COMMENTARY

Is the Psychiatric History Losing Its Relevance?

Richard J Moldawsky, MD[1]

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ABSTRACT

One of the axioms of medical practice is that obtaining a good history is key to making a correct diagnosis and developing a treatment plan. This is particularly true in psychiatry, in which laboratory or imaging investigations are not typically of great value. Any factor that compromises a history may compromise care. This area of practice has not been formally studied, although it is widely believed to be true. In mental health settings, there are many factors that affect obtaining the history. Among these are the skills of the clinician in eliciting relevant information in a limited time, the clinician's philosophy regarding the importance of such history, and lack of formal training in history-taking. Nonphysician clinicians may be more likely than psychiatrists to confront these barriers. Practice settings may, in their effort to maximize access, patient turnover, and cost control, convey a here-and-now approach to patient care, implicitly downplaying the importance of a complete history. There may be some cultural factors at play as well, reflecting American society's gradually decreased interest in the study of history. Despite these understandable barriers, the need for a complete history is still the highest priority in an initial evaluation. Some suggestions are offered to support clinicians' and organizations' struggles to keep a comprehensive history at the forefront of care.

INTRODUCTION

One axiom of medical practice is that a good history is key to making a diagnosis and developing a treatment plan with the patient. Despite a clinician's best efforts, errors will still occur.[1,2] There seems to be relatively little in the published literature or clinical guidelines that addresses errors in psychiatric care. Much of what has been published concerns itself with medications.[3]

Psychiatric diagnoses are largely dependent on the patient history. Although few studies look specifically at history-taking in psychiatric care, it stands to reason that barriers to obtaining a proper history will lead to less accurate diagnoses. This Commentary identifies some of these barriers—some specific to psychiatric history-taking, some more broadly applicable to other specialties—and considers some other possible factors not directly related to medical care. This is not a catalog of the myriad errors that can be made in taking a history.

I offer what follows largely on the basis of my own observations as a psychiatrist in several interdisciplinary settings over 40 years, including 15 years' experience as a peer reviewer for the Kaiser Permanente (KP) Orange County-Anaheim Medical Service Area's Department of Psychiatry in CA, and 3 years as an expert reviewer in psychiatry for the Medical Board of California. Although most of my work has been with KP, I believe that these observations are not unique to that model of care.

OBSERVATIONS ON HISTORY-TAKING

It must be acknowledged at the outset that, among mental health practitioners, there is an unresolved tension as to the primacy of the medical model in history-taking. The importance of making a diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) widely varies depending on the clinical situation and the evaluator, and therefore taking a diagnosis-oriented history is irrelevant to some.[4] That said, in most settings (if for no other reason than regulatory or billing purposes), a DSM-V diagnosis must be made.

Much of this discussion is based on the widespread belief that obtaining a full history is essential to a correct diagnosis and for treatment planning. As with many aspects of clinical practice that are held to be true, there is no good evidence that validates this belief. Even the recent American Psychiatric Association Guidelines on the Psychiatric Evaluation of Adults,[5] based on broad input from "expert" psychiatrists and others, cites virtual unanimity on the critical importance of the history while noting the lack of study of this link.

The approach to history-taking traditionally starts with the patient's chief concern followed by the history of the present illness (HPI). The HPI is intended to reflect some sequence of events and symptoms, which start at whatever point the patient began to experience changes from whatever his/her baseline was. The assumption is that the patient was in a relatively stable state before that onset; on the basis of the patient's prior history of psychiatric problems and functional level, his/her ability to manage stressors, and current symptoms would vary accordingly, but the HPI dates from that point. At times, the HPI may reflect a continuation of some illness that had never remitted.

