Psychiatric interview and history taking

LPT Gondar Mental Health Group
Safe interview

- Ask someone senior who knows the patient whether it is safe to interview the patient alone.
- Interview in the view or hearing of others, or accompanied by another member of staff.
- Do it in a safe quiet room (for confidentiality), not by the bed.
- Place yourself between the door and the patient.
- Carry an alarm or find out where the alarm is (in the room) and how to use it.
- Have a low threshold for violence, be firm and call security or police if in doubt.
Basics

- When doing a physical examination, always ask for a chaperon.
- Introduce self to patient, be respectful and non-judgemental.
- Put patient at ease, think of her/him as one of your family member in need of medical help.
- Start with open Q: allows patient to elaborate problems.
- Listen attentively/ show interest/be kind, honest, empathic and warm but at same time firm.
- Seek clarification of words used by patients.
Basics

- Phrase questions simply and clearly
- Be patient, do not rush, use silence appropriately especially in those with depression
- Be sensitive and if patient cries, offer tissue, glass of water.
- Recognise patients' verbal and non-verbal cues
- Use normalization and generalization when asking about the substance misuse, sexual history or any psychopathology
Outline of an assessment

- Socio-demographic details, reason and source of referral
- Presenting complaint
- History of presenting complaint
- Past Psychiatric History
- Past Medical History
- Current Medications & past/present adverse reactions
- Family History
- Personal History
- Alcohol and drug history
- Forensic History
- Current social circumstances
- Premorbid personality
- Mental state examination & Physical Examination
Socio-demographic details
Name, age, DOB, address, occupation, marital status, Mental Health Act status

Circumstances of referral: Who referred and from where

Presenting complaints: Patients own words and/or as described by others (informant)
History of presenting complaint

- What is the main problem?
- When did you first notice that? When did you last feel well?
- Precipitating factors?
- Aggravating factors and alleviating factors?
- What are the associated symptoms? Biological symptoms? chronological order of the symptoms
- Elicit other signs and symptoms based on ICD 10 criteria for dementia, depression, mania, schizophrenia (Delusions and hallucinations), substance misuse and anxiety disorders
- What have the GP done?
- The effects of these symptoms on job, family, relationship and leisure.
- Support available?
- Coping strategies?: self harm? substance misuse?
PAST PSYCHIATRIC HISTORY
- In the past have you ever had problems with your mental health/nerves/depression?
- Past history of self harm?
- Have you ever seen a psychiatrist before?
- Have you ever been admitted to a psychiatric hospital? How many times? Presentation each time? Previous mental health act status?
- What treatments have you had? Injections? ECT? Clozapine? Lithium?
- Functioning between episodes? Regular follow up? Compliance? Services involved? CPN/ SW/OT?

PAST MEDICAL HISTORY
- Do you have any problems with your physical health? Like DM, asthma, hypertension and epilepsy?
- What about in the past?
- Have you ever had any operations or been in hospital?
CURRENT MEDICATIONS

- What medications do you take regularly? Regular monitoring of side effects by blood tests and examination?
- What medications have you had in the past?
- Any history of past/present adverse reaction/allergies?

FAMILY HISTORY

- Family tree-details names, ages, alive/dead, relationships and illnesses of 1st and 2nd degree relatives.
- As far as you know, has anyone in your family ever had problems with their mental health/physical health?
- History of self harm or suicide?
PERSONAL HISTORY

Infancy and early childhood
- Where were you born?
- Where did you grow up?
- As far as you know was your mother’s pregnancy normal? normal delivery?
- Did you have any serious illnesses as a young child?
- Ask about milestones, any delay?

Adolescence and education
- Which school did you go to?
- Did you enjoy school?
- What are your lasting memories of school?
- Did you have many friends at school? Whether In contact with them/not.
- Any qualifications?
- Were you ever in trouble at school?
Occupational record
- When did you leave school?
- What did you work at? For how long? Then what happened?

Sexual development, relationships and marriage
- Are you married at present? How would you describe your marriage?
- Have you had many relationships? Sexual orientation and preferences? Any problems with sexual life?
- Any relationship difficulties encountered?
- Do you have any children? How old are they?
Alcohol and drug History

- Do you take a drink/smoke? Ask about the units for drinking.
- Have you been drinking any more or less than normal recently?
- Use the CAGE questionnaire.
- Have you ever taken drugs? Tell me more about that.
- Ask about the consequences of substance misuse:
  - Loss of job, leisure, family and friends
  - Trouble with police
  - Physical adverse effects
- For suspected dependence, ask about a narrowing of the drinking repertoire, drink-seeking behaviour, tolerance, withdrawal, drinking to relieve or avoid withdrawal symptoms, subjective awareness of the compulsion to drink, and a return to drinking after a period of abstinence (seven features)
**Forensic history**

Have you ever been in trouble with the police, or criminal justice system?
Past offences/ convictions with dates, sentences.
Any outstanding charges/Court attendance?

