The Psychiatric Interview

FIFTH EDITION

Daniel J. Carlat

Wolters Kluwer

THE PSYCHIATRIC INTERVIEW

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Fifth Edition

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Preface

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

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

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

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

Looking for such a system became my little project over the rest of my residency. I labeled a manila file folder *interviewing pearls* and started throwing in bits and pieces of information from various sources, including interviewing textbooks, lectures in our Wednesday seminars, and conversations with my supervisors and with other residents. When I became chief resident of the inpatient unit, I videotaped case conferences and took notes on effective interviewing techniques. Later, during my first job as an attending psychiatrist, I practiced and fine-tuned these techniques with inpatients at Anna Jaques Hospital and outpatients at Harris Street Associates.

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

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

WHAT THIS MANUAL *IS*

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

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

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

WHAT THIS MANUAL IS *NOT*

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

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

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

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

Introduction to the Fifth Edition

It's been 24 years since the first edition of *The Psychiatric Interview* was published. What began as a little pet project while I was a chief resident at Massachusetts General Hospital in 1995 has, surprisingly to me, become a standard text for those seeking a brief how-to manual for the psychiatric interview.

This latest edition incorporates the changes in diagnostic criteria published in DSM-5-TR, the latest version of our field's official categorization of mental disorders. There is a new diagnosis, prolonged grief disorder, and I have added a new chapter on interviewing techniques for the agitated patient. Beyond that, I did an updated literature review and made a few revisions as a result.

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

Daniel J. Carlat, M.D.
West Newbury, Massachusetts, 2023

Acknowledgments

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

My father, Paul Carlat, who was also a psychiatrist before his retirement, has bestowed upon me whatever personal qualities have been helpful as I work with patients.

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

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

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

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GENERAL PRINCIPLES OF EFFECTIVE INTERVIEWING

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- Negotiate a treatment plan with your patient.

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FOUR TASKS OF THE DIAGNOSTIC INTERVIEW

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

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

Since 2005, when the second edition of this book was published, psychiatry has begun to question its fixation on the value of diagnostic categories. We have come to realize that "major depression" does not imply a specific "disease" but rather a huge range of potential problems. Each of our patients present with their own versions of depression, in other words, and each version requires an individualized treatment approach. A 24-year-old woman floundering around after graduating from college a few years ago is depressed—and the solution may lie in helping her to clarify her goals. A 45-year-old public relations manager just found out his wife has been having an affair and he is depressed—the solution may be helping him to decide if he can ever trust her enough to engage in couple's therapy. A 37-year-old woman with three well-adjusted children and a good marriage says her life seems okay but she is depressed—she may need a course of antidepressants.

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

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

Studies show that up to 30% of patients drop out of treatment prematurely, and many never return after the first appointment (Olfson et al., 2009). The reasons for treatment dropout are many. Some patients do not return because they formed poor alliances with their clinicians, some because they weren't really interested in treatment in the first place, and others because the initial interviews alone boosted their morale enough to get them through their stressors (Pekarik, 1993). The upshot is that much more than diagnosis should occur during the initial interview. Alliance building, morale boosting, and treatment negotiating are also vital.

The four tasks of the initial interview blend with one another. You establish a therapeutic alliance as you learn about your patient. The very act of inquiry is an alliance builder; we tend to like people who are warmly curious about us. As you ask questions, you formulate possible diagnoses, and thinking through diagnoses leads naturally to the process of negotiating a treatment plan.

Build a Therapeutic Alliance

A therapeutic alliance forms the groundwork of any psychological treatment. Chapter 3, The Therapeutic Alliance, focuses on the alliance directly, and Chapters 4-14 provide various interviewing tips that will help you increase rapport with your patient.

Obtain the Psychiatric Database

Also known as the *psychiatric history*, the psychiatric database includes historical information relevant to the current clinical presentation. These topics are covered in Section II, The Psychiatric History, and include history of present illness, psychiatric history, medical history, family psychiatric history, and aspects of the social and developmental history. Gleaning this information is the substance of the interview, and throughout this step, you will have to work on building and maintaining the alliance. You will also make frequent forays into the next task, interviewing for diagnosis.