The importance of this (as it relates to diagnosis) is that focusing too much on the immediate issue, without assessing the premorbid status, can lead to a less severe diagnosis than is truly called for. For example, a patient who reports a few weeks of anxiety and insomnia in the context of job stress, leading to perhaps a diagnosis of adjustment disorder or occupational problem, may have a history of similar episodes that are not work-related but suggest, for example, an anxiety, mood, or personality disorder. The premorbid status is relevant to a more accurate diagnosis. Treatment of a less severe (but incorrect) diagnosis would not likely be very successful, and the patient will have unintentionally been denied better care.

Author Affiliations

[1] Departments of Psychiatry and Addiction Medicine, Southern California Permanente Medical Group, Laguna Hills, CA

Corresponding Author

Richard J Moldawsky, MD (richard.j.moldawsky@kp.org)

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CAUSES OF ERRORS

Errors or omissions in history-taking have many causes, of course, and no one is immune from making them. Clinicians of all disciplines vary in their fund of knowledge and skills regarding diagnostic acumen and interviewing ability. Although such variation is likely the most salient factor affecting the quality of the history, there are some other factors worth identifying that also play a role.

Some form of the medical model generally predominates in most mental health settings. However, not all practitioners consider the organization of the history that way (ie, HPI and other traditional categories as the personal or developmental history, the family history, the social history, and the medical history) as immediately relevant or helpful to the person being evaluated. If a practitioner's toolkit includes primarily psychotherapies and psychoeducation, the role of genetic or medical factors may not seem pertinent. Some practitioners are untrained and/or uncomfortable asking about such factors, so it is predictable that genetic or medical factors are at higher risk of being overlooked.

All practitioners are prone to error. Among the better known and studied errors are 1) confirmation bias,[6] by which we look for data that support what we initially think is the problem, and dismiss or not pursue data that would cause us to change our first formulation; and 2) premature closure,[7] by which we too rapidly decide on a diagnosis and begin to plan treatment for that diagnosis, as if there might not be concurrent diagnoses and/or alternative diagnoses to entertain. To these errors I would add confusing correlation with causation, for example, assuming that the existence of prior trauma or substance abuse is the cause of the current clinical situation. Each of these kinds of errors closes off the history-taking, and it is done at the peril of the patient.

A practitioner's professional discipline or theoretical orientation also can lead to errors. Psychiatrists who are primarily psychopharmacologists are at risk of looking narrowly for medication-responsive symptoms. Those who work in substance abuse are at risk of overemphasizing the role of substance use or seeing any situation in terms of addictive behaviors. Those who do primarily cognitive behavioral therapy are at risk of ignoring psychodynamic or family factors. In my experience, nonphysician practitioners are more prone than physicians to miss or normalize milder but potentially important signs of a major mental disorder, such as suspicion without formal delusions, or heightened self-consciousness without overt paranoia. All mental health practitioners are at risk of not recognizing medical factors that may be causative or important contributors to a set of symptoms. None of the errors described here is unique to any professional discipline or theoretical orientation, and we must all be humble.

Errors in history-taking cannot be fully understood without regard to the practice setting. The pressures of working in a high-volume, high-demand environment naturally add stress to an evaluation. This stress, although most commonly experienced in the outpatient setting, also often applies to Emergency Department and medical inpatient settings. The need to rapidly assess and develop a plan of action in a short time is often achieved at the expense of a fuller history. Patients who come to an appointment late or are intoxicated or otherwise unable to provide a coherent history will necessarily have treatment plans based on precious little information.

In recent years, the focus on customer service and satisfaction has led to providing the treatment that a patient wants and will accept. Although such patient preferences cannot and should not be ignored, the odds that that preferred treatment will be effective may be quite low if the history is limited. The approach that says, "What can I do for you today?" often presupposes a here-and-now framework, which limits how the problem is addressed. The "quick fix" may be satisfying to the patient, even if not necessarily in his/her best interests over the longer term. An organization that overemphasizes that approach may be doing a disservice to its patients, especially as it tries to simultaneously address broader issues of access and cost control. Many mental illnesses are chronic and recurring, for which a quick-fix model is of limited effectiveness.

