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Indian Psychiatric Society Publication

Bedside PSYCHIATRY



Arabinda N Chowdhury

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CHAPTER 2

Psychiatric History

BEFORE STARTING THE INTERVIEW

- *Be sure about the logistics of the interview setting: Appropriate seating arrangement, privacy, safety, and undisturbed environment.*
- *Greet the patient verbally; introduce yourself and any other people, if present.*
- *Explain the purpose of the interview.*
- *Explain the focus of this interview (e.g. current problems or response to treatments, etc.)*
- *Explain the need to take notes and seek the patient's consent.*
- *If you need to speak to an informant, take the patient's permission.*
- *Sensitive topics such as suicide, sexuality, abuse or forensic history should be asked tactfully and with great skill.*
- *Reassure the patient about confidentiality. The patient should be informed about who will have access to the notes and who will be sent letters relating to this assessment.*
- *Psychiatry/mental health is known to be associated with an age-old stigma—from both social and professional concerns. Many have voiced that the term "patient" is often derogatory and hence it is a good practice to use the term "service user" instead of "patient".*

Be sure about the quality of a good history: The history should be:

- Systematic and coherent with appropriate headings
- Comprehensive with positive features and relevant negative findings
- Reflect the clinical relevance and priorities
- Unnecessary details should be avoided
- Multidimensional in approach, taking consideration of relevant psychological, social, and cultural/spiritual aspects.

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IDENTIFYING DATA

Clinic registration number:_____ Date:_____
Name:_____ Sex:_____
Date of birth:_____ Age:_____ Ethnicity:_____
Marital status:_____
Education: _____
Occupation: _____
Socioeconomic status: _____
Family (nuclear/extended): _____
Religion: _____
Mother tongue: _____
Address:_____ House number:_____ Street:_____
Country:_____ Post code:_____ Phone number:_____
Nearest relative/caregivers*:_____
Name: _____ Relation:_____
Address and Phone number:
_____
_____
Accompanied by:_____
Purpose of consultation:_____
Referral:_____
History taken by: Name/designation and signature with date:
_____
_____

Note: *"Caregiver" means a person who resides with a person with mental illness and is responsible for providing care to that person and includes a relative or any other person who performs this function either free or with remuneration.

CHIEF COMPLAINTS

Chief or presenting complaint: Description of main *current* problem or distress (usually since last 4 weeks) for which the patient is visiting this clinic. The usual question to be asked: "What are the major problems that have been troubling you currently?" or "What are the difficulties that have brought you here?"

Usually, we record the account from the patient, but some situations need corroboration from the accompanying relative or informant. In grossly psychotic patients, the informant may be the only source for getting proper complaints and history. Some of the symptoms relating to beliefs and behavior also need to be cross-checked with family members. It is customary to record the patient's words verbatim without paraphrasing or interpreting them. The account should be recorded in simple and nontechnical language.

- *From patient*: Verbatim—in chronological order with severity and duration of each complaint
- *From informant (collateral information)*: Relevant details in support of the patient's complaints or any valuable additional information in relation to the current distress.

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HISTORY OF PRESENT COMPLAINTS

It is the coherent and relevant background history of the development of presenting symptoms. It has two basic components, both of which help as the pointer to the diagnosis:

1. *Symptomatic context:* The way in which the lead symptom points toward the identifiable mental disorder; and
2. *Temporal context*: Nature, extent, and time course of the symptomatology.

Points to be covered:

- Precipitating factors (if any)
- *Mode of onset*: Acute/gradual/not known
- Total duration of illness (in months or weeks)
- *Course of the present complaints*: Continuous/episodic/in remission/exacerbation?/not known
- *History of present complaints*: A narrative account of lead symptom(s), sequence of distress; the impact of symptoms; evaluation of associated symptoms; nature and details of dysfunction
- *Concomitant changes in biological needs/functions*:
  - *Appetite*: No change/mildly or moderately reduced/markedly reduced/enhanced
  - *Libido*: No change/mildly or moderately reduced/markedly reduced/enhanced
  - *Sleep*: Normal/disturbed
- *Treatment history, if any, for the present complaints*: Details with medications used their clinical response/adverse reactions, if any.
- Allergy/drug reaction history.

