VIEW POINT

History taking: an invaluable tool in expert hands

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ABSTRACT

Background: History taking in psychiatry is perhaps the only method by which it is possible to reach a diagnosis. This requires initial training and constant practice and attempts to hone one’s skills that makes one a good clinician.

Objective: This paper describes different approaches involved in psychiatric history taking.

Discussion: A well recorded history of the patient going into the nuances of the evolution of illness and its dynamics facilitates diagnosis and paves way for psychological therapies.

Conclusion: The importance of history taking in psychiatry is highlighted. Constant practice of good history taking is helpful to a clinician during his practice and a post graduate student to create a good impression in his clinical examinations.

Key words: psychiatry; history taking; evaluation; diagnosis

INTRODUCTION

The traditional teaching in medicine is to record the complaints, enquire the details of illness, examine, investigate, try to diagnose and treat the illness. Unlike in medicine, in Psychiatry there is confusion between a sign and a symptom. Moreover there are no specific laboratory tests, has multifactorial causation, and absence of external limiting criteria. So, clinician largely, if not entirely depends on evaluation of the case by eliciting history and couples it with evaluation to arrive at a diagnosis. A question was posed to some clinicians by email, whether understanding the illness and then treating it is important or treat the illness and then try to understand it. Many responses suggested that whether you understand the illness or not treating is very important as that is what is being done even after understanding it. In an emergency treat first, then understand may be true but in all other situations it is necessary to understand and then treat is important, as treating without understanding leads to time consuming, experimental, and only symptomatic treatments. Treating the illness after understanding it gives a satisfactory result; otherwise treatment will result in poly pharmacy and side effects to these medications.

Medical men are also called ‘doctors’, a word which is derived from a Latin ‘docere’ meaning “to teach”, teach the patient and their family about the natural course, prognosis, possible management and other influencing factors which also medical ethics dictate. This can be achieved only after a detailed history taking. The purpose of a psychiatric diagnostic interview is to gather information that will enable the examiner to make a diagnosis. Having established a diagnosis, the clinician can then make predictions about the future course of a disorder and the likely response to treatment. As with all areas of medicine, treatment decisions are guided by diagnosis. Unlike most disciplines of physical medicine, psychiatry has no external validating criteria, no laboratory tests to confirm or refute diagnostic impressions. In Psychiatry it is necessary to understand while evaluating the patient to determine what has led the patient to the present state of suffering, what is apparent is the real cause, or there is something more than what the patient is trying to communicate. This is necessary to understand in certain “Neurotic” (stress induced) disorders. The first attempt to understand a patient’s illness and what causes it and how to plan management depends so much on evaluation of the patient. So, history taking is a very important tool which leads us to understand the patient’s illness better and plan further management. Some people may have an expertise picking up essential points in history that leads to an accurate diagnosis, but for many others it comes by practice. For others, honing their skills makes them better psychiatrists.

OBJECTIVE

This paper describes various methods and approaches including the nuances to be followed during the process of recording history in psychiatry and how it helps in diagnosis, therapy and prognostication of a case.
**DISCUSSION**

**Methods of recording history:** There are 3 methods of history taking,

1. Structured
2. Semi-structured
3. Unstructured.

In a structured history taking, the examiner follows a prepared proforma and the order is strictly followed verbatim. In an unstructured interview, the order as given in the proforma is not followed but all points are covered and this method requires experience. Where as in semi structure method, the order is followed without referring the proforma, till the contents of history taking format are internalized one has to refer the proforma and follow the structured method. Usually in the first year of post graduate studies it is prudent to follow the structured method. This method may also be followed when data is collected, to study certain aspects of an illness, and when certain rating scales are being used. This method of history taking can be done consulting the standard proforma given as in CASH (Comprehensive assessment of symptoms and history (Nancy Andreason (1992).) The CASH is designed as a structured interview and recording instrument for documenting the signs, symptoms, and history of subjects evaluated in research studies of the major psychoses and affective disorders. Its major emphasis is to provide broad descriptive coverage in order to permit investigators to make diagnoses using a variety of criteria (e.g., RDC, DSM III, DSM III-R) and also to examine biological, social, or cognitive psychological correlates in relation to phenomenology rather than just diagnosis alone. [1]

