

### **Social Cognition:**

"Have you noticed changes in their behavior?"



# Dementia and Delirium-Cognitive Impairment

## Timeline

"When did you first start noticing these changes ?"

"Has the decline been gradual and steady, / have there been sudden drops?"

**"Are there good days and bad days, / is it fairly consistent?"**



# Down Syndrome with Low Mood and Memory Issues

## Medical factors

Medical Screening

Recent infections

Medication changes

Pain management

Hydration/nutrition

Sleep

# Dementia and Delirium-Cognitive Impairment

## Functional – Impact - Risk

"Are they safe to be left alone, / do they need constant supervision?"

"Any wandering, getting lost, or safety concerns?"

"How are they managing personal care compared to normal?"

"Any falls or accidents since the confusion started? How then do you bring him to the hospital?"

**Risks to carer – Keywords to jump on – Aggression/ Irritated/ Confused**

## Dementia and Delirium-Cognitive Impairment

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- **Summarise Symptoms:** "From what you're describing, [name] has experienced an **[acute?]** change in their mental state over **[timeframe]**, which represents a big change from their baseline functioning."
- The **[fluctuating nature]** of their confusion, strongly suggests **delirium rather than a gradual dementia process. (Or vice versa if not acute/fluctuating)**
- **If Delirium:** Given the **[cause]**, this appears to be a reversible condition that requires more investigation and treatment of the causes."

**Task:** Take a collateral history to arrive at a diagnosis.



# Carer of Vascular Dementia

- Challenges faced by Mrs. Doe in managing her husband's condition.
- Task:  
As part of the assessment, approach Mrs. ... to gather information about the **difficulties she faces in managing her husband's condition.**

## Carer of Vascular Demenia

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**1. Rapport- Engagement**

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**2. Carer Burden**

---

**3. Support System - Coping**

---

**4. Carer health - Impact**

---

**5. Formulation- Risk**



## Carer of Vascular Dementia

### Carer Burden Assessment – Zarit Burden Interview

#### Domain 1: Physical & Emotional Impact

"How has caring for your husband affected your own health / energy levels?"

"What does a typical day look like for you now compared to before his diagnosis?"

"How are you sleeping and eating?"

"Have you noticed changes in your own mood or stress levels?"

#### Domain 2: Social Life & Relationships

"How has this affected your relationships with friends and family members?"

"Are you able to do activities important to you?"

"Do you feel socially isolated / supported?"

**"Are you comfortable managing his medications and medical appointments?"**



## Carer of Vascular Dementia

### Carer Burden Assessment – Zarit Burden Interview

#### Domain 3: Time & Personal Freedom

"How much time each day do you spend on him?"

"When was the last time you had time completely to yourself?"

"Are you able to leave your husband alone, / does he need constant supervision?"



## Carer of Vascular Dementia Support System - Coping

### Formal

"What professional help or services are you currently receiving?"

"Have you had a carer's assessment from social services?"

"Are you getting any respite care or day center support?"

### Informal

"Anyone you can rely on for support?"

"How have family and friends responded to your husband's diagnosis?"

"Is there anyone you can talk to about how you're feeling?"

### Are you equipped?

"Do you feel you have enough information about vascular dementia?"

"Have you received any training on how to manage this?"

"What would be most helpful for you to know right now?"

## Carer of Vascular Dementia

### Carer Health

#### Physical

"Have you noticed any changes in your own physical health since becoming a carer?"

"Are you keeping up with your health needs?"

"Any new aches, pains, / health concerns?"

#### Mental Health

"How has your mood been lately / overwhelmed?"

"Have you had thoughts that you can't cope / hopeless?"

"Any thoughts of harming yourself / wishing you weren't here / leaving him?"

#### Relationship role change?

"Do you find your role in the relationship changed?"

"Do you still feel like a wife/partner, or more like a carer?"

"What have you lost / gained through this experience?"



## Carer of Vascular Dementia

### Risks to ask in between

"Has your husband ever become aggressive / physically threatening?"

"Do you ever feel afraid / unsafe at home?"

"How often do you have meaningful contact with others?"

"How confident do you feel managing medical emergencies / crises?"

"Have there been any accidents / close calls recently?"

## Carer of Vascular Dementia

---

- **Summarise Challenges:** I can see you're managing an enormous amount as you care for your husband with vascular dementia. You're dealing with [challenges] while this has clearly [impact]
- **Highlight Support/ Risks:** “You’ve received help from [family or services] but still face [Risks}
- **Next Steps**

**Task:** As part of the assessment, approach Mrs. ... to gather information about the difficulties she faces in managing her husband’s condition.



# PTSD and Anxiety Disorders

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# PTSD

- Symptoms following a traumatic event and their impact on daily functioning.
- **Task:**  
Obtain a **history** to arrive at a **diagnosis**.

