UNIT 1 TECHNIQUES OF INTERVIEWING AND CASE HISTORY TAKING

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1.0 INTRODUCTION

George Engel stated, “Virtually indispensable for the physician–patient interaction, the well-constructed interview truly may be regarded as the most powerful, the most sensitive and the most versatile instrument available to the physician”. Truly, the psychiatric interview is the most essential and also the most important aspect in the evaluation and care of persons with mental illness. All mental health professionals, regardless of theoretical orientation, must struggle to learn and master this skill of listening and constructing both, the patient’s symptomatology and his/her life history. While the biological or phenomenologically oriented professional try to identify patient’s symptomatology; cognitive–behaviourally oriented professional look for distortions, assumptions or inferences; psycho-dynamically oriented professional look for hints at unconscious conflicts; behaviourists search for covert patterns of anxiety and stimulus associations. Therapeutic listening requires sensitivity to the storyteller and an ability to integrate a patient orientation with a disease focus. Listening to someone requires time, concentration, imagination, a sense of humor, and an attitude that places the patient as the central focus of his or her own life story. In this Unit, we discuss the various aspects of history taking that transforms the art of listening into an admixture of art and science.
1.1 LEARNING OBJECTIVES

After studying this Unit, you will be able to:

- Recognize the role of history taking in the management of patient’s with mental health problems/disorders;
- Become aware of the general principles of history taking;
- Understand the various elements of history taking;
- Know and incorporate the different techniques of history taking; and
- Learn how to interview a difficult patient.

1.2 AIM OF HISTORY TAKING

The major purpose of the initial interview is to obtain information that will help to establish a criteria-based diagnosis. This diagnosis is useful not only in identifying and labeling the patients problems but also in predicting the course of the illness, the prognosis and the ensuing treatment decisions. A well-conducted psychiatric interview results in the understanding of the bio-psychosocial aspects of the disorder and provides the information necessary to develop an individualized treatment plan.

Additionally, the initial interviews and interactions shape the nature of the patient–physician relationship, which can have a profound impact on the outcome of management.

1.3 SETTING OF THE INTERVIEW

The setting in which the psychiatric interview takes place include psychiatric inpatient units, medical/ surgical inpatient units, emergency rooms, outpatient offices, etc. For having a proper interview, the atmosphere in which interview is held is of paramount importance. The interview room should be relatively sound proof. The furnishings and the decor should be pleasant and not distracting. It is suggested that the interviewer’s chair and the patient’s chair be of relatively equal height so that the interviewer does not tower over the patient (or vice versa) and the two should be seated approximately 4 to 6 feet apart. The mental health professional should not be seated behind a desk. The therapist should dress professionally and be well groomed. Distractions should be kept to a minimum. Unless there is an urgent matter, there should be no telephone or beeper interruptions during the interview. The patient should feel that the time has been set aside just for him or her and that for this designated time he is the exclusive focus of the mental health professionals attention.

1.4 DURATION OF THE INTERVIEW

The length of time for the interview and its focus vary, depending on the setting, the specific purpose of interview, and other factors (including availability of professional services). For an initial interview, 45 to 90 minutes is generally required. Despite this, more than one session may be necessary to complete an evaluation. For medically ill patients or in acutely disturbed or violent patients, the time duration of one sitting may be 20 to 30 minutes or less. In these situations, a number of brief sessions may be necessary. The clinician must accept the reality that the history obtained is never complete or fully accurate. An interview is continuous process and some aspects of the evaluation are ongoing, as the patient learns to trust the therapist, he/she will possibly reveal more information that will guide further exploration and treatment.
Nevertheless, there are basic principles and techniques that are important for all psychiatric interviews and these will be discussed in the next section. There are special issues in the evaluation of children that will not be addressed. This section focuses on the psychiatric interview of adult patients only.

Check Your Progress 1

Note:  
1. Read the following questions carefully and answer in the space provided below.
2. Check your answer with that provided at the end of this unit.

