

# THE INITIAL PSYCHIATRIC INTERVIEW

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## 1. What are the primary aims of the first psychiatric interview?

To make an initial differential diagnosis and to formulate a treatment plan. These goals are achieved by:

• Gathering information	
Chief complaint	History of current and past suicidal and homicidal ideation
History of presenting problem(s)	Current and past history of victimization (e.g., domestic violence, child abuse)
Precipitating factors	History of psychiatric problems, including treatment and response
Symptoms	Social and developmental history
Affective	Family psychiatric and social history
Cognitive	Mental history
Physical	Medical history
Substance use and abuse	
Changes in role and social functioning	

• Arriving at an empathic understanding of how the patient feels. This understanding is a critical base for establishing rapport with the patient. When the clinician listens carefully and then communicates an appreciation of the patient's worries and concerns, the patient gains a sense of being understood. This sense of being understood is the bedrock of all subsequent treatment, and allows the clinician to initiate a relationship in which an alliance for treatment can be established.

## 2. That's a lot to focus on in the first meeting. What about helping the patient?

The initial diagnosis and treatment plan may be rudimentary. Indeed, when patients present in a crisis, the history may be confused, incomplete, or narrowly focused. As a result, some interventions are started even when basic information about history, family relationships, and ongoing stressors is being gathered. It is critical to remember that emotional difficulties often are isolating. The experience of sharing one's problem

with a concerned listener can be enormously relieving in and of itself. Thus, the initial interview is the start of treatment even before a formal treatment plan has been established.

## 3. How should the initial interview be organized?

There is no single ideal, but it is useful to think of the initial interview as having three components:

**Establish initial rapport** with the patient, and ask about the presenting complaint or problems, i.e., what has brought the patient to the first meeting. Some patients tell their stories without much guidance from the interviewer, whereas others require explicit instructions in the form of specific questions to help them organize their thoughts. During this phase of the first interview, the patient should be allowed to follow his or her own thought patterns as much as possible.

**Elicit specific information**, including a history of the presenting problems, pertinent medical information, family background, social history, and specific symptom and behavioral patterns. Formally test mental status (see that Chapter).

**Ask if the patient has any questions** or unmentioned concerns. Initial recommendations are then made to the patient for further evaluation and/or beginning treatment.

Although the three parts of the interview can be considered separately, they often weave together, e.g., mental status observations can be made from the moment the clinician meets the patient. Pertinent medical and family history may be brought up in the course of presenting other concerns, and patients may pose important questions about treatment recommendations as they present their initial history.

## 4. Is the initial assessment different for complex situations?

The initial psychiatric assessment may require more than one session for complex situations—for example, when evaluating children or families, or when assessing a patient's suitability for a particular therapeutic approach, such as brief psychotherapy. The initial assessment also may require information gathering from other sources: parents, children, spouse, best friend, teacher, police officers, and/or other healthcare providers. These contacts may be incorporated into the first visit, or may occur later. The first step in making such arrangements is to explain the reason for them to the patient and to obtain explicit, written permission for the contact.

### 5. How should a referral source be approached?

It is almost always appropriate to call the referral source to gather information and to explain the initial diagnostic impressions and treatment plans. Exceptions may occur when the referral comes from other patients, friends, or other nonprofessionals, whom the patient wishes to exclude from treatment.

### 6. Are there any variations on these guidelines for an initial assessment?

Specific theoretical orientations may dictate important variations in the initial assessment. For example, a behavioral therapist guides discussion to specific analyses of current problems and spends little time on early childhood experiences. The psychopharmacologic evaluation emphasizes specific symptom patterns, responses to prior medication treatment, and family history of psychiatric illness. The approach presented in this chapter is a broadly applicable set of principles that can be used in evaluating most patients.

### 7. How is information gathered from an interview?

The interviewer must discover as much as possible about how the patient thinks and feels. During the clinical interview, information is gathered from what the patient tells the interviewer; critically important clues also come from how the history unfolds. Thus, both the content of the interview (i.e., **what the patient says**) and the process of the interview (i.e., **how the patient says it**) offer important routes to understanding the patient's problems. Consider the order of information, the degree of comfort in talking about it, the emotions associated with the discussion, the patient's reactions to questions and initial comments, the coherence of the presentation, and the timing of the information. The full elaboration of such information may take one or several sessions over the course of days, weeks, or months, but in the first interview hints of deeper concerns may be suggested.