Note: Please see Appendix 1; page-65.

HISTORY OF PAST ILLNESS

- Past medical illness: Absent/present
- Past surgical illness/operation/accidents: Absent/present
- Past psychiatric illness: Absent/present
- Previous or current medications and *allergies* or side effects, if any
- Record the details—nature, duration, treatment, and outcome of the illness
- A quick medical system probing may be useful to elicit any dysfunction or existing illness: Ask the patient—*have you ever had any problem/difficulties like*:

Body system	*Findings*
• Headaches, blackouts, or fits?	
• Problems with your vision, hearing, taste?	
• Thyroid problems?	
• Infections or injury?	
• Problems with your breathing or your heart or hypertension?	
• Trouble with urination or passing stools?	
• Joint pain or skin conditions?	
• Difficulties with balance or walking?	

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FAMILY HISTORY

A detailed family history is of great importance as family relationships, upbringing, and dynamics can be closely linked to the etiology, management, and prognosis of some mental disorders. In general, the family history aims to establish the following issues:

- To ascertain the *inherited risk* of a psychiatric or medical disorder (note any genetic disorder present in the family)
- To understand the family structure, working and relationships, and any pathology
- To complement the social and personal history.

Following points to be recorded:

1. Consanguinity in parents: Absent/present
2. Step parents: Yes/No
3. Adopted: Yes/No
4. Parents:

	Father	*Mother*
Living/present age		
Deceased/at age		
Patient's age at parent's death		
Cause of death		
Education		
Occupation		
Personality		
Relation with patient: poor/bad/usual/good		
History of mental illness*		
History of physical illness*		
History of substance use*		

Note: *Record the detailed account of specific symptoms/diagnosis, course, treatment, and outcome.

5. Siblings: History of any psychiatric illness
6. Family history of suicide
7. Family cohesion and quality of relationship with the patient: Good/bad/usual
8. Family stress: Major illness or accident/bereavement/suicide/separation or divorce
9. Any other relevant information
10. Put the relevant information in a simplified genogram *(Please see Appendix: 2; page-66)*.

PERSONAL HISTORY

1. *Prenatal history*: Nature of mother's pregnancy [planned or unplanned; health status during pregnancy; immunization, history of trauma; drug ingestion (prescribed or abused; use of abortifacient) and any other significant finding].
2. *Birth history*: Normal/abnormal

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Order	Only child	First child	Middle child	Last child
Term	Before	Full	After	
Place of delivery	Home	Institution	Other	
Type of delivery	Normal	Forceps	Cesarean	Other
Labor	Normal	Distressed	Prolonged	Other
Cry	Normal	Abnormal: Specify		
Cyanosis/jaundice	Absent	Present: Specify		
Immediate breastfeeding	Yes	No: Reason		
Any other relevant information				

3. *Early childhood (through age 3 years)*:
   - *Feeding habits:* Breastfeed/bottle-fed/age of weaning/eating problems (food fad/pica/others)
   - *Early developments:* Walking/talking/teething/language development/motor development/sleep pattern/object constancy/stranger anxiety/maternal deprivation/separation anxiety
   - *Toilet training:* Age/attitudes of parents/feelings about it/other
   - *Behavioral problems*: Thumb sucking/bedwetting and soiling/temper tantrums/tics/head bumping/rocking/night terrors/fears/nail biting/stammering/truancy/other
   - *Childhood disorders:* Febrile convulsions/seizures/other illness
   - *Temperament as a child*: Shy/restless/overactive/withdrawn/outgoing/timid/athletic/friendly/patterns of play
   - *Milestones of development:* Normal/delayed
4. *Middle childhood (3–11 years)*:
   - *Early school history:* Feeling about going to school/school phobia/adjustment to school
   - *Gender identification:* Normal/abnormal: Specify_____
   - *Peer relations*: Normal/abnormal: Specify_____
   - *Behavioral problems:* (Phobias/bedwetting/fire setting/cruelty to animal/attention or concentration/hyperactivity problem)
5. *Late childhood (puberty through adolescence)*:
   - *Social relationship:* Attitudes toward siblings and schoolmates/number and closeness to friends/leader or follower/participation in group or gang activity/idealized figures/pattern of aggression/other
   - *School history:* Level reached/adjustment with teachers and classmates/favorite study or interest/particular assets or abilities/extracurricular activities/sports/hobbies/scholastic performance—poor, average, good/relation of problems or symptoms to any school period/other like suspension from school for any behavioral problem, etc.

