BRITISH JOURNAL OF HOSPITAL MEDICINE

MMC Modernising Medical Careers

MODERNISING MEDICAL CAREERS

IN NEXT MONTH'S MMC SUPPLEMENT

Medical students attitudes to MMC: will it affect training or career choice?

Conducting a mental state examination

Paediatric radiology

Metatarsal fractures

Taking a psychiatric history

Introduction

This article is part of a series on psychiatry aimed at providing a framework for the diagnosis and management of common psychiatric disorders.

Unlike most other medical specialties, psychiatry relies almost exclusively on the history and mental state examination in order to establish a diagnosis and enable an understanding of the aetiology of the disorder for that individual. Equally, it is a means by which the clinician can establish a rapport to facilitate the development of a trusting and therapeutic relationship. This is particularly important when the patient is ambivalent about seeking assistance, or may feel a problem does not exist, for instance in psychosis. The process of history taking can itself have a therapeutic value as well as provide a tool for motivating and educating the patient.

It is pertinent to remember that many physical disorders can present with psychiatric symptoms (e.g. hypothyroidism and depression, Cushing's syndrome and psychosis). Furthermore, many psychiatric disorders may initially present with physical symptoms (e.g. panic disorder and chest pain).

Principles

The setting for the consultation is important in order to ensure personal safety and to make the patient feel comfortable. The doctor should always ensure that he/she carries a personal alarm or informs staff that the interview is taking place, and should ensure that there is easy access to the door, which should open outwards. This is particularly important in emergency settings such as accident and emergency. The patient should be seated at the same eye level and to one side of the doctor, rather than opposite.

After an appropriate introduction to the patient and those accompanying the patient, briefly explain the purpose of the meeting. Commence with open questions (see below), using closed questions to obtain a clearer understanding of the patient's experience. Allow plenty of time for the patient to talk, accepting that there may be periods of silence. If possible, always obtain a collateral history from relatives, friends and carers as they may give a more accurate description of changes in the patient's thoughts and behaviours.

It is important to be aware of cultural issues influencing the expression of symptoms, which can therefore complicate history taking. For example, in a woman of south Asian origin presenting with depression, psychosomatic symptoms (chest pain, aches and pains in joints) may prevail over more typical psychological symptoms such as low mood or feelings of guilt.

It may be necessary to collect information over a period of several interviews, recognizing that discussion of personal issues such as sexual orientation may be a sensitive issue in the initial consultation.

History

The history should take note of demographic details (age, sex, occupation, marital status and ethnicity), reason for referral (e.g. depression not responding to treatment), and the source of referral (e.g. GP, community psychiatric nurse, psychologist).

The presenting complaint should be stated using the patient's own words.

History of presenting complaint

The question that needs to be answered is 'why is this patient presenting in this way at this moment in time?' Commence the interview with an open question such as 'what have you come to see me about?' and 'what concerns do you have at the moment?' It may be helpful to write a list of problems and then ask the patient to prioritize them. Establish the nature and duration of the symptoms in chronological order, and the mode of onset: did the symptoms develop suddenly or insidiously? This can have a bearing on the prognosis, as insidious symptoms are often associated with a poorer outcome. Identify any precipitants or stressors, such as psychosocial problems (housing problems, loss of a job, financial and relationship difficulties, bereavement, substance misuse), physical problems (chronic disease, malignancy), or non-compliance with treatment.

Identify the effects of the symptoms on social, interpersonal and occupational functioning (e.g. relationships, marriage, work), and enquire about sleep, appetite, weight, mood and sexual activity. It is also important to enquire about suicidal ideation (*Table 1*). Attempt to understand how the patient views the symptoms and what coping mechanisms he/she has been using (e.g. alcohol abuse). Establish whether any treatment has been received and the response and compliance to treatment.

Family history

The family history is ideally illustrated using a family tree. Enquire about the patient's first degree relatives (parents, siblings, offspring) and ask about their age, occupation, physical and mental health, and the cause of death. Ask specific questions about alcohol and drugs, suicide and nature of treatment. Enquire about the quality of the relationships, emotional bonding and any interpersonal conflicts during childhood and at present.

Personal history

The purpose of the personal history is to understand the patient's current problems in the context of their previous experiences, as this may be important in exacerbating and maintaining the patient's illness. An attempt should be made to understand how these experiences may have influenced the personality and attitudes of the patient and how he/she relates to others. The details in each section will vary depending on the age and background details of the patient. The personal history is divided into the following:

Developmental and childhood history
Enquire about place of birth and any difficulties during birth. Some psychiatric illnesses are associated with obstetric complications (e.g. schizophrenia). Ask about the ages at which milestones were attained (smiling, sitting, standing, walking, talking, and bladder and bowel control). This is particularly important in children with learning disabilities. The patient's relationships with parents and siblings should be discussed, including any periods of separation from parents and any childhood illnesses.