For example, a 35-year-old woman presented with worries about her son's recurrent asthma and associated difficulties in school. She talked freely about her worries and sought advice on how to help her son. When asked about her husband's thoughts, she became momentarily quiet. She then said that he shared her concern and switched the discussion back to her son. Her hesitancy hinted at other problems, which were left unaddressed in the initial session. Indeed, she began the next session by asking, "Can I talk about something else besides my son?" After being reassured, she described her husband's chronic anger at their son for his "weakness." His anger and her own feelings in response became an important focus of subsequent treatment.

### 8. How should the interview be started?

The here and now is the place to begin all interviews. Any one of a number of simple questions can be used: "What brings you to see me today? Can you tell me what has been troubling you? How

is it that you decided to make this appointment?" For anxious patients, structure is useful: early inquiry about age, marital status, and living situation may give them time to become

comfortable before embarking on a description of their problems. If the anxiety is evident, a simple comment about the anxiety may help patients to talk about their worries.

### 9. Is a highly structured format important?

No. Patients must be given some opportunity to organize their information in the way that they feel most comfortable. The interviewer who prematurely subjects the patient to a stream of specific questions limits information about the patient's own thinking process, does not learn how the patient handles silences or sadness, and closes off the patient's opportunities to hint at or introduce new topics. Furthermore, the task of formulating one specific question after another may intrude on the clinician's ability to listen and to understand the patient.

This does not mean that specific questions should be avoided. Often, patients provide elaborate answers to specific questions such as "When were you married?" Their responses may open new avenues to the inquiry. The key is to avoid a rapid-fire approach and to allow patients to elaborate their thoughts.

### 10. How should questions be asked?

Questions should be phrased in a way that invites patients to talk. Open-ended questions that do not indicate an answer tend to allow people to elaborate more than specific or leading questions. In general, leading questions (e.g., "Did you feel sad when your girlfriend moved out?") can be conversation stoppers, because they may give the impression that the interviewer expects the patient to have certain feelings. Nonleading questions ("How did you feel when your girlfriend moved out?") are as direct and more effective.

### 11. What is an effective way to deal with patient hesitancy?

When patients need help in elaborating, a simple statement and/or request may elicit more information: "Tell me more about that." Repeating or reflecting what patients say also encourages them to open up (e.g., "You were talking about your girlfriend."). Sometimes comments that specifically reflect the clinician's understanding of the patient's feelings about events may help the patient to elaborate. This approach provides confirmation for both the interviewer and the patient that they are on the same wavelength. When the interviewer correctly responds to their feelings, patients frequently confirm the response by further discussion. The patient whose girlfriend left may feel understood and freer to discuss the loss after a comment such as "You seem discouraged about your girlfriend moving out."

### 12. Give an example of how comprehensive information-gathering can pinpoint a problem.

An elderly man was referred for increasing despondency. In the initial interview, he first described financial difficulties and then brought up the recent development of medical problems, culminating with the diagnosis of prostatic carcinoma. As he began talking about the cancer and his wish to give up, he fell silent. At this point in the interview, the clinician expressed his recognition that the patient seemed to feel overwhelmed by the build-up of financial and, most of

all, medical reversals. The patient nodded quietly and then elaborated his particular concerns about how his wife would get on after he died. He did not feel that his children would be helpful to her. It was not yet clear whether his pessimism reflected a depressive overreaction to the diagnosis of cancer or an accurate appraisal of the prognosis. Further assessment of his symptoms and mental state and a brief discussion with his wife later in the meeting revealed that the prognosis was quite good. The treatment then focused on his depressive reactions to the diagnosis.

