Interviewing techniques

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Introduction

- One supreme skill of any physician is active listening.
- Physicians should monitor :

1)the content of the interaction (what patient and doctor say to each other)

2)the process (what patient and doctor may not say but clearly convey in many other ways).

- Physicians who are sensitive to the effects of history, culture, environment, and psychology on the doctor–patient relationship work with patients who are multifaceted people, not mere disease syndromes.

Introduction

- Models of the doctor–patient relationship include:
  - the active-passive model,
  - the teacher–student (or parent–child, guidance–cooperation) model,
  - the mutual participation model,
  - the friendship (or socially intimate) model.
- The more that doctors understand themselves, the more secure they feel, and the better able they are to modify destructive attitudes.
- Increased flexibility leads to a responsiveness to the subtle interplay between doctor and patient and also assumes a certain tolerance for the uncertainty present in any clinical situation with any patient.

Goals for psychiatric interview:

1) Determining the nature the problem.
2) To establish a relationship with the patient.
3) To provide feedback and formulate a treatment plan.

Content versus Process of the interview

- Every interview has three main components:
  - the beginning
  - the interview itself
  - the closing of the interview.

Major tips for interview

- introduce yourself
- greet the patient by name
- arrange for a private comfortable setting
- appropriately tell the purpose of the interview
- put the patient at ease
- be supportive, attentive, non judgmental and encouraging.
- Avoid excessive note-taking
- observe the patient’s nonverbal behavior.

I.D :-

(name, age, nationality, sex, marital, education, job, residency)

C.C :- *Pt verbatim +duration

SOURCE OF INFORMATION

RELIABILITY

H.P.I :-

- ✓ Dissect main symptoms (*duration, severity ,stressors)*
- ✓ Precipitating & reliving F.
- ✓ Check for function.
- ✓ Comorbid and DDx.
- ✓ Any medical intervention *(seek medical advice , Mx)*
- ✓ *Don't forget* S.O.A.P
  - S- suicidal & homicidal
  - O- organisity
  - A- Alcohol and sub abuse.
  - P- psychosis

PAST HISTORY :-

- ☒ Psychiatric:-

previous episodes(reason) ,
f/u,
admission (number, duration)
Management (What, dose, response ,S/E)

- ☒ Medical and Surgical Hx :

Don't forget (*head trauma, epilepsy, thyroid, and Sys. Review*)

FAMILY HISTORY :-

- ☒ Parents *(age ,consanguinity, illness)*
- ☒ Sibling *(age, illness, order of Pt.)*
- ☒ +ve Hx of (*psych , drug abuse , homicide , suicide)*

Don't forget relation bet. Themselves & with Pt .

PERSONAL & SOCIAL HX :-

- ☒ Childhood *(preg. ,Development)*
- ☒ Schooling *(age, level ,performance , relations ,misconduct)*
- ☒ Occupation *(age, duration , relation , performance)*
- ☒ Social *(living situation, financial stat , support)*
- ☒ *Don't forget detail & reasons of any (stop of school ,change or quit of job)*

- ☒ Psychosexual *(puberty , menstrual reg. , sig relationships ,abuse ,dysfunction)*
- ☒ Marital *(age, consanguinity, children, relation past & current)*

- ☒ Forensic (*arrest, prison & why)*

PRE-MORBID PERSONALITY

- ✓ How described by other?
- ✓ Prevailing mood
- ✓ Social skills
- ✓ Hobbies
- ✓ Religion (beliefs , practices)
- ✓ ?impulsivity
- ✓ coping

M.S.E

- ☒ Appearance & behavior
- ☒ Speech
- ☒ Mood and affect
- ☒ Thought form and contents(suicidal , homicidal , overvalued , delusion , obsession .. etc)
- ☒ Perception
- ☒ Insight & judgment
- ☒ Cog. function (if impaired do MMSE)

