CLINICAL COMMUNICATION SKILLS THEME

STAGE/LEVEL 2: 2011-2012

INTERVIEWING THE PSYCHIATRIC PATIENT

George Cruikshank, 1792-1878 Woman committing suicide by jumping off of a bridge

FACILITATORS' PACK V.15 (03/05/2011)

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INTERVIEWING THE PSYCHIATRIC PATIENT

Introduction

The 'interviewing the psychiatric patient' session of the Clinical Communication Skills Theme occurs within the Stage Two Psychiatry module and has been jointly planned by the Psychiatry department and the CCS team.

Format of the 'interviewing the psychiatric patient' session:

Each three hour session will be co-facilitated by a communication facilitator and a facilitator from the psychiatry department (consultants and specialist registrars). The session will normally occur in Week Two of the students' eight week attachment.

There are two one and a quarter hour sections with a coffee break between. The group will be divided into sub-groups of between six and eight students. Actors will be present and will move between groups at the end of the first section, so that each group will see two actors during the half day, spending one section on each role.

Please note that student packs now contain the following information:
Facilitators have been asked to adhere to strict timekeeping for all CCS sessions. Therefore, you can expect this session to start and finish on time. Please ensure that you arrive at least 5 minutes before the start of the session as students arriving after the initial group introductions may not be allowed to join the group.

Verbal feedback is provided to individual students throughout the session. Students wanting to discuss/request further feedback may wish to speak to the facilitator privately. Similarly, if the facilitator has additional feedback for individuals they may request a meeting at the end of the session. Facilitators will aim to finish by 16.50 to allow time for this and student evaluation/feedback.

Students' written feedback on the sessions will be made using the CCS system

Recording equipment will be used in all sessions but, please note that there probably won't be time to watch the recordings back during the sessions.

Patient roles

1. A depressed patient sitting in the accident and emergency department following a planned overdose of 40 paracetamol 12 hours ago. A psychiatrist is coming to see the patient who is sure that this will not help.

2. A patient in their 20s or 30s in their own home. Their partner has asked the GP to visit. The patient has delusions and auditory hallucinations and is behaving unusually.

Please see end of this document for roles in full

Aims of the 'interviewing the psychiatric patient' session:

Specific aims of the Psychiatry attachment:

1. to provide an opportunity for students to have safe, observed practice in taking the psychiatric history
2. to enable students to explore the specific areas of:
   i) assessing suicidal risk and depression following an overdose
   ii) interviewing and assessing the patient with delusions and hallucinations
3. to enable students to learn interviewing strategies to cope with potentially disturbing and emotionally challenging situations for both doctor and patient
4. raising awareness that effective communication is essential in diagnosing, managing and helping patients with psychiatric problems wherever they may present

The students will already have received a lecture-based introduction to psychiatric history taking and to the nature and symptoms of depression and psychosis. They will have had limited opportunities to observe psychiatric interviews in out-patients clinics and on the wards. This session aims to provide safe protected learning for coping with difficult situations in practice.

Specific aims of the CCS curriculum:

1. reiteration of the students' communication skills learning in the introductory course: initiating the session, gathering information, structuring the interview and building the relationship
2. exploration of the specific communication issue of interviewing the psychiatric patient:
   i) how the core skills of gathering information and of building the relationship need to be applied with greater depth and intensity in the psychiatric interview
   ii) how some of the key communication skills of the Calgary-Cambridge guide can be inappropriate when dealing with disturbed patients

At this stage in students' development, we are concentrating on information gathering rather than information giving skills. The two scenarios chosen will allow us to highlight some of the specific communication challenges of taking the psychiatric history while emphasising the importance of the core skills of gathering information and building the relationship.

One of the scenarios enables us to explore depression: in particular the need for building the relationship, using sensitivity, empathy and appropriate non-verbal communication and the need for both open and very specific closed questions to enter the arena of assessment of suicide risk successfully. The second scenario involves interviewing a psychotic patient – here we will look specifically at how such an interview differs from the routine medical interview and what basic skills can be employed to help in such an encounter – we will not be expecting students to learn the high level skills that we might expect a specialist registrar to master

<u>Assessing suicidal risk and depression following an overdose</u>

In the first half of this session, we will be looking specifically at the assessment of a patient following an overdose

<u>Key objectives for students are to consider and practise how:</u>

- to engage with a patient who has taken an overdose
- to assess suicidal risk

<u>Key core skills include:</u>

Initiating the session

- introduction of yourself and role, consent
- demonstrating interest, concern and respect
- opening question: re feelings

Gathering information

- listening, use of silence
- proceeding at the patient's pace
- gauging the patient's emotional state
- discovering and responding to patient's feelings
- picking up, reflecting and checking out non-verbal and verbal cues
- eliciting the patient's ideas and concerns and the effects of the illness on their life
- facilitation through repetition, interpretation and paraphrase and use of silence
- using open questions
- clarifying
- asking directive questions re suicidal risk and depression
- signposting

Building the relationship

- non verbal communication
- empathy
- acceptance
- lack of premature reassurance
- support

Key information required to assess suicidal risk:

- how does the patient feel now
- why did the patient take the overdose, what was going through their head
- does the patient regret the suicide attempt - is the patient glad to be alive
- how does the patient view the future

- what method did the patient use to harm themselves
- did the patient plan the suicide attempt or was it an impulsive action (note this is key to the assessment of a depressed patient prior to a suicide attempt – have you thought how you would kill or hurt yourself – have you made any plans or preparations – what is the closest you have come to actually doing it)
- how did the patient plan it (i.e. final acts, avoid being found, what methods used to avoid detection by other people? violent method? alcohol?)
- did the patient leave a suicide note

- does the patient think they might harm themselves in the future
- is there anything that would stop them doing it
- social and personal circumstances of the patient particularly with regard to social isolation and unemployment
- has the patient tried to harm themselves before - details of methods and seriousness of attempts.
- were drugs or alcohol involved at the time of the attempt

- symptoms of clinical depression:
    - disturbance of mood
    - hopelessness/helplessness
    - feelings of worthlessness, low self-esteem
    - poor concentration
    - loss of interest or pleasure
    - guilt/self-blame
    - alterations in appetite
    - alterations in weight
    - difficulty in sleeping - sleep pattern
    - agitation or retardation

- does the patient think he could be helped with the right treatment
- would they consider that?

