

WRITING A PSYCHIATRIC CASE HISTORY

General Instructions:

This model case history is quite comprehensive. Most case histories are under 10 pages (size 10 font). Number of pages do not necessarily translate to a better mark.

Reading this model case history, one will have an excellent understanding of the patient's history, development, current situation and presentation. It also has an excellent diagnostic formulation and exhaustive management plan.

We do not expect most students to achieve this level of comprehension but it is helpful to see an ideal case history written by another 4th year student.

If you have problems with written English, we expect you to seek assistance in your case history. Ask assistance from the Student Learning Centre, friends or classmates. Microsoft word has spell check so please use it. Poor written English can affect your mark.

Medical records or clinic files cannot be taken home. Patients' names, details or other identifying data should not appear in your report. Use pseudonyms or initials.

Your case discussion should be your own.

Do not "cut and paste" from medical records onto your case histories. It is much better to paraphrase information from medical records rather than copying them verbatim.

Introductory statement

This should be one sentence to orientate the readers to the case and to provide focus for discussion. It proves to the examiners that you are not just presenting facts elicited but that you have the skill to synthesise and make sense of a psychiatric presentation.

Examples of introductory statements: - "This case illustrates the complexity of diagnosis in a person with a first presentation of psychotic symptoms", "This case illustrates the clinical and ethical dilemmas of managing a woman with ongoing para suicidal behaviour and borderline personality traits", This case illustrates the importance of a comprehensive psychosocial rehabilitation assessment and strong treatment alliance in a man with a twenty year history of schizophrenia". These statements should be based on what you believe to be the crux of the issue. If safety concerns are present it is important to highlight this e.g "This case illustrates the importance of managing suicide risk in an elderly man with an agitated depression."

Demography

Again one or two sentences – you must put age, gender, occupation and ethnicity. Do not guess clients race or cultural affiliation ask this. You cannot practice psychiatry without understanding how the illness impacts on the individuals cultural world view or what it would mean to them about themselves or what the implications are for treatment alliance.

In demography you may also wish to put number of children or living circumstances e.g “ Mr Pearce is a sixty year old Caucasian widower who is a retired bus driver and lives with his only daughter” “ Mr Toto is a thirty year old Maori who lives with his wife and two year old son. He is a civil engineer.” Immediately with a demographic statement the readers start to form a picture of the person as an individual.

Mode of referral

This is a brief description of the context that you are seeing the person in e.g “ Janet Jones has been a client of her community mental health centre for two years receiving treatment for depression” “ Mr Smith was referred to the liaison psychiatry service yesterday by the inpatient cardiology team who were concerned about his bizarre behaviour”

History of presenting complaint

This is a description of the current complaints that the person has. This requires detailed elaboration often using the persons own words and supported by a relevant functional enquiry. Quote the patient but in a selective way so that information is going to support your mental state and diagnosis and be consistent with the theme of the case e.g “ John describes both male and female voices talking about him. They say insulting statements such as “ He has a hideous nose, no wonder everybody thinks he’s a freak”. With an important piece of history like this you must tag on relative negatives e.g “ the voices do not tell or command John to do anything.”

It would be helpful if the identified symptom (ie low mood, rapid speech, suicidal thoughts) are qualified in terms of a) onset b) duration c) precipitating or mitigating factors d) severity. For example, “Chris has had on and off thoughts of ending his life for about 2 yrs now. It started after he separated from his partner. He noticed that everytime he drinks alcohol, for the next 48 hours, these suicidal thoughts increase. On the other hand, when he spends time with his kids, the thoughts seem to melt away.”

If you have someone with psychotic symptoms you must present a relevant functional enquiry e.g look for common delusions such as persecutory, mind reading and delusions of reference. In history of presenting complaint this section should be detailed and must include the patients **attribution** of their experiences e.g “ John believes the voices come from the devil as a result of a voodoo curse put on him by his neighbours.” Attribution should also cover cultural understanding of illness.

History of presenting complaint must also include **impact** of illness, e.g. “ Because of John’s voices he has left home in fear and is now homeless. He has also dropped out of

his Unitec course and has no contact with either family or friends.” This impact statement shows the examiner that you are familiar with the concepts of disability and handicap. A common criticism is that Drs can elicit symptoms but make no sense of them in terms of the individuals life experiences.

