

Psychiatric Interview
PGY I
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How does the Psychiatric Interview differ from the Medical Interview?

- 1) Diagnosis is of limited value
- 2) Therapy and treatment are not as clearly tied to Diagnosis
- 3) Psychiatric Assessment is more complex than Medical Assessment

Frameworks:

- 1) Biopsychosocial Model
- 2) Illness Behavior/Sick Role
 - a. Illness behavior is influenced by previous experience, personality, and the socio-cultural context.
 - b. Stages of the Sick Role:
 - i. Symptom experience stage – “Something is wrong!”
 - ii. Assumption of sick role – “I need help”
 - iii. Medical care contact stage – “I have come to you for help”
 - iv. Dependent patient role stage – “I will do what you tell me”
 - v. Recovery or rehabilitation stage – “I am well”
- 3) Doctor-Patient Relationship
 - a. Both have expectations, needs, and personalities that affect the interaction
 - b. Types:
 - i. Active – Passive Model
 - ii. Teacher – Student Model
 - iii. Mutual Participation Model
 - iv. Friendship Model
 - v. Producer – Consumer Model
 - c. Physician – boundaries, limits to power, defensiveness
- 4) Systems Model

Both involve assessing a chief complaint, its history, and a review of systems, but in the Psychiatric Assessment “Systems” include not only behavior, affect, cognition, intelligence, and judgment, but also personality, interpersonal relations, ability to satisfy needs, modes of adaptation, and psychological defenses. The Psychiatric Assessment involves active listening, paying attention to not only the content, but also the process. This also includes listening for significant absences and what is not said.

The Psychiatric Interview has three parts:

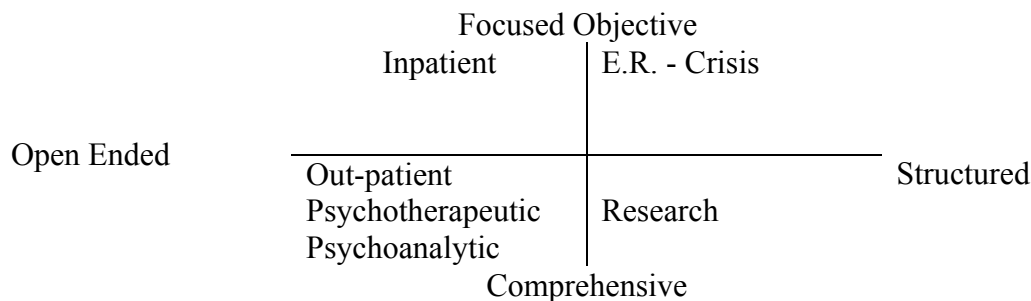
- 1) Medical Interview:
 - a) Sections – History of Present Illness, Past History, Social History, Family History.
 - b) Goals – The assessment of the problem, develop and maintain a relationship, communicate information and treatment plan, education.

- c) Clinical task – Understand the time course of the symptoms, their relation to each other, and the meaning.
- 2) Psychiatric Interview – The Person’s “Story”
 - a) Individual context – Their psychological make-up, their motivation (conscious and unconscious), their ego strengths and weaknesses, their coping strategies, their defense mechanisms, their vulnerabilities, their areas of aptitude and achievement.
 - b) Environmental context – Their relationship to their environment, significant religious and socio-cultural influences, their support system/network, environmental stressors.
- 3) Therapeutic Encounter/Alliance
 - a) Means – Empathic listening, therapeutic interactions using mirroring, reflection, empathy, etc.
 - b) Goals – Provide a “Holding” Environment, a “Corrective Experience,” increase insight, and alter behavior.

The Psychiatric Interview has three stages:

- 1) Initial – Open ended questions
Chief Complaint
Feelings related to the Chief Complaint
Encouragement
“Medical Interview”
- 2) Middle – Background and context
Movement from more positive things to more difficult things
“Psychiatric Interview”
- 3) Conclusion – Other areas?
Questions from the patient
Formulation
Initial plan
Consents to talk to others

The interview is affected by context and goal:



Interview

1) Othmer Model:

Phase	Rapport	Technique	Mental Status	Diagnosis
1) Warm up and Screening of problem	Put them at ease, set limits, and establish empathy	Broad questions	Observe appearance and behavior, cognition	Classify chief complaint, assess symptoms
2) Follow-up of Preliminary Impression	Alliance	Shift topics – open to closed questions	Assess thinking and Suicidal ideation	Verify and exclude diagnosis
3) History and Data Base	Express expertise, interest, and leadership	Organize data	Judgment, memory, specific mental status functions	Assess course and impact on life
4) Diagnosis and feedback	Acceptance of diagnosis	Explain	Discuss findings	Five Axis
5) Prognosis and Treatment Contract	Leadership and assure compliance	Discuss treatment contract	Make inferences	Give prognosis and treatment effects