1) What are the chief aims of history taking?
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2) How much time should be allotted to history taking?
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3) What are the important characteristics of place when the interview is being held?
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1.5 GENERAL PRINCIPLES OF INTERVIEWING

Consent for the Interview

Prior to the interview, the professionals should introduce her/him self and, depending on the circumstances, may need to identify why they are speaking with the patient. Unless implicit (the patient coming to the office), consent to proceed with the interview should be obtained and the nature of the interaction and the approximate amount of time for the interview should be stated. A crucial issue is whether the patient is, directly or indirectly, seeking the evaluation on a voluntary basis or has been brought involuntarily for the assessment. This should be established before the interview begins, as this information will guide the interviewer especially in the early stages of the interview process.

Privacy and Confidentiality

Confidentiality is the most important component of the patient–therapist relationship. The interviewer should make every attempt to ensure that the content of the interview cannot be overheard by others. Sometimes, in a hospital unit or other institutional setting,
this may be difficult. If the patient is sharing a room with others, an attempt should be made to use a different room for the interview. If this is not feasible, the interviewer may need to avoid certain topics or indicate that these issues can be discussed later when privacy can be assured. Generally, at the beginning, the interviewer should indicate that the content of the session(s) will remain confidential except for what needs to be shared with the referring physician or treatment team. Some evaluations, including forensic and disability evaluations, are less confidential and what is discussed may be shared with others. In those cases, the interviewer should be explicit in stating that the session is not confidential and identify who will receive a report of the evaluation. This information should be carefully and fully documented in the patient’s record.

A special issue concerning confidentiality is when the patient indicates that he intends to harm another person. When the evaluation suggests that this might indeed happen, the mental health professional has a legal obligation to warn the potential victim and must inform the appropriate authorities depending on the law of the state (the law concerning notification of potential victim varies from place to place).

Often members of the patient’s family, including spouse, adult children, or parents come with the patient to the first session or are present in the hospital or other institutional setting when the mental health professional first sees the patient. If a family member wishes to talk to the mental health professional, it is generally preferable to meet with the family member(s) and the patient together at the conclusion of the session and after the patient’s consent has been obtained. As a rule, except in an emergency, consent should be obtained from the patient before the mental health professional speaks to the relative. While interviewing the relatives, the mental health professional should not bring up material that the patient has shared but listen to the input from the family member.

In educational and occasionally forensic settings, there may be occasions when the session is recorded. The patient must be fully informed about the recording and how the recording will be used. Occasionally in educational settings, one-way mirrors may be used as a tool to allow trainees to benefit from the observation of an interview. The patient should be informed of the use of the one-way mirror and the category of the observers and be reassured that the observers are also bound by the rules of confidentiality. These devices will have an impact on the interview that the mental health professional should be open to discussing as the session unfolds. Issues concerning confidentiality are crucial in the evaluation/treatment process and may need to be discussed on multiple occasions.

Respect and Consideration

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 is often may be experiencing considerable pain or other distress and frequently have the feeling of vulnerability and uncertainty of what may happen. Because of the stigma of mental illness and misconceptions about mental health disorders, the patient may not be comfortable about seeing a mental health professional. The professional should be aware of these issues and attempt to decrease the distress.

Rapport/Empathy

Respect for and consideration of the patient will contribute to the development of rapport. In the clinical setting, rapport can be defined as the harmonious responsiveness of the physician to the patient and the patient to the physician. It is important that the patient increasingly feels that the evaluation is a joint effort and that the professional is truly interested in his story. Empathic interventions (“that must have been very hard for you”)
or even a nonverbal response (with appropriate facial gestures) further increase the rapport. Empathy is understanding what the patient is thinking and feeling and occurs when the professional is able to put oneself in the patient’s place while at the same time maintaining objectivity. Head nodding, putting down one’s pen, leaning towards the patient, or a brief comment, “I see,” can accomplish this objective and simultaneously indicate that this is important material. In fact, the large majority of empathic responses in an interview are nonverbal. While empathy is essential, the professional should not forget to retain his/her objectivity. Maintaining objectivity is crucial in a therapeutic relationship and differentiates empathy from identification. With identification, the professional not only understands the emotion but also experiences it to the extent that he or she loses the ability to be objective. This is especially important in those patients who as part of their illness already have significant boundary problems (e.g., individuals with borderline personality disorder).

