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The Psychiatric Interview

FOURTH EDITION

Daniel J. Carlat

Wolters Kluwer

THE PSYCHIATRIC INTERVIEW

Fourth Edition

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To my patients, past, present, and future. Thank you for allowing me to ask you question after question, and thank you for answering so honestly.

Foreword

The Psychiatric Interview is straightforward, practical, and wise, yet often lighthearted and funny, a breath of fresh air where comparable references have often been boring and ponderous. It brims with extraordinary gifts for its readers. It is a scholarly review of the research literature, yet it moves swiftly and has a light, even jaunty, tone. It is very much up-to-date and serves as a useful introduction to many ideas, such as those from psychodynamics, that are not widely available to contemporary students.

Best of all, the book is alive, an extraordinary achievement in view of the amount of detailed material presented. It emphasizes the *person within the patient* and the need to form an *alliance* with that person to secure reliable information and cooperation in treatment. We *feel* the patients presented by Dr. Carlat; they are not simply diagnoses. Dr. Carlat offsets the profession's reputation for being cheerless and pathology minded; he illustrates many ways by which effective relationships can be formed and shows how relationships that are endangered can be repaired, perhaps especially at the close of an interview.

The Psychiatric Interview is designed in an easily accessible format, with aids for memory, appendices for organizing information, and sensible guides for recordkeeping. This is teaching by example at its best, with the examples both vivid and pointed, so that they stick in the reader's mind.

Truly understanding another human being is a daunting challenge, yet nothing is more important if we are to soothe the suffering of a ravaged soul. Use this book as a guide to reach for that understanding.

Leston Havens, M.D.
Professor of Psychiatry, Emeritus
Harvard Medical School
The Cambridge Health Alliance
Cambridge, Massachusetts

Preface

Over the course of a 40-year professional career, you will do ~100,000 diagnostic interviews. The diagnostic interview is by far the most important tool in the arsenal of any clinician, and yet the average training program directs relatively few resources to specific training in the skills required for it. The general assumption seems to be that if you do enough interviews with different kinds of patients, you'll naturally pick up the required skills. That may be true, but it can take a long time, and the learning process can be painful.

I hatched the idea for this manual one night during my first year of psychiatric residency. Starting my shift in the acute psychiatry service (APS), I noticed five patients in the waiting room; the resident who handed me the emergency room beeper said that there were two more patients in the emergency room, both in restraints. At that moment, the beeper sounded, and I called the number. "Psychiatry? This is Ellison 6. We have a patient up here who says he's depressed and suicidal. Please come and evaluate, stat." That meant that I had a total of eight diagnostic assessments to do.

As the night stretched on, my interviews got briefer. The developmental history was the first to go, followed quickly by the formal mental status examination. This trimming process continued until, at 5 a.m., it reached its absurd, but inevitable, conclusion. My entire interview consisted of little more than the following question: "Are you suicidal?"

As I handed the beeper off to my colleague at 8 a.m. (I had slept for 50 minutes, about the length of a psychotherapeutic hour), I began to think about those interviews. Were they too short? (I was sure they were.) Were they efficient? (I doubted it.) Had anyone come up with a system for conducting diagnostic assessments that were rapid but at the same time thorough enough to do justice to the patient?

Looking for such a system became my little project over the rest of my residency. I labeled a manila file folder *interviewing pearls* and started throwing in bits and pieces of information from various sources, including interviewing textbooks, lectures in our Wednesday seminars, and conversations with my supervisors and with other residents. When I became chief resident of the inpatient unit, I videotaped case conferences and took notes on effective interviewing techniques. Later,

during my first job as an attending psychiatrist, I practiced and fine-tuned these techniques with inpatients at Anna Jaques Hospital and outpatients at Harris Street Associates.

What I ended up with was a compendium of tips and pearls that will help make your diagnostic interviews more efficient and, I hope, more fun. Mnemonics will make it easier for you to quickly remember needed information. Interviewing techniques will help you move the interview along quickly without alienating your patients. Every chapter begins with an Essential Concepts box that lists the truly take-home items of information therein. The appendices contain useful little stocking stuffers, such as "pocket cards" with vital information to be photocopied and forms that you can use during your interviews to ensure that you're not forgetting anything important.