Interview for Diagnosis

The ability to interview for diagnosis—without sounding as if you're reading off a checklist of symptoms and without getting sidetracked by less relevant information—is one of the supreme skills of a clinician, and one that you will hone and develop over the course of your professional life. Section III, Interviewing for Diagnosis: The Psychiatric Review of Symptoms, is devoted to this skill; it contains chapters on how to memorize *DSM-5-TR* criteria (Chapter 20) and on the art of diagnostic hypothesis testing (Chapter 21) and several disorder-specific chapters that focus on how to use screening and probing questions for each of the major *DSM-5-TR* disorders (Chapters 23-32).

Negotiate a Treatment Plan and Communicate It to Your Patient

This process is rarely taught in residency or graduate school, and yet, it is probably the most important thing you can do to ensure that your patient adheres to whatever treatment you recommend. If your patient doesn't understand your formulation, doesn't agree with your advice, and doesn't feel comfortable telling you so, the interview may as well never have taken place. See Section IV, Interviewing for Treatment, for tips on the art of patient education and clinical negotiation.

THREE PHASES OF THE DIAGNOSTIC INTERVIEW

The diagnostic interview, like most tasks in life, has a beginning, a middle, and an end. Although this may seem obvious enough, novice interviewers often lose sight of it and therefore fail to actively structure the interview and control its pacing. The result is usually a panic-filled ending, in which 50 questions are wedged into the last 5 minutes.

It's true that there's a huge amount of information to obtain during the first interview, and time may feel like the enemy. Excellent interviewers, however, rarely feel rushed. They have the ability to obtain large amounts of information in a brief period, without giving patients the sense that they are being hurried along or made to fit into a preordained structure. One of the secrets of a good interviewer is the ability to actively structure the interview in its three phases.

Opening Phase (5-10 Minutes)

The opening phase includes meeting your patient, learning a bit about her life situation, and then shutting up and giving her a few uninterrupted minutes to tell you why she came. This is discussed in more detail in Chapter 3, because the opening phase is a crucial period for alliance building; the patient is making an initial decision as to your trustworthiness. The opening phase is based on careful, preinterview preparation, covered in Chapter 2, Logistic Preparations: What to Do Before the Interview. Attention to logistics ensures that you will be completely attuned to the relationship with your patient during the first 5 minutes.

Body of the Interview (30-40 Minutes)

Over the course of the opening phase, you will come up with some initial diagnostic hypotheses (Chapter 21), and you will decide on some interviewing priorities to explore during the body of the interview. For example, you may decide that depression, anxiety, and substance abuse are likely problems for a particular patient. You will map out an interviewing strategy for exploring these topics, which will include asking about the history of the present illness (Chapter 15); history of depression, suicidal ideation, and substance abuse (Chapters 23, 24, and 27); family history of these disorders (Chapter 18); and a detailed assessment of whether the patient actually meets *DSM-5-TR* criteria (Chapters 21, 22, and 25) for each disorder. Once you've accomplished these priority tasks, you can move on to other topics, such as the social/developmental history (Chapter 19), medical history (Chapter 17), and psychiatric review of symptoms (Section III).

Closing Phase (5-10 Minutes)

Although you may be tempted to continue asking diagnostic questions right up to the end of the hour, it's essential to reserve at least 5 minutes for the closing phase of the interview. The closing phase should include two components: (1) a discussion of your assessment, using the patient education techniques outlined in Chapter 33, and (2) an effort to come to a negotiated agreement about treatment or follow-up plans (Chapter 34). Of course, early in your career, it will be difficult to come up with a coherent assessment on the spot, without the benefit of hours of postinterview supervision and reading. This skill will improve with practice.

> *The most tactful question in the world is still inquisitive and requests an answer. To some measure, it carries the memory of all questions that could not be answered or were shaming or damning to acknowledge.*
>
> Leston Havens, M.D.
> A Safe Place

2
Logistic Preparations: What to Do Before the Interview

Essential Concepts

- Prepare the right space and time.
- Use paper tools effectively.
- Develop your policies.

The work of psychological healing begins in a safe place, to be compared with the best of hospital experience or, from an earlier time, church sanctuary. The psychological safe place permits the individual to make spontaneous, forceful gestures and, at the same time, represents a community that both allows the gestures and is valued for its own sake.

Leston Havens, M.D.
A Safe Place

Logistic preparation for an interview is important because it sets up a mellower and less stressful experience for both you and your patient. Often, trainees are thrown into the clinic without training in how to find and secure a room, how to deal with scheduling, or how to document effectively. You'll eventually arrive at a system that works well for you; this chapter will help speed up that process.