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- *Cognitive and motor development*: Learning/reading/intellectual skills/motor skills/other
- *Adolescent emotional or physical problems*: Nightmares/phobias/bedwetting/running away/smoking/alcohol/substance use/delinquency/eating disorders/weight problems/feelings of inferiority or concern for physical look
- *Adolescent turmoil*: Any significant event

6. *Psychosexual history (childhood through adolescence)*:
   - *Early curiosity/infantile masturbation/sex play*
   - *Acquisition of sexual knowledge*
   - *Attitude of parents toward sex*
   - *Sexual or physical abuse* (detailed history—perpetrator, nature, outcome, safeguarding, etc.)
   - *Onset of puberty:* Feelings about it/kind of preparation/feelings about masturbation/feelings about menarche/development of secondary sexual characters
   - *Adolescent sexual activity*
   - *Attitude toward opposite sex*: Timid/shy/aggressive/seductive/anxiety
   - *Sexual practices:* Sexual problems/heterosexual or homosexual experiences/paraphilias/promiscuity/orientation preferences
7. *Home situations in childhood and adolescence*: Congenial/broken home/disturbing/others
8. *Any parental lack before 18 years of age*: Dead/separated/habitually absent for more than a year
9. *Adulthood*:
   - *Occupational history:* Applicable/Not applicable
     (Started working at the age of__/Any change of job and reason/Present job—nature and duration__; Satisfaction/work position—rising, falling, static/Work record—good, satisfactory, unsatisfactory/ambition and conflicts/relation with peers and colleagues)
   - *Social history:* Has friends/withdrawn/socializing well. Social mixing/Participation—poor/usual/good. Relationship with people of same and opposite sex/Others___
     Present living conditions/Social support system/Quality of life
   - *Adult sexuality*: Problematic/no problem (*very sensitive part of history taking*)
     Sexual symptoms: Lack of desire/erectile dysfunctions/premature ejaculation/anorgasmia/dyspareunia/vaginismus/impotence/others: present prior to present illness?
     Contracted STD or tested for HIV: Yes/No (details)
     Current sexual preference (orientation): Same sex/opposite sex/both sex
     Sexual practices:
     Coital problems (if any)_____
     Pre- and extramarital sexual relations: Yes/No
     Any conflict or stress related to pregnancy/abortion/infertility
   - *Marital history:*
     Married or living together

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Age at marriage___
Consanguineous: No/yes—relation_____
Spouse: Age at marriage, present age, occupation, physical/mental illness?
Marital adjustment: Good/satisfactory/unsatisfactory—specify_____
Sexual adjustment: Good/satisfactory/unsatisfactory—specify_____
Family planning/contraceptive measures?
In-laws problems: No/yes
Marital conflict: No/yes
Domestic violence: No/yes—specify
Number of Issues:
History of divorce or separation?

- *Menstrual history:*
  Menarche age_____
  Periods: Regular or irregular/duration/amount—normal, scanty, excess, spots/premenstrual symptoms/relation of menstruation with present problems/enquire about premenstrual syndrome *(Please see Appendix 3: page-67)*
  Amenorrhea (primary/secondary)—present or absent
  Menopause: Applicable/not applicable; postmenopausal symptoms?
- *Quick checkbox for personal history*:

1. Birth/infancy	***Any positive findings***	***2. Childhood***	***Any positive findings***
Birth timing and complications		Family relationships in the upbringing	
Breastfed or bottle-fed		Nursery and early schooling	
Any separation from mother		Socializing and befriending	
Growth and developmental targets		Academic and sporting abilities	
Any significant pathology		Any physical/sexual abuse	
3. Adolescence		***4. Adulthood***	
School life and academic achievements		Marital and sexual history (list of past relationships, children, bereavements)	
Pubertal development (physically and psychological)		Occupational history (list of jobs, promotions, satisfaction)	
Peer relationships (including sexual)		Family and support network	
Experimentation with alcohol or drugs, any antisocial behavior		Present financial condition	
Any significant event with potential impact		Future goals and plans	

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10. *Self-harm history*: Not applicable/applicable

Number of attempts/date	*Method (cutting or burning skin/punching or hitting themselves/poisoning/misuse of drugs or alcohol/deliberate starving (AN) or binge eating)*	*Outcome*
Acute suicidal ideation ever (detail):		

Record detailed account of each attempt: An account of circumstances, stress factor present, precautions taken against discovery, preparatory acts (procuring means, warning statements, suicidal note), type and lethality of the method, communication after attempt, the reason for the attempt and outcome (hospitalization and stay).

11. *Addiction history*: Not applicable/applicable

Substance	*Type/brand and mode*	*Quantity/ frequency*	*Time period*	*Current use*	*Dependence*
Tobacco					
Alcohol					
Cannabis					
Opium					
Heroin					
Cocaine					
Amphetamine					
LSD					
Solvent					
Intravenous (IV) drug					
Medicine					
Other					
Gambling					
Internet					

Mode of onset:
Impact: Personal/family/social/occupational/legal/other
Comorbid disorders: No/yes
Withdrawal symptoms: No/yes
Treatment received (details):
Comments: In active substance use disorder, a category of dual diagnosis may be made.

12. *Forensic history*: Not applicable/applicable

This is an important part of the psychiatric history as patients with mental health problems have a higher incidence of forensic involvement (Zaman and Makhdum, 2000). It is sometimes

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difficult to probe forensic history because it is unlikely a patient will tell about his criminal past voluntarily unless asked. A nonjudgmental approach with reaffirming confidentiality may help to elicit forensic history.

Chronologically record the details of all offences, charges, convictions, and sentences passed. It is also important to make mention of any impact this has had on the patient's life and their attitude toward their past. Usual questions to be asked are: *"Have you had any involvement with the law?", "Do you have a police or criminal record?", "Have you ever done anything against the law, or had any allegations made against you?"*

Nature	*Yes*	*No*	*Number of times*	*Reason with dates*
Police caution				
Arrest				
Conviction				
Ongoing court case/any legal binding/probation?				
Any aggressive behavior/homicidal attempt				

13. *Social history*:

Social situations	*Facts and problems/strength and weakness*
Social support and network (social contacts—opportunities and functioning)	
Family support and care (living alone or not)	
Accommodation (type, quality, security, sharing, quality of neighborhood)	
Financial situation (source of income, savings, expenditure, debts)	
Domestic activities (daily living skills, daily routine)	
Outdoor activities (travel, holidays, leisure activities)	
Any disadvantageous social condition	

Please note that any positive information on self-harm/addiction/forensic and social history would heavily influence the risk assessment.

14. *History of abuse and violence*: Any childhood abuse (physical, emotional, neglect, or sexual) and violence including details of any domestic violence must be enquired in detail.

PREMORBID PERSONALITY

Personality and functioning before the onset of the illness: Briefly describe the nature of personality with regards to patient's general temperament and mood, aspirations, standards, interpersonal relations, social relations, attitude to work, and responsibility. It is difficult to

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delineate proper personality assessment in a single interview, several extended interviews and discussion with family members may be necessary. Personality consists of enduring characteristics, viz cognition (ways of thinking), affectivity (emotions and feelings), and behavior (interpersonal, reaction, self-control)—some pointers may be identified at the starting interview—general discussion on issues like: Are you happy go lucky, tense, shy, greedy, insecure? Or are you an anxious person? Or evidence of obsessional traits and predominant mood state or the overall quality of relationship with kins, friends, and workmates or some enquiry about hobbies and interests, how was the childhood, religious and moral beliefs, ambitions and aspirations, coping styles, may yield some general impression about premorbid personality.

