1 Making Sense of the Senseless: How to Gather and Organize Pertinent Information

LEARNING OBJECTIVES

- ☐ Recognize the pertinent positive and negative features that comprise an organized psychiatric clinical history
- ☐ Identify cohesion versus disparities between signs and symptoms
- ☐ Understand the RIME model for developing sophisticated clinical assessments as a precursor to devising clinical formulations and pursuing therapeutic decision-making

A IT'S ALL ABOUT THE NARRATIVE

Patient histories are, fundamentally, stories. As such, their details either hang together in a logical and cohesive fashion or they appear fragmented and mystifying. The challenge for clinicians is to frame the story in a coherent narrative. Purposeful data-gathering allows one to triage information and discern the relevant from the nonrelevant, follow threads that point to a unified phenomenon, formulate testable hypotheses about likely psychopathological processes, and match appropriate treatments to a coherent symptom picture for a given patient. Appropriate treatment options can enter into the picture only after enough pertinent information has been distilled and organized into a cogent summary of symptoms and clinical problems that might otherwise seem disparate and arbitrarily strung together. Clinical reasoning and decision-making hinge on obtaining high-quality data. A cogent summary includes elements such as:

- Affirming that symptom presentations fit within known epidemiological parameters; for instance, it is awfully rare to see new-onset psychosis or mania arise de novo in older adults (suggesting that either an earlier history was concealed, denied, or missed; or that truly new psychiatric symptoms are high-probability secondary manifestations of an underlying medical or toxic-metabolic condition)
- Appreciating the match between symptoms and functioning (e.g., complaints of "anxiety" or "depressed mood" *alone* may not sufficiently account for pervasively impaired functioning, such as chronic unemployment or a persistent inability to live independently in the community)

- Appreciating behavioral, cognitive, or emotional *departures from a baseline* versus the static persistence of problems that show little deviation over time (i.e., distinguishing states versus traits)
- Recognizing symptoms that belong together within a known pattern or constellation (for example, complaints of "inattention" that also involve a formal thought disorder may point more to schizophrenia, while those involving vegetative signs may reflect depression, and those involving behavioral apraxias may suggest dementia; or strange ideas that are fixed and resistant to challenge or scrutiny point more toward psychosis, while those that seem odd to the patient himself may more likely reflect obsessional thoughts)
- Formulating a hierarchical explanation about how symptoms are best accounted for under an overarching conceptualization. Occam's razor favors the simplest and most parsimonious explanation for a phenomenon, as when a single syndrome or cause accounts for multiple signs and symptoms. Parsimony also aligns with the modern nosological principle that symptoms potentially associated with one disorder are not better accounted for by another (e.g., impulsive aggression that results more proximally from alcohol intoxication than "underlying" bipolar disorder)

B ORGANIZING A COHERENT HISTORY: START FROM THE BEGINNING

The core foundation of excellent psychiatric treatment starts with obtaining a coherent history, preferably as a longitudinal narrative that follows a chronological timeline, with an emphasis on parsing relevant pertinent "positives" and "negatives" from that narrative. A simple organizing principle is to have patients present their concerns from a chronological perspective, in order for the clinician to develop a clear narrative. "When was the very first time you recall having any problems involving your mental health?" provides a good starting point, followed by "When was the first time you sought any kind of treatment for those problems?" A chronologically organized narrative gives some sense not only about the backdrop and longevity of a psychiatric disorder but, moreover, clues about the degree of distress and disruption caused by symptoms, the potential duration of untreated illness, and symptom severity as reflected by the kinds of interventions that previously occurred. A clinical timeline that starts with years of psychotherapy differs from one that begins with an involuntary psychiatric hospitalization or a suicide attempt; low-grade symptoms that persist for extended periods unnoticed by others, or cause no outward functional impairment, imply a different level of severity and debilitation, and possible prognosis, from those linked with more obvious outward signs of disability.

For persistent problems, one always wonders why the patient is seeking help *now* and not a week or month or two ago.

Careful clinical assessments are not a race to formulate a diagnostic impression as fast as possible; quite the contrary, when facing symptoms that might overlap across two or more constellations (such as anxiety, psychosis, or inattention), the time spent reasoning through a thoughtful differential diagnosis often pays its eventual dividends in perpetuity. Box 1.1 summarizes a number of basic principles for framing a patient's history within a meaningful clinical context.