PREPARE THE RIGHT SPACE AND TIME

Secure a Space

A space war is raging in most clinics and training programs, and you must fight to secure territory. If you can't create a safe physical space for you and your patient, there will be no treatment at all.

I remember one early lesson in this reality: I was 2 months into my training and just finishing supervision in the Warren Building of the Massachusetts General Hospital (MGH) campus. It was 12:55 PM, and I had a therapy patient scheduled for 1:00 PM in the Ambulatory Care Clinic, a building so far from Warren that it practically had its own time zone. I zigged and zagged around staff and patients in the hallways on their way to the cafeteria and rushed into the clinic by 1:05 PM. My patient was in the waiting room and got a good view of sweat trickling down my forehead. I scanned the room schedule and found that no rooms were free. Panic set in, until the secretary pointed out that the resident who had room 825 for that hour had not yet shown up. So I led my patient to 825, and we started, 10 minutes late. Five minutes later, there was a knock on the door. I opened it, and there stood the resident and his patient. I redeposited my patient in the waiting room and scoured the list for another room.

I won't torture you with the rest of this saga. Suffice it to say, we were evicted from the next room as well, and the therapy session was, in the end, only 15 minutes long, with much humiliation on my part and good-natured amusement on my patient's.

Here are some time-honored tips on how to secure a room and what to do with it once you have it:

- **Schedule the same time every week.** Try to secure your room for the same time every week. That way, you'll be able to fit interviews into your weekly schedule routinely. When it comes to psychiatric interviewing, routine is your friend. Psychodynamic psychotherapists call this routine—the same time, the same room, the same greeting—the "frame." Making it invariable reduces distractions from the work of psychological exploration.
- **Make your room your own in some way.** This isn't easy when you only inhabit it for a few hours a week. Clinic policy may forbid this, or it may be impolite (eg, if you're using an office that belongs to a regular staff member). If possible, put a picture on the desk or the wall, bring a plant in, place some reference books on a shelf, hang some files. The room will feel more like your space, and it will seem homier to your patient. In my current office, I have a photo of my two children on my desk. In the past, I worried that this little piece of self-disclosure could cause problems with transference. Would lonely patients envy me for having a family? Would angry patients believe that I was "bragging" by showcasing my "beautiful family"? In fact, these problems haven't occurred (at least to my knowledge)—the photo is generally a good conversation starter and, for most patients, makes me seem more human and less intimidating.
- **Arrange the seating so that you can see a clock** without shifting your gaze too much. A wall clock positioned just behind your patient works well. A desk clock or a wristwatch placed between the two of you is also acceptable. The object is to allow you to keep track of the passage of time without this being obvious to your patient. It is alienating for a patient to notice a clinician frequently looking at a clock; the perceived message is "I can't wait for the end of this interview." You do need to monitor the time, though, to ensure that you obtain a tremendous amount of information in a brief period. Actually, keeping track of time will paradoxically make you *less* distracted and *more* present for your patient, since you'll always know that you're managing your time adequately.

Protect Your Time

Time is but the stream I go a-fishing in.

Henry David Thoreau

This is not to say that you should go fly-casting with your patients (though you're usually fishing for something or other during an interview). Rather, you should protect the time you schedule for interviews, so that it has that same peaceful, almost sacred quality. How to do it?

Arrive Earlier Than the Patient

You need time to prepare yourself emotionally and logistically for the interview. Compose yourself. Lay out whatever forms or handouts you'll need. Answer any urgent messages that you just picked up at your message box. Breathe, meditate, do a crossword puzzle, or whatever you do to relax.

I once observed an interviewer who was visibly anxious. He crossed and uncrossed his legs and constantly kneaded his left palm with his right thumb. Eventually, the patient interrupted the interview and asked, "Doctor? Are you all right? You look nervous." He laughed. "Oh, I'm fine," he said. And no, this was not a resident, but one of my professors.

Prevent Interruptions

There are various ways to prevent interruptions:

- Ask the clinic secretary to take messages for you.
- Ask the page operator to hold all but urgent pages.
- Put your pager or phone on vibrate mode and answer only urgent calls.
- Sign your pages out to a colleague.

Don't Overbook Patients

Know your limits. At the beginning, it may take you an hour and a half to complete an evaluation, not including the write-up. If so, book only one patient per 2-hour slot. Obviously, your training program won't allow you to maintain such a leisurely schedule for long, but you will improve and become more efficient. Eventually, you should aim toward completing the evaluation and write-up (or dictation) in 1 hour.