Patient–Physician Relationship

The patient–physician relationship is the core of the practice of medicine. While the relationship between any one patient and physician will vary depending on each of their personalities and past experiences as well as the setting and purpose of the encounter, there are general principles that, when followed, help to ensure that the relationship established is helpful. The patient comes to the interview seeking help. This desire for help motivates the patient to share information and feelings that are upsetting and often private. The patient is willing, to varying degrees, to do so because of a belief that the professional has the expertise, by virtue of training and experience, to be of help. The sharing is reinforced by a nonjudgmental attitude and behaviour of the physician. Being able to share thoughts and feelings with a nonjudgmental listener is generally a positive experience. Carl Rogers’ unconditional positive regard epitomizes the nonjudgmental response of the clinician.

There are two additional essential ingredients in a helpful patient–physician relationship. One is the demonstration by the physician that he or she understands what the patient is stating and emoting. The other essential ingredient in a helpful patient–physician relationship is the recognition by the patient that the physician cares. The patient–physician relationship is reinforced by the genuineness of the physician.

Patient-Centered

A psychiatric interview should be patient-centered. That is, the focus should be on understanding the patient and his/her life story. The patient’s early life experiences, family, education, occupation(s), religious beliefs and practices, hobbies, relationships, and losses are some of the areas that, in concert with genetic and biological variables, contribute to the development of the personality. An appreciation of these experiences and their impact on the person is necessary in forming an understanding of the patient. It is especially important that the resulting treatment plan be based on the patient’s goals and not on the professional’s goals. Numerous studies have demonstrated that often the patient’s goals for treatment (e.g., continuing education) are not the same as the professional’s (e.g., decrease in psychotic symptoms). Traditionally, medicine has focused on illness and deficits rather than strengths and assets. A patient-centered approach focuses on strengths and assets as well as deficits.

Safety and Comfort

Both the patient and the interviewer must feel physically safe. On occasions, especially in hospital or emergency room settings, this may require other staff being present or the door to the room where the interview is conducted left ajar. In emergency room settings,
it is generally advisable for the interviewer to have a clear, obstacle free exit path. Patients, especially if psychotic or confused, may feel threatened and need to be reassured that they are safe and the staff will do everything possible to ensure their safety. The interview may need to be shortened or quickly terminated if the patient becomes more agitated and threatening. Once issues of safety have been assessed (and for many outpatients this may be accomplished within a few seconds), the interviewer should inquire about the patient’s comfort and continue to be alert to the patient’s comfort throughout the interview.

Check Your Progress 2

Note:  
i) Read the following question carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What are the various principles of history taking?

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1.6 ELEMENTS OF HISTORY TAKING AND RECORDING

The two overarching elements of the psychiatric interview are the patient history and the mental status examination (detailed in next Unit). The patient history is based on the subjective report of the patient and in some cases, the report of additional sources, including other health care providers, family members and other caregivers. Chief components of the history should include:

Identifying Data

This section is brief, of one or two sentences, and typically includes the patient’s name, age, gender, educational, occupational and marital status (or significant other relationship), race or ethnicity, socio-economic status and area of residence. Often the referral source is also included. Having a good understanding of these variables can at times influence the treatment decisions. For example, which antidepressant to prescribe to a poor patient, which medication must not be prescribed to a young woman, etc.

Source and Reliability

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.

Chief Complaint

This should be the patient’s complaint, ideally in their own words. Examples include, “I’m sad,” or, “Neighbours are trying to harm me”.

History of Present Illness

The present illness is a description of the evolution of the symptoms of the current
episode. In addition, the account should also include any other changes that have occurred during this same time period in the patient’s interests, interpersonal relationships, behaviours, personal habits, physical health, biofunctions and the extent of socio-occupational dysfunction. The chronology of patient’s symptoms must be maintained. The presence or absence of stressors should be established, and these may include situations at home, work, school, legal issues, medical comorbidities, and interpersonal difficulties. Also important are factors that alleviate or exacerbate symptoms such as medications, support, coping skills, or time of day. The essential questions to be answered in the history of the present illness include what (symptoms), how much (severity), how long, and associated factors. It is also important to identify why the patient is seeking help now, and also what were the ‘precipitating’ and ‘maintaining’ factors. If any treatment has been received for the current episode, it should be defined in terms of what was done (e.g., psychotherapy or medication), and the specifics of the modality used (e.g., doses of medication), adequacy of the treatment and the effect of these interventions. Often it can be helpful to include a psychiatric review of systems in conjunction with the history of the present illness to help rule in or out other psychiatric diagnoses with pertinent positive and negative history. This may help to identify whether there are comorbid disorders or disorders that are actually more bothersome to the patient but are not initially identified for a variety of reasons.