---

## 1. Rapport- Engagement

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## 2. Trauma exploration

---

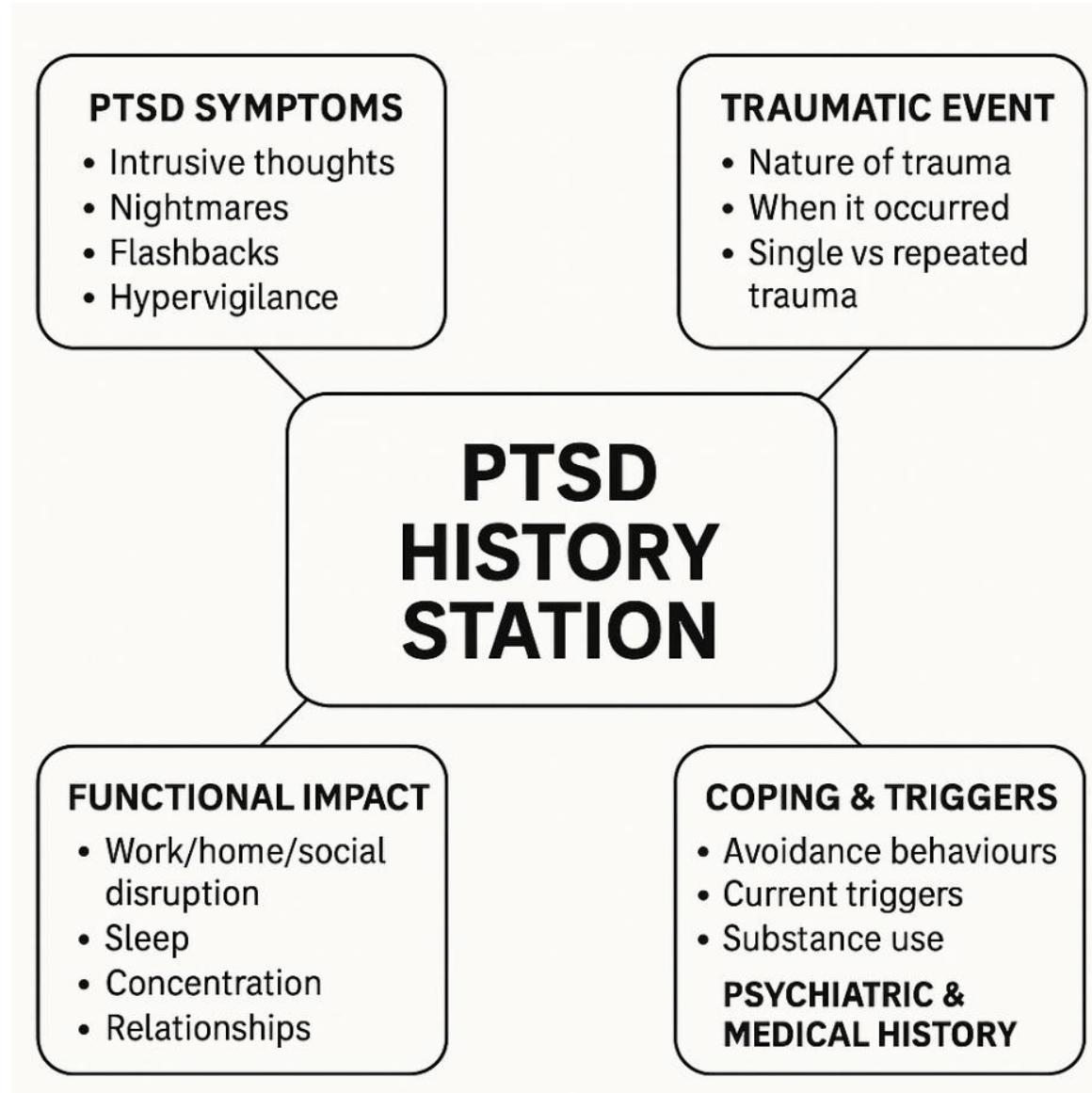
## 3. PTSD symptom assessment

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## 4. Functional- Impact

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## 5. Formulation- Risk





# PTSD

## Rapport-Engagement

**Validate presenting symptoms**

**Normalise distress**

**Establish safety and control**

**Set collaborative tone**

**Example of getting in the station:**

"You mentioned these body sensations come suddenly - when that happens, what goes through your mind? Are there images, memories, or thoughts that force their way in, even when you're trying not to think about what happened?"



## PTSD

### Trauma Exploration

#### The "Permission-Seeking" Approach

"These [body sensations , flashbacks etc.] often connect to difficult experiences people have been through. I'm wondering if there might be a particular experience that these symptoms remind you of? "

#### If patient hesitates:

"Many people find it difficult to talk about traumatic experiences ... that's completely normal"

"Sometimes our bodies remember things even when our minds try to protect us from thinking about them"



## PTSD

### PTSD symptoms

**Intrusive memories:** "Do you have unwanted/ upsetting memories that force their way into your mind?"

**Nightmares:** "How has your sleep been .... any disturbing dreams or nightmares?"

**Flashbacks:** "During these episodes, do you ever feel like you're back there experiencing it again?"

**Emotional distress:** "How do you feel when you're reminded of these experiences?"

**Physical reactivity:** "What does your body do when you encounter reminders?"

**Avoidance:** "Do you find yourself avoiding thinking about what happened?"



## PTSD

### PTSD symptoms

**Negative Cognitions and Mood:** "Do you blame yourself for what happened or how you handled it?"/ Anhedonia?  
"Since this happened, how would you say you're different as a person? How you see yourself, the world, other people?"

#### Arousal/ Hypervigilance:

Instead of: "Do you have hypervigilance?"

Try: "It sounds like this experience has left you feeling like you need to be really aware of what's happening around you  
"Do you feel the need to be watchful / alert to danger?"

#### Timeline

#### Risk



# ☐ Integrating Mood Assessment

Moving Beyond the Depression Checklist

## ✗ Checklist Approach

- "Do you feel sad?"
- "Have you lost interest in activities?"
- "How's your sleep?"
- "Any appetite changes?"

*Sounds robotic, doesn't show empathy or clinical thinking*

## ✓ Conversational Integration

**Use emotional bridging from their primary presentation**

*Shows empathy, clinical reasoning, and opens natural dialogue*

### 🔥 In PTSD Station:

*"Trauma affects people in so many ways ... not just the flashbacks you've described, but often people find their emotion changes as well. Have you noticed feeling more down since this happened?"*

### ⚡ In OCD Station:

*"Having these intrusive thoughts must be emotionally exhausting. Beyond the anxiety, how has this affected your overall mood / enjoyment of life?"*

### ☐ In Autism Station:

*"Changes in routine can be really difficult. Along with the stress this causes, have you noticed feeling more low / losing interest in things you normally enjoy?"*

### 👀 In Psychosis Station:

*"Hearing voices must be incredibly frightening. How has this whole experience affected your mood ... are you feeling hopeless about things?"*

## PTSD

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- **Summarise** : “you’ve shared that you’re using [amount] of heroin [frequency], and it’s affecting your [specific areas like health, relationships, or finances].”
- **Risks**: “This use has led to challenges like [e.g., withdrawal symptoms, legal issues, or physical health complications].”
- **Next Steps**: eg. opioid substitution therapy

**Task:** As part of the assessment, approach Mrs. ... to gather information about the difficulties she faces in managing her husband’s condition.



# Specific Phobia: Fear of Driving

- Fear of driving after a car accident and its impact on daily life.
- Task:  
Take a **history** of her core symptoms, make a **diagnosis**, and **address her concerns**.



## Specific Phobia: Fear of Driving

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**1. Rapport- Engagement**

---

**2. Core phobic response**

---

**3. Avoidance-Functional- Impact**

---

**4. Background briefly**

---

**5. Formulation- Risk**

## Specific Phobia: Situational

### What's the criteria?

- Specific phobia – situational (driving)
- Marked, immediate fear when driving (steering-wheel trigger).
- Fear provokes sweating, panic, “blanking out”.
- Patient avoids or endures with intense anxiety – refuses to drive, yet can be passenger.
- Fear is out of proportion; no fear on public transport.
- **Persistent > 6 months likely (Timeline!)**
- Causes occupational / social impairment (**lost independence**).
- **No intrusions, nightmares, hypervigilance or broad avoidance → PTSD criteria not met**

# Assessing Traumatic Events

Reading Patient Response Patterns & Clinical Responses



## CALM DISCUSSION

Patient talks openly

### □ THINK

May NOT be PTSD  
Consider: Specific phobia, adjustment disorder, resolved trauma

### ▢ RESPOND

"I'm glad to see as you were telling me about this accident, you seem really calm...I'm getting the sense you must be at peace with this"

"Can you tell me more about how this affects you day-to-day?"