I.D :- (name, age, nationality, sex, marital, education, job, residency) C.C :- *كلام المريض+duration (لا تنسى سبب التنويم, عن طريق الطوارئ او العيادة , من جاء به وهل هو اول تنويم) **SOURCE OF INFORMATION** **RELIABILITY**	**FAMILY HISTORY :-** ☒ Parents *(age ,consanguinity, illness)* ☒ Sibling *(age, illness, order of Pt.)* ☒ +ve Hx of (*psych , drug , homicide , suicide)* *Don't forget relation bet. Themselves & bet. Pt*	**M.S.E** ☒ Appearance & behavior ☒ Mood (subjective & obj.) ☒ Thought (suicidal , homicidal , overvalued , delusion , obsession .. etc) ☒ Perception ☒ Cog. function (if impaired do MMSE) ☒ Insight & judgment
H.P.I :- ✓ Dissect symptoms (*onset , severity ,course)* ✓ Chick main illness ✓ Precipitating & reliving F. ✓ Chick for function ✓ Any medical intervention *(seek medical advice , Mx)* ✓ *Don't forget* S.O.A.P S- suicidal & homicidal O- organisity A- addiction P- psychosis	**PERSONAL & SOCIAL HX :-** ☒ Childhood *(preg. Development)* ☒ Schooling *(age, level ,performance , relations ,misconduct)* ☒ Psychosexual *(puoporty , menstrual reg. , extra relation ,abuse ,dysfunction)* ☒ Marital *(age, consanguinity, children, relation past & current)* ☒ Occupation *(age, duration , relation , performance)* ☒ Forensic (*arrest, prison & why)* ☒ Social *(living situation, financial stat , support)* *Don't forget detail & reason of any (stop of school ,change or quit of job , divorce & other wife's)*	**SUMMARY & FORMULATION** ✓ Current Sx ✓ Precipitating F. ✓ Brief past psych. Hx ✓ Predisposing F. (biopsychosocial) ✓ Safety ✓ Imp. Point in Tx.
PAST HISTORY :- ☒ Psychiatric.:- *previous episode(reason) , f/u, admission (number, duration) & Mx (What, dose, response ,S/E)* ☒ Medical ☒ Surgical *Don't forget (head trauma, epilepsy, thyroid, and Sys. Review)*	**PRE-MORBID PERSONALITY** ✓ How described by other? ✓ Prevailing mood ✓ Social skill ✓ Hopes ✓ Religion (attitude , practice) ✓ ?impulsivity ✓ coping	**DDx & Mx:** *Don't forget :- Axis V = GAF* *Setting = in or outpt. & Brief psychotherapy in ER* *BioPsychoSocial in assessment & treatment* *Short & long tarm Tx* *Be specific ((e.g. I'll start pt on risperdal 2mg NOT I'll star pt on atypical antipsychotic.))* *Education of pt & family*

THE PSYCHIATRIC HISTORY

- It is the chronological story of the patient's life from birth to present.
- It includes information about who the patient is, his problem (bio psycho-social aspects) and its possible causes and available support.
- Information elicited both from the patient and from one or more informants.

The mental status examination

*patient's feelings, thoughts, perception and behavior during the interview.

THE PSYCHIATRIC HISTORY

- Identification data
- Referral Source
- Chief Complaint
- History of present illness
- Family history
- Personal history
- Medical history
- Past Psychiatric history
- Personality traits

- **Identification of the Patient:**

- Name, age, sex, marital status, occupation, education, nationality, residency and religion.

- **Referral Source:**

- Brief statement of how the patient came to the clinic and the expectations of the consultation.
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- **Chief Complaint:**

- Exactly why the patient came to the psychiatrist, preferably in the patient's own words (a verbatim statement).

- **History of Present Illness:**

- Chronological background of the psychiatric problem: nature, onset, course, severity, duration, effects on the patient (social life, job, family…), review of the relevant problems, symptoms not mentioned by the patient (e.g. sleep, appetite, …), and treatment taken so far (nature and effect).

- **Family History:**

- Mother and father: current age (if died mention age and cause of death, and patient's age at that time), relationship with each other and with the patient.

- Siblings: list, in order of age, brothers and sisters, education, occupation, marital status, major illnesses and relationship with the patient.