Unstructured interview when followed, some important areas of patient’s life may be forgotten or left untouched while the structured or Questionnaire method gives an impression to the patient that he or she is in a Pupil /School master relation and not one of therapist/patient relationship, so it is necessary that the evaluator should note this and practice a semi structured method which comes only by practice and experience. The evaluator all through the process, should maintain an attitude of being neutral and sympathetic but not that of a Prophet and savior, which may compromise in evaluating all the details, an attitude of being ‘gentle but firm’ is always beneficial and conducive to good history taking. [2-6]

**Approaches of recording history:** There are two popular models of recording history

1. Phenomenological
2. Dynamic

In phenomenological history, only patient’s symptoms and signs are taken into consideration, to arrive at a diagnosis and then treat them, the physician’s focus is symptomatic treatment and may not be total outcome without considering the other linking and influencing factors. In dynamic history, the focus is not only symptomatic relief but on the dynamics and evolution of illness, with an emphasis on

- Why this symptom,
- Why in this person (factors of vulnerability) and
- Why now (Precipitating factor or exacerbation of symptom or any social reason)

Psychiatric history should also include various predisposing and perpetuating factors. It is also necessary to ask why he chose to seek consultation now, when he has the symptoms since several months or years. Several reasons may be there, like convenience, financial constraints or any other reason, asking that some important clues may pop up, like a very disturbing behavioural symptom of recent onset. This type of history taking may be time consuming but comprehensive in nature, sometimes history taking in detail may have therapeutic effects.

It may not be possible to complete the entire history in one sitting, but while trying to end an interview or history taking process certain norms have to be followed, the most important of that is the patient’s satisfaction. History taking in Psychiatry or even elsewhere in other branches of medicine has both diagnostic and therapeutic effects, it is more so in Psychiatry as history taking and evaluation of the patient is the fundamental requisite for future psychological therapies. So, history should be taken on

- Several occasions,
- From several persons/informants
- By several persons (in an institutional setting this will be possible and more helpful and beneficial to the patient, often yielding good results.)

Not only taking history at several occasions and comparing the history obtained from another informant may be important and yields beneficial results, even taking history from several significant persons in patients life is important but one has to take proper care of protecting patients autonomy and willingness. Even after having obtained enough history to reach a working diagnosis, the process of history taking continues and may have a therapeutic significance.

**How to take history**

As should happen in all clinical settings, the patient must be treated with respect, and the interviewer should be considerate of the circumstances of the patient’s condition. The patient often experiences considerable pain or other distress and frequently feels vulnerable and uncertain of what may happen. Because of the stigma of mental illness and misconceptions about psychiatry, the patient may be especially concerned, or even frightened, about seeing a psychiatrist. The skilled interviewer should be aware of these potential issues and interact in a manner to decrease, or at least not increase, the
distress. The success of the initial interview will often depend on the physician’s ability to allay excessive anxiety. [7]

**Initial interview** There is no single ideal way to initiate the interview, but it is useful to think of having the following three components:

- Establish initial rapport with the patient, and ask about the presenting complaint or problems, i.e., what has brought the patient to the first meeting. Some patients tell their stories without much guidance from the interviewer, whereas others require explicit instructions in the form of specific questions to help them organize their thoughts. During this phase of the first interview, the patient should be allowed to follow his or her own thought patterns as much as possible.
- Elicit specific information, including a history of the presenting problems, pertinent medical information, family background, social history, and specific symptom and behavioural patterns. Formally test mental status
- Ask if the patient has any questions or unmentioned concerns. Initial recommendations are then made to the patient for further evaluation and/or beginning treatment.

