Interviewing in Consultation-Liaison Psychiatry

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6.1 Vignette

After being paged by the CL service receptionist that there was a consultation request for evaluation of suicidality and psychosis for Melinda Smith in 3W Room 302, the psychiatric consultant rushed into the four-bed room. Around the third bed, the curtains were drawn, and there seemed to be a procedure being performed. Another patient was snoring. Another patient seemed to be in the middle of her lunch but looked at the consultant curiously. The fourth patient with a nasogastric tube was surrounded by several visitors. The consultant looked around the room, and asked in a loud voice, "Which one of you is Melinda Smith?" One of the visitors of the fourth patient pointed to the woman with the nasogastric tube