# Chapter 4: The Psychiatric History

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*"The good physician treats the disease; the great physician treats the patient who has the disease."*

William Osler

## Introduction

At the beginning their psychiatry term, many medical students are demoralised when confronted by what they see as a completely different approach to taking a history. In fact, though, the approach to taking a good psychiatric history is, in essence, exactly the same as the approach to taking a good medical history. It is just that in psychiatry many of the elements that were not obvious in taking a history from most medical and surgical patients are brought into sharp relief.

A psychiatric interview has three main aims: to gather information sufficient to allow for formulation and diagnosis of the person's predicament and to speculate on its origins; to develop and maintain the therapeutic relationship; and to communicate information so that a management plan can be negotiated.

These are, of course, exactly the same aims as any medical interview. Just like any patient with a medical or surgical problem, the way people with mental

illness experience their maladies are heavily influenced by their personality styles, coping mechanisms and the extent of their family and social supports. Just like any medical or surgical patient, the predicaments that psychiatric patients find themselves in are diverse and multifaceted, going far beyond the simple impact of a series of symptoms. Like many medical and surgical patients, many psychiatric patients will not readily fall into the patient role and accept that everything suggested by their doctor is for the best or that all directions should be slavishly adhered to. And, like many medical and surgical patients, many psychiatric patients will not understand management suggestions without considerable effort on the part of the doctor and will not accept suggested plans without negotiation.

Leaving to one side the fact that all doctors will frequently see patients with mental illness, you may think of your psychiatry term as a way of gaining advanced interviewing skills that will be vital when engaging with all of your future patients. By the time they do their psychiatry term, most medical students are relatively proficient at eliciting a history of a disease. During psychiatry you'll be practicing eliciting the history of the person who has the disease. In Osler's terms, you'll be learning the skills to become a great physician.

In this chapter we will provide a step-by-step guide to taking a psychiatric history. We shan't be focussing too much on exactly what symptoms to elicit – details on those will be given in the chapters to come. Instead, we'll be examining more general issues – how to begin, what areas to cover and how to continue when things seem hard.

We'll start with examining what needs to be attended to even before the interview begins. We'll then go on to review the beginning of the interview and the way to elicit the presenting complaint. Most of the chapter will focus on the history of the presenting illness and the ways in which the approach to that might differ from what you've become used to. The rest of the chapter will run quickly through the other headings of the history, focusing on two issues given special prominence in psychiatry: personality; and insight and capacity.

Frequently the secret to a great interview is hidden in the subtleties of how questions are phrased, so from time to time we'll suggest a form of words that might be useful in a particular situation. When we do, we'll place that text in a little box like this. These are suggestions, and not meant to be slavishly learnt. Ideally, the student will develop their own preferred words and phrases.

*"Hello Ms Pappenheim, I'm Bill Osler. I'm a fourth-year student at Sydney University working on the ward here with Dr Jung. I was wondering if I could ask you a few questions about how things are going?"*

## The Set Up

In some ways taking a history is just another medical procedure and, like all medical procedures, setting things up properly before you begin is vital.

People in the grip of psychiatric illness may become very agitated, may be prone to misinterpret cues in their environment, or may lose control of their actions. As a result of those realities, very rarely staff and students on psychiatric wards are assaulted, sometimes seriously. This is not something that you should lie awake at night worrying about – serious incidents are rare, but it is something to keep in mind.

To minimise the chances of such incidents all psychiatry wards will have some rules or guidelines on how interviews should be conducted. These are not always obvious and may not be written down anywhere. They might include the need to carry a duress alarm, or they may place restrictions on who students can, and can't, see. Most likely your supervisor will let you know about these rules when you first arrive on the ward, but if you're not sure, always ask. In the same way, you should check with a staff member before you begin interviewing any patient. Some patients may be particularly agitated or upset at that moment, or may have particularly acute privacy issues, or may simply have seen hundreds of students and have requested a break.

Psychiatric patients don't spend the day sitting conveniently by their beds waiting for doctors and students to approach them. Generally, you'll find patients in common rooms or courtyards, and having secured their agreement to be interviewed, you'll usually need to find somewhere that the patient will be comfortable talking to you. On occasion, a quiet area of the courtyard will be fine, but often it will mean retiring to the patient's room or an interview room on the ward. Many patients will be on routine observations that require they be sighted by a staff member every 10 to 30 minutes, so if you take a patient away somewhere, make sure you tell the nursing staff where you're going. This will also give the nursing staff the opportunity to tell you that it is not a good idea to take this particular patient to the isolated interview room at the end of the corridor.