## EMOTIONAL/HESITANT

Shows distress, reluctant

### □ THINK

Consider: PTSD, domestic abuse, ongoing trauma

### ▢ RESPOND

"I can see this is difficult to talk about"

"You're safe here"

"What we discuss is confidential unless there's any harm to yourself or the kids"

**Especially important if domestic abuse suspected**



## ANGER/REFUSAL

Becomes hostile, shuts down

### □ THINK

Consider: EUPD (emotional dysregulation), trauma with avoidance

### ▢ RESPOND

"I notice this topic seems to upset you"

"Let's talk about what brought you here today instead"

"We can circle back to this later when you feel ready"



## Specific Phobia: Situational Rapport Engagement and overall style to approach this station

**When the roll player tells you about his accident:**

**(Don't forget to check if he is ok after the accident!)**

"That's really interesting that you can talk about the accident itself *quite calmly*, ....but something very different happens when you try to drive. ....(then maybe f/up with: Help me understand exactly what happens the moment you put your hand on the steering wheel."

**Reflective questions:**

"It's *peruliar* that you can be a passenger in the same car without problems. What do you think might be different about being the driver versus passenger?"

"you've described this intense physical reaction specifically to driving, but not to other car-related situations. *Have you noticed this pattern anywhere else*, or is it purely when you're in control of the vehicle?"



## Specific Phobia: Situational Core Phobia

"Is this reaction immediate / does it build up?" (DSM-5 Criterion B)

"What does your body do ...sweating, heart racing?" (Physical symptoms)

"You mentioned 'blanking out' ...can you describe that?/ What goes through your mind then" (Cognitive symptoms)

"Any other situations that trigger similar reactions?" (Rule out other phobias)

"How do you feel about other forms of transport like trains, buses?" (Specificity assessment)

"What about being driven by different people in different cars?" (Stimulus specificity)



## Specific Phobia: Situational Impact and Avoidance

### Avoidance behavior:

"Do you ever try to practice driving/get back on the wheel, or do you avoid it completely?"

"How do you manage when you need to get somewhere?"

### Functional:

"Work commitments?"

"Family responsibilities?"

"Social activities?"

### Loss of independence



# Specific Phobia: Situational

## Bg Hx

**Medical conditions/medication**

**Previous psychiatric diagnoses / treatment:**

**Family / childhood anxiety loading (one-liner):**

–“Anyone else in the family anxious drivers? /As a youngster were you generally a worrier?”

## Specific Phobia: Fear of Driving

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- **Summarise** : Based on this pattern, it sounds like you've developed what we call a specific phobia ... in this case, a driving phobia. Your brain has learned to associate being in control of a vehicle with danger, even though rationally you know the passenger seat of the same car/using public transport is safe
- **Impact**: “This fear is affecting your [work, social life, or daily activities].”
- **When patient asks about PTSD**: "That's a really good question, and I can understand why you might wonder about that. However: No PTSD symptoms..."

**Task:** Take a **history** of her core symptoms, make a **diagnosis**, and **address her concerns**.

# Specific Phobia:

## Social phobia

- Fear of social gatherings.
- Task:  
Take a **history** of his core symptoms, make a **diagnosis**, and **address his concerns**.

## Specific Phobia: Social Phobia (Same Thing!)

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**1. Rapport- Engagement**

---

**2. Core phobic response**

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**3. Avoidance-Functional- Impact**

---

**4. Background briefly**

---

**5. Formulation- Risk**



## Specific Phobia: Situational Rapport Engagement and overall style to approach this station

**“Ideal Wedding” Pivot – If patient is having lots of difficulties talking about the wedding**

“*You tense up at ‘wedding’ ... Let’s just change topic. Picture the perfect ceremony where you feel relaxed—what would need to change?*”

### Follow-ups:

“Smaller crowd? Fewer speeches? Different layout?”

“How many people in there would feel comfortable?”

“What do you think guests would notice about you?”



# Specific Phobia: Situational Functional impact

## Avoidance - Work

“Do crowds frighten you in other settings?”

“Ever avoided work events?”

## Childhood- Trauma?

## Specific Phobia: Social phobia

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**“Is Something Wrong with Me—Should I Cancel?”**

- “You fear embarrassment, not marriage itself.”
- “May I explain why your body reacts this way?”
- “Social anxiety is common... 1 in 10 adults have it”
- “Anyone would feel trapped facing [eg 200 eyes].”

**One line Mx:** “With brief CBT and stepwise exposure (maybe...practising vows to two friends, then ten)..you can keep your date.”

- **Diagnosis**

**Task:** Take a history of **symptoms**, provide a **diagnosis**, and **address concerns**.

## Specific Phobia: Social phobia

---

Your symptoms occur only when you expect to be the centre of attention; the worry is about embarrassing yourself in front of others. That pattern matches Social Anxiety Disorder—often called a specific social phobia of performance.

**Task:** Take a history of **symptoms**, provide a **diagnosis**, and **address concerns**.

# Somatoform Pain Disorder/ Conversion Hx

- Somatoform-Chronic pain symptoms, their impact, and associated psychological factors.
- Conversion- Been under the neurology team for 5 days with paralysis of her right arm and left leg. Physical examination and investigations are normal. You are asked to assess her today.
- **Task:**  
Obtain a **history** to arrive at a **diagnosis**.

## Somatoform Pain Disorder/Conversion Hx

---

**1. Rapport- Engagement**

---

**2. Pain/Physical Symptom narrative**

---

**3. Perception – Functional impact**

---

**4. Link to Recent Stress-Background briefly**

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**5. Formulation- Risk**

# 🧠 Handling Challenging Opening Responses

When Role Players Surprise You - Stay Calm & Redirect



## ⌚ The Core Strategy

"Agree without agreeing"

- Give them what they want conditionally while maintaining control and showing empathy

⌚ Challenging Response	⌚ Your Professional Reply
"I asked for a neurologist—why am I seeing you?"	" <b>I hear you</b> wanted a nerve-specialist because the symptoms worry you. I'm the liaison psychiatrist; my job is to check whether stress or mood might be making things worst. <b>If after we talk</b> you still want neurology we can arrange that. <b>Is it okay if</b> we spend a few minutes working out together whether any stress is playing a part?"
"I'm sick of doctors, just let me go home."	" <b>I can see</b> you've had a lot of medical conversations already, and you're tired of them. My role isn't to keep you here longer than necessary; it's to check nothing important is being missed before you leave safely. <b>Could we take</b> five minutes to make sure you're all set to go home?"
"Give me a lorazepam script and I'll leave."	" <b>You already know</b> lorazepam calms you quickly. My job is to how its benefiting you and if there's any risks. <b>If, after we talk,</b> lorazepam still seems best, we'll weigh that up."
"I'm only here to see Jenny." (erotomania)	" <b>I understand</b> Jenny feels like the right person to talk to. She isn't available right now, so let me assist you instead. Any reason you're looking forward to seeing Jenny today? <b>Is that ok?</b> "
"You're wasting my time—I'm going."	" <b>It sounds like</b> talking to yet another professional feels pointless. Help me make this useful: tell me the one thing that would make our chat worthwhile, and <b>if I can't deliver</b> that quickly I'll let you go."

