KAPLAN AND SADOCK'S

SYNOPSIS OF PSYCHIATRY

BEHAVIORAL SCIENCES CLINICAL PSYCHIATRY

SEVENTH EDITION

HAROLD I. KAPLAN, MD
BENJAMIN J. SADOCK, MD
JACK A. GREBB, MD

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Williams & Wilkins
428 East Preston Street
Baltimore, Maryland 21202, USA

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Printed in the United States of America

First Edition 1972
Spanish
Second Edition 1976
Italian
Third Edition 1981
Portuguese
Spanish
Fourth Edition 1985
Portuguese
Spanish
Fifth Edition 1988
Portuguese
Spanish
Sixth Edition 1991
Greek
Portuguese
Spanish

Library of Congress Cataloging-in-Publication Data
Kaplan, Harold I.
Kaplan and Sadock's synopsis of psychiatry : behavioral sciences, clinical psychiatry / Harold I. Kaplan, Benjamin J. Sadock, Jack A. Grebb—7th ed.
p. cm.
Rev. ed. of: Synopsis of psychiatry. 6th ed. c1991.
Includes bibliographical references and index.
ISBN 0-683-04530-X
1. Mental illness. 2. Psychiatry. I. Sadock, Benjamin J. II. Grebb, Jack A. III. Kaplan, Harold I. Synopsis of psychiatry. IV. Title. V. Title: Synopsis of psychiatry.
[DNLM: 1. Mental Disorders. WM 100 K172k 1994]
RC454.K35 1994
616.89—dc20
DNLM/DLC 93-27556
for Library of Congress CIP

95 96 97 98
3 4 5 6 7 8 9 10

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Preface

This is the seventh edition of *Kaplan and Sadock's Synopsis of Psychiatry*; the first edition was published in 1972. The appearance of this edition—so soon after the sixth edition, published in 1991—was brought about by the publication of the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) by the American Psychiatric Association. DSM-IV revamped, once again, the psychiatric nosology. This edition of *Synopsis* is consistent with the new nosology. Indeed, it is one of the first psychiatric textbooks that relies on the new terminology completely and that includes the current DSM-IV diagnostic criteria for all mental disorders.

Frequent revisions of *Synopsis* have been necessary to keep up with the steady expansion of the body of knowledge in behavioral science and psychiatry. New advances have been made in the neural sciences, particularly in the areas of neurochemistry, neurophysiology, psychoimmunology, and psychoendocrinology. New data about the diagnosis and the treatment of mental disorders, particularly in the area of psychopharmacology, are presented in detail.

The eclectic and multidisciplinary approach that is the hallmark of all our books is also implemented in this edition. Accordingly, biological, psychological, and sociological factors are integrated and presented as they affect the person in health and in disease. We repeat what we wrote in the preface to the sixth edition:

> Modern psychiatry must emphasize the humane and compassionate aspects of medicine; this textbook is dedicated to the humanism that is unfortunately often lost in technically based modern medical education, training, and practice. Of equal importance, the interactions between medical school faculty and students require a high level of mutual empathic concern if America is to avoid producing computerlike robotic physicians. . . . If taught properly, with quality and sensitivity, psychiatry should be a dramatic and continuing reminder to all in medicine of its mission—the diagnosis, treatment, and elimination of pain, suffering, and disease through the treatment of the whole patient.

SOCIOPOLITICAL ISSUES

Medicine in the United States is undergoing a dramatic change. The introduction of the American Health Security Bill in 1993 has fueled intense debate about the future of medicine. Psychiatry is likely to be affected adversely, since prejudice toward mental illness has always existed in many quarters—political policy makers, insurance companies, the general public, and, sadly, the medical profession itself. The reality is that mental illness is a fact of life that must be dealt with by society at large, as well as by the medical profession.