Box 1.1

Key considerations for contextualizing the history of present illness

- Clarify sudden versus gradual onset of symptoms, and changes to a "stable" equilibrium state of affairs
- Identify how (and whether) symptom complaints represent a clear departure from (versus exacerbation of) someone's usual state
- Why now? Particularly for more longstanding complaints, what factors have prompted help-seeking behavior now as opposed to any time previously?
- Is the decision to seek treatment the patient's, or someone else's? (That is, are the patient's problems more bothersome to themselves or to someone around them?)

Subjective symptoms should correspond to outward signs that together reflect a distinct core underlying problem. Wise clinicians can anticipate problems almost intuitively when they truly recognize the signature pattern of a particular ailment – such as the anosognostic detachment from reality in psychosis, or the flat vacancy and absence of emotion in negative symptoms versus the presence of sadness and "feelingful" despair in depression, coupled with a sheer absence of hedonic capacity. The art of psychiatric evaluation means more than applying DSM-5 (the fifth edition of Diagnostic and Statistical Manual of Mental Disorders; American Psychiatric Association, 2013) criteria to arrive at a most likely diagnosis – or, for that matter, simply making "just" a diagnosis from checklist criteria. It involves sifting relevant from extraneous information in order to render plausible explanations for symptoms, drug effects, or the environmental contexts in which symptom profiles arise. It is more the clinician's than the patient's job to order their narrative, and to understand the context in which symptoms arise.

Tip

Negative/deficit symptoms, such as flat affect, entail the *absence* of emotion; depression involves the amplified *presence* of sadness and despair.

In fact, when we elicit a chief complaint by asking the proverbial open-ended question, "Tell me what brings you here," an enormous amount of data comes forth in the moments that follow. The "sifting" clinician learns the following by not (yet) interrupting the patient's verbiage:

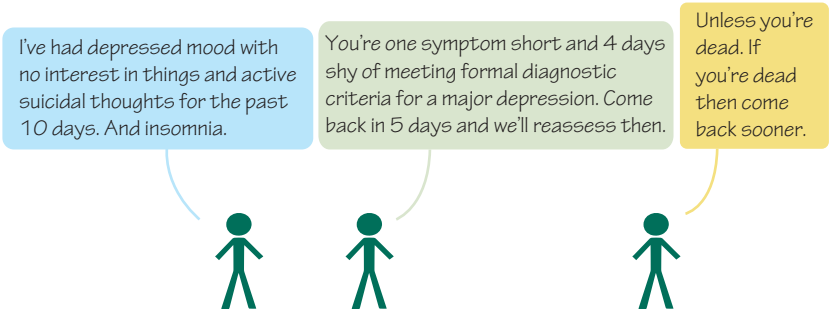
- Can the patient tell a coherent narrative? Do they present logical threads that can be followed without the need to interrupt for clarification?
- Does the patient lose their train of thought? If flow of thinking is not linear and coherent, what are the possible explanations? Is a formal thought disorder present? Is the patient intoxicated? Is a delirium, dementia, or other major cognitive disorder present? Could they be malingering?
- Does the patient display intact social cognition? That is, do they check in with the clinician to see if they are being understood? Or are they oblivious to their effect on the listener?
- Is the patient reasonable? Entitled? Demanding? Aggressive or threatening? Cognizant of the impact of their words and actions on other people?
- Do they display insight into the nature of their condition and an appreciation for the risks, benefits, alternatives, and consequences of proposed treatment options?
- Do "pertinent positives" occur contemporaneously in ways that point to a cohesive clinical entity? Or are symptoms disjointed and fail to add up to a recognizable syndrome?

C ARE DIAGNOSTIC CRITERIA MET?

Meeting the operational definition of a syndrome is often a bugaboo for both clinicians and researchers. The crux of such approaches to diagnosis involves the concept that diagnoses equate to the number, severity, and persistence of signs and symptoms that comprise the criteria for recognizing a clinical entity as unique. Does fleeting psychosis fall under the heading of trauma-related phenomena or micropsychosis during times of stress in someone with borderline personality disorder, rather than a more full-fledged psychotic disorder? Could a thyroid-stimulating hormone level of 5.1 mU/L really be enough to account for current mood symptoms? Clinical investigators can agonize at length over a given patient's history in order to determine whether or not formal diagnostic criteria for a particular clinical entity are or are not met, in a rigid and binary fashion.

