The Psychiatric Interview
Evaluation and Diagnosis

The patient interview is at the heart of psychiatric practice. Listening and interviewing skills are the primary tools the psychiatrist uses to obtain the information needed to make an accurate diagnosis and then to plan appropriate treatment. The American Board of Psychiatry and Neurology and the Accrediting Council on Graduate Medical Education identify interviewing skills as a core competency for psychiatric residents.

The Psychiatric Interview: Evaluation and Diagnosis is a new and modern approach to this topic that fulfills the need for training in biopsychosocial assessment and diagnosis. It makes use of both classical and new knowledge of psychiatric diagnosis, assessment, treatment planning, and doctor–patient collaboration. Written by world leaders in education, the book is based on the acclaimed Psychiatry, Third Edition, by Tasman and Kay et al., with new chapters to address assessment in special populations and formulation. The psychiatric interview is conceptualized as integrating the patient’s experience with psychological, biological, and environmental components of the illness.

This is an excellent new text for psychiatry residents at all stages of their training. It is also useful for medical students interested in psychiatry and for practicing psychiatrists who may wish to refresh their interviewing skills.
The Psychiatric Interview
Evaluation and Diagnosis

THE PSYCHIATRIC INTERVIEW
Evaluation and Diagnosis

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Preface

The tools of diagnosis in psychiatry, as is true for all of medicine, have vastly improved in the past decades. We now can image the brain to look at structures, see changes in the brain with development, identify functional areas of the brain as they are operating, and measure blood levels of hormones and medications. All of these allow us to better assess and care for our patients. Although these have been remarkable advances, the patient interview and the evolving doctor–patient relationship continue to provide the setting and the structure to gather core data to begin assessment and treatment in all of medicine and especially in psychiatry. This is true regardless of the clinical setting, whether inpatient, outpatient, consultation/liaison, the emergency department, or telepsychiatry. This book provides both the information needed to conduct an in-depth psychiatric evaluation as well as a thorough discussion of how to begin forming and maintaining the therapeutic alliance. The heart of the philosophy embodied in this work is that we must learn who is the person with the illness, as well as what is the illness, and why it appeared, reappeared, or continues, in order to maintain the treatment relationship most likely to produce a positive clinical outcome. The strengthening of this relationship and assuring the best treatment is facilitated through the development of a case formulation which also is addressed in depth within the book.

The clinical interview is the process of listening to and understanding the patient, and effectively communicating that understanding within the context of the doctor–patient relationship. How to conduct an interview to maximize discerning the most important information while developing and maintaining the best long-term relationship on which to build treatment is the goal of this book. Interviewing requires knowing how to listen for information often outside of the patient’s awareness, how to communicate, how to maintain the therapeutic relationship, and appreciate the dynamic, interpersonal, cultural, and ethical issues central to the clinical process. The advances in both understanding the effect of development on the patient’s capacities to form meaningful relationships and the improved diagnostic systems used to recognize specific psychopathology have helped improve the clinician’s assessment of the varying degrees of the individual patient’s pre-existing capability to trust the physician. The ability to discern these limitations alerts the interviewer to the need to tailor the style of the interview for each patient in order to maximize the success of a multimodal treatment plan.

We believe this book will be of particular importance for students, postgraduate trainees, and those in the early stages of their careers. But we also know that no
matter what the stage of a clinician’s career, the material in this book will serve as a useful guide and reference. We hope you find this book as useful to your practice as we have found it gratifying to prepare.

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Jerald Kay
Robert J. Ursano
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Listening: The Key Skill in Psychiatry

It was Freud who raised the psychiatric technique of examination – listening – to a level of expertise unexplored in earlier eras. AsBinswanger (1963) has said of the period prior to Freudian influence: psychiatric “auscultation” and “percussion” of the patient was performed as if through the patient’s shirt with so much of his essence remaining covered or muffled that layers of meaning remained unpeeled away or unexamined.