All medical textbooks, including our own, have an obligation to provide a forum for the discussion of some of the new sociopolitical forces that affect medical practice. Decisions are now being made that involve diverse issues affecting physicians and patients: managed care; third-party insurance reimbursement for medical care, including psychiatric care; Medicare and Medicaid; the use, classification, and definition of controlled substances; the use of triplicate prescriptions; homosexual men and women in the military; poverty, homelessness, and deinstitutionalization; and the working conditions and the number of hours on duty of medical house staff are only a few of the current sociopolitical issues.

Unfortunately, most physicians, because of the nature of their medical education, are poorly prepared to deal with the socioeconomics of health care delivery. But now they are being forced to become involved, as a result of the American Health Security Bill and the current domestic controversy about the delivery and the quality of medical care, including psychiatry.

Medical schools have an obligation to educate physicians in sociopolitical areas. Toward that end, we have made observations about controversial areas. Psychiatrists, who are involved in the humane aspect of medical care, have a special obligation to become knowledgeable about all issues that affect the physical and psychological well-being of their patients. We hope that other medical textbooks will also exercise their editorial prerogatives in those areas.

DECADE OF THE BRAIN

By presidential proclamation, 1990–1999 was declared the decade of the brain. Many studies regarding the human brain are being conducted at the National Institutes of Health, particularly the National Institute of Mental Health. As the presidential proclamation states:

> Over the years, our understanding of the brain—how it works, what goes wrong when it is injured or diseased—has increased dramatically. However, we still have much more to learn. The need for continued study of the brain is compelling: millions of Americans are affected each year by disorders of the brain ranging from neurogenetic diseases to degenerative disorders such as Alzheimer's, as well as stroke, schizophrenia, autism, and impairments of speech, language, and hearing.

A new era of psychiatric discovery is dawning. We hope that this textbook contributes to that new era of discovery and leads to a continued improvement in the diagnosis and treatment of mental disorders.

CHANGES IN THIS EDITION

Format. This edition has 344 more pages than the previous edition because of the inclusion of more written material, illustrations, and tables, including all the tables from DSM-IV. The color illustrations of all the major drugs currently used in psychiatry in their various dosage forms have been expanded to include all the latest drugs available in the United States. The psychotherapeutic drug identification guide has been one of the more popular features of *Synopsis*. To keep the book from becoming too large, we have limited the references to the major books, monographs, and articles. And we have used small type in some sections to conserve space.

DSM-IV. The mental disorders discussed in this textbook are consistent with the nosology of the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), which is being published in 1994. Many psychiatrists have reservations about the DSM-IV nosology; in several sections of this book, those objections are clearly stated. Such terms as "neurosis" and "psychosomatic" are used in this book, even though those terms are not a part of the official nosology.

The inclusion of the DSM-IV nosology and diagnostic criteria means that almost every section dealing with clinical disorders has undergone a thorough and extensive revision. For example, DSM-IV no longer uses the term "organic mental disorders." An entirely new chapter in this textbook—"Delirium, Dementia, and Amnestic and Other Cognitive Disorders"—has been written to reflect that change. Similarly, the topic of psychoactive substance-induced organic mental disorders—the term used in the revised third edition of DSM (DSM-III-R)—is now covered in Chapter 12, "Substance-Related Disorders," which is the DSM-IV classification. The entire textbook has been reorganized to reflect the DSM-IV organization, and new chapters, such as "Relational Problems" and "Problems Related to Abuse or Neglect," have been added.

DSM-IV is now the law of the land; accordingly, it is strictly adhered to in this book. However, DSM-IV is a manual on nosology; it is *not* a textbook. *Synopsis* and other textbooks on psychiatry cover the entire field of psychiatry, not just nosology.