Before you begin the interview proper make sure the room is arranged so that everyone will be comfortable. Almost always this will mean allowing the patient to choose where they would like to sit and then arranging a chair for yourself. Multiple studies have shown that patients perceive doctors who sit during interviews as more compassionate and caring and as spending more time with their patients, even when the actual time spent was the same (Gupta et al., 2015; Swayden et al., 2012). Consequently, you should always sit during interviews even if, on the medical wards, that means scooting off first to find a chair. Don't sit on the patient's bed without asking permission.

Once you've established the environment you may begin the interview proper. Introduce yourself again, re-affirm your role, thank the patient again for their time and set out the purpose of the interview, which in your case will usually be primarily so that you can become a better doctor - "this is part of my training". Let patients know the broad areas you intend to cover and apologise in advance for asking them some of the same questions they would have been asked many times before. If you've not looked at the patient's medical record, you might want to be explicit about that so that the patient understands why you're asking about things that have already been recorded by others.

Refer to the patient by their honorific and their second name (e.g., Mr Lanzer) and only use their first name if invited to do so. If you are not sure if its "Miss" or "Mrs", "Ms" is usually safest.

## Beginning the Interview Proper – Demographics and Presenting Complaint

Begin the interview by gathering some basic demographic data. Not only will this be of great of assistance in coming to understand the patient's situation, but since demographic questions tend to be routine, it will give you more time to deepen your rapport before getting into more sensitive areas.

Ask for the patient's age and occupation or, if unemployed how they support themselves financially. If you're not familiar with what the patient's job entails, ask. Once again this will give you a greater understanding of the patient's circumstances and will demonstrate that you're interested in the patient's life, not just his or her disease. Ask patients where they live, and who lives with them. Avoid asking if the patient has a "husband" or "wife" as these questions usually assume things about the patient's sexual orientation that are likely to distance you from same-sex attracted patients.

As a general rule you should take notes as you go. This tends to be much faster and more accurate than making notes later and allows you to copy down some important patient responses verbatim. It also gives you a little more time to consider the responses you get and formulate your next question. Taking notes as you go though is a skill in itself and (like everything) you'll get better with practice. While with some patients it might be a barrier to building rapport, the reverse is also true, and many patients appreciate the attention you appear to be giving to their utterances. Obviously be circumspect about eagerly scribbling down patient descriptions of deeply personal experiences and be aware that some patients with persecutory ideation may be suspicious of avid note taking.

By the time you've obtained their demographics, patients should be reasonably comfortable in your presence and hopefully you in theirs. Now is the time to explore the presenting complaint.

Of course, in psychiatry, the presenting complaint may well have been a complaint of someone else - not the patient. On occasion patients are perplexed or even dumbfounded as to why the ambulance or police were called or why their partner insisted they should come to hospital. In those instances, simply note down what the patient recalls of that time.

"*May I ask … how did you come to be in hospital here? What happened for you to be admitted?*"

## Staking Out the History of the Presenting Illness

At the front end of the history of the presenting illness, your focus should remain on open-ended questions, with the occasional exception of some closed questions aimed to anchor the patient's experience in time. Be cautious about asking questions that begin "Why did you …" as they may be taken as implying criticism and provoke a defensive response.

Taking the history of the presenting illness can often seem a daunting task for medical students. Commonly students feel a tension between allowing patients to express themselves and the desire to gain as much relevant information as possible. The sheer length of time required to gain the history requires a certain level of adaptation, as it is expected that a psychiatric history will require much more time than the sort of focused history usually encouraged in other specialities. Experienced psychiatrists will usually set aside an hour or so to take a history from a new patient,

and even they realise that this will be insufficient to cover everything that will need to be addressed.

*"Ok. I see. And then what happened?"*
*"Can you tell me more about that?"*
*"Can you say more about that?"*
*"Could you fill me in on that?"*
*"Right, what did you make of that?"*
*"When was that exactly?"*
*"When was the last time you felt completely yourself?"*
*"Avoid questions beginning with "Why"?"*

For at least the first five minutes or so, try to let the patient lead the way. Even if you hear something extremely unusual (perhaps suggesting a delusion, say), try not to interrupt but instead note it down as an area to return to clarify. If you focus in on one aspect of the history too early, you risk patients never revealing other vital elements of their experience.