### 13. How are questions best worded?

The interviewer should use language that is not technical and not overly intellectual. When possible, the patient's own words should be used. This is particularly important in dealing with intimate matters such as sexual concerns. People describe their sexual experience in language that is quite varied. If a patient says that he or she is gay, use that exact term rather than an apparently equivalent term such as homosexual. People use some words and not others because of the specific connotations that different words carry for them; at first, such distinctions may not be apparent to the interviewer.

### 14. What about patients who are unable to communicate coherently?

The interviewer must remain aware at all times of what is going on during the interview. If the patient is hallucinating or intensely upset, failure to acknowledge the upset or the disconcerting experience may elevate the patient's anxiety. Discussing the patient's current upset helps to alleviate tension and tells the patient that the clinician is listening. If the patient's story rambles or is confusing, acknowledge the difficulty of understanding the patient and evaluate the possible reasons (e.g. psychosis with loosened associations vs. anxiety about coming to the visit).

When general questions (e.g., "Tell me something about your background.") are ineffective, it may be necessary to ask specific questions about parents, schooling, and dates of events. Realize, however, that it can be tempting to ask endless questions to alleviate your own anxiety rather than the patient's.

### 15. Summarize key points to remember about the initial interview.

Allowing the patient freedom to tell his or her own story must be balanced by attending to the patient's ability to focus on relevant topics. Some people require guidance from the interviewer to avoid getting lost in tangential themes. Others may need consistent structure because they have trouble ordering their thoughts, perhaps due to a high degree of anxiety. An empathic comment about the patient's anxiety may reduce it and thus lead to clearer communication.

<i>Some Interviewing Guidelines</i>
• Let the first part of the initial interview follow the patient's train of thought.
• Provide structure to help patients who have trouble ordering their thoughts or to finish obtaining specific data.
• Phrase questions to invite the patient to talk (e.g., open-ended, nonleading questions).
• Use the patient's words.
• Be alert to early signs of loss of behavioral control (e.g., standing up to pace).
• Identify the patient's strengths as well as problem areas.
• Avoid jargon and technical language.
• Avoid questions that begin with "why."
• Avoid premature reassurance.
• Do not allow patients to act inappropriately (e.g., break or throw an object).
• Set limits on any threatening behavior, and summon help if necessary.

### 16. What specific pitfalls should be avoided during the initial interview?

**Avoid jargon or technical terms**, unless clearly explained and necessary. Patients may use jargon, for example, "I was feeling paranoid." If patients use a technical word, ask about their meaning for the term. You may be quite surprised by the patient's understanding. For example, patients may use "paranoid" to suggest fear of social disapproval or pessimism about the future. Also, be careful about assigning a diagnostic label to the patient's problems during the interview. The patient may be frightened and confused by the label.

In general, **avoid asking questions that begin with "why."** Patients may not know why they have certain experiences or feelings, and can feel uncomfortable, even stupid, if they believe their answers aren't "good." Asking why also implies that you expect the patient to provide quick explanations. Patients discover more about the roots of their problems as they reflect on their lives during the interview and in subsequent sessions. When tempted to ask why, rephrase the question so that it elicits a more detailed response. Alternatives include "What happened?" "How did that come about?" or "What thoughts do you have about that?"

**Avoid premature reassurance.** When patients are upset, as they often are during first interviews, the interviewer may be tempted to allay the patient's fear by saying "Everything will be fine" or "There is nothing really seriously wrong here." However, reassurance is genuine only when the clinician (1) has explored the precise nature and extent of the patient's problems and (2) is certain of what he or she is telling the patient. Premature reassurance can heighten the patient's anxiety by giving the impression that the clinician has jumped to a conclusion without a thorough evaluation or is just saying what the patient wants to hear. It also leaves patients alone with their fears about what is really wrong. Furthermore, premature reassurance tends to close off discussion rather than encourage further exploration of the

problem. It may be more reassuring to ask what the patient is concerned about. The process (i.e., the nature of the interaction) comforts the patient more than any single thing the interviewer may say.