New and revised areas. The first chapter, on the doctor-patient relationship, has been expanded to include a discussion of interviewing techniques. Chapter 2, "Human Development Throughout the Life Cycle," has been revised to include discussions of the psychological aspects of pregnancy and childbirth. The subject of fetology and fetal life has been expanded to reflect new advances in that area. Section 2.7, "Thanatology: Death and Bereavement," includes a discussion of physician-assisted suicide. A review and critique of President Bill Clinton's American Health Security Bill, sent to Congress in 1993, is included in Section 4.9, "Socioeconomic Aspects of Health Care." For the first time, the theories of Erik Erikson and Jean Piaget appear as separate sections in this edition. Chapter 3, "The Brain and Behavior," has been updated to provide coverage of the fields of neurochemistry, neurophysiology, and psychoendocrinology; a new section, "Behavioral Genetics," has been added. Chapter 11, "Neuropsychiatric Aspects of Human Immunodeficiency Virus (HIV) Infection and Acquired Immune Deficiency Syndrome (AIDS)," has been updated, and Section 7.3, "Medical Assessment in Psychiatry," has been added. Other extensively changed areas include geriatric psychiatry, brain-imaging techniques, ethics in psychiatry, neuropsychiatric tests and rating scales, the role of laboratory tests in psychiatry, behavioral medicine, and the psychiatric aspects of immunology.

Childhood disorders. The chapters on child and adolescent psychiatry have been heavily rewritten. As in the adult areas, the new organization is based on DSM-IV. The new chapters include "Assessment, Examination, and Psychological Testing," "Mental Retardation," "Learning Disorders," "Mood Disorders and Suicide," and "Schizophrenia with Childhood Onset."

Biological therapies. A major change introduced in the sixth edition of *Synopsis* is continued in this edition. Drugs used in the treatment of mental disorders are classified and discussed pharmacologically, rather than as antidepressants, antipsychotics, and the like. We use that unique format to provide the student with an understanding not only of the general principles of psychopharmacology but also of the use of each psychotherapeutic drug according to its pharmacological activity as a discrete drug, rather than as one of a family of drugs. This edition adds information about the uses, cautions, interactions, and dosages of drugs and includes information on the drugs most recently introduced in the United States. Chapter 33, "Biological Therapies," also includes information about drugs not yet on the market. A tinted page contains an index to guide the reader to the section where each of the drugs used in psychiatry is discussed.

TEACHING SYSTEM

This textbook forms one part of a comprehensive system we have developed to facilitate the teaching of psychiatry and the behavioral sciences. At the head of the system is *Comprehensive Textbook of Psychiatry*, which is global in depth and scope; it is designed for and used by psychiatrists, behavioral scientists, and all workers in the mental health field. *Kaplan and Sadock's Synopsis* is a relatively brief, highly modified, original, and current version useful for medical students, psychiatric residents, practicing psychiatrists, and mental health professionals. Another part of the system is *Study Guide and Self-Examination Review for Kaplan and Sadock's Synopsis of Psychiatry*, which consists of multiple-choice questions and answers; it is designed for students of psychiatry and for clinical psychiatrists who require a review of the behavioral sciences and general psychiatry in preparation for a variety of examinations. The questions are modeled after and consistent with the new format used by the National Board of Medical Examiners and the Federation of State Medical

Boards' United States Medical Licensing Examination. Other parts of the system are the pocket handbooks: *Pocket Handbook of Clinical Psychiatry*, *Pocket Handbook of Psychiatric Drug Treatment*, and *Pocket Handbook of Emergency Psychiatric Medicine*. Those books cover the diagnosis and the treatment of psychiatric disorders, psychopharmacology, and psychiatric emergencies, respectively, and are compactly designed and concisely written to be carried in the pocket by clinical clerks and practicing physicians, whatever their specialty, to provide a quick reference. Finally, *Comprehensive Glossary of Psychiatry and Psychology* provides simply written definitions for psychiatrists and other physicians, psychologists, students, other mental health professionals, and the general public.

Taken together, those books create a multipronged approach to the teaching, study, and learning of psychiatry.