Only after patients have staked out the general territory of their problems, should you zoom in to try to clarify what each part of that territory really looks like. Sometimes efforts at closer surveillance will open up whole new vistas of concerns, and in that case, it might be wise to zoom out again, until this new piece of real estate is also marked out. The discipline to modulate between structure and flexibility, between big picture and fine detail, is another skill that only comes with exposure and with practice.

Though it hardly seems worth saying, take care to listen to what the patient is actually saying. Remember that a patient's aims and motivations in giving a history are not necessarily the same as your aims in taking it. Patients don't necessarily know what's important and sometimes it is a feature of their illnesses that they do not recognise the importance of what would be to us crucial pieces of information. We regularly see students completely miss clear diagnostic markers or bright red flags important in a patient's future management, simply because patients gave no weight to them in their utterances and students were distracted by formulating their next question.

In many ways your aim in eliciting the first part of the history of the present illness is to come to as good as understanding as possible of what it is like to be the patient. There are two main ways of pulling this off.

First, after the patient has set the ground of his or her complaints, return to specific important events in that ground and take the patient through them in detail. It is important to get the time sequence of events and when symptoms appeared. Summarise this back to the patient and check with them that you have it correct. Probably the most common example of an important event prior to an admission is a suicide attempt that precipitated the admission. Focus in on the attempt, taking the patient back to a time before they decided to act, and then ask them to describe events as they unfolded. Details are crucial here. The patient who, after an argument, took a handful of tablets in the bathroom after announcing their intention and slamming shut the bathroom door, may have been in a very different state of mind to the patient who, after an argument, slipped into the bathroom unseen, closing the door quietly behind him. By the end of this history of the event, you should be able to construct a movie in your mind's eye of the patient's experience – a movie complete with surtitles explaining what the patient was thinking and feeling as the events unfolded (Ryan et al., 2015b).

The second approach to understanding what it is like to be the patient is to ask for clarification. Remember that patients do not simply relay their symptoms as detached factual reportage; they also try to interpret and make sense of them. The chapters that follow will deal with the variety of clinical features found within psychiatry's myriad syndromes and specialities, but for the purposes of this chapter it is important to emphasise that as each new symptom emerges, you should do your level best to clarify exactly what the patient means when they say that they had that experience or feeling.

> *"Different people mean different things when they say depression. Depression affects people in different ways. Can you tell me more about how your depression affects you? You said you were having trouble sleeping. Can I ask, what time do you usually go to bed? … And do you usually go straight to sleep? … What time to you wake up? … Is that early for you? … Do you ever get back to sleep again?"*

Although students will always feel pressure to move on from the history of the presenting illness, and eventually of course other areas must be covered, you should feel very reluctant to leave any particular piece of symptomatology without nailing exactly (or as exactly as possible) what the patient meant when he or she reported it.

Before moving on to the second phase of the history of the presenting illness it is worth dealing explicitly with one anxiety-provoking situation that occasionally arises. Sometimes you can be nine or ten minutes into taking the history and despite

your best efforts, you still have no real notion what this patient's problem is, or even how the patient came to be in hospital. There are two main ways of dealing with this.

First, consider the possibility that the reason that you cannot discover the reason for the patient's admission may relate to the patient himself being unable to recall it. Many psychiatric disorders seriously impair patients' cognitive abilities, and this may not be readily apparent until their cognition is formally tested. Though in the normal course of events one would not perform formal cognitive testing until toward the end of the interview, this situation might prompt you to embark on cognitive testing much earlier, midway through the history of the presenting illness. If it turns out that the patient is significantly cognitively impaired, then that will place any historical details you elicit under a cloud, and the focus of interview may turn to performing the best mental state examination possible.

The second approach to the patient whose presentation still remains a mystery nearly 15 minutes in, especially one where cognitive impairment is not the problem, involves what might be called a "jump-out question". A jump-out question is like a meta-question, a question to the patient about the interview process.

> *"I have got to tell you Ms Bauer, I'm confused. You see we've been chatting for about 10 minutes and you've been very kind in answering all my questions, but despite your best efforts, well … this is a psychiatric ward and I'm still not at all clear what happened for you to be admitted here."*

Sometimes by clearly putting your dilemma on the table patients can come to see this as an issue for the first time, and sometimes having seen what exactly you're after they are able to address that issue, with a sort of "why didn't you tell me that's what you wanted to know" attitude. Many times, it must be said, even this approach fails to clarify the situation, but even in that event, if you are unfortunate enough to encounter such a patient during an observed exam, at least the question signals to the examiner that you know you're having trouble and you're doing all you can to get out of it.

