01 - 1. History Taking & Interview Skills

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1. History Taking & Interview Skills The four tasks of a psychiatric interview are 1. Build a therapeutic alliance. 2. Obtain the demographic information required. 3. Interview for diagnosis. 4. Negotiate a treatment plan. Basic concepts on approaching threatening topics: 1.Use normalizing questions to decrease a patient's sense of embarrassment about a feeling or behaviour. 2. Use symptom expectation and reduction of guilt to defuse the admission of embarrassing behaviour. 3. Use symptom exaggeration to determine the actual frequency of a sensitive or shameful behaviour. 4.Use familiar language when asking about behaviours. Nondirective techniques Use Example Comments Open-ended Qs The opening stage of the interview, to allow free narration. Non-directive technique What brings you to the hospital? Preferable when highly suggestible; not very useful to focus if overtalkative or extremely poor historian. Usually starts with ‘tell me’, ‘describe’, etc. Repetition Repeating the exact words of the patient Pt: I was having bad dreams last night.

Dr: So, you were having bad dreams last night. Helps patient to feel that doctor is listening actively Restatement Similar to repetition but phrases rearranged Pt: I was having bad dreams last night.

Dr: So, you are getting disturbed by the dreams you have. Helps patient to feel that doctor is listening actively Summation Brief summarisation of what the patient has said up to a point in the interview

‘So from what you have told so far, you are worried for last 4 months and not sleeping well, and your job is at risk. Right?’ Helps patient to check if he has said what he intended to say. Helps the doctor to form an idea of the narration so far. Clarification Doctor tries to get details from patients about what the patient has already said.

‘You said you are feeling depressed ever since you can remember. When do you feel most depressed?’ Helps in avoiding misconceptions by the clinician. Also shows clinician’s interest in knowing more. Facilitation Helping patients continue the interview by providing both verbal and nonverbal encouragement.

Approval nods, leaning forward slightly to express interest, ‘Yes. And then?’, ‘yeah, go on…’ ‘Uh-huh’ etc. Helps patient to feel that doctor is listening actively. Encourages flow of information.

© SPMM Course Techniques when changing topics: 1. Use smooth transitions to hint at something the patient just said. 2. Use referred transitions to hint for something said earlier in the interview. 3. Use introduced transitions to pull a new topic from thin air.

1. Non-directive techniques: These techniques are employed without focussing on a particular answer.
2. Directive techniques: These are focussed on seeking a particular answer or driven by other motives of the doctor. Note that these are not necessarily detrimental but must be used judiciously. Directive techniques Use Example Comments Closed questions When, where, how many, which and what questions. Answers can only be ‘yes or no’, in most occasions. When clubbed with non-facilitative gestures, can be detrimental to interview process. Stating a presumption followed by tags can be very directive. Did you sleep well last night?

You have lost weight. Haven’t you? Better avoided in early parts of the interview as they can produce prescribed answers lacking in detail. Also avoid in highly suggestible patients. Good technique is to start with open; move to closed by the end of the interview. Useful to rule out less likely symptoms. Question rephrasing Persisting with a question to seek an answer; so, restating the question in different terms for a second time.

Often used when patient digresses from the topic of discussion. The motive is to collect the specific information. Redirection Gently reorienting patient towards the topic of discussion. Pt: ‘It is not good if one’s parents are divorced even before one goes to school.’ Doc: ‘I’d like to hear more about your parents, but first let me get a picture of what’s happening to you of late’. The motive is to keep the patient on track. Transition Moving from one to another topic – this is a special skill and preferably must be done as smoothly as possible to keep the patient interested. ‘You mentioned that your mother is a medical secretary. What about yourself? What job do you do?’ Smooth transitions – uses the cue off something the patient just said. Referred transitions – uses the cue off something said earlier in the interview. introduced transitions -uses a new topic to proceed.

© SPMM Course Limit setting Useful to manage time pressure, especially in garrulous patients. ‘I am going to interrupt you as there are few important things we need to cover today’. To be used cautiously, overuse may detach patient from the doctor. The motive is to use time effectively.

© SPMM Course Other methods to elicit information:

Technique Description Example Comments Confrontation Point out to a patient something to which the doctor thinks the patient is missing or denying.

‘You seem not to have gained any weight in last 6 months. Is it possible that your eating has been poor again?’ Must be done in a respectful way. The aim is to help patients face a difficult aspect rather than dismissing patients by showing a negative aspect. Interpretation Clarifying certain associations or relationships that the patient may not see.

You seem very anxious when talking about your job. Are you having any problems at workplace? Sophisticated technique and should generally be used only after the doctor has established some rapport. Should be stated as a hypothesis after sufficient collection of evidence from the interview. Self-revelation Limited, discreet selfdisclosure by physicians

‘Do you like Shakespeare? I was a mad fan when I was at school.’ Helps physician feel atease sometimes. Excessive self-revelation is a boundary violation. Silence Silence can be used either to facilitate discourse or to indicate disapproval or disinterest. Sometimes useful and allows free emotional expression.

Relieves patient’s pressure and he/she may fell relaxed that not every moment must be spent talking. Symptom expectation

Without a formal admission from the patient, asking about details of problem behaviour. Doctor assumes (rightly) that the patient is involved in the act. What sorts of drugs do you usually use when you're drinking? (Assuming that the patient uses drugs)

Defuse the admission of embarrassing behaviour. May help in reduction of guilt. But must be used with experience and according to the context. Symptom exaggeration When deception or minimisation is expected, overstating a guessed frequency in order to elicit a true answer. How many times have you taken overdoses since your last hospitalization? Four? Five? Also helpful in reducing guilt to certain extent as the patient feels that the doctor has expected a higher amount of problem that what she/he actually has brought.

