

# The Psychological Interview

## 1) *Setting the Scene*

### a) **Purpose of the Interview**

The collection of data for the purpose of making informed decisions is an important part of medicine. Typically this will involve careful history taking, as well as a number of routine observations such as taking a patient's blood pressure. Treating the Mental Health patient is no different- it requires the same careful observation and history taking. The psychological interview is the equivalent of the medical examination and the assessment of mood, behaviour and thoughts is the equivalent of taking blood pressure.

Accordingly, just as the GP learns to use a stethoscope to listen to a patient's heart/lungs, the GP treating psychological conditions needs to develop skills to listen to / observe a patient's moods, thoughts and behaviours.

### b) **The Interview as Therapy**

In the process of collecting this information it is important to remember that every aspect of your interaction with your patient has the capacity to be positive (therapeutic) or negative (counter-therapeutic). As a result it is crucial for the GP dealing with mental health issues to develop a good psychological "beside manner". The quality of the interaction with your patient can be just as, if not more, powerful than the content.

### c) **The Relationship**

As a GP you are in a privileged position. Your familiarity with your patient's medical and social history, as well as your established relationship, places you in a unique position to help your patient with psychological problems. Over-familiarity however can be a problem. It may blind you to non-medical explanations for your patient's symptoms or you may feel embarrassed to broach sensitive personal issues for fear of embarrassing your patient, yourself or showing disrespect. Likewise, although the trust your patient has in you may allow them to divulge personal material, they may also be too ashamed or fearful of opening up to a known person with whom they intend to continue having contact. This fine line between familiarity and over-familiarity needs to be continually monitored and openly discussed. Eg: *"I understand that this is not the kind of material we usually discuss. I'm wondering if you have any concerns about talking to me about this subject? Is there anything I can do to make things easier for you?"*

You may also want to revisit confidentiality issues, especially in cases where you are the family GP.

## **2) Basic Interview skills**

The material in this handout covers two basic skills involved in the psychological interview: 1) basic listening skills and 2) history taking and problem formulation.

To facilitate the learning process several examples of each skill will be illustrated. The following case scenario will be used throughout to provide continuity.

### **Case Scenario:**

*David is a 27-year-old married man. He presents to his GP with episodes of breathlessness and palpitations. During these episodes he becomes confused and finds it difficult to talk. He interprets these symptoms as signs of a serious illness and anticipates collapsing. These episodes occur in social situations. He is fearful that people will think he is weird or drunk. At the first signs of symptoms he tries to leave the situation. If this is not possible he uses alcohol to help him cope. Over the past few years he has begun to avoid social situations. As a result he has become increasingly isolated and lonely. His avoidance of social situations and alcohol use has become a source of conflict between him and his wife.*

## **Part 1: Communication Skills – The Basics**

Good communication is a crucial aspect of any meaningful interaction. Your ability to understand your patients will maximise your impact as a GP. All the knowledge in the world is wasted if your ability to apply and impart that knowledge is deficient. It is not enough simply to say, “I’m listening” or “I understand”, rather it is important to demonstrate that this is the case. You need to look like you’re listening and sound like you understand. Although these skills apply across the board- no matter what the presenting problem- they are particularly useful with psychological problems, where what a person says and does is the predominant data available.

### **1) Looking the part**

To look like you are listening you need to:

- i. Face the client squarely (avoid sitting behind a desk)
- ii. Adopt an open posture (unfold those arms)
- iii. Lean slightly forward
- iv. Make eye contact

The message to the patient is “I’m here and I’m interested”

## 2) ***Sounding the part***

The art of listening is showing you understand and the best way to communicate understanding is to reflect back to the patient:

- i) the words they have used
- ii) the message you have heard
- iii) the feelings they have expressed.

### i. Reflecting words

To reflect words, simply repeat a few words the patient has said.

Pt:: *“I am concerned about the way my heart beats and the way I can’t breathe properly when I’m stressed.”*

GP (repeating): *“Your heartbeat changes when you’re stressed”*

This type of response will encourage the patient to continue talking without the need for you to ask a question. To try and avoid sounding like a parrot, mix it up a bit by substituting similar words and slightly rephrasing what was said.

GP (rephrasing): *“When you feel uptight, you notice physical changes in your body ”*

### ii. Reflecting the message

To reflect the message, the meaning of what was said is inferred and reflected back in new words:

Pt:: *“ I become confused and can’t talk think of anything to say. I feel like I’m going to collapse.”*

GP (Paraphrasing): *“When you experience these physical changes you find it hard to think or communicate and you start to worry that you might lose control and pass out.”*

### iii. Reflecting feelings

So far you have focused on what the patient has said to you. Now you need to reflect the emotions that accompany the words. This is a more difficult, but extremely powerful, skill. Luckily feelings tend to congregate around the following major categories a) Happiness, b) Sadness, c) Fear and d) Anger. Each of these emotions vary from mild/moderate to extreme. For example mild sadness can be reflected with words such as “blue” or “sad”, whilst extreme, unrelenting and pervasive sadness is more like “despair” or “depression”. Table 1 gives examples of different feeling words. Expanding your own feeling vocabulary will make you a better communicator.