## ★ Universal Backup Response

*"I can see you'd rather not be here; that makes sense given everything you've been through. My role is to check there's nothing urgent being missed and to support whatever next step would help most. Could we talk for just a few minutes and decide together?"*

### ☛ Immediate Validation

*"I hear..." / "I understand..." / "It sounds like..." / "I can see..."*

### ☐ Collaboration & Choice

*"Could we...?" / "Is that okay?" / "Would it help if...?" / "Let's... together"*



## Somatoform Pain Disorder/Conversion Hx Rapport Engagement - Style

I gather pain's been dominating life. I'd like to understand the pain itself, how it affects you, and what worries you most—okay?"

**Validate** ("That sounds exhausting") then add a single follow-up

### Lots of Reflective questions:

"Scans all clear, yet pain 10/10—why?" – *Challenge mismatch*

"Worry pain means something deadly?" – *Catastrophising-Hypochondriasis?*

"Pain worse when mood dips?"

"Stopped exercise/hobbies for fear of damage?"



## Somatoform Pain Disorder/Conversion Hx Pain/Physical Symptoms Narratives

“Where exactly hurts?”

→ “Pain quality?”

→ “Always or in episodes?”

→ “What brings it on / eases it?”

→ “Day or night?”

“Any weight-loss, fevers, weakness, numbness?”

“Other body parts started aching too?”



# Somatoform Pain Disorder/Conversion Hx

## Perception- Functional impairments

### Perception:

“Doctors found anything serious?”/ “What do other say?” – **Attention seeking/ Doctor - shopping**

“Pain worse than test results suggest?”

“How long did you spend researching?”

### Cognition- Emotion:

“What goes through your mind in a flare?”

“How do you feel—frightened, low, angry?”

“How do family react when pain’s bad?”

### Impact:

“Work/housework/finance—what’s changed?”

“Sleep? hobbies?”

“What helps even a little?”



## Somatoform Pain Disorder/Conversion Hx

### Link to recent stresses (this is the core of the station)

Transition :

**“Sometimes when tests are normal, we also think about how stress and life pressure can affect the body. Would it be okay if I ask about what life has been like for you recently?”**

**Work stress – main trigger:**

“Can you tell me about your work?”

“What do you do?”

“Has anything changed at work in the last few months?”

“I understand there was a change in department – how did you feel about that?”

“What’s different about the new department?”

“Do you feel more pressure, conflict, or stress there?”

“Have you thought about leaving or asking to move back?”

“Since that change, have you noticed feeling more tense, anxious, or low in mood?”

# Somatoform Pain Disorder/Conversion Hx

## Link to recent stresses (this is the core of the station)

### Caring responsibilities – ?someone with stroke:

“I also understand your mum has had a stroke. How long have you been caring for her?”

“What sort of help does she need day to day?”

“Are you the main person looking after her, or does anyone else help?”

“How has that been for you emotionally and physically?”

“Do you ever feel worn out or that it’s too much for you?”

“How has caring for your mum affected your work, sleep, and time for yourself?”

### Current stress load and coping:

“How has your sleep been?”

“Are you managing to eat properly?”

“Do you have any time for yourself or things you enjoy?”

“When things feel overwhelming, how do you usually cope?”



## Somatoform Pain Disorder/Conversion Hx

### Link to recent stresses (this is the core of the station)

#### Insight:

“Sometimes when people are under a lot of strain – for example a big change at work and caring for a very unwell parent – **the body can react in strong ways, even when tests are normal.**”

“Have you **noticed whether your weakness got worse around the time things were most stressful at work or at home?**”

“**Do you think the stress you’ve been under could be affecting your body?**”



## Somatoform Pain Disorder/Conversion Hx Risks

“Feeling hopeless or suicidal?”

“Any tablets, alcohol, cannabis to cope?” – Over the counter drugs! Accidental overdose to knock off pain!

Physical Health: major illnesses, surgeries

*What would you like to change of your current situation if you could? – Goals to get fears!*

## Somatoform Pain Disorder

### How to end? Focus on the pain-loop

---

- “You’ve been *living with this [really tough pain]* for [timeline]. Even though all the scans and tests haven’t found anything seriously wrong, *the pain feels just as bad/worst because it’s affecting your mood, sleep, work, and life with your family*. What I’m hearing is that your mind and body get stuck in a ‘pain loop’—pain leads to worry and stress, which then makes the pain feel even more powerful. This is something we call ‘persistent pain’—it’s not just about physical damage, but also how the nervous system and thoughts play a central role.

**Task:** Obtain a **history** to arrive at a **diagnosis**.

## Conversion Disorder

### How to end? Focus on symptom-stress

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- “From what you’ve told me, this weakness started suddenly, but all the physical tests have been normal. At the same time, **you’ve had a huge amount on your plate** – [a stressful department change at work that you’re unhappy with, and a year of caring for your mum after her stroke more or less on your own.]
- It sounds **[as if your body may be expressing some of this stress through these symptoms]**.  
**Mx-** The good news is that there are ways we can help you cope with the stress and work towards getting movement back.”

**Task:** Obtain a **history** to arrive at a **diagnosis**.

## Somatoform Pain Disorder

### How to end? Focus on the pain-loop

- You think its not real?

“I believe your pain/symptom is very real. What I am saying is that the pain can be just as intense...even when tests can't find a clear cause...because your **pain system is being affected by stress, emotions and how the body processes pain**. *This isn't your fault, and it doesn't mean you're making it up.*”

# BDD

- Concerns about appearance and their impact on daily life.
- Task:  
Obtain a **history** to explore the nature and **extent** of her problems and clarify her **diagnosis**.

