



The Psychiatric Interview

The interview is the principal means of assessment in clinical settings. Despite major advances in neuroimaging and neurochemistry, there are no laboratory procedures as informative as observing, listening to, and interacting with the patient, and none as yet are more than supplementary to the information gathered by the psychiatric interview. This chapter deals with the interview as a means of assessing the patient and developing an initial treatment plan in clinical situations.

Goals of the psychiatric interview

The interviewer may be thought of as seeking the answers to several basic questions about the patient and the presenting problems. These questions provide the mental framework of the interview (although not its explicit form). They begin by triaging the patient's problem into broad categories of type and severity and progress to inquiry about details in each salient area. Table 1.1 lists the questions which the interview addresses and the implications of each for understanding and treating the patient.

The answers to the questions in Table 1.1 are presented here in greater detail.

Does the patient have a mental disorder?

This is the most basic question which the clinician is called upon to answer, and determines whether or not there is any need for further assessment or treatment.

How severe is the disorder?

The answer to this question determines the necessary level of treatment, ranging from hospitalization with close observation to infrequent outpatient visits. The main determinants of severity are dangerousness to self and others and impairment in ability to care for oneself and function in social and occupational roles.

What is the diagnosis?

Descriptive information about signs, symptoms, and course over time is used to assign a diagnosis to the presenting problem. Not all mental diagnoses have well-established validity, but most convey knowledge of prognosis, comorbidity, treatment response, occurrence in family members, or associated biological or psychological findings. Even in the case of poorly understood entities, our present system of diagnosis using specific criteria maximizes uniformity in the description and naming of mental disorders.

Are there abnormalities in brain function?

Although the question of brain abnormalities is basic to psychiatric triaging, we do not yet have a clear-cut biological etiology for any disorder outside of those historically classified as "organic." Standard laboratory studies (such as brain imaging or electroencephalography) are not generally diagnostic of psychopathology; however, there is research-based evidence of altered brain function in many mental disorders. Table 1.2 presents an overview of the current state of knowledge of brain abnormalities in mental disorders, along with known responses to biological and psychosocial treatments.

What is the patient's baseline level of functioning?

Determining what the patient has been like in his/her best or most usual state is a vital part of the assessment. This information allows the interviewer to gauge when the patient became ill, and how he/she is different when ill versus well. Environmental, biological, and psychological factors that contribute to low baseline levels of functioning may also predispose a patient to the development of mental disorders. Thus, information

Table 1-1 Issues to be addressed in a psychiatric assessment

Question	Implications
Does the patient have a mental disorder?	Need for treatment
How severe is the disorder?	Need for hospitalization Need for structure or assistance in daily life Ability to function in major life roles
Are there abnormalities of brain function?	Degree of dysfunction of major mental processes such as perception, cognition, communication, regulation of both mood and affect Responsiveness of symptoms to environmental and motivational features Responsiveness of symptoms to biological treatment
What is the diagnosis?	Description of the illness, prognosis and treatment response
What is the patient's baseline level of functioning?	Determination of onset of illness State vs. trait pathology Goals for treatment Capacity for treatment
What environmental issues contribute to the disorder?	Prediction of conditions which may trigger future episodes of illness Need for focus on precipitating stressors Prevention of future episodes through amelioration of environmental stressors and/or increased environmental/social support
What biological factors contribute to the disorder?	Need for biological therapy Place of biological factors in explanation of illness presented to the patient Focus on biological factors as part of ongoing therapy
What psychological factors contribute to the disorder?	Responsiveness of the symptoms to motivational, interpersonal, reinforcement factors Need to deal with psychological or interpersonal issues in therapy
What is the patient's motivation and capacity for treatment?	Decision to treat Choice of treatment

about baseline functioning provides clues about the patient's areas of vulnerability to future illness as well as his/her capacity to benefit from treatment. It is also an important guide to realistic goals and expectations for such treatment. Table 1.3 lists major components of functioning with examples of elements of each.

What environmental factors contribute to the disorder?

Environmental contributions to the presenting problem are factors external to the patient. They may be acute events which precipitate illness, or long-standing factors which increase general vulnerability. Loss, change, and traumatic events are very common acute precipitants. Long-standing environmental stressors may predispose the patient to the development of illness and may also worsen the outlook for recovery.

It is important to identify adverse environmental influences which can be modified, and to help the patient or family make necessary changes. For example, a patient with recurrent paranoid psychosis needed yearly hospitalization as long as she worked in an office with many other people. Once she was helped to find work which she could do in her own home, she no longer suffered severe relapses. However, even irreversible precipitants, such as death of a loved one, must be identified and dealt with in the treatment plan.

What biological factors contribute to the disorder?

Biological factors may contribute to mental disorders directly by their effects on the central nervous system and indirectly through the effects of pain, disability, or social stigma. Thus, biological factors must be assessed through both the psychiatric history and the general medical history.

Biological factors affecting the central nervous system may be genetic, prenatal, perinatal, or postnatal. There is strong evidence of genetic contributions to Schizophrenia, Bipolar I Disorder, and Alcohol Dependence, among others. Conditions such as maternal substance abuse or intrauterine infections may affect fetal brain development; birth complications may cause cerebral hypoxia with resultant brain damage. In postnatal life, the entire range of diseases which affect the brain may alter mental function and behavior, as may exposure to toxins at work, in the environment, and through substance abuse. In addition, medical conditions which do not directly affect brain functioning may have profound effects on the patient's state of mind and behavior.

