History taking for mood disorder

PC – mood (can be high (elevated) and/or low)

HPC – the three areas to explore

- Timeline
    - When did this start?
    - Do they have any idea if there was a trigger?
    - Can they describe how they are/were feeling? You can ask them to use a 0-10 scale (0 being very low and 10 very high to rate their current mood)
    - What is their coping mechanism?
    - Any support they are seeking for themselves at the moment?
    - Has this happened before? If yes, what was the intervention they received?
    - Any episodes where they felt the opposite to what they are currently feeling?

- Key mental state examination
    - Mood, energy, enjoyment
    - Changes in appetite, sleep, concentration and, if appropriate, libido
    - Screen for psychotic symptoms such as grandeur/nihilistic delusions, hallucinations
    - Risk assess patient
        - Risk to own-self – self harm, suicide ideation
        - Risk to others – harming others
        - Risk of neglect – to own-self and others

- Non-psychiatric causes (can be explored further down your history taking)
    - Do they have any organic causes?
    - Are they taking any recreational drugs?

Past medical history – organic cause such as hypothyroidism or chronic disease can both contribute to depression

Drug history – medications that they are taking (or previously taken for their mood disorder) and allergies

Social history

- Explore housing conditions
    - Do they live alone or otherwise? Any pets?
    - Any friends/family members who live close by?
- What do they do for a living? (beware this could be a source of stressor too)
- Do they smoke?
- Do they drink alcohol?
- Do they take recreational drugs?

*during the consultation in terms of your symptoms and concerns?

To take a good history, try to put yourself in the patient's situation. What do you want to tell your doctor during consultation in terms of your symptoms and concerns? Empathizing with patients and taking time to understand how they feel will help you to develop a deeper interest or motivation to help them. You would have developed your own empathizing phrases to use during OSCEs but body language counts too! In psychiatry, it helps patient to open up to you when they know you are invested to help them. Listen to their concerns and let them answer your questions as much as possible. Try to practice this communication skill during your clinical placement and reflect on your encounter each time

*Empathising (British spelling)

*In psychiatry, it will help the patient to open up to you when they know you are invested to helping them

Instructions to candidate – Aim for 8 minutes

You are a foundation doctor in a general practice.

John Smith is a 40 year old gentleman. He booked an appointment at your surgery as he has been experiencing low mood recently.

Take a history from John.

At 7 minutes, the examiner will ask you questions.

SP script

Name: John Smith

Age: 40 years old

Throughout your consultation, you avoid eye contact with the candidate, your speech is low in volume and slightly low in rate. However, make sure they can hear what you are saying and attempt to finish the script in time.

You booked an appointment with your doctor because you have been feeling down recently. This has been going on for the past 3 weeks. In your own words, you describe your feeling as being low in mood and you find nothing sparks joy and interest in you. You used to like going out for a run but not in these recent days as you are just drained of energy. This has persisted over the past weeks.

Weirdly, your sleep pattern has changed. You find it difficult to go to sleep as your mind doesn't settle easy. You keep thinking about you and your family's future. On many occasions, you wake up very early in the morning (even before your alarm) and struggle to go back to sleep. This causes your mood to be even lower in the morning and you are tired throughout the day. You struggle to read the news and play Sudoku, things that you normally enjoy doing during your free time. Similar to your sleeping issue, you put this down to difficulty of your mind to focus on tasks as things have been quite stressful for you lately.

When asked specifically, you deny having mood swings or having previous episodes of feeling very high or elated. This is the first time you are feeling so low. You find it weird that the doctor is asking if you are seeing or feeling things but you deny it. You don't feel someone is controlling your thoughts.

You have no suicidal ideation, no intention to harm yourself nor others.

You have been eating regularly so far. You realised you've put on some weight, about 4 stones recently. You don't feel your surrounding is especially cold, no swelling around your neck, don't feel particularly thirsty, don't think you've gone to toilet more often, no night sweats, no temperature.

PMH - Nil

FH – Nil

DH – Nil and NKDA

SH – You live in a flat with your wife and two children. You worked as a business consultant, in which you have been made redundant about two months ago. Your wife works as a manager. Both of your children are in college, in which you fund their tuition fees. Your parents live far from you, so do your siblings (1 brother and 1 sister). You have no pets. You don't smoke and don't do recreational drugs. You admit to drinking more lately but you know your limits and try not to exceed 14 units a week.

ICE

- I – things have been quite stressful lately. You have just lost your job and you are struggling to provide for your family financially. You feel it's one of your main responsibilities yet you have failed to do so.
- C – your family is your main support system at the moment and you are worried about your wife as she's been working more hours. This adds more stress to you!

- E – you acknowledge that the doctor can't do much with your life circumstances but you are hoping if they could provide you with something to help you feel better

Questions

- What are your differentials?
- What is the management of depression using the biological, psychological and sociology method?

Differentials

- Depression
- Anxiety
- Hypothyroidism

Depression

The ICD-10 criteria in diagnosing depression

- Must have at least 2 of the core symptoms
    - Persistent low mood
    - Loss of interest or pleasure i.e. anhedonia
    - Fatigue or low energy

  AND
- At least 2 of additional symptoms
    - Disturbed sleep (early awakening with diurnal mood variation)
    - Reduced concentration
    - Reduced self confidence
    - Diminished appetite
    - Suicidal thoughts or acts
    - Agitation of slowing of movement
    - Guilt or self-blame
- Symptoms must persist for at least 2 weeks for a diagnosis

Management via the BPS method

Biological – antidepressant

Psychology – CBT, mindfulness

Social – Mind Matters, building social support, education about depression so patient can detect early symptoms in the future.

Feedback

Did the candidate	**Y/N**
Explore the symptoms the patient is presenting with	
Rule in/out the biological causes of his low mood	
Establish previous episodes of mood changes	
Perform a risk assessment	
Establish if patient is experiencing psychosis	
Explore the factor(s) leading to his presentation	
Explore patient's ICE in a patient-centered manner	