This metaphor and parallel to the cardiac examination is one worth considering as we first ask if listening will remain as central a part of psychiatric examination as in the past. The explosion of biomedical knowledge has radically altered our evolving view and practice of the doctor–patient relationship. Physicians of an earlier generation were taught that the diagnosis is made at the bedside – that is, the history and physical examination are paramount. Laboratory and imaging (radiological, in those days) examinations were seen as confirmatory exercises. However, as our technologies have blossomed, the bedside and/or consultation room examinations have evolved into the method whereby the physician determines what tests to run, and the tests are often viewed as making the diagnosis. So can one imagine a time in the not-too-distant future when the psychiatrist’s task will be to identify that the patient is psychotic and then order some benign brain imaging study which will identify the patient’s exact disorder?

Perhaps so, but will that obviate the need for the psychiatrist’s special kind of listening? Indeed, there are those who claim that psychiatrists should no longer be considered experts in the doctor–patient relationship, where expertise is derived from their unique training in listening skills, but experts in the brain. As we come truly to understand the relationship between brain states and subtle cognitive, emotional, and interpersonal states, one could also ask if this is a distinction that really makes a difference. On the other hand, the psychiatrist will always be charged with finding a way to relate effectively to those who cannot effectively relate to themselves or to others. There is something in the treatment of individuals whose illnesses express themselves through disturbances of thinking, feeling, perceiving, and behaving that will always demand special expertise in establishing a therapeutic relationship – and that is dependent on special expertise in listening (Clinical Vignette 1).

All psychiatrists, regardless of theoretical stance, must learn this skill and struggle with how it is to be defined and taught. The biological or phenomenological psychiatrist
listens for subtle expressions of symptomatology; the cognitive–behavioral psychiatrist listens for hidden distortions, irrational assumptions, or global inferences; the psychodynamic psychiatrist listens for hints at unconscious conflicts; the behaviorist listens for covert patterns of anxiety and stimulus associations; the family systems psychiatrist listens for hidden family myths and structures.

This requires sensitivity to the storyteller, which integrates a patient orientation complementing a disease orientation. The listener’s intent is to uncover what is wrong and to put a label on it. At the same time, the listener is on a journey to discover who the patient is, employing tools of asking, looking, testing, and clarifying. The patient is invited to collaborate as an active informer. Listening work takes time, concentration, imagination, a sense of humor, and an attitude that places the patient as the hero of his or her own life story. Key listening skills are listed in Table 1.1.

### Table 1.1 Key Listening Skills

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<td>Stream of associations</td>
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<td>Gestures</td>
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<td>Facial expressions (e.g., eyes watering, jaw clenched)</td>
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<td>Other outward expressions of emotion</td>
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<td>Comparing</td>
<td>Noting what is omitted</td>
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<td>Dissonances between modes of expression</td>
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<td>Intuiting</td>
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<td>Reflecting</td>
<td>Attending to one’s own internal reactions</td>
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<td>Thinking it all through outside the immediate pressure to respond during the interview</td>
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Clinical Vignette 1

A 28-year-old white married man suffering from paranoid schizophrenia and obsessive–compulsive disorder did extremely well in the hospital, where his medication had been changed to clozapine with good effects. But he rapidly deteriorated on his return home. It was clear that the ward milieu had been a crucial part of his improvement, so partial hospitalization was recommended. The patient demurred, saying he didn’t want to be a “burden”. The psychiatrist explored this with the patient and his wife. Beyond the obvious “burdens” of cost and travel arrangements, the psychiatrist detected the patient’s striving to be autonomously responsible for handling his illness. By conveying a deep respect for that wish, and then educating the already insightful patient about the realities of “bearing schizophrenia”, the psychiatrist was able to help the patient accept the needed level of care.
The enduring art of psychiatry involves guiding the depressed patient, for example, to tell his or her story of loss in addition to having him or her name, describe, and quantify symptoms of depression. The listener, in hearing the story, experiences the world and the patient from the patient’s point of view and helps carry the burden of loss, lightening and transforming the load. In hearing the sufferer, the depression itself is lifted and relieved. The listening is healing as well as diagnostic. If done well, the listener becomes a better disease diagnostician. The best listeners hear both the patient and the disease clearly, and regard every encounter as potentially therapeutic.