- Ask about mental illnesses in second-degree relatives (grand parents, uncles, aunts, nephews, & nieces).

Personal History:

- Birth & Early development: developmental
- School
- Occupations
- Puberty & Adolescence:
- Marital history.
- Current social situation:
- Tobacco and substance abuse.
- legal (forensic) problems.

- **Medical History**
- **Past Psychiatric History**
- **Personality Traits:**

- Attitude to self (self-appraisal, performance, satisfaction, past achievements and failures, future..)
- Moral and religious attitudes and standards.
- Prevailing mood and emotions.
- Reaction to stress (ability to tolerate frustration and disappointments, pattern of coping strategies).
- Personal interests, habits, hobbies and leisure activities.
- Interpersonal relationships.

The Mental State Examination J:\KKUH\MENTAL STATE EXAMINATION.ppt

- Appearance,Behaviour &Attitude
- Speech
- Mood & Affect
- Thoughts
- Perception
- Cognitive functions and consciousness
  - Consciousness level
  - attention
  - concentration
  - orientation(time, place, person)
  - memory
- Abstract thinking
- Visuospatial ability
- Language and reading.
- Judgment
- Insight

Six strategies to develop rapport

- putting patients and interviewers at ease.
- finding patients' pain and expressing compassion.
- evaluating patients' insight and becoming an ally
- showing expertise
- establishing authority as physicians and therapists
- balancing the roles of empathic listener, expert, and authority.

Techniques

- Bay attention to both content & process.
- Open-ended question versus Closed-ended questions.
- REFLECTION. In the technique of reflection, a doctor repeats to a patient in a supportive manner something that the patient has said.
- FACILITATION. Doctors help patients continue in the interview by providing both verbal and nonverbal cues.
- SILENCE.

- CONFRONTATION. The technique of confrontation is meant to point out to a patient something that the doctor thinks the patient is not paying attention to, is missing, or is in some way denying.
- CLARIFICATION. In clarification, doctors attempt to get details from patients about what they have already said.
- INTERPRETATION. The technique of interpretation is most often used when a doctor states something about a patient's behavior or thinking that a patient may not be aware of.

- SUMMATION. Periodically during the interview, a doctor can take a moment and briefly summarize what a patient has said thus far.
- EXPLANATION. Doctors explain treatment plans to patients in easily understandable language and allow patients to respond and ask questions
- TRANSITION. The technique of transition allows doctors to convey the idea that enough information has been obtained on one subject; the doctor's words encourage patients to continue on to another subject.

- SELF-REVELATION. Limited, discreet self-disclosure by physicians may be useful in certain situations, and physicians should feel at ease and should communicate a sense of self-comfort.
- POSITIVE REINFORCEMENT
- REASSURANCE
- ADVICE

Table 7–1. Five phases of the interview and the four components

Phase	Rapport	Technique	Mental status	Diagnosis
1. Warm-up and screening of problem	Put patient at ease, set limits, empathize with suffering, become a compassionate listener	Select productive and broad screening questions	Observe appearance, psychomotor functions, speech, thinking, affect, orientation, memory, and explore mood, insight, memory, judgment	Note clues, classify the chief complaint; assess symptoms, severity, course, stressors; list differential diagnoses
2. Follow-up of preliminary impressions	Become an ally, make shifts in topics clear	Shift topics, progress from open- to closed-ended questions	Assess thinking, thought content, suicidality	Verify or exclude diagnoses
3. History and database	Show expertise, interest, thoroughness, leadership and motivate for testing	Shift topics, handle defenses, fill in gaps, follow up clues, reconcile inconsistencies	Evaluate judgment, memory, test specific mental status functions and IQ	Assess course of disorders; impact on social life; family and medical history
4. Diagnosis and feedback	Secure acceptance of diagnosis	Explain disorders and treatment options	Discuss mental status findings, explore compliance	Establish diagnoses on five axes
5. Prognosis and treatment contract	Assume the leadership role and assure compliance	Discuss treatment contract	Make inferences about insight, judgment, and compliance	Give prognosis; predict treatment effects

Thank you