The Psychiatric Interview
Clinical interviewing is the single most important skill required in psychiatry. The interview constitutes the principal means for gaining an understanding of a patient's difficulties. This understanding leads to a diagnostic formulation and the development of treatment plan. The interview is as important to psychiatry as the operating room is to surgery and the laboratory is to internal medicine.

The assessment process in psychiatry relies primarily on the interviewing and observational skills of practitioners because there is no laboratory test, tissue diagnosis or imaging method available to confirm a psychiatric diagnosis.

The interview can be defined as "the skill of encouraging disclosure of personal information for a specific professional purpose" (McCready, 1986), and serves a variety of functions:
• Collecting clinical information in an efficient manner
• Eliciting emotions, feelings, and attitudes
• Establishing a doctor-patient relationship and developing rapport
• Generating and testing a set of hypotheses to arrive at a preferred diagnosis, accompanied by a list of other conditions (called a differential diagnosis) which must be considered
• Determining areas for further investigation
• Developing a treatment plan

Interviewing is not simply the task of taking a history. Rather, it is the process of determining which illness the patient has, and understanding how he or she has been affected by it. Far more than a series of questions, a well-conducted interview yields information that helps develop an individualized approach for treating the patient.

While providing treatment is not usually identified as an explicit aim of initial interviews, it often is a component. Pekarik (1993) and Talmon (1990) reported that a single meeting gave a number of patients enough relief from their stressors that follow-up was not required. Interviews can form a large, if not the entire part, of the treatment process in ongoing types of therapy, particularly in psychotherapy.

A careful history contributes more to determining a diagnosis in medically ill patients than does the physical examination which, in turn, is of greater usefulness than laboratory testing (Anfinson, 1992; Hampton, 1975). Patient satisfaction was found to be strongly correlated with courtesy shown, and information given, by interviewers — a further benefit of good communication skills (Comstock, 1982).

Langsley (1982 & 1988) conducted studies to elucidate the core skills and knowledge that defined a specialist in psychiatry. He sent a questionnaire to members of the **American Association of Chairmen of Departments of Psychiatry (AACDP)** and the **American Association of Directors of Psychiatric Residency Training (AADPRT)**, as well as to randomly selected members of the **American Psychiatric Association (APA)**. The study was repeated eight years later. The ranking of skills and knowledge related to interviewing figured prominently in the results of these studies:

Skill (Aggregate Rank)
• Conduct a comprehensive diagnostic interview – 1
• Make accurate psychiatric diagnoses – 3
• Demonstrate the qualities of reliability, conscientiousness, and integrity – 5
• Assess suicidal and homicidal potential, and the potential for assaultive behavior – 6
• Demonstrate consistent interest, tact, and compassion for the patient and family – 7
• Remain objective, keep a professional stance, yet not become too distant or too involved – 10
• Maintain adequate records, including history, mental status exam, physical examination, diagnostic tests, and notes indicating progress – 10

Knowledge (Aggregate Rank)
• Differential diagnosis of psychiatric syndromes – 5
• Descriptive psychiatry, including various clinical syndromes – 7
• Nosology and classification of mental disorders, including childhood disorders – 12
• Genetic and dynamic formulations, including precipitating stress, interpersonal relationships, character structure, psychodynamics, and effects of illness on others – 12

More than any other discrete group of skills and knowledge, facility with the interview and associated abilities ranked the highest.

Anatomy of the Psychiatric Interview
In 1996, the APA published a set of practice guidelines for general psychiatric evaluation of adults. The following "domains of evaluation" comprise a complete psychiatric interview:

A. Reason for the Evaluation
B. History of the Present Illness
C. Past Psychiatric History
D. General Medical History
E. History of Substance Use
F. Psychosocial/Developmental History (Personal History)
G. Social History
H. Occupational History
 I. Family History
J. Review of Symptoms
K. Physical Examination
L. Mental Status Examination (MSE)
       Appearance
       Behavior
       Cooperation
       Speech
       Thought (Content & Process)
       Affect
       Mood
       Perception
       Level of Consciousness
       Insight & Judgment
       Cognitive Functioning & Sensorium
       Knowledge Base
       Endings — Suicidal & Homicidal Ideation
       Reliability of Information
M. Functional Assessment
N. Diagnostic Tests
O. Information Derived From The Interview Process

In some practice situations, interviews are done for a specific purpose, and certain aspects of the interview are emphasized while others are minimized or deferred. For example:

Emergency Room Interview
• Presenting Complaint
• History of Present Illness
• Dangerousness to Self or Others
• Substance Use or Intoxication
• Mental Status Examination (MSE)

Consultation-Liaison Interview
• Reason for Referral (consult request)
• History of Present Illness (psychiatric and medical illnesses)
• Medical and Substance Use History
• Current Medications
• MSE

Psychotherapy Assessment
• Personal and Social History
• Developmental History
• Family History
• Past Psychiatric Illnesses
• Details of Past Treatments

Functions of the Interview
Nurcombe (1982) indicated that interviewers must develop an understanding (sometimes called a **formulation**) of two domains, **nosologic** and **dynamic**. Nosologic refers to the exercise of figuring out which condition(s) the patient suffers from. The dynamic domain involves an application of eliciting the biopsychosocial aspects of the patients illness:
• In what way(s) was the patient **predisposed** to getting this condition?
• What **precipitating** factors caused this illness to emerge at this time?
• What factors **perpetuate** this illness in its current form?
• What **protective factors** (strengths, supports, resources, etc.) does this patient have?

Often, these parameters are divided into biological, social, and psychological components.

Thus, while the **nosologic** or **diagnostic formulation** can be completed relatively early in the interview, the **dynamic formulation** can take an extended period of time. The interview can be considered as having two tasks: making a diagnosis and understanding the patient's psychosocial milieu. The sections of the interview particularly relevant to these areas are as follows:

Diagnostic Formulation	Dynamic Formulation
Reason for Referral	Identifying Factors
History of Present Illness	Personal History
Psychiatric History	Family History
General Medical History	Social History
History of Substance Use	Occupational History
Review of Symptoms	
Mental Status Exam	

How Do Novice Interviewers Fare?
Maguire (1976) studied a group of clinical clerks conducting a fifteen-minute interview for the purpose of determining the patient's current problems and found the following deficiencies:
• Only 4% mentioned the time constraints on the interview, indicated they would like to take notes, or asked if the patient felt at ease
• Only 8% explained the purpose of the interview
• Just 16% checked to see if patients understood that the interview would be recorded
• 24% failed to discover the patient's main problem(s)
• 30% failed to introduce themselves to the patients
• 44% did not mention they were medical students
• 66% of the information deemed available in the interview was not obtained

The point of Maguire's article was not to ridicule students, but to document that proper interview skills are not emphasized early enough in medical school. He points out that a lack of coordination between departments gives students a fragmented, and often contradictory

approach, to interviewing. Many authors have commented on the difficulties in teaching interviewing skills and the resultant deficiencies in students' abilities. Because good interviewing skills are critical in clinical psychiatry, interest and recruitment into the specialty may suffer as a result of teaching deficits (Sierles, 1995).

Why Are Interviewing Methods Difficult to Teach?
Interviewing can be compared to surgery, where each question seeks to further dissect or delineate problem areas. Surgeons do not make unnecessary incisions, and over time develop a precise "economy of movement." Similarly, proper interviewing technique takes years to develop, but rarely involves the supervision and feedback that a surgery resident receives.

One of the most obvious causes for deficiencies in teaching interviewing is that it is not emphasized in undergraduate or graduate programs (McGuire, 1982). McCready (1986) suggests that educators take interview skills for granted, as if they will be acquired by osmosis from time spent in psychiatric settings. He further indicates that direct feedback to those who have performed weak assessments is often misconstrued as personal criticism, causing a level of discomfort that both students and supervisors would rather avoid. Because the emphasis of teaching in many centers focuses on psychopathology and treatment rather than on interviewing skills (Pollock, 1985), critiquing students and residents on areas such as data collection, formulation, diagnosis, and management is more readily accepted.

There is diversity in what is considered an effective interviewing style (Rutter, 1981). Many supervisors emphasize their own approach instead of nurturing a student's natural style. McCready (1986) notes that there is little research to back commonly held assumptions about interviewing techniques (e.g. that asking "why" questions will make patients feel criticized). Further, he points out the lack of research into the clinical interview at the postgraduate psychiatric level. The majority of published articles focus on either medical students or family practice residents.

In many cases, scheduling and budgetary constraints impact on the availability of methods such as simulated patient interviews and detailed videotape analysis. Undergraduate and postgraduate programs rarely coordinate their curricula, especially considering the high likelihood of students going to other locations to complete their residencies. Educators may well view the formal teaching of interviewing skills as the responsibility of "some other party."

