ROB POOLE AND ROBERT HIGGO

Psychiatric Interviewing and Assessment

SECOND EDITION

CAMBRIDGE Medicine

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Second Edition

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Second Edition

This second edition is dedicated to the memory of Dr Kevin White and Richard Marley, who provided us with the inspiration and support we needed to write about psychiatric skills.

Preface

We are living through difficult times, and psychiatric practice is changing rapidly. During the preparation of this book, two ageing psychiatrists sat at a kitchen table, drinking coffee, and discussing the state of their profession, their country and the world. One said to the other:

'You know, for millennia, men of our age have sat around tables like this, complaining that since they were young, everything has gone to the dogs. It's just our luck that this time it really has.'

Despite continued declarations of the imminent demise of our profession, we believe that psychiatry has a strong intellectual and clinical tradition that has a great deal to offer people with mental illness, and that it will continue to flourish in a recognisable form long after the current turmoil in the world and in the health professions has passed.

This book aims to help mental health professionals to develop core clinical skills in psychiatric interviewing and assessment. We have tried to produce a book that we would have found helpful at the beginning of our careers. The content is relevant to a range of mental health disciplines, including nursing and social work, despite a strong focus on psychiatric practice. We have aimed to write in a readable and authentic style, and working as psychiatrists is what we know best. We have not attempted to write from the viewpoint of other disciplines. Responses to the first edition suggested that this decision was correct, and we hope that this second edition will be helpful to practitioners of other professions.

This book is not about treatment, pharmacological or psychological. It is not about highly specialised assessments. It is about broad-based generic skills, which form the foundation of all other clinical interventions.

The book assumes the level of knowledge of psychiatry necessary to qualify as a medical practitioner or as a mental health nurse in the UK. The book has a general orientation towards community psychiatric practice. British psychiatry has a strong tradition of pragmatism and theoretical eclecticism whilst aspiring to follow the evidence base. This book follows that tradition. Where we have expressed opinions, or have taken a controversial point of view, we have tried to clearly indicate this. We have kept referencing to a minimum, as we believe it undermines readability.

The book is intended to be a guide to clinical practice. It is built around situations that are recognisable from clinical experience. We have used clinical vignettes to illustrate principles throughout the book. We have taken great care to make these realistic. We have not used true stories. Our patients and colleagues may feel that they recognise themselves in the vignettes. If so, they are mistaken. If some stories seem familiar, it is because there are recurrent themes in clinical practice.

We have 65 years of clinical experience between us: in deprived inner city areas; in rural Wales; in assertive outreach; amongst the homeless; in acute inpatient care; and in general hospital liaison psychiatry. We have learned that the most important objective in psychiatry is to get alongside patients. This does not mean doing whatever patients want. It means working in an alliance whereby the patient is supported by the clinician to find a route to recovery. The task is relational, embedded in everything that goes on between the professional and the patient. It cannot be neglected while some technical task is completed.

Furthermore, it can only be achieved if the clinician has an awareness of the importance of context and is able to understand the patient's point of view. It is true that this perspective demands some effort from the clinician early in the relationship. However, we have found that, overall, it takes less effort to do psychiatry well than to do it badly.

In writing the two editions of this book, we reflected long and hard on our own clinical practice. We hope that this has not resulted in a text that is idiosyncratic and anecdotal, but that other experienced clinicians will recognise the processes and dilemmas that we have identified. The book has five overarching and interrelated themes, which are important in clinical practice. These are:

- Process: assessment is not a battery of questions to be asked, but a process between two people. Attention to process optimises assessment and creates the foundations for a therapeutic alliance.
- Patient-centredness: understanding the patient as a person and understanding their subjective experience of their illness is an essential perspective in evaluating psychopathology, risk and other issues. We explore the patient's experience of the interview through examination of the separate agendas of the professional and the patient. Resolving the tensions and conflicts between these agendas is a key task for the clinician.
- Context: we explore the impact of the patient's psychological and social context, the context of the interview and the professional's psychological and social background as important factors that can assist or interfere with assessment.
- Hypothesising: it is often suggested that assessment consists of information gathering and mental state examination followed by diagnosis or formulation. In fact, experienced clinicians operate by forming hypotheses and testing them throughout an assessment. This is an efficient, flexible and critical process. There are significant pitfalls. If you fail to recognise that you are likely to form impressions very early in interviews, then those impressions are not easily challenged. A conscious awareness of the hypothesising process makes for better assessments.
- Clinical scepticism: this is that essential critical and independent-minded quality that is shared by all good doctors. It leads to a questioning of psychiatric orthodoxy and to an awareness that patients, their families and their friends all provide information that is affected by their subjective standpoint.

The most useful psychiatric books are read as much for pleasure as for self-improvement. This book is intended to be a light read, but its objective is serious. We felt that the process of writing the first edition made us more reflective, self-aware clinicians. We hope that this second edition proves relevant and helps other clinicians to avoid the mistakes we made along the way.

Acknowledgements

We were delighted and surprised that the first edition of this book was well received in the UK, the USA and beyond. We had a great deal of help from friends and colleagues in preparing that original text, including Dr Sue Ruben, Gordon Kennedy, Dr Theresa McArdle, Dr Richard Barnes, Gill Strong, Richard Marley, Dr Kevin White and Dr Michael Göpfert.

In preparing a second edition, we have expanded the scope of the book to accommodate some changes in the way that psychiatrists work. There is new material on neurodevelopmental assessments, on assessing adolescents and on rhetorical interviews, amongst other topics. We have adapted the text to the arrival of DSM-5, and we have tackled issues over the use of psychometric instruments in clinical practice. Ignoring wise counsel, we have rewritten most of the old material.

The task was daunting for a number of reasons. Firstly, there is the risk of following success with failure. Secondly, clinical practice has changed dramatically in the years since the first edition was published. Capturing current practice without being overly negative was quite a challenge. Finally, we have, through an unusual set of circumstances, both become clinical academics. In our earlier existence as inner city community psychiatrists, we were often dismissive of our academic colleagues. As we have written, we have internally heard the mocking voices of our younger selves, amused that two academics would presume to write a book about clinical skills. We have been fortunate to have significant assistance in the task, especially from Professor Catherine Robinson, Dr Sue Ruben, Dr Theresa McArdle, Dr Daniel Poole and Professor Peter Lepping. We have particularly valued their assistance in preparing the substantial amount of completely new material. We have retained the striking cover image from the first edition, painted by Sue Ruben.

Contents

Section 1 What Am I Trying To Find Out Here?

There is an unavoidable problem at the heart of the work of all health professionals. The practice of medicine and allied professions is increasingly based on empirical science, generating interventions that are essentially technological and standardised. These technologies may be psychological, social or biological (or involve a combination of these modalities). The scientific-technological has to be applied in the context of patients' lives, which are rich in complexity and ambiguity. At its simplest, no matter how efficacious a drug may be, it cannot work if the patient does not take it. The factors that make patients reluctant to accept advice may appear irrational to clinicians, but they are highly relevant to patients. No one can be expected to accept an intervention unless they are reasonably certain that the balance of the cost–benefit equation will lead to a positive change that is relevant to the quality of their life.

Much of this book is concerned with the development of the fundamental skills of forming and maintaining relationships with patients in order to deploy technologies without causing harm. This first section, however, is about a simultaneous, more technical task: developing a formulation, including a diagnostic understanding of the patient's problem. This is based on history taking and mental state examination.

The objective of this section is to understand what you are looking for during assessment, and to explore some of the problems associated with this technical task.