Commentary

Depression is a very frequently occurring psychiatric disorder which is all too easily missed in medical practice. Accurate recognition and diagnosis depends very much on the skill of the doctor. There are distinct skills needed both to uncover covert depression and also to assess the severity and in particular the risk of suicide once depression has been recognised.

In this session, we are concentrating on someone who has taken an overdose, who may or may not be depressed. We are not looking at the patient who you think is depressed in other circumstances and has not attempted self-harm.

Yet all possibly depressed patients are at risk of suicide and must be asked specifically about thoughts of hopelessness, self harm, death or suicide. Do not fall into the trap of avoiding these questions – be reassured that you will not plant suicidal ideas into someone's thoughts who has not already thought of them.

It is often possible to ask a direct question, or it may be appropriate to ask in a more oblique fashion, "testing the water" first. For example:

"I'm wondering how low you really are....can you bear to tell me?"

"You look depressed today.........would you like to tell me about how you are feeling?"

"You are wondering if you are depressed. I'd like to ask you some specific questions about your mood, concentration, appetite and sleeping patterns which will help us..."

"Do you ever feel that there's a light at the end of the tunnel?"

"You've told me how difficult it is to sleep...what is going through your mind when you are lying tossing and turning........?"

"Have you ever felt that you might want to harm yourself?"

"Some people feel that they can't go on when they are depressed....have you had thoughts like that?.....that you'd like to end it all?"

Interviewing and assessing the patient with delusions and hallucinations

In the second half of this session, we will be looking specifically at the interview and assessment of a patient with delusions and hallucinations

Patients with delusions and hallucinations present considerable communication challenges. The patient is in some way out of touch with reality; this may be quite a subtle state or the patient may be acutely ill and out of control. Not only may the patient be unable to function normally but their communication skills are often impaired and they may be frightened, bewildered and untrusting. In fact, it may be impossible to make a relationship with the patient; attempts to get close to the patient may be misinterpreted and feel threatening. On the other hand patients with mental illness greatly value being understood.

The challenge for the doctor is to overcome the barriers to communication while simultaneously gathering information, often from diverse cues, of the presence and extent of a psychotic disorder. Gathering information in a sensitive and empathic manner when the doctor himself is ill at ease requires communication skills of a high order. Do not underestimate the effect of anxiety, fear and discomfort on both doctor and patient.

Key objectives for students

The main purpose of this exercise is to give you the opportunity to work through a potentially difficult situation before it happens to you in real life. Please remember that psychosis is as difficult, important, and devastating a diagnosis as AIDS.

We hope that you develop some key skills that enable you to feel more prepared to face similar situations in the future.

Our key objectives are therefore for you to practise:

- engaging a disturbed patient in interview, teasing out information
- attempting to make an assessment of psychotic symptoms
- feeling comfortable discussing psychotic symptoms and identifying some appropriate responses
- assessing what you see and picking up on aspects of appearance and behaviour to cue questions, e.g. "You seem to be bothered at times while we talk by something else, you look away. Is there something you are hearing or think you hear?"
- empathising (without colluding) with a patient (and their family) struggling to make sense of events around them and of strange internal and external stimuli
- dealing with the emotional impact on the patient, making contact with the patient's experiences

Key issues to be assessed by the end of an interview include:

- abnormal behaviour, dress or manner of the patient
- the emotional state of the patient
- the predominant mood of the patient during the interview

- speech and thought flow, content and form
- whether the patient has delusional beliefs

- whether the patient has a systematized delusional system or many different types of delusions
- whether the patient feels that their thoughts or actions are being controlled by an outside agency

- whether the patient is hallucinating in any modality
- nature of hallucinations: whether persecutory in nature, whether as commands, whether thought broadcasting

- whether the patient has insight into their illness
- apathy and loss of interest in family, occupational or social life
- whether alcohol or illicit drugs were involved in presentation

- risk to patient of self harm/neglect/inattention to normal daily risks
- risk to others from patient, e.g. threat to individuals that the patient has delusional beliefs about specifically, or to the public at large if delusions incorporate many people/everyone

Commentary

There are a number of presentations of psychosis that we see which influence the communication skills that we need to employ. In this scenario, we are looking at the second of the three presentations below although elements of the first situation still apply:

1. **The florid psychotic patient with obvious thought disorder, pressure of speech, agitation, paranoia and hallucinations and delusions.**

Here the key core skills from the Calgary Cambridge guide which may be helpful are:

- preparation
- introducing yourself and explaining why you are there (but see below)
- checking that the patient is not in any physical discomfort
- sitting still, keeping calm, confident, relaxed pose, keeping neutral
- open posture, facing the patient, non threatening body language
- eye contact, but not staring
- starting with very directed simple non-threatening questions – name, where they live, age etc
- building rapport by exploring patient's 'external' rather than 'internal' problems first
- attentive, quiet listening, slowing the pace down
- accurate observation of the patients nonverbal behaviour
- picking up verbal and non-verbal cues and deciding when to pursue
- use of patient's own language
- lack of surprise, non-judgemental acceptance
- gauging the patient's emotional state
- flexibility
- appreciating and making allowances for the possible effect of poor concentration and pre-occupation with internal thoughts on ordered communication
- respect
- support – offer to help with their problems as best as you can

Skills which may be unhelpful, which may make the patient more agitated and liable to misinterpret you include:

- introducing yourself if you are a psychiatrist and explaining why you are there: the patient has not sought this interview - on one hand there is a need for a clear explanation of who the doctor is and why they have been asked to see the patient – on the other, if the patient is thought disordered, full explanation of your psychiatric role can immediately increase suspicion and impair rapport.
- either too early open-ended questioning or very directed questions about psychosis can increase anxiety
- reflecting back verbal and non-verbal cues immediately: may increase suspicion
- eye contact for too long
- sharing your thinking
- silence
- touch

Attempts to assess the extent of the patient's thoughts, beliefs and thinking processes can be difficult and need judicial use of open and closed questions. "Following" with closed questions rather than open ones will clarify how thought disordered the patient is without confrontation:

Patient: "I can see people at the window"
Doctor: "what are they wearing?" (Rather than, "tell me all about them?" This may upset and agitate the patient)

The patient may then follow on your line of questioning clarifying that he has a major thought disorder. Some psychiatrists describe this technique as analogous to fishing.

Alternatively, open questions can be used:

"I'm wondering what you were thinking when you said......."
"You said that people were controlling you through the television...can you tell me a bit more about that?"