## Body Dysmorphic Disorder

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**1. Triad**

---

**2. Insight - Reassurance**

---

**3. Functional impact**

---

**4. Risks- Differentials**

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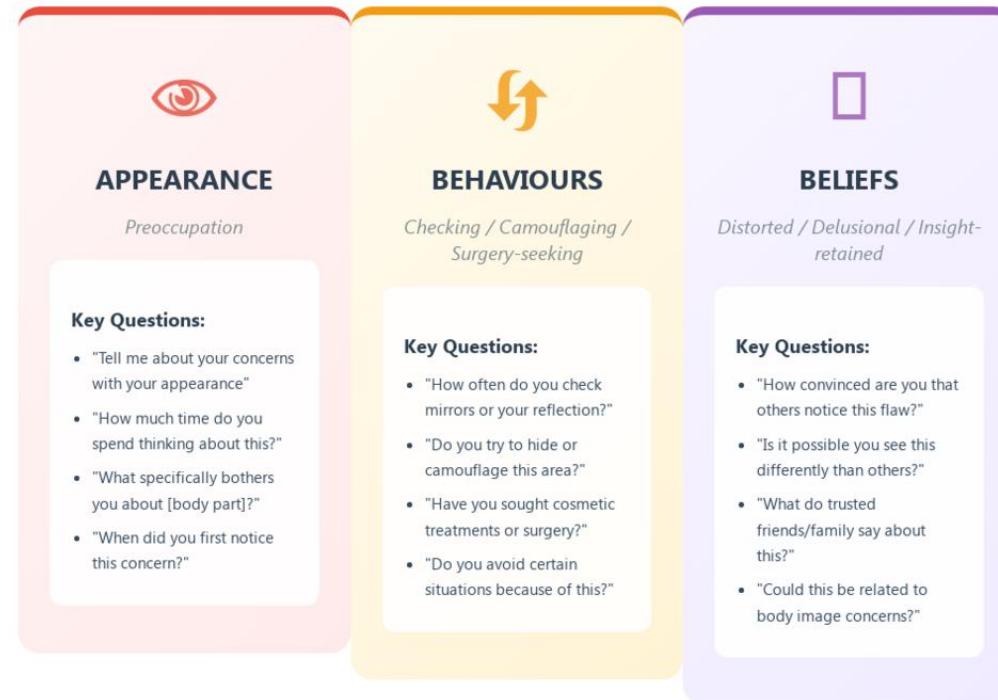
**5. Bg Hx**



# BDD Triad

## □ Body Dysmorphic Disorder

The BDD Assessment Triad - Comprehensive Clinical Evaluation



### ⌚ Clinical Pearls

#### Functional Impact

Always assess **how much time** is spent on BDD behaviors and their impact on relationships, work, and social functioning

#### Insight Spectrum

BDD exists on a spectrum from **good insight** to **delusional** - this affects treatment approach

#### Suicide Risk

BDD has **high suicide rates** - always assess for suicidal ideation and plans

#### Comorbidities

Common overlap with **depression, anxiety, OCD**, and eating disorders



**BDD**

## Insight- Reassurance

“When doctors say ‘looks normal,’ how believable is that?”

“On good days, does your view change?”

“Photos of yourself—still see the same flaw?

“Since you keep checking them, do mirrors ever reassure, even briefly?”

“Do you think most people notice the flaw?/ What goes through your mind when they see your eyes?”

“What proof convinces you the flaw exists?” (*Social Media*)

“Have you found yourself asking people what they think about your appearance—even if you find their answer hard to believe?”

“Is there anyone who ‘gets’ how tough this is for you?”



**BDD**

## Functional- impact

“How has this affected work or friendships?”

“Have you cancelled events because of it?”

“Seen doctors or had procedures for this before?”

“Any places or people you now avoid?”

Don’t say she “looks fine” → invalidation.



**BDD**

## Risks - Differentials

“Feeling low / anxious about this lately?”

“Ever thought life isn’t worth living?”

“Any big worries about weight or food?”

“Anyone commented on how you look?”

What if you wont be seeing a neurologist sooner?- *Self Mutilation*



**BDD**

**Bg Hx**

Medical and surgical

Psychiatric

Substance misuse/ medication (*over the counter – cream? Ozempic?*)

Family

Childhood- Personality

## BDD

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- “From everything you’ve shared, it’s clear how much these worries about your appearance **have been weighing on you—how your mind keeps coming back** to your eyes, and **how hard you’ve tried to cope or find reassurance**, even from doctors. **It’s not about flaws, but about distress and feeling stuck in a loop that steals your confidence** and your day-to-day joy. This is a real condition called body dysmorphic disorder. We can help—with support focused on getting you your life back, not just changing your looks.”

**Task:** Obtain a **history** to explore **the nature and extent** of her problems and clarify **her diagnosis.**

# Bulimia Nervosa (and other eating disorders including Anorexia)

- Insulin dependent DM-poor diabetic control-omits insulin in order to loose weight.
- Task:  
Take a **history** to assess for the **presence of eating disorder** and **assess prognostic factors**

## Bulimia Nervosa

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**1. Triad**

---

**2. Insight – Body image**

---

**3. Functional impact**

---

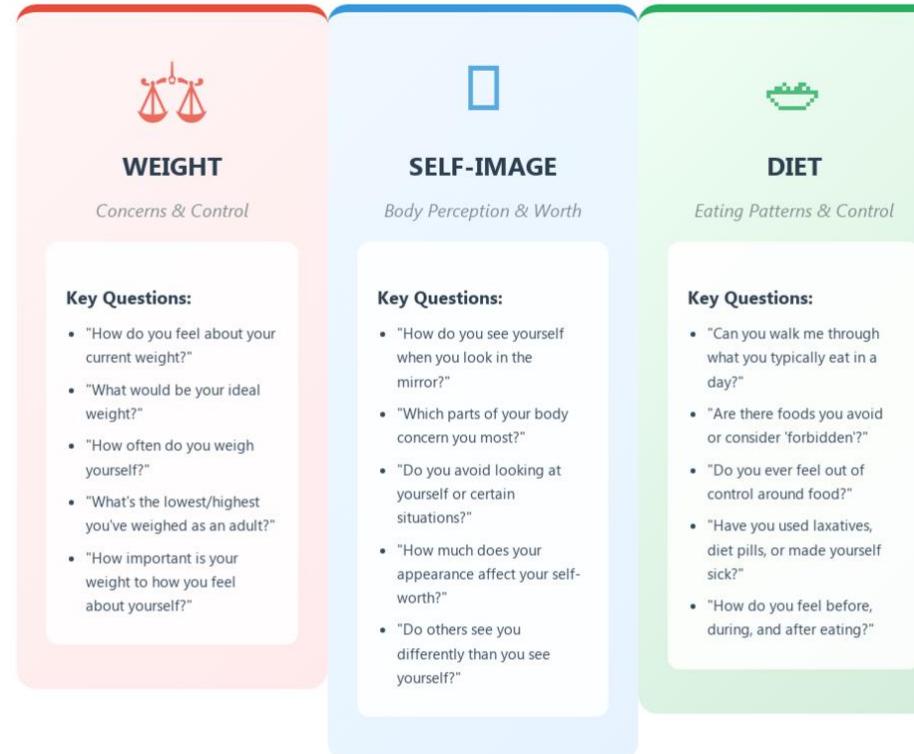
**4. Risks- Differentials**

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**5. Bg Hx**

## Eating Disorders Assessment

The Core Triad - Weight, Self-Image & Diet Behaviors



# Bulimia Nervosa Core symptoms

## Diagnostic Considerations

**Anorexia Nervosa:** Restriction, low weight, body image distortion, amenorrhea

**ARFID:** Restriction without body image concerns, often in neurodevelopmental conditions

**Bulimia Nervosa:** Binge-purge cycles, normal/high weight, dental issues

**Binge Eating Disorder:** Recurrent binges without compensation, often overweight

## Clinical Pearls

### Functional Impact

Assess impact on **relationships, work, social activities** - eating disorders are highly isolating

### Developmental History

Explore **onset triggers, family dynamics**, and any history of trauma or life changes

### Comorbidity Screen

High rates of **depression, anxiety, OCD, substance use**, and personality disorders

### Family Assessment

Family attitudes toward **food, weight, appearance** often play a crucial role in development and recovery



## Bulimia Nervosa

### Medical and Risks screening

#### Diabetes-Specific Behaviours

- “Ever skip or cut back insulin to lose weight?”
- “How often? Entire doses or part-doses?”
- “Any episodes of DKA or hospital admissions?”
- “Blood-sugar testing—regular or avoided?”