Chapter 1

Diagnosis

The Medical Model

'The medical model' is a puzzling concept. For many years, there appeared to be a consensus that the medical model as applied to mental disorder was a bad thing, and for the most part only the most convinced biological psychiatrists were prepared to defend it. However, it is far from clear what the term actually means. Sometimes it is used to mean the dominance of doctors amongst the mental health care professions. On other occasions, it refers to institutional models of care. Most frequently, it is used to characterise a sterile, de-humanised, genetic-pharmacological stance that does exist, but which cannot be reasonably described as the mainstream of psychiatry. A telling definition of 'the medical model' was given to us by a clinical psychologist many years ago, which is that it is anything that doctors do. This definition has the virtue of being logical.

In recent years there have been efforts to reassert the importance of medical skills and perspectives in mental health care (e.g. Craddock et al. 2008; Burns 2013). We are happy to defend one type of medical model, which remains in robust good health, despite decades of sustained criticism and attack from a wide variety of sources. We recognise that it has limitations and contradictions, but it is the de facto model of mental health care across the world, and it is not going to go away. Furthermore, it has some strengths. So far, no one has come up with a better alternative that could plausibly be expected to improve our ability to help people with mental disorder.

Few people could work in health care without being embarrassed or angered by the actions of doctors from time to time, either because of individual shortcomings or because of institutional self-interest. No profession could defend itself on the basis of the activities of its worst practitioners. The underlying model of medicine is the application of empirical science to help people in the context of their lives and environments. The scientific and human tasks are of equal importance. When medicine runs into trouble, it is usually because the scientific and the human tasks have become disconnected.

Out of this medical model have sprung pharmacological and surgical treatments, and also the whole of public health, including understanding of the role of hygiene, sanitation, nutrition, housing and inequality. The origins of psychotherapy and of social intervention to improve the health of the population lie within medicine and have a basis in this paradigm.

Where medicine has tried to impose crude technologies on patients, it has usually been based on poor or even pseudo-science, which is a betrayal of the fundamental task of the profession. The strength of medicine, and therefore the medical model, is its ability to understand problems at multiple levels simultaneously and to intervene in helpful ways that are informed, but not dominated, by scientific empiricism.

Diagnosis is a component of the medical model. It is a concept that unequivocally belongs to medicine and to the general medical approach to the understanding of human suffering. Embedded within the idea of diagnosis is an implicit assumption that symptoms, signs and natural history group together to form syndromes; that such syndromes can be understood at a physiological level; and that this can lead to the discovery of pathological processes and underlying causations.

The movement of diagnosis from syndrome, to physiology, to pathology, to causation, has underpinned a substantial proportion of all progress in medicine. It has been particularly effective in understanding infectious diseases and finding treatments and preventive measures for them. It has underpinned the substantial progress that has been made in responding to the global AIDS pandemic and the Ebola epidemic in West Africa.

The same process has sometimes been effective in understanding mental disorders. In the nineteenth century, 'general paralysis of the insane' (a type of neuro-syphilis) and some forms of complex partial epileptic seizure were regarded as part of an undifferentiated syndrome of 'insanity'. Now they are well understood and can be treated with reference to underlying organic pathologies and physiological processes. In modern times, this process led to the identification and better understanding of Lewy body disease from amongst the dementias of old age.

Categorical Diagnosis in Psychiatry

Notwithstanding these examples, and despite recurrent claims that psychiatric diagnosis in general is about to move on from the level of syndrome to neurophysiology, it must be acknowledged that there is little evidence that we are anywhere close to this. Despite extensive research effort into the major syndromes (such as schizophrenia, bipolar affective disorder and depression), consistent and coherent underlying physiologies, pathologies and causations remain elusive. The lack of clear biological causations is probably not just the consequence of inadequate scientific knowledge. No matter how far we progress scientifically, some psychiatric problems are unlikely to prove to have a primarily biological basis (although as scientific materialists we assume that all psychological activity must have associated brain activity).