Table 1-2 Brain dysfunction in mental disorders

Disorder	Evidence for Brain Dysfunction	Response to Biological Treatments	Response to Psychosocial Treatments
Delirium, dementia, amnesic, and cognitive disorders	Well established	Reversible causes respond to appropriate treatment, neuroleptics, anxiolytics, antidepressants, lithium, and anticonvulsants; beta blockers may be helpful	Environmental support and supportive psychotherapy may be helpful
Schizophrenia	Strong evidence	Most respond to antipsychotics; antidepressants, mood stabilizers, and anxiolytics may be helpful adjunctively	Environmental support, supportive psychotherapy, cognitive-behavioral therapy, family therapy, and skills training are helpful
Delusional Disorder	Little evidence: few studies	Poor to fair response to psychotics	Poor response to psychotherapy
Schizoaffective Disorder	Evidence for relationship to Schizophrenia and mood disorders.	Most respond to combinations of antipsychotics, antidepressants, mood stabilizers, carbamazepine, or ECT	Not well established. Similar range of treatments as for Schizophrenia may be helpful
Brief Psychotic Disorder	Little evidence: few studies	Not well established	Environmental support and supportive psychotherapy helpful
Bipolar I Disorder	Strong evidence	Most respond to lithium, antidepressants, anticonvulsants, neuroleptics, or ECT	Supportive and educative psychotherapy and family therapy helpful
Major Depressive Disorder	Evidence suggestive—considerable heterogeneity	Often responds to antidepressants or ECT	Less severe cases respond to cognitive, interpersonal, and psychodynamic psychotherapy
Panic Disorder	Evidence suggestive	Most respond to anxiolytics or antidepressants	Variable. Cognitive-behavioral therapy more effective than psychodynamic
Generalized Anxiety Disorder	Little evidence	Variable. Anxiolytics may be helpful	Variable. Psychodynamic, or cognitive-behavioral psychotherapies are often helpful
Specific Phobia	Little evidence	Medications not usually helpful	Most respond to behavioral therapy
Posttraumatic Stress Disorder	Evidence suggestive	Variable. Antidepressants and mood stabilizers may be helpful	Psychotherapy with exploratory, supportive, and behavioral features usually helpful
Obsessive-Compulsive Disorder	Evidence suggestive	Most respond to selective serotonin reuptake inhibitors	Rituals but not obsessive thoughts respond to behavioral therapy
Somatization Disorder	Preliminary evidence	Poor. Medication for comorbid depression or anxiety may be helpful	Poor. Supportive psychotherapy may be helpful

(continued)

Table 1-2
(Continued)

Disorder	Evidence for Brain Dysfunction	Response to Biological Treatments	Response to Psychosocial Treatments
Conversion Disorder	None known	Amytal interview may be helpful; otherwise not indicated	Most respond to psychotherapy with exploratory, expressive, and behavioral features. May remit spontaneously
Hypochondriasis	None known	No direct response. Medications may be helpful for treatment of comorbid depression and anxiety	Variable. Supportive-educative psychotherapy may be helpful
Dissociative disorders	None known	No direct response. Medications may be helpful for treatment of comorbid depression and anxiety	Variable. Many respond to expressive-exploratory psychotherapy
Alcohol-related disorders	Strong evidence in subgroups	No well-demonstrated direct effects. Opiate antagonists may be helpful	Group and individual psychotherapies most common treatment modalities. Response variable, relapse high
Other substance use disorders	Little evidence; some subgroups	No well-demonstrated direct effects	Group and individual psychotherapies most common treatment modalities. Response variable, relapse high
Sexual disorders	May be due to metabolic disorders; otherwise little evidence	Medications for underlying medical conditions may be necessary. Anti-androgens or serotonergic antidepressants may be helpful for paraphilias	Sexual dysfunctions often respond to behavior therapy. Couples therapy or exploratory therapy may also be helpful
Eating disorders	Evidence suggestive	Antidepressants may be helpful ameliorate symptoms	Expressive exploration, family, and behavioral therapy often helpful
Adjustment disorders	None known	Medications may alleviate symptoms of anxiety or depression	Supportive psychotherapy often helpful
Personality disorders: Cluster A	Evidence for relationship of schizotypal personality to Schizophrenia; otherwise none known	Schizotypal patients may improve on antipsychotic medication; otherwise not indicated	Poor. Supportive psychotherapy may be helpful
Personality disorders: Cluster B	Evidence suggestive for antisocial and borderline personalities; otherwise none known	Antidepressants, antipsychotics, mood stabilizers may be helpful for borderline personality; otherwise not indicated	Poor in antisocial personality. Variable in borderline, narcissistic and histrionic personalities
Personality disorders: Cluster C	None known	No direct response. Medications may be helpful with comorbid anxiety, depression	Most common treatment for these disorders. Response variable

Table 1-3 Assessment of baseline functioning

Component	Examples
Level of symptoms	Depression Anxiety (including obsessions and compulsions) Delusions Hallucinations Impulsive behaviors
Interpersonal relations	Sexual relationships and marriage Quality and longevity of friendships Capacity for intimacy and commitment
Work adjustment	Employment history Level of responsibility Functioning in nonpaid roles, for example homemaker, parent Satisfaction with work life
Leisure activities	Hobbies and interests Group and social activities Travel Ability to take pleasure in nonwork activities
Ego functions	Talents, skills, intelligence Ability to cope; reality testing Control over affects and behaviors Ability to formulate and carry through plans Stable sense of self and others Capacity for self-observation

Biological factors may both predispose to and precipitate episodes of illness. Thus, a patient with a genetic vulnerability to schizophrenic illness may have an episode of acute psychosis precipitated by heavy cocaine use. Similarly, a patient with borderline low intellectual capacity due to hypoxia at birth may have a marginal ability to care for himself or herself; an accident resulting in a fractured arm might overwhelm this person's coping capacity and precipitate a severe adjustment disorder.

What psychological factors contribute to the disorder?