Table 1: Feeling words

<b>Happiness</b>	<b>Sadness</b>	<b>Fear</b>	<b>Anger</b>
Happy	Sad	Fearful	Miffed
Stoked	Blue	Scared	Angry
Pleased	Down	Worried	Shitty
Glad	Gloomy	Anxious	Pissed off
Content	Miserable	Nervous	Irritated
Delighted	Distressed	Afraid	Annoyed
Joyful	Despair	Apprehensive	Livid
Over the moon	Depressed	Frightened	Rage
On cloud nine		Terrified	
Ecstatic			

To reflect feelings, choose a word from the appropriate category and desired strength.

Pt: *“I really hate feeling this way and would do anything to avoid it.”*

GP: *“It sounds like you are really frightened when this happens”*

Using qualifiers such as *“sounds like...”* or *“I get the sense that...”* allows the patient to either confirm your hunch or help you adjust it.

#### iv. Getting More Information - Using questions

Although reflective listening will help you communicate and encourage your patients to expand and explore their problem, asking questions is still one of the best and reliable means of getting the information you are looking for.

Questions come in two forms: a) open and b) closed

##### a) Open Questions

Open questions (ie questions that do not lead to a simple *Yes* or *No* response) are a good way to encourage the patient to think about things more deeply. Open questions start with *How?* and *What?*

- *How does this affect your life?*
- *What happens if you can't escape from the situation?*
- *How does your wife feel about your problems?*

##### b) Closed Questions

Closed questions like *Is it...? Can you...? Would you...?* can all be answered with a simple *Yes* or *No* and discourage the person from thinking more deeply about their answers.

Closed questions are useful when a very specific piece of information is required or when you want to focus on a specific subject:

- *Do you also feel nauseous or sweat a lot?*
- *Does this happen only in social situations?*

v. Non-Verbal Communication

Words are not the only means of communication. A patient's tone of voice, facial expressions, gestures and eye contact are also valuable sources of information. Non-verbal communication can give strength to words and either confirm or contradict what is being said. Non-verbal communication is a great source of information about what your patient is feeling.

You can also reflect a patient's non-verbals to show you are listening. For example:

- *"Your voice sounds really frightened"*
- *"The way you said that gives me the idea that you are quite worried about..."*
- *"You look very tense?"*
- *"I notice your wringing your hands a lot?"*

vi. Summarising (Putting it all together)

Summarising is a great way to end a session.

GP: *"You experience bouts of breathlessness and rapid heart beat in social situations. You also feel confused and find it hard to talk. When this happens you imagine you are about to collapse. These symptoms frighten you and you would do anything to avoid them. Does that sound about right to you?"*

In summary, the above micro skills allow you to convey interest and empathy whilst also facilitating the acquisition of important information.

<b>Part II: Making Sense of What Your Patient Tells You.</b>
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Now that you can effectively communicate with your patients, your next task is to make sense of what they tell you. Commonly your patients will talk about their symptoms and how they feel. Sometimes, they will tell you what they do and the circumstances involved. Rarely, they will tell you about what they think. Your job is to collect information about all of these aspects to form a complete picture.

i. Circumstances

Behaviours, feelings and experiences seldom occur in a vacuum. Rather, each influences the other, giving rise to a chain of events. Table 1 illustrates the kinds of questions that will help you discover these underlying links.

Table 1: Sample questions to uncover links

<ol style="list-style-type: none"> <li>1. <i>Under what circumstances do you feel anxious?</i></li> <li>2. <i>What triggers these symptoms?</i></li> <li>3. <i>In what situations do you experience breathlessness and rapid heart beat?</i></li> <li>4. <i>What makes it worse or better?</i></li> <li>5. <i>Does it occur at a particular time of day or after a specific behaviour?</i></li> <li>6. <i>Can you describe to me in detail the events that led up to you feeling this way?</i></li> <li>7. <i>How often does this occur?</i></li> <li>8. <i>Can you predict when it will next happen?</i></li> </ol>
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To assist your patient in providing you with this type of information, you can request that they monitor their behaviour, feelings ... over a designated period of time using a self-monitoring diary (Figure 1).