Clinical investigators undergo formal training in how to administer semi-structured clinical interviews, which they then rely on to form operational definitions of a suspected diagnosis. In clinical trials, diagnosticians must gain inter-rater reliability (meaning, they must demonstrate a minimally acceptable level of consensus agreement on the presence of a particular diagnosis based on interviews that elicit concrete information about symptoms and their duration).

There is no reason clinicians working "in the trenches" cannot adopt as rigorous an approach to diagnostic assessment, regardless of the use of formal semi-structured clinical interviews.



Diagnostic interviews are keyed to the concept of reviewing specific symptom criteria and durations, as well as ruling out other causes that might better account for a clinical presentation. Though detailed and time-consuming, clinical interviewers who undergo formal training to conduct such diagnostic interviews markedly increase the **reliability** with which they can identify specific psychiatric disorders and differentiate them from look-alike mimics. An end result is the determination that a patient either does or does not fulfill the operationally defined criteria for a particular diagnosis. Critics of this approach argue that diagnostic "criteria" are established by committee consensus rather than the laws of nature, and often involve arbitrariness (e.g., defining hypomania by syndromal persistence for at least 4 days, or major depression by at least 2 weeks).

Tip

Reliability means that two or more observers of the same content reach the same conclusion to explain what they see. Diagnostic reliability has nothing to do with validity, a much harder construct, which asks if the observer's conclusions are true and accurate.

Diagnostic categorization also can change over time in ways that may reflect less science and more the sentiments and vagaries of prevailing opinion (e.g., the construct of somatic symptom disorder replaces the concept of "imagined" or inaccurately perceived health problems in hypochondriasis with the concept of "distress" about health problems, regardless of their objective reality; the emphasis has

Not-so-fun fact

In the DSM-5 field trials, 9 of 23 diagnoses had "questionable" or "unacceptable" reliability of their criteria based on test-retest assessment, including major depressive disorder and generalized anxiety disorder (Regier et al., 2013).

shifted from misperception or impaired reality testing to a focus mainly on how patients react to or feel about their symptoms).

Nosological systems such as the DSM-5 tend not to be particularly lavish in how they account for the context in which symptoms may arise. Frantic psychomotor agitation could superficially look the same in a patient with psychotic mania as someone trapped in an elevator in a burning building. Attributing an adolescent's poor school efforts "just" to depression may sacrifice a lot of information if one ignores the context of, say, Julie's parents' acrimonious divorce process, Isabel's sexual abuse by a boyfriend, or David's experience of bullying for identifying as LGBTQ+. Contexts influence treatment decisions, both pharmacologically and psychosocially, as elaborated further in Box 1.2.

Box 1.2

How context matters in establishing a diagnostic formulation or treatment recommendation

The particular context in which psychiatric symptoms arise is fundamental to establishing diagnoses. For example, the diagnosis of posttraumatic stress disorder (PTSD) requires an antecedent trauma that poses some threat to one's fundamental safety and well-being, although obviously not all traumas result in PTSD. What exactly was the impact of the trauma? Or: suicidal thinking that arises in the context of intoxication is fundamentally different from sober suicidality in the context of a major depression. Or: relapse of a psychiatric disorder in the context of treatment nonadherence is different from relapse that occurs *despite* ongoing treatment that had, until then, been perceived as effective.

What we might call "Newtonian psychopharmacology" means that an object in motion stays in motion unless an opposing force acts on it. If a clinical condition has been quietly in remission and symptoms re-emerge – or a system otherwise in stable equilibrium falls out of equilibrium – one ideally searches for that opposing force. It can be helpful to pose questions such as the following:

- When exactly did things change? What events or circumstances preceded the change in equilibrium?
- Did a change in medications (such as nonadherence) or psychotherapy precede a clinical change?
- Did a change in work, finances, or social supports coincide with the emergence of psychiatric symptoms? Life stresses can be like pollen's relationship to hay fever – not as the cause of disease, but as its catalyst in someone with a biological predisposition (see also Chapter 5, Box 5.1 for more on the diathesis–stress model in vulnerable individuals)