Lake (1984) points out that not all of the difficulty in teaching interviewing skills results from departmental limitations. He notes that, compared to assessing patients with medical illnesses, there are particular challenges in dealing with mentally ill patients:
• Reluctance to admit having an illness
• Procrastination in seeking treatment
• Attending appointments under duress
• Being in the midst of a psychosocial crisis during the interview
• Defense mechanisms and suppression of information interfere with the accuracy and completeness of the information obtained

The supervision required by students and residents changes with time. Several authors have noted the variation in skills displayed by students, and that time and experience often erode interviewing abilities (Helfer, 1970).

What Happens To Interview Skills Over Time?
Many students, either because of their personalities or experience before medical school, have particular strengths in interviews. Some articles even document a decline in certain interviewing skills with time (Maguire, 1976; Rutter, 1981). Not surprisingly, anxiety is the main hurdle for students to get over initially (Knox, 1979).

Knox (1979) reports that junior students often seem to have a more personal interest in patients, and obtain more information about emotions and interpersonal problems. He estimated that about two-thirds of novice interviewers are able to manage without significant difficulties. Scott (1975) studied the interview styles of students two years apart and found that in later years there was a more directive style with less reassurance, empathy, and support being offered. McCready (1986) attributes this to junior students showing concern for patients, but lacking the knowledge to explore psychiatric disorders.

Over time, the ability to direct an interview and take a psychiatric history seems to occur at the expense of maintaining a personal concern for patients. Byrne (1976) found that a student's style tended to persist throughout his or her training, and in many instances improvement in one area was coupled with a decline in another. Wright (1980) thought that interview style was relatively impervious to change and a manifestation of a student's personality (which gives credence to the apprehension supervisors feel when giving criticism). Without the intervention of programs specifically designed to meet the ongoing needs of interviewers, experience alone does not improve interviewing technique.

Fletcher (1980) went as far as to suggest that students doing particularly poorly in interviews should be advised to go in to non-clinical branches of medicine.

Pollock (1985) noted that interviewing skills seemed to be independent of other measures of ability. Specifically, there was no correlation between the quality of interviews and students':
• Overall performance during clerkship psychiatry rotations
• Scores on written examinations (set by departments and licensing bodies)
• Attitude towards psychiatry

What Are the Consequences of Poor Interviewing Skills?
The benefits of a well-conducted, thorough, and empathic interview are intuitively obvious. The effects of poorly conducted interviews are extensive and unfortunate:
• Patient dissatisfaction (Reynolds, 1978)
• Poor compliance (Ley, 1982)
• Missed diagnoses (Goldberg, 1980)
• Inappropriate treatment (McCready, 1986)
• Formal complaints (Fletcher, 1980)
• Increased litigation (Carroll, 1979)

Poor interviewing skills also impact on students and residents. During training, students and residents are much more likely to fail rotations and examinations (such as the American Board of Psychiatry & Neurology Part II Exam) as a result of deficient interviewing skills. Students failing psychiatric examinations in medical school may develop a bias against the specialty, which can even extend to patients with mental illnesses encountered on medical or surgical wards. Residents failing rotations or examinations may need to defer their career plans, and some may even change their entire career path after encountering such difficulties.

Common Pitfalls in Interviewing
Interview skills can be compared to golf. Students of either of these endeavors have inherent abilities and weaknesses, both of which must be uncovered before improvement can begin.

There has never been a perfect psychiatric interview, just as no one has played a "perfect" round of golf (miniature golf excluded). Sitting across from another human being and extracting highly sensitive information is a daunting task. A myriad of considerations flow through the interviewer's mind, just as golf has many mental challenges. Almost everyone misses the ball on the first golf swing, and almost everyone performs a lackluster, or sometimes abysmal, first interview.

Two things separate great golfers and great interviewers from their mediocre colleagues: an awareness of their deficits, and the willingness to improve upon them.

On many occasions, great sport is made of novice interviewers, frequently by their peers. While at times students do some genuinely humorous things, they are rarely intended. Supervisors will determine their own level of comfort and tolerance for these occasions, and can often turn awkward moments into useful teaching examples. However, a sense of perspective needs to be reinforced. Like a first swing at a golf ball, initial efforts at interviewing are the least fruitful.