Or the more direct

"Do you have thoughts that you hear out loud in your head?"
Or
"Do you feel you have special powers?"

It is important not to confront delusions as false beliefs – empathise with the patient's situation and legitimise their experience without necessarily agreeing or colluding with their interpretation of reality. Do not rebuff but remain interested in their view and offer empathy and help with their problems:

I can certainly understand that you would feel so upset because you think you are being poisoned

In response to "Don't you believe me?"

"You ask if I believe you about whether you are being poisoned. I can tell you for sure that I am not poisoning you. I can't tell for sure right now whether anyone else my be poisoning you, but I'd like to listen to you and help in any way that I can"

Later in the interview, being the advocate of the patient at the same time as challenging and confronting the patient with his illness is a real skill. Offering explanations that accept the patient's experiences as valid and shows empathy but providing an alternative view is a difficult balancing act with a psychotic patient. It is helpful for the doctor to find phrases that work well in different circumstances and to practice them.

"I know that you feel that you are not ill at the moment, but I am concerned about you today.....I think that you need some treatment and would like to help."

It is often very important to get accurate information from others who know the patient well. This can be perceived as threatening and unsupportive to a paranoid person with disordered thinking and it is important to have the patient's permission if the doctor is aiming to achieve a collaborative relationship. Of course, their relatives and friends are often anxious and sometimes angry and this may also complicate the interviewing process.

2. The less florid psychotic patient

Many of the above issues still apply but helpful core skills in this less dramatic situation include:

- Initial open questions about the patient's situation
- Attentive listening
- Eliciting the patient's concerns - staying initially with the patient's world view and problems rather than attempting too fast to explore thought disorders will help build rapport; use of patient's own language

- The effects of the patient's problems on their life: the patient may not think they are "ill" and the doctor needs to reflect back the patient's experiences and develop a shared understanding of how these experiences are affecting the patient's life
- Structuring the interview with signposting and sequencing to help a patient with thought disorder: signposting is vital as the patient may not be concentrating and misunderstand reasons for focussed questions
- Being non judgemental and being able to accept the patient's beliefs and the fact they are valid for them while not necessarily agreeing
- Empathy without collusion
- Support – offers to help sort out their problems as best as you can
- Assessing the patient's <u>insight</u> into his illness with signposting and sensitive phrasing of specific questions, for example

> "You've told me that you are hearing voices again.....I remember last time you were ill, and the same thing was happening....what do you think?"

3. The suspicious patient who shows few overt signs of psychosis.

Here the key core skills for building the relationship with the patient are all important as long as you don't "invade" the patient's space too much. Empathy and support are vital (e.g. attempting to understand why psychotic patients dislike taking medication as they perceive that it alters their persona etc.)

In this situation you may need to ask directive questions re disordered thinking, paranoid ideas and the presence of auditory and visual hallucinations, ideas of reference etc. How to do this without making the patient increasingly suspicious and paranoid can be difficult. If you know the patient you can signpost quite nicely:

> "I remember when you were last ill, you were concerned that the neighbours were thinking ill of you/you thought you had special powers…..is that how you are thinking now?

If you don't know the patient and listening initially doesn't elicit any psychotic thinking then asking a general question sensitively about paranoia

> "Do you feel people are a bit against you at the moment?" may open the patient up a bit.
> Once you gain their confidence it's easier to follow with more direct questions about psychosis. Asking right out "are you hearing people talking to you in your head?" can provoke anger and threatening behaviour.

Plan
Three hour session 14:00-17:00

14.00 Introduction:	10 mins

The general introductions are really important. We also need to move at quite a pace: this is quite a fast session – don't labour safety – create safety through structure.

- Welcome, introduce your self, explain how this session fits in with their overall learning
- Round of names
- Outline a temporal plan for the session; explain the joint Psychiatry and CCS aims and signpost methods of the session.
  Really helpful to have the plan of the session on a flipchart so that they can keep a structure in their heads and what happens when

14.10 Difficulties in taking the psychiatric history	15 mins

1. Have you all watched psychiatric interviews? What have you seen so far? What have you done yourself?
2. Brainstorm problems that you have had or might have in interviewing psychiatric patients – difficulties you have already had or could anticipate experiencing. Do as a round.
3. Explain the scenario of the first case. You are a specialist registrar who has been asked to assess a patient in the Accident and Emergency Department. The patient was admitted last night having taken an overdose of 40 paracetamol 12 hours ago and is now on a drip.
4. Look at handout of objectives, skills and key information relevant to assessment of suicide risk. Tick the objectives and skills which you would personally find difficult and would like to practise. What information might be challenging to obtain?

Explain that this is a chance to practise something difficult before they have to in real life. It is not a judgmental exercise in any way but a golden opportunity – we will provide them with guidance and help.

Facilitator to summarise the following areas

1. Where the psychiatry questions fit into the stages of the interview on the CC guide - particular need to start open here
   iii) The communication areas in the psychiatric history that you need to consider even more than usual: **how the core skills of gathering information and of building the relationship need to be applied with greater depth and intensity in the psychiatric interview**
2. The skills you can use to help in these situations: please provide upfront some selected key skills: e.g. start with empathic introductions and feelings questions

14.25 First simulated patient	60 mins

Facilitator to set up communication session:

- ensure they understand the specific scenario in enough detail to orientate the group (setting, information already known, notes etc.)
- specifically explain who the learners are and what their role is in the scenario (i.e. specialist registrar in psychiatry)
- **it is a good idea in this session to guide the students about the difficulty of each role.**
- the actor will start the role quite retarded and will gradually come out if the students are empathetic and gentle
- to help the actors, please give them plenty of time to get back into the role at the right part

Then get started as soon as possible to maximally use the actor. First person to go will give us raw material to work on

Encourage one of the students to start the process:

- What would be the particular issues for you here (try to get the participant to hone them down)
- What are your personal aims and objectives for the role-play
- What would you like to practise and refine and get feedback on
- How can the group help you best
- How and what would you like feedback on

Emphasise to the “doctor” that OK to stop and start whenever. Take time out or start again, as required. Re-play a section or re-play the whole lot, or just stop when help needed.

Chunk this into small aliquots. Although the flow of the interview is truncated this way, you can get many more participants involved and the feedback on communication skills works much better. You can remember what happened in each small bit, give more focused feedback, use the actor's feedback better and do re-rehearsal of different approaches much more. This latter makes the students see the importance of working with the actor - instead of being on trial, they really discover how to do the stages of the interview and find different ways to do so.