Another key area is **coping** - how does the individual cope with their experiences – later it can be discussed in the formulation whether this is protective or not e.g “ Jack copes with the voices by drinking alcohol which he feels reduces their intensity” e.g “Jane copes with her feelings of being unreal by ringing her mother. If her mother is not available she cuts her wrist with a scalpel which she says helps her feel focused.”

The other major area is **safety**. The most basic concepts of safety are suicidal risk and homicidal risk. You have to make very clear emphatic statements on this “Jack presents a very serious suicide risk. He has an active plan to kill himself by hanging. He has brought the rope and has selected a branch of a tree in his garden. He intended to hang himself tomorrow on the anniversary of his wife’s death.” It is not enough to say someone is high or low risk, you must elaborate.

“Patrick has ongoing intent to assault and possibly kill his sister because he believes that she is interfering with his thoughts and that she has conspired to give him schizophrenia and put him in hospital. He assaulted her with his fists and an end of a hammer last night in response to these beliefs and he poses a serious ongoing risk to this sister and possibly others.”

Safety also includes self cares “ Mr Jones is at serious risk regarding his personal safety as he frequently wanders the streets in a confused state, walks in front of traffic and forgets his home address.”

There are also specific high risk groups e.g. young men with a recent diagnosis of schizophrenia who have just been discharged from hospital and who have depressive symptoms e.g. women with puerperal psychosis and risk of infanticide (5%).

Current medication duration of treatment, efficacy and side effects should be documented.

Current neurovegetative signs and symptoms have to be included. These are sleep, energy, concentration, ability to experience pleasure, appetite and libido.

A common problem that medical students experience is how to write up the history of presenting complaint in the person seen in a community mental health setting. The key is to start with their current well being not when they were referred several years ago. The details of referral several years ago is part of the person’s past psychiatric history.

Past psychiatric history

If this is extensive, summarise the pertinent points. Exact dates are less important but treatments received, responses and serious events leading to hospital are. If no past

attempts at harming self or others say this if there, detail it e.g “John has had at least ten hospitalisations over the last six years with what sounds like an exacerbation of his schizophrenia. On one occasion he had a serious suicide attempt where he jumped in front of a car and fractured his hip in response to command hallucinations. He tells me he has been on a number of medications including chlorpromazine, haloperidol, pimozide and an injectable antipsychotic. He also describes frequent side effects such as tremor, impotence and akathisia. He does not believe that the medicine treats his voices only dampens them down” .

By presenting past psychiatric history in this way you have directed the key issues that you can raise both in formulation and management namely treatment resistant psychotic symptoms and forming a therapeutic alliance with a disengaged high risk patient with revolving door admissions.

Forensic history

Useful to put here as it may relate to past psych history e.g “ Janet has had one arrest for dangerous driving when she was manic.” Always mention even if negative “There is no forensic history.”

Substance abuse history

Need to not only quantify amounts of substances but show the distinction between abuse and dependency by relevant positives and negatives. If the case is clearly a substance abuse one, the substance abuse history should be presented in history of presenting complaint. e.g “ Jean drinks two bottles of wine a night. She has at least five episodes of blackouts in the last year and two DIC charges. In the last week she has started to have shaking hands in the morning which go when she takes 5mg of diazepam prescribed by her GP for anxiety. Last year she went to one AA meeting after an ultimatum from her partner but has had no help since.”

Family psychiatric history

Not just psychiatric diagnosis and treatment but ask about family suicides and substance abuse. E.g Alcoholic parents are relevant for a risk of alcoholism in children but also vulnerability to personality or mood problems in children because of attachment experiences. This section can not only relate to genetic risk in formulation but also the meaning of the illness to the individual.

Medical History

You may wish to put this heading higher in your presentation e.g if doing an elderly patient. The order of the headings can be flexible but each must be clearly articulated. Use common sense to the most relevant parts e.g don't write in detail on an appendectomy that is likely to be of no relevance. However, a diagnosis of diabetes in a woman with an eating disorder is highly relevant and would require detailed discussion.

Key points are physical illness and their treatment either presenting as a mental illness or increasing risk for a mental illness e.g. post CVA depression or the impact of a chronic illness on an individual's personality development and mental well being e.g. major importance if you get a young person who has had a chronic severe physical illness throughout of their life. Clearly a psycho geriatric case requires detailed consideration of medical history.

