Assessment and Management

Part 1

Chapters

1 Psychiatric History

An example psychiatric history

Introduction and presenting complaint: Mr John Smith is a 36-year-old Caucasian man, a mechanic, admitted to Florence Ward three days ago after police detained him on Section 136 for acting bizarrely in the street. He is now on Section 2. He thinks his neighbours are plotting to kill him.

History of presenting complaint: Mr Smith last felt free from worry four months ago. Since witnessing his neighbour staring at him, he has believed this neighbour and his wife are intercepting his mail, using a machine so no one can tell that the letters have been opened. He sees red cars outside, which he thinks the neighbours use to monitor his movements. After an altercation on the street three days ago in which he accused these neighbours of pumping gas into his flat, he has believed that they want to kill him or force him to move out so that they can purchase the property. He denies low mood. He cannot rule out the possibility he might defend himself against the neighbours but denies specific plans to retaliate. He denies hearing the neighbours or others talking about him or feeling that they can control him or his thoughts. He has been sleeping poorly. His appetite is reasonable.

Collateral history: Mrs Smith confirmed that her husband had been very preoccupied for the past month with worries about the neighbours intercepting mail and pumping gas into the flat. She witnessed the recent altercation in which her husband was verbally but not physically aggressive to the neighbours. The neighbours are a retired couple who are polite and considerate. Mr Smith has become withdrawn, staying mostly in the kitchen, the only room he believes is 'safe'. He has been hostile to his wife at times this week, which is unusual. This occurred when she questioned his beliefs. He has never threatened her or their daughter.

Past psychiatric history: Mr Smith has seen a psychiatrist once before, aged 8, when he was diagnosed with 'emotional problems'. His GP diagnosed depression when he was 24 and prescribed fluoxetine, which he never took. He believes he was depressed for a couple of years in his mid-20s but denies mental health problems since then. No previous psychiatric admissions. He has never taken medication for mental illness.

Past medical/surgical history: Mild asthma. Nil else of note.

Drug history and allergies: No current medication. No known allergies.

Family history: When Mr Smith was 28, his father died from lung cancer aged 60. His mother and brother, who is eight years younger, live nearby. Both are well, in regular contact and supportive. No known family psychiatric history.

Personal history – early life and development: Normal vaginal delivery, no known complications, no developmental delay. Mr Smith lived in the same house in Doncaster throughout his childhood. His father was a shopkeeper, and his mother a housewife. His parents were happily married, and there were no financial problems at home. No childhood abuse.

Educational history: Mr Smith left school at 16 with five GCEs. He had good friends from school. He was often in trouble with his teachers; he was suspended once for cheating in an exam but was never expelled.

Occupational history: On leaving school Mr Smith worked in the family plumbing business for a few years, then trained and worked as a mechanic. He has never been sacked and has been in his current job for three years. He has been on sick leave for the last two weeks because of 'stress'.

Relationship history: Happily married for 10 years. He has one daughter, aged 5, who is well.

Substance use: Mr Smith drinks 30 units of alcohol a week, mainly wine in the evenings. There is no history of alcohol dependence. He has used cannabis regularly in the past (aged 16–28) but no illicit drug use since this time.

Forensic history: Conviction and fine for driving without due care aged 21. No other arrests or convictions.

Social history: Mr Smith owns his three-bedroom detached house. He usually sees his mother, brother and work friends regularly, but not in the past month. No current financial difficulties.

Premorbid personality: Mr Smith described himself as a sociable, calm person who thought the best of people and didn't tend to get into disputes with others until his current difficulties. He is a keen cyclist and member of a local cycling club.

The psychiatric history and mental state assessment (discussed in Chapter 2) are undertaken together in the ***psychiatric interview***. This is a critical time for establishing rapport as well as systematically obtaining this information. In this chapter and the next, we present a format for written documentation; greater flexibility is clearly required during the actual interview. You should always do a physical examination too.

Introduction and presenting complaint

- Patient's name, age, occupation, ethnic origin, circumstances of referral (and, in the case of inpatients, whether voluntary or compulsory) and presenting complaint (in the patient's own words).

History of the present illness

- Start with open questions, e.g. 'Can you tell me what has been happening?'
- Establish when the illness first began (and, if a relapsing/remitting illness, when this illness episode began), e.g. 'When did you last feel well?
- What does the patient think might have caused the illness as a whole or this relapse/recurrence, and what makes it better or worse?
- What has been the effect on daily life/relationships/work?
- Depending on the presenting complaint, you will need to ask follow-up questions about other symptoms to help you make a diagnosis. Your questions should be guided by the diagnostic criteria for

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the individual disorders (discussed in later chapters). For example, if the patient describes feeling anxious, you would ask questions to establish if the anxiety is situational and if panic attacks occur.

- Enquire about mood, sleep and appetite, even if they appear normal, and whether there are risks of harm to self or others (see Chapters 4 and 5).

Especially in psychosis or dementia, the patients' views of events might differ from those of their family, friends or other collateral sources. In this case, you can record their accounts, followed by any collateral information available.

Previous psychiatric history

- Dates of illnesses, symptoms, diagnoses, treatments.
- Hospitalisations, including whether treatment was voluntary or compulsory.

Past medical/surgical history

- Dates of any serious medical illnesses.
- Dates of any surgical operations.
- Dates of any periods of hospitalisation.

Drug history and allergies

- All current medication.

Note psychotropic medications that patients have received previously, their dosage and duration, and whether or not they helped. It may be necessary to obtain this information from the patients' GP or hospital notes.

Family history

- Parents' and siblings' physical and mental health, their frequency of contact with, and the quality of their relationship with the patient.
- If a close relative is deceased, note the cause of death, the patient's age at the time of death and their reaction to that death (see Chapter 10).
- Ask about family history of psychiatric illness ('nervous breakdowns'), suicide or drug and/or alcohol abuse, forensic encounters and medical illnesses.

Personal history

- **Early life and development:** Include details of the pregnancy and birth (especially complications), any serious illnesses, bereavements, emotional, physical or sexual abuse, separations in childhood or developmental delays. Describe the childhood home environment (atmosphere and any deprivation). Note religious background and current religious beliefs/practices.
- **Educational history:** Include details of school, academic achievements, relationships with peers (did they have any friends?) and conduct (whether suspended, excluded or expelled). Bullying and school refusal or truancy should be explored.
- **Occupational history:** List job titles and duration, reasons for change; note work satisfaction and relationships with colleagues. The longest duration of continuous employment is a good indicator of premorbid functioning.
- **Relationship history:** Document details of relationships and marriages (duration, gender of partner, children, relationship quality, abuse); sexual difficulties; in the case of women, menstrual pattern, contraception, history of pregnancies. Those who are in a long-term relationship should be asked about the support they receive from their partner and the quality of the relationship – e.g. whether there is good communication, aggression (physical or verbal), jealousy or infidelity.

Substance use

- Alcohol, drug (prescribed and recreational) and tobacco consumption.

Forensic history

- Any arrests, whether they resulted in conviction and whether they were for violent offences.
- Any periods of imprisonment, for which offences and the length of time served.

Social history

- Describe current accommodation, occupation, financial situation and daily activities.

Premorbid personality

- A description of the patient's character and attitudes before they became unwell (e.g. character, social relations). You could ask:
  - How would you describe yourself before you became unwell?
  - How would your friends describe you?
  - What do you enjoy doing?
  - How do you usually cope when things go wrong?