THE FUTURE OF PSYCHIATRY

The publication of this book coincides with seismic changes in the delivery of health care in this country that are likely to affect the field of psychiatry. For example, managed-care programs are attempting to limit mental health benefits in an effort to control costs. Some proposals curtail the number of outpatient visits for psychotherapy to 5 to 20 sessions a year. Although some types of psychotherapy can be conducted within that framework, other types of psychotherapy, particularly insight-oriented psychotherapies, require frequent visits over an extended period. In addition, before a patient can be referred to a psychiatrist, many health maintenance organizations (HMOs) require that a primary care physician (the so-called gatekeeper) see the patient for several weeks before the referral; during that time, pharmacotherapy, rather than psychotherapy, is administered. Drugs, rather than psychotherapy, will become the treatment of choice, in spite of the fact that many studies have found the superior efficacy of drugs used in conjunction with psychotherapy in the treatment of most mental disorders, particularly depressive disorders. In addition, persons who are emotionally well make fewer general medical visits than do persons with emotional disorders; the result is savings in the overall cost of general medical care.

We believe that managed-care oversight of psychiatric treatment will undermine the doctor-patient relationship. It can destroy the psychotherapeutic process, which requires confidentiality, trust, independent judgment, and freedom from external bureaucratic constraints to be effective. We believe that prejudice toward psychiatry and fear of mental illness are largely responsible for those limitations.

ACKNOWLEDGMENTS

A new author, Jack Grebb, M.D., has joined us. A distinguished clinician and scholar, Dr. Grebb helped in the conceptualization, the writing, and the implementation of every aspect of this textbook.

We thank our contributing editors: Glen Gabbard, M.D., Rebecca Jones, M.D., Peter Kaplan, M.D., Caroly Pataki, M.D., and Virginia A. Sadock, M.D. Each made major contributions that were of immeasurable value.

Others who helped us were Norman Sussman, M.D., Richard Perry, M.D., Eugene Rubin, M.D., and Clifford Feldman, M.D. We express our appreciation to Jay E. Kantor, Ph.D., Research Associate Professor of Humanities at New York University School of Medicine, for his help in the ethics section of the book. We also thank Nancy B. Kaplan, James Sadock, Victoria Sadock, and Phillip Kaplan, M.D., for their help.

Justin Hollingsworth played a key role in assisting us in all aspects of our work. His prodigious efforts were extremely important. Laura Marino and Lynda Abrams Zittell, M.A., were also of great help.

In addition, we thank our close friend, Joan Welsh, who has done outstanding editorial work for this book, as she has done in the past for other books. We also thank Dorice Vieira, Head of Educational Services of the Frederick L. Ehrman Medical Library of the New York University School of Medicine, for her valuable assistance in this project.

We also take this opportunity to acknowledge those who have translated this and other works into foreign languages. Current translations include Italian, French, Portuguese, Spanish, Indonesian, and German, in addition to a special Asian and international student edition of *Synopsis*.

We thank Robert Cancro, M.D., Professor and Chairman of the Department of Psychiatry at New York University School of Medicine, who participated as Senior Contributing Editor of this edition. Dr. Cancro's commitment to psychiatric education and psychiatric research is recognized throughout the world. He has been a source of great inspiration and friendship to us and has contributed immeasurably to this and previous books.

Finally, we thank our publishers, Williams & Wilkins, for their cooperation in every aspect of this textbook.

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New York University Medical Center
New York, New York
February 1994

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The Doctor-Patient Relationship and Interviewing Techniques

The physician has many tools with which to diagnose, manage, and treat patients' disorders. The tools range from in-depth laboratory investigations to highly sophisticated radiographic procedures. Although medical schools and residencies provide training grounds for the acquisition of complex and essential skills, one such skill is often treated superficially. The capacity to develop an effective doctor-patient relationship requires a solid appreciation for the complexities of human behavior and a rigorous education in the techniques of talking and listening to people. To diagnose, manage, and treat an ill person's disorder, the physician must learn to listen. For many physicians—trained to be, first and foremost, active, aggressive, and in control—the act of listening may take on the mantle of an uncomfortable passivity. One of the supreme tasks of any medical training center is to help the physician acquire skills of active listening, both to what the physician and the patient are saying and to the undercurrents of the unspoken feelings between the two. A physician who is continually monitoring not only the content of the interaction (what the patient and the doctor say) but also the process (what the patient or the doctor may not say but conveys in a variety of other ways) is a physician who realizes that communication between two people occurs on several levels at once. A physician who is sensitive to the effects that history, culture, environment, and psychology have on that relationship is a physician who is working with a multifaceted patient, not a disease syndrome. When the art and the technique of active listening are not emphasized, respected, and conveyed, physicians fail to be trained in the rudiments of establishing a relationship with their patients, and patient care is the inevitable loser.