When considered overall, psychiatric diagnosis is heterogeneous, embracing a wide diversity of disorders. This includes dementias (which definitely have a basis in coarse brain disease), psychoses (some of which probably have a basis in either brain dysfunction or subtle structural abnormalities), personality disorders (which are probably in large part developmental problems as a consequence of childhood adversity) and psychological reactions (which arguably lie within the range of normal human experience). The biological reductionist approach on its own is unlikely to be useful in understanding or managing many of these problems, no matter what scientific advances occur.

A primary concern of patients is the development of effective, safe, tolerable and user-friendly treatments, and here progress has been relatively good. However, few treatments in psychiatry are specific to diagnosis. In the main, our treatments are effective for particular symptoms. Antipsychotic drugs are useful in treating delusions and hallucinations, irrespective of diagnosis, and cognitive–behavioural therapy (CBT) has been shown to be useful in treating virtually every major mental disorder, provided the symptoms make the person

either anxious or depressed. Some modern critics of psychiatric diagnosis (e.g. Bentall 1992; British Psychological Society 2013) have argued that the whole nosology is illogical and unscientific, and should be abandoned. It is argued that we should focus on specific psychological problems rather than on diagnoses. Whilst this stance has utility, it ignores the secure knowledge that we do possess, which has important practical and scientific implications. We do have an excellent understanding of the ways in which symptoms group together, the course that such syndromes generally follow, some of the ways in which these disorders develop and the factors that tend to relieve or exacerbate them.

Until the 1970s it was difficult to defend psychiatric diagnosis, as, frankly, the nosology was a total mess. A series of well-known international studies (e.g. Cooper et al. 1972) used operational definitions to show that the prevalence of the major psychoses was remarkably similar in different countries. Nonetheless, national statistics showed wide variation, as psychiatrists of different nationalities had entirely incompatible definitions for the same disorders. Consequently there was no common international psychiatric language. At that time, psychiatric diagnosis could be criticised for lacking basic semantic validity. As a consequence, idiosyncratic diagnostic systems and diagnostic concepts in various countries came under critical scrutiny.

One of the repetitive errors of psychiatry has been to base diagnosis on supposed, but unproven, causations. A key example was the distinction in the UK between 'endogenous' and 'reactive' depression. Endogenous depression was said to arise from within the person without psychological or social antecedents (probably owing to a hereditary factor). It was said to be severe and characterised by biological symptoms. Reactive depression was less severe and closely related to the person's circumstances. Vulnerability to reactive depression was believed to be related to social stress and personality. Unfortunately, the neat distinction fell apart when studied closely (e.g. Kendell 1976). The presence of biological symptoms turned out to be a reflection of the severity of depression, and stressors were shown to be equally important at either end of the severity spectrum. Not only did symptoms fail to cluster into two groups, it was also more difficult than expected to demonstrate that anxiety and depression were separate syndromes.

The development of the International Classification of Diseases, Tenth Edition (World Health Organization, 1992) (itself influenced by the development of successive Diagnostic and Statistical Manuals in the USA) elevated psychiatric diagnosis to the level where categories had some basis in demonstrable syndromes. This classification (universally known as ICD-10) is a multi-axial diagnostic system with operational criteria for various diagnostic categories. It has been shown to have face validity and clinical utility. It allows psychiatrists to share an international scientific language that can be readily understood by reference to an accessible and understandable glossary. Indeed, the ICD-10 glossary is essential reading for psychiatrists in training. It is well written, clear and includes explanations of the nature of the categories. However, there are new controversies over psychiatric nosology.

ICD-10 is almost 25 years old, and ICD-11 has been under preparation for some time. In 2013, the American Psychiatric Association published the fifth edition of DSM, DSM-5 (APA 2013). Amongst many other changes, this version of DSM is not a multi-axial classification but a dimensional one. This document is intended for use in the USA, where it is ubiquitous. One important use is by health care insurers to determine remuneration for psychiatric treatment.