It is also advisable to record a negative history of what all symptoms were not present during the course of the present illness, as this is often useful in differential diagnosis.

Past Psychiatric History

In the past psychiatric history, the clinician should obtain information about all psychiatric illnesses and their course over the patient’s lifetime, including symptoms and treatment. Because comorbidity is the rule rather than the exception, in addition to prior episodes of the same illness (e.g., past episodes of depression in an individual who has a major depressive disorder) the professionals should also be alert for the signs and symptoms of other psychiatric disorders. Description of past symptoms should include when they occurred, how long they lasted, and the frequency and severity of episodes.

Past treatment should also be reviewed in detail. These include outpatient treatment such as psychotherapy (individual, group, couple, or family), inpatient treatment, including voluntary or involuntary and what precipitated the need for the higher level of care, support groups, or other forms of treatment such as vocational training. Medications and other modalities such as electroconvulsive therapy or alternative treatments should be carefully reviewed. One should explore what was tried, how long and at what doses these were used (to establish adequacy of the trials), and why these were stopped. Important questions must include what was the response to the medication/modality and whether there were any side effects. It is also helpful to establish whether there was reasonable compliance with the recommended treatment.

Special consideration should be given to establishing a lethality history that is important in the assessment of current risk. Past suicidal ideation, intent, plan, and attempts should be reviewed including the nature of attempts, perceived lethality of the attempts or other death preparations. Because many patients will withhold specific information about recent suicidal behaviours or suicidal ideation, several specific behavioural questions may be used to determine how close the patient was to a lethal attempt. Violence and homicidal history should include any violent actions or intent. History of nonsuicidal self-injurious behaviour should also be recorded.
Past Medical History

The past medical history includes an account of major medical and surgical illnesses and conditions as well as treatments, both past and present. The patient’s reaction to these illnesses and coping skills employed are important to understand. The past medical history is an important consideration when determining potential causes of mental illness as well as comorbid or confounding factors and may dictate potential treatment options or limitations. Medical illnesses can precipitate a psychiatric disorder (e.g., depression in an individual recently diagnosed with HIV), imitate a psychiatric disorder (hyperthyroidism resembling an anxiety disorder), be precipitated by a psychiatric disorder or its treatment (metabolic syndrome in a patient on a second-generation antipsychotic medication), or influence the choice of treatment of a psychiatric disorder (hepatic dysfunction disorder and the use of disulfiram). It is important to pay special attention to neurological issues including seizures, head injury and pain disorder. Non-psychotropic medications, over-the-counter medications, sleep aids, herbal, and alternative medications should also be reviewed. These can all potentially have psychiatric implications including side effects or producing symptoms as well as potential medication interactions.

Family History

Because many psychiatric illnesses are familial, a careful review of family history is an essential part of the psychiatric assessment. Furthermore, an accurate family history helps not only in defining a patient’s potential risk factors for specific illnesses but also the formative psychosocial background of the patient. Psychiatric diagnoses, medications, hospitalizations, substance use disorders and lethality history should all be covered. The importance of these issues is highlighted, for example, by the evidence that, at times, there appears to be a familial response to medications and a family history of suicide is a significant risk factor for suicidal behaviours in the patient. Proper understanding of medical illnesses present in family members may also be important in both the diagnosis and the treatment of the patient. Family traditions, beliefs, and expectations may also play a significant role in the development, expression, or course of the illness. Also the family history is important in identifying potential support as well as stresses for the patient.

Personal History

The personal history reviews the stages of the patient’s life. It is an important tool in determining the context of psychiatric symptoms and illnesses and may, in fact, identify some of the major factors in the evolution of the disorder. Frequently, current psychosocial stressors will be revealed in the course of obtaining a social history. It can often be helpful to review the social history chronologically to ensure all information is covered.