These are a few clues to understand the basic personality types, but to make a diagnosis of specific disorder, an in-depth review is necessary, and the diagnosis is made from the account after 18 years of age. Behavioral clues of different personality types are tabulated in *Appendix 4: page-68*.

CULTURAL HISTORY AND ASSESSMENT

Cultural Issues in Assessment

Cultural Formulation

It provides a systematic method of considering and incorporating sociocultural issues into the clinical formulation *(Appendix 5: page-70)*. Cultural assessment improves patient safety in a healthcare organization. Five components of cultural formulation (Focus, 2006; DSM-5, 2013) are:

1. *Cultural identity*: Focus is on ethnicity, migration, age, gender, acculturation, language, socioeconomic status, sexual orientation, religious and spiritual beliefs, disabilities, health literacy, involvement with the culture of origin and host culture.
2. *Cultural explanation of the illness*: The focus is on the patient's explanatory models or idioms of distress, past help-seeking and present treatment expectations and preferences.
3. *Cultural factors related to psychosocial environment and levels of functioning* involve information on available social supports, levels of function or disability, the roles of family systems, religion and spirituality in providing emotional and informational support.
4. *Cultural elements of the relationship between the individual and the clinician* include the ethnocultural identity of physician, language, knowledge about the client's culture, cross-cultural skill and ability and eagerness of the physician to understand client's problem from their cultural context.
5. *Overall cultural assessments*: How the cultural assessment will apply to diagnosis, treatment and care planning?

Cultural history taking: Following is a brief interview format which may be helpful to elicit (by active listening) relevant cultural data for clinical assessment and care (Chowdhury, 2016).

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Sl. No.	*Cultural issues*	*Comments/ findings*
1	*Ethnocultural identity*	
	Original culture/host culture	
	Mother tongue/present language	
	Immigration/migration history (first/second generation)	
	Level of the tie with original culture	
	The degree of acculturation and level of assimilation with the host culture	
2	*Cultural background*	
	Family role—extended/nuclear family	
	Religious/spiritual beliefs and practices	
	Social support and network	
	Experience of any discrimination and/or prejudice due to race, religion, cultural identity, gender, sexuality, or disability? (stigma)	
	Experience of any trauma, its cultural explanation	
3	*Present problem/difficulties (distress narratives)*	
	Symptoms—culture-specific meanings and its therapeutic implication or culture congruent mood, guilt, somatization, delusion, or hallucination	
	Cultural explanation of cause (EMI) and cure/illness meaning and idioms of distress	
	Past help-seeking(s) (including culture-based)	
4	*Treatment expectations (patient's agenda)*	
	Perception of any cross-cultural barrier or cultural distance?	
	Treatment expectations (what is most helpful?)	
	Involvement of family/community/traditional healer in the treatment process	
	Therapeutic modality desired: Pharmacotherapy/psychotherapy/traditional/ religious/community support	
5	*Cultural formulation*	
	Rate: Level of illness severity/functioning/stressors/social support	
	Diagnosis: Cultural narrative (discuss with the client/family) and medical (discuss and clarify the meanings of diagnostic labels)	
	Note: Any special cultural issues to be addressed in treatment and care Record client's satisfaction score over this assessment	

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Emil Kraepelin (15.02.1856–7.10.1926), a German psychiatrist, is the founder of modern scientific psychiatry with a profound contribution in psychiatric methodology.

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Salient Features

- It is a milestone in the world of Indian psychiatric literature, admirably filling a very important vacant slot.
- Contains the distillate of life-time experience and felt need of a Senior Professor of psychiatry and a Teacher par-excellence, who has worked across the world.
- Presents a comprehensive as well as 'ready-to-use' modules of evaluation of patients who present with mental symptoms.
- This book is sure to be of great help not only to young trainee psychiatrists and other mental health professionals, to whom it has been dedicated, but also as a reference book for experienced senior mental health professionals, inclusive of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses

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