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THE LEARNER'S VOICE

Mental Health Collateral and the Living Family's Illness Narrative

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His wife had arranged for a Lyft to take him to our psychiatric emergency department. Faye, as we will call her, confided hopefully, "He finally told me he was tired." Tired of using drugs, she meant. I was on the phone with her collecting collateral information, something I've since learned is especially important in psychiatric care. The story itself was familiar. It started with an oxycodone prescription after a back injury and accelerated in the years following to heroin, to fentanyl, to cocaine. This evening, he'd used all of them and was now barely conscious, slouched over one of the heavy and unforgiving blue plastic chairs of the locked emergency unit.

This was the first time I'd been asked to make a call of this kind. When the conversation began, I didn't know what I was supposed to ask. So, I did what I was used to doing and began with, "What brings your husband to the emergency department tonight?" In a situation where the patient himself was unable to tell me his story, she became the most reliable narrator. After thirty minutes, I learned they have been married for decades, the patient has children at home whom he loves with all his heart, and he is a big professional football fan. I also learned that he has been in multiple recovery programs, that he has two siblings who both struggle with addiction, and that Faye wanted more than anything for him to survive this illness that she feared might soon go too far. Tonight, she was hopeful that he could be connected with a recovery center where he would be safe, off the street, and where she could visit before eventually welcoming him back home.

Minutes later, I heard screaming and banging. Faye's husband was now conscious — angry and agitated and demanding release. Nursing and medical staff entered with a security team to attempt verbal de-escalation with no success. I watched from the other side of the glass barrier as he shoved furniture and threatened the care team. After multiple attempts to calm him, he was pinned down to the same blue plastic chair where previously he'd been resting as his nurse administered intramuscular sedatives. All I could think about was Faye, how compelled I'd been by her story and how she had believed her life partner had reached a pivotal moment for change. Leaving my shift, I hoped that despite the evening's events, the next day would bring about an opportunity for that change. When I returned in the morning, his name was gone. He had left overnight.

An illness narrative is the story that a patient tells to give coherence to the distinctive events and long-term course of suffering [1]. We translate the patient's narrative into the categories of the history of present illness, past medical history, and family history. The contrast between my conversation with Faye and what I witnessed that evening in the emergency room made me wonder: what is the significance of the *family's* illness narrative? The information that I collected from Faye was not a family history or history of the present illness in the strictest sense, but I realized that she had formed her own illness narrative to make sense of her experience as a caregiver.

More so than the patient's *reported* family history, collateral information has become increasingly valuable to me in my early clinicals and in part, provides a place in the medical record for the "family illness narrative." I've only started to understand the value that these supplemental perspectives may have for developing an accurate clinical impression and for making appropriate disposition assessments in both emergency and inpatient settings. There are complexities surrounding this process that are most apparent in cases of conflicting wishes like that of Faye and her husband. *Would this experience give Faye less hope and trust in the medical system? Would I doubt another family's account of their loved one in the future? Or worse, would I begin to avoid family conversations to protect myself against the burden of this complexity?*

Loved ones can certainly turn a blind eye in cases of illness, but rather than dismiss incongruent accounts of addiction and recovery, the stories of family members should more often elicit empathy and curiosity from us. What I saw in the medical setting that evening was an incomplete image of this man's disease and his progression towards recovery. It's not

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that Faye's collateral account was unreliable or that she didn't understand her husband's wishes; to the contrary, her reality was perfectly true to her. That her husband resisted accepting treatment did not invalidate her account. As Petrik writes in his paper on collateral information and patient care, "attempts to explain the divergence and convergence of information" is wherein lies the most complete understanding of a patient's experience and most likely, the best assessment and treatment plan [2]. Despite this patient's "unsuccessful" treatment, the illness narratives by Faye and her husband evolved that night to perhaps become more congruent. In retrospect, this felt like progress towards recovery.

As a learner, I wish I had been taught the value of these supplemental family accounts when I first began to practice the art of history taking my first year of medical school. These narratives inform a patient's illness over time and can be used to better cultivate teamwork between a patient, their family, and the outpatient and inpatient care teams. A family member's illness narrative is undoubtedly a part of a patient's *living* family history and as such, should be treated with as much importance as other aspects of their history to appreciate the full picture of someone's illness experience.

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