Leave Plenty of Time for Notes and Paperwork

The time required for paperwork (or computer-work) will vary, depending on both the setting and the clinician. The key is to figure out how long it takes you and then to make room for it in your schedule. Don't fall into denial. If you happen to be very slow at paperwork, admit it and plan accordingly.

I know an excellent psychiatrist who has learned from experience that he has to spend 30 minutes on charting, telephoning, and miscellaneous paperwork related to patients for every hour of clinical work he does. If he spends 6 hours seeing patients, he schedules 3 hours in the evening to take care of the collateral work. Although his hourly wage decreases, he gains the satisfaction of knowing that he's doing the kind of job he wants to do.

Now, that wouldn't work for me. I schedule slightly less time with patients so that I can finish all collateral work before I see my next appointment. The point, as Polonius said in Hamlet, is to "Know thyself, and to thine own self be true."

USE CLINICAL TOOLS EFFECTIVELY

By “clinical tools,” I mean the whole array of interview forms, cheat sheets, patient handouts, and patient questionnaires. Since earlier editions of this book, most of us have moved to electronic health records, so we might fill out the forms on the computer and we might e-mail patients handouts. Regardless, these tools are indispensable when you see a lot of patients every day. All of the paper versions of the tools that I discuss below are in the appendices of this manual, and you are welcome to copy and use what you want. In addition, electronic versions of the forms are available from many sources online. You might find all, some, or none of them useful, or you may want to adapt them to better suit your needs.

Psychiatric Interview Long Form

This psychiatric interview long form (in Appendix B) is adapted from the one used by Anthony Erdmann, one of my supervising psychiatrists at MGH. He took notes on it while talking to patients and then he put it in his chart.

Advantages

Use of this form ensures a thorough data evaluation and saves time, because notes can be placed directly into the chart.

Disadvantages

Some patients may be alienated if you seem more interested in completing a form than in getting to know them.

Psychiatric Interview Short Form

The short form (in Appendix B) can be used for rough notes when you are going to dictate the evaluation or write it up in a longer version later.

Advantages

This form presents less of a barrier between clinician and patient than the long form and is easy to refer to while dictating.

Disadvantages

Use of the short form may lead to a less thorough evaluation.

Psychiatric Interview Pocket Card

The pocket card (in Appendix A) is used to remind you of all the topics to cover. You can jot rough notes on a blank piece of paper or not take notes at all, if you’re able to remember most information.

Advantages

The card allows maximum interaction between clinician and patient, since there is no form to fill out.

Disadvantages

Required information is not fully spelled out on the pocket card, so more use of memory is required.

Patient Questionnaire[1]

Some clinicians give their patients a questionnaire (in Appendix B) such as this one before the first meeting, to decrease the time needed to acquire basic information.

Advantages

The patient questionnaire allows more time during the first session to focus on issues of immediate concern to the patient. It may heighten the patient's sense that he is actively participating in his care.

Disadvantages

If all of the patient's answers on the questionnaire are accepted at face value, invalid information may be collected. Some patients may view filling out the questionnaire as a burden.

Patient Handouts

Patients usually appreciate receiving some written information (in Appendix C) about their disorder, and it probably increases treatment compliance.

Advantages

Patient handouts increase patients' understanding of their diagnosis and give them a sense that they are collaborating in their treatment.

Disadvantages

The handouts may present more information than some patients can handle early in their treatment. Information may also be misinterpreted.

DEVELOP YOUR POLICIES

From the first appointment with a particular patient, you are entering into a relationship. You need to determine the parameters of this relationship, including issues such as how and when you can be contacted, what the patient should do in case of an emergency, who you can talk to about the patient, and how to deal with missed appointments. As you face this array of decisions, the following tips and ideas should help you devise policies that fit your personality and clinical setting.

Contacting You

You define the boundaries of the clinical relationship by setting limits on where and when patients can reach you. Do this early on; if you don't, you'll eventually suffer for it.