The goals of an interview are to determine the illness a patient has, and the effect that the illness has made on his or her life. In order to achieve these goals, a successful interview must be a balance of many factors. Assessments can be poorly conducted for many reasons. Authors of several papers and texts have cataloged lengthy lists of the mistakes novice interviewers make. These foibles can be coalesced into four main areas:

A/ Weak Introduction and/or Ending of the Interview

B/ Problems with Content (Flawed Data Base)
Amount of Data Elicited, Quality of Data Elicited

C/ Problems with Process (Deficient Technique)
Inappropriate Control Style, Poor Formulation of Questions
Interview Style Impedes Information Exchange

D/ Failure to Generate Hypotheses (Clinical Reasoning)

A/ Introduction
• Fails to identify self and professional status
• Purpose of the interview and time available is not mentioned
• Omits to say what was expected of the patient
• Patients' comfort is not considered
• Fails to indicate that notes would be taken
• Doesn't ask if the patient has any questions or is ready to proceed

End of Interview
• Ends abruptly
• Fails to follow-up on areas partially dealt with in the interview (i.e. information given out of sequence that was deferred until later, but was not asked about again)
• Doesn't provide an opportunity for the patient to ask questions
• Doesn't inquire about the emotional effect the interview has had on the patient
• Doesn't ask about safety concerns (suicide or homicide)
• Forgets to acknowledge the patient's efforts
• Does not outline a treatment plan

B/ Content (*What* information was obtained)
• Fails to discover the main/most significant problems
• Assumes there is only one problem
• Early focus on diagnostic criteria or the sequence of events, without understanding their relevance to the patient
• Fails to ask about the effect of the illness on lifestyle and family
• Lack of empathy
• Accepts jargon without exploration
• Imprecise understanding of the manifestations of symptoms
• Avoids the more difficult/sensitive areas (e.g. sexual history, substance use history, suicidal ideation)
• Ignores expressed emotions or cues given by patients

• Fails to follow a patient's lead (especially returning to a previous area)
• Early reassurance for incompletely understood difficulties
• Interrupts patients
• Cuts off expression of emotional difficulties
• Doesn't summarize/recapitulate the history to demonstrate that the patient has been understood
• Poor use of time (e.g. rushing through the interview, repeating areas already covered)

C/ Process (*How* the information was obtained)
• Not directive enough; lets patients wander with information
• Too directive; left little to no chance for spontaneity
• Disjointed inquiries; moves to other areas before all relevant information obtained
• Utterances or mannerisms impede the flow of information (e.g. "OK," "I see," fixed posture, tapping pen or foot, hand covering mouth, taking refuge in note-taking)
• Style of questioning inhibits information sharing (e.g. leading questions, rapid sequence of questions, prolonged silence)
• Rephrases patients' complaints in a way that enhances or minimizes the significance of their symptoms

D/ Hypothesis Generation (Clinical Reasoning)
This is a frequent scenario in interview situations:

Nicole Novice is a clinical clerk finishing the first week of her psychiatry rotation. She is an above-average student who prepared all week for a supervised interview with Dr. Eager, the chief resident. Following the outline provided in lectures, she allots 50 minutes for the interview and covers all required areas. However, at the end she is perplexed. In the 20 minutes she spent on the History of Present Illness, she elicited a hodgepodge of symptoms from the following areas: Impulse-Control Disorders, Eating Disorders, Mood Disorders, Dissociative Disorders, and Anxiety Disorders. She is unable to sort out which of these several options apply to the patient, so she asks Dr. Eager if there are any areas left to clarify. Within five minutes, Dr. Eager has elicited a history of perpetually unstable relationships, a poor sense of self-image (emptiness), and long-standing difficulties in controlling anger. The diagnosis of Borderline Personality Disorder becomes clear when these themes are explained to Nicole.

Dr. Eager, a veteran of many nights in the Emergency Department, was familiar with the dramatic, erratic, and emotionally labile presentation of Borderline Personality Disorder which is a "great imitator" of other psychiatric conditions (Robinson, 1999)

The art of interviewing is knowing which questions to ask and how to ask them. Nurcombe (1982) described the thought processes of experienced clinicians as "rapid, sophisticated pattern-matching, consideration of alternatives, and discriminating plans of enquiry." Feinstein (1974) notes that diagnostic reasoning goes from effect to cause; that is from manifestations of illness to disease entities. Signs and symptoms are assigned to patterns which the clinician then further gathers information about to prove or disprove suspected diagnoses.

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