#### Medical & Risk Screen

- “Fainting, palpitations or abdominal pain lately?”
- “Any self-harm or suicidal thoughts?”
- “Alcohol or stimulant use to curb appetite?”
- “Periods?” – *Don’t forget to prime the patient before asking this sensitive question!*

#### Childhood “History of bullying / perfectionism?”



# Bulimia Nervosa

## Impact and comorbid

“Social events avoided over food?”

“Family meals—tension at home?”

“Concentration or memory problems?”

### **Comorbids:**

Depression

BDD – *surgeries?*

## Bulimia Nervosa

### Bg Hx or also Prognostic Factors

#### Prognostic Factors (explicitly flagged to examiner)

##### Good

“Family support?”/ “family attitude towards food”

“Motivation for change?” (‘willingness to get help?’)

“Past therapy that helped?”

##### Poor

Early onset (<14 y)?

Duration (>5 y)?

Purging methods multiple?

Co-morbid depression/OCD?

Substance misuse present? – *Over the counter drugs- Ozempic*

## Bulimia Nervosa

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- It sounds like your worries about shape and eating **have taken over your life—they seem to be impacting your life and decisions**. That's a very real illness called eating disorder. I believe from what you said, we can very much help you because [prognostic factor]

**Task:** Take a **history** to assess for the **presence of eating disorder and assess prognostic factors**

# Schizophrenia relapse and weight gain hx

- Mr. B, 32, stopped Olanzapine 2 weeks ago due to weight gain.

## Task:

Take a **history** of the **changes** regarding his illness and assess the **causes/impact of weight changes**.

## Schizophrenia relapse and weight gain hx

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**1. Illness Change**

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**2. Weight Change**

---

**3. Functional impact - insight**

---

**4. Risks- Differentials**

---

**5. Bg Hx**



## Schizophrenia relapse and weight gain hx

### Illness Change

“Since you stopped olanzapine, what changes in your experiences have you noticed?”

“Any return of hearing voices, suspicious thoughts, / low mood?”

“How severe are these symptoms now compared to while on the tablet?”

“Have you had any difficulties with daily tasks or sleep?”



## Schizophrenia relapse and weight gain hx

### Weight changes and causes

“When did you first notice your weight increasing on olanzapine?”

“Approximately how much weight did you gain and over what time?”

“What changes in diet or appetite did you observe?”

“Any changes in activity levels or exercise habits?”

“Did you try any strategies (diet, exercise) to manage the gain?”



## Schizophrenia relapse and weight gain hx

### Functional impact and insight

“How has the weight gain affected your self-esteem / mood?”

“Has it influenced your social life / relationships?”

“Any physical issues—joint pain, breathlessness, sleep problems?” – *physical Health*

“Concerns about metabolic health—diabetes, cholesterol?” - *physical Health*

#### ***Insight:***

“*What do you think caused the weight gain—medication or lifestyle?*”

“*How do you feel about restarting an antipsychotic?*”

“*Seeing that you’re noticing these distressing symptoms coming back, how important is controlling your weight versus controlling psychosis?*”

“*What would need to change for you to feel comfortable taking medication again?*”



## Schizophrenia relapse and weight gain hx

### Risks- Differentials – Bg Hx

#### **Self-harm risk:**

“Any thoughts of harming yourself?”

#### **Metabolic risk:**

“Family history of diabetes or heart disease?”

#### **Medication/ medication Hx:**

“Any other medicines / conditions affecting weight?”

## Schizophrenia relapse and weight gain hx

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- **Summarise** : Mr B, I can see the weight gain **has been really upsetting for you**, especially since it's **changed how you feel about yourself and your health**. I also understand why **you stopped your tablets**, hoping it would help your weight. Since then, though, the voices and difficult thoughts have come back, **which must be hard to face again**.
- **What I'm hearing is** that you want to feel well in your mind and in your body—without having to choose between the two. I want you to know we have ways to help: we can look at different medicines that don't cause as much weight gain, and offer support with your diet and activity if you'd like.
- **Restart of treatment, and psychoeducation around weight-neutral options.**

**Task:** Take a history of the changes regarding his illness and assess the **causes/impact** of weight changes.



# Medication and Physical Health, Related Issues

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# Elevated Prolactin in Schizophrenia

- Mrs. GG, 34, on Risperidone for Schizophrenia, found to have elevated prolactin (770 mIU/L). – felt dizzy when on Risperidone/ no menstruation- on coil/ psychotic symptoms quietened

**Task:**

Discuss **results**, take **history** to **assess medical condition**.

## Elevated Prolactin in Schizophrenia

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**1. Rapport - Engagement**

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**2. Results explanation**

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**3. Symptom Hx - Risks**

---

**4. Impact-Background**

---

**5. Formulate**



# Elevated Prolactin in Schizophrenia

## Rapport - Engagement

"Hello Mrs GG, I'm Dr X. Thank you for coming in today. I know these can be difficult things to discuss, so please take your time."

### **Strategy in this station:-**

**When she hesitates:** "I can see this might be uncomfortable to talk about. That's completely understandable - these are very personal symptoms." – *get her to tell the symptoms*

**Normalise or Collaborative:** "Lets try to get to the bottom of why this is happening."

**Validating impact:** "It sounds like this has really affected your quality of life and relationships (*if she tells you how*). That must be incredibly difficult."

**Recognise and adapts to patient's shyness** – Lower tone of voice

**Prime the patient before discussing sensitive topics** – "I have a few sensitive questions to ask..."

**Show Empathy:** Praise bravery + Thank her for openness.



# Explaining Abnormal Results

The 5-Step Approach to Breaking Bad News Sensitively

## 1 Give the "Warning Shot" 🚨

"I'd like to discuss your [test type] results with you. I'm afraid they show something that might explain the symptoms you've been experiencing."

|| PAUSE for 3-5 seconds - let them brace themselves

## 2 Start with What They Know ↗

"You mentioned you've been having [their symptoms]. Your [test type] shows that [relevant finding] which might explain what you've been experiencing."