NHS England has devised a system of 'diagnostic clusters' for a similar purpose, in order to introduce 'payment-by-results' into mental health care. Although there is widespread support for incentivising better outcomes for patients, the mental health diagnostic cluster system is deeply flawed. Psychiatrists working in England are unlikely to be able to ignore the Mental Health Care Clustering Tools associated with this system, as they determine the amount of cash that returns to the organisation for treating each patient. Tools to determine tariff payments should not be mistaken for diagnostic instruments. They are actuarial tools for estimating appropriate cost of treatment. They have to be endured rather than reified.

In the media, DSM-5 is frequently described as 'the psychiatrist's Bible'. This is wildly inaccurate. It has nothing in common with a sacred text. Far from being unassailable to criticism, controversy has raged about DSM-5. There are allegations that it has proliferated the number and range of psychiatric diagnoses, pathologising normal psychological processes; that it lacks proper scientific validity; that the committees that developed it were overly influenced by the pharmaceutical industry; and that there is excessive secrecy over how decisions were made. At first, the American Psychiatric Association and the US National Institute of Mental Health appeared to disagree over the value of DSM-5, although they have said subsequently that this was based upon a misunderstanding of the two organisations' positions.

Everyone appears to agree that there are significant problems with current diagnostic systems. Despite an aspiration to an evidence-based nosology, we retain diagnoses that take putative causation, rather than symptom clusters, as their starting point (e.g. post-traumatic stress disorder). Given the state of development of psychiatry as a science, our diagnostic schedules are provisional, and they will be revised and replaced in due course. They are useful as long as you recognise the limitations to their application.

A diagnostic manual is like a cross between a dictionary and a map. Diagnosis provides a model for understanding the relationship between different disorders. It tells patients and clinicians where an individual's mental health problem lies within the whole psychiatric terrain. It tells you little or nothing about the person and their life. Like a dictionary or a map, diagnosis does not necessarily tell you very much beyond generalities.

Beyond Diagnosis: Formulation

Psychiatry has recognised the inadequacies of using categorical diagnosis in isolation for a very long time. After the Second World War, British psychiatry emphasised the need to develop a 'formulation' of each case, largely under the influence of Sir Aubrey Lewis (the first Professor of Psychiatry at the Institute of Psychiatry in London). A formulation was a detailed understanding of the contextual factors, biological, psychological and social, which had predisposed, precipitated and perpetuated a patient's disorder. The concept of formulation implicitly acknowledged that diagnosis on its own was of limited usefulness in helping people. The importance of the formulation was that it gave a far more detailed understanding, and could guide treatment. The term fell from use in the UK quite suddenly when two psychiatrists conducted research on the concept (Hollyman and Hemsi 1983). They asked British psychiatrists (and psychiatric postgraduate examiners) what should be included in a formulation. There was no general agreement. As a consequence, the term was dropped from British postgraduate examinations, and was replaced by the term 'assessment'. This had an identical function to formulation. No doubt if a further study had been conducted, there would still have been no general agreement. Box 1.1 sets out some key elements of formulation.

BOX 1.1 Some Components of Formulation

Wherever it is possible, formulation should be a collaborative process with the patient, which should include:

- A summary of the patient's core problems
- An indication of how those problems relate to one another
- An indication as to why the patient presents now, with these problems, in this form
- A plan for treatment/intervention

Formulation has made something of a comeback in the past decade. It is mentioned in the curriculum for Membership of the Royal College of Psychiatrists, as a skill in the Health and Care Professions Council regulations for psychologists, and it is used in cognitive–behavioural, systemic, psychodynamic, personal construct and narrative therapies. The British Psychological Society has claimed that the ability to formulate a case is unique to clinical psychologists (Division of Clinical Psychology 2010), but we have to disagree. It is a skill common to all professions that attempt to help people with mental disorders on the basis of scientific knowledge.