Figure 1: Self-Monitoring Diary

<b>Date:</b>	<b>Situation:</b>	<b>Behaviour:</b>	<b>Feeling:</b>

The aim of this line of questioning is for both you and your patient to gain a better understanding of the circumstances surrounding the behaviour, symptoms or feelings under examination. Even if, at the end of this exercise, your conclusion is that no links exist and that your patient's troubles are unpredictable and random, this information is worth knowing before you move on to discuss management issues.

ii. Symptoms

It is not hard to get patients to talk about their symptoms. Symptoms are most often the reason why patients will consult their GP and symptom relief is most likely to be the desired outcome. At times however your patient's description of their symptoms will be vague and you will need to use a combination of open and closed questions to clarify them. In many cases you may also want to know the intensity of the symptom described. For example, if anxiety is involved, you may want to ask your patient to rate the intensity of the anxiety on a scale of 0-100 (where 0 is absolutely no anxiety and 100 is the worst anxiety they can imagine). In doing so, it is important to remember that this is a subjective rating, which may be either minimised or exaggerated depending on the patient's personal style. You may also want to ask questions about non-physical symptoms such as lack of concentration or memory loss.

In making sense of this information, it will be important for you to know whether you are dealing with an isolated symptom or a range of symptoms that, when considered together, point to the existence of an underlying syndrome such as depression. For example the patient that reports anxiety may also experience sleep disturbance or appetite loss, alongside social withdrawal and a depressed mood. Your familiarity with the various psychological syndromes will help you enquire about related symptoms that your patient may have not mentioned.

### iii. Feelings

Sometimes patients will present complaining of emotional distress. “I feel nervous, anxious, depressed”. Most often however you will have to enquire about your patient’s emotions. This is the case not just when your patient is suffering primarily from an emotional disorder such as depression or anxiety, but also when they present with discrete physical symptoms or following an event such as a loss of job. The use of open questions is often the most useful way to proceed. e.g.: “How have you been feeling over the past week?” “How have you been feeling since you were told you no longer had a job?”

### iv. Behaviours

What patients do is also an important piece of information. How do they react to their symptoms or feelings? Do they try and avoid situations or respond with aggression? When feeling anxious, do they leave the situation or push on regardless? Do they seek relief from medication or alcohol? Are they isolating themselves from friends? These are all questions that will uncover how your patient is coping with their situation. It is worthwhile remembering that not all coping mechanisms are adaptive. Some, such as using substances or avoiding anxiety-provoking situations, are maladaptive and, in the long term, exacerbate the problem.

### v. Thoughts

The meaning your patient gives to an event or symptom will have a great bearing on how they feel and react. If your patient interprets a symptom as a sign of a serious illness, then they are likely to experience intense feelings such as fear or depression and act in ways that will avoid or minimize these experiences. Often your patient will not volunteer their thoughts because a) they may not be aware of them or b) they consider them to be irrelevant. As a result, you will need to enquire about “thoughts” directly using open questions. Eg: “*What is it about these symptoms that worries you?*”, “*What did you think was going on?*”, “*What did you think was about to happen?*”, “*What do you think is likely to happen in the future?*” **A word of caution:** Although the question “*why?*” appears to be a useful question, it is more often a hindrance. Patients rarely know “*why?*” and will often become confused and frustrated with their inability to answer what appears to be a relatively simple question. “*What?*” is a much more useful and productive question to ask. Eg: Rather than asking, “*Why are you frightened of these symptoms?*” you can ask “*What is it about these symptoms that frightens you?*”

### vi. Consequences

The last link in the preceding chain of events is the consequences that the symptoms, behaviours, thoughts and feelings have on the patient and the people around them. Enquiring about the consequences will provide you with the final piece of the puzzle. Here again open and closed questions are a useful tool. Eg: “*What are the consequences of this problem?*”, “*How does it affect your relationships?*”, “*Are you losing sleep or not turning up for work?*”, “*What are the positives and negatives of having this problem?*” Knowing about consequences will also reveal information about your patient’s likely

motivation towards change. Without any immediate, adverse consequences the reason for and need to change may be weak or non-existent.

vii. Problem Formulation

Now that you have an understanding of:

- a) *your patient's symptoms*
- b) *the circumstances in which they occur*
- c) *their intensity and frequency*
- d) *how they are related to other symptoms*
- e) *how they think and feel about it*
- f) *how they react*
- g) *the consequences involved*

- you are in a position to build a working model of the patient's problem. You can now present this model to your patient for discussion. For example:

*“So far you have told me that you feel breathless when you enter a social situation. Your heart pounds and you become confused. You interpret these symptoms to mean that you are ill and are about to collapse. You are worried that people will look down upon you and think that you are drunk. You feel fearful and either try and leave the situation immediately or avoid it all together. Although this makes you feel better immediately, the consequences are that you have lost many friends and are quite isolated and lonely. You have also begun to use alcohol as a way of coping with your problem and this has created conflict between you and your wife. Do you think that is a fair assessment of the problem? Have I left anything out?”*

Having reached this point you have achieved two crucial tasks:

- 1) Using your basic communication skills you have demonstrated that you are listening and interested and
- 2) Having pieced together the chain of events, you have formulated a working model of the patient's problems.

From the point of view of the patient you have fulfilled several major requirements of a “helper”: you listen, you care and you understand.