The Primary Tools: Words, Analogies, Metaphors, Similes, and Symbols

To listen and understand requires that the language used between the speaker and the hearer be shared – that the meanings of words and phrases are commonly held. Patients are storytellers who have the hope of being heard and understood. Their hearers are physicians who expect to listen actively and to be with the patient in a new level of understanding. Because all human beings listen to so many different people every day, we tend to think of listening as an automatic ongoing process, yet this sort of active listening remains one of the central skills in clinical psychiatry. It underpins all other skills in diagnosis, alliance building, and communication. In all medical examinations, the patient is telling a story only she or he has experienced. The physician must glean the salient information and then use it in appropriate ways. Inevitably, even when language is common, there are subtle differences in meanings, based upon differences in gender, age, culture, religion, socioeconomic class, race, region of upbringing, nationality and original language, as well as the idiosyncrasies of individual history. These differences are particularly important to keep in mind in the use of analogies, similes, and metaphors. Figures of speech, in which one thing is held representational of another by comparison, are very important windows to the inner world of the patient. Differences in meanings attached to these figures of speech can complicate their use. In psychodynamic assessment and psychotherapeutic treatment, the need to regard these subtleties of language becomes the self-conscious focus of the psychiatrist, yet failure to hear and heed such idiosyncratic distinctions can affect simple medical diagnosis as well (Clinical Vignettes 2 and 3).

Clinical Vignette 2

A psychiatric consultant was asked to see a 48-year-old man on a coronary care unit for chest pain deemed “functional” by the cardiologist who had asked the patient if his chest pain was “crushing”. The patient said no. A variety of other routine tests were also negative. The psychiatrist asked the patient to describe his pain. He said, “It’s like a truck sitting on my chest, squeezing it down”. The psychiatrist promptly recommended additional tests, which confirmed the diagnosis of myocardial infarction. The cardiologist may have been tempted to label the patient a “bad historian”, but the most likely culprit of this potentially fatal misunderstanding lies in the connotative meanings, each ascribed to the word “crushing” or to other variances in metaphorical communication.
The Psychiatric Interview

In psychotherapy, the special meanings of words become the central focus of the treatment.

How Does One Hear Words in This Way?

The preceding clinical vignettes, once described, sound straightforward and easy. Yet, to listen in this way, the clinician must acquire specific yet difficult-to-learn skills and attitudes. It is extremely difficult to put into words the listening processes embodied in these examples and those to follow, yet that is what this chapter attempts to do.

Students, when observing experienced psychiatrists interviewing patients, often express a sense of wonder such as: “How did she know to ask that?” “Why did the patient open up with him but not with me?” “What made the diagnosis so clear in that interview and not in all the others?” The student may respond with a sense of awe, a feeling of ineptitude and doubt at ever achieving such facility, or even a reaction of disparagement that the process seems so indefinable and inexact. The key is the clinician’s ability to listen. Without a refined capacity to hear deeply, the chapters on other aspects of interviewing in this textbook are of little use. But it is neither mystical nor magical nor indefinable (though it is very difficult to articulate); such skills are the product of hard work, much thought, intense supervision, and extensive in-depth exposure to many different kinds of patients.