Social history

Key areas need to be covered but again select information that is relevant to the overall presentation. This should cover family composition, what was childhood like e.g. major events like death of family member e.g. overall family atmosphere e.g. "John is the oldest of three sons. He describes a chaotic and traumatic family life where he often witnessed his father assaulting his mother. Frequently John and his brothers would be taken from the house by different extended family members. He had been to ten different schools by the age of fourteen and had difficulty forming friends and learning to read to write. He frequently got into trouble with the teachers and was expelled at fourteen for assaulting a teacher."

You also need to give a vocational and relationship history e.g. Ann has worked for ten years as a teller in the bank. She married her first boyfriend at the age of nineteen but describes the marriage as "loveless". She finds she has little in common with her husband and has never enjoyed sex as she finds it "dirty". Her husband is 10yrs older and tends to be controlling. They have no children and Ann has little social contact outside the fundamentalist church she attends weekly." Hobbies and religion are good things to present here as both are related to recovery.

Premorbid personality

Don't leave this out because its difficult. You get major clues from how people cope or appraise illness, forensic history, relationship and work history. Also from your observations in interviewing people e.g. the style of communication of someone who is histrionic and flamboyant or with the overinclusive obsessional person who makes you particularly irate in a setting which is time limited. Generally not good to label as "disorder" unless very clearly able to defend the case as such e.g. you may get a woman with borderline disorder. Better to say "Sam has features (traits) of an obsessional personality. He describes a need for orderliness and perfection and control over a number of situations. Sometimes it also helps if you ask the patient (and or family) how the patient was as a person prior to the onset of illness.

Physical examination

Generally brief and *tailored* – in psycho-geriatric cases may need more detail e.g. detailing physical findings of Parkinsons. In eating disorders you will fail if you don't have weight+height for BMI and look for features of anorexia or bulimia. In some one

with a primary substance abuse diagnosis look for this eg stigmata of alcoholism. In someone on long term anti-psychotics do an AIMS in someone on lithium look for tremor/hypothyroidism.

“On physical examination Jane had a BMI of 16 her skin was dry and showed lanugo. Her teeth were chipped with dark staining. On cardiovascular examination she was bradycardic with a pulse of 48/minute regular. Her BP was 110/60 and her heart sounds were dual with no murmurs. Her temperature was 36.5C. No further abnormalities were detected on a brief examination.”

Mental state examination

This is the art and science of psychiatry. It must be organised, detailed and consistent with what has been presented. Use the phenomenological terms and be sure you can justify and define them. Do not leave out a section you cannot say “cognition was not assessed” unless you have an exceptionally good reason such as the patient walked out of the room.

A Appearance, behaviour, eye contact and rapport

Paint a picture of the person in front of you – its good psychiatry and it makes it interesting to listen to eg “Paul was dressed in unevenly buttoned hospital pyjamas with a ripped denim jacket on top. During the interview he remained curled into the corner of the couch and avoided eye contact. Rapport was difficult to establish as he seemed frightened both of being in hospital and the experiences he was going through.” Comment on the quality of the rapport don’t just say good or bad elaborate on it. Describing why rapport was bad doesn’t mean that you are necessarily a bad Dr rather that you are a reflective Dr with a conception about dynamics. **DO NOT BLAME THE PATIENT OR MAKE DEROGATORY REMARKS ABOUT THEIR APPEARANCE.**

Orientation/Cognition

Present a MMSE with frontal lobe extensions. If there are no abnormalities this can be done quickly eg “ No abnormalities were detected on a Folstein Mini Mental State Examination or on tests of frontal lobe function.” If there are any cognitive abnormalities this is always relevant and you have to say what tests were abnormal.

“Mrs Jones scored 27/30 on a Folstein Mini State Examination. She made two errors on testing of attention and concentration and scored two out of three on short term memory testing at five minutes. On frontal lobe testing she displayed several deficits. She perseverated on copying alternative patterns of w’s and m’s. She perseverated on alternative tapping testing and had a reduced verbal fluency only naming 8 words beginning with ‘a’ in one minute with two repetitions.

Her new word learning was impaired only recalling two out of four word pairs after two attempts and her ability to describe similarities between an orange and a banana was

impaired after saying they were both fruit she was unable to generate further ideas. On proverb interpretation she was concrete to both simple and easy proverbs. When asked a meaning of “two many cooks spoil the broth” she told me she had a small kitchen where not many people would fit in.”

A Speech -

Comment on rate, rhythm, volume and intonation

B Thought form –

Is the thought form logical, irrational, loose?