BIOPSYCHOSOCIAL MODEL

George Engel has been the most prominent proponent of the biopsychosocial model of disease, which stresses an integrated systems approach to human behavior and disease. The biopsychosocial model is derived from general systems theory. The biological system emphasizes the anatomical, structural, and molecular substrate of disease and its effects on the patient's biological functioning; the psychological system emphasizes the effects of psychodynamic factors, motivation, and personality on the experience of illness and the reaction to it; and the social system emphasizes cultural, environmental, and familial influences on the expression and the experience of illness. Engel postulated that each system affects and is affected by every other system. Engel's model does not assert that medical illness is a direct result of a person's psychological or sociocultural makeup but, rather, encourages a comprehensive understanding of disease and treatment. A dramatic example of Engel's conception of the biopsychosocial model was a 1971 study of the relation between sudden death and psychological factors. After investigating 170 sudden deaths over about six years, he observed that serious illness or even death may be associated with psychological stress or trauma. Among the potential triggering events Engel listed are the following: the death of a close friend, grief, anniversary reactions, loss of self-esteem, personal danger or threat and the letdown after the threat has passed, and reunions or triumphs.

The doctor-patient relationship is a critical component of the biopsychosocial model. All physicians must not only have a working knowledge of the patient's medical status but also be familiar with how the patient's individual psychology and sociocultural milieu affect the medical condition, the emotional responses to the condition, and involvement with the doctor.

ILLNESS BEHAVIOR

Illness behavior is the term used to describe a patient's reactions to the experience of being sick. Some describe aspects of illness behavior as the sick role. The *sick role* is the role that society ascribes to the sick person because he or she is ill. Characteristics of the sick role include such factors as being excused from certain responsibilities and being expected to want to obtain help to get well. Edward Suchman described five stages of illness behavior: (1) *the symptom experience stage*, in which a decision is made that something is wrong; (2) *the assumption of the sick role stage*, in which a decision is made that one is sick and needs professional care; (3) *the medical care contact stage*, in which a decision is made to seek professional care; (4) *the dependent-patient role stage*, in which a decision is made to transfer control to the doctor and to follow prescribed treatment; and (5) *the recovery or rehabilitation stage*, in which a decision is made to give up the patient role.

Illness behavior and the sick role are affected by a person's previous experience with illness and by a person's cultural beliefs about disease. The influence of culture on the reporting and the presentation of symptoms must be evaluated. The relation of illness to family processes, class status, and ethnic identity are also important. The person's and the culture's attitudes about dependency and helplessness greatly influence how and if a person asks for help, as do such psychological

factors as personality type and the personal meaning attributed to the experience of being ill. For instance, different persons react to illness in different ways, depending on their habitual modes of thinking, feeling, and behaving. Some persons experience illness as overwhelming loss, whereas others see in the same illness a challenge to be overcome or a punishment for something they feel guilty about. Table 1–1 lists essential areas to be addressed in the assessment of illness behavior and questions that are helpful in making that assessment.

MODELS OF THE DOCTOR-PATIENT RELATIONSHIP

The doctor-patient relationship has a number of potential models. Often, neither the doctor nor the patient is fully conscious of choosing one or another model. The models most often derive from the personalities, expectations, and needs of both the doctor and the patient. The fact that the personalities, the expectations, and the needs are largely unspoken and may be different for doctor and patient may lead to miscommunication and disappointment for both participants in the relationship. The doctor must be consciously aware of which model is operating with which patient and be able to shift models, depending on the particular needs of specific patients and on the treatment requirements of specific clinical situations.