Any available information concerning prenatal or birth history and developmental milestones should be noted. For the large majority of adult patients such information is not readily available and when it is, it may not be fully accurate. Any known history of prenatal or birth problems or issues with developmental milestones should be noted. Childhood history should include childhood home environment including members of the family and social environment including the number and quality of friendships. A detailed school history including how far the patient went in school and how old they were at that level, any special education circumstances or learning disorders, behavioural problems at school, academic performance, and extracurricular activities should be obtained. Childhood physical and sexual abuse should be carefully queried.
Work history must cover the types of jobs, performance at jobs, reasons for changing jobs, and current work status. The nature of the patient’s relationships with supervisors and co-workers should be reviewed. The patient’s income, financial issues, and insurance coverage including pharmacy benefits are often important issues.

Marriage and relationship history including sexual preferences and current family structure should be explored. This should include the patient’s capacity to develop and maintain stable and mutually satisfying relationships as well as issues of intimacy and sexual behaviours. In women, a reproductive and menstrual history is important as well as a careful assessment of potential for current or future pregnancy. Current relationships with parents, grandparents, children, and grandchildren are an important part of the social history. It is important to identify cultural and religious influences on the patient’s life and current religious beliefs and practices.

Premorbid Personality

The premorbid personality of the patient often gives valuable insights into his/her symptomatology, diagnosis and management. Ideally, the premorbid personality of an individual should be assessed in the interview with corroborative evidence. Patients who are unwell often give a false reporting of their premorbid personality, and in cases where there is no available informant, a reassessment may be warranted once patient’s symptoms have improved.

Substance Use/Abuse and Addictions

A careful review of substance use, abuse, and addictions is essential to the psychiatric interview. The clinician should keep in mind that this information may be difficult for the patient to discuss, and a nonjudgmental style will elicit more accurate information. If the patient seems reluctant to share such information specific questions may be helpful (e.g., “Have you ever used intravenous drugs?” or “Do you drink alcohol every day?”). History of use should include what substances have been used including alcohol, drugs, medications (prescribed or not prescribed to the patient), and routes of use (oral or intravenous). The frequency and amount of use should be determined keeping in mind the tendency for patients to minimize or deny use that may be perceived as socially unacceptable.

Other important substances and addictions that should be covered in this section include tobacco and caffeine use.

Check Your Progress 3

(Note: i) Read the following question carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) Enumerate the various elements of history taking and recording.

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Techniques of Interviewing and Case History Taking
1.7 TECHNIQUES OF HISTORY TAKING

General principles of the psychiatric interview such as the doctor-patient relationship and confidentiality are described in the earlier section. In addition to the general principles, there are a number of specific techniques that can be effective in obtaining information in a manner consistent with the general principles. These helpful techniques can be described as facilitating and expanding interventions. There are also some interventions that are generally counterproductive and interfere with the goals of helping the patient tell their story and reinforcing the therapeutic alliance.

Effective Listening

The first and foremost skill in eliciting a good history is the art of patient and receptive listening. The professionals must not only listen to what has been said by the patient but also focus on to the non-verbal gestures and observe the behaviour through different phases of the history. Other important components of effective listening are given in the Text Box-1.

Text Box-1

Key to effective listening
1) Connotative meanings of words
2) Idiosyncratic uses of language
3) Voice tones and modulation
4) Observe posture, gestures, facial expressions
5) Awareness of dissonances between modes of expression
6) Attending to one’s own internal reactions

At times, despite their best attempts, professionals often hit road blocks and are unable to obtain valuable information from the patient. It is best to learn to be aware of such situations and to assess the possible reasons that may be causing the same (see Text Box -2).

Text Box-2

Factors which may block collection of information
1) Patient-therapist dissimilarities - Race, Gender, Culture, Religion, Dialect, Socioeconomic class
2) Superficial similarities may lead to incorrect assumptions of shared meanings
3) Counter-transference - therapist fails to hear or reacts inappropriately to content reminiscent of one's own unresolved conflicts
4) Emergency department
5) Professional having a bad day

Questioning

While trying to various areas of the history the therapist should start with open ended broad questions and then should gradually narrow down the focus. For example, the opening question can be “what brings you here?”. Whenever possible, questions which can elicit only a “yes” or “no” answer must be avoided.
Facilitating Information Gathering

These are some of the techniques (see Text Box-3) that are effective in enabling the patient to continue sharing their story and also are helpful in promoting a positive doctor-patient relationship.