Although the three parts of the interview can be considered separately, they often weave together, e.g., mental status observations can be made from the moment the clinician meets the patient. Pertinent medical and family history may be brought up in the course of presenting other concerns, and patients may pose important questions about treatment recommendations as they present their initial history. [8]

However, one should remember that a comprehensive psychiatric evaluation may be necessary to diagnose emotional, behavioural, or developmental disorders and this forms the basis for all treatments in psychiatry. Careful evaluation by history taking increases the patient confidence and paves way for a good doctor patient relationship which is fundamental to the recovery process. The best method of history taking is the direct face-to-face interview of the patient. Evaluations based solely on review of records and interviews of persons close to the patient and sometimes interviews on mobile phones have their limitations and may lead to unreliable information. The clinical interview should provide the psychiatrist with a sample of the patient’s interpersonal behaviour and emotional processes. It can either support or qualify diagnostic inferences and can also aid in prognosis and treatment planning. Important information should be obtained about the patient’s general style of relating, the ways in which the patient minimizes or exaggerates certain aspects of his or her history, and whether particular questions appear to evoke hesitation or signs of discomfort.

Additional observations concern the patient’s ability to communicate about emotional issues, the defence mechanisms the patient uses when discussing emotionally important topics, and the patient’s responses to the psychiatrist’s comments and to other behaviour, such as the psychiatrist’s handling of interruptions or time limits. The most comprehensive and accurate information emerges from a combination of

- Open-ended questioning with empathic listening and
- Structured inquiry about specific events and symptoms

Attention to the most pressing concerns, whenever possible, will improve the therapeutic alliance and is likely to facilitate increased cooperation; other inquiries may be more limited initially in the service of the alliance. Patient satisfaction with open-ended inquiry is greatest when the psychiatrist provides feedback to the patient at multiple points during the interview. Throughout the evaluation process, useful clinical information is obtained by being sensitive to issues of development, culture, race, ethnicity, primary language, health literacy, disabilities, gender, sexual orientation, familial/genetic patterns, religious and spiritual beliefs, social class, and physical and social environment influencing the patient’s symptoms and behaviour.

Respectful evaluation involves an empathic, nonjudgmental attitude and appropriate responses concerning the patient’s cultural identity, his or her own explanation of illness and treatment pathways, sociocultural stressors and supports, and modes of interpersonal communication, both verbal and nonverbal. An awareness of one’s possible biases or prejudices about patients from different subcultures and an understanding of the limitations of one’s knowledge and skills in working with such patients may help one determine when it is advisable to consult with a clinician who has expertise concerning a particular subculture. The physician should maintain a gentle but firm attitude while obtaining information and should not indicate bias. Sometimes the important and critical information is given by the patient, when he/she is about to leave the interview room called as “Colombo phenomenon” or “doorknob phenomenon”. [8] A patient’s typical day should be recorded before and after the onset of illness and compare the change in activities of daily living

**Important Interviewing Guidelines**[8]

- Let the first part of the initial interview follow the patient’s train of thought.
- Provide structure to help patients who have trouble in ordering their thoughts or to finish obtaining specific data.
- Phrase questions to invite the patient to talk (e.g., open ended, non-leading questions).
- Use the patient’s words.
- Be alert to early signs of loss of behavioural control (e.g., standing up to pace).
- Identify the patient’s strengths as well as problem areas.
- Avoid jargon and technical language.
- Avoid questions that begin with “why.”
Avoid premature reassurance.

Do not allow patients to act inappropriately (e.g., break or throw an object).

Set limits on any threatening behaviour, and summon help if necessary.

Use of collateral sources in obtaining history:

Family members, other important people in the patient’s life, and records of prior medical and psychiatric treatment are frequently useful sources of information. Collateral information is particularly important when patients have impaired insight, including when patients have substance use disorders or cognitive impairment, and is essential for treatment planning when patients require a high level of assistance or supervision because of impaired function or unstable behaviour. Family members and others who know the patient well may provide important information about the patient’s personality before the onset of illness, since the patient’s own account may be unduly influenced by his or her mental state. Collateral sources may also provide essential information about the illness course, the current symptoms and behaviour, and the reasons for the evaluation. The extent of the collateral interviews and the extent of prior record review should be commensurate with the purpose of the evaluation, the complexity of the clinical presentation, and the diagnostic and therapeutic goals. For example, in an acute inpatient or emergency setting, collateral information may be crucial to developing an understanding of the patient’s clinical condition, whereas in long-term outpatient psychotherapy the impact on the treatment process of obtaining collateral information from family or others needs to be considered. Except when immediate safety concerns are paramount, the confidentiality of the patient should be respected. At the same time, it is permissible for the psychiatrist to listen to information provided by family members and other important people in the patient’s life, as long as confidential information is not provided to the informant.