Specific Models

Models of the doctor-patient relationship include the active-passive model, the teacher-student (or parent-child, guidance-cooperation) model, the mutual participation model, and the friendship (or socially intimate) model.

The *active-passive model* implies the complete passivity of the patient and the taking over by the physician that necessarily results. In that model the patient assumes virtually no responsibility for his or her own care and takes no part in treatment. The model is appropriate when a patient is unconscious, immobilized, or delirious.

In the *teacher-student model* the dominance of the physician is assumed and emphasized. The role of the physician is paternalistic and controlling; the role of the patient is essentially one of dependence and acceptance. That model is often observed during a patient's recovery from surgery.

The *mutual participation model* implies equality between doctor and patient; both participants require and depend on each other's input. The need for a doctor-patient relationship based on a model of mutual, active participation is most obvious in the treatment of such chronic illnesses as renal failure and diabetes, in which a patient's knowledge and acceptance of treatment ramifications are critical to the success of the treatment. The model may also be effective in subtle situations—for example, in pneumonia.

The *friendship model* of the doctor-patient relationship is generally considered dysfunctional if not unethical. It most often represents a primary, underlying psychological problem in the physician, who may have an emotional need to turn the care for the patient into a relationship of mutual sharing of personal information and love. The model often involves indeterminate perpetuation of the relationship, rather than an appropriate ending, and a blurring of boundaries between professionalism and intimacy.

Table 1–1
Assessment of Individual Illness Behavior

Prior illness episodes, especially illnesses of standard severity (childbirth, renal stones, surgery)
Cultural degree of stoicism
Cultural beliefs concerning the specific problem
Personal meaning or beliefs about the particular problem
Specific questions to ask to elicit the patient's explanatory model:
1. What do you call your problem? What name does it have?
2. What do you think caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?
5. How severe is it? Will it have a short or long course?
6. What do you fear most about your sickness?
7. What are the chief problems that your sickness has caused for you?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from treatment?
9. What have you done so far to treat your sickness?

Table from M Lipkin Jr: Psychiatry and medicine. In *Comprehensive Textbook of Psychiatry*, ed 5, H I Kaplan, B J Sadock, editors, p 1280. Williams & Wilkins, Baltimore, 1989.

General Considerations

Gaining conscious insight into the relationship between physicians and patients requires constant evaluation. The better understanding that doctors have of themselves, the more secure they feel, and the better able they are to modify destructive attitudes. Doctors need to empathize but not to the point of assuming the burdens of their patients or unrealistically fantasizing that only they can be the patients' saviors. They should be able to leave behind the problems of their patients when away from the office or the hospital and not use their patients as substitutes for an intimacy or a relationship that may be missing in their personal lives. Otherwise, they will be handicapped in their efforts to help sick people, who need sympathy and understanding but not sentimentality and overinvolvement.

The physician is prone to some defensiveness, partly with good reason, for many innocent doctors have been sued, attacked, and even killed because they did not give some patients the satisfaction they desired. Consequently, the physician may assume a defensive attitude toward all patients. Although such rigidity may create the image of thoroughness and efficiency, it is frequently inappropriate. Greater flexibility leads to a responsiveness to the subtle interplay between the two persons. It also assumes a certain tolerance for the uncertainty present in any clinical situation with any patient. The doctor must learn to accept the fact that, as much as he or she may wish to control everything in the care of a patient, that wish can never be fully realized. In some situations a disease cannot be controlled, and death cannot be prevented, no matter how conscientious, competent, or caring a physician is.

Physicians must also avoid sidestepping issues that they find difficult to deal with because of their own sensitivities, prejudices, or peculiarities when those issues are important to the patient.