Education
The age of starting and leaving school should be recorded, as well as relationships with peers and teachers alongside academic and sporting achievements. Was the patient bullied or disruptive at school, did he/she play truant or get expelled? What qualifications did the patient leave with? Did the patient attend college or university and what qualifications were attained?

Occupational history
All the jobs should be listed in chronological order and the length of employment for each, highlighting reasons for changing jobs. Ask about relationships with colleagues and about any problems with his/her current job. Frequent changes of jobs without an adequate explanation may suggest personality difficulties, while lack of promotion and decline in responsibility may suggest progressive impairment as a result of mental illness.

Psychosexual history
Ask about age at menarche, and age of first sexual contact. Enquire about sexual orientation; the number and duration of previous relationships; any unwanted sexual experiences (abuse, rape); and any terminations of pregnancy. Ask about any current relationships and the quality and intensity of the relationship. Establish whether the patient has children and his/her relationship with them.

Past psychiatric history
Identify age of first contact with psychiatric services and the reasons for presenting. Details regarding each episode of illness, its presentation and any treatment whether in hospital or the community is vital. Were there any admissions under the Mental Health Act? Were there any episodes of self harm or harm to others? Enquire about compliance with medication and engagement with services, as suggested by attendance at outpatient clinics and meetings with the community psychiatric nurse or care coordinators.

Past medical history
State all past and current physical illnesses.

Drug history
List all current medication and doses as well as allergies. This should include any products obtained from the chemist and alternative practitioners, such as herbal remedies.

Substance use history
All patients should be asked about drug and alcohol consumption, past and present. Ask how often they drink, how

Table 1. Asking about suicidal ideation

How do you feel about the future?	
Do you feel that life is not worth living?	
Do you feel hopeless or helpless?	
Do you feel so dreadful that you have thought about ending it all?	
Have you made any plans?	
Have you ever attempted to take your own life?	If so, how?
	Is there anything preventing you from doing so?
Have you made any arrangements for your affairs after your death?	

Table 2. The CAGE tool

Do you feel that you should Cut down on your drinking?
Do you get Annoyed when people criticize your drinking?
Do you feel Guilty?
Do you have a drink first thing in the morning to calm the nerves (Eye opener)?

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much they drink on a typical day, the number of units a week and the type of alcoholic beverage. The CAGE screening tool can be used to screen for harmful or excessive use (*Table 2*).

If alcohol dependency is suspected then a more thorough history, including questions about dependency, is needed (e.g. 'Do you feel compelled to drink?' 'Do you get withdrawal symptoms if you miss a drink?'). Also ask about the use of non-prescription medication and illegal drugs such as amphetamines, ecstasy, cocaine/crack, lysergic acid diethylamide, heroin and cannabis, as well as the use of benzodiazepines. Establish the quantity and frequency of drug use.

Forensic history

Ask about any encounters with the police or courts of law such as arrests, cautions, convictions and imprisonment.

Social history

Current accommodation, income from employment, benefits and financial difficulties should be discussed. It may be helpful to ask the patient to briefly describe a typical day in order to determine the nature of activities within and outside of the home, as well as any social contacts. This provides a picture of the level of personal and community support available to the patient, for example, after discharge from hospital psychiatric care.

Premorbid personality

Determining the patient's personality may be difficult during an acute episode of illness and therefore it is important to gather information from informants. However, useful questions to ask the patient include 'before you became unwell, what were you like as a person?' or 'how would your friends describe you?' (*Table 3*).

Table 3. Assessing premorbid history

Relationships	Do they have many friends? Do they have difficulty making and maintaining friendships? Are the relationships superficial or meaningful? Are there any issues with trust? Interest in sexual relationships
Character traits	Impulsive, cautious, shy, dependent, perfectionist?
Predominant mood	Does mood fluctuate or is it stable? Do they have an optimistic or pessimistic outlook?
Personal habits and coping mechanisms	Smoking, drug and alcohol use
Attitudes and values	Religious, moral, and political, attitudes about psychiatric treatment
Interests and activities	Do they prefer solitary activities? Have they any creative interests?
Fantasy life	Frequency, content and duration of day dreams

KEY POINTS

- It is important to corroborate the history by obtaining reports from friends or relatives who know the patient well.
- It may take several interviews before the history is complete.
- Be aware of cultural differences in the presentation of psychiatric problems.

Conclusions

A detailed and comprehensive psychiatric history requires considerable time and skill to develop. The complete 'picture' is usually never apparent until after several sessions, and even then it is crucial to seek a corroborative history from people who know the patient well. This is especially important when the patient's insight into their changing thoughts and behaviour is limited.

Taking a psychiatric history is followed by the mental state examination, which will be covered in the next article in this series. BJHM

Conflict of interest: none.

Further reading

Goldberg D, Murray R (2002) *The Maudsley Handbook of Practical Psychiatry.* 4th edn. Oxford University Press, Oxford

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