**Text Box-3**

Techniques which may facilitate information gathering

- Reinforcement
- Reflection
- Summarizing
- Education
- Reassurance
- Encouragement
- Acknowledging emotion
- Humor
- Nonverbal communication
- Silence

Expanding the scope of information: There are a number of techniques (see Text Box-4) that can be used to expand the focus of the interview. These techniques are helpful when the line of discussion has been sufficiently mined, at least for the time being, and the interviewer wants to encourage the patient to talk about other issues. These techniques are most successful when a degree of trust has been established in the interview and the patient feels that the professional is nonjudgmental about what is being shared.

**Text Box-4**

Techniques for expanding the scope of information

- Clarifying
- Associations
- Leading
- Probing
- Transitions
- Redirecting

Techniques which can Impede the Information Collection

While supportive and expanding techniques facilitate the gathering of information and the development of a positive doctor-patient relationship, it is important to note that certain techniques can actually hamper the interview and collection of information (see Text Box-5). Some of these activities are from the same categories as the more useful interventions but are unclear, unconnected, poorly timed, and not responsive to the patient's issues or concerns.
Text box-5

Techniques which can impede the information collection

- Closed-ended questions
- Compound questions
- Why questions
- Judgmental questions
- Minimizing patient's concerns
- Premature advice
- Premature interpretations
- Abrupt transitions
- Nonverbal communication

Check Your Progress 4

**Note:**

i) Read the following question carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) Enlist the various techniques which can impede history taking.

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1.8 CLOSING OF INTERVIEW

The last 5 to 10 minutes of the interview are very important and often sufficient attention is not given to the same by an inexperienced interviewer. Patients often keep important issues or questions until the end of the interview and having at least a brief time to identify the issue is helpful. If there is to be another session, then the psychiatrist can indicate that this issue will be addressed at the beginning of the next session or ask the patient to bring it up at that time. It can also be useful to give the patient an opportunity to ask a question. “I’ve asked you a lot of questions today. Are there any other questions you’d like to ask me at this point?” or asking the patient if he has any other additional information to share which therapist has not asked.

If this interview was to be a single evaluative session, then a summary of the diagnosis and options for treatment should generally be shared with the patient. If this was not to be a single session and the patient will be seen again, then the professional may indicate that they can work further on the treatment plan in the next session.

1.9 MEDICAL RECORDS

Throughout the interview, most professionals take notes. Generally, these are not verbatim recordings, except for the chief complaint or other key statements. Occasionally, patients may have questions or concerns about the note-taking. These concerns, which often have to do with confidentiality, should be discussed (and during this discussion notes
1.10 INTERVIEWING THE DIFFICULT PATIENTS

1) Hostile, Agitated and Potentially Violent Patients

Safety for the patient and the therapist is the priority when interviewing agitated patients. Hostile patients are often interviewed in emergency settings, but angry and agitated patients can present in any setting. The chairs should ideally be placed in a way in which both the interviewer and patient could exit if necessary and not be obstructed. The professional should be aware of any available safety features and should be familiar with the facility’s security plan. If the professional is aware in advance that the patient is agitated, then they can take additional preparatory steps such as having security closely available if necessary. The professional should be aware of their own body position and avoid postures that could be seen as threatening including clenched hands or hands behind the back. The therapist must avoid having things like stethoscope around the neck, nor should have other things hanging around here and there. Therapist attitude should never convey a violent patient that he may be deceived or punished. Adequate distance must be maintained from the patient.

The professional should approach the interview in a calm, direct manner and take care not to bargain or promise to elicit cooperation in the interview. As stated above, the priority must be safety. However, a professional who is fearful regarding their own physical safety will be unable to perform an adequate assessment. Similarly, a patient who feels threatened will be unable to focus on the interview and may begin to escalate thinking that he or she needs to defend him/herself. An interview may need to be terminated early if the patient’s agitation escalates. Generally, unpremeditated violence is preceded by a period of gradually escalating psychomotor activity, professional should consider whether other measures are necessary including assistance from security personnel or need for medication and/or restraint.

If the patient makes threats or gives some indication that they may become violent outside the interview setting, then further assessment is necessary. Because past history of violence is the best predictor of future violence, past episodes of violence should be explored as to setting, what precipitated the episode, and what was the outcome or potential outcome (if the act was interrupted). Also, what has helped in the past in preventing violent episodes (medication, time-out, physical activity, or talking to a particular person) should be explored. Is there an identified victim and is there a plan for the violent behaviour? Has the patient taken steps to fulfill the plan? Depending on the answers to these questions the professional may decide to prescribe or increase antipsychotic medication, recommend hospitalization, and perhaps, depending on the jurisdiction, notify the victim.

