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Conducting a psychiatric interview requires striking a balance between empathy, precise questioning, and careful consideration of diagnostic criteria for various disorders. Each question posed should serve a specific purpose, such as uncovering symptoms, or assessing safety risks. A good psychiatrist avoids unnecessary questions, just as a skilled surgeon minimizes unnecessary incisions during surgery. The goal is to make every question count without sacrificing empathy or substance. - For patients in crisis: - Ask pertinent social history upfront for framing the interview and understanding their situation. - Use timing to guide these questions: "Now I'm going to ask you about some other symptoms people might feel when they're depressed." - Key questions to ask include: - Anxiety and depression simultaneously, as these symptoms often overlap and are co-morbid. - For bipolar symptoms and course of illness: - Mania - Depression - Number of lifetime manic episodes - Number of lifetime depressive episodes - Index episode - Last episode - Triggers/precipitants - In patients with substance use in the context of psychosis, specifically ask if psychotic symptoms appeared before or after substance use started. - For individuals with OCD, include high sensitivity screening questions and a good OCD history: - Obsessions - Compulsions - Screening for borderline personality disorder - During the interview, pay attention to the mental status examination (MSE), which is a systematic way of describing a patient's mental state at the time. Today, the clinical interview is a 40% assessment, 40% therapy, 25% relational, and 20% technical tool. It's a flexible method used to achieve various goals by many researchers and practitioners. The clinical interview can be both a structured procedure for collecting data and establishing mental disorder diagnoses, as well as a means of interpersonal connection with clients. Recently, I came across an article by Allen Frances on diagnostic interviewing. As always, our emphasis is on balancing technical tasks with essential relational components. We start with the advantages and disadvantages of structured diagnostic interviews and then move on to less structured models. Advantages include standardized schedules, systematic questioning, a diagnosis that relieves clinicians of subjective weighing, better reliability and validity than unstructured methods, suitability for scientific research, and supporting research on disorder nature, course, prognosis, and treatment responsiveness. Structured interviews are also part of the scientific foundation of psychology and counseling, with ongoing revisions aiming to improve systems. Structured diagnostic interviews can be time-consuming, often requiring several hours to complete. For instance, the Schedule for Affective Disorders and Schizophrenia for School-Age Children can take anywhere from one to four hours to administer. This format doesn't allow for shortcuts or intuition-based diagnoses, which may not accurately reflect clients' needs. Some clinicians find this structure too rigid, de-emphasizing rapport building and interpersonal communication between client and therapist. Others prefer a more flexible approach that emphasizes relationship development and intuition. Despite their reliability, some question the validity of structured diagnostic interviews due to limitations in capturing essential information about clients' personal history, personality style, and contextual variables. Two therapists may administer the same interview schedule yet arrive at incorrect diagnoses. This highlights the need for time-efficient evaluation methods in clinical practice. Critics argue that diagnostic criteria are more suitable for researchers than clinicians, who prioritize uniformity over individualized assessments. Less Structured Diagnostic Clinical Interviews offer an alternative approach, focusing on culturally sensitive warmth and active listening during the assessment process. Clinicians may use standardized questionnaires and intake information to gather data. A detailed review of client problems and goals is also essential, incorporating symptom analysis and personal history discussions. Given text here The goal of creating a diagnosis and treatment plan should not change the therapist's interest in the client as an individual. To start, therapists must review confidentiality limits and introduce diagnostic interviews using a statement that emphasizes collaboration and avoids focusing on pathology. This can be done by saying something like: "Today, we'll work together to understand what's been troubling you." This approach encourages clients to share their thoughts freely while also asking questions to clarify their experiences. By identifying the client's main concerns, a treatment plan can be developed. During diagnostic interviews, therapists should strive for a balance between being structured and allowing client spontaneity. This can be achieved by actively listening and asking diagnostic questions. It's essential to remember that clients' perspectives may differ from our own, and we shouldn't automatically accept their self-diagnosis as valid. When reviewing client problems, it's crucial to respect the client's perspective while also seeking accurate information. Clients often provide their own diagnosis at the beginning of interviews, which can be misleading. For example, they might say, "I'm depressed" or "I have ADHD." However, these terms are often misused and lack specificity. By using more precise diagnostic terminology, such as depression being a syndrome rather than a mood state, therapists can gather more accurate information. Research has shown that relying on a single question like "Are you depressed?" is inadequate for an accurate diagnosis. Similarly, clients may use the term "compulsive" to describe behaviors associated with various disorders. Therapists must be aware of these nuances and ask follow-up questions to gather additional information. By doing so, they can develop a more accurate diagnosis and create a treatment plan that addresses the client's unique needs. Given article text here The ICD-10-CM and DSM-5 provide essential tools for handling diagnostic uncertainty. Practitioners can utilize V codes and Z codes to indicate treatment focus on issues not meeting diagnostic criteria for mental disorders, such as F99 for Unspecified Mental Disorder. Provisional diagnosis, marked with "(provisional)," signals a working diagnosis pending further information. Being uncertain after an intake interview is a call to action - to delve deeper into the client's history. Social-developmental history provides critical context for accurate diagnosis, especially in cases where depressive symptoms are present. Discriminating between depressive disorders and comorbid conditions relies heavily on adequate historical information, as seen in panic disorder requiring previous panic attacks or posttraumatic stress disorder necessitating a trauma history. Current situations can be better understood through information about the client's current state. A comprehensive intake interview is crucial for understanding a client's situation. Key areas to focus on include their typical day, social support network, coping skills, physical health, and personal strengths. These aspects provide vital information for the diagnostic process. Reviewing a client's daily schedule can be particularly revealing, as it may uncover hidden habits or patterns that could impact treatment goals and plans. In some cases, it may also be necessary to gather information from people other than the client, such as parents or close friends, especially when dealing with young clients or those experiencing psychosis or personality disorders. Assessing a client's coping skills is another important aspect of the intake interview. This can involve evaluating whether they are actively working through problems or merely reacting to them, which could impact treatment planning and outcomes. Finally, a medical examination may be necessary for making an accurate mental disorder diagnosis. By inquiring about a client's physical health during the intake process, therapists can gather more comprehensive information that aids in developing effective treatment plans. Some therapists ask about physical examination results during the intake process and discuss them with clients. This is because physical and mental states can have a significant impact on each other. For instance, a long-term illness or serious injury can contribute to anxiety and depression. When conducting a diagnostic assessment, consider gathering information about physical examination results, consulting with the client's primary care physician, or referring them for a physical examination. It's essential to identify potential medical or physical causes of mental disorders and document them. When working with clients who are struggling, it's also crucial to focus on their strengths and positive qualities. This can help counteract feelings of sadness or demoralization that may arise during the assessment process. Explore these strengths by asking open-ended questions, such as: "What are some things you're proud of accomplishing?" or "How have you managed to cope with your current challenges?" Incorporating a solution-oriented approach, diagnosis and assessment procedures can be used to identify clients' abilities, strengths, and resources rather than solely focusing on their deficits. As Bertolino and O'Hanlon (2002) noted: Formal assessment procedures can assist in learning about clients' abilities, strength, and resources, and in searching for exceptions and differences. Effective diagnostic interviewing involves more than just gathering facts; it also requires expressing compassion and support for the client. The goal of diagnosis is not only to establish a diagnosis but also to begin developing an individualized treatment plan that addresses the client's unique needs.

Clinical depression interview. Interview depression patient. Purpose of clinical interview.