- 2) The interview is affected by the participant’s personality, the setting, technical factors (interruptions, use of a translator, taking notes, the patient’s illness), and the doctor’s style and experience.
- 3) Goals/Styles
 - a. Recognition of the psychological determinants of behavior/insight oriented
 - b. Symptom classification/symptom oriented
- 4) Functions (Lipkin)
 - a. Determine the nature of the problem
 - b. Develop and maintain a therapeutic relationship
 - c. Communicate information and develop a treatment plan
- 5) Differences between a psychiatric interview and a medical/surgical interview
 - a. Increased stigma
 - b. Illness related interferences with the interview
 - c. Frequent need for outside information
 - d. Increased reliance on observation

Rapport – establishing trust and understanding

- 1) Barriers – differences due to culture, economic background, education
- 2) Psychodynamic aspects
 - a. Transference – the patient’s expectations, beliefs, and emotional responses
 - b. Countertransference – the doctor’s expectations, beliefs, and emotional responses. Issues of the “ideal patient”

Beginning the Interview

- 1) Establish rapport, put the patient at ease, show respect
- 2) Introduce self, learn their name
- 3) Request to have someone else present
- 4) Introduce professional status

How to begin:

- 1) Request for information
- 2) Talk about the interview itself in order to give knowledge and assurance
- 3) Why now?

The Interview proper:

- 1) Content versus process
- 2) Techniques –
 - Open ended versus closed ended questions
 - Reflection
 - Facilitation
 - Silence
 - Confrontation
 - Clarification
 - Interpretation
 - Summation
 - Exploration
 - Transition
 - Self-revelation
 - Positive reinforcement
 - Reassurance
 - Advice
- 3) Techniques to avoid –
 - Excessively direct questions
 - Pre-emptive topic shift, agenda conflict
 - Premature advise
 - False reassurance
 - Doing without explaining
 - Put down questions
 - “You are bad” statements
 - Trapping the patient with their own words
- 4) If psychotic – increased respect, less intrusiveness, increased distance, increased structure, decreased humiliation, increased telling what you are going to do
- 5) Ending the interview –
 - Allow them to ask questions
 - Thank patient
 - Clarify about medications
 - Clarify the next step, i.e., return to clinic, referral, etc.
- 6) Compliance Adherence – The doctor-patient relationship is most important
 - Rule of 1/3 or 50%
 - Illness related motivation
 - Effective communication

Be practical, write things down

- 7) Business issues – Fees
 - Confidentiality
 - Supervision
 - Missed appointments and length of sessions
 - Doctor's availability
 - Follow-up, disruptions
- 8) Mini-mental status exam
 - a. It is reliable, replicable, standardized, and sensitive
 - b. Score is altered by cognitive deficits, physical ability, education, motivation
 - c. Designed for assessing Alzheimer's Dementia and does not do as well with frontal cortical, focal, or sub-cortical pathology

Management of the difficult patient interview – Practical suggestions:

1) Many of the below strategies involve more than just the initial interview, but trying to build a connection with a difficult patient begins with the interview, so it should be seen as the first step in this directions. Various strategies have been proposed for the management of the difficult patient. Many echo Kaplan's (1988) guidelines for management of somatization:

- a) Encourage the development of a trusting relationship.
- b) Don't argue about their reality.
- c) Respectfully and systematically evaluate physical symptoms.
- d) Establish appropriate therapeutic goals
- e) Regular follow-up, independent of symptoms
- f) Appropriate treatment of psychiatric conditions
- g) Only appropriate referrals, but maintain involvement.

In addition, Schwenk and Romano (1992) suggest the following management goals: a) Minimize medicalization; b) Maintain physician-patient continuity; c) Maintain physician self-esteem through appropriate behaviors and support; d) Focus on positive aspects of patient's personality or behavior; and e) Set realistic expectations for accomplishments and satisfaction.

Thus the difficult patient is to be respected and approached as a partner in care. This includes good baseline care, anticipate problems, explain, give control, negotiate, understand patient's point of view, mobilize external support, staff support each other, try and match staff with patient (Wolf et al 1997). Juliana, et al. (1997) echoes these and adds that it is not helpful to try and control the patient or make threats. Adams and Murray (1998) suggest that it is

important to maintain a healthy distance which allows empathy without becoming personally challenged or being too distant, while supporting trust by listening and caring. These are gained through experience, self-awareness, and support from others.

As to suggestions with specific personality types, Schwenk and Romano (1992) develop the following specific strategies:

a) Passive, dependent, demanding patient - see behavior as arising from negative self-esteem and dependency, give a little, but then explain clearly limits and why

b) Dramatic, seductive, affectionate patient - see as symptom, do not respond in kind, maintain clear, professional limits in a non-punitive manner

c) Long-suffering, masochistic, denying patient - see as possibly best way of coping, empathize, but not give unrealistic assurance, support their control

d) Somaticizing and hypochondriacal patient - acknowledge their reality, work to support their control over symptoms, rational medical response, regular visits and control over-use.

e) Angry, demanding, complaining patient - comes from fear of loss and helplessness, allow expression of anger, but within safe parameters, offer control and in-put into decisions.

Much has been written about the management of the Borderline patient, but I find two suggestions especially important. Stone (1988) argues that it is most important to understand the "inner script," the psychodynamic story that those with a Borderline Personality Disorder repeat again and again. This allows empathy and understanding, as well the ability to predict reactions and gain the correct distance suggested above. In addition Miller (1990) describes the proper use of the therapeutic contract.

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