Giving examples helps

C Thought content –

Comment on delusions, ruminations, obsessions or overvalued ideas if they are present. Describe what is the person actually saying to you, what is important e.g “Tom spoke in a self deprecatory manner outlining his many failures although this was neither delusional or ruminatory in nature.”

Be very clear on accurate terminology regarding delusions – especially highlight threat/control/passivity as very relevant for dangerousness.

I put **SUICIDE/HOMICIDE** here as well as judgement.

D Perception-

Illusions, hallucinations, also know rarer ones and comment if present . Always discuss command hallucinations in detail.

E Mood –

eg Apathetic, euthymic, dysphoric, despondent, depressed elevated, angry fearful etc

You can also ask mood directly – and quoting the patient’s response “Mark says he is feeling grumpy.”

F Affect

Be clear that this is a different concept to mood – discuss range, reactivity, mobility, intensity and congruence.

G Insight

This has several parts

1. Does the person think that something different is going on ie they see the symptoms as different to usual self?
2. Do they see symptoms as illness?
3. Do they see symptoms as part of mental illness?
4. What is their attitude to help seeking/treatment?
5. Do they see impact of illness?
6. In people with personality disorders concept of psychological insight important.

Always relate insight to the appropriate other part of the MSE ie is it the persons's mood, psychosis or cognition for example that makes insight less than full. It is inadequate to say "insight is impaired" "insight is partial" without adequate exploration of the components insight.

H Judgement-

How does all the mental state you have presented impact on decision making regarding action. Clearly key ones = suicide, risk to others and ability to self care. Again don't make global statements without discussion – not adequate to say " judgement is impaired" without saying why and how.

WHAT IS A FORMULATION?

A formulation is more than a summary. It is your opportunity to define how you understand why this person is presenting in this way at this time. The art of formulating is a skill that psychiatrists continue to develop throughout their careers. As medical students the key aspects to appreciate is that a formulation contains three core parts.

1. DSM IV

A formulation using the 5 Axis system. This should be included in the write up as part of the student's diagnostic formulation.

2. a) Descriptive

A formulation starts with a brief statement about the case. This should link to your introductory statement.

For example "Mr Jones has had multiple admissions for treatment refractory schizophrenia and has significant disability and a range of rehabilitation needs"

b) Explanatory

The models of understanding discussed in the explanatory aspect of the formulation can vary according to the individual's presentation and the field of interest of the psychiatrist. In general a biopsychosocial framework is the most appropriate one for a medical student to use. How does the biology of the individual relate to their psychological and social world? Even in a "very biological" condition such as Alzheimer's Dementia the persons psychological coping style and family structure and support create a unique aspect to understanding the situation.

The developmental stage of the individual is a key aspect of the explanatory component of a formulation. For example what is the difference between a person developing schizophrenia at age 14yr compared with age 30yr? Clearly there is a marked difference. The fourteen-year-old will have a significant disruption to the tasks associated with that age – education, peer relationships, becoming aware of their sexuality. The tasks for a thirty-year-old that would be disrupted by the illness would be consistent with developmental areas such as employment and developing or sustaining a family network of their own.

c) Prognosis

This is not a statement merely relating to a statistical likelihood of a cure. A prognostic statement needs to include factors related to the individual, both protective and risk related. It also needs to consider factors that may relate to the ease or difficulty of forming a therapeutic alliance. For example: "Although I have emphasised the need for adequate antidepressant therapy a key issue remains the ability for health services to engage with this man in a culturally appropriate manner as his religious beliefs leave him with fear regarding taking medication"

MANAGEMENT PLAN COMPONENTS

1.Safety

What are the current safety concerns? Priority lies with immediate risk to self from suicidality or diminished self cares and risk to others. Be aware of risk factors e.g age, gender, substance abuse and of course significant past events and personality style. An accurate and thorough mental state examination will identify features which specifically increase risk e.g command hallucinations, delusions of threat/control, an irritable and elevated mood or suicidal ideation. Long term risk relates to ongoing factors either in the individual's mental state or environment.

Psychiatry has moved away from predicting dangerousness to *managing risk*. Strategies for managing risk include engagement with the individual, frequency of contact and education around early warning signs for illness relapse. Increase in nursing and medical supervision, respite admissions and or acute in-patient hospitalisations are options in

managing unwell and unsafe patients. On some occasions the mental health act may be required to ensure appropriate medication use or inpatient care at times of acute crisis. An active plan to address substance abuse issues may be part of managing safety as may attention to environmental stress such as housing stability.