Reliability and credibility of history

Information available should always be checked for reliability and adequacy to make a diagnosis. The credibility of the informant is also important while taking the history from him or her. Information available is called reliable when it’s continuous, consistent and corroborative.

It is important to clarify where the information has come from, especially if others have provided information and/or records reviewed, and the interviewer’s assessment of how reliable the data is. Because of the absence of external validating criteria or biologic markers, diagnostic reliability is an intrinsic problem in clinical psychiatry. Before 1980 the problem was compounded by official diagnostic descriptions that were narrative and impressionistic. Schizophrenia was over diagnosed in the United States because the description failed to distinguish it sufficiently from mood disorders with psychotic symptoms. Starting with the third edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-III) of the American Psychiatric Association (APA) in 1980 and through subsequent editions and revisions, diagnostic criteria have been based on descriptive phenomenology of clinical symptoms and course of the illness. The interpretive, intuitive, and impressionistic diagnosis has succeeded in improving diagnostic reliability. It has also strengthened the medical model of psychiatry. Adequacy determines whether the information obtained is sufficient enough to arrive at a working diagnosis. Reliability is determined on several factors like, the continuity, conformability of the history obtained, whether the same can be corroborated with history given by the patient with that of the primary informant, reliability of history is also counted on the credibility of history. The credibility of the informant depends on many factors such as age, sex, educational status, marital status, relationship with the patient, familiarity, length of stay with the patient and history of physical illness and mental illness in the informant, including intelligence and it is also necessary to determine how much informant is motivated in patient’s improvement. Age is an important credible factor as we all know that children are poor informants and while the elderly people due to senile forgetfulness may confabulate. In terms of sex, details of some of the problems can only be given by informants of same sex eg: menstrual problems in female patients better given by female informant. Educated are better able to verbalize the details of illness, prior treatment and prognosis. Married informant will be better able to understand and express the psychosocial stressors associated with marriage or divorce or widow. Relationship with the patients another important factor in credibility, for example daughters are able to express the details of illness of their mother and daughter-in-laws may give biased history. Person who is a close relative or who has seen the previous episodes or who has been staying with the patient since the onset of illness may give better history.

Attitude towards patient and illness and his admission to the hospital is also important. Some people may say the wrong history to get rid of the patient from home. History of mental illness in the family as the mental illness runs in the family should be checked before obtaining history from informant. Sometimes, the history given can be maximized and minimized based on underlying disorders. For example, alcoholic patients are notorious for minimizing the extent of their drinking in contrast somatization and facitious disorder patients may exaggerate their complaints. In these scenarios it’s always good to cross check by talking to a member of the family to learn that what the patient said is right or wrong. The physician should also gauge the reliability of a patient as an informant. A patient’s reliability is determined in part by comparing the history obtained from him with that obtained from other informants. Example: Alcoholic patients are notorious for minimizing the extent of their drinking. Talking to a member of the family, one may learn that what the patient...
said “was just a drink or two” could be a quart of whiskey per day. A patient who contradicts himself without seeming to realize it gives independent evidence of unreliability, and one can make a determination of reliability without outside corroboration.

**Time**

The amount of time set aside for an initial psychiatry outpatient evaluation varies ranging from 45-90 minutes. If the evaluation is conducted at the bed side, length of interview is often shorter because of patient’s medical condition and more frequent, brief visits may be necessary. In emergency room settings, the evaluation may be prolonged particularly if hospitalization is in question and supporting data are needed from resources not immediately available such as from relatives and treating physicians who have to be reached on telephone. In a patient with psychotic behaviour at OPD, the interview may be abbreviated if in the judgment of the psychiatrist, prolonging the interview will aggravate the patient’s condition.

Psychiatrist can learn much about patient’s handling of time by exploring the reasons. A patient who arrives much earlier could be anxious. Those arriving very late are often conflicted about coming to psychiatrists, and are not aware and conscious of their own handling of time and appointments with doctors as well. Undue diagnostic significance should not be given to this and should be understood in the patient’s sociocultural background.