## More of the History of the Presenting Illness

Once the patient has provided their version of the history of the presenting illness and you have clarified that as much as you can, it is time to move onto other questions designed to enrich your understanding and to challenge or confirm your

emerging assumptions about diagnosis and the factors that led to the patient's current predicament. This will involve using a range of fairly standardised enquiries.

By this time in the history of the presenting illness, you're likely to have hypothesised that much of the patient's experience represents features of one or more psychiatric syndromes. This is now the time to find out if the patient has any of the other features associated with the various diagnoses you're considering.

No medical student interview should be completed without having broached the possibility of the patient being suicidal. Concerns about suicidality will often have been the reason for a patient being admitted, so suicidality will be a common (but sometimes unvoiced) issue among the patients you see on the wards. In the exam situation, few examiners will feel comfortable passing a student if he or she thought that the patient may have experienced suicidal ideation, but the student did not explore this.

> *"You told me that sometimes you got very depressed/sad/frightened. Sometimes when people feel like that, they begin to think that it's not worth going on. Have you ever felt like? Have you ever considered ending it all?"*

If there is some hint that the patient might have considered suicide, you cannot leave this topic, until, as much as possible, you understand the whole of patient's thinking on it. These questions are important and now is not the time for euphemisms such as "*you wouldn't do anything silly would you?*". Be sensitive about these enquiries but be direct.

Two things ought to be said about questions into a person's suicidality. First, though it is a common concern among students, there is no evidence, and no reason to think, that simply asking patients about suicide makes them any more likely to try to suicide. The hope is, of course, that such enquiries may *decrease* the likelihood of patients suiciding as they may feel relief in being able to talk about their fears and distress. Try to look comfortable asking about suicide (even if that's not exactly how you feel). Practice helps here.

*"Have you thought of killing yourself?"*
*"Have you thought how you would do this?"*
*"Have you (ever) made any plans or taken any action?"*
*"Do you still feel like that now?"*
*"What might stop you from killing yourself if those thoughts came back?"*

Second, many textbooks of psychiatry state that it is important to ask questions about suicide so that the interviewer may make an estimate of the patient's suicide risk. That makes no sense. It *is* important to ask about suicide, but its importance has nothing to do with gauging the likelihood of the patient eventually dying by suicide.

While all psychiatric inpatients are, and will continue to be, at many times the population at risk of completed suicide, countless studies have now demonstrated that there are no clinical features, either alone or in combination, that can be used to usefully divide this group of patients into those at even higher risk of suicide and those at relatively lower risk (Large and Ryan, 2014). The futility of efforts to do so is a direct result of the extremely low base rate of suicide even in this very high relative risk population. Despite its popularity in textbooks and even some government policies, useful suicide risk assessment of acute psychiatric patients is simply impossible (Ryan et al., 2010).

It is important to ask about patients' suicidality, and about all the clinical features relevant to that, not because we can then predict who is more likely to die by suicide, but because that enables us to better understand the patient, and understanding the patient is our primary tool in caring for and minimising the chances of suicide in all our patients.

In a similar vein, and for essentially the same reasons, it is impossible to usefully classify psychiatric patients into those more or less likely to harm someone else (Paton et al., 2014). Nonetheless, if there is any suggestion that a person might come to harm another, similar questions need to be pursued.

*"Have you thought of hurting other people?"*
*"Have you thought how you would do this?"*
*"Have you ever hurt others physically?"*

Having clarified *your* views on the patient's clinical state, now is the time to clarify the *patient's* views on the patient's clinical state.

> *"What do you think is wrong?"*
> *"What have the doctors said the problem is? Have they suggested a diagnosis? What do you think of that?"*
> *"What do you think could be helpful?"*
> *"The doctors have put you on this medication. Do you think that that is helping? Many people simply forget to take all the medications they are prescribed, do you find that you often forget to take your tablets?"*

Try too to gain the patient's perspective on the impact of their illness. How has it affected his or her life? How is it still causing disability and to what extent has he or she been affected by the stigma still so closely attached to psychiatric illness?

The final task in gathering the HPI is some sort of "systems review" looking for features of the major psychiatric illnesses that did not come up as the patient presented the history and that might never come up unless explicitly explored. The exact nature of the systems review will vary from patient to patient but might include screening questions for features of:

1. Psychosis – delusions or hallucinations (see Chapter 15)
2. Mania – elevated or irritable mood, increased energy or racing thoughts (see Chapter 17)
3. Depression – low mood, anhedonia, guilt, sleep or appetite changes (see Chapter 16)
4. Anxiety – worry, obsessions, panic (see Chapter 18)

## The Bulk of the Psychiatric History

The history of the presenting illness successfully negotiated, students can run through much of the rest of the psychiatric history covering pretty familiar ground. The rest of the history is after all just the standard medical history with a few added headings and some slight changes in emphasis.

Under the heading of "past psychiatric history" review any previous episodes of illness, any previous suicide attempts or any previous treatments or hospitalisations. It is useful to know if previous episodes have involved treatment under the mental health act, or the use of electroconvulsive therapy, lithium or

clozapine, as these reveal the views of previous psychiatrists about the nature of the patient's disorder.

Review the patient's "substance use history" carefully gaining details on any type of substance ever used including, of course, tobacco. In many instances, substance use can overlap with the History of the Presenting Illness; for example, in those whose episodes of illness were precipitated by substances, or where increased substance use is a symptom of a disorder (see Chapter 29). It is important to remember that co-morbid substance use may be the rule, rather than the exception, in severe psychiatric disorders. Remember too that alcohol misuse is the most common substance use disorder and that its manifestations can mimic many other psychiatric disorders. This is also the place to ask whether the patient gambles. Given that you've just has asked about illicit drugs, whose use, of necessity, involves breaking the law, this is also the time to ask about any "forensic history".

*"Have you ever had any trouble with the law?"*

Next move onto "medical history" focusing particularly on those illnesses that have particular psychiatric relevance – epilepsy, closed head injury, intellectual disability, diabetes, cancer, thyroid disease and chronic pain disorders. Then onto "family psychiatric and medical history".

*"Anyone in the family have problems with their nerves?"*
*"Anyone in the family have anything to do with psychiatrists, psychologists or social workers?"*
*"Are there any heavy drinkers in the family? [Bear in mind that alcohol or other substance use disorders are frequently not seen as psychiatric problems]"*
*"Did anyone in the family die by suicide as far as you know?"*

Though a "personal history" and "social history" are often formal parts of a medical interview, these are usually given much greater focus in psychiatry. Enquire into where the patient was born and their position in the family. It could be relevant to ask about birth trauma and achieving milestones.

*"Are you the oldest or youngest in the family?"*
*"What was the atmosphere like in your family when you were growing up?"*
*"What was the worst thing that happened to you when you were young?" "Did really bad things happen to you?"*
*"Tell me about your Mum/Dad. What sort of a person was she/he? What was your relationship like with them growing up? What's that relationship like now?"*

Ask about the patient's school performance, not only academically, but also socially and on the sporting field. Find out when the patient left school and if it was younger than expected, why? Take an occupational history, focusing on what jobs were done and how long they were held. Try to discover any pattern if the patient moved from job to job. Ask about the patient's relationships and sexual history looking again at stability and any patterns that might be discernible or that the patients themselves have identified. Ask if religion or spirituality is important to the person, and if so try to find out in what ways. For those from cultural backgrounds markedly different from yours, it can be helpful to ask the patient about demands and expectations related to this, bearing in mind that people are not always faultless interpreters of their own culture.

## Premorbid Personality

This is not a standard section of a general medical interview, though arguably it should be. As will become obvious in the chapters to come, a person's personality style will colour the way they give their history and must be accounted for when designing and communicating a management plan. Failure to take account of the person's customary style of interacting with others, the world and their own internal world is likely to cause the best laid plans to go awry.

Many of your judgements about a person's personality style are made from responses given over the course of history. Right back at the time of gathering demographic data it should have been obvious that the person who reported that he worked as an actuary was unlikely to be a devil-may-care free spirit, and similarly that a professional exotic dancer was unlikely to be shy and retiring (though it's best not to make too many assumptions on this sort of thing without further evidence). Some mental state features too will be strongly suggestive of certain personality types.

*"This is often quite a hard question, but if you were asked to give a thumbnail sketch of yourself (as you are usually, not perhaps right now), how would you describe yourself?"*
*"How do you think others would describe you?"*
*"What do you like about yourself? What are you proud of?"*
*When you get very angry/sad, how do you cope with that? What do you do?"*

In this "premorbid personality" section of the history the issue of personality style is dealt with head on. It need hardly be said of course that patients' responses to these questions do not necessarily translate into accurate descriptions of their personality traits. The patient who responds to an inquiry as to how others see him with "modest, despite all my many achievements; modesty is my middle name" is probably revealing a great deal about his personality, but his revelations don't necessarily match his words.