However, if you're looking for theoretical justifications and point-by-point evidence for the efficacy of these techniques, you won't find it here. Go to one of the many textbooks of psychiatric interviewing for that. Every piece of information in this manual had to meet the following stringent standard: It had to be immediately useful knowledge for the trainee about to step into the room with a new patient.

WHAT THIS MANUAL *IS*

First, this is *only* a manual. It's not a residency or an internship. The way to learn how to interview patients is by interviewing them under good supervision. Only there can you learn the subtleties of the interview, the skills of understanding the interactions between you and your patients.

It is a tool that lends you a guiding hand in your initial efforts to interview patients. It's confusing territory. There are lots of mistakes to be made and many embarrassing and awkward moments ahead. This book won't prevent all of that, but it will catalyze the development of your interviewing skills.

It is a handbook for any beginning clinician who does psychiatric assessments as part of his or her training. This includes psychiatric residents, medical students, psychology interns, social work interns, mental health workers, nursing students, and residents in other medical fields who may need to do an on-the-spot diagnostic assessment while waiting for a consultant.

WHAT THIS MANUAL IS *NOT*

It is not a *textbook* of psychiatric interviewing. There are a number of interviewing textbooks already available (Shea 1998; Othmer 2001; Morrison 2014), my favorite being Shea's *Psychiatric Interviewing: The Art of Understanding.* Although textbooks are more thorough and encyclopedic, the drawback is that they do not guide the beginner to the essence of what he or she needs to know. Also, textbooks aren't portable, and I wanted to write something that you can carry around to your various clinical settings. That said, please buy a textbook, and have it around for those times when you want to read in more depth.

This is also not a handbook of psychiatric *disorders*. There are plenty of good ones already published, and I wrote this manual to fill the need for a brief, how-to guide to diagnosing those disorders.

Finally, it is not a *psychotherapy* manual. Doing a rapid diagnostic assessment isn't psychotherapy, although you can extend many of the skills used in the first interview to psychotherapy.

I hope that you will enjoy this book and that it will help you to develop confidence in interviewing. As you embark, remember these words of Theodore Roosevelt: "The only man who never makes a mistake is the man who never does anything." Good luck!

Introduction to the Fourth Edition

It's been 17 years since the first edition of *The Psychiatric Interview* was published. What began as a little pet project while I was a chief resident at Massachusetts General Hospital in 1995 has, surprisingly to me, become a standard text for those seeking a brief how-to manual for the psychiatric interview.

This latest edition incorporates the changes in diagnostic criteria published in DSM-5, the latest version of our field's official categorization of mental disorders. There are significant changes in how we diagnose dementia (now called major neurocognitive disorder), substance abuse, eating disorders, ADHD, and somatization disorder (which has evaporated from DSM-5). Beyond that, I did an updated literature review and made a few revisions as a result.

The Psychiatric Interview has now been translated into German, Japanese, Korean, Portuguese, and Greek. It's gratifying to me that clinicians all over the world understand the importance of active listening and of asking the right questions at the right times. Becoming a great clinician requires a lifetime of dedication. As Vince Lombardi once said, "Perfection is not attainable, but if we chase perfection we can catch excellence."

Daniel Carlat, M.D.
Newburyport, Massachusetts, 2016

Acknowledgments

For this fourth edition, as in the previous three editions, I start by thanking Dr. Shawn Shea, whose classic textbook, *Psychiatric Interviewing: The Art of Understanding*, got me interested in this topic. Dr. Shea has been a great friend and mentor throughout my career.

My father, Paul Carlat, who is also a psychiatrist, has bestowed upon me whatever personal qualities have been helpful as I work with patients. He continues to practice psychiatry, offering a unique blend of psychotherapy and medication treatment, and is a role model both for me and for many other young psychiatrists in the San Francisco Bay Area who have benefited from his supervision.