A medical student insisted on questioning a patient about

her relationship with her 23-year-old son. The playback of a tape-recorded interview revealed that the patient wished to talk about her problems with her husband. When the patient was later interviewed by the supervising doctor, she said: "The medical student was a nice fellow, but I could see that he was having trouble with his mother. It made me understand my own son more."

In such a complex interaction as the doctor-patient relationship, mistakes are usually not disastrous to the relationship if they are relatively infrequent. When the patient senses interest, enthusiasm, and goodwill on the part of the interviewer, the patient is apt to tolerate considerable inexperience.

INTERVIEWING

One of the most critical tools a physician has is the ability to interview effectively. A skillful interview is able to gather the data necessary to understand and treat the patient and in the process to increase the patient's understanding of and compliance with the physician's advice. Every interview has three main components, all of which require special techniques and skills: the beginning of the interview, the interview itself, and the closing of the interview.

Ekkehard Othmer and Sieglinde Othmer described an interview as taking place in four dimensions—establishing rapport, assessing the patient's mental status, using specific techniques, and diagnosing—with the interviewing process progressing through seven stages. Table 1–2 and Figure 1–1 summarize their conceptualization of an ideal interview. They stress that the order of completion of the interview tasks is determined by following the patient's needs; the order is not necessarily the order outlined in Table 1–2. In general, an interviewer must convey an attitude that is nonjudgmental, interested, concerned, and kind; otherwise, potentially crucial information may not be obtained.

Many factors influence both the content and the process of the interview: (1) The patient's personality and character style significantly influence reactions and the emotional context in which the interview unfolds. (2) Various clinical situations—including whether the patient is seen on a general hospital ward, on a psychiatric ward, in the emergency room, or as an outpatient—shape the type of questions asked and the recommendations offered. (3) Technical factors—such as telephone interruptions, the use of an interpreter, note taking, and the room's physical space and comfort—affect the interview. (4) The timing of the interview in the patient's illness, be it in the most acute stage or during a remission, influences the interview's content and process. (5) The interviewer's style, orientation, and experience have a significant influence on the interview. Even the timing of interjections, such as "uh-huh," can influence what a patient does or does not say and when, as the patient tries unconsciously to follow the subtle leads and cues provided by the doctor.

Every interview has two major technical goals: recognition of the psychological determinants of behavior and symptom classification. Othmer and Othmer described goals as encompassing two styles of interviewing: the insight-oriented or psychodynamic style and the symptom-oriented or descriptive style. *Insight-oriented interviewing*

Table 1–2
Seven Phases of the Interview and the Four Components

Phase	Rapport	Mental Status	Technique	Diagnosis
1. Warm-up	Put patient at ease, set limits	Observe appearance, psychomotor function, speech, thinking, affect, orientation, memory	Select productive questions	Note diagnostic clues from patient's behavior
2. Screening of the problem	Empathize with suffering, become a compassionate listener	Explore mood, insight, memory, judgment	Open with broad screening questions	Classify the chief complaint; assess symptoms, severity, course, stressors; list differential diagnoses
3. Follow-up of preliminary impressions	Become an ally, make shifts in topics clear	Assess speed of thinking, ability to shift sets	Shift topics, progress from open-ended to closed-ended questions	Verify or exclude diagnostic impressions
4. Confirmatory history	Show expertise, interest, thoroughness, and leadership	Evaluate responsibility, judgment, remote memory	Follow-up, shift topics, handle defenses	Assess course, effects on social life, family and medical history
5. Completion of data base	Motivate for testing	Test mental status functions	Fill in gaps, follow up clues, reconcile inconsistencies	Exclude unlikely disorders
6. Feedback	Secure acceptance of diagnosis	Discuss mental status findings, explore interest in help	Explain disorders and treatment options	Establish diagnosis and prognosis
7. Treatment contract	Assume the authority role and assure compliance	Make inferences about insight, judgment, and compliance	Discuss treatment contract	Predict treatment effects

Table from E Othmer, S C Othmer: *The Clinical Interview Using DSM-III-R*, p 246. American Psychiatric Press, Washington, 1989. Used with permission.