INTRODUCTION

What Is Interviewing?

You'll probably never forget your first interviewing experience; I know I'll forever remember mine. The patient, a young woman hospitalized with a thought disorder that turned out to be early schizophrenia, spoke vaguely and often wandered off the topic. She'd occasionally make sexual references that I, a young student in a more innocent era, had never before encountered. I wasn't sure what to talk about, and I spent more time planning what to ask next than I did considering what the previous answer meant. Despite it all, this patient seemed to like me, which was a good thing; I needed three more trips to the ward that weekend just to get the entire history.

I now realize that my early experience was about par for the course. No one had told me that most novice interviewers have trouble thinking up questions, or that many feel uncomfortable with their first few patients. I wish someone had pointed out what I now know: that mental health interviewing is usually easy and almost always quite a lot of fun.

It should be both. After all, clinical interviewing is little more than helping people talk about themselves, which most people love to do. In the field of mental health, we ask patients to reveal something of their emotions and their personal lives. Practice teaches us what to ask and how to direct the conversation toward the information we need to help the patient best. Developing this ability is important: In a survey of practicing and teaching clinicians, comprehensive interviewing was ranked the highest of 32 skills needed by mental health practitioners.

If interviewing only involved getting patients to answer questions, clinicians could assign the task to computers and spend more time drinking coffee. But computers and paper questionnaires cannot begin to perceive a nuance of wording, or assess the hesitation or the moist eye—signs that can alert a live clinician to a fruitful line of inquiry. A good interviewer

must know how to work with a range of different personalities and problems: to give free rein to the informative patient, to guide the rambling one, to encourage the silent one, and to mollify the hostile one. Nearly anyone can learn these skills. There is no single kind of interviewing personality, and you can succeed with a variety of interviewing styles. Still, you will need guidance and practice to develop a style that works well for you.

Clinical interviews are used to accomplish various goals, of course, and professionals from diverse fields have different agendas. But all interviewers—psychiatrists, psychologists, family practitioners, social workers, nurses, occupational therapists, physicians' assistants, pastoral counselors, and drug rehabilitation specialists (I apologize if I've left anyone out)—must first obtain basic information from each patient they encounter. The similarities in the sort of data they need far outweigh any differences that might be expected from their different kinds of training and perspectives.

Good interviewers share three features. They . . .

1. obtain the greatest amount of accurate information relevant to diagnosis and management,
2. in the shortest period of time,
3. consistent with creating and maintaining a good working relationship (rapport) with the patient.

Of these three components, (1) the database and (3) rapport are crucial. If you ignored time constraints, you could provide good care, although you might have difficulty coping with more than a very few patients at one time.

Your first contact with any patient could be made for a variety of reasons—a brief screening, an outpatient diagnostic intake, an emergency room visit, a hospital intake, or a consultation for medication or psychotherapy. A nurse clinician might need to develop a nursing treatment plan based on several behavioral diagnoses. Forensic reports and research interviews have very different goals, but their methods and content have much in common with all the other types of interviews I've mentioned—each of which is a specialized use of the basic, comprehensive initial interview. Whatever your interview goals, this book aims to present the information you should try to obtain for all patients and to recommend techniques that will help you during the different stages of your interview.

Over the past several decades, we have learned a great deal about the interview process. However, in my everyday evaluations of young mental health professionals, I am often disconcerted at how little this knowledge is being used in training. Clinicians often use far less than the

time allotted for an interview, fail to ask about suicidal ideas, and forget that many mental health patients also have substance use issues. In short, much of what we know about the processes of interviewing and evaluation is being ignored. *The First Interview* attempts to remedy this deficit. Addressed primarily to beginners, it emphasizes the basic material that clinicians of all mental health disciplines need to know. I hope that experienced clinicians will also find this book a helpful review.

THE NEED FOR COMPREHENSIVE INFORMATION

Clinicians can view a patient in an astonishing variety of ways. Indeed, all clinicians should be able to view each patient from biological, dynamic, social, and behavioral perspectives, because a single patient may need the treatment implied by any or even all of these theoretical standpoints. For example, the problems of a young married woman who drinks too much alcohol might be determined by a combination of factors:

> *Dynamic.* Her overbearing husband resembles her father, who also drinks.
>
> *Behavioral.* She associates drinking with relief from the tensions induced by these relationships.
>
> *Social.* Several girlfriends drink; drinking is accepted, even encouraged, in her social milieu.
>
> *Biological.* We should also consider the genetic contribution toward alcohol misuse from her father.

A comprehensive evaluation brings out the contributions of each of these points of view. Each is folded into the treatment plan.

Throughout the book I emphasize the need to hold all perspectives when you are conducting a comprehensive interview. Unless you do a complete evaluation, you are likely to miss vital data. You might not learn, for example, that a patient who seeks help for a "problem of living" actually has an underlying psychosis, is in the midst of a depression, or misuses substances. Even if your patient turns out to have no actual mental disorder, you need to understand how past experiences contribute to the current problems. Only a complete interview can satisfactorily give you this information.

Needless to say, you will obtain much more additional information as treatment progresses. You may even find that you must revise certain of the opinions you formed during your first meeting. But you can plan rationally for management only if you first carefully elicit the relevant material during the initial interview.

Your success as a mental health interviewer will hinge on several different skills. How well can you elicit the entire story? Can you probe deeply enough to obtain all the relevant information? How quickly can you teach your patient to tell you accurate, pertinent facts? How adequately do you evaluate and respond to your patient's feelings? Can you, when necessary, motivate your patient to reveal embarrassing experiences? All of these skills are needed by anyone who must elicit mental health histories. The time to learn them is early in your training, before ineffective—or even maladaptive—interviewing habits become a fixed part of your style. The benefits of early training should persist for a lifetime.

More than half a century ago, two volumes set the tone for interviewing style: *The Initial Interview in Psychiatric Practice* by Gill, Newman, and Redlich, and *The Psychiatric Interview* by Harry Stack Sullivan. Although many other books on interviewing have appeared over the years, most have followed the models established by these two volumes. But taste and needs have changed over the decades, and such venerable works no longer adequately serve the mental health interviewer. Over the past several decades, a number of research papers—most notably those by Cox and associates—have provided a scientific basis for modern interviewing practice. I have based much of this book on these sources. I have also consulted nearly every available relevant monograph and research article on interviewing published during the past 60 years. Citations for the more important of these are provided in Appendix F.

In their monograph, Cannell and Kahn (1968) stated, "The people who write instructions and books for interviewers are not themselves given much to interviewing." At least in the case of *The First Interview*, that assertion is dead wrong. A significant part of what has gone into this volume comes from my own experience over the years with more than 15,000 mental health patients. The interviewing approach I recommend is an amalgam of clinical research, the experience of others, and my own perception of what works. If it sometimes seems formulaic, it's a formula that works well. Once you have learned the basics, you can adapt and expand it to create your own interviewing style.

THE IMPORTANCE OF PRACTICE

When I was in training, my professors often said that a student's best textbook is the patient. Nowhere is this truer than in learning to do a mental health interview. Indeed, no textbook can be more than a supplement—a guide to the real learning that comes through experience. I therefore urge you to practice early and often.

First, read Chapters 1 through 5 quickly. Don't try to memorize this material; the amount may be daunting, but it is presented in sequence to

help you learn it a bit at a time. (Appendix A provides a concise outline of the information you need and strategies you can use at each stage of the typical initial interview.) Then find a patient who will help you learn.

For the beginning interviewer, patients hospitalized in a mental health unit are an excellent resource. Many of them have been interviewed before (some are highly experienced!), so they have a good idea of what you expect of them. Even on contemporary hospital wards with many scheduled activities, they usually have time available. Many patients appreciate the chance to ventilate, and most enjoy the feeling that from their own difficulties some good can come—in this case, the training of a mental health professional. (A study in 1998 found that most patients were highly satisfied with the students who participated on their hospital care teams; another study reported that students were experienced as "kind and understanding" by patients, most of whom said they'd be happy to repeat the experience.) And sometimes an interview by a fresh observer, even a trainee, reveals new insights that can help redirect therapy.

So enlist the aid of a cooperative patient and start to work. Don't worry about trying to find a "good teaching patient"; for your purposes, any cooperative patient will do, and all lives are inherently interesting. Don't try to follow an outline too closely, especially in the early going. Relax and try to give both yourself and the patient an enjoyable experience.

After an hour or so—a longer session will be too tiring for both of you—break off the interview with the promise that later you'll come back for more. Return to *The First Interview* to read about any areas of interview management that gave you trouble. Carefully compare the personal and social information you have obtained with the Chapter 8 recommendations (which are also outlined in Appendix A). How complete is your mental status exam? Compare your observations with the suggestions in Chapters 11 and 12.

A student might reasonably ask, "How can I interview about mental disorders when I know so little?" Doing a complete interview does imply knowing the symptoms, signs, and course typical of various mental disorders, but you can study these while you learn interview technique. In fact, learning about disorders from patients who have experienced them will fix the characteristics of these diagnoses in your mind forever. In Chapter 13 you will find listed the features that you should cover in your interview, broken down by the areas of clinical interest your patient presents.

Armed with a list of the questions you forgot to ask the first time through, return for another session with your patient. As I learned that weekend as a beginning medical student, there is no better way to learn what to ask than by going back to correct your own omissions. The more patients you interview, the less you will forget. When you have completed your interview, any of several standard textbooks (see Appendix F for

an annotated list) can help you with the differential diagnosis of your patient's disorder.

You will become skilled faster if you have feedback from an experienced interviewer. It could be direct, as when an instructor sits with you while you interview your patient. Numerous studies have demonstrated the effectiveness of audio or video recordings, which can be played back while you and your instructor discuss the facts you have omitted and the interview techniques you could have used to better effect. You will probably find that you can learn a lot just by listening in private to recordings of your own early interviews. I've provided a score sheet in Appendix E to help you evaluate the content and process issues of your interviews.