Stop each person at a pre-determined point e.g. at the end of the introductions and establishing rapport. Again after taking an open history and before asking detailed questions. At each stage do good well paced communication skills teaching. It will be much easier to do revisiting the intro course stuff if we break it down into sections and get everyone involved - five minutes or so each rather than 40 minutes for one!

It will be essential to balance their exploration of the disease aspects within the interview with their exploration of the patient’s perspective. Overall, we need to work with effective ways of gathering information about both disease and illness.

When the learner rejoins the group, provide communication skills feedback on the interview so far

Feedback

- Start with the learner –
  how do you feel?
  can we go back to the objectives? Have they changed?
  how do you feel in general about the role-play in relation to your objectives?
  tell us what went well, specifically in relation to the objectives that you defined?
  what went less well in relation to your specific objectives?
  or "you obviously have a clear idea of what you would like to try."
  would you like to have another go?
  what do you want feedback on?
- Then get descriptive feedback from the group
- If participants make suggestions, ask prime learner if they would like to try this out or if they would like the other group member to have a go. Try to get someone else to role-play a section if they make a suggestion for doing it differently. "Would anyone else like to practise?"
- possibly bring in the actor for insights and further rehearsal: ask actor in role questions that the group has honed down
- note feedback is difficult in both roles, especially the second – if the actor can do it, they need plenty of time to recover and think back

Remember to:

- look at the micro-skills of communication and the exact words used
- practise and rehearse new techniques after suggestions from the group
- make sure to balance positive and negative feedback
- bring out patient centred skills (both direct questions and picking up cues) as well as discovering facts
- utilise actor feedback

Please note that we should be prepared to teach here - it is not all self-revelation – facilitator and psychiatrist to input positive feedback, then one or two suggestions for change – do not overload. Give the students a good chance to work it out for themselves, but if they can't, be prepared to do limited demonstration, not as a definitive approach but as a suggestion that can also be discussed.

15.25 – 10.40 Coffee	**15 mins**

15.40 Second simulated patient	**60 mins**

- Very specifically run through our objectives for interviewing and assessing the patient with delusions and hallucinations
- Explain carefully what we hope to achieve for them here
- Explain the setting: you are a GP who has been asked to visit a patient at home by their partner because he/she is worried about them. He/she has noticed that the patient is not getting on with their daily routine and does not go out of the house any more and has been keeping the children inside. He/she has told the GP that the patient has had some odd ideas about the neighbours talking to them which the partner didn't really understand
- Look at handout of objectives and key issues to be assessed in the interview relevant to this case. What might be difficult?
- What would they like to practise?
- Facilitators to summarise some of the skills you can use to help in these situations: please provide a few key skills and explore the differences between this situation and the standard medical interview
- Start by ushering the doctor into the room as if you are the spouse: "Oh thanks so much for coming doctor, John/Jane is in the living room – I'll be upstairs looking after the children – just call me if you need me"
- At some point, throw in patient-centred round – what must it be like to be a patient with this, what do you think they are feeling; and the family; what would the impact be? This is probably best done half way through or near the end to help build up empathy – you cannot empathise easily with disordered thoughts but you can with how they make the patient feel

Some of the key skills to bring out as the role play progresses are:

- Introductions: *'hello, I'm Dr Silverman, I don't think we've met before. Your husband mentioned that he was worried about you and asked me to visit – would that be OK?'*
- Initial open questions about the patient's situation: *'how are you at the moment, how can I help'*
- Attentive listening
- Eliciting the patient's concerns - staying initially with the <u>patient's world view and problems</u> rather than attempting too fast to explore thought disorders will help build rapport; use of patient's own language
- The <u>effects of the patient's problems on their life</u>**:** the patient may not think they are "ill" and the doctor needs to reflect back the patient's experiences and develop a shared understanding of how these experiences are affecting the patients life
- **it is helpful here to explain to the students how disease and illness works in this psychiatric situation: the way to help and support the patient here is to understand and offer help for the problems that the patient feels they are experiencing (tiredness, stress, coping, keeping it going for the children) – this is the <u>patient's perspective or illness</u> in this instance – as usual this is vital to discover and empathise with. The delusions and hallucinations here are the symptoms of the <u>disease or biomedical perspective</u>.**

- Structuring the interview with signposting and sequencing to help a patient with thought disorder: signposting is vital as the patient may not be concentrating and misunderstand reasons for focussed questions.
- Being non judgemental and being able to accept the patient's beliefs and the fact they are valid for them while not necessarily agreeing.
- Empathy without collusion
- Support – offers to help sort out their problems as best as you can
- **Following an open early period where following the patient's cues sensitively and non-judgementally pays dividends, the next stage is a definite shift to exploring the psychotic symptoms in much the same way as you would start to analyse a pain. Here you need to gently and sensitively ask directive questions about whether the patient has a systematized delusional system or many different types of delusions, whether the patient feels that their thoughts or actions are being controlled by an outside agency, whether the patient is hallucinating in any modality, whether thought broadcasting, whether the patient has insight into their illness etc**

16.40 Closure	**10 mins**

Rounds of what learnt

Summary from facilitator

Handouts

16.50 Evaluation and feedback	**10 mins**

Your evaluation of the session

There is a feedback form provided for your comments on the session as a whole and to feedback on any student who is struggling and requires extra help in any way. If a student has been referred for help on more than 2 occasions in any one stage/level of their clinical studies, they will be contacted by the Senior Tutor in Clinical Communication and offered an appropriate programme of remedial support.

Please inform the student that you are being referred for support but that they will only be contacted on receiving the third referral. If they have any concerns about this they should be advised to contact Mandy Williams (mw480@medschl.cam.ac.uk), Senior Tutor in Clinical Communication.

It is important that you state why you are highlighting a student for help and what you have observed. This will assist the team in ensuring appropriate and timely support is provided.

We would also like you to identify any student who is clearly performing at a high level and you would like to nominate for the CCS prize

Assessment of suicide risk

Name: Susan/James Gilbert ***Age:*** Actors own age

Setting

You are sitting in the accident and emergency department of Addenbrooke's hospital feeling depressed. You took an overdose of forty paracetamol tablets washed down with half a bottle of vodka twelve hours previously. On the previous night you waited until your partner had gone to sleep and went unobserved to the kitchen to take the tablets. After taking the tablets and the alcohol, you were found by your partner some hours later, semi-conscious. You were treated with something they made you swallow and were put on a drip. You remember being examined by a taciturn doctor in the middle of the night who said that you were lucky to be alive. This made you feel more guilty and ashamed than you already were. You regret being found before the tablets had a chance to work.

Clinical details

Life had been tolerably good till twelve months ago. You were enjoying working as a computer technician in a small software company. You were getting on reasonably well with your partner but didn't communicate all that well with each other. Your Mother then died unexpectedly after a routine operation and your world gradually caved in. You had never got on well with her; in fact you had hardly spoken to her for ten years. She had always been bitter, cold and unloving after your father left and you had eventually left home at an early age. You felt guilty about the relationship and especially the fact that you didn't patch things up before she died.

Since her death you gradually became more unsociable and withdrew into yourself. You no longer enjoyed going out for meals with your partner and stopped enjoying television or reading. You felt down and irritable most of the time and people at work started commenting that you had become very serious. Work has always been enjoyable, but over the last six months you noticed that your concentration has been poor and you had been making more mistakes than usual. Things took much longer to do and you lost confidence in your abilities.

You started to ruminate incessantly about your relationship with your partner and your mother and became convinced that these problems have been your fault. You have had numerous arguments with your partner, as he/she does not understand that you are too tired to socialize and consequently you have no interest in sex. Recently he/she has talked about counselling or separating and you feel like a millstone around his/her neck. You have never talked a lot, but things have been really distant lately. You have lost interest in food and have lost ½ a stone in weight since becoming depressed. Over the past month you have lain awake at night trying to solve your problems and wake exhausted at 5 am every morning but can't get back to sleep. Over the past month you have started to think about death as a way out of this mess. Initially this came on only fleetingly but over the past week you have been thinking about ending it all and made active plans to overdose.

Past medical history

None

Medication

None

Family history
Mother was always down, bad tempered and irritable. You think she was probably depressed especially when your parents separated when you were eleven. Parents were always rowing when you were a child. No contact with father since he emigrated to the United States when you were thirteen. Only child

Personal/Social history
You had an unhappy childhood with family rows and friction at home. Your father was unemployed with consequent financial problems. You found it difficult to settle at school. Always shy a loner and school refusal intermittently during childhood. Academically bright but didn't do well in exams, always froze. You met your partner at work; first major relationship. Very different people – your partner is outgoing.
Personality: serious, dedicated, tend to internalize your problems
Cigarettes – none, alcohol - 3-4 glasses of wine per week. Recently drinking more ½ bottle of wine a night to cheer you up but with no improvement.

Patients ideas and thoughts
Guilty about difficult relationships you have with other people and tearful when talking about significant relationships. You blame yourself for what has happened in recent times. You see no way things will ever improve and have thought about other means of killing yourself. You feel you will take a bigger overdose next time. You feel a total failure and that you have never achieved anything in your life. You are apathetic and reluctant to talk at first. Apologize for wasting their time as there is nothing they can do for you. It's all your fault for messing up your life. Become more expansive if empathy shown and open-ended questions asked. Respond by elaborating more on your history if reassurance given. Causes of depression only revealed if asked for.

Patients feelings
You feel very depressed. You see no hope for the future and would prefer to be dead. You feel initially apprehensive towards the interviewer. You feel that nothing can help you now.

Effect on life
Everything around you is falling asunder. You can't enjoy yourself or work and the relationship is almost over. Death is the easiest possible solution.

Behaviour
It is important that this role starts in misery and withdrawn but reasonably quickly picks up speed if sensitively handled by the student. Too slow and we get nowhere in the hour and the student is not rewarded – too fast and there is no challenge.

You are feeling hopeless - you are a waste of time to everyone – it is you who is guilty not your family or the doctors or nurses. You look distressed and haunted but cannot engage with the person who is approaching you – it is all too much effort – everything is internal for you. You sit huddled in a chair with your legs crossed away from the interviewer. Avoid eye contact and look away at first.

You don't see the point of talking to a psychiatrist but are not angry or difficult. You respond at first with

'Sorry……' and look away
Then after a silence:

‘I feel…….’: leave the sentence uncompleted but shoot a glance of eye contact with desperation in it.

Then gradually come out with:

‘I shouldn’t be here’
or
‘I feel so guilty’
or
‘I feel awful’

Become more animated if the interviewer is empathic and reassurance given or gives you time – start to respond to their questions about what happened or why you feel like you do. You begin to feel that at last someone is listening – it is a relief; you start to give some eye contact

Outcome of interview
You see little point in coming into hospital and become fearful at the thought of admission to a psychiatric unit. Nevertheless you still think suicide is an option to consider. Ask what can they do for you there? You can’t see how talking or tablets will improve things. Agree to admission if a persuasive case is made for treatment. Maybe there is light at the end of the tunnel.

Assessing delusions and hallucinations (2)

***Name**:* John/Jane Reynolds ***Age**:* Actors own age

Setting

Patients own home. Partner has asked GP to come and visit because he/she is worried about you. He/she has noticed that you are not getting on with your daily routine, and don't go out of the house any more and have been keeping the children inside. He/she has told the GP that you have had some odd ideas about the neighbours talking to you which he/she didn't really understand. You don't know all of this: all you know is that your partner has told you that he has asked the GP to visit you because you are under stress
You don't know quite why the doctor has come to see you and you are a little wary of what he wants but because you are a polite person you invite the doctor in, and offer them a cup of tea, and make sure they are comfortable. You are quite chatty but 'off the subject'. When he/she asks what is wrong with you, you don't want to talk about what has happened in the last few weeks at first.

Clinical details

You do not feel that you are ill or need to see a doctor but you are feeling quite stressed and you haven't been sleeping well.