**Setting**

The setting should be one that promotes comfort for both the patient and doctor. Establishing privacy in a setting is most important where in confidentiality can be ensured. The psychiatrist should do everything possible to put the patient at ease during the interview. The height of chairs should be equal in size approximately, so that neither party is looking down on another. There should be no barriers between patient and doctor such as desk. It is important for the psychiatrist to have unimpeded access to an exit door. There should be sufficient light to maximize the visual observation and avoid glaring light that disturbs the patients. Background sound should be minimized. For young children, a play room setup with toys that children can express themselves with them is preferable for interview. Psychiatrist’s skill and experience counts a lot in this type of setting.

**Note taking**

The purpose of taking written notes during interview is so that the psychiatrist has accurate information for preparing the report of interview. Neophyte interviews tend to take extensive notes because they lack in knowledge and experience about what is relevant and what is not. The greatest limitation in excessive note taking is that, it can inhibit the free flow of exchange between patient and doctor. If preoccupied with taking notes, there is a chance to miss the patient’s important nonverbal messages and will not perceive important leads in the interview.

If the patient’s resentment about note taking interferes with the interview, the psychiatrist should refrain from doing so. Notes help psychiatrists to remember information accurately. It helps in summarizing the observations and conclusions. For an experienced psychiatrist 5-10 minutes at the conclusion of a 45-50 minute interview usually suffices.

**Confidentiality**

Psychiatrists are bounded by medical and ethical principles not to divulge any information revealed to them unless they have patient’s consent. They must protect patients and assume responsibility for seeing that no harm will come to them by virtue of the patient’s reaching information about themselves. If patients refuse to give permission to reveal information, whether it be to a referring physician or filling out an insurance form, psychiatrist must respect patient’s wishes. In hospital or clinic settings, the patient is told about the types of information that will be recorded and who may have access to the information. While recording the information in the general hospital try to record only data pertinent to the overall care of the patient such as medications prescribed, and minimize recording the personal information and others that has no relevance to the general medical care of the patient. These documents come handy for reference in case any legal problem arises in future. Only when patients are in danger of hurting themselves or others by virtue of their mental illness, the psychiatrist is obliged to reveal such information in order to institute involuntary hospitalization. When third party care givers are seeking psychiatric information, psychiatrist reviews with the patients the information that has been prepared for the care giver and obtains patient’s permission to submit reports.

**Points in history taking**

For better understanding it is necessary to keep the entire history in separate subheadings, like

- Complaints with duration in chronological order including reasons for consultation
- History of the Present Illness
- Past Psychiatric History/past physical illness
- Family history
- Personal history
- Premorbid personality (or inter morbid functioning)

Special emphasis should be made to obtain developmental, psychosocial, and socio cultural History. General medical history including medications taken or being taken (Prescription or OTC), history of substance use, occupational and military history, legal history and the significance of first five years of life is not to be underestimated and has to be taken in great detail as per the prescribed format. At the end...
of history, examiner should be able to identify with reasonable certainty about the type of illness, answering the following question may give clues to the diagnosis

- The illness is arising de novo,
- Relapsing and remitting illness, or
- Exacerbation of an underlying illness

CONCLUSION

We should remember that much of history taking is not only recording what patient and his informant reports, but also conducting an enquiry about the what, why, where, when and how of it. It should be noted that we are trained to elicit history but patient is not trained to give history about his illness. A careful enquiry should be conducted till sufficient clues are obtained to come to a diagnostic conclusion with a rich differential, diagnosis which will be useful in understanding the evolution of illness and subsequently its treatment and outcome. One should learn to document history as narrated by the patient or informant instead of noting few points and trying to dilate them, as good documentation will facilitate an easy flow during presentation. History given at different points should also be documented at appropriate places as this will help in future during follow up of the case and during psychotherapy. History taking should always be comprehensive and unbiased. For example, while interviewing an elderly patient, sexual history is not asked and in schizophrenic patients the occupational history might not have been taken in detail deeming that schizophrenics do not go to work. History taking should not be an exercise where a trained person not only records what the informant or patient report but should be accompanied by detailed enquiry to understand the what, why and how of the evolution and dynamics of symptoms and illness.

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References:


