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CHAPTER 1

The Psychiatric Interview and Mental Status Examination

John W. Barnhill, M.D.

The psychiatric interview involves the development of a history of the patient's present illness, a mental status examination (MSE), an assessment of dangerousness and substance use, and a differential diagnosis and treatment plan. Developmental, family, and social histories are also part of the initial interview, as is a history of prior psychiatric treatments and co-occurring medical conditions. A therapeutic alliance and a therapeutic effect are both reasonable expectations, as is some sort of psychological understanding of the patient. This information is generally compiled within an often-clunky electronic medical record. Such efforts are a challenge, especially when the clinician is also expected to be kind, tactful, patient, and friendly.

The goal of this chapter is to simplify and clarify the interview process so that the clinician can confidently approach this foundational psychiatric skill. The chapter will begin with a discussion of ways in which the clinician might prepare for doing the interview, including the development of a psychiatric attitude, a biopsychosocial approach, and an ever-evolving fund of psychiatric knowledge. The second section focuses on the performance of the interview, including an outline of the phases of the typical interview and a roster of core interviewing techniques. The third section explores common clinical situations and types of patients. The chapter concludes with a discussion of ways in which goals focus and simplify the actual interview.

General Preparation

Setting the Stage

Effective psychiatric interviews can be done under almost any conditions. One interview with an agitated patient might last for a few moments in a hallway surrounded

by patients, staff, and security guards. Another interview might consist of an hour-long session in a calm, quiet, uncluttered outpatient office. A third might feature a patient and trainee being observed as part of a 30-minute oral examination. Although the details vary, an underlying goal of all interviews is to provide a safe and respectful opportunity for the patient to tell his or her story. Regardless of whether the interview takes a minute or an hour, each interview has a similar underlying structure that involves observation, interaction, assessment, and plan.

Clinicians who work in an emergency department or a consultation-liaison service or who are in training generally interview everyone they are assigned. Other clinicians often decline outpatient evaluations because of a lack of expertise in a specific subspecialty area, such as substance abuse or child psychiatry. After agreeing to conduct the interview, the clinician might clarify to herself the initial goals of the patient and/or referring clinician. Clarity can ensure that the presenting issues are adequately addressed. In addition, hints of violence or other special difficulties should help steer inexperienced staff and students away from dangerous encounters.

A quick perusal of the patient's medical records, either before or after the initial interview, can inform the overall assessment by providing cross-sectional MSEs, medication lists, contact numbers, and an array of co-occurring medical and psychiatric diagnoses. Such information can suggest issues that might not otherwise be addressed in the interview.

> **Tip:** Outside information warrants appreciative skepticism. Such data can be very helpful. On the other hand, the patient's situation and diagnosis may have evolved, and the prior evaluation may have been incomplete or misguided.

Clinicians vary in the extent to which they take notes during the interview. Some only write down hard-to-remember facts, such as medication dosages and dates of hospitalizations. Others jot down reminders to themselves. For example, if an anxious patient mentions binge drinking early in the interview but is in the midst of an emotionally charged story, the interviewer might write down "alcohol" to trigger a more thorough discussion later in the session. Some interviewers bring with them an outline of an initial write-up and jot down brief notes as pertinent material comes up. Whether the interviewer is using paper and pencil or a computer, the goal is to avoid letting the recording device interfere with the development of an alliance or with the interviewer's ability to pay attention to nonverbal behavioral and interpersonal clues.

Prior to seeing the patient, the interviewer may discover that relatives and/or friends expect to be involved, either by sitting in on the interview or via an open communication with the interviewer. Some outpatient clinicians hardly ever talk to relatives. When family members are going to be involved in the eventual treatment and/or possess pertinent historical information, they are often brought into the interview. For example, family members are routinely involved in the evaluation of children and of patients who have a developmental disorder or a dementia. In addition, patients from most of the world anticipate that family members will be involved in their medical evaluations and treatment. The American emphasis on individuality and privacy can be seen as idiosyncratic to an immigrant family that presents en masse for a psychiatric evaluation. At the same time, adults are generally allowed to refuse access to

relatives. States vary somewhat in regard to privacy legislation, but they generally restrict the psychiatrist's right to contact relatives over patient objection to situations that involve acute risk. Even in emergency situations, the interviewer aims to elicit information from the family without giving up unnecessary or confidential information.

Interviewer Attitude

The preferred clinical attitude combines a host of desirable emotions, such as warmth and spontaneity. Of course, interviewing styles vary, but in general, interviewers try to maintain an attitude of respectful curiosity.

Interviewers listen differently. In interviewing a patient who presents with prominent anxiety, one psychiatrist might listen with an ear for symptom clusters that fit DSM-5 (American Psychiatric Association 2013) criteria for disorders that often co-occur with anxiety: substance use, trauma, obsessions/compulsions, or one of the anxiety disorders. A more psychodynamically oriented therapist might look for factors that contributed to the anxiety; for example, unreliable early caregivers might lead to an inhibited ability to express anger, associated with a variety of defenses (e.g., denial, undoing, reaction formation) that reduce efficacy and perpetuate the baseline anxiety (Auchincloss 2015). A couples counselor might hear the same anxiety but listen for maladaptive patterns of interpersonal behavior, focusing less on the individual and more on the couple. A therapist with a cognitive-behavioral perspective might listen for cycles of thinking and behavior that could contribute to and exacerbate the presenting symptoms (Beck 2011). Most interviewers learn to listen in ways that conform to the needs of the patient and situation as well as their own training and theoretical and personal biases.

Biopsychosocial Approach

Without having a broad working knowledge of psychiatry, the interviewer will be awash in unanalyzed data and will be unable to develop a coherent narrative that explains the patient's situation. Sherlock Holmes is the quintessential interviewer-observer. Underestimated, however, is the amount of background information available to him. He might notice mud on shoes, for example, and conclude that the victim (or perpetrator) had spent time in a particular quarry in the north of England. Although anyone might notice the muddy shoes, Holmes notices the relevance both because he is observant and because he maintains a vast fund of knowledge. Even with the Internet readily available, the modern interviewer needs to be able to spontaneously recognize a wide variety of triggers that should prompt further investigation.

Clinicians who study only the areas that interest them risk making systematic errors throughout their careers. Practice may make perfect, as the saying goes, but practice also makes permanent; without diligently studying the entire field, the interviewer will miss unappreciated details.

There are several ways for the interviewer to develop and maintain a knowledge base. The first is to read and study broadly via journals, texts, conferences, and review courses (Muskin and Dickerman 2016; Roberts and Louie 2014). Another is to read pertinent information prior to seeing a particular patient. Some interviewers jot notes during the interview that can later trigger an Internet or textbook search. Such a process can improve the quality of the interviewer's understanding of the patient and—

when the search is explained to the patient at the next meeting—lay the groundwork for a deepening of the therapeutic alliance.

The types of information sought can be subdivided into three categories, conforming to the biopsychosocial model of psychiatry (Engel 1980). Although the three pillars will not be equally pertinent in each clinical situation, there are few psychiatric interviews that can afford to completely neglect any one component of the biopsychosocial model.

Biological

Interviewers do not need to be psychopharmacologists, but the mention of venlafaxine, for example, may prompt the clinician to wonder if some physician had diagnosed the patient with depression. Venlafaxine, however, is also used for anxiety and panic, is frequently used for pain, and—as is true for all medications—is sometimes mistakenly prescribed. If the patient then mentions having diabetes, the interviewer would want to spontaneously recognize the interrelationship between depression, psychiatric medication, and diabetes. When the interviewer then asks whether the patient gained weight on psychiatric medications or whether the patient has troublesome diabetic neuropathy (which might have been the trigger for choosing venlafaxine), the story of the illness becomes more coherent, and the patient is implicitly reassured of the interviewer's competence (Goldberg and Ernst 2012; Levenson and Ferrando 2016).

Similarly, the interview is simplified and strengthened when the interviewer recognizes the relevance when the patient indicates that he has been dutifully taking 25 mg/day (or 225 or 375 mg/day) of venlafaxine for the past 2 months, or when he mentions that he only takes it on the days he feels especially symptomatic, or when he casually mentions that he ran out of pills several days earlier and has been feeling sick ever since. Without quite a lot of practical knowledge about all of the pertinent medications, the interviewer will not know whether the patient's story includes a therapeutic trial or whether the patient's symptoms might be attributable to side effects from a high dosage or side effects from withdrawal. In other words, the mention of a drug like venlafaxine or an illness like diabetes may prompt the interviewer to consider a broad array of topics, including depression, anxiety, panic, pain, metabolic syndrome, medication adherence, and medication withdrawal effects. Such recognition simplifies and strengthens the interview by bringing together seemingly disparate bits of information and by helping to guide the direction of the interview.

Psychological

The psychological understanding of patients can be separated into diagnostic descriptions (e.g., DSM-5 criteria) and narrative descriptions that are heavily informed by psychotherapeutic schools of thought (e.g., psychodynamics, cognitive-behavioral therapy [CBT], interpersonal therapy).

The currently dominant model in American psychiatry is descriptive. In the descriptive model, which is featured in DSM-5 and other medical nomenclatures such as the *International Classification of Diseases,* 10th Revision (ICD-10; World Health Organization 1992), symptoms are clustered into recognizable disorders. For example, people with schizophrenia do not all have the same symptoms, but they generally do have a history of psychosis, cognitive problems, and psychosocial dysfunction. One

or two of these variables (e.g., long-standing homelessness and poor functioning) might trigger an efficient search for commonly co-occurring symptoms (Black and Grant 2014; First 2014).

> **Tip:** All combinations of information can yield a differential diagnosis that can evolve with additional information.

For example, "car wreck + 20-year-old man" might prompt inquiry into substance abuse and impulse-control problems, whereas "new-onset depression + hospitalization + elderly" might prompt a focused inquiry into delirium as well as depression. An understanding of typical symptom constellations improves the interviewer's efficiency and thoroughness and simplifies the process of doing the interview.

Interviews are prone to systematic error. For example, we might have a tendency to repeatedly see the same diagnosis, finding, say, mood instability or trauma in almost every patient. Such "confirmation bias" may reflect a training or personal bias or an unconscious defense against the complexity and ambiguity of psychiatry and medicine. Confirmation bias may also allow the clinician to make use of a preferred therapeutic modality (a mood stabilizer for bipolar disorder, for example, or perhaps CBT for posttraumatic stress disorder [PTSD]). Another common bias relates to the "loudness" of a disorder. Obvious and potentially dangerous complaints are generally recognized, whereas less-obvious diagnoses (e.g., obsessive-compulsive disorder, avoidant personality disorder) can get ignored. Evidence increasingly points to the reality that treatments are more successful when they address all pertinent psychiatric disorders (e.g., substance use and depression) rather than addressing diagnoses sequentially (Avery and Barnhill 2018).

Description may be the dominant psychiatric paradigm, but much of the field also relies on narrative. Data-gathering in psychiatry, unlike that in other medical fields, involves information that is filtered through a patchwork of complex and uncomfortable wishes, fears, and memories. Such complexity presumably underlay Jerome Groopman's decision to specifically exclude psychiatrists from his best-selling book *How Doctors Think.* As he wrote, "How psychiatrists think was beyond my abilities" (Groopman 2007, p. 7).

The psychiatric interviewer will frequently encounter *resistance,* which refers to anything that prevents the patient from talking openly to the interviewer. *Conscious resistance* occurs when the patient knowingly neglects, distorts, or makes things up. *Unconscious resistance* leads to similarly incomplete stories, but the mechanism is assessed to be outside of the patient's awareness. Sigmund Freud focused much of his work on this process of keeping material out of awareness (i.e., *repression*), although later psychoanalysts focused on delineating a variety of other defenses.

Sublimation and *humor* are considered to be healthy defenses, and they can contribute to alliance building and treatment decisions. Other defenses are more likely to derail a successful interview. For example, a paranoid patient may *project* malevolent thoughts onto the interviewer, and the interviewer may accept and internalize such projections in a process known as *projective identification.* In such a situation, the clinician may find him- or herself behaving with uncharacteristic hostility. By recognizing his or her own internal reaction, the clinician can better maintain equilibrium while also gaining greater insight into the patient (Gabbard 2014; Yudofsky 2005).

Unconscious processes also contribute to the development of *transference,* which is defined as the redirection of feelings from one relationship to another; most classically, the transference grows out of an early relationship (such as with a parent) onto the therapist. *Positive transference* allows patients to trust strangers with their life stories. Such automatic reactions are generally not discussed in an extended therapy, much less in a single interview, but without them, the interview would likely remain superficial (Viederman 2011). Transference is more often discussed when it interferes with the interview, such as when the patient has a *negative transference.* Although some so-called difficult patients may be manifesting negative transference, others are manifesting generic hostility. In either event, the initial interview is rarely the time for the clinician to try to explicitly interpret the transference to the patient. More typically, the interviewer silently identifies the defense (e.g., devaluation or projection), prompting both a deeper understanding of the patient and maintenance of a professional, helpful attitude toward a patient who might otherwise be experienced as difficult.

The interviewer may also want to monitor his or her own reactions to patients, especially when these reactions feel unusual. This recognition of one's own reactions—generally described as *countertransference*—can help the interviewer maintain a professional attitude under trying circumstances and can also provide crucial insight into the patient's interpersonal world. For example, if the interviewer feels an uncharacteristic aversion to a particular patient, she might wonder if this patient has pushed a particular historical button (perhaps an overbearing patient is reminiscent of the interviewer's overbearing parent). If so, the silent recognition of her own countertransference reaction can be a personal "Aha!" moment for the clinician and allow her to proceed more robustly with the interview. In addition, the interviewer's sense of aversion provides a visceral understanding of the patient's world when he says that he is lonely and people always avoid him.

Social

The "social" aspect of *biopsychosocial* refers to the sociological, religious, spiritual, ethnic, and racial issues that may be pertinent to patients. Some of this information may seem like "common knowledge," but exploring specifics will often lead to a discussion that can inform an understanding of the patient (Lewis-Fernández et al. 2016; Lim 2014).

For example, a 20-year-old woman might come in with a chief complaint of sadness after a loss. If the patient is also a lesbian African American college student, the interviewer has choices. One option is to dutifully write down these demographic details in the section for "identifying information" and then forget them, perhaps in an effort to see the patient as an individual rather than as some sort of reductionistic stereotype. This option may, however, be a mistake, because it might ignore clues that help make sense of the patient's situation (Gara et al. 2012).

Instead of passing over these demographic variables, the preferable action for the interviewer is to mull over possible links and listen for clues to their possible relevance. For example, what is this particular patient's perspective on being lesbian? In what phase of the coming out process is she? To what extent is she ambivalent about her orientation? Has she told her family? Is she dating (Levounis et al. 2012)? Similar questions might arise regarding her being African American. Although an inter-

viewer from the dominant subculture (e.g., white in many areas of the United States) may view America as being beyond racial issues, such a view is not shared by many people who belong to marginalized subcultures. For them, discrimination remains an ongoing threat to mental health (Chae et al. 2011). Alternatively, if the clinician is also black or gay (or both), then shared, unanalyzed assumptions can lead to other kinds of blind spots and errors.

When interviewing people from differing backgrounds, the interviewer need not become either de-skilled or a cultural anthropologist. If "sadness after a loss" is the patient's chief complaint, cultural factors may or may not be especially pertinent to an initial assessment. It is difficult for the interviewer to know in advance which aspects of the patient's life might have significantly triggered or complicated the presenting constellation of symptoms. When in doubt, the interviewer can simply ask for the patient's perspective.

Performance of the Interview

The psychiatric interview begins with observation, but the interviewer needs to recall that first impressions work both ways. At the same time that the clinician is silently creating and discarding potential diagnoses, the patient is likely formulating questions of her own. Does the interviewer seem pleasant? Respectful? Trustworthy? Knowledgeable? It would be difficult to overstate the importance of nonverbal communication to the psychiatric interview.

For purposes of discussion, the interview is divided into three phases (for an overview of the structure of an interview, see Table 1–1). The *initial phase* allows the patient to voice his or her chief concern, whereas the *later phase* will become increasingly driven by efforts to clarify the history, MSE, and DSM-5 diagnoses. The interview concludes with a period of *negotiation and summary.* Information from all phases of the interview will inform the overall assessment of the patient. Distillation of many types of information into a straightforward note is integral to the process of completing an interview (discussed in the section "Structure of the Write-Up of the Psychiatric Interview").

Following discussion of these three interview phases, this section of the chapter concludes with a roster of interview *techniques.*

Initial Phase: The Patient's Chief Concern

The initial phase of the interview has two main goals. The first is to understand and explore the patient's current chief concern. The second is to give the interviewer the time and the information to begin to make a set of tentative hypotheses about the patient. This phase allows the patient to tell her own story.

While the patient is talking, the clinician might consciously consider how she is dressed; how she moves, speaks, and interacts; and what she chooses to discuss. Such observations can lead almost immediately to tentative theories about the patient and the beginnings of a differential diagnosis.

An opening, nondirective question might be "Tell me about what brought you here today." The initial interview is not, however, the moment to become a caricature of a mid-twentieth-century psychoanalyst—that is, a silent, dour, and impassive observer. Even silence is active; nonverbal encouragements can include nods of the

TABLE 1–1. **Performance of the interview**

Initial phase
Patient's chief concern
Later phase
Active development of the story
Mental status examination
Negotiation and summary
Patient preferences
Treatment plan

head, appropriate amounts of eye contact, and body language that conveys attentive concern. Short requests can help—for example, "Tell me more about what you mean"—as can specifically going back to a point that the patient made moments earlier. An empathic stance is surprisingly difficult to maintain, however, and the interviewer may feel tempted to quickly shift the interview to fit her own agenda and associations. Under most circumstances, the interviewer preserves this initial phase for the patient's point of view.

When given an opportunity to speak freely, some patients will present a crystalline story that fits exactly what the interviewer is looking for. Others will spin a story that may be internally consistent but barely touches on the issues that brought the patient in for the evaluation. Still others will founder and either drift across seemingly unrelated life events or grind to a halt within a few moments. While "saying what comes to mind" is a central tenet in psychoanalysis, a diagnostically oriented interviewer pays consistent attention to his or her goals. Even early on, the interviewer may flexibly and tactfully bring the patient back to the reason he or she has appeared for the interview. One way to accomplish this redirection is to ask the patient why he called for an appointment on that particular day or to speculate on what has led others to be concerned about him (e.g., "Do you have any thoughts about what might have prompted your wife to call the ambulance?").

While providing the patient with the opportunity to speak freely, the interviewer continues to develop a tentative differential diagnosis and history of present illness. The rest of the interview will be devoted to gathering additional information and testing hypotheses that spring from these initial observations.

> **Tip:** While developing a differential diagnosis, consciously consider diagnoses that span multiple DSM-5 chapters (e.g., anxiety, depression, obsessive-compulsive disorder) before investigating any one of them.

Techniques vary during this early phase. Open-ended questions are most often recommended (see subsection "Techniques" following discussion of phases), but some patients do best with "warm-up" questions that are intended to yield straightforward demographic information and yes/no answers. Some people prefer to begin with small talk, while others resent discussion that does not refer specifically to their most

pressing issues. Patients generally allow attentive and well-meaning interviewers the opportunity to try out different approaches to determine what works best.

Later Phase: Deepening the Understanding

By the end of the initial phase of the interview, the clinician will have a sense of likely diagnoses as well as a tentative understanding of the patient. Much of the rest of the interview consists of completing three tasks that were begun during the initial phase: 1) further development of the history of present illness, 2) collection of other aspects of the patient's history, and 3) performance of the MSE.

A core goal of this later phase is for the interviewer to make a conscious effort to shift the patient's concerns and complaints into the interviewer's story of the patient's present illness. To do so, the interviewer considers silent hypotheses, likely comorbidities, and the breadth of possible diagnoses. While remaining attentive to various points of view (including that of the patient), the clinician begins to fashion a narrative that is his own.

A working alliance underlies this data acquisition. Attentive, kindly curiosity goes a long way, especially when the patient is being asked by a near stranger to explore behaviors, thoughts, and feelings that she might prefer to avoid. A clinician armed with a lot of excellent questions (or validated rating tools) and a harsh manner is likely to compile data that are incomplete and misleading. In contrast, the creation of a strong initial working alliance can be therapeutic in itself, encouraging transparency and smoothing the transition when the interviewer wants to shift to a more active, direct assessment of symptoms or history.

The interviewer should elicit a significant amount of other information, including psychiatric, medical, family, developmental, and social histories. As described later in the section "Components of the Psychiatric Write-Up," historical information may not be directly related to the presenting complaint but may play a crucial role in an understanding of the person and the development of a treatment plan.

The MSE is a cross-sectional evaluation of the patient and is a core aspect of every psychiatric contact. It includes assessments of the patient's general appearance, mood, affect, speech, thought process, thought content (including suicidality and homicidality), perceptions, cognition, and executive functioning. Mental status is assessed throughout the interview, although some aspects of the MSE, such as cognition and memory, tend to be more formally assessed toward the end of the interview. See the section titled "Mental Status Examination" later in the chapter for definitions and a more thorough discussion of these terms.

The later phase of the interview features an increasing number of closed-ended questions that seek clear-cut answers. Approving nods and tactful eye contact can help maintain the alliance during this period of data acquisition. It is fine for the clinician to explicitly explain the situation, saying, for example, "We are short on time, so let's move on to talk about your work," or "It sounds like the situation at work has been rough, but let's shift gears to talking about your family." Transitions can often be smoothly effected by making use of any topics or words that the patient has recently used. If, for example, the patient has been talking about her family at length, the interviewer might say, "You mentioned that your husband has been having some 'senior moments.' Have you been having problems with your own memory?" Re-

gardless of the answer to that question, the interviewer can then shift to a more formal cognitive assessment.

Prior to ending this phase, the interviewer may want to ask the patient if there is anything else he or she would like the clinician to know.

Negotiation and Summary Phase

The interview is generally incomplete without some discussion of diagnosis and treatment. This conversation might take place at the end of the initial session, or it might occur during an ensuing session after the interviewer has had a chance to obtain more information, seen the patient for a second (or third) visit, or received supervision. This phase of the process is not part of the standard oral examinations taken by trainees and may seem superfluous to the interviewer, but to the patient it is often the key element of the evaluation. Active patient participation is strategically crucial because cooperation and adherence are central to treatment success, and patient preference plays a critical role in treatment success (van Schaik et al. 2004).

The negotiation phase is also the time for psychoeducation, referral to another clinician or clinic, and gaining a sense of whether the patient has been satisfied with the assessment process. Before the interview ends, the interviewer might ask the most relevant clinical question of all: "Do you think you will follow through with the recommended treatment?"

Techniques

Verbal and nonverbal communications are central to the psychiatric interview. These communications can be divided into three overlapping types: nonspecific, nondirective, and directive. *Nonspecific* interview techniques are used throughout the interview to enhance the patient's experience and lay the groundwork for an alliance and a more productive interview. *Nondirective* techniques encourage the patient to continue on a train of thought. *Directive* techniques narrow the focus, perhaps to a factual answer or a topic change. Table 1–2 lists these core interview techniques.

There are many ways to develop interview skills. Observation is the classic method, and the novice interviewer will quickly see that senior interviewers have a variety of styles. Trainees may practice with each other, sometimes interviewing actual patients and sometimes interviewing each other. Other interviewers read guidebooks (e.g., Evans et al. 2010). Knowledge of core techniques and the avoidance of derailing errors can improve all aspects of the interaction.

Tact and timing are central to the interview. For example, a patient might say, "I've been so sad since my mother died." In response to that poignant piece of information, the interviewer has choices. For example, she might decide to explore the patient's emotional reaction to the mother's death by looking directly at the patient, appearing warmly interested, and saying, "Could you tell me more about it?" An attentive, open-ended approach can allow the patient to express reactions to the death that are more complex than relatively straightforward sadness. If the patient then discusses ambivalence or relief, the interviewer might decide to tactfully make use of a confrontation (e.g., "It sounds like you've been very sad since your mother's death, and that her death after so many years of suffering has also felt like a relief"). On the other hand, time might be short or the patient may be especially dramatic or tangential, and