Psychiatrists, more than any other physicians, must simultaneously listen symptomatically and narratively/experientially. They must also have access to a variety of theoretical perspectives that effectively inform their listening. These include behavioral, interpersonal, cognitive, sociocultural, and systems theories. Symptomatic listening is what we think of as traditional medical history taking, in which the focus is on the presence or absence of a particular symptom, the most overt content level of an interview. Narrative–experiential listening is based on the idea that all humans are constantly interpreting their experiences, attributing meaning to them, and weaving a story of their

Clinical Vignette 3

A psychiatrist had been treating a 35-year-old man with a narcissistic personality and dysthymic disorder for 2 years. Given the brutality and deprivation of the patient’s childhood, the clinician was persistently puzzled by the patient’s remarkable psychological strengths. He possessed capacities for empathy, self-observation, and modulation of intense rage that were unusual, given his background. During a session, the patient, in telling a childhood story, began, “When I was a little fella…”. It struck the psychiatrist that the patient always said “little fella” when referring to himself as a boy, and that this was fairly distinctive phraseology. Almost all other patients will say, “When I was young/a kid/a girl (boy)/in school”, designate an age, etc. On inquiry about this, the patient immediately identified “The Andy Griffith Show” as the source. This revealed a secret identification with the characters of the TV show, and a model that said to a young boy, “There are other ways to be a man than what you see around you”. Making this long-standing covert identification fully conscious was transformative for the patient.
lives with themselves as the central character. This process goes on continuously, both 
consciously and unconsciously, as a running conversation within each of us. The 
conversation is between parts of ourselves and between ourselves and what Freud called 
“internalized objects”, important people in our lives whose images, sayings, and attitudes 
become permanently laid down in our memories. This conversation and commentary on 
our lives includes personal history, repetitive behaviors, learned assumptions about the 
world, and interpersonal roles. These are, in turn, the products of individual background, 
cultural norms and values, national identifications, spiritual meanings, and family system 
forces (Clinical Vignette 4).

Clinical Vignette 4

A 46-year-old man was referred to a psychiatrist from a drug study. The patient 
had both major depression and dysthymic disorder since a business failure 2 years 
earlier. His primary symptoms were increased sleep and decreased mood, libido, 
energy, and interests. After no improvement during the “blind” portion of the 
study, he had continued to show little response once the code was broken, and he 
was treated with two different active antidepressant medications. He was referred 
for psychotherapy and further antidepressant trials. The therapy progressed slowly 
with only episodic improvement. One day, the patient reported that his wife had 
been teasing him about how, during his afternoon nap, his snoring could be heard 
over the noise of a vacuum cleaner. The psychiatrist immediately asked additional 
questions, eventually obtained sleep polysomnography, and, after appropriate 
treatment for sleep apnea, the patient’s depression improved dramatically.

It seems that three factors were present that enabled the psychiatrist in Clinical 
Vignette 4 to listen well and identify an unusual diagnosis that had been missed by at least 
three other excellent clinicians who had all been using detailed structured interviews that 
were extremely inclusive in their symptom reviews. First, the psychiatrist had to have 
readily available in mind all sorts of symptoms and syndromes. Second, he had to be in a 
curious mode. In fact, this clinician had a gnawing sense that something was missing in 
his understanding of the patient. There is a saying in American medicine designed to 
focus students on the need to consider common illnesses first, while not totally ignoring 
rarer diseases: when you hear hoofbeats in the road, don’t look first for zebras. We would 
say that this psychiatrist’s mind was open to seeing a “zebra” despite the ongoing assump-
tion that the weekly “hoofbeats” he had been hearing represented the everyday “horse” of 
clinical depression. Finally, he had to hear the patient’s story in multiple, flexible ways, 
including the possibility that a symptom may be embedded in it, so that a match could be 
noticed between a detail of the story and a symptom. Eureka! The zebra could then be 
seen although it had been standing there every week for months.

Looking back at Clinical Vignette 3, we see the same phenomenon of a detail leaping 
out as a significant piece of missing information that dramatically influences the treatment 
process. To accomplish this requires a cognitive template (symptoms and syndromes; 
developmental, systemic, and personality theories; awareness of cultural perspectives),