In our opinion, the difficulty in pinning down exactly what should be included in a formulation reflects the futility of operationalising the obvious. The diversity of factors that may be important is such that it is impossible to make a single statement as to what should be included and, more importantly, what should be left out. Assessment has to include the patient's concerns and those pressures, weaknesses and strengths operating in their lives, because these are the factors that are most important in finding a path to recovery. Ways of understanding mental disorder that avoid meaning at a human level are essentially sterile and are of very limited helpfulness. It is self-evident that disorders that affect feelings, thinking and behaviour have an important dimension of meaningfulness: not obscure or unconscious meaning, but a more accessible emotional and practical meaning. Whilst it may be useful at times to think of mental disorders as arising within the brain or the mind, the true location of these problems is in people's lives.

Alternatives to Formulation

ICD-10 attempts to deal with complexity by having five axes (see Box 1.2). This does allow a more comprehensive, operationally defined description of a problem, and does clearly allow for the fact that personality disorder is a risk factor for mental illness, not a mutually exclusive diagnosis. However, the system is only useful administratively. In the clinical situation, a list of categorically arranged problems, stripped of all context and meaning, is of little help.

An alternative approach to both formulation and multi-axial classification is the use of the problem list. This was developed, for the most part, by clinicians with an interest in CBT, and it closely follows the intellectual traditions of that approach. The model is widely used in the clinical assessment schedules that have become prevalent since professions other than psychiatry have taken on the task of initial assessment.

It is not suggested that problem lists replace diagnosis. The problem list is a tool, sitting alongside diagnosis and providing a way of breaking complex difficulties down into a series

BOX 1.2 ICD-10 Axes

Axis I: Mental disorder (e.g. syndromic mental illness)
Axis II: Developmental disorder (e.g. personality disorder)
Axis III: Intellectual impairment (e.g. learning disability)
Axis IV: Physical disorder
Axis V: Psychosocial problems

BOX 1.3 A Problem List

Mrs A, a 53-year-old woman with late-onset paranoid schizophrenia

Problem 1 Auditory, tactile and olfactory hallucinations and paranoid delusions regarding neighbours

Action 1 Consultant psychiatrist to arrange treatment with antipsychotic medication

Problem 2 Reluctant to take medication owing to limited insight into the nature of the problem

Action 2 Community mental health nurse to carry out insight directed or concordance therapy

Problem 3 Conflict with neighbours owing to arguments based on paranoid delusions

Action 3 Social worker to organise rehousing for patient and her husband

Problem 4 Psychosis worsened by worries over debts

Action 4 Social worker to organise referral to welfare rights worker to maximise state benefits and to assist with debt management

Problem 5 Conflict with daughters, who have been unable to comprehend their mother's behaviour

Action 5 Community mental health nurse to conduct sessions with the family

of discrete identifiable problems, each of which can be tackled with reference to an action plan. A problem list might look something like Box 1.3.

Problem lists have an attractive commonsense quality, and lend themselves to clear monitoring of progress. Most clinicians use some form of problem list to organise interventions, even if the list is not formalised in this way. There are potential pitfalls to the approach. Breaking problems down can lead to a loss of long-term and thematic perspectives, in other words breaking things down too much can drain the meaningful connections between individual problems. As far as possible, problem lists need to be developed with the patient, not imposed on them, as they can turn into a paternalistic and disempowering programme. Some clinicians feel that they overlook the importance of more subtle, but important, factors arising out of relationships with individual clinicians that can contribute to (or impede) recovery.

There are many other approaches to the task of producing a concise, coherent account of the important features of a patient's disorder in the context of their life. Like many experienced clinicians our preference is for a narrative, a story that draws all the threads together so that we, and the patient, can understand what has happened to them, set in a chronological framework. This preference may simply reflect our personalities, but we believe that it has real advantages. We find that a narrative is easier to remember, and is easier to convey verbally to other professionals. Even in an age of assessment proformas it is important to find an approach to formulation that works for oneself and one's patients.