Psychological factors are mental traits which the patient brings to life situations. While they interact with social and environmental factors, they are intrinsic to the individual, and not readily changed by outside influences.

Psychological factors predisposing to illness include both general and focal deficits in coping adaptability. General deficits encompass the entire range of ego functioning, including poor reality testing, rigid or maladaptive psychological defense mechanisms, low ability to tolerate and contain affects, impulsivity, poorly formed or unstable sense of self, low self-esteem, and hostile, distant, or dependent relationships with others.

Patients with such deficits generally meet diagnostic criteria for one or more personality disorders and are at increased risk for episodes of acute illness.

Focal psychological issues may also contribute to mental disorders. These issues, which typically involve conflicts between opposing motivations, may affect the patient in certain specific areas of function or life situations, leaving other broad areas of function intact. Such conflicts are most likely to cause maladaptive behaviors or symptoms when the patient is not clearly aware of them.

The meaning of an event in the context of the patient's life course is another focal issue which may contribute to illness.

What is the patient's motivation and capacity for treatment?

Whatever the clinician's view of the presenting problem, the patient's wishes and capacities are major determinants of treatment choice. Some patients seek relief of symptoms; some wish to change their behavior or the nature of their relationships; some want to understand themselves better. Patients may wish to talk or to receive medication or instructions.

The patient's capacity for treatment must also be considered in the treatment plan. For example, a patient with Schizophrenia may agree to medication but be too disorganized to take it reliably without help. Suitability for exploratory psychotherapy depends upon such factors as the ability to observe oneself, tolerate unpleasant affects, and establish and maintain a working relationship with the treater. Such factors must be evaluated in the interview.

The psychiatric database

The body of information to be gathered from the interview may be termed the psychiatric database (Table 1.4). It is a variable set of data: either very specific or general, mainly limited to the present state or focused on early life, dominated by neurological questions or inquiry into relationships. To avoid setting the impossible task of learning everything about every patient, one must consider certain factors which modify the required database.

Whose questions are to be answered: the patient's concern about himself or herself, a family or friend's concern about him or her, another clinician's diagnostic dilemma, a civil authority's need to safeguard the public, or a research protocol requirement? Who will have access to the data gathered and under what circumstances? What is the setting of the interview? Priorities

Table 1-4 Core database		
Identifying Data	Chief Complaint	History of Present Illness
Name Age/date of birth Next of kin	Reason for Consultation	Major Symptoms Time course Stressors Change in functioning Current medical problems and treatment
Past Psychiatric History	Past Medical History	Family History
Any previous psychiatric treatment History of suicide attempts Functioning problems secondary to psychiatric symptoms Alcohol/drug abuse	Ever hospitalized Surgery Medications	Psychiatric illness
Personal History	Mental Status	
Educational level Ever married/committed relationship Work history Means of support Living situation	Appearance Attitude Affect Behavior Speech Thought process Thought content Perception Cognition Insight Judgment	

in an emergency room differ from those in an office setting. Is the interview to be the first session of a psychotherapy regimen, or is it a one time only evaluation? What is the nature of the pathology? For example, negative responses regarding the presence of major psychotic symptoms, coupled with a history of good occupational function, will generally preclude a detailed inventory of psychotic features. A missed orientation or memory question will require careful cognitive testing. Patients with personality disorder symptoms warrant careful attention to the history of significant relationships, work history, and the feelings evoked in the interviewer during the evaluation process. The database should be expanded in areas of diagnostic concern to support or rule out particular syndromes. The amount and nature of the data obtained is also, of necessity, limited by the patient's ability to communicate and his or her cooperativeness.

Database components

Identifying data

This information establishes the patient's identity, especially for the purpose of obtaining past history from other contacts, when necessary, as well as to fix his or her position in society. The patient's name should be recorded, along with any nickname or alternative names he/she may have been known by in the past. This is important for women who might have been treated previously under a maiden name, or a patient who has had legal entanglements and so has adopted aliases.

Date of birth, or at least age, and race are other essential parts of every person's database. A number of different classifications for race exist, as well as different terms and controversies. In the United States and Canada, the categories of white, black (or African-American), Asian, Native American, and others are generally accepted. The additional modifier of ethnicity, especially Hispanic/non-Hispanic, is becoming more widely used. If a patient is a member of a particular subculture based on ethnicity, country of origin, or religious affiliation, it may be noted here.

A traditional part of the identifying data is a reference to the patient's civil status: single, married, separated, divorced, or widowed. The evolution of relationship patterns over the last two decades, with less frequent formalization of relationships, has made classification more difficult, especially in the case of homosexual patients, whose relationships may have different degrees of recognition and terms depending upon the particular jurisdiction.

The patient's social security number (or other national ID number) can be a very useful bit of data when seeking information from other institutions. It is sometimes set aside for particular protection due to the danger of identity theft.

In most cases, it is assumed that the informant (supplier of the history) is the patient. If other sources are used, and especially if the patient is not the primary informant, this should be noted at the beginning of the database.

Chief complaint

The chief complaint is the patient's responses to the question "What brings you to see me/to the hospital today?" or some variant. It is usually quoted verbatim, placed within quotation marks, and should be no more than one or two sentences.

Even if the patient is very disorganized or hostile, quoting his or her response can give an immediate sense

of where the patient is as the interview begins. If the patient responds with an expletive, or a totally irrelevant remark, the reader of the database is immediately informed about how the rest of the information may be distorted. In such cases, or if the patient gives no response, a brief statement of how the patient came to be evaluated should be made and enclosed in parentheses.