There are both advantages and disadvantages in adopting a "criteria-based approach" to diagnosis. The most obvious disadvantage involves the notion that operational criteria may be reliable (and even then, not always) but not valid. This latter point makes it rather disingenuous to speak of diagnostic "accuracy," if in fact diagnoses by operational criteria are mainly heuristic constructs that provide a way of organizing narrative information but involve elements of arbitrariness that undermine accuracy. A compelling example might be the categorization of excessive worry as a diagnostic entity. Known as "overanxious disorder" in DSM-III-R (American Psychiatric Association, 1987), the construct was revised in DSM-IV (American Psychiatric Association, 1994) to generalized anxiety disorder (GAD) but criticisms have surrounded both its reliability and validity based on several of its operational criteria. Some authors suggest that determining "excessiveness" of anxiety and worry (an "A" criterion) is subjective and may vary depending on the evaluator; the imposed duration criteria of at least 6 months also has been associated with poorer inter-rater reliability than if a shorter duration (such as 1 month) were acknowledged; and that many of the associated symptoms listed as "C" criteria for GAD are highly nonspecific (e.g., fatigue, poor concentration, insomnia) and unduly overlap with other disorders (such as major depression) (Andrews et al., 2010).

An obvious advantage of using operationally based diagnostic criteria for clinical decision-making is that doing so minimizes subjectivity or ambiguity about how to characterize the phenomenon being treated; the definition is agreed upon, regardless of whether it is accurate. However, without an appreciation for context, this approach could lend itself to overly concrete thinking among practitioners. Imagine if one concluded that because stimulants treat inattention in attention deficit–hyperactivity disorder (ADHD), they might equally improve attention in people with delirium or dementia; or, if tryptans improve migraine headaches, they should expectably improve all other forms of headache; or, if nitrates help chest pain from angina, why not assume they should also alleviate chest pain from a peptic ulcer or rib fracture? Diagnosticians cannot undertake clinical reasoning without ruling out look-alike conditions that might superficially imitate other clinical entities (phenocopies; see Box 1.3) lest we resign ourselves to clinical decision-making as being no more than a wild-West lawless enterprise.

The nature of enrolling patients in a clinical trial hinges on affirming the specificity of diagnosis – for example:

- A patient with suspected major depressive disorder must manifest at least five of nine symptoms for at least 2 weeks, uncontaminated by other factors that might better account for the presenting features (such as, active substance use or clinically meaningful hypothyroidism); or

Box 1.3

What are psychiatric phenocopies?

To the extent that we construe at least some elements of many if not most psychiatric conditions as having some contribution from genetic factors, we refer to the observable manifestations of genetic expression as phenotypes. (Less overt manifestations of genetic forces are sometimes called **endophenotypes**, or "hidden" phenotypes – that is, phenomena that are influenced by genetic factors but are not outwardly visible, or visible only when subjected to tests that elicit a certain behavior or stimulus response, such as poor working memory or an innately diminished capacity to efficiently metabolize certain medications.) The term **phenocopy** is used to describe a genetically influenced observable entity that could resemble a different genetically determined entity. In a phenocopy, the clinical signs and symptoms can outwardly or superficially resemble another clinical entity that is believed to have a different underlying pathology, course, and possible treatment trajectory.

- A patient whose "mood swings" are called "cyclothymia" has never been fully manic, nor had a sufficient number or duration of hypomanic or depressive symptoms to constitute a full syndrome of either polarity; or
- "Panic disorder" connotes the occurrence of specific autonomically driven events with physical (not just psychic) manifestations; or
- PTSD is not a catch-all phenomenon that encapsulates any and all forms of highly stressful events – such as difficult relationship break-ups, job losses, or reversals of financial fortune; in fact, the treatments geared to PTSD focus on its recognized clusters, such as avoidance, autonomic hyperarousal (e.g., exaggerated startle response) or involuntary intrusive thoughts and memories causing physiological distress in response to associated cues; or
- A patient who periodically smokes cannabis would not formally be identified as having cannabis use disorder unless they use for increasingly longer periods in larger amounts, their use adversely affects their work and social functioning, physical or psychological problems ensue from use, and other formal diagnostic criteria are met that differentiate "use" from a "use disorder"

Real-world patients do not always fully meet formal diagnostic definitions of a categorical disorder, and real-world clinicians often do not painstakingly appraise every item within a diagnostic checklist. Nevertheless, for better or worse, there is objective merit behind the phrase "the diagnostic criteria are (or are not) met." Why? In large part, it allows apples-to-apples comparisons between a real-world patient's presentation relative to the patient descriptions found in clinical trials or textbooks. Disparities mean extrapolation, which in turn means that "real-world" outcomes may differ substantially from "prototypical" patients who embody the characteristics of a textbook presentation.

D ARE DSM CRITERIA WRITTEN MAINLY FOR CLINICIANS OR RESEARCHERS?