2) Deceptive Patients

Mental health professionals are trained to diagnose and treat psychiatric illness. Although professionals are well trained in eliciting information and maintaining awareness for deception, these abilities are not foolproof. Patients lie or deceive their doctors for many different reasons. Some are motivated by secondary gain (e.g., for financial resources, absence from work, or for a supply of medication). Some patients may
deceive, not for an external advantage, but for assuming a sick role. There are no current biological markers to definitively validate a patient's symptoms. Hence, professionals are dependent on the patient's self report. Given these limitations, it may be useful, especially when there is question about the patient's reliability (may be related to inconsistencies in the patient's report), to gather collateral information regarding the patient. This allows having a more broad understanding of the patient outside of the interview setting, and discrepancies in symptom severity between self report and collateral information may suggest deception.

3) **Suicidal Patient**

There is a false notion that patients should not be questioned about suicidal behaviour directly as talking about suicide may actually provoke such acts. However, in reality, most of the patients who commit suicide do communicate about the same either verbally, non-verbally or both. It is always better to ask the patient directly about wish to die, any suicidal thoughts, suicidal plans, or suicidal attempts, etc. In fact, this may be the first opportunity given to the patient to discuss about the same and may be therapeutic on its own.

### 1.11 LET US SUM UP

History taking is an art. A good interviewer is one who shows concern for the patient, has adequate time to listen to the patient, is able to convey empathy and build a strong doctor-patient relationship, and does not lose the focus. For good history taking, the professional should be properly dressed and groomed and should spare at least 45-90 minutes. At the beginning of the interview, consent of the patient should be sought and they should be ensured about the privacy and confidentiality. The therapist should respect the patient's needs and these should be given the upmost consideration. The data must be obtained in the form of identification data, chief complaints, elaboration of the same in a chronological order as part of history of present illness, effect of various biopsychosocial factors on the development, progression, continuation/persistence or amelioration of symptoms must also be understood. Besides focusing on the current symptomatology, history taking should also include past psychiatric and medical history, family history of medical and psychiatric disorders, personal history including history of birth, early development, education, occupation, present living situation, premorbid personality, history of substance abuse, treatment history should be evaluated. Wherever possible, the therapist should use open ended questions, and should avoid closed ended or compound questions and should refrain from giving premature advice. The interview must end with giving the patient an opportunity to ask questions. Further, by the end of the history taking the therapist should convey to the patient about the possible diagnosis and possible management strategies available for the same.

### 1.12 ANSWER TO CHECK YOUR PROGRESS EXERCISES

**Check Your Progress 1**

1) To establish a criteria-based diagnosis.

2) 45-90 minutes.

3) Interview room should be relatively sound proof.
Check Your Progress 2

Consent must be obtained from all the patients prior to starting the interview. Patient should be provided an environment of privacy and confidentiality of the information must be ensured. Therapist must respect the patients need, must be empathetic to the patient and strive to build a good rapport with the patient.

Check Your Progress 3

Elements of history taking and recording include identification data, chief complaints, assessing the reliability, evaluating the onset, precipitating, aggravating and maintaining factors and course of the symptoms. Every attempt must be made to understand the chronology of the symptoms. Further history taking should focus on past and current medical history, family history of psychiatric and medical disorders, personal history (early birth, developmental history, educational history, occupational history, marital and sexual history, present living situation etc.), premorbid personality and substance abuse history.

Check Your Progress 4

Use of closed-ended questions, compound questions, questions starting with ‘why’ can impede the information gathering. Additionally, questions which can be interpreted as therapist trying to make judgment about some aspect of patients can also impede the flow of information. Similarly, if the therapist tries to minimize the patient's concerns, or prematurely tries to interpret the information or give advice, it may hamper the doctor-patient relationship and the flow of information. Similarly, if the non-verbal communication of the therapist indicates that he/she are not interested in patient, it can lead to interruption of flow of information.

1.13 UNIT END QUESTIONS

1) What are the most important aspects of history taking?

2) What are the important aspects of evaluation of a violent patient in an emergency setting?

1.14 REFERENCES AND SUGGESTED READINGS