↗ This connects their lived experience to the medical findings - makes it relevant to them

## 3 Explain in Simple, Relatable Terms 🌐

### Option 1 - Direct with Numbers (Only the main ones and not everything!):

"The [substance] is called [name] - it's [simple function]. Your level is [number], and the normal range is [range]."

### Option 2 - Use Metaphors:

"Think of [substance] like [relatable comparison]. Sometimes [cause] can [effect metaphor]."

### Option 3 - Link to Symptoms:

"This explains why you've been having [symptoms] - your body is [simple explanation of mechanism]."

### ✗ Avoid Medical Jargon:

"Your [lab value] is significantly elevated"

"You have [medical condition name]"

"This could indicate [scary medical term]"

#### 4 Link to Cause (Non-Alarming) 🌟

"This is actually quite common with [medication/condition] - it happens to about [proportion] of people who [circumstance]. The good news is that we know what's causing it, and there are things we can do to help you."

💡 Normalize the finding while maintaining hope and control

#### 5 Normalize & Reassure 🌟

"These symptoms - the [list their symptoms] - they're all connected to this [simple explanation]. It's not dangerous, but I can understand how distressing it must be for you."

💡 Validate their experience while providing appropriate reassurance

### ⌚ Key Communication Principles



#### Use Pauses

Allow processing time after delivering news - don't rush to fill silence



#### Make it Relevant

Connect findings to **their symptoms** and experience



#### Plain Language

Avoid medical jargon - use **everyday words** and metaphors



#### Show Empathy

Acknowledge the **emotional impact** and validate their concerns

# Elevated Prolactin in Schizophrenia

## Results explanation

### 1. Give "Warning Shot" :

"Mrs GG, I'd like to discuss your blood test results with you. I'm afraid they show something that might explain the symptoms you've been experiencing."

[PAUSE for 3-5 seconds - let her brace herself]

### 2. Start with What She Already Knows (you can skip this or use this chance to summarise what she says):

"You mentioned you've been having some changes with your periods and some discharge from your breasts. Your blood test shows that one of your hormone levels is higher than we'd expect."

### 3. Explain Prolactin in Simple, Relatable Terms:

Option 1: "The hormone is called prolactin - it's the one that normally helps women produce breast milk when they have a baby. Your level is 770, and the normal range is under 600."

Option 2: "Think of prolactin like a switch that tells your body to prepare for breastfeeding. Sometimes medications like risperidone can turn this switch on when it shouldn't be." (**In Metaphors**)

Option 3: "This explains why you've been having the breast discharge and why your periods have stopped - your body is getting signals that you're preparing to breastfeed, even though you're not pregnant (*Confirm before if she is!*)."



# Elevated Prolactin in Schizophrenia

## Results explanation

Avoid These Phrases:

- ✗ "Your prolactin is significantly elevated"
- ✗ "You have hyperprolactinaemia"
- ✗ "This could indicate a pituitary problem"



# Elevated Prolactin in Schizophrenia

## Results explanation

### 4. Link to Medication in a Non-Alarming Way

"This is actually quite common with risperidone - it happens to about 7 out of 10 people who take it. The good news is that we know what's causing it, and there are things we can do to help you."

### 5. Normalise and reassure (*Optional*)

"These symptoms - the missed periods, breast discharge, and changes in how you feel - they're all connected to this hormone change. It's not dangerous, but I can understand how distressing it must be for you."

# Elevated Prolactin in Schizophrenia

## Symptoms Hx

### A. Symptom Assessment:

Onset/duration of amenorrhoea, galactorrhoea, dizziness

Impact on daily functioning and relationships

Severity and frequency of symptoms

### B. Medication History:

Risperidone dose, duration, adherence

Previous antipsychotic trials

Other medications (including contraception)

### C. Reproductive Health:

Previous menstrual pattern

Sexual health impact

# Elevated Prolactin in Schizophrenia

## Symptoms Hx

### D. Red Flag Screening:

Headaches, visual changes (screen for pituitary macroadenoma)

Mood changes, suicidal ideation

Neurological symptoms

Fractures

### E. Psychosocial Impact:

Relationship breakdown

Social isolation/avoidance

Self-esteem and body image



# Elevated Prolactin in Schizophrenia

## Symptoms Hx – Funnel Approach

**Use the funnel Approach (Open – Close- Super Close):**

**Open:** "Can you tell me about the *changes you've noticed since starting risperidone?*"

**Focused:** "You mentioned breast discharge - can you *describe what that's like?*"

**Specific:** "*When did you last have a period?*"

**Then use impact to bounce of the next set of questions**

**Impact:** "*How has this affected your relationship / daily life?*"



# Elevated Prolactin in Schizophrenia

## Symptoms Hx

### Red Flag Screening

- a. "I'd like to ask you a few routine questions to make sure we have the full picture of how you're feeling."
- b. "As part of my assessment, I always check for other symptoms that can sometimes go along with hormone changes."

#### Then ask:

✓ "Have you been getting any headaches recently?"

(Not: "Are you having painful/serious headaches?")

✓ "How has your vision been - any changes in what you can see?"

(Not: "Have you had any visual issues?")

✓ "Have you noticed any changes in how you feel generally - energy levels, temperature, that sort of thing?"

### If She Reports Concerning Symptoms

"Tell me more about these headaches - where do you feel them, and are they different from headaches you've had before?"

"I want to make sure these aren't related to the hormone changes we've found."

## Elevated Prolactin in Schizophrenia

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- **Summarise** “Risperidone can cause raised prolactin, leading to [mention side effects]. We will closely monitor how you are doing on it.”

**One line management:** Physical health monitoring and discuss medication review if needed.

**Offer Encouragement:** “Many with similar challenges see good results with the right support, and we can work on this together.”

**Task:** Discuss **results**, take **history** to **assess medical condition**.



# SSRI sexual dysfunction

- Patient has depression and was started on fluoxetine 40 mg by his GP. He told his CPN he wants to stop the medication. You are reviewing him today in clinic.
- Task:  
**Address his concerns and explore why he wants to stop fluoxetine. Obtain further history to identify the cause of his concerns.**

## SSRI sexual dysfunction

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**1. Rapport - Engagement**

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**3. Symptom Hx – Sexual History**

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**4. Impact-Rule out other causes-Depression**

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**5. Formulate**



# SSRI sexual dysfunction

## Rapport - Engagement

### Open and normalise side-effects

"Hi Mr ..., I'm Dr \_\_\_. I understand you've been on fluoxetine for your depression and that you're thinking about stopping it.

I'd really like to understand what's worrying you so we can decide together what to do. Is that okay?"