#### **Set limits on behavior.**

Because of their psychiatric problems, some patients may lose control in the session. Although the approach described here emphasizes letting the patient direct much of the verbal discussion, at times limits must be set on inappropriate behavior. Patients who are aroused and want to take off their clothes or threaten to throw an object need to be controlled. This goal is most often accomplished by commenting on the increasing arousal, discussing it, inquiring about sources of upset, and letting patients know the limits of acceptable behavior. On rare occasions outside help may be necessary (e.g., security guards in an emergency department), especially if the behavior is escalating, and if the interviewer senses danger. The interview should be stopped until the patient's behavior can be managed so that it is safe to proceed.

#### **17. What is commonly forgotten in evaluating patients?**

The new patient initiates contact with the clinician because of problems and worries; these are the legitimate first topics of the interview. It also is helpful to gain an understanding of the patient's strengths, which are the foundation on which treatment will build. Strengths include ways in which the patient has coped successfully with past and current distress, accomplishments, sources of inner value, friendships, work accomplishments, and family support. Strengths also include hobbies and interests that patients use to battle their worries. Questions such as "What are you proud of?" or "What do you like about yourself?" may reveal such information.

Often the information comes out as an afterthought in the course of conversation. For example, one patient took great pride in his volunteer work through the church. He mentioned it only in passing as he discussed his activities of the week before the meeting. Yet this volunteer work was his only current source of personal value. He turned to it when he became upset about his lack of success in his career.

#### **18. What is the role of humor in the interview?**

Patients may use humor to deflect the conversation from anxiety-provoking or troubling topics. At times, it may be useful to allow such deviations to help patients maintain emotional equilibrium. However, probe further if the humor seems to lead to a radical change in focus from a topic that seemed important and/or emotionally relevant. Humor also can direct the interviewer toward new areas for investigation. A light joke by the patient (e.g., about sex) may be the first step in introducing a topic that later takes on importance.

On the part of the interviewer, humor may be protective and defensive. Just as the patient can feel anxious or uncomfortable, so can the interviewer. Be careful, because humor can backfire. It may be misunderstood as ridicule. It also can allow both patient and interviewer to avoid important topics. Sometimes humor is a wonderful way to show the human qualities of the interviewer and thus build a therapeutic alliance. Nonetheless, keep in mind the

problematic aspects of humor, especially when you and your patient don't know each other well.

#### **19. How is suicidal intent assessed?**

Because of the frequency of depressive disorders and their association with suicide, it always is necessary to address the possibility of suicidal intent in a first interview. Asking about suicide will not provoke the act. If the subject does not arise spontaneously, several questions can be used to draw out the patient's thoughts on suicide (listed in the order that they may be used for beginning a discussion):

- How badly have you been feeling?
- Have you thought of hurting yourself?
- Have you wanted to die?
- Have you thought of killing yourself?
- Have you tried?
- How, when, and what led up to your attempt?
- If you have not tried, what led you to hold back?
- Do you feel safe to go home?
- What arrangements can be made to increase your safety and to decrease your risk of acting on suicidal feelings?

Such discussion may need to be extended until it is clear whether the patient may safely leave or needs hospital admission).

#### **20. What is the best way to bring a first evaluation interview to a close?**

One way is to ask the patient if he or she has any specific questions or concerns that have not been addressed. After addressing such issues, briefly summarize important impressions and diagnostic conclusions and then suggest the course of action. Be as clear as possible about the formulation of the problem, diagnosis, and next steps. This is the time to mention the need for any tests, including laboratory examinations and further psychological assessments, and to obtain permission for meeting or talking with important others who may provide needed information or should be included in the treatment plan.

Both clinician and patient should recognize that the plan is tentative and may include alternatives that need further discussion. If medication is recommended, the clinician should describe the specific benefits and expected time course as well as inform the patient about potential side effects, adverse effects, and alternative treatments. Often patients want to think over suggestions, get more information about medications, or talk with family members. In most instances, the clinical situation is not so emergent that clear action must be taken in the first interview. However, be clear in presenting recommendations, even if they are tentative and primarily oriented to further diagnostic assessment.

At this point it is tempting to provide false reassurance, such as "I know everything is going to be okay." It is perfectly legitimate—and indeed better—to allow for uncertainty when uncertainty exists. Patients can tolerate uncertainty, if they see that the clinician has a plan to elucidate the problem further and to arrive at a sound plan for treatment.