Many members of the faculty of Massachusetts General Hospital (MGH), where I did my psychiatric residency, were extremely helpful in the shaping of the manuscript. In particular, I thank the late Dr. Ed Messner, whose very practical approach to patient care was refreshing; Dr. Paul Hamburg, who taught empathy and innumerable other aspects of connecting with patients; Dr. Paul Summergrad, a consummate clinician and the director of the inpatient unit during my chief residency, who supported me in my efforts to create an interviewing course for residents; Dr. Carey Gross, who taught me much about how to rapidly make the right diagnosis for the most difficult patients; and Dr. Anthony Erdmann, who generously contributed several screening questions. In addition, special thanks go to the late Dr. Leston Havens, who was very encouraging throughout this project.

I also thank the psychiatry residents at MGH. The PGY-2 residents of the 1994 to 1995 academic year were extremely accommodating as I developed my interviewing curriculum while teaching it; the residents and psychology fellows in my own class constantly cheered me on, particularly Drs. Claudia Baldassano, Christina Demopulos, and Alan Lyman; comembers of the Harvard Gardens Club; and Dr. Robert Muller, psychologist supreme.

Finally, thanks are due to the staff of the Anna Jaques Hospital inpatient psychiatry unit, where I have "road tested" the many techniques described in this book. I especially thank Dr. Rowen Hochstedler, my former medical director at the hospital, and my friend, who is living proof that excellent mentoring can continue far beyond the reaches of academia.

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I

GENERAL PRINCIPLES OF EFFECTIVE INTERVIEWING

1 The Initial Interview: A Preview

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- Build a therapeutic alliance.
- Obtain the psychiatric database.
- Interview for diagnosis.
- Negotiate a treatment plan with your patient.

The Three Phases

- Opening phase
- Body of the interview
- Closing phase

FOUR TASKS OF THE DIAGNOSTIC INTERVIEW

When you meet a patient for the first time, you know very little about her, but you know that she is suffering. (Note: Throughout this book, I switch genders when discussing theoretical patients rather than resorting to the awkward "him or her.") While this may seem obvious, this implies something that we often lose sight of. Our job, from the first "hello," is to ease our patients' suffering, rather than to make a diagnosis.

Don't get me wrong—the diagnosis is important. Otherwise, I wouldn't be subjecting you to yet another edition of this book! But diagnosis is only one step on the path of relieving suffering. And often, you can do plenty to help a patient during the first session without having much of a clue as to the official DSM diagnosis.

Since 2005, when the second edition of this book was published, psychiatry has begun to question its fixation on the value of diagnostic categories. We have come to realize that "major depression" does not imply a specific "disease" but rather a huge range of potential problems. Each of our patients present with their own versions of depression, in

other words, and each version requires an individualized treatment approach. A 24-year-old woman floundering around after graduating from college a few years ago is depressed—and the solution may lie in helping her to clarify her goals. A 45-year-old public relations manager just found out his wife has been having an affair and he is depressed—the solution may be helping him to decide if he can ever trust her enough to engage in couple's therapy. A 37-year-old woman with three well-adjusted children and a good marriage says her life seems okay but she is depressed—she may need a course of antidepressants.

My point with these examples? Before you dive into the worthy project of becoming a world-class DSM diagnostician, experiment with spending much of your face-to-face patient time thinking about their lives, rather than your diagnosis of their lives. Engage your natural empathy, compassion, and intuition—because these represent the essence of psychological healing. And even as you progress through your career and have logged thousands of patient hours (as I have), always remind yourself of something that a wise colleague, Brian Greenberg, once told me: "I often put the DSM manual aside and tell myself, 'Brian, how are you going to make this person's journey easier?'"

The diagnostic interview is really about treatment, not diagnosis. It is important to keep this larger goal in mind during the interview, because if you don't, your patient may never return for a second visit, and your finely wrought *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) diagnosis will end up languishing in a chart in a file room.

Studies show that up to 50% of patients drop out before the fourth session of treatment, and many never return after the first appointment (Baekeland and Lundwall 1975). The reasons for treatment dropout are many. Some patients do not return because they formed poor alliances with their clinicians, some because they weren't really interested in treatment in the first place, and others because the initial interviews alone boosted their morale enough to get them through their stressors (Pekarik 1993). The upshot is that much more than diagnosis should occur during the initial interview: Alliance building, morale boosting, and treatment negotiating are also vital.