### If he shows any signs of irritation/ shyness/ hesitancy

"Lots of people taking this kind of medication get side-effects, including some that can feel embarrassing to talk about. Whatever it is, **it's very common and you won't shock me.**"



## SSRI sexual dysfunction

### Get him to talk about sex!

#### 1. Gently explore his reason for stopping (keep it open first):

“What have you noticed since starting fluoxetine that’s making you want to stop it?”

2. If he’s vague (leading statement): “Some people notice physical changes, some emotional, some to do with sleep, appetite, or even sex. What have you noticed most?”

?3. (*For the ultra difficult patient*) Because he’s shy, you need to lead him there in a normalising way:

“One of the common things with fluoxetine is that it can affect sexual function.

Have you noticed anything like that?”

If he nods / partially admits:

“Can you tell me a bit more about what’s changed for you, in your own words?”



# SSRI sexual dysfunction

## Get him to talk about sex!

### 4. Clarify the sexual problems (enough for formulation)

**Ask 2–3 focused questions, not an interrogation:**

**“Is it more:**

Trouble getting or keeping an erection?

Trouble reaching orgasm, or orgasms feeling weaker?

Less interest in sex overall?”

“When did this start – was it after the dose went up to 40 mg, or before?”

“Are you in a relationship at the moment? How has this affected things between you and your partner?”

“How do you feel about it – is it causing you a lot of worry or embarrassment?”

## SSRI sexual dysfunction

### Rule out other causes- Depression

#### Rule out other causes briefly

“Any problems like this before starting fluoxetine?”

“Do you drink much alcohol or use any drugs?”

“Any other medical conditions – diabetes, blood pressure problems, prostate issues?”

“Any other medications – for blood pressure, prostate, or anything else?”

#### Check how depression is doing

##### You need to show you're balancing mood vs side-effects:

“How has your mood been recently compared to before starting fluoxetine?”

“Sleep, appetite, energy, concentration?”

“Any thoughts of harming yourself or that life isn't worth living?”

## SSRI sexual dysfunction

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- **Validate and explain clearly:** “Thank you for telling me that – I know it’s not easy to talk about. Fluoxetine and other SSRIs commonly cause sexual difficulties, especially at higher doses. **It doesn’t mean anything is wrong with you as a man – it’s a well-known effect of the medicine.**”
- **Mx:** “The good news is there are several options. We don’t have to choose between your mood and your sex life – we can work together to find a balance.”
- **Close collaboratively:** “Would you be open to adjusting things rather than stopping suddenly? We can decide together on the next step, but I’m really glad you told me about this.”

**Task: Address his concerns and explore why he wants to stop fluoxetine.**  
Obtain further history to **identify the cause of his concerns.**



# Psychosocial Weight Gain Assessment

- **Task:**  
Take a **psychosocial history** and **evaluate motivation** to lose weight.

## Psychosocial Weight Gain Assessment

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**1. Rapport - Engagement**

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**2. Results**

---

**3. Psychosocial History**

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**4. Motivation & Readiness to Change**

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**5. Formulate**

# Elevated Prolactin in Schizophrenia

## Rapport - Engagement

“Weight changes are a really common effect for people on olanzapine—can we talk openly about how this has affected you?”

### **Normalise:**

“This isn’t your fault; medication can have a real impact.”

### **Respond to cues (embarrassment, low self-esteem) with validation:**

“A lot of people feel the same way. You’re not alone in this.”

### **Reflect his own words back to him.**

Eg “You said you don’t like going out—is that because you worry what people will think, or are there other reasons?”

### **Always tie physical findings back to hope, not just risk.**

**“These changes are reversible**—we can work together on a plan that fits your life.”



# Elevated Prolactin in Schizophrenia

## Results – Physical health

### Discuss blood results

“Your test results show higher cholesterol and glucose levels. *These sometimes go up with medication and weight changes—have you ever been told about these risks before?*”

### Symptoms screening

“Any trouble with thirst, urination, getting tired easily?”

### Ask about activity and diet specifics

“What does a typical day’s eating look like now, compared to before?”



# Elevated Prolactin in Schizophrenia

## Psychosocial Hx

### Relationships & Social Withdrawal

Explore loss of girlfriend, avoidance of friends or activities (“*What was your social life like before? How is it now?*”)

### Mood & Self-Esteem

Screen for depression, hopelessness, loss of enjoyment, thoughts of self-harm.

### Daily Routine Change

Sleep pattern, eating habits (comfort eating, night eating), physical activity (“*You mentioned stopping outdoor activities—what do you miss most?*”)

### Work/Education & Financial Impact

*If working or studying*, has weight gain affected this?

### Substance Use

Smoking more? Alcohol? Any change since stopping social activities?

### Family/Support Structure

Who is there for him? Does he live alone?



# Elevated Prolactin in Schizophrenia

## Motivation & Readiness to Change (Behavioural Change Model)

**Don't stop at "Do you want to lose weight?" Go deeper using the stages of change**

### **Precontemplation/Contemplation**

"What are your thoughts about your weight changes?"

### **Ambivalence/Resistance**

"Have you ever tried to make changes before?" "What do you see as the pros and cons?"

### **Past Successes & Failures**

"Have you lost weight in the past? How did you do it? What made it hard?"

### **Support & Confidence**

"How confident are you that you could work on this?" "What would help you feel more confident?"

### **Barriers & Facilitators**

"What makes it hard? What could make it easier for you?"



# Elevated Prolactin in Schizophrenia

## Motivation & Readiness to Change (Collaborative Planning)

**Don't stop at "We will refer you to so and so?" Check motivation to work with others**

**"Would you be open to discussing different strategies**

—like support from a dietitian, small changes to activity, or reviewing your current medications with your psychiatrist?"

**"Do you want to work together on some ideas,**

or would you prefer to start with small steps yourself?"

**"I can link you with resources that don't involve groups, if going out is tough right now."**

## Psychosocial Weight Gain Assessment

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- **Summarise** “Your weight gain seems connected to [specific factors]”
- **Risks**
- **Offer Encouragement:** “Many with similar challenges see good results with the right support, and we can work on this together.”

**Task:** Take a **psychosocial history** and **evaluate motivation** to lose weight.

**Big group Session:**

Free Zoom session, every Saturday 3-5pm UK time, the link will be shared directly on our WhatsApp community.

**Small Groups Sessions:**

Limited seats, 6 candidates + 2 observers, playing a total of 96 height yield stations total (6 stations per session , 16 session)

**CASCers Mocks:****4:1 mock (16 stations)**

-played with 2 other role players and feedback contributed by them

**2:1 mock (8 stations)**

-with detailed feedback from Mohammad and Praveen

**Private Sessions:**

One to one or two to one sessions (1 or 2 hours per session)

**Practice Sessions(Coming Soon):**

Where you will be practicing with different candidates the new stations every week



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