2. Clarifying diagnosis and differential diagnosis

Is it clear what the individual's diagnosis is? It is surprising how many consumers are treated within the system for years with an unclear or inconsistent diagnosis. Too often diagnoses like schizo-affective disorder are used in a loose and meaningless way to justify unfortunate poly-pharmacy. Management addressing differential diagnosis includes reviewing old notes both psychiatric and medical, obtaining a thorough longitudinal history from the individual and meeting with family members for clarification

3 Cultural issues

The individual and family's cultural identification must be established on first contact. This is so the family and individual can have access to culturally appropriate support and the staff can receive advice on how to work with the consumer and appreciate their world view. It is essential to utilise the interpreting service when the consumer requests this or when English is not their first language.

4 Biological Management

a) Pertinent diagnostic tests and examinations

Consideration of the physical health of the individual is essential. This is because physical conditions may present with an altered mental state e.g. delirium. Another important reason is because of the possible medication interactions with pre-existing medicines taken for a physical condition. It is important to establish baseline blood tests prior to prescribing many medications eg renal function and thyroid function prior to lithium.

In certain populations, a comprehensive physical examination and investigation is particularly important as in potentially life threatening conditions such as anorexia nervosa. It is important to remember that consumers with schizophrenia have poorer general physical health than the general population and often do not access General Practitioners. A physical examination on someone prescribed anti psychotic medication must include an examination for tardive dyskinesia and extrapyramidal side effects.

b) Medication

The other major component of biological management is medication. What does the evidence tell us about which medications are effective for someone with this condition? Clearly the attitude of the consumer and their family to medication is important. A

discussion of the advantages and disadvantages of medication and possible side effects is obligatory in good management. It is also important to discuss the dosing regime, the expected time for effect, the need for any special monitoring and practical issues such as what to do if a dose is missed. There should also be a statement on how often the person will be reviewed. Written information sheets in the appropriate language are important. Directing patients to websites which detail medication side effects can be helpful (www.medsafe.govt.nz).

5 Psychological management

Psycho-education (discussing what the individual's condition is and potential treatment strategies) and exploring the patients coping style and aggravating stressors are components of general psychological management. Additionally specific psychological therapy may be indicated such as cognitive behavioural therapy for depression or a number of anxiety disorders. Psychological management may include special assessments such as neuropsychological testing. As with all management, psychological strategies should be a planned intervention with specific goals and outcomes to be evaluated.

6 Social and Family issues

A major criticism of mental health services has been the lack of communication with family members. Family members are not only a valuable source of information but are often a major support in the individual's recovery process. Families may experience their own stress from seeing a member unwell and community organisations such as the "Supporting Families" can be invaluable. Family support groups from the CMHC's and inpatient units are also useful resources. Specific interventions involving the family such as Integrated Mental Health Care or Family therapy may be indicated. The individual's family or major social support person should be involved in developing a wellness plan with early warning signs and contact numbers.

Social issues often relate to housing, money, education and employment. There is clear evidence that for people with ongoing mental illness the quality of their housing relates to their ability to maintain wellness in the community. Hopefully as a service we can move past the language of "placement" to working together with the consumer to find a stable home. Assessment of living skills may alert the team to specific needs for the individual for example budgeting or cooking. Management of employment issues may range from providing a letter to employers supporting a gradual return to the workplace to a referral to specialist agencies.

7 Rehabilitation Management

This is of more relevance to consumers with the more severe and enduring mental disorders. Rehabilitation is not concentrating solely on symptoms but rather looks at the impact of the illness on the individual's ability to function within and as part of the community. Establishing goals with the individual and their family and looking at the

steps needed to achieve these are important. A rehabilitation plan identifies areas for skill retrieval, skill development and community integration.

8 Critique of Management

In asking the students to write case histories, we do not just expect them to be “scribes”. We encourage critical thinking and reflection. In this section of the Case History , we want you to comment on the overall management of the case. Were there areas of engagement or treatment that could have improved? Were medication used properly? Was there effort to involve families? Were non-medication treatments utilized? If not, why?

Marking Criteria for Case Study Reports

4	Well structured, logical with discussion significantly above expected standard (and handed in on time.)
3	The expected standard for Year 4. Meets all general standards (accurate, referenced, legible, dated and named), complete in all areas, basic management plan outlined and short discussion (1-2 pages plus references) presented which relates to the patient.
2	Below expected standard but has remediable features.
1	A very poor report that is unacceptable.
0	Not handed in.
N/A	Not assessed this attachment