Sometimes you can ask a series of questions to test out any hypotheses about the person's personality you formed while taking the rest of the history.

*"Would you say you're a worrier?"*
*"Some people like everything to be just right: "A place for everything and everything in its place". Are you a bit like that?"*
*"Some people like to spend a lot of time on their own. Often times they find that they don't really get other people."*
*"Some people would like to spend time with others, but they find that that never seems to work."*
*"Some people like to be the life of the party."*

## Insight and Decision-Making Capacity

While both these issues can be central to the assessment of medical and surgical patients, it is the nature of some psychiatric illnesses that both of these can be seriously impaired. Insight refers to the level of understanding that patients have into various elements of their own predicament. Never be tempted to comment that a patient's insight is "absent" or "poor". Insight is much more complicated than that.

Consider patients' insight into the nature of their symptoms. Do they, for example, think that their delusions or hallucinations reflect reality? Consider their insight into the nature of their illness. Would they agree that they might be unwell in some way and if they would, what do they feel is wrong? Consider their insight

into any need for treatment. Oddly all these three dimensions of insight are, to some extent, independent (Diesfeld, 2003). It is not that unusual to meet a person with schizophrenia, who knows that his voices are hallucinations, but denies vehemently they are due to schizophrenia, but is nonetheless happy to take antipsychotics to assist with the troubling voices.

Decision-making capacity is related to insight, but the two do not neatly overlap. The assessment of decision-making capacity is relevant only to a particular decision at a particular time. No one loses the capacity to make *all* decisions, unless they become unconscious or profoundly catatonic.

In adults an assessment of decision-making capacity begins with a presumption that capacity is intact. However, this is a presumption that can be rebutted if either the person cannot comprehend and retain the information relevant to the decision, or if he or she is unable to use and weigh that information to come to a decision (Bird, 2011).

Assessing a patient's ability to comprehend and retain information is usually as simple as providing the patient with that information and then asking them to paraphrase it back to you. Obviously, the information has to be given in a form that maximises the patient's chances of understanding it. This might involve getting an interpreter or, even in native English speakers, ensuring the facts and opinions are delivered in plain and simple terms.

Assessing the ability to use and weigh is a little more tricky. Basically, someone can use and weigh the relevant information if they can consider it and hold the pros and cons in the balance in a normal fashion. Importantly the assessment of capacity, is the assessment of the *process* of coming to a decision, and not an assessment of the decision itself. A person with decision-making capacity is allowed to make a decision which others might view as foolish or irrational and it does not matter that the refusal of some treatment might be thought to be risky or harmful (Ryan et al., 2015a).

Assessments of decision-making capacity are particularly important in psychiatry because it is not at all unusual for a patient to refuse psychiatric treatment. In some Australian jurisdictions psychiatric patients cannot be forced to have treatment if they competently refuse it and are deemed to have decision making capacity (Callaghan and Ryan, 2016). In others, such as New South Wales, doctors can override competent refusals but only in very unusual circumstances (Ryan and Callaghan, 2016).

## Concluding the Interview

As mentioned above the psychiatric interview will often conclude with questions related to cognitive testing and the rest of the mental state exam, and these will be covered in Chapters 5 and 6. Before finishing though it is often wise to check that nothing important has been missed or that patients themselves don't have any lingering questions.

> *"Is there anything I haven't asked that you think it's important that I should know?"*
> *"Is there anything you'd like to ask me?"*

## Conclusion

You can't be a great doctor without being great at taking a history. The only way to get better at interviews is to practice. The more you practice, the better you'll get and the less anxious you'll be when things don't go exactly as planned. It is important to note that rapport with the patient during the interview increases the information given. Rapport can be increased by paying attention to the patient's distress and their view of their situation. There is little to be lost, and much to be gained, by showing warmth and empathy. For those who have learnt to use it, humour can also have an important part to play. It is important not to say things you believe to be false, even if circumstances require that you do not fully reveal all that you believe to be true. One should avoid premature reassurance.

Rapport can be increased by using language suitable to the patient: that is, plain English, not jargon. A patient shouldn't be asked if his "affect has lifted now that he is ambulatory", but if he feels "better now that he is walking". Patients shouldn't be asked if they have "siblings" or are "experiencing hallucinations", not using those words anyway.

History taking is not just about obtaining information. A patient interview, conducted with respect and sensitivity is frequently therapeutic, that is, it makes the patient feel better. They may also be psychoeducational, generating insight and understanding for the patient. It will also be easier to negotiate an agreed management plan from someone who has felt understood.

## Further Reading

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