© SPMM Course Supportive techniques – not aimed at eliciting information: Supportive technique Use Example Reassurance Used to instil positive hope and avoid or reduce despair. Must not be falsely reassuring. ‘The depression may be very difficult for you. I think it is very likely with the proper treatment you can get back to your job’.

Advice Many patients seek advice directly; it is acceptable to provide advice but based on sound understanding of the context. Premature advice can be obstructive than facilitative.

‘I think it is best for you to consider ECT at this time. If I am you, I will give this a serious thought.' Postponement Conscious and deliberate postponement of delicate issues; but must be opened at an appropriate time. ‘I can see that you are uneasy to tell me about your relationships. That’s OK, we can come back to this when you feel ready to discuss with me.’ Validation / normalisation Helps to decrease a patient's sense of embarrassment about a feeling or behaviour. Generally done by quoting how it is normal for people to have different emotions/ reactions/ behaviours, etc. ‘Sometimes when people are very depressed, they think of hurting themselves. Has this been true for you?’

Acknowledgement of affect Making a remark about patient’s affect can facilitate disclosure. I can see that you look anxious when talking about those voices.

Positive reinforcement Gently uplifting self-esteem by statements of praise (but at a realistic extent) ‘I've never been good at expressing my problems’. ‘Well, I think you've described the situation in a way that helped me understand what you have been going through’. Statement of respect Affirmative statements (must be genuine and appropriate) indicating respect and dignity along with positive reinforcement “You have been through a lot.” “I’m impressed at how you have hung in there.” “You must be a very strong person.” Partnering The interviewer encourages the patient to ask questions and to express any concerns, encouraging team working “I’m here to help.” “Let’s plan on working on this together.”

© SPMM Course Obstructive techniques that may hamper the progress of information sharing: Obstructive techniques Use Example Suggestive questions Answers are contained in the question itself. Misleads both the patient and the doctor. The patient is left with little choice. These voices are not from your head. Am I right? Why questions These questions ask the patient to discover their own problems, in a way. Not useful when used to elicit information from a distressed patient. Why do you keep waking up so early in the morning? Compound questions Adding two or more questions in a single statement. This confuses the patient and will lead to either a vague response or non-response. Do you take a vacation every year, and are you able to relax? Negative Nonverbal gestures Facial expression, body posture, and behaviour that indicate lack of interest or inattentiveness, The doctor is yawning or repeatedly checking his/her watch, other repetitive gestures like tapping the table, etc. Disapproval Expressing unhappiness with a topic that the patient wants to discuss; may lead to withdrawal and not revealing the important problem faced b y the patient. ‘Over the last month I have had trouble with sex’. ‘Dr: We are here to talk about your sleep.' Setting traps Tricking the patient using his own words. Often seen as doctor’s attempt to negate patient’s problems. You wanted to see me as nothing had gone well for you, but you just said that you have got a new job and keeping a good shape. Adapted from Kay J & Tasman A. Essentials of Psychiatry, 2nd edition, 2006. John Wiley & Sons, Ltd.

© SPMM Course Open-Ended vs. Closed-Ended Questions Open-Ended Questions Closed-Ended Questions Highly informative answers They produce spontaneous formulations. Low yield answers They lead the patient. Low reliability of answers. Non-reproducible at a later date, or by a different doctor. High reliability. Low precision – do not focus on target symptoms.

The intent of the question is clear, and so precise, focused answers elicited. Not very time efficient. My lead to circumstantial elaborations. High time efficiency.

Low diagnostic coverage as patient selects the content revealed. Good diagnostic coverage as doctor selects interested content. Adapted from Othmer E, Othmer SC. The Clinical Interview Using DSM-IV. Washington, DC: American Psychiatric Press; 1994. Techniques for a poor historian Use open-ended questions and commands to increase the flow of information. Use continuation techniques to keep the flow coming. The Shift to the neutral ground when necessary. Schedule a second interview when all else fails. Techniques for over-talkative garrulous historian Use closed-ended and multiple-choice questions to limit the flow. Perfect the art of the gentle interruption. Educate the patient about the need to move along in the interview. Ancillary

methods of gathering information: Behavioural observation methods: Observing and recording behavioural events, to study mental state or plan intervention. Often used when patients are in seclusion. Event sampling: e.g. every fifth or tenth event is coded in detail Time sampling: observations may be made only every 5 or 10 mins ‘Functional analysis' refers to attempts to explain and predict the functions of a phenomenon by examining any relationships to the outcome. It is a special variant of behavioural observation methods, where the sequence of antecedent environmental events, target behaviour and concurrent events and consequent outcomes are observed. This is also called ABC analysis. Often used in LD setting, dementia care, and challenging behaviour services.

© SPMM Course Using an interpreter: Explain the goals of the interview to the interpreter Explain structure and content of interview Explain the need for literal translation – not interpreted translation in the Mental Status Examination Ask for feedback when something is hard to translate Offer to debrief the interpreter to address any of their own emotional concerns following the interpretation Ask interpreter about the patient’s degree of openness or disclosure Preferably work with same interpreter/culture-broker for the same case whenever possible

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