Depression history taking

geekymedics.com/depression-history-taking

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Taking a **depression history** is an important skill often assessed in OSCEs. It's a key skill that you'll require whichever speciality you're heading towards. The guide below provides a structured framework to ensure that all of the key points are covered in addition to some stock phrases that may come in handy. Check out the depression history taking mark scheme here.

A few general tips for these type of situations:

- Use the patient's own language when describing their feelings, and use this to get them to expand on their presenting symptoms. Repeating parts of phrases can help develop the consultation and show the patient you are listening and trying to understand.
- Be careful with your "active listening" fillers – nodding and making affirmative noises to show engagement may be more appropriate than saying "Okay…", you may accidentally re-affirm some of the patient's negative beliefs about themselves or their situation.

- Don’t be afraid to (sensitively) ask about suicide risk. Screening for risk and asking about suicide does not increase the likelihood of a patient attempting it!
- Signpost and summarise as you go.

Definition of depression

ICD-10 criteria

Depression is;

- persistent sadness or low mood; and/or
- loss of interests or pleasure
- fatigue or low energy

At least one of these, most days, most of the time for at least 2 weeks.

Additional symptoms to ask about include:

- Sleep
- Appetite
- Concentration
- Low confidence
- Suicidality
- Agitation
- Slowing of movements
- Guilt

These will help you to determine the severity of depression, as shown in the table below.

Not depressed	<4 symptoms
Mild depression	4 symptoms
Moderate depression	5-6 symptoms
Severe depression	7 symptoms +/- psychotic symptoms

*Symptoms should be present for a **month** or more and **every symptom** should be present for most of every day.*

Opening the consultation

Introduce yourself – *name/role*

Confirm patient details – *name/DOB*

Confirm reason for presentation:

“What’s brought you in to see us today?”

Open questions can help the patient to explain how they are feeling, without placing words into their mouth or assuming a specific reason for presentation.

Developing a rapport

Enquiring about mood and general feelings before jumping into a history may help the patient feel more at ease:

“How are you today?”

“How have you been feeling recently?”

Screening for core symptoms

Screen for core symptoms of depression :

- persistent sadness or low mood; and/or
- loss of interests or pleasure (anhedonia)
- fatigue or low energy

“In the past month have you…”

- **Felt down, depressed or hopeless?**
- **Found that you no longer enjoy, or find little pleasure in life?**
- **Been feeling overly tired?**

Assessing symptoms of depression

Screen for the presence, and assess the extent of any biological symptoms.

Biological symptoms

Sleep cycle

*“How has your **sleep** pattern been recently?”*

“Have you had any difficulties in getting to sleep?”

“Do you find you wake up early, and find it difficult to get back to sleep?”

Mood

*“Are there any **particular times of day** that you notice your mood is worse?”*

“Does your mood vary throughout the day?”

“Do you find that your mood gradually worsens throughout a day?”

Appetite

*“Have you noticed a change in your **appetite**?”*

“What is your diet like at the moment?”

“What are you eating in a typical day?”

Libido

*“Have you noticed a change in your **libido**?”*

“Since you have been feeling this way, have you noticed a difference in your sex drive?”

Cognitive symptoms

Screen for, and assess the extent of any cognitive symptoms of depression.

Concentration

*“How do you feel your **ability to concentrate** has been?”*

*“Can you follow TV programmes/ read the newspaper/*insert hobby here* without getting distracted?”*

Perception of current/future situation

“How do you feel about your current situation?”

*“How do you feel about the **future**?”*

Perception of self

“How do you feel about yourself?”

*“Do you often **criticise** yourself?”*

*“Do you **blame** yourself when things go wrong?*

Ruling out differential psychiatric diagnoses

Identify any previous episodes of mania (rule out bipolar affective disorder diagnosis at this time)

> *“Have you ever experienced periods of feeling particularly high/energetic/euphoric?”*

Elicit any evidence of psychosis

When asking these questions, you may find it useful to use a lead-in. This allows you to signpost, maintain the patient’s trust, and normalise any feelings they may have, enabling an open conversation.

“People who feel the way that you have been describing can experience some seemingly bizarre events and feelings…”

- *“Have you ever heard voices speaking when there seems to be no-one around?”*
- *“Do you ever feel that people are discussing you negatively?”* (If so, get context!)
- “*Do you fear that people may be ‘out to get you’?”*
- “*Have you ever felt that something or someone is able to put thoughts into your head?”*
- *“Have you ever felt that something or someone can remove thoughts from your brain?”*
- *“Have you noticed any sensations that seem odd or inexplicable?”*

Assess risk

Assess suicide risk, and risk of harm to self.

Again, this is something that you may feel more comfortable approaching with a lead-in!

- *“When people feel down and depressed, they can feel that life is no longer worth living. Have you ever felt like this?”*
- *“Have you had any thoughts of taking your life?”*(if so – how often, when) / *“Have you thought of how you would do something like this?” /“Have you made any plans?” / “Have you ever tried to take your own life?”*
- *“Have you tried to hurt yourself in any way?”* If so, how – if not *“Have you thought of hurting yourself?”*
- *“What things do you have that you feel stop you from harming/killing yourself?”*
- *“Are you managing to eat and drink as you usually would?”*
- *“Has your alcohol intake changed?”, “Have you been relying on anything to help you feel better? ” (Drugs, alcohol, food, etc.)*
- *“Have you felt able to see your friends/socialise?”*

Past psychiatric history

Previous episodes of depression or dysthymia:

- “*Have you ever felt like this before?”*
- *“Have you ever had any other periods of feeling particularly low?”*

Previous psychiatric history:

- *“In the past, have you had any problems with your mental health?”*
- *“Have you had any counselling for any issues before?”*
- *“Have you ever been admitted to hospital because of your mental health?”* (If so, obtain details – time, method of admission, result.)

Past medical history

Any chronic illnesses, or biological basis for mood disturbance *(chronic illness is a major risk factor for depression).*

- *"Do you have any medical conditions?"*
- *"Is there anything you see the GP for?"*
- *"Have you ever been in a hospital for any reason?"*
- *"Is there anything you take medication for?"*

Drug history

Note current medications and record allergy status

- *"Are you prescribed any medication at the moment?"*if so, check compliance
- "*Do you take any other medications?"*
- *"Do you buy any medications over the counter?"*
- *"Do you take any herbal remedies?"*
- *"Has the dose changed of any of your medications recently?"*
- *"Is there anything you are allergic to?"* if so – *note reaction*

Family history

Enquire about any physical or psychological illnesses in the family.

A genogram may be useful – *to account for family relationships and history of psychiatric illness in the family.*

Social history

Determine the social circumstances of the patient:

- *"Who lives with you at the moment?"*
- *"Where are you living at the moment?"*
- *"Do you have any financial or housing concerns?"*

Assess the impact of the depressive symptoms on the individual's relationships and work:

- "*Has your mood affected your friendships?"*
- *"Are you able to socialise regularly with others?"*
- *"Are you in a relationship at the moment? Has this been affected?"*
- *"Have you told any friends/family/anyone how you are feeling?"*
- *"Has your mood affected your ability to work?"*
- *"Are you able to concentrate on tasks at work?"*
- *"Has your mood caused you to take any time off work?"*

Elicit patient's drug, smoking and alcohol intake, if not already elucidated:

- *“Do you smoke?”*
- *“Do you drink alcohol?”*
- *“Do you take any other drugs?”*

Insight

Assess if the patient has insight into their problem:

> *“Do you feel there is something wrong?”*

ICE – *Ideas, concerns and expectations:*

> “*What do you expect/what would you like from the consultation?”*

Closing the consultation

Summarise the history back to the patient

Ask if there is anything else they would like to add

Ask if there are any questions

Thank the patient

Assessment

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