The operational criteria captured in nosologies such as the DSM or the International Classification of Diseases (ICD) are collections of symptoms and duration criteria arrived at by consensus agreement among experts, rather than "absolute truths" found in nature. They are subject to change and can sometime even become eliminated altogether (as in the case of Asperger syndrome) or "voted" into existence by committee opinion (as in the case of disruptive mood dysregulation disorder or major depressive disorder with mixed features). "Cardinal" symptoms are also subject to greater or lesser importance as consensus opinions about psychiatric diagnoses change over time. For example, neologisms, bizarre delusions, and so-called first-rank symptoms of psychosis (e.g., believing one's thoughts or actions are controlled by outside forces) were once strongly associated with schizophrenia, but eventually were felt to lack diagnostic specificity and consequently "demoted" to the status of holding less pathognomonic importance based on clinical consensus of opinion.

As noted in Section C above, investigators think about psychiatric diagnoses differently than practitioners; like bookkeepers, they focus on whether or not the requisite number and duration of symptoms have been met, and the phrase "the criteria are not met" becomes a ubiquitous refrain when deciding that a patient is ineligible to qualify as a research subject in a clinical trial. Twists occur along the way with regard to problems like "double counting" symptoms that could be attributed to more than one condition. A well-known example is the DSM-5 "mixed features" course specifier, which was conceptually meant to embrace the notion that mania and depressive symptoms could occur on a continuum across all mood disorders. Four particular symptoms – distractibility, irritability, insomnia, and psychomotor agitation ("DIIP") could occur in the context of either a mania or depression and, consequently, crafters of the DSM-5 suggested that none of these symptoms could be used to constitute a "tie-breaker" when deciding on the presence of an opposite affective pole. Critics of this stipulation have argued that DIIP symptoms can be integral to the construct of mixed states, and to exclude them (as polarity-deciding factors) would be akin to excluding fever as a criterion when differentiating an infection from an autoimmune process. Both perspectives are correct in their own way, and underscore the dilemma for the practitioner (who may be altogether less fastidious in even registering DIIP symptoms as casting a decisive diagnostic vote).

E HIERARCHICAL DIAGNOSTIC TREATMENT APPROACHES: HOW TO TRIAGE

It should come as no surprise to in-the-trenches practitioners that most patients with significant psychiatric symptoms often have more than one diagnosable psychiatric condition. Part of the assessment challenge is parsing symptoms that could overlap between two or more disorders in trying to understand "overarching" diagnostic constructs from the collision of multiple separate ailments. When is inattention or distractibility an indication of comorbid ADHD rather than an intrinsic component of depression, anxiety, or psychosis? When are problems with impulse control or emotional self-regulation artifacts of a broader condition such as bipolar disorder rather than manifestations of a comorbidity such as PTSD or a significant personality disorder? And perhaps most important of all, when and how does one determine which is the "core" or predominant psychiatric condition and which are – for want of a better term – subsidiary coexisting conditions?

There is often an implicit assumption that if a predominant or overarching condition is recognized, perhaps its successful treatment will lead to some attenuation of the comorbid or subsidiary conditions. This is an interesting but largely empirically untested hypothesis. Some comorbid conditions may spring from a common underlying process but, once initiated, follow their own trajectories and require their own independent treatment. Outside of psychiatry, diabetes may be the most illustrative example. Diabetic patients who develop neuropathy, retinopathy, nephropathy, poor wound healing, and worsening of cardiovascular disease can ultimately attribute blame to how their body manages glucose – and yet, once the wheels have been set in motion for these end-organ consequences of impaired glucose metabolism, fixing the initial source of the problem will not necessarily repair the collateral downstream damage.

In psychiatry, perhaps substance use disorders represent a comparable dilemma when they are viewed as incidental to some larger, overarching clinical problem. When substance use disorders involve problems with mood or anxiety, patients or their families (and sometimes also their clinicians) sometimes may hypothesize that comorbid substance use might evaporate if only a more effective therapy were in place for the more fundamental problem being "self-medicated." There may very well be instances in which optimal control of mood or anxiety (or other) disorders can help make inroads in active substance use disorders, but a reductive approach such as this discounts the notion that addictions often constitute ailments that exist unto themselves (i.e., disorders of the reward pathway), which typically require their own treatment. Moreover, unmanaged substance use disorders may in turn aggravate and perpetuate a comorbid psychiatric condition such as depression or anxiety. Which condition is subsidiary to which? Or should the preferred rule of thumb be to assume that