POSSIBLE ROLE OF SOCIETAL FACTORS

Having discussed some of the clinician and environmental factors affecting history-taking, I here briefly review some evidence that our American society's interest in history as a field of study has dwindled, and I speculate that this could have an indirect effect on both clinicians' and patients' views of the relevance of history to the initial health care evaluation. If our society is, as a whole, more "here-and-now" oriented and less interested in history in its broader context, such a trend might permeate clinical practice.

Recent data indicate that fewer college students are majoring in history.[8] This appears to be independent of students' sex or ethnicity and is correlated with the increased interest in science, technology, engineering, and mathematics in school curricula. There is also some evidence that history courses offered in colleges are shifting more toward special-interest foci, such as sex-based or ethnic perspectives, and away from the traditional courses that address the major historical events or periods.[9] Perhaps the newer offerings, although they may well provide some balance and alternate perspectives, do so at the expense of teaching what most would call the basics of a given historical era. Might clinicians sometimes be distracted from the basics of a clinical history by their own special interests? Might younger clinicians be less focused on a patient's longitudinal history as well? Linking these clinical and societal factors would admittedly be difficult to investigate systematically, but I propose that it may play a role.

I posit that the recent interest in the narrower range of some college courses is paralleled by some of the narrowly focused histories that I have come across more frequently in my work. Examples include the "trauma-focused" history or the "addiction-focused" history. Although such histories are often critical, they should be interpreted in a broader history; otherwise, the errors of premature closure and confirmation bias are more likely. The value of a generalist approach to history-taking is that such errors are less likely to reflect a clinician's bias or expertise, and it allows the treatment plan to be more comprehensive and accurate. To complete the parallel, one who studies history through, say, the lens of ethnicity or sex, may find it harder to see a bigger picture.

RECOMMENDATIONS

After the earlier categorization of history-taking errors into those centered on the clinician, the practice setting, and larger cultural factors, it is appropriate to offer some ideas for decreasing such errors.

Although not firmly based on scientific study, the expert consensus on the importance of a thorough history should be the "default" position. There are times when deviation from a thorough history is unavoidable, but the clinician must endeavor to obtain that history. It means that clinicians need to improve their skills at asking questions and eliciting information in the time allotted. There are many snares that move the clinician away from this task, and therein lies the challenge. Clinicians must be aware that many diagnoses will fit a patient's initial complaint and keep as many of those in mind as possible while obtaining the history that rules in or out those diagnoses. Such an approach should decrease the incidence of the errors discussed earlier. There is no pathognomonic finding for any psychiatric condition. Despite the shortcomings of DSM-V both as a diagnostic aid and as a helper in treatment planning, there is for now no better system, and it is the "coin of the realm." It can be tempting to dismiss diagnosis altogether, but that has greater risks.

Health system leaders and clinical managers need to be clear with clinicians as to what the reasonable expectations are for such initial evaluations, including how to address these individual and system challenges. The use of a template can point a clinician to what the categories are, but without instruction, supervision, and support, the template degenerates into a stereotyped set of preprogrammed phrases without providing clinically meaningful data. Most patient questionnaires and validated rating scales help in highlighting areas for further historical and current exploration but are not, in themselves, diagnostic. Accepting what a patient reports, in an interview or questionnaire, on face value must be resisted; handled sensitively, it will not disrupt the formation of a therapeutic alliance but will reflect the clinician's desire to more fully understand the patient.

CONCLUSION

This Commentary has discussed the link between a good history and good treatment. That this link has not been rigorously studied speaks to the difficult methodologic issues in such a study but perhaps even more to the power of the belief in that link.

The noble impulse to be rapidly helpful is only noble if well placed and well timed. Clinicians (and the organizations in which they serve) need to see that the more complete the history, the better the chance to direct that impulse for good. Good treatment demands the best possible history, and despite the unrelenting competing pressures, mental health clinicians must still aim high.❖

Disclosure Statement

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