I found this out the hard way with my very first therapy patient during residency. She was a 40-year-old woman I'll call Sally who had panic disorder and depression. I first met her in the crisis clinic, where she came after an upsetting conversation with her father. I spoke to her for half an hour, and I gave her a follow-up appointment for the next week—and I gave her my pager number and told her that this was a way to reach me, "anytime." The next Saturday morning, over breakfast and the paper, I got my first page: "Call Sally." She was in the middle of a panic attack, which subsided after a 10-minute conversation. Later that day, as I was riding my bike, I got another page. "Call Sally." I was somewhere on a country road in Concord, Massachusetts, and far from a phone. Ten minutes later: "Call Sally. Urgent." Over the next hour, I received six pages, each sounding more urgent as the alarmed hospital operator added more and more punctuation. The last page read, "Call Sally!!! Emergency!!!!!!" When I finally found a pay phone, my heart pounding, Sally said, "Doctor! I just had another panic attack."

I felt the first hint of what I later learned was "countertransference." At the time, I called it "being pissed off." I tried to keep the irritation out of my voice as I told her she didn't have to call me every time she had a panic attack. At our next appointment, after some good supervision, I laid out some ground rules. Sally could page me only during the week between 8 AM and 5 PM. Otherwise, she was instructed to go to the crisis clinic. This in itself helped decrease the frequency of her panic attacks, since it took away the reinforcement of a phone conversation with her therapist every time she panicked.

Suggestions

- Never give your home or cell phone number to patients, and consider keeping an unlisted phone number. Having made that pronouncement, I acknowledge that some of my colleagues disagree, and give patients their cell phone numbers. They do so with the understanding that they are to use that phone only under extraordinary, life-threatening circumstances. They tell me that this privilege is rarely abused and that sharing their cell phone number tells patients that you care enough about them to make sure that they can always reach you.
- You may give out your paging number, but specify the times when you're available to be paged. Don't let your life revolve around your pager. Tell your patient what to do if there is an emergency at a time when you are not available for paging. For example, he can call the crisis clinic, and you can give the clinic instructions to page you after hours if the on-call clinician judges that the situation warrants your immediate involvement.
- If you have a voice-mail system, have patients reach you there. Your voice mail is accessible 24 hours a day, and you can check it whenever you want and decide who to call back and when. Some patients will call your voice mail just to be soothed by your recorded voice.
- When you're on vacation, I suggest you sign your patients out to a clinician you know and trust, rather than have them call the crisis clinic during regular hours. That way, you can ensure that someone is prepared to deal with any impending crises. For example, you may have patients who are chronically suicidal but rarely require hospitalization and can be managed through crises with frequent outpatient support. Letting your colleague know about these patients may prevent inappropriate hospitalization. Before you go on vacation, don't forget to change your outgoing

voice-mail message to tell patients how to reach your coverage. I make things easy by writing out two scripts: one for regular outgoing messages and one for vacations.

Many clinicians use e-mail as a way of contacting patients. This can be a time-saver, because you can answer quick questions without being at the mercy of the availability of your patient's cell phone or voice mail. But again, without certain ground rules, this can (and will) get out of hand. Make sure your patients know that e-mail communication is not a form of treatment. Specify what you are willing to use e-mail for. Typically, this will be limited to scheduling changes and requests for prescription refills. If you start answering more involved clinical questions over e-mail, be aware that this is part of the medical record, and you should print out a copy of any correspondence and put it in the chart. In addition, many authorities believe that HIPAA regulations require that you use an encrypted e-mail system for any electronic communication. Such systems are expensive and somewhat inconvenient, so I personally do not follow this guidance. Instead, I append a message at the end of my e-mails to patients saying: "Please be aware that e-mail communication can be intercepted in transmission or misdirected. Your use of e-mail to communicate protected health information to us indicates that you acknowledge and accept the possible risks associated with such communication. Please consider communicating any sensitive information by telephone, fax, or mail. If you do not wish to have your information sent by e-mail, please contact the sender immediately."

Contacting the Patient

Be sure to get your patient's various phone numbers (eg, home, work, day treatment program) and e-mail (if applicable to your practice). Ask whether it's okay for you to identify yourself when you call, because some patients don't want employers or family members to know that they're in treatment. Obtain numbers of family members or close friends so that you can contact them either to gather clinical information or in emergency situations. You'll need to obtain your patient's consent for this ahead of time.

Missed Appointments

The usual practice is to tell patients that they must inform you at least 24 hours in advance of any missed appointments or they will be charged, except in emergency situations. As a salaried trainee, the financial aspects of this policy aren't relevant, but there are important clinical benefits. Patients who make the effort to show up for sessions show a level of commitment that bodes well for therapeutic success. This policy encourages that commitment.