History of the present illness

Minimum essential database

The present illness history should begin with a brief description of the major symptoms which brought the patient to clinical attention. The most troubling symptoms should be detailed initially; later a more thorough review will be stated. At a minimum, the approximate time since the patient was last at his or her baseline level of functioning, and in what way the patient is different from that now, should be described, along with any known stressors, the sequence of symptom development, and the beneficial or deleterious effects of interventions.

How far back in a patient's history to go, especially when he or she has chronic mental illness, is sometimes problematic. In patients who have required repeated hospitalization, a summary of events since last discharge (if within six months) or last stable baseline is indicated. It is rare that more than six months of history be included in the history of the present illness, and detailed history is more commonly given on the past month.

Expanded database

A more expanded description of the history of the present illness would include events in a patient's life at the onset of symptoms, as well as exactly how the symptoms have affected the patient's occupational functioning and important relationships. Any concurrent medical illness symptoms, medication usage (and particularly changes), alterations in the sleep-wake cycle, appetite disturbances, and eating patterns should be noted; significant negative findings should also be remarked upon.

Past psychiatric history

Minimum essential database

Most of the major mental illnesses are chronic in nature. For this reason, often patients have had previous episodes of illness with or without treatment. New onset of symptoms, without any previous history of mental illness, becomes increasingly important with advancing age in terms of diagnostic categories to be considered. At

a minimum, the presence or absence of past psychiatric symptomatology should be recorded, along with psychiatric interventions taken and the result of such interventions. An explicit statement about past suicide and homicide attempts should be included.

Expanded database

A more detailed history would include names and places of psychiatric or psychological treatment, dosages of medications used, and time course of response. The type of psychotherapy, the patient's feelings about former therapists, his or her compliance with treatment as well as circumstances of termination are also important. Note what the patient has learned about the biological and psychological factors predisposing him or her to illness, and whether there were precipitating events.

Past medical history

Minimum essential database

In any clinical assessment, it is important to know how a patient's general health status has been. In particular, any current medical illness and treatment should be noted, along with any major past illness requiring hospitalization. Previous endocrine or neurological illness is of particular pertinence.

Expanded database

An expanded database could well include significant childhood illnesses, how these were handled by the patient and his or her family, and therefore the degree to which the patient was able to develop a sense of comfort and security about his or her physical well-being. Illnesses later in life should be assessed for the degree of regression produced. The amount of time a patient has had to take off work, how well he or she was able to follow a regimen of medical care, and his or her relationship with the family physician or treating specialist can all be useful in predicting future response to treatment. A careful past medical history can also at times bring to light a suicide attempt, substance abuse, or dangerously careless behavior, which might not be obtained any other way.

Family history

Minimum essential database

Given the evidence for familial, genetic factors in so many mental disorders, noting the presence of mental illness in biological relatives of the patient is a necessary part of any database. It is important to specify during questioning the degree of family to be considered, usually

to the second degree: aunts, uncles, cousins, and grandparents, as well as parents, siblings, and children.

Expanded database

A history of familial medical illness is a useful part of an expanded database. A genogram (pedigree), including known family members with dates and causes of death and other known chronic illnesses, is helpful. Questioning about causes of death will also occasionally bring out hidden mental illness, for example sudden, unexpected deaths which were likely suicides or illness secondary to substance abuse.

Personal history

Minimum essential database

Recording the story of a person's life can be a daunting undertaking and is often where a database can expand dramatically. At a minimum, this part of the history should include where a patient was born and raised, and in what circumstances—intact family, number of siblings, and degree of material comfort. Note how far the patient went in school, how he/she did there, and what his/her occupational functioning has been. If he/she is not working, why not? Has the patient ever been involved in criminal activity, and with what consequences? Has the patient ever married or been involved in a committed relationship? Are there any children? What is his/her current source of support? Does he/she live alone or with someone? Has he/she ever used alcohol or other drugs to excess, and is there current use? Has he/she ever been physically or sexually abused or been the victim of some other trauma?

Expanded database

An expanded database can include a great deal of material beginning even prior to the patient's conception. What follows is an outline of the kind of data which may be gathered, along with an organizational framework.

Family of origin

Were parents married or in committed relationships?
 Personality and significant events in life of mother, father, or other significant caregiver.
 Siblings: how many? List their ages, significant life events, personality, and relationship to patient.
 Who else shared the household with the family?

Prenatal and perinatal

Was the pregnancy planned? Quality of prenatal care; mother's and father's response to pregnancy.

Illness, medication or substance abuse, smoking; trauma during pregnancy; labor: induced or spontaneous?
 Number of weeks' gestation, difficulty of delivery: vaginal or Caesarean section?

Presence of jaundice at birth, birth weight, Apgar score.
 Baby went home with mother or stayed on in hospital?

Early childhood

Developmental milestones: smiling, sitting, standing, walking, talking; type of feeding: food allergies or intolerance?

Consistency of caregiving: interruptions by illness, birth of siblings?

Reaction to weaning, toilet-training, maternal separation.
 Earliest memories; problematic behavior (tantrums, bed-wetting, hair-pulling, or nail-biting)?

Temperament: shy, overactive, outgoing, fussy?

Sleep problems: insomnia, nightmares, enuresis, parasomnias?

Later childhood

Early school experiences: evidence of separation anxiety?

Behavioral problems at home or school: fire-setting, bed-wetting, aggressive toward others, cruelty to animals, nightmares?

Developmental milestones: learning to read, write.

Relationships with other children and family: any loss or trauma?

Reaction to illness.

Adolescence

School performance: ever in special classes?

Athletic abilities and participation in sports.

Evidence of gender identity concerns: overly 'feminine' or 'masculine' in appearance/behavior, or perception by peers?

Ever run away? Ability to be left alone and assume responsibility.

Age onset of puberty (menarche or nocturnal emissions), reaction to puberty?

Identity

Sexual preference and gender identity, religious affiliation (same as parents?).

Career goals: ethnic identification.

Sexual history

Early sexual teaching: earliest sexual experiences, experience of being sexually abused, attitudes toward sexual behavior.

Dating history, precautions taken to prevent sexually transmitted diseases and/or pregnancy.

Episodes of impotence and reaction.

Masturbating patterns and fantasies.

Preoccupation with particular sexual practices, current sexual functioning, length of significant relationships, ages of partners.

Adulthood

Age at which left home, level of educational attainments.

Employment history, relationships with supervisors and peers at work, reasons for job change.

History of significant relationships, including duration, typical roles in relationships, patterns of conflict: marital history, legal entanglements and criminal history, both covert and detected, ever victim or perpetrator of violence.

Major medical illness as adult.

Participation in community affairs.

Financial status: own or rent home, stability of living situation.

Ever on disability or public assistance?

Current family structure, reaction to losses of missing members (parents, siblings), if applicable.

Substance abuse history.

Mental status examination

It can be helpful to conceptualize the recording of the Mental Status Examination as a progression. One begins with a snapshot: what can be gained from a cursory visual exam, without any movement or interaction—appearance and affect. Next, motion is added: behavior. Then comes sound: the patient's speech, though initially only as sound. The ideas being expressed come next: the thought process and content, perception, cognition, insight, and judgment. Table 1.5 gives a summary of areas to be commented on, along with common terms.

At every level of the Mental Status Examination, preference should be given for explicit description over jargon. Stating that a patient is delusional is less helpful than describing him or her as believing that his or her neighbors are pumping poisonous gases into his bedroom while he sleeps.

Conduct of the interview

Factors which affect the interview

A skillful interview will not necessarily yield all the relevant information but will make the most of the opportunities in a clinical situation, given the limitations which both the patient and interviewer bring. Factors which influence the development of an alliance and the amount which can be learned in the interview include the following:

The patient's physical or emotional distress

Patients who are in acute distress either from physical discomfort or from emotional factors such as severe depression or anxiety will be limited in their motivation and ability to interact with the interviewer. The interviewer may be able to enhance communication by addressing the patient's discomfort in a supportive manner. However, the interviewer must also recognize times when the patient's discomfort necessitates a more limited interview.

The cognitive capacities of the patient

Patients who are demented, retarded, disorganized, thought-disordered, amnesic, aphasic, or otherwise impaired in intellectual or cognitive capacity have biologically based deficits which limit the amount of information they can convey.

The emotionally based biases of the patient

Patients bring to the interview a wide variety of preconceptions, expectations, and tendencies toward distortion, which influence how they view and relate to the interviewer. Such biases are commonly referred to as *transference* because they frequently can be understood as arising from interactions with important figures in childhood, such as parents, which then color perceptions of others during adult life. Transference biases may be positive or negative. Thus, even before the start of the interview, one patient may be primed to view the doctor as a wise and kindly healer, while another will be predisposed to see him or her as an exploitative charlatan. Clearly, such biases affect the amount of openness and trust which the patient brings to the interview and the quality of information he or she provides.

The emotionally based biases of the interviewer

The interviewer, like the patient, may have feelings stirred up by the interaction. The interviewer's emotional reactions to the patient can be an invaluable asset in assessment if he or she can be conscious of them and reflect on their causes. For example, an interviewer finds himself or herself becoming increasingly annoyed at a highly polite patient. On reflection, he realizes that the politeness serves to rebuff his attempts to establish a warmer, more spontaneous relationship and is a manifestation of the patient's underlying hostile attitude.

When the interviewer is unable to monitor and examine his or her emotional reactions, they are more likely to impede rather than enhance understanding of the patient. This is most likely to happen when emotional reactions are driven more by the interviewer's

Table 1-5 Mental Status Examination**Appearance**

Level of consciousness (alert, hypervigilant, somnolent, stuporous)
 Dress (casual, appropriate for weather, eccentric, careless, disheveled)
 Grooming (style of hair, degree of makeup, shaven/unshaven, clean, malodorous)
 Idiosyncrasies: tattoos (professional or amateur), prominent scars, religious emblems

Attitude

Cooperative, hostile, evasive, threatening, obsequious

Affect

Range (restricted, expansive, blunted, flat)
 Appropriateness to items discussed
 Stability (labile, shallow)
 Quality (silly, anxious)

Mood

Response to question: "How are you feeling/How's your mood been?"
 Behavior
 Psychomotor agitation or retardation

Speech

Rate (rapid, slowed, pressured, hard to interrupt)
 Volume (loud, soft, monotone, highly inflected or dramatic)
 Quality (neologisms, fluent, idiosyncratic)

Thought Process

Goal-directed, disorganized, loose associations, tangential, circumstantial, flight of ideas

Thought Content

Major preoccupations, ideas of reference, delusions (grandiose, paranoid, bizarre, state exactly what it is the patient appears to believe)
 Thought broadcasting, insertion, or withdrawal
 Suicidal or homicidal ideation. Plan and intent to carry out ideas

Perception

Illusions and hallucinations: type (auditory, visual, olfactory, tactile, gustatory), evidence (patient spontaneous report, answer to interviewer question, observation of patient attending or responding to nonexistent external stimuli)
 Patient's beliefs about hallucinatory phenomenon: (do they seem to originate from the outside or inside, how many voices, what gender, talking to patient or to other voices, are they keeping up constant commentary on the patient)

Cognition

Orientation: time, place, person, situation
 Memory: number of remembered objects, digit span, presidents backward, recent events
 Concentration: serial 7s, *world* spelled backwards
 Abstraction: proverb interpretation: what would someone mean by "The grass is always greener on the other side of the fence" ("Get off my back")
 Similarities: (How are these things alike: apple–orange, table–chair, eye–ear, praise–punishment?)
 Computation: number of digits successfully added or subtracted, ability to calculate change
 (How many quarters are in \$1.50? If you bought a loaf of bread for 89 cents and gave the cashier a dollar, what change would you get back?)

Insight

Knows something is wrong, that he/she is ill, that illness is psychiatric; understands ways in which illness disrupts function

Judgment

Response to standard questions (If you found a sealed, addressed, stamped letter, what would you do? If you smelled smoke in a crowded theater?)
 Evidence from behavior prior to and during interview (Was the patient caring for himself/herself properly, handling business affairs well?)
 Does the behavior during the interview match his/her stated goals—e.g., if he/she wishes to be thought to be in control, is he/she keeping the voice down and movement in check?)

own biases than by the patient's behavior. Such reactions are referred to as the interviewer's *countertransference*. In the example cited in the previous paragraph, the interviewer might inaccurately perceive a polite patient as rigid and hostile due to unconscious

biases (countertransference) based on his relationship with his own rigidly polite parent. The entire range of countertransference interviewer attitudes toward the patient, from aversion to infatuation, might similarly bias judgment.

Situational factors

Patients' attitudes toward the interview will be strongly influenced by the situation in which the consultation arises. Some patients decide for themselves that they need treatment, while others come reluctantly, under pressure from others. Patients who are being evaluated for disability or in connection with a lawsuit may feel a need to prove that they are ill, while those being evaluated for civil commitment or at the insistence of family members may need to prove that they are well. Similarly, a patient's past history of relationships with mental health professionals or with health care professionals in general is likely to color his or her attitude toward the interviewer.

The interviewer may also be affected by situational factors. For example, pressure of time in a busy emergency service may influence the interviewer to omit important areas of inquiry and reach premature closure; the experience of a recent patient suicide may bias the interviewer toward overestimation of risk in someone with suicidal thoughts. As with countertransference reactions, it is important for the interviewer to minimize distortions due to situational factors by being as aware of them as possible.

Racial, ethnic, and cultural factors

The degree of racial, ethnic, cultural, and socioeconomic similarity between the patient and interviewer can influence the course and outcome of the interview in many ways. It may affect the level of rapport between patient and interviewer, the way both view the demands of the situation, the way they interpret each other's verbal and nonverbal communications, and the meaning the interviewer assigns to the patient's statements and behaviors. Not only racial or cultural prejudice but also well-intentioned ignorance can interfere with communication and accurate assessment.

Some cultures, for example, place a higher value on politeness and respect for authority than does Western culture. A patient from such a background might be reluctant to correct or disagree with the interviewer's statements even when they are erroneous. The interviewer might not suspect that he or she was hearing distorted information or, conversely, might see the patient as pathologically inhibited or unemotional. Many non-Western cultures place a higher value on family solidarity than on individuality. Pressing a patient from such a culture to report angry feelings toward family members might raise his or her anxiety, decrease rapport with the interviewer, and produce defensive distortions in the material.

General features of psychiatric interviews

Setting

The ideal interview setting is one which provides a pleasant atmosphere and is reasonably comfortable, private, and free from outside distractions. Such a setting not only provides the physical necessities for an interview but also conveys to the patient that he or she will be well cared for and safe. Providing such a setting may pose special problems in certain interviewing situations. For example, it may be necessary to interview highly agitated patients in the presence of security personnel; interviewers on medical-surgical units must pay special attention to the patient's comfort and privacy.

Verbal communication

Verbal communication may be straightforward imparting of information: "Every year around November, I begin to lose interest in everything and my energy gets very low." However, patients may convey information indirectly through metaphor, or use words for noninformational purposes such as to express or contain emotions or to create an impact on the interviewer.

In metaphorical language, one idea is represented by another with which it shares some features. For example, when asked how she gets along with her daughter-in-law, a woman replies, "I can never visit their house because she always likes to keep the thermostat down. It's never as warm as I need." Such a reply suggests that the woman may not feel "warmly" accepted and welcomed by her son's wife. Metaphor may also use the body to represent ideas or feelings. A man who proved to meet the diagnostic criteria for major depressive disorder described his mood as "OK" but complained that his life was being ruined by constant aching in his chest for which the doctors could find no cause. In this instance, the pain of depression was experienced and described metaphorically as a somatic symptom.

Language may be used to express emotions directly ("I'm afraid of you and I don't want to talk to you"), but more often is used indirectly by influencing the process of the interview. Patients may shift topics, make off-hand remarks or jokes, ask questions, and compliment or belittle the interviewer as a way of expressing feelings. The process of the interview frequently expresses the patient's feelings about his or her immediate situation or interaction with the interviewer. For example, a woman being evaluated for depression and anxiety suddenly said, "I was just wondering doctor, do you have any children?" The further course of the interview revealed that she was terrified of being committed to a hospital

and abandoned. The question was an attempt to establish whether the interviewer was a good parent and therefore safe as a caretaker for her.

Language may also be used in the service of psychological defense mechanisms to contain rather than express emotions. For example, a young man with generalized anxiety was asked whether he was sexually active. He replied by talking at length about how all the women he knew at college were either unappealing or attached to other men. Further discussion revealed that he developed severe symptoms of anxiety whenever he was with a woman to whom he felt sexually attracted. His initial reply represented an automatic, verbal mechanism (in this case, a rationalization) for keeping the anxiety out of awareness.

Another form of process communication is the use of language to make an impact on the interviewer. A statement such as “If you can’t help me I’m going to kill myself” might convey suicidal intent, but may also serve to stir up feelings of concern and involvement in the interviewer. Similarly, the patient who says “Dr. X really understood me, but he was much older and more experienced than you are” may be feeling vulnerable and ashamed, and unconsciously trying to induce similar feelings in the interviewer. When language is used in this way, the interviewer’s subjective reaction may be the best clue to the underlying feelings and motivations of the patient.

Nonverbal communication

Emotions and attitudes are communicated nonverbally through facial expressions, gestures, body position, movements of the hands, arms, legs, and feet, interpersonal distance, dress and grooming, and speech prosody. Some nonverbal communications such as gestures are almost always conscious and deliberate, while others often occur automatically outside one’s awareness. The latter type are particularly important to observe during an interview because they may convey messages entirely separate from or even contradictory to what is being said.

Facial expression, body position, tone of voice, and speech emphasis are universal in the way they convey meaning. The interviewer will automatically decode these signals but may ignore the message due to countertransference or social pressure from the patient. For example, a patient may say, “I feel very comfortable with you, doctor,” but sit stiffly upright and maintain a rigidly fixed smile, conveying a strong nonverbal message of tension and mistrust. The nonverbal message may be missed if, for example, the interviewer has a strong need

to be liked by the patient. Another patient denies angry feelings while sitting with a tightly clenched fist. The interviewer may unconsciously collude with the patient’s need to avoid his anger by ignoring the body language.

As with any medical examination, observation of nonverbal behavior may provide important diagnostic information. For example, a leaden body posture may indicate depression, movements of the foot may arise from anxiety or tardive dyskinesia, and sudden turning of the head and eyes may suggest hallucinations.

Nonverbal communication proceeds in both directions, and the nonverbal messages of the interviewer are likely to have a considerable effect on the patient. Thus, the interviewer who sits back in his chair and looks down at his notes communicates less interest and involvement than one who sits upright and makes eye contact. Similarly, an interviewer who gives a weak handshake and sits behind a desk or far across the room from the patient will communicate a sense of distance, which may interfere with establishing rapport. It is important that the interviewer be aware of his or her own nonverbal messages and adapt them to the needs of the patient.

Listening and observation

The complexity of communication in the psychiatric interview is mirrored by the complexity of listening. The interviewer must remain open to literal and metaphorical messages from the patient, to the impact the patient is trying to make, and to the degree to which nonverbal communication complements or contradicts what is being said. Doing this optimally requires that the interviewer also be able to listen to his/her own mental processes throughout the interview, including both thoughts and emotional reactions. Listening of this kind depends upon having a certain level of comfort, confidence, and space to reflect, and may be very difficult when the patient is hostile, agitated, demanding, or putting pressure on the interviewer in any other way. With such patients, it may take many interviews to do enough good listening to gain an adequate understanding of the case.

Another important issue in listening is maintaining a proper balance between forming judgments and remaining open to new information and new hypotheses. On the one hand, one approaches the interview with knowledge of diagnostic classifications, psychological mechanisms, behavioral patterns, social forces, and other factors which shape one’s understanding of the patient. The interviewer hears the material with an ear to fitting the information into these preformed patterns and

categories. On the other hand, the interviewer must remain open to hearing and seeing things which extend or modify his/her judgments about the patient. At times the interviewer may listen narrowly to confirm a hypothesis, while at others he/she may listen more openly, with relatively little preconception. Thus, listening must be structured enough to generate a formulation but open enough to avoid premature judgments.

Attitude and behavior of the interviewer

The optimal attitude of the interviewer is one of interest, concern, and intention to help the patient. While the interviewer must be tactful and thoughtful about what he/she says, this should not preclude behaving with natural warmth and spontaneity. Indeed, these qualities may be needed to support patients through a stressful interview process. Similarly, the interviewer must try to use natural, commonly understood language and avoid jargon or technical terms. The interviewer must communicate his/her intention to keep the patient as safe as possible, whatever the circumstances. Thus, while one must at times set limits on the behavior of an agitated, threatening, or abusive patient, one should never be attacking or rejecting.

Empathy is an important quality in psychiatric interviewing. While sympathy is an expression of agreement or support for another, empathy entails putting oneself in another's place and experiencing his/her state of mind. Empathy comprises both one's experiencing of another person's mental state and the expression of that understanding to the other person. For example, in listening to a man talk about the death of his wife, the interviewer may allow himself to resonate empathetically with the patient's feelings of loneliness and desolation. Based on this resonance, he might respond, "After a loss like that, it feels as if the world is completely empty."

As a mode of listening, empathy is an important way of understanding the patient; as a mode of response, it is important in building rapport and alliance. Patients who feel great emotional distance from the interviewer may make empathic understanding difficult or impossible. Thus, the interviewer's inability to empathize may itself be a clue to the patient's state of mind.

Structure of the interview

The overall structure of the psychiatric interview is generally one of reconnaissance and detailed inquiry. In reconnaissance phases, the interviewer inquires about broad areas of symptomatology, functioning, or life course: "Have you ever had long periods when you felt

very low in mood?" "How have you been getting along at work?" "Tell me what you did between high school and when you got married." In responding to such questions, patients give the interviewer leads which then must be pursued with more detailed questioning. Leads may include references to symptoms, difficulty in functioning, interpersonal problems, ideas, states of feeling, or stressful life events. Each such lead raises questions about the nature of the underlying problem, and the interviewer must attempt to gather enough detailed information to answer these questions. Reliance on yes or no "gate questions" to rule out areas of pathology has been shown to increase the risk of missing important information. This risk may be minimized by asking about important areas in several ways.

In general, the initial reconnaissance consists of asking how the patient comes to treatment at this particular time. This is done by asking an open-ended question such as "What brings you to see me today?" or "How did you come to be in the hospital right now?" A well-organized and cooperative patient may spontaneously provide most of the needed information, with little intervention from the interviewer. However, the patient may reveal deficits in thought process, memory, or ability to communicate, which dictate more structured and narrowly focused questioning.

The patient's emotional state and attitude may also impede a smooth flow of information. For example, if the patient shows evidence of anxiety, hostility, suspiciousness, or indifference, the interviewer must first build a working alliance before trying to collect information. This usually requires acknowledging the emotions which the patient presents, helping the patient to express his or her feelings and related thoughts, and discussing these concerns in an accepting and empathic manner. As new areas of content open up, the interviewer must continue to attend to the patient's reactions, both verbal and nonverbal, and to identify and address resistance to open communication.

Setting an appropriate level of structure is an important aspect of psychiatric interviewing. Patients may spontaneously report a low number of symptoms, and initial diagnostic impressions may be misleading. Over the past two decades, a variety of structured interview formats have been developed for psychiatric assessment. In these interviews, the organization, content areas, and, to varying degrees, wording of the questions are standardized; vague, overly complex, leading or biased, and judgmental questions are eliminated, as is variability in the attention given to different areas of content. The major benefits of such interviews are that they ensure complete coverage of the specified areas and greatly

increase the reliability of information gathered and diagnostic judgments. In addition, formats which completely specify the wording of questions can be administered by less highly trained interviewers or even as patient self-reports.

The disadvantages of highly structured interviews are that they diminish the ability to respond flexibly to the patient and preclude exploration of any areas not specified in the format. They are therefore used to best advantage for interviews with focused goals. For example, such interviews may aim to survey certain DSM-IV Axis I disorders, to assess the type and degree of substance abuse, or to delineate the psychological and behavioral consequences of a traumatic event. They are less useful in a general psychiatric assessment where the scope and focus of the interview cannot be preordained.

In the usual clinical situation, while the interviewer may have a standardized general plan of approach, he or she must adapt the degree of structure to the individual patient. Open-ended, nondirective questions derive from the psychoanalytic tradition. They are most useful for eliciting and following emotionally salient themes in the patient's life story and interpersonal history. Focused, highly structured questioning derives from the medical/descriptive tradition and is most useful for delineating the scope and evolution of pathological signs and symptoms. In general, one uses the least amount of structure needed to maintain a good flow of communication and cover the necessary topic areas.

Phases of the interview

The typical interview comprises an opening, middle, and closing phase. In the opening phase, the interviewer and patient are introduced, and the purposes and procedures of the interview are set. It is generally useful for the interviewer to begin by summarizing what he/she already knows about the patient and proceeding to the patient's own account of the situation. For example, the interviewer may say, "Dr. Smith has told me that you have had several episodes of depression in the past, and now you may be going into another one" or "I understand that you were brought in by the police because you were threatening people on the street. What do you think is happening with you?" or "When we spoke on the phone you said you thought your marriage was in trouble. What has been going wrong?" Such an approach orients the patient and sets a collaborative tone.

The opening phase may also include clarification of what the patient hopes to get from the consultation. Patients may sometimes state this explicitly, but often do

not, and the interviewer should not assume that his/her goals are the same as the patient's. A question such as "How were you hoping I could help you with the problem you have told me about?" invites the patient to formulate and express his/her request and avoids situations in which the patient and interviewer work at cross-purposes. The interviewer must also be explicit about his/her own goals and the extent to which they fit with the patient's expectations. This is especially important when the interests of a third party, such as an employer, a family member, or a court of law, are involved.

The middle phase of the interview consists of assessing the major issues in the case and filling in enough detail to answer the salient questions and construct a working formulation. Most of the work of determining the relative importance of biological, psychological, environmental, and sociocultural contributions to the problem is done during this phase. The patient's attitudes and transferential perceptions are also monitored during this phase so that the interviewer can recognize and address barriers to communication and collaboration.

When appropriate, formal aspects of the Mental Status Examination are performed during the middle phase of the interview. While most of the mental status evaluation is accomplished simply by observing the patient, certain components such as cognitive testing and review of psychotic symptoms may not fit smoothly into the rest of the interview. These are generally best covered toward the end of the interview, after the issues of greatest importance to the patient have been discussed and rapport has been established. A brief explanation that the interviewer has a few standard questions he/she needs to cover before the end of the interview serves as a bridge and minimizes the awkwardness of asking questions which may seem incongruous or pejorative.

In general, note-taking during an assessment interview is helpful to the interviewer and not disruptive of rapport with the patient. Notes should be limited to the brief recording of factual material such as dates, durations, symptom lists, important events, and past treatments, which might be difficult to keep in memory accurately. The interviewer must take care not to become so involved in taking notes as to lose touch with the patient. It is especially important to maintain a posture of attentive listening when the patient is talking about emotionally intense or meaningful issues. When done with interpersonal sensitivity, note-taking during an assessment interview may actually enhance rapport by communicating that what the patient says is important and worth remembering. This is to be distinguished from

note-taking during psychotherapy sessions, which is more likely to diminish the treater's ability to listen and respond flexibly.

In the third or closing phase of the interview, the interviewer shares his or her conclusions with the patient, makes treatment recommendations, and elicits reactions. In situations where the assessment runs longer than one session, the interviewer may sum up what has been covered in the interview and what needs to be done in subsequent sessions. Communications of this kind serve several purposes. They allow the patient to correct

or add to the salient facts as understood by the interviewer. They contribute to the patient's feeling of having gotten something from the interview. They are also the first step in initiating the treatment process because they present a provisional understanding of the problem and a plan for dealing with it. All treatment plans must be negotiated with the patient, including discussion of mutual goals, expected benefits, liabilities, limitations, and alternatives, if any. In many cases, such negotiations extend beyond the initial interview and may constitute the first phase of treatment.