- For the last few weeks your neighbours have been causing you trouble by speaking to you through the walls. You can hear them - they often seem to be giving you messages in code or sort of railway timetables. They talk to each other about you, and also talk to you telling you state secrets. They are telling you that you are going to be made into a secret agent. They are menacing to you and upset you. You don't know why they are telling you these things and you don't want to know the information.
- You would assume that everyone can hear them because they speak quite loudly but on the other hand your partner says that unless they are very loud he/she can't hear them. They are particularly bad at night, and it stops you getting to sleep.
- You don't go out of the house because you are worried that they might be waiting for you and might try to take over your mind. You are aware that they can read your thoughts without you saying anything and they also put thoughts into your head. This might be through some special telepathy but you're not sure.
- Sometimes you feel compelled to walk around the room or open doors, without really knowing why, and this is the neighbour taking over your mind and body.
- You also see messages from them on the television, when the weather forecast comes on. It is speaking directly to you and telling you that they are coming for you.
- You don't feel there is anything you can do to help these problems, but it makes you worried for your safety, and the safety of your children. You keep them inside because you don't want to put them in danger.
- You are having difficulty looking after the house because it seems too much effort. You also have trouble getting up in the morning; you feel as though you have lost your get up and go.
- You feel scared and alone, because when you tried to talk to your husband he didn't believe you and told you to stop 'being mad'

- You have actually hidden knives or a baseball bat in each room – no-one knows this – it is to protect you in case the neighbours actually come round. You would only divulge this if asked directly when the doctor has your confidence.

Past psychiatric history
Any previous illnesses? No

Medication
Are you on any prescribed medication? No

Family history
Any family history of mental illness? Your mother was taken into hospital when you were a small child with 'stress'. She was away for several months but you weren't allowed to visit

Social history
Marital: You have been married for 10 years. Your husband/wife works away from home so you only really see each other at weekends. You have 2 children that you stay at home to look after – you are the house-wife/husband. They haven't been going to school recently because of the difficulty with getting out of the house.

Smoking: no
Alcohol: no

Patients framework

Ideas and thoughts
What do you think might have caused your problems? You have no idea why these people are giving you trouble. You do not feel it is an illness as the experiences are real and not in your mind.

Concerns
You are worried that your neighbour will take over your mind and that you won't get any rest from the trouble they are causing you. You are worried for your children's safety

Expectations
You don't really know what the doctor can do to help because you are not ill

Feelings
You feel very alone and afraid. You are being picked on but you don't really feel there is anything you can do about it. You feel very isolated, because no-one understands what you are going through, and you don't think there is anywhere to go for help

Effect on life
You are aware that it is interfering with your day to day life and that the children are suffering because you won't let them out of the house.

Behaviour

You are polite at first and friendly in a sort of guarded way. Internally you are bewildered and anxious and a little frightened but you are trying to give a good

impression so it comes our more that you are a little agitated and fidgety. You speak in a somewhat stuttery disjointed manner in half sentences sometimes and with a ‘knight’s move logic’.

You start with ‘everything’s fine really, it’s just you know the normal stress…’. When the doctor asks you to explain, you start with the stress and how you are coping and the fact that you are not sleeping rather than talk about the messages. Mention that you have not been to the shops and provisions are running low but don’t say why. Either spontaneously at some point early on mention that the stress is because you have such difficult neighbours or respond in this way if the doctor says that your partner had said that you were having problems with the neighbour. You can drop cues about the children early on too (‘I ought to check that they are OK’).

About three or four times in the role, you get up momentarily or look away for a few seconds and if distracted. If asked why, say you don’t know what made you do that.

When asked more about the neighbours, or people troubling you, you do tell the doctor, but cautiously at first. You start with safe information like the timetables and messages and at first don’t mention the state secrets or the threat to you and the children or that they are controlling you. If the doctor is empathetic and non-judgemental about your experiences, then you are reassured and you start to tell him more fully. You ask the doctor whether he can hear the voices. Then you mention more about what the messages actually say and about the secret agent and eventually that they are menacing. Mention the TV messages.

Only if asked directly do you let on that the voices control your actions and your mind or that others can hear your thoughts. Don’t hide this if asked – someone understands – but don’t mention unless asked. Again only mention the weapons if asked if you have taken any actions against your neighbours.

At some point ask whether he believes what you are telling him.

If the doctor talks about the voices as an illness, or is too abrupt, then you get upset and say how difficult it is for you to cope with all this by yourself, and how he isn’t going to help you at all. You do not understand if he asks any questions about illness or ‘imagining’ voices because to you they are real, not illness. If the doctor fires questions at you too rapidly, you get irritable and your answers are a little inappropriate.

If the doctor asks how you are coping with all this and how he can help, admit that you realise that there is a problem, particularly with looking after the children. You can show that you are troubled by your experiences and that it is difficult for you to keep it all together emotionally. Accept help if it is for helping with stress or childcare but do not accept that you need treatment for an illness or need to see a psychiatrist.

HANDOUT I

KEY OBJECTIVES IN INTERVIEWING AND ASSESSING THE PATIENT WITH DELUSIONS AND HALLUCINATIONS

Key objectives

The main purpose of this exercise is to give you the opportunity to work through a potentially difficult situation before it happens to you in real life. Please remember that psychosis is as difficult, important and devastating a diagnosis for patients and their families as AIDS

Our key objectives are therefore for you to practice:

- engaging a disturbed patient in interview and teasing out information
- attempting to make an assessment of psychotic symptoms
- feeling comfortable discussing psychotic symptoms and identifying some appropriate responses
- assessing what you see and picking up on aspects of appearance and behaviour to cue questions, e.g. "You seem to be bothered at times while we talk by something else, you look away. Is there something you are hearing or think you hear?"
- empathising (without colluding) with a patient (and their family) struggling to make sense of events around them and of strange internal and external stimuli
- dealing with the emotional impact on the patient, making contact with the patients' experiences

KEY ISSUES IN THE ASSESSMENT OF THE PATIENT WITH DELUSIONS AND HALLUCINATIONS

- abnormal behaviour, dress or manner of the patient
- the emotional state of the patient
- the predominant mood of the patient during the interview

- speech and thought flow, content and form.
- whether the patient has delusional beliefs.
- whether the patient has a systematized delusional system or many different types of delusions
- whether the patient feels that their thoughts or actions are being controlled by an outside agency

- whether the patient is hallucinating in any modality.
- nature of hallucinations: whether persecutory in nature, whether as commands, whether thought broadcasting

- whether the patient has insight into their illness
- apathy and loss of interest in family, occupational or social life
- whether alcohol or illicit drugs were involved in presentation.

- risk to patient of self harm/neglect/inattention to normal daily risks.
- risk to others from patient, e.g. threat to individuals that the patient has delusional beliefs about specifically, or to the public at large if delusions incorporate many people/everyone.

HANDOUT II

Phrases in the psychiatric interview

These interviews can be challenging and frightening. The key sections of the Calgary-Cambridge guide which you need to focus on are:

- Preparation
- Building the relationship
- Gathering information flexibly. (It is often counter-productive to keep to an order)

Particularly useful skills include:

- Wait time
- Matching the patient's mood
- Offering support
- Using the accepting response and not colluding
- Sensitively combining the empathic response with saying what you think and why, especially when the patient lacks insight

Remember that when you are taking a psychiatric history, eliciting the story and where the patient is coming from, you are also analysing the content of what the patient is saying, how they look and how they are behaving. You have to store in your head what data you are collecting, what you still need to know, and do some clinical reasoning about the patient's diagnosis and risk all at the same time! Not easy when you are inexperienced, but it does help to know some patterns of for instance life events; when a patient is depressed, they almost certainly have experienced some form of loss or many losses, for example a bereavement, loss of job, or a broken relationship.

Remember too that you will not be able to get the whole history in one interview – it may take many consultations before the patient trusts you, or is well enough to talk about very painful problems.

Your objective is not only to elicit an accurate history, you must show compassion, relieve distress and begin to form a therapeutic alliance too.

Interviewing the depressed patient and assessing suicidal risk

Getting into feelings as a way of helping the patient to open up is a good way to start.
After introducing yourself:
How are you feeling now?
You feel….. (echo what the patient has said)
Pick up a non-verbal cue:
You look very unhappy/troubled/anxious….am I right/would that be true……..? (pause)

A useful follow on phrase would be:
Have you felt like this for a while?

You can follow with the following if the patient is finding it very difficult to talk.
In your own time/ it's fine….just take your time…..
Do you want to tell me a little bit………
Or more direct, you can try moving on to the story of what happened.:
Would you like to tell me what happened last night? Did something particular go wrong yesterday?

A supportive comment here may be helpful.
You are quite safe here...

Follow the patient whenever they drop a cue and pick it up, and summarise where appropriate;
You shouldn't be here – what do you mean by that?
You said that you shouldn't be here…that you shouldn't be taking up the doctor's time and that you feel guilty...what is it you feel guilty about?
Why do you think that?

Sometimes, in order to move the patient on and hold the reigns for them, you can link things that they say and make a bit of a guess, when for instance you know that they took an OD the night before:
You look very troubled...what upset you the most last night?

Offering support/hope (needs to be realistic):
We're here to help you.
We can certainly look at that/help you with sleeping….

Looking to the future and working together:
How do you see the future?
You said you wanted help with your relationships……and you looked hopeful when you said that; there is hope/ I feel hopeful…….and we need to build on it…..
Or
I know you feel hopeless, that's part of your illness……I feel that there are things that we can do which will help/make life more tolerable for you…..what do you think?

Assessing the patient's risk of taking another OD.
Think of asking direct questions about the patient's risk as similar to clarifying the patient's history about rectal bleeding.
You've said how depressed you've been, and despairing since your mother died……you took a large dose of paracetamol last night….you said you wanted to end it all…..I am concerned about you……….I need to ask how you feel about this today………do you regret that someone found you in time/would you do the same again?

Interviewing the patient who appears psychotic

Introducing yourself to a psychotic patient in their home when they are not expecting/not wanting to see you can be tricky. Unless there is a real risk to your safety, it's best to be honest.
I'm……..your husband/mother asked me to come to see you……they are worried about you…that you are not going out and that you are so worried about the children……they aren't going to school……..
You can follow with:
Do you know exactly what you husband is worried about?
And the answer will help you with not only how psychotic/suspicious the patient is and how much insight they have.

Pick up what you see and hear and check it out with the patient.
You seem a bit distracted/agitated…..
You seem to be hearing something over there……
What are you looking at/what is it that you are seeing over there…….?

Follow the patient – don't give up too soon!
You said that you wish the voices would quieten down…… who do you wish would quieten down/what exactly are they saying to you…..
You seem concerned about the children……what is it exactly that you are worried about?
Can I just take you back to……I'm not sure I quite understand………
You seem to be very concerned about the time…..and that you don't miss the news on the television……are the people talking to you on the television…what are they saying?

And again, make a link and an educated guess:
You said that the kids aren't going to school, and that you are worried that they aren't safe….are you concerned about their safety outside the house?

Where others are at risk as well as the patient's deteriorating health, you must try to clarify what the patient is thinking or planning to do.
You said you ought to get the police in………so that they can stop you doing things you don't want to do…..what kind of things?
I'm very concerned about the children to……what exactly are the neighbours telling you to do?

Your own safety is important. If you pick up cues that the patient doesn't trust you and that you are part of their delusional system; if the patient says something like, *"you're in there with them, too, I can feel it…"*; and is getting increasingly agitated/violent, you must put yourself first and make sure you can leave the room at any time/call the police.

Offering support:
That's what I've come here for…to help sort things out….
If the patient thinks that the doctor is too busy:
I've set aside time to come to see you….I'm not in a hurry…this is very important….we need to sort this out together.

When a patient says: *"Do you think I'm mad doctor?"* , and they are clearly psychotic;
You have several options, but you must be reasonably honest, without losing their trust or getting into conflict (which may be counter-productive):

- *Mmm…..mmmmm (encouraging them to go on talking but do not answer)*

- *What do you think? (put it back to the patient)*
- *I'm concerned about you, and your husband is too……*

If this recurrent illness:

- *I remember how ill you were last year……it's rather the same isn't it……….I am very concerned about you…………I think you need some help…….*

When a patient says, *"but surely you can hear them too doctor?"*
Again, the patient needs a sense of reality so use the accepting response and be honest:
No, I can't hear them, but I know that you can, and it seems that what they are saying is making you anxious…what is it they are saying?

When you need to call in a psychiatrist to assess the patient or section the patient:
Combine empathy with support and try to link in with something the patient is concerned about, and move smoothly towards saying what you think should happen:
I'm concerned about how you are today…how agitated you are and how little sleep you've had in the last month…you look exhausted……I am also concerned about what you think the neighbours are saying and that the children may be in danger……I'd like to ask a psychiatrist/doctor who is an expert in these sort of problems to come and see you today………

Be careful to avoid conflict and anger. You need to be safe yourself. The patient who is hallucinating is usually agitated, and trying to concentrate on what they are seeing and hearing and make some sort of sense of it. They are often exhausted and frightened. They will almost certainly misinterpret some things that you say, and touch will be counter productive. So, once you have obtained enough information to diagnose/assess the patient's illness and how much insight they have, don't prolong the gathering information stage; move on now to explanation and planning.

Finally remember that the patient and their family will always remember how the doctor or nurse conducted an interview when they were seriously mentally ill for the first time, just like patients remember how bad news is broken. But from time to time you will have to make a painful decision about treatment or hospitalisation with an unwilling patient who lacks insight.

So be prepared, compassionate, and honest. Take your time; these interviews can't be conducted fast, so be gentle too.

**Further reading; have a look at the following article published in November last year.
McCabe R, Heath C, Burns T, Priebe S. (2002) Engagement of patients with psychosis in the consultation: conversation analytic study. BMJ 35; 1148-1151

HANDOUT III

THE PSYCHIATRIC INTERVIEW

The content to be discovered during the psychiatric interview is similar to any medical interview although there are additional areas to explore, such as pre-morbid personality, forensic history, and relationships. A summary of the features of a mental state examination is attached, but please note that the mental state examination is not performed as a separate phase of the consultation, as with a physical examination, but is largely incorporated into the interview, with the exception of the assessment of cognitive functions. An examination of mental state involves being aware of the appearance and behaviour of the patient, including the appropriateness of behaviour and listening to a patient's speech to decide whether there are any abnormalities of form or flow. It also includes a categorisation of the psychopathology elicited during the course of the interview. For instance a patient may describe how they hear a voice speaking to them when there is no-one around. The nature of this experience, the impact on their life and their feelings or concerns about it would all be recorded in the history, while in the mental state it would be categorized as a 2nd person auditory hallucination.

The process skills involved in taking a psychiatric interview are the same as any medical interview, although some additional flexibility in structuring the history taking may be needed at times. We will explore the specific skills that may be helpful during the CCS session in your psychiatric attachment.

RECORDING THE CONTENT OF THE PSYCHIATRIC INTERVIEW:

1. INTRODUCTION

Name, age and address of patient; occupation/source of income; housing; living group; name of any informants and their relationship to the patient; source of referral. Circumstances that have led to the consultation.

2. PATIENT'S PROBLEM LIST

3. EXPLORATION OF PATIENT'S PROBLEMS

Biomedical perspective
(Disease)

sequence of events

symptoms

review of *relevant syndromes*

Patient's perspective:
(Illness)

ideas and beliefs

concerns

expectations

effects on life

feelings

4. ESSENTIAL BACKGROUND INFORMATION

4a. Past psychiatric history

4b. Past medical history (including past drug treatments/allergy, systems review, current medication)

4c. Family history, including relationships

Parents: age (now or at death), occupation, personality, and relationship with the patient.
Similar information about siblings
Social position, atmosphere of the home
Mental disorder in other members of the (extended) family; abuse of alcohol and drugs

4d. Personal and social history

Mother's pregnancy and the birth
Early development

Childhood
Separations
Emotional problems
Illnesses
Schooling and higher education
Occupations
Sexual relationships
Menstrual history
Marriage/co-habitation
Children
Drug/alcohol history
Social circumstances/financial situation

4e. Forensic history

4f. Personality (i.e. patterns of behaviour)
e.g. Relationships (including recent 'social network')
Leisure activities
Prevailing mood
Attitudes and standards

4g. Informant history

MENTAL STATE EXAMINATION

PHYSICAL EXAMINATION

FORMULATION
1. Signs and symptoms of psychiatric disorder
2. Diagnosis/diagnoses in relation to DSM/ICD classifications
    - Consideration of differential diagnoses
    - Consideration of diagnoses co-occurring with main diagnosis/diagnoses
3. Consideration of relevant predisposing/precipitating/maintaining factors

PLAN OF MANAGEMENT
e.g. further assessments may include
- General physical examination and screening tests
- Neurological examination
- Further psychiatric or neuropsychological evaluation
- Interviews with informants
- Psychological, neurological or laboratory tests as indicated

Recommendations for treatment/management

EXPLANATION AND PLANNING
- what the patient has been told
- what the relatives have been told
- plan of action negotiated

THE MENTAL STATE EXAMINATION

APPEARANCE AND BEHAVIOUR:

Facial expression, posture, abnormal movements, social behaviour, attitude to interviewer

SPEECH (physical characteristics)

Quantity, rate, loudness, quality

MOOD

Objective and subjective
Prevailing mood, variability, associated symptoms, appropriateness.

THOUGHT PROCESSES

e.g. Poverty, flight of ideas, continuity (loosening of associations, thought blocking, circumstantial, rambling, evasive, perseverative)
Others e.g. clang associations, punning, and neologisms

THOUGHT CONTENT

Delusions
Obsessional thoughts
Preoccupations (e.g. of suicide in depressive disorders)

PERCEPTUAL DISTURBANCES

Hallucinations
Illusions
Depersonalisation/Derealisation

COGNITION

Clouding: a reduced awareness of the environment

Attention and concentration, e.g.

Attention: ability to focus on the matter in hand
Concentration: ability to sustain attention
e.g. tested by 'serial sevens' test (Ask patient to subtract 7 from 100 and then take 7 from the remainder repeatedly)

Memory

Short-term memory

e.g. tested by 'digit span': ask patient to repeat sequences of digits immediately after they have been spoken.

Memory for new information/recent events

e.g. ask patient to remember a name, address and flower. Ask the patient to repeat these to ensure registration. Tell the patient you will be asking him/her to recall these is a few minutes. Discuss other topics for 5 minutes before testing recall.

e.g. ask about recent experiences (or news) during last few days

Remote memory

e.g. ask to recall personal events or well-known public events from some years before

Capacity for abstract thinking

Orientation, e.g.:

Time (e.g. time of day, approximate date)
Place (e.g. ask patient to name place where interview is held)
Person (e.g. ask about the identity other people in the current environment)

Capacity to read and write/intelligence

INSIGHT: e.g.

Assess patient's awareness of his/her disorder and of current situation.
What does patient expect from the consultation?
Assess degree of insight in relation to delusions/hallucinations

SYMPTOMS ENQUIRY

e.g. Depression

Anhedonia
DMV (Diurnal mood variation)
Sleep/EMW (Early morning waking)
Appetite
Energy
Libido
Suicidality

Psychosis

Delusions
Hallucinations
Thought insertion/withdrawal
Passivity phenomena
Negative symptoms