What if a patient repeatedly cancels sessions (albeit in time to avoid paying)? First, figure out why she is canceling. Is it for a legitimate reason, or is she acting out some feelings of anxiety or hostility? Did you just return from vacation? If so, this is a common time for patients to act out a sense of having been abandoned by you.

One way to approach this issue is head-on:

> *I notice that since I returned from vacation, you've cancelled three sessions in a row. What's going on? Sometimes, people get angry at their therapists.*
> *I've noticed that since we started talking about the causes of your bulimia, you've missed a lot of sessions. Should we be going a bit more slowly with these*

issues?

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[1] Adapted from the questionnaire of the late Edward Messner, M.D.

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The Therapeutic Alliance: What It Is, Why It's Important, and How to Establish It

Essential Concepts

- Be warm, courteous, and emotionally sensitive.
- Actively defuse the strangeness of the clinical situation.
- Give your patient the opening word.
- Gain your patient's trust by projecting competence.

The therapeutic alliance is a feeling that you should create over the course of the diagnostic interview, a sense of rapport, trust, and warmth. Most research on the therapeutic alliance has been done in the context of psychotherapy, rather than the diagnostic interview. Jerome Frank, author of *Persuasion and Healing* (Frank and Frank, 1991) and the father of the comparative study of psychotherapy, found that a therapeutic alliance is the most important ingredient in all effective psychotherapies. Creating rapport is truly an art and therefore difficult to teach, but here are some tips that should increase your success.

BE YOURSELF

While there is much to be learned from books and research about how to be a good interviewer, you'll never enjoy psychiatry very much unless you can find some way to inject your own personality and style into your work. If you can't do this, you'll always be working at odds with who you are, and this work will exhaust you.

CLINICAL VIGNETTE

My friend and colleague, Leo Shapiro, does both inpatient and outpatient work. He's a character, no question about it. As a patient, you either love him or hate him, but either way, what you see is what you get.

Two examples of Dr. Shapiro's unorthodox style:

1. Walking down the hallway of the inpatient unit, Dr. Shapiro spotted the patient he needed to interview next.

   "Hey, what's wrong, does your face hurt?"

Patient: "No, my face doesn't hurt."

Dr. Shapiro: "Well, it's killing me!"

The patient chuckled, and the rapport was solidified.

2. The Shapiro thumb wrestling ploy

An angry, depressed man was demanding to be discharged, prematurely according to staff reports. Dr. Shapiro agreed that discharge would be risky, partly because the patient had developed little in the way of rapport with anyone.

Dr. Shapiro: "I understand you want to be discharged?"

Patient: "Of course, this place is stupid, no one's helping me."

Dr. Shapiro: "If you can beat me at thumb wrestling, I'll let you leave."

Patient: "What?!!!"

Dr. Shapiro (putting out his hand): "Seriously. Or are you afraid of the challenge?"

Patient (reluctantly joining hands with Shapiro): "This is crazy."

Dr. Shapiro: "One, two, three, go"

Dr. Shapiro quickly wins, as he always does. "Well, I guess you have to stay another day. See you tomorrow."

Patient (smiling, despite himself): "That's it?"

Dr. Shapiro: "What? You wanna talk, OK, let's talk."

A significant exchange ensued, and the patient was in fact discharged that afternoon with appropriate follow-up.

No, I'm not endorsing the Shapiro technique. It works great for him, because that's his personality, but it would be a disaster for me, a mellow Californian at heart. The key is to be able to adapt your own personality to the task at hand—helping patients feel better.

BE WARM, COURTEOUS, AND EMOTIONALLY SENSITIVE

Are there any specific interviewing techniques that lead to good rapport? Surprisingly, the answer appears to be "no," and that is good news. A group of researchers from London studied this question in depth and published their results in seven papers in the *British Journal of Psychiatry* (Cox et al., 1981a,b, 1988). Their bottom line was that several interviewing styles were equally effective in eliciting emotions. As long as the trainees whom they observed behaved with a basic sense of warmth, courtesy, and sensitivity, it didn't particularly matter which techniques they used; all techniques worked well.

No book can teach you warmth, courtesy, or sensitivity. These are attributes that you probably already have if you are in one of the helping professions. Just be sure to consciously activate these qualities during your initial interview.

There are, however, some specific rapport-building techniques that you should be aware of:

- **Empathic or sympathetic statements**, such as "you must have felt terrible when she left you," communicate your acceptance and understanding of painful emotions. Be careful not to overuse empathic statements, because they can sound wooden and insincere if forced.