**Present social circumstances**

Who lives at home with you at the moment?
Do you have any worries about debt or money in general?
Do you have friends or family who live nearby?
Ask about socialising with friends/family?
PREMORBID PERSONALITY

- When you are feeling well, how would you describe yourself?
- How would other people describe you?
- How do you cope with difficult situations?
- What sort of things do you like to do to relax?
- Do you have any hobbies?
- Do you like to be around other people or do you prefer your own company?
- Are you religious?
- Do you have any ambitions or plans?
- Prevailing mood?
- Substance misuse?
- Sexual life?
MENTAL STATE EXAMINATION

APPEARANCE, ATTITUDE, ACTIVITY

Describe appearance:
- Body habitus
- Prominent physical characteristics: tattoos, scars, needle sites
- Grooming
- Level of consciousness
- Apparent age
- Position and posture
- Eye contact
- Facial expressions

Describe attitude:
- Degree and type of co-operation
- Resistance

Describe activity:
- Voluntary movements and their intensity
- Involuntary movements
- Tics, mannerisms, compulsions
SPEECH AND LANGUAGE
Assess for:
- Fluency of speech (rate and volume)
- Repetition
- Comprehension
- Naming
- Reading and writing
- Prosody
- Quality of speech

MOOD AND AFFECT
- Describe predominant mood in patients own words (subjective feeling)
- Describe affect (objective assessment):
  - Intensity
  - Range
  - Reactivity
  - Congruency
THOUGHT PROCESSES
- Degree of connectedness of ideas (loose associations, etc.,)
- Presence of formal thought disorders (flight of idea, clang associations, blocking, neologisms, etc.,)

THOUGHT CONTENT
- Predominant topic or issues
- Preoccupations, ruminations, obsessions
- Suicidal or homicidal ideation
- Phobias
- Describe any delusions:
  - Thought interference
  - Reference or persecution
  - Control or passivity
  - Nihilistic
  - Grandiose
PERCEPTUAL ABNORMALITIES
- Illusions
- Hallucinations
- Depersonalisation, derealisation, déjà vu, jamais vu etc.,

COGNITION
- General: Alertness and awareness
- Orientation: Time, Place and Person
- Registration: Three objects (apple, table and penny)
- Attention: WORLD backwards and Serial Sevens
- Recall: the three objects
- Language: Naming and Repetition
- Calculation: Division and Subtraction
- Right Hemisphere Function: Intersecting pentagons and Clock-face
- Abstraction: Proverbs and Similarities
- Memory: STM and Long-term memory
- Praxis: Wave good-bye and Comb hair
The mini-mental state examination
(do not forget this in elderly patients!)

Refer to handout
INSIGHT AND JUDGEMENT

Awareness of disease:
- Do you consider that you are ill in any ways?
- Why have you come into hospital?
- Do you have a physical or a mental illness? What is it?
- What is your explanation of these experiences?

Willingness to take treatment:
- How do you feel about being in hospital….. coming to the clinic….?
- How do you feel about taking medication?
- Has the medication been helpful? Have any other treatments been helpful?
- Do you think that medication helps you to remain well?

PHYSICAL EXAMINATION
- General observations: Vital signs : HR, BP, RR, Temp, EPS Autonomic arousal, tremor, sweating etc.,
- Important features: scars, tattoos, signs of liver disease, signs of thyroid disease, etc.,
- Specific CVS, RS, GI, and CNS examination findings and important negative findings
Case formulation

- Descriptive - summarise salient points of history in 3/4 sentences, including any identified risks

- Diagnostic - preferred and differential diagnosis, with evidence for/against choice

- Aetiological - (predisposing, precipitating and perpetuating factors) (biological/ psychological/social)

- Management (short and long-term/ bio-psycho-social):
  - Assessment
  - Treatment
  - Risk Management

- Prognosis (short and long-term)
After the interview

- Gather information from relatives (maintain confidentiality), GP, previous case records, nursing staff.
Provided by The Leicester Gondar Link Collaborative Teaching Project

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