01 - 5.1 Psychiatric Interview, History, and Menta

5.1 Psychiatric Interview, History, and Mental Status Examination

Examination and Diagnosis of the Psychiatric Patient 5.1 Psychiatric Interview, History, and Mental Status Examination The psychiatric interview is the most important element in the evaluation and care of persons with mental illness. A major purpose of the initial psychiatric interview is to obtain information that will establish a criteria-based diagnosis. This process, helpful in the prediction of the course of the illness and the prognosis, leads to treatment decisions. A well-conducted psychiatric interview results in a multidimensional understanding of the biopsychosocial elements of the disorder and provides the information necessary for the psychiatrist, in collaboration with the patient, to develop a person-centered treatment plan. Equally important, the interview itself is often an essential part of the treatment process. From the very first moments of the encounter, the interview shapes the nature of the patient–physician relationship, which can have a profound influence on the outcome of treatment. The settings in which the psychiatric interview takes place include psychiatric inpatient units, medical nonpsychiatric inpatient units, emergency rooms, outpatient offices, nursing homes, other residential programs, and correctional facilities. The length of time for the interview, and its focus, will vary depending on the setting, the specific purpose of interview, and other factors (including concurrent competing demands for professional services). Nevertheless, there are basic principles and techniques that are important for all psychiatric interviews, and these will be the focus of this section. There are special issues in the evaluation of children that will not be addressed. This section focuses on the psychiatric interview of adult patients. GENERAL PRINCIPLES Agreement as to Process At the beginning of the interview the psychiatrist should introduce himself or herself and, depending on the circumstances, may need to identify why he or she is speaking with the patient. Unless implicit (the patient coming to the

office), consent to proceed with the interview should be obtained and the nature of the interaction and the approximate (or specific) amount of time for the interview should be stated. The patient

should be encouraged to identify any elements of the process that he or she wishes to alter or add. A crucial issue is whether the patient is, directly or indirectly, seeking the evaluation on a voluntary basis or has been brought involuntarily for the assessment. This should be established before the interview begins, and this information will guide the interviewer especially in the early stages of the process. Privacy and Confidentiality Issues concerning confidentiality are crucial in the evaluation/treatment process and may need to be discussed on multiple occasions. Health Insurance Portability and Accountability Act (HIPAA) regulations must be carefully followed, and the appropriate paperwork must be presented to the patient. Confidentiality is an essential component of the patient–doctor relationship. The interviewer should make every attempt to ensure that the content of the interview cannot be overheard by others. Sometimes, in a hospital unit or other institutional setting, this may be difficult. If the patient is sharing a room with others, an attempt should be made to use a different room for the interview. If this is not feasible, the interviewer may need to avoid certain topics or indicate that these issues can be discussed later when privacy can be ensured. Generally, at the beginning, the interviewer should indicate that the content of the session(s) will remain confidential except for what needs to be shared with the referring physician or treatment team. Some evaluations, including forensic and disability evaluations, are less confidential and what is discussed may be shared with others. In those cases, the interviewer should be explicit in stating that the session is not confidential and identify who will receive a report of the evaluation. This information should be carefully and fully documented in the patient's record. A special issue concerning confidentiality is when the patient indicates that he or she intends to harm another person. When the psychiatrist's evaluation suggests that this might indeed happen, the psychiatrist may have a legal obligation to warn the potential victim. (The law concerning notification of a potential victim varies by state.) Psychiatrists should also consider their ethical obligations. Part of this obligation may be met by appropriate clinical measures such as increasing the dose of antipsychotic medication or hospitalizing the patient. Often members of the patient's family, including spouse, adult children, or parents, come with the patient to the first session or are present in the hospital or other institutional setting when the psychiatrist first sees the patient. If a family member wishes to talk to the psychiatrist, it is generally preferable to meet with the family member(s) and the patient together at the conclusion of the session and after the patient's consent has been obtained. The psychiatrist should not bring up material the patient has shared but listen to the input from family members and discuss items that the patient introduces during the joint session. Occasionally, when family members have not asked to be seen, the psychiatrist may feel that including a family member or

caregiver might be helpful and raise this subject with the patient. This may be the case when the patient is not able to communicate effectively. As always, the patient must give consent except if the psychiatrist determines that the patient is a danger to himself or herself or others. Sometimes family members might telephone the psychiatrist. Except in an emergency, consent should be obtained from the patient before the psychiatrist speaks to the relative. As indicated above, the psychiatrist should not bring up material that the patient has shared but listen to the input from the family member. The patient should be told when a family member has contacted the psychiatrist even if the patient has given consent for this to occur. In educational and, occasionally, forensic settings, there may be occasions when the session is recorded. The patient must be fully

informed about the recording and how the recording will be used. The length of time the recording will be kept and how access to it will be restricted must be discussed. Occasionally in educational settings, one-way mirrors may be used as a tool to allow trainees to benefit from the observation of an interview. The patient should be informed of the use of the one-way mirror and the category of the observers and be reassured that the observers are also bound by the rules of confidentiality. The patient's consent for proceeding with the recording or use of the one-way mirror must be obtained, and it should be made clear that the patient's receiving care will not be determined by whether he or she agrees to its use. These devices will have an impact on the interview that the psychiatrist should be open to discussing as the session unfolds. Respect and Consideration As should happen in all clinical settings, the patient must be treated with respect, and the interviewer should be considerate of the circumstances of the patient's condition. The patient is often experiencing considerable pain or other distress and frequently is feeling vulnerable and uncertain of what may happen. Because of the stigma of mental illness and misconceptions about psychiatry, the patient may be especially concerned, or even frightened, about seeing a psychiatrist. The skilled psychiatrist is aware of these potential issues and interacts in a manner to decrease, or at least not increase, the distress. The success of the initial interview will often depend on the physician's ability to allay excessive anxiety. Rapport/Empathy Respect for and consideration of the patient will contribute to the development of rapport. In the clinical setting, rapport can be defined as the harmonious responsiveness of the physician to the patient and the patient to the physician. It is important that patients increasingly feel that the evaluation is a joint effort and that the psychiatrist is truly interested in their story. Empathic interventions ("That must have been very difficult for you" or "I'm beginning to understand how awful that felt") further increase the rapport. Frequently a nonverbal response (raised eyebrows or leaning toward the patient) or a very brief response ("Wow") will be similarly effective. Empathy is understanding what

the patient is thinking and feeling and it occurs when the psychiatrist is able to put himself or herself in the patient's place while at the same time maintaining objectivity. For the psychiatrist to truly understand what the patient is thinking and feeling requires an appreciation of many issues in the patient's life. As the interview progresses, the patient's story unfolds and patterns of behaviors become evident, and it becomes clearer what the patient may actually have experienced. Early in the interview, the psychiatrist may not be as fully confident of where the patient is or was (although the patient's nonverbal cues can be very helpful). If the psychiatrist is uncertain about the patient's experience, it is often best not to guess but to encourage the patient to continue. Head nodding, putting down one's pen, leaning toward the patient, or a brief comment, "I see," can accomplish this objective and simultaneously indicate that this is important material. In fact the large majority of empathic responses in an interview are nonverbal. An essential ingredient in empathy is retaining objectivity. Maintaining objectivity is crucial in a therapeutic relationship and it differentiates empathy from identification. With identification, psychiatrists not only understand the emotion but also experience it to the extent that they lose the ability to be objective. This blurring of boundaries between the patient and psychiatrist can be confusing and distressing to many patients, especially to those who as part of their illness already have significant boundary problems (e.g., individuals with borderline personality disorder). Identification can also be draining to the psychiatrist and lead to disengagement and ultimately burnout. Patient–Physician Relationship The patient–physician relationship is the core of the practice of medicine. (For many years the term used was "physician–patient" or "doctor–patient," but the order is sometimes reversed to reinforce that the treatment should always be patient centered.) Although the

relationship between any one patient and physician will vary depending on each of their personalities and past experiences as well as the setting and purpose of the encounter, there are general principles that, when followed, help to ensure that the relationship established is helpful. The patient comes to the interview seeking help. Even in those instances when the patient comes on the insistence of others (i.e., spouse, family, courts), help may be sought by the patient in dealing with the person requesting or requiring the evaluation or treatment. This desire for help motivates the patient to share with a stranger information and feelings that are distressing, personal, and often private. The patient is willing, to various degrees, to do so because of a belief that the doctor has the expertise, by virtue of training and experience, to be of help. Right from the very first encounter (sometimes the initial phone call), the patient's willingness to share is increased or decreased depending on the verbal and often the nonverbal interventions of the physician and other staff. As the physician's behaviors demonstrate respect and consideration, rapport begins to develop. This is increased as the patient feels safe and comfortable. If the patient feels secure that what is said in the interview remains

confidential, he or she will be more open to sharing. The sharing is reinforced by the nonjudgmental attitude and behavior of the physician. The patient may have been exposed to considerable negative responses, actual or feared, to their symptoms or behaviors, including criticism, disdain, belittlement, anger, or violence. Being able to share thoughts and feelings with a nonjudgmental listener is generally a positive experience. There are two additional essential ingredients in a helpful patient–physician relationship. One is the demonstration by physicians that they understand what the patient is stating and emoting. It is not enough that the physician understands what the patient is relating, thinking, and feeling; this understanding must be conveyed to the patient if it is to nurture the therapeutic relationship. The interview is not just an intellectual exercise to arrive at a supportable diagnosis. The other essential ingredient in a helpful patient–physician relationship is the recognition by the patient that the physician cares. As the patient becomes aware that the physician not only understand but also cares, trust increases and the therapeutic alliance becomes stronger. The patient–physician relationship is reinforced by the genuineness of the physician. Being able to laugh in response to a humorous comment, admit a mistake, or apologize for an error that inconvenienced the patient (e.g., being late for or missing an appointment) strengthens the therapeutic alliance. It is also important to be flexible in the interview and responsive to patient initiatives. If the patient brings in an item, for example, a photo that he or she wants to show the psychiatrist, it is good to look at it, ask questions, and thank the patient for sharing it. Much can be learned about the family history and dynamics from such a seemingly sidebar moment. In addition, the therapeutic alliance is strengthened. The psychiatrist should be mindful of the reality that there are no irrelevant moments in the interview room. At times patients will ask questions about the psychiatrist. A good rule of thumb is that questions about the physician's qualifications and position should generally be answered directly (e.g., board certification, hospital privileges). On occasion, such a question might actually be a sarcastic comment ("Did you really go to medical school?"). In this case it would be better to address the issue that provoked the comment rather than respond concretely. There is no easy answer to the question of how the psychiatrist should respond to personal questions ("Are you married?," "Do you have children?," "Do you watch football?"). Advice on how to respond will vary depending on several issues, including the type of psychotherapy being used or considered, the context in which the question is asked, and the wishes of the psychiatrist. Often, especially if the patient is being, or might be, seen for insight-oriented psychotherapy, it is useful to explore why the question is being

asked. The question about children may be precipitated by the patient wondering if the psychiatrist has had personal experience in raising children, or more generally does the psychiatrist have the skills and experience necessary to meet the patient's needs. In this instance, part of the psychiatrist's response may be that he or she has had considerable experiences in helping people deal with issues of parenting. For patients being seen for supportive psychotherapy or medication management, answering the question, especially if it is not very personal, such as "Do you watch

football?," is quite appropriate. A major reason for not answering personal questions directly is that the interview may become psychiatrist centered rather than patient centered. Occasionally, again depending on the nature of the treatment, it can be helpful for the psychiatrist to share some personal information even if it is not asked directly by the patient. The purpose of the self-revelation should always be to strengthen the therapeutic alliance to be helpful to the patient. Personal information should not be shared to meet the psychiatrist's needs. Conscious/Unconscious In order to understand more fully the patient–physician relationship, unconscious processes must be considered. The reality is that the majority of mental activity remains outside of conscious awareness. In the interview, unconscious processes may be suggested by tangential references to an issue, slips of the tongue or mannerisms of speech, what is not said or avoided, and other defense mechanisms. For example, phrases such as "to tell you the truth" or "to speak frankly" suggest that the speaker does not usually tell the truth or speak frankly. In the initial interview it is best to note such mannerisms or slips but not to explore them. It may or may not be helpful to pursue them in subsequent sessions. In the interview, transference and countertransference are very significant expressions of unconscious processes. Transference is the process of the patient unconsciously and inappropriately displacing onto individuals in his or her current life those patterns of behavior and emotional reactions that originated with significant figures from earlier in life, often childhood. In the clinical situation the displacement is onto the psychiatrist, who is often an authority figure or a parent surrogate. It is important that the psychiatrist recognizes that the transference may be driving the behaviors of the patient, and the interactions with the psychiatrist may be based on distortions that have their origins much earlier in life. The patient may be angry, hostile, demanding, or obsequious not because of the reality of the relationship with the psychiatrist but because of former relationships and patterns of behaviors. Failure to recognize this process can lead to the psychiatrist inappropriately reacting to the patient's behavior as if it were a personal attack on the psychiatrist. Similarly, countertransference is the process where the physician unconsciously displaces onto the patient patterns of behaviors or emotional reactions as if he or she were a significant figure from earlier in the physician's life. Psychiatrists should be alert to signs of countertransference issues (missed appointment by the psychiatrist, boredom, or sleepiness in a session). Supervision or consultations can be helpful as can personal therapy in helping the psychiatrist recognize and deal with these issues. Although the patient comes for help, there may be forces that impede the movement to health. Resistances are the processes, conscious or unconscious, that interfere with the therapeutic objectives of treatment. The patient is generally unaware of the impact of these feelings, thinking, or behaviors, which take many different forms including exaggerated emotional responses, intellectualization, generalization, missed

appointments, or acting out behaviors. Resistance may be fueled by repression, which is an unconscious process that keeps issues or feelings out of awareness. Because of repression, patients may not be aware of the conflicts that may be central to their illness. In insight-oriented

psychotherapy, interpretations are interventions that undo the process of repression and allow the unconscious thoughts and feelings to come to awareness so that they can be dealt with. As a result of these interventions, the primary gain of the symptom, the unconscious purpose that it serves, may become clear. In the initial session, interpretations are generally avoided. The psychiatrist should make note of potential areas for exploration in subsequent sessions. Person-Centered and Disorder-Based Interviews A psychiatric interview should be person (patient) centered. That is, the focus should be on understanding the patient and enabling the patient to tell his or her story. The individuality of the patient's experience is a central theme, and the patient's life history is elicited, subject to the constraints of time, the patient's willingness to share some of this material, and the skill of the interviewer. Adolf Meyer's "life-charts" were graphic representations of the material collected in this endeavor and were a core component of the "psychobiological" understanding of illness. The patient's early life experiences, family, education, occupation(s), religious beliefs and practices, hobbies, talents, relationships, and losses are some of the areas that, in concert with genetic and biological variables, contribute to the development of the personality. An appreciation of these experiences and their impact on the person is necessary in forming an understanding of the patient. It is not only the history that should be person centered. It is especially important that the resulting treatment plan be based on the patient's goals, not the psychiatrist's. Numerous studies have demonstrated that often the patient's goals for treatment (e.g., safe housing) are not the same as the psychiatrist's (e.g., decrease in hallucinations). This dichotomy can often be traced to the interview where the focus was not sufficiently person centered but rather was exclusively or largely symptom based. Even when the interviewer specifically asks about the patient's goals and aspirations, the patient, having been exposed on numerous occasions to what a professional is interested in hearing about, may attempt to focus on "acceptable" or "expected" goals rather than his or her own goals. The patient should be explicitly encouraged to identify his or her goals and aspirations in his or her own words. Traditionally, medicine has focused on illness and deficits rather than strengths and assets. A person-centered approach focuses on strengths and assets as well as deficits. During the assessment, it is often helpful to ask the patient, "Tell me about some of the things you do best," or, "What do you consider your greatest asset?" A more open-ended question, such as, "Tell me about yourself," may elicit information that focuses more on either strengths or deficits depending on a number of factors including the patient's mood and self-image. Safety and Comfort

Both the patient and the interviewer must feel safe. This includes physical safety. On occasion, especially in hospital or emergency room settings, this may require that other staff be present or that the door to the room where the interview is conducted be left ajar. In emergency room settings, it is generally advisable for the interviewer to have a clear, unencumbered exit path. Patients, especially if psychotic or confused, may feel threatened and need to be reassured that they are safe and the staff will do everything possible to ensure their safety. Sometimes it is useful to explicitly state, and sometimes demonstrate, that there are sufficient staff to prevent a situation from spiraling out of control. For some, often psychotic patients who are fearful of losing control, this can be reassuring. The interview may need to be shortened or quickly terminated if the patient becomes more agitated and threatening. Once issues of safety have been assessed (and for many outpatients this may be accomplished within a few seconds), the interviewer should inquire about the patient's comfort and continue to be alert to the patient's comfort throughout the interview. A direct question may be helpful in not only making the patient feel more comfortable but also in enhancing the patient–doctor relationship. This might include, "Are you warm enough?" or "Is that

chair comfortable for you?” As the interview progresses, if the patient desires tissues or water it should be provided. Time and Number of Sessions For an initial interview, 45 to 90 minutes is generally allotted. For inpatients on a medical unit or at times for patients who are confused, in considerable distress, or psychotic, the length of time that can be tolerated in one sitting may be 20 to 30 minutes or less. In those instances, a number of brief sessions may be necessary. Even for patients who can tolerate longer sessions, more than one session may be necessary to complete an evaluation. The clinician must accept the reality that the history obtained is never complete or fully accurate. An interview is dynamic and some aspects of the evaluation are ongoing, such as how a patient responds to exploration and consideration of new material that emerges. If the patient is coming for treatment, as the initial interview progresses, the psychiatrist makes decisions about what can be continued in subsequent sessions. PROCESS OF THE INTERVIEW Before the Interview For outpatients, the first contact with the psychiatrist office is often a telephone call. It is important that whomever is receiving the call understands how to respond if the patient is acutely distressed, confused, or expresses suicidal or homicidal intent. If the receiver of the call is not a mental health professional, the call should be transferred to the psychiatrist or other mental health professional, if available. If not available, the caller should be directed to a psychiatric emergency center or an emergency hotline. The receiver of the call should obtain the name and phone number of the caller and offer to initiate the call to the hotline if that is preferred by the caller.

Most calls are not of such an urgent nature. The receptionist (or whomever receives the call) should obtain the information that setting has deemed relevant for the first contact. Although the requested information varies considerably, it generally includes the name, age, address and telephone number(s) of the patient, who referred the patient, the reason for the referral, and insurance information. The patient is given relevant information about the office including length of time for the initial session, fees, and whom to call if there are additional questions. In many practices the psychiatrist will call the patient to discuss the reason for the appointment and to determine if indeed an appointment appears warranted. The timing of the appointment should reflect the apparent urgency of the problem. Asking the patient to bring information about past psychiatric and medical treatments as well as a list of medications (or preferably the medications themselves) can be very helpful. Frequently a patient is referred to the psychiatrist or a psychiatric facility. If possible, reviewing records that precede the patient can be quite helpful. Some psychiatrists prefer not to read records prior to the initial interview so that their initial view of the patient’s problems will not be unduly influenced by prior evaluations. Whether or not records are reviewed, it is important that the reason for the referral be understood as clearly as possible. This is especially important for forensic evaluations where the reason for the referral and the question(s) posed will help to shape the evaluation. Often, especially in the outpatient setting, a patient is referred to the psychiatrist by a primary care physician or other health care provider. Although not always feasible, communicating with the referring professional prior to the evaluation can be very helpful. It is critical to determine whether the patient is referred for only an evaluation with the ongoing treatment to be provided by the primary care physician or mental health provider (e.g., social worker) or if the patient is being referred for evaluation and treatment by the psychiatrist. If the patient is referred by the court, a lawyer, or some other non–treatment-oriented agency such as an insurance company, the goals of the interview may be different from diagnosis and treatment recommendations. These goals can include determination of disability, questions of competence or capacity, or determining, if possible, the cause or contributors of the psychiatric

illness. In these special circumstances, the patient and clinician are not entering a treatment relationship, and often the usual rules of confidentiality do not apply. This limited confidentiality must be explicitly established with the patient and must include a discussion of who will be receiving the information gathered during the interview. The Waiting Room When the patient arrives for the initial appointment, he or she is often given forms to complete. These generally include demographic and insurance information. In addition, the patient receives information about the practice (including contact information for evenings and weekends) and HIPAA-mandated information that must be read and signed. Many practices also ask for a list of medications, the name and address of the

primary care physician, and identification of major medical problems and allergies. Sometimes the patient is asked what his or her major reason is for coming to the office. Increasingly, some psychiatrists ask the patient to fill out a questionnaire or a rating scale that identifies major symptoms. Such scales include the Patient Health Questionnaire 9 (PHQ-9) or the Quick Inventory of Depression Symptomatology Self Report (QIDS-SR), which are scales of depressive symptoms based on the Diagnostic and Statistical Manual of Mental Diseases (DSM). The Interview Room The interview room itself should be relatively soundproof. The decor should be pleasant and not distracting. If feasible, it is a good idea to give the patient the choice of a soft chair or a hard-back chair. Sometimes the choice of the chair or how the chair is chosen can reveal characteristics of the patient. Many psychiatrists suggest that the interviewer’s chair and the patient’s chair be of relatively equal height so that the interviewer does not tower over the patient (or vice versa). It is generally agreed that the patient and the psychiatrist should be seated approximately 4 to 6 feet apart. The psychiatrist should not be seated behind a desk. The psychiatrist should dress professionally and be well groomed. Distractions should be kept to a minimum. Unless there is an urgent matter, there should be no telephone or beeper interruptions during the interview. The patient should feel that the time has been set aside just for him or her and that for this designated time he or she is the exclusive focus of the psychiatrist’s attention. Initiation of the Interview The patient is greeted in the waiting room by the psychiatrist who, with a friendly face, introduces himself or herself, extends a hand, and, if the patient reciprocates, gives a firm handshake. If the patient does not extend his or her hand, it is probably best not to comment at that point but warmly indicate the way to the interview room. The refusal to shake hands is probably an important issue, and the psychiatrist can keep this in mind for a potential inquiry if it is not brought up subsequently by the patient. Upon entering the interview room, if the patient has a coat, the psychiatrist can offer to take the coat and hang it up. The psychiatrist then indicates where the patient can sit. A brief pause can be helpful as there may be something the patient wants to say immediately. If not, the psychiatrist can inquire if the patient prefers to be called Mr. Smith, Thomas, or Tom. If this question is not asked, it is best to use the last name as some patients will find it presumptive to be called by their first name especially if the interviewer is many years younger. These first few minutes of the encounter, even before the formal interview begins, can be crucial to the success of the interview and the development of a helpful patient–doctor relationship. The patient, who is often anxious, forms an initial impression of the psychiatrist and begins to make decisions as to how much can be shared with this doctor. Psychiatrists can convey interest and support by exhibiting a warm, friendly face and other nonverbal communications such as leaning forward in

their chair. It is generally useful for the psychiatrist to indicate how much time is available for the interview. The patient may have some questions about what will happen during this time, confidentiality, and other issues, and these questions should be answered directly by the psychiatrist. The psychiatrist can then continue with an openended inquiry, “Why don’t we start by you telling me what has led to your being here,” or simply, “What has led to your being here?” Often the response to this question will establish whether or not the patient has been referred. When a referral has been made, it is important to elicit from the patient his or her understanding of why he or she has been referred. Not uncommonly, the patient may be uncertain as to why he or she has been referred or may even feel angry at the referrer, often a primary care physician. Open-Ended Questions As the patient responds to these initial questions, it is very important that the psychiatrist interacts in a manner that allows the patient to tell his or her story. This is the primary goal of the data collection part of the interview, to elicit the patient’s story of his or her health and illness. In order to accomplish this objective, open-ended questions are a necessity. Open-ended questions identify an area but provide minimal structure as to how to respond. A typical open-ended question is, “Tell me about your pain.” This is in contrast to closed-ended questions that provide much structure and narrow the field from which a response may be chosen. “Is your pain sharp?” The ultimate closed-ended question leads to a “yes” or “no” answer. In the initial portion of the interview questions should be primarily open ended. As the patient responds, the psychiatrist reinforces the patient continuing by nodding or other supportive interventions. As the patient continues to share his or her story about an aspect of his or her health or illness, the psychiatrist may ask some increasingly closed-ended questions to understand some of the specifics of the history. Then, when that area is understood, the psychiatrist may make a transition to another area again using open-ended questions and eventually closed-ended questions until that area is well described. Hence, the interview should not be a single funnel of open-ended questions in the beginning and closed-ended questions at the end of the interview but rather a series of funnels, each of which begins with open-ended questions. ELEMENTS OF THE INITIAL PSYCHIATRIC INTERVIEW The interview is now well launched into the present illness. Table 5.1-1 lists the sections or parts of the initial psychiatric interview. Although not necessarily obtained during the interview in exactly this order, these are the categories that conventionally have been used to organize and record the elements of the evaluation. Table 5.1-1 Parts of the Initial Psychiatric Interview

The two overarching elements of the psychiatric interview are the patient history and the mental status examination. The patient history is based on the subjective report of the patient and in some cases the report of collaterals including other health care providers, family, and other caregivers. The mental status examination, on the other hand, is the interviewer’s objective tool similar to the physical examination in other areas of medicine. The physical examination, although not part of the interview itself, is included because of its potential relevance in the psychiatric diagnosis and also because it usually is included as part of the psychiatric evaluation especially in the inpatient setting. (In addition, much relevant information can be verbally obtained by the physician as parts of the physical examination are performed.) Similarly, the formulation, diagnosis, and treatment plan are included because they are products of the interview and also influence the course of the interview in a dynamic fashion as the interview moves back and forth pursuing, for example, whether certain diagnostic criteria are met or whether potential elements of the treatment plan are realistic. Details of the psychiatric interview are discussed below. I. Identifying Data This section is brief, one or two sentences, and typically includes the patient’s name, age, sex, marital status (or significant other relationship), race or ethnicity, and occupation. Often the referral source is also

included. II. Source and Reliability It is important to clarify where the information has come from, especially if others have provided information or records reviewed, and the interviewer's assessment of how reliable the data are. III. Chief Complaint This should be the patient's presenting complaint, ideally in his or her own words. Examples include, "I'm depressed" or "I have a lot of anxiety."

A 64-year-old man presented in a psychiatric emergency room with a chief complaint, "I'm melting away like a snowball." He had become increasingly depressed over 3 months. Four weeks before the emergency room visit, he had seen his primary care physician who had increased his antidepressant medication (imipramine) from 25 to 75 mg and also added hydrochlorothiazide (50 mg) because of mild hypertension and slight pedal edema. Over the ensuing 4 weeks, the patient's condition deteriorated. In the emergency room he was noted to have depressed mood, hopelessness, weakness, significant weight loss, and psychomotor retardation and was described as appearing "depleted." He also appeared dehydrated, and blood work indicated he was hypokalemic. Examination of his medication revealed that the medication bottles had been mislabeled; he was taking 25 mg of imipramine (generally a nontherapeutic dose) and 150 mg of hydrochlorothiazide. He was indeed, "melting away like a snowball." Fluid and potassium replacement and a therapeutic dose of an antidepressant resulted in significant improvement. IV. History of Present Illness The present illness is a chronological description of the evolution of the symptoms of the current episode. In addition, the account should also include any other changes that have occurred during this same time period in the patient's interests, interpersonal relationships, behaviors, personal habits, and physical health. As noted above, the patient may provide much of the essential information for this section in response to an open-ended question such as, "Can you tell me in your own words what brings you here today?" Other times the clinician may have to lead the patient through parts of the presenting problem. Details that should be gathered include the length of time that the current symptoms have been present and whether there have been fluctuations in the nature or severity of those symptoms over time. ("I have been depressed for the past two weeks" vs. "I've had depression all my life"). The presence or absence of stressors should be established, and these may include situations at home, work, school, legal issues, medical comorbidities, and interpersonal difficulties. Also important are factors that alleviate or exacerbate symptoms such as medications, support, coping skills, or time of day. The essential questions to be answered in the history of the present illness include what (symptoms), how much (severity), how long, and associated factors. It is also important to identify why the patient is seeking help now and what are the "triggering" factors ("I'm here now because my girlfriend told me if I don't get help with this nervousness she is going to leave me."). Identifying the setting in which the illness began can be revealing and helpful in understanding the etiology of, or significant contributors to, the condition. If any treatment has been received for the current episode, it should be defined in terms of who saw the patient and how often, what was done (e.g., psychotherapy or medication), and the specifics of the modality used. Also, is that treatment continuing and, if not, why not? The psychiatrist should be alert for any hints of abuse by former therapists as this experience, unless addressed, can be a major

impediment to a healthy and helpful therapeutic alliance. Often it can be helpful to include a psychiatric review of systems in conjunction with the history of the present illness to help rule in or out psychiatric diagnoses with pertinent positives and negatives. This may help to identify whether there are comorbid disorders or disorders that are actually more bothersome to the patient but are

not initially identified for a variety of reasons. This review can be split into four major categories of mood, anxiety, psychosis, and other (Table 5.1-2). The clinician will want to ensure that these areas are covered in the comprehensive psychiatric interview. Table 5.1-2 Psychiatric Review of Systems V. Past Psychiatric History

In the past psychiatric history, the clinician should obtain information about all psychiatric illnesses and their course over the patient's lifetime, including symptoms and treatment. Because comorbidity is the rule rather than the exception, in addition to prior episodes of the same illness (e.g., past episodes of depression in an individual who has a major depressive disorder), the psychiatrist should also be alert for the signs and symptoms of other psychiatric disorders. Description of past symptoms should include when they occurred, how long they lasted, and the frequency and severity of episodes. Past treatment episodes should be reviewed in detail. These include outpatient treatment such as psychotherapy (individual, group, couple, or family), day treatment or partial hospitalization, inpatient treatment, including voluntary or involuntary and what precipitated the need for the higher level of care, support groups, or other forms of treatment such as vocational training. Medications and other modalities such as electroconvulsive therapy, light therapy, or alternative treatments should be carefully reviewed. One should explore what was tried (may have to offer lists of names to patients), how long and at what doses they were used (to establish adequacy of the trials), and why they were stopped. Important questions include what was the response to the medication or modality and whether there were side effects. It is also helpful to establish whether there was reasonable compliance with the recommended treatment. The psychiatrist should also inquire whether a diagnosis was made, what it was, and who made the diagnosis. Although a diagnosis made by another clinician should not be automatically accepted as valid, it is important information that can be used by the psychiatrist in forming his or her opinion. Special consideration should be given to establishing a lethality history that is important in the assessment of current risk. Past suicidal ideation, intent, plan, and attempts should be reviewed including the nature of attempts, perceived lethality of the attempts, save potential, suicide notes, giving away things, or other death preparations. Violence and homicidality history will include any violent actions or intent. Specific questions about domestic violence, legal complications, and outcome of the victim may be helpful in defining this history more clearly. History of nonsuicidal self-injurious behavior should also be covered including any history of cutting, burning, banging head, and biting oneself. The feelings, including relief of distress, that accompany or follow the behavior should also be explored as well as the degree to which the patient has gone to hide the evidence of these behaviors. VI. Substance Use, Abuse, and Addictions A careful review of substance use, abuse, and addictions is essential to the psychiatric interview. The clinician should keep in mind that this information may be difficult for the patient to discuss, and a nonjudgmental style will elicit more accurate information. If the patient seems reluctant to share such information specific questions may be helpful (e.g., "Have you ever used marijuana?" or "Do you typically drink alcohol every day?"). History of use should include which substances have been used, including alcohol, drugs, medications (prescribed or not prescribed to the patient), and routes of

use (oral, snorting, or intravenous). The frequency and amount of use should be determined, keeping in mind the tendency for patients to minimize or deny use that may be perceived as socially unacceptable. Also, there are many misconceptions about alcohol that can lead to erroneous data. The definition of alcohol may be misunderstood, for example, "No, I don't use alcohol," yet later in the same interview, "I drink a fair amount of beer." Also the amount of alcohol

can be confused with the volume of the drink: “I’m not worried about my alcohol use. I mix my own drinks and I add a lot of water.” in response to a follow-up question, “How much bourbon? Probably three or four shots?” Tolerance, the need for increasing amounts of use, and any withdrawal symptoms should be established to help determine abuse versus dependence. Impact of use on social interactions, work, school, legal consequences, and driving while intoxicated (DWI) should be covered. Some psychiatrists use a brief standardized questionnaire, the CAGE or RAPS4, to identify alcohol abuse or dependence. CAGE includes four questions: Have you ever Cut down on your drinking? Have people Annoyed you by criticizing your drinking? Have you ever felt bad or Guilty about your drinking? Have you ever had a drink the first thing in the morning, as an Eye-opener, to steady your nerves or get rid of a hangover? The Rapid Alcohol Problem Screen 4 (RAPS4) also consists of four questions: Have you ever felt guilty after drinking (Remorse), could not remember things said or did after drinking (Amnesia), failed to do what was normally expected after drinking (Perform), or had a morning drink (Starter)? Any periods of sobriety should be noted including length of time and setting such as in jail, legally mandated, and so forth. A history of treatment episodes should be explored, including inpatient detoxification or rehabilitation, outpatient treatment, group therapy, or other settings including self-help groups, Alcoholics Anonymous (AA) or Narcotics Anonymous (NA), halfway houses, or group homes. Current substance abuse or dependence can have a significant impact on psychiatric symptoms and treatment course. The patient’s readiness for change should be determined including whether they are in the precontemplative, contemplative, or action phase. Referral to the appropriate treatment setting should be considered. Other important substances and addictions that should be covered in this section include tobacco and caffeine use, gambling, eating behaviors, and Internet use. Exploration of tobacco use is especially important because persons abusing substances are more likely to die as a result of tobacco use than because of the identified abused substance. Gambling history should include casino visits, horse racing, lottery and scratch cards, and sports betting. Addictive type eating may include binge eating disorder. Overeaters Anonymous (OA) and Gamblers Anonymous (GA) are 12-step programs, similar to AA, for patients with addictive eating behaviors and gambling addictions. VII. Past Medical History The past medical history includes an account of major medical illnesses and conditions as well as treatments, both past and present. Any past surgeries should be also

reviewed. It is important to understand the patient’s reaction to these illnesses and the coping skills employed. The past medical history is an important consideration when determining potential causes of mental illness as well as comorbid or confounding factors and may dictate potential treatment options or limitations. Medical illnesses can precipitate a psychiatric disorder (e.g., anxiety disorder in an individual recently diagnosed with cancer), mimic a psychiatric disorder (hyperthyroidism resembling an anxiety disorder), be precipitated by a psychiatric disorder or its treatment (metabolic syndrome in a patient on a second-generation antipsychotic medication), or influence the choice of treatment of a psychiatric disorder (renal disorder and the use of lithium carbonate). It is important to pay special attention to neurological issues including seizures, head injury, and pain disorder. Any known history of prenatal or birthing problems or issues with developmental milestones should be noted. In women, a reproductive and menstrual history is important as well as a careful assessment of potential for current or future pregnancy. (“How do you know you are not pregnant?” may be answered with “Because I have had my tubes tied” or “I just hope I’m not.”) A careful review of all current medications is very important. This should include all current psychiatric medications with attention to how long they have been used,

compliance with schedules, effect of the medications, and any side effects. It is often helpful to be very specific in determining compliance and side effects including asking questions such as, “How many days of the week are you able to actually take this medication?” or “Have you noticed any change in your sexual function since starting this medication?,” as the patient may not spontaneously offer this information, which may be embarrassing or perceived to be treatment interfering. Nonpsychiatric medications, over-the-counter medications, sleep aids, herbal, and alternative medications should also be reviewed. These can all potentially have psychiatric implications including side effects or produce symptoms as well as potential medication interactions dictating treatment options. Optimally the patient should be asked to bring all medications currently being taken, prescribed or not, over-the-counter preparations, vitamins, and herbs to the interview. Allergies to medications must be covered, including which medication and the nature of, the extent of, and the treatment of the allergic response. Psychiatric patients should be encouraged to have adequate and regular medical care. The sharing of appropriate information among the primary care physicians, other medical specialists, and the psychiatrist can be very helpful for optimal patient care. The initial interview is an opportunity to reinforce that concept with the patient. At times a patient may not want information to be shared with his or her primary care physician. This wish should be respected, although it may be useful to explore if there is some information that can be shared. Often patients want to restrict certain social or family information (e.g., an extramarital affair) but are comfortable with other information (medication prescribed) being shared. VIII. Family History

Because many psychiatric illnesses are familial and a significant number of those have a genetic predisposition, if not cause, a careful review of family history is an essential part of the psychiatric assessment. Furthermore, an accurate family history helps not only in defining a patient’s potential risk factors for specific illnesses but also the formative psychosocial background of the patient. Psychiatric diagnoses, medications, hospitalizations, substance use disorders, and lethality history should all be covered. The importance of these issues is highlighted, for example, by the evidence that, at times, there appears to be a familial response to medications, and a family history of suicide is a significant risk factor for suicidal behaviors in the patient. The interviewer must keep in mind that the diagnosis ascribed to a family member may or may not be accurate and some data about the presentation and treatment of that illness may be helpful. Medical illnesses present in family histories may also be important in both the diagnosis and the treatment of the patient. An example is a family history of diabetes or hyperlipidemia affecting the choice of antipsychotic medication that may carry a risk for development of these illnesses in the patient. Family traditions, beliefs, and expectations may also play a significant role in the development, expression, or course of the illness. Also the family history is important in identifying potential support as well as stresses for the patient and, depending on the degree of disability of the patient, the availability and adequacy of potential caregivers. IX. Developmental and Social History The developmental and social history reviews the stages of the patient’s life. It is an important tool in determining the context of psychiatric symptoms and illnesses and may, in fact, identify some of the major factors in the evolution of the disorder. Frequently, current psychosocial stressors will be revealed in the course of obtaining a social history. It can often be helpful to review the social history chronologically to ensure all information is covered. Any available information concerning prenatal or birthing history and developmental milestones should be noted. For the large majority of adult patients, such information is not readily available and when it is it may not be fully accurate. Childhood history will include childhood home environment including members of the

family and social environment including the number and quality of friendships. A detailed school history including how far the patient went in school and how old he or she was at that level, any special education circumstances or learning disorders, behavioral problems at school, academic performance, and extracurricular activities should be obtained. Childhood physical and sexual abuse should be carefully queried. Work history will include types of jobs, performance at jobs, reasons for changing jobs, and current work status. The nature of the patient's relationships with supervisors and coworkers should be reviewed. The patient's income, financial issues, and insurance coverage including pharmacy benefits are often important issues. Military history, where applicable, should be noted including rank achieved, combat exposure, disciplinary actions, and discharge status. Marriage and relationship history,

including sexual preferences and current family structure, should be explored. This should include the patient's capacity to develop and maintain stable and mutually satisfying relationships as well as issues of intimacy and sexual behaviors. Current relationships with parents, grandparents, children, and grandchildren are an important part of the social history. Legal history is also relevant, especially any pending charges or lawsuits. The social history also includes hobbies, interests, pets, and leisure time activities and how this has fluctuated over time. It is important to identify cultural and religious influences on the patient's life and current religious beliefs and practices. A brief overview of the sexual history is given in Table 5.1-3. Table 5.1-3 Sexual History X. Review of Systems The review of systems attempts to capture any current physical or psychological signs and symptoms not already identified in the present illness. Particular attention is paid to neurological and systemic symptoms (e.g., fatigue or weakness). Illnesses that might contribute to the presenting complaints or influence the choice of therapeutic agents

should be carefully considered (e.g., endocrine, hepatic, or renal disorders). Generally, the review of systems is organized by the major systems of the body. XI. Mental Status Examination The mental status examination (MSE) is the psychiatric equivalent of the physical examination in the rest of medicine. The MSE explores all the areas of mental functioning and denotes evidence of signs and symptoms of mental illnesses. Data are gathered for the mental status examination throughout the interview from the initial moments of the interaction, including what the patient is wearing and their general presentation. Most of the information does not require direct questioning, and the information gathered from observation may give the clinician a different dataset than patient responses. Direct questioning augments and rounds out the MSE. The MSE gives the clinician a snapshot of the patient's mental status at the time of the interview and is useful for subsequent visits to compare and monitor changes over time. The psychiatric MSE includes cognitive screening most often in the form of the Mini-Mental Status Examination (MMSE), but the MMSE is not to be confused with the MSE overall. The components of the MSE are presented in this section in the order one might include them in the written note for organizational purposes, but as noted above, the data are gathered throughout the interview. Appearance and Behavior. This section consists of a general description of how the patient looks and acts during the interview. Does the patient appear to be his or her stated age, younger or older? Is this related to the patient's style of dress, physical features, or style of interaction? Items to be noted include what the patient is wearing, including body jewelry, and whether it is appropriate for the context. For example, a patient in a hospital gown would be appropriate in the emergency room or inpatient unit but not in an outpatient clinic. Distinguishing features, including disfigurations, scars, and tattoos, are noted. Grooming and hygiene also are included in the overall appearance and can be

clues to the patient’s level of functioning. The description of a patient’s behavior includes a general statement about whether he or she is exhibiting acute distress and then a more specific statement about the patient’s approach to the interview. The patient may be described as cooperative, agitated, disinhibited, disinterested, and so forth. Once again, appropriateness is an important factor to consider in the interpretation of the observation. If a patient is brought involuntarily for examination, it may be appropriate, certainly understandable, that he or she is somewhat uncooperative, especially at the beginning of the interview. Motor Activity. Motor activity may be described as normal, slowed (bradykinesia), or agitated (hyperkinesia). This can give clues to diagnoses (e.g., depression vs. mania) as well as confounding neurological or medical issues. Gait, freedom of movement, any unusual or sustained postures, pacing, and hand wringing are described. The presence or absence of any tics should be noted, as should be jitteriness, tremor, apparent

restlessness, lip-smacking, and tongue protrusions. These can be clues to adverse reactions or side effects of medications such as tardive dyskinesia, akathisia, or parkinsonian features from antipsychotic medications or suggestion of symptoms of illnesses such as attention-deficit/hyperactivity disorder. Speech. Evaluation of speech is an important part of the MSE. Elements considered include fluency, amount, rate, tone, and volume. Fluency can refer to whether the patient has full command of the English language as well as potentially more subtle fluency issues such as stuttering, word finding difficulties, or paraphasic errors. (A Spanish-speaking patient with an interpreter would be considered not fluent in English, but an attempt should be made to establish whether he or she is fluent in Spanish.) The evaluation of the amount of speech refers to whether it is normal, increased, or decreased. Decreased amounts of speech may suggest several different things ranging from anxiety or disinterest to thought blocking or psychosis. Increased amounts of speech often (but not always) are suggestive of mania or hypomania. A related element is the speed or rate of speech. Is it slowed or rapid (pressured)? Finally, speech can be evaluated for its tone and volume. Descriptive terms for these elements include irritable, anxious, dysphoric, loud, quiet, timid, angry, or childlike. Mood. The terms mood and affect vary in their definition, and a number of authors have recommended combining the two elements into a new label “emotional expression.” Traditionally, mood is defined as the patient’s internal and sustained emotional state. Its experience is subjective, and hence it is best to use the patient’s own words in describing his or her mood. Terms such as “sad,” “angry,” “guilty,” or “anxious” are common descriptions of mood. Affect. Affect differs from mood in that it is the expression of mood or what the patient’s mood appears to be to the clinician. Affect is often described with the following elements: quality, quantity, range, appropriateness, and congruence. Terms used to describe the quality (or tone) of a patient’s affect include dysphoric, happy, euthymic, irritable, angry, agitated, tearful, sobbing, and flat. Speech is often an important clue to assessment of affect but it is not exclusive. Quantity of affect is a measure of its intensity. Two patients both described as having depressed affect can be very different if one is described as mildly depressed and the other as severely depressed. Range can be restricted, normal, or labile. Flat is a term that has been used for severely restricted range of affect that is described in some patients with schizophrenia. Appropriateness of affect refers to how the affect correlates to the setting. A patient who is laughing at a solemn moment of a funeral service is described as having inappropriate affect. Affect can also be congruent or incongruent with the patient’s described mood or thought content. A patient may report feeling depressed or describe a depressive theme but do so with laughter, smiling, and no suggestion of sadness.

Thought Content. Thought content is essentially what thoughts are occurring to the patient. This is inferred by what the patient spontaneously expresses, as well as responses to specific questions aimed at eliciting particular pathology. Some patients may perseverate or ruminate on specific content or thoughts. They may focus on material that is considered obsessive or compulsive. Obsessional thoughts are unwelcome and repetitive thoughts that intrude into the patient's consciousness. They are generally ego alien and resisted by the patient. Compulsions are repetitive, ritualized behaviors that patients feel compelled to perform to avoid an increase in anxiety or some dreaded outcome. Another large category of thought content pathology is delusions. Delusions are false, fixed ideas that are not shared by others and can be divided into bizarre and nonbizarre (nonbizarre delusions refer to thought content that is not true but is not out of the realm of possibility). Common delusions include grandiose, erotomanic, jealous, somatic, and persecutory. It is often helpful to suggest delusional content to patients who may have learned to not spontaneously discuss them. Questions that can be helpful include, "Do you ever feel like someone is following you or out to get you?" and "Do you feel like the TV or radio has a special message for you?" An affirmative answer to the latter question indicates an "idea of reference." Paranoia can be closely related to delusional material and can range from "soft" paranoia, such as general suspiciousness, to more severe forms that impact daily functioning. Questions that elicit paranoia can include asking about the patient worrying about cameras, microphones, or the government. Suicidality and homicidality fall under the category of thought content but here are discussed separately because of their particular importance in being addressed in every initial psychiatric interview. Simply asking if someone is suicidal or homicidal is not adequate. One must get a sense of ideation, intent, plan, and preparation. Although completed suicide is extremely difficult to accurately predict, there are identified risk factors, and these can be used in conjunction with an evaluation of the patient's intent and plan for acting on thoughts of suicide. Thought Process. Thought process differs from thought content in that it does not describe what the person is thinking but rather how the thoughts are formulated, organized, and expressed. A patient can have normal thought process with significantly delusional thought content. Conversely, there may be generally normal thought content but significantly impaired thought process. Normal thought process is typically described as linear, organized, and goal directed. With flight of ideas, the patient rapidly moves from one thought to another, at a pace that is difficult for the listener to keep up with, but all of the ideas are logically connected. The circumstantial patient overincludes details and material that is not directly relevant to the subject or an answer to the question but does eventually return to address the subject or answer the question. Typically the examiner can follow a circumstantial train of thought, seeing connections between the sequential statements. Tangential thought process may at first appear similar, but the patient never returns to the original point or question. The tangential thoughts are seen as irrelevant and related in a minor, insignificant manner. Loose thoughts or associations differ from circumstantial and tangential thoughts in that with

loose thoughts it is difficult or impossible to see the connections between the sequential content. Perseveration is the tendency to focus on a specific idea or content without the ability to move on to other topics. The perseverative patient will repeatedly come back to the same topic despite the interviewer's attempts to change the subject. Thought blocking refers to a disordered thought process in which the patient appears to be unable to complete a thought. The patient may stop midsentence or midthought and leave the interviewer waiting for the completion. When asked about this, patients will often remark that they don't know what happened and may not remember

what was being discussed. Neologisms refer to a new word or condensed combination of several words that is not a true word and is not readily understandable, although sometimes the intended meaning or partial meaning may be apparent. Word salad is speech characterized by confused, and often repetitious, language with no apparent meaning or relationship attached to it. A description of formal thought disorders is given in Table 5.1-4. Table 5.1-4 Formal Thought Disorders Perceptual Disturbances. Perceptual disturbances include hallucinations, illusions, depersonalization, and derealization. Hallucinations are perceptions in the absence of stimuli to account for them. Auditory hallucinations are the hallucinations most frequently encountered in the psychiatric setting. Other hallucinations can include

visual, tactile, olfactory, and gustatory (taste). In the North American culture, nonauditory hallucinations are often clues that there is a neurological, medical, or substance withdrawal issue rather than a primary psychiatric issue. In other cultures, visual hallucinations have been reported to be the most common form of hallucinations in schizophrenia. The interviewer should make a distinction between a true hallucination and a misperception of stimuli (illusion). Hearing the wind rustle through the trees outside one's bedroom and thinking a name is being called is an illusion. Hypnagogic hallucinations (at the interface of wakefulness and sleep) may be normal phenomena. At times patients without psychosis may hear their name called or see flashes or shadows out of the corners of their eyes. In describing hallucinations the interviewer should include what the patient is experiencing, when it occurs, how often it occurs, and whether or not it is uncomfortable (ego dystonic). In the case of auditory hallucinations, it can be useful to learn if the patient hears words, commands, or conversations and whether the voice is recognizable to the patient. Depersonalization is a feeling that one is not oneself or that something has changed. Derealization is a feeling that one's environment has changed in some strange way that is difficult to describe. Cognition. The elements of cognitive functioning that should be assessed are alertness, orientation, concentration, memory (both short and long term), calculation, fund of knowledge, abstract reasoning, insight, and judgment. Note should be made of the patient's level of alertness. The amount of detail in assessing cognitive function will depend on the purpose of the examination and also what has already been learned in the interview about the patient's level of functioning, performance at work, handling daily chores, balancing one's checkbook, among others. In addition the psychiatrist will have already elicited data concerning the patient's memory for both remote and recent past. A general sense of intellectual level and how much schooling the patient has had can help distinguish intelligence and educational issues versus cognitive impairment that might be seen in delirium or dementia. Table 5.1-5 presents an overview of the questions used to test cognitive function in the mental status examination. Table 5.1-5 Questions Used to Test Cognitive Functions in the Sensorium Section of the Mental Status Examination

Abstract Reasoning. Abstract reasoning is the ability to shift back and forth between general concepts and specific examples. Having the patient identify similarities between like objects or concepts (apple and pear, bus and airplane, or a poem and a painting) as well as interpreting proverbs can be useful in assessing one's ability to abstract. Cultural and educational factors and limitations should be kept in mind when assessing the ability to abstract. Occasionally, the inability to abstract or the idiosyncratic manner of grouping items can be dramatic. Insight. Insight, in the psychiatric evaluation, refers to the patient's understanding of how he or she is feeling, presenting, and functioning as well as the potential causes of his or her psychiatric presentation. The patient may have no insight, partial insight, or full insight. A component of insight often is reality testing in

the case of a patient with psychosis. An example of intact reality testing would be, “I know that there are not really little men talking to me when I am alone, but I feel like I can see them and hear their voices.” As indicated by this example, the amount of insight is not an indicator of the severity of the illness. A person with psychosis may have good insight, while a person with a mild anxiety disorder may have little or no insight. Judgment. Judgment refers to the person’s capacity to make good decisions and act on them. The level of judgment may or may not correlate to the level of insight. A patient may have no insight into his or her illness but have good judgment. It has been traditional to use hypothetical examples to test judgment, for example, “What would you do if you found a stamped envelope on the sidewalk?” It is better to use real situations from the patient’s own experience to test judgment. The important issues in assessing judgment include whether a patient is doing things that are dangerous or going to get him or her into trouble and whether the patient is able to effectively participate in his or

her own care. Significantly impaired judgment can be cause for considering a higher level of care or more restrictive setting such as inpatient hospitalization. Table 5.1-6 lists some common questions for the psychiatric history and mental status. Table 5.1-6 Common Questions for Psychiatric History and Mental Status

XII. Physical Examination The inclusion and extent of physical examination will depend on the nature and setting of the psychiatric interview. In the outpatient setting, little or no physical examination may be routinely performed, while in the emergency room or inpatient setting, a more complete physical examination is warranted. Vital signs, weight, waist circumference, body mass index, and height may be important measurements to follow particularly given the potential effects of psychiatric medications or illnesses on these parameters. The Abnormal Involuntary Movement Scale (AIMS) is an important screening test to be followed when using antipsychotic medication to monitor for potential side effects such as tardive dyskinesia. A focused neurological evaluation is an important part of the psychiatric assessment.

In those instances where a physical examination is not performed the psychiatrist should ask the patient when the last physical examination was performed and by whom. As part of the communication with that physician, the psychiatrist should inquire about any abnormal findings. XIII. Formulation The culmination of the data-gathering aspect of the psychiatric interview is developing a formulation and diagnosis (diagnoses) as well as recommendations and treatment planning. In this part of the evaluation process, the data gathering is supplanted by data processing where the various themes contribute to a biopsychosocial understanding of the patient’s illness. Although the formulation is placed near the end of the reported or written evaluation, actually it is developed as part of a dynamic process throughout the interview as new hypotheses are created and tested by further data that are elicited. The formulation should include a brief summary of the patient’s history, presentation, and current status. It should include discussion of biological factors (medical, family, and medication history) as well as psychological factors such as childhood circumstances, upbringing, and past interpersonal interactions and social factors including stressors, and contextual circumstances such as finances, school, work, home, and interpersonal relationships. These elements should lead to a differential diagnosis of the patient’s illness (if any) as well as a provisional diagnosis. Finally, the formulation should include a summary of the safety assessment, which contributes to the determination of level of care recommended or required. XIV. Treatment Planning The assessment and formulation will appear in

the written note correlating to the psychiatric interview, but the discussion with the patient may only be a summary of this assessment geared toward the patient's ability to understand and interpret the information. Treatment planning and recommendations, in contrast, are integral parts of the psychiatric interview and should be explicitly discussed with the patient in detail. The first part of treatment planning involves determining whether a treatment relationship is to be established between the interviewer and patient. Cases where this may not be the case include if the interview was done in consultation, for a legal matter or as a third-party review, or in the emergency room or other acute setting. If a treatment relationship is not being started, then the patient should be informed as to what the recommended treatment is (if any). In certain cases this may not be voluntary (as in the case of an involuntary hospitalization). In most cases there should be a discussion of the options available so that the patient can participate in the decisions about next steps. If a treatment relationship is being initiated, then the structure of that treatment should be discussed. Will the main focus be on medication management, psychotherapy, or both? What will the frequency of visits be? How will the clinician be paid for service and what are the expectations for the patient to be considered engaged in treatment?

Medication recommendations should include a discussion of possible therapeutic medications, the risks and benefits of no medication treatment, and alternative treatment options. The prescriber must obtain informed consent from the patient for any medications (or other treatments) initiated. Other clinical treatment recommendations may include referral for psychotherapy, group therapy, chemical dependency evaluation or treatment, or medical assessment. There also may be recommended psychosocial interventions including case management, group home or assisted living, social clubs, support groups such as a mental health alliance, the National Alliance for the Mentally Ill, and AA. Collaboration with primary care doctors, specialists, or other clinicians should always be a goal, and proper patient consent must be obtained for this. Similarly, family involvement in a patient's care can often be a useful and integral part of treatment and requires proper patient consent. A thorough discussion of safety planning and contact information should occur during the psychiatric interview. The clinician's contact information as well as after-hours coverage scheme should be reviewed. The patient needs to be informed of what he or she should do in the case of an emergency, including using the emergency room or calling 911 or crisis hotlines that are available. TECHNIQUES General principles of the psychiatric interview such as the patient–doctor relationship, open-ended interviewing, and confidentiality are described above. In addition to the general principles, there are a number of specific techniques that can be effective in obtaining information in a manner consistent with the general principles. These helpful techniques can be described as facilitating interventions and expanding interventions. There are also some interventions that are generally counterproductive and interfere with the goals of helping the patient tell his or her story and reinforcing the therapeutic alliance. Facilitating Interventions These are some of the interventions that are effective in enabling the patient to continue sharing his or her story and also are helpful in promoting a positive patient– doctor relationship. At times some of these techniques may be combined in a single intervention. Reinforcement. Reinforcement interventions, although seemingly simplistic, are very important in the patient sharing material about himself or herself and other important individuals and events in the patient's life. Without these reinforcements, often the interview will become less productive. A brief phrase such as "I see," "Go on," "Yes," "Tell me more," "Hmm," or "Uh-huh" all convey the interviewer's interest in the patient continuing. It is important that these phrases fit naturally into the dialogue.

Reflection. By using the patient's words, the psychiatrist indicates that he or she has heard what the patient is saying and conveys an interest in hearing more. Summarizing. Periodically during the interview it is helpful to summarize what has been identified about a certain topic. This provides the opportunity for the patient to clarify or modify the psychiatrist's understanding and possibly add new material. When new material is introduced, the psychiatrist may decide to continue with a further exploration of the previous discussion and return to the new information at a later point. Education. At times in the interview it is helpful for the psychiatrist to educate the patient about the interview process. Reassurance. It is often appropriate and helpful to provide reassurance to the patient. For example, accurate information about the usual course of an illness can decrease anxiety, encourage the patient to continue to discuss his or her illness, and strengthen his or her resolve to continue in treatment. It is generally inappropriate for psychiatrists to reassure patients when the psychiatrist does not know what the outcome will be. In these cases, psychiatrists can assure patients they will continue to be available and will help in whatever way they can. Encouragement. It is difficult for many patients to come for a psychiatric evaluation. Often they are uncertain as to what will happen, and receiving encouragement can facilitate their engagement. Psychiatrists should be careful not to overstate the patient's progress in the interview. The psychiatrist may provide the patient feedback about his or her efforts, but the secondary message should be that there is more work to be done. Acknowledgment of Emotion. It is important for the interviewer to acknowledge the expression of emotion by the patient. This frequently leads to the patient sharing more feelings and being relieved that he or she can do so. Sometimes a nonverbal action, such as moving a tissue box closer, can suffice or be used adjunctly. If the display of the emotion is clear (e.g., patient openly crying), then it is not helpful to comment directly on the expression of the emotion. It is better to comment on the associated feelings. Humor. At times the patient may make a humorous comment or tell a brief joke. It can be very helpful if the psychiatrist smiles, laughs, or even, when appropriate, add another punch line. This sharing of humor can decrease tension and anxiety and reinforce the interviewer's genuineness. It is important to be certain that the patient's comment was indeed meant to be humorous and that the psychiatrist clearly conveys that he or she is laughing with the patient, not at the patient.

Silence. Careful use of silence can facilitate the progression of the interview. The patient may need time to think about what has been said or to experience a feeling that has arisen in the interview. The psychiatrist whose own anxiety results in any silence quickly being terminated can retard the development of insight or the expression of feeling by the patient. On the other hand, extended or repeated silences can deaden an interview and become a struggle as to who can outwait the other. If the patient is looking at his or her watch or looking about the room, then it might be helpful to comment, "It looks like there are other things on your mind." If the patient has become silent and looks like he or she is thinking about the subject, then the psychiatrist might ask, "What thoughts do you have about that?" Nonverbal Communication In many good interviews, the most common facilitating interventions are nonverbal. Nodding of the head, body posture including leaning toward the patient, body positioning becoming more open, moving the chair closer to the patient, putting down the pen and folder, and facial expressions including arching of eyebrows all indicate that the psychiatrist is concerned, listening attentively, and engaged in the interview. Although these interventions can be very helpful, they can also be overdone especially if the same action is repeated too frequently or done in an exaggerated fashion. The interviewer does not want to reinforce the popular caricature of a psychiatrist nodding his or her head repeatedly regardless of the content of what is being said or the emotion being expressed. Expanding Interventions There

are a number of interventions that can be used to expand the focus of the interview. These techniques are helpful when the line of discussion has been sufficiently mined, at least for the time being, and the interviewer wants to encourage the patient to talk about other issues. These interventions are most successful when a degree of trust has been established in the interview and the patient feels that the psychiatrist is nonjudgmental about what is being shared. Clarifying. At times carefully clarifying what the patient has said can lead to unrecognized issues or psychopathology. A 62-year-old widow describes how it feels since her husband died 14 months ago. She repeatedly comments that “everything is empty inside.” The resident interprets this as meaning her world feels empty without her spouse and makes this interpretation on a few occasions. The patient’s nonverbal cues suggest that she is not on the same wavelength. The supervisor asks the patient to clarify what she means by “empty inside.” After some avoidance, the patient states that she is indeed empty inside; all her organs are missing—they have “disappeared.”

The resident’s interpretation may actually have been psychodynamically accurate, but a somatic delusion was not identified. The correct identification of what the patient was actually saying led to an exploration of other thoughts, and other delusions were uncovered. This vignette of “missing” the delusion is an example of the interviewer “normalizing” what the patient is saying. The interviewer was using secondary process thinking in understanding the words of the patient, while the patient was using primary process thinking. Associations. As the patient describes his or her symptoms, there are other areas that are related to a symptom that should be explored. For example, the symptom of nausea leads to questions about appetite, bowel habits, weight loss, and eating habits. Also, experiences that are temporally related may be investigated. When a patient is talking about his or her sleeping pattern, it can be a good opportunity to ask about dreams. Leading. Often, continuing the story can be facilitated by asking a “what,” “when,” “where,” or “who” question. Sometimes the psychiatrist may suggest or ask about something that has not been introduced by the patient but that the psychiatrist surmises may be relevant. Probing. The interview may point toward an area of conflict, but the patient may minimize or deny any difficulties. Gently encouraging the patient to talk more about this issue may be quite productive. Transitions. Sometimes transitions occur very smoothly. The patient is talking about her primary education major in college and the psychiatrist asks, “Did that lead to your work after college?” On other occasions, the transition means moving to a different area of the interview and a bridge statement is useful. Redirecting. A difficult technique for unseasoned interviewers is redirecting the focus of the patient. If the interviewer is concentrating on reinforcing the patient’s telling of his or her story, it can be especially difficult to move the interview in a different direction. However, this is often crucial to a successful interview because of the time constraints and the necessity to obtain a broad overview of the patient’s life as well as the current problems. Also, the patient may, for conscious or often unconscious reasons, avoid certain important areas and need guidance in approaching these subjects. Redirection can be used when the patient changes the topic or when the patient continues to focus on a nonproductive or well-covered area. Obstructive Interventions Although supportive and expanding techniques facilitate the gathering of information

and the development of a positive patient–doctor relationship, there are a number of other interventions that are not helpful for either task. Some of these activities are in the same categories as the more useful interventions but are unclear, unconnected, poorly timed, and not responsive to the patient’s issues or concerns. Closed-Ended Questions. A series of closed-ended

questions early in the interview can retard the natural flow of the patient's story and reinforces the patient giving one word or brief answers with little or no elaboration. Compound Questions. Some questions are difficult for patients to respond to because more than one answer is being sought. Why Questions. Especially early in the psychiatric interview, "why" questions are often nonproductive. Very often the answer to that question is one of the reasons that the patient has sought help. Judgmental Questions or Statements. Judgmental interventions are generally nonproductive for the issue at hand and also inhibit the patient from sharing even more private or sensitive material. Instead of telling a patient that a particular behavior was right or wrong, it would be better for the psychiatrist to help the patient reflect on how successful that behavior was. Minimizing Patient's Concerns. In an attempt to reassure patients, psychiatrists sometimes make the error of minimizing a concern. This can be counterproductive in that rather than being reassured, the patient may feel that the psychiatrist does not understand what he or she is trying to express. It is much more productive to explore the concern; there is likely much more material that has not yet been shared. Premature Advice. Advice given too early is often bad advice because the interviewer does not yet know all of the variables. Also it can preempt the patient from arriving at a plan for himself or herself. Premature Interpretation. Even if it is accurate, a premature interpretation can be counterproductive as the patient may respond defensively and feel misunderstood. Transitions. Some transitions are too abrupt and may interrupt important issues that the patient is discussing. Nonverbal Communication. The psychiatrist that repeatedly looks at a watch, turns away from the patient, yawns, or refreshes the computer screen conveys boredom, disinterest, or annoyance. Just as reinforcing nonverbal communications can be powerful facilitators of a good interview, these obstructive actions can quickly shatter an interview and undermine the patient–doctor relationship.

Closing of Interview The last 5 to 10 minutes of the interview are very important and are often not given sufficient attention by inexperienced interviewers. It is important to alert the patient to the remaining time: "We have to stop in about 10 minutes." Not infrequently, a patient will have kept an important issue or question until the end of the interview and having at least a brief time to identify the issue is helpful. If there is to be another session, then the psychiatrist can indicate that this issue will be addressed at the beginning of the next session or ask the patient to bring it up at that time. If the patient repeatedly brings up important information at the end of sessions, then this should be explored as to its meaning. If no such item is spontaneously brought up by the patient, then it can be useful to ask the patient if there are any other issues that have not been covered that the patient wanted to share. If such an issue can be dealt with in short order, then it should be; if not, then it can be put on the agenda for the next session. It can also be useful to give the patient an opportunity to ask a question: "I've asked you a lot of questions today. Are there any other questions you'd like to ask me at this point?" If this interview was to be a single evaluative session, then a summary of the diagnosis and options for treatment should generally be shared with the patient (exceptions may be a disability or forensic evaluation for which it was established at the outset that a report would be made to the referring entity). If the patient was referred by a primary care physician, then the psychiatrist also indicates that he or she will communicate with the primary care physician and share the findings and recommendations. If this was not to be a single session and the patient will be seen again, then the psychiatrist may indicate that he or she and the patient can work further on the treatment plan in the next session. A mutually agreed upon time is arrived at and the patient is escorted to the door. Motivational Interviewing Motivational interviewing is a technique used to motivate the patient to change his or her maladaptive behavior.

The therapist relies on empathy to convey understanding, provides support by noting the patient's strengths, and explores the ambivalence and conflicting thoughts or feelings the patient may have about change. Guidance is provided in the interview by imparting information about issues (e.g., alcoholism, diabetes), while at the same time, getting the patient to talk about resistances to altering behavior. It has been used effectively in persons with substance-use disorders to get them to join AA, to help change lifestyles, or to enter psychotherapy. It has the potential to combine diagnosis and therapy in a single interview with the patient and can be applied to a wide range of mental disorders. MEDICAL RECORD Most psychiatrists take notes throughout the interview. Generally these are not verbatim recordings, except for the chief complaint or other key statements. Many psychiatrists use a form that covers the basic elements in the psychiatric evaluation. Occasionally, patients may have questions or concerns about the note taking. These concerns, which often have to do with confidentiality, should be discussed (and during this discussion

notes should not be taken). After the discussion, it is rare for a patient to insist that notes not be taken. In fact, it is much more common for patients to feel comfortable about the note taking, feeling reassured that their experiences and feelings are important enough to be written. However, too much attention to the record can be distracting. It is important that eye contact be maintained as much as possible during the note taking. Otherwise patients will feel that the record is more important than what they are saying. Also, the interviewer may miss nonverbal communications that can be more important than the words being recorded. Increasingly, the electronic health record (EHR) is now being used throughout medicine. There are great advantages of computerized records, including rapid retrieval of information, appropriately sharing data among various members of the health care team, access to important data in an emergency, decreasing errors, and as a tool for research and quality improvement activities. Evidence-based practice guidelines can also be integrated with EHRs so that information or recommendations can be provided at the point of service. However, the use of computers can also present significant challenges to the developing patient–physician relationship. Frequently, physicians using computers during an interview will turn away from the patient to enter data. Especially in a psychiatric interview, this can be very disruptive to a smooth and dynamic interaction. As improved technology becomes more widespread (e.g., the use of notepads held in the lap) and psychiatrists become more accustomed to using the equipment, some of these disruptions can be minimized. CULTURAL ISSUES Culture can be defined as a common heritage, a set of beliefs, and values that set expectations for behaviors, thoughts, and even feelings. A number of culture-bound syndromes that are unique to a particular population have been described (see Section 3.3). Culture can influence the presentation of illness, the decision when and where to seek care, the decision as to what to share with the physician, and the acceptance of and participation in treatment planning. Often, individuals from a minority population may be reluctant to seek help from a physician who is from the majority group especially for emotional difficulties. Some minority groups have strong beliefs in faith healers, and in some areas of the United States "root doctors" carry significant influence. These beliefs may not be apparent in the interview as the patient may have learned to be quite guarded about such matters. A patient may only report that he or she is "frightened" and not discuss the reality that this fear began when he or she realized someone was working "roots" on him or her. The psychiatrist needs to be alert to the possibility that the patient's thoughts about what has happened may be unusual from a traditional Western medical perspective and at the same time recognize that these culturally shared beliefs are not indications of psychosis. By being

humble, open, and respectful the psychiatrist increases the possibility of developing a trusting working relationship with the patient and learning more about the patient's actual experiences. The psychiatrist clearly understanding what the patient is saying and the patient

clearly understanding what the psychiatrist is saying are obviously crucial for an effective interview. It is not just both being fluent in the language of the interview, but the psychiatrist should also be aware of common slang words and phrases that the patient, depending on their cultural background, may use. If the psychiatrist does not understand a particular phrase or comment, then he or she should ask for clarification. If the patient and psychiatrist are not both fluent in the same language, then an interpreter is necessary. Interviewing with an Interpreter When translation is needed, it should be provided by a non–family-member professional interpreter. Translation by family members is to be avoided because (1) a patient, with a family member as an interpreter, may justifiably be very reluctant to discuss sensitive issues including suicidal ideation or drug use and (2) family members may be hesitant to accurately portray a patient's deficits. Both of these issues make accurate assessment very difficult. It is helpful to speak with the interpreter prior to the interview to clarify the goals of the exam. If the interpreter does not primarily work with psychiatric patients, then it is important to highlight the need for verbatim translation even if the responses are disorganized or tangential. If the translator is not aware of this issue, then the psychiatrist may have difficulty diagnosing thought disorders or cognitive deficits. Occasionally, the patient will say several sentences in response to a question and the interpreter will remark, "He said it's okay." The interpreter should again be reminded that the psychiatrist wants to hear everything that the patient is saying. It is helpful to place the chairs in a triangle so that the psychiatrist and patient can maintain eye contact. The psychiatrist should continue to refer to the patient directly to maintain the therapeutic connection rather than speaking to the interpreter. The examiner may need to take a more directive approach and interrupt the patient's responses more frequently to allow for accurate and timely translation. Once the interview is concluded, it may be helpful to again meet briefly with the interpreter. If the interpreter is especially knowledgeable about the patient's cultural background, they may be able to provide helpful insights regarding cultural norms. INTERVIEWING THE DIFFICULT PATIENT Patients with Psychosis Patients with psychotic illnesses are often frightened and guarded. They may have difficulty with reasoning and thinking clearly. In addition, they may be actively hallucinating during the interview, causing them to be inattentive and distracted. They may have suspicions regarding the purpose of the interview. All of these possibilities are reasons that the interviewer may need to alter the usual format and adapt the interview to match the capacity and tolerance of the patient. Auditory hallucinations are the most common hallucinations in psychiatric illnesses in

North America. Many patients will not interpret their experiences as hallucinations, and it is useful to begin with a more general question: "Do you ever hear someone talking to you when no one else is there?" The patient should be asked about the content of the hallucinations, the clarity, and the situations in which they occur. Often it is helpful to ask the patient about a specific instance and if he or she can repeat verbatim the content of the hallucination. It is important to specifically ask if the patient has ever experienced command hallucinations, hallucinations in which a patient is ordered to perform a specific act. If so, the nature of the commands should be clarified, specifically if the commands have ever included orders to harm himself or herself or others, and if the patient has ever felt compelled to follow the commands. The validity of the patient's perception should not

be dismissed, but it is helpful to test the strength of the belief in the hallucinations: “Does it seem that the voices are coming from inside your head? Who do you think is speaking to you?” Other perceptual disturbances should be explored including visual, olfactory, and tactile hallucinations. These disturbances are less common in psychiatric illness and may suggest a primary medical etiology to the psychosis. The psychiatrist should be alert for cues that psychotic processes may be part of the patient’s experience during the interview. It is usually best to ask directly about such behaviors or comments. By definition, patients with delusions have fixed false beliefs. With delusions, as with hallucinations, it is important to explore the specific details. Patients are often very reluctant to discuss their beliefs as many have had their beliefs dismissed or ridiculed. They may ask the interviewer directly if the interviewer believes the delusion. Although an interviewer should not directly endorse the false belief, it is rarely helpful to directly challenge the delusion, particularly in the initial exam. It can be helpful to shift the attention back to the patient’s rather than the examiner’s beliefs and acknowledge the need for more information: “I believe that what you are experiencing is frightening and I would like to know more about your experiences.” For patients with paranoid thoughts and behaviors it is important to maintain a respectful distance. Their suspiciousness may be increased by an overly warm interview. It may be helpful to avoid sustained direct eye contact as this may be perceived as threatening. Harry Stack Sullivan recommended that rather than sitting face to face with the patient who is paranoid, the psychiatrist might sit more side by side, “looking out” with the patient. Interviewers should keep in mind that they themselves may become incorporated into the paranoid delusions, and it is helpful to ask directly about such fears: “Are you concerned that I am involved?” The psychiatrist should also ask whether there is a specific target related to the paranoid thinking. When asked regarding thoughts about hurting others, the patient may not disclose plans for violence. Exploration of the patient’s plan on how to manage his or her fears may elicit information regarding violence risk: “Do you feel you need to protect yourself in any way? How do you plan to do so?” If there is some expression of possible violence toward others, the psychiatrist then needs to do further risk assessment. This is further discussed in the section below on hostile, agitated, and violent patients.

Depressed and Potentially Suicidal Patients The depressed patient may have particular difficulty during the interview as he or she may have cognitive deficits as a result of the depressive symptoms. The patients may have impaired motivation and may not spontaneously report their symptoms. Feelings of hopelessness may contribute to a lack of engagement. Depending on the severity of symptoms, patients may need more direct questioning rather than an open-ended format. A suicide assessment should be performed for all patients including prior history, family history of suicide attempts and completed suicides, and current ideation, plan, and intent. An open-ended approach is often helpful: “Have you ever had thoughts that life wasn’t worth living?” It is important to detail prior attempts. The lethality risk of prior attempts and any potential triggers for the attempt should be clarified. This can help with assessing the current risk. The patient should be asked about any current thoughts of suicide, and if thoughts are present, what is the patient’s intent. Some patients will describe having thoughts of suicide but do not intend to act on these thoughts or wish to be dead. They report that although the thoughts are present, they have no intent to act on the thoughts. This is typically referred to as passive suicidal ideation. Other patients will express their determination to end their life and are at higher risk. The presence of psychotic symptoms should be assessed. Some patients may have hallucinations compelling them to hurt themselves even though they do not have a desire to die. If the patient reports suicidal ideation, they should be asked if they have a plan to end his or her life. The specificity of the plan

should be determined and whether the patient has access to the means to complete the plan. The interviewer should pursue this line of questioning in detail if the patient has taken any preparatory steps to move forward with the plan. (A patient who has purchased a gun and has given away important items would be at high risk.) If the patient has not acted upon these urges, then it is helpful to ask what has prevented him or her from acting on these thoughts: “What do you think has kept you from hurting yourself?” The patient may disclose information that may decrease their acute risk, such as religious beliefs that prohibit suicide or awareness of the impact of suicide on family members. This information is essential to keep in mind during treatment especially if these preventative factors change. (A patient who states he or she could never abandon a beloved pet may be at increased risk if the pet dies.) Although the intent of the psychiatric interview is to build rapport and gather information for treatment and diagnosis, the patient’s safety must be the first priority. If the patient is viewed to be at imminent risk, then an interview may need to be terminated and the interviewer must take action to secure the safety of the patient. Hostile, Agitated, and Potentially Violent Patients Safety for the patient and the psychiatrist is the priority when interviewing agitated

patients. Hostile patients are often interviewed in emergency settings, but angry and agitated patients can present in any setting. If interviewing in an unfamiliar setting, then the psychiatrist should familiarize himself or herself with the office setup, paying particular attention to the chair placement. The chairs should ideally be placed in a way in which both the interviewer and patient could exit if necessary and not be obstructed. The psychiatrist should be aware of any available safety features (emergency buttons or number for security) and should be familiar with the facility’s security plan. If the psychiatrist is aware in advance that the patient is agitated, then he or she can take additional preparatory steps such as having security closely available if necessary. As increased stimulation can be agitating for a hostile patient, care should be taken to decrease excess stimulation as much as feasible. The psychiatrist should be aware of his or her own body position and avoid postures that could be seen as threatening, including clenched hands or hands behind the back. The psychiatrist should approach the interview in a calm, direct manner and take care not to bargain or promise to elicit cooperation in the interview: “Once we finish here you will be able to go home.” These tactics may only escalate agitation. As stated above, the priority must be safety. An intimidated psychiatrist who is fearful regarding his or her own physical safety will be unable to perform an adequate assessment. Similarly, a patient who feels threatened will be unable to focus on the interview and may begin to escalate thinking that he or she needs to defend himself or herself. An interview may need to be terminated early if the patient’s agitation escalates. Generally, unpremeditated violence is preceded by a period of gradually escalating psychomotor agitation such as pacing, loud speech, and threatening comments. At this point the psychiatrist should consider whether other measures are necessary, including assistance from security personnel or need for medication or restraint. If the patient makes threats or gives some indication that he or she may become violent outside the interview setting, then further assessment is necessary. Because past history of violence is the best predictor of future violence, past episodes of violence should be explored as to setting, what precipitated the episode, and what was the outcome or potential outcome (if the act was interrupted). Also, what has helped in the past in preventing violent episodes (medication, timeout, physical activity, or talking to a particular person) should be explored. Is there an identified victim and is there a plan for the violent behavior? Has the patient taken steps to fulfill the plan? Depending on the answers to these questions the psychiatrist may decide to prescribe or increase antipsychotic medication, recommend hospitalization, and perhaps, depending on the jurisdiction, notify the threatened

victim. (See discussion of confidentiality above.) Deceptive Patients Psychiatrists are trained to diagnose and treat psychiatric illness. Although psychiatrists are well trained in eliciting information and maintaining awareness for deception, these abilities are not foolproof. Patients lie or deceive their psychiatrists for many different

---

Revision #1
Created 2026-01-04 19:50:38 UTC by Omar Ayman
Updated 2026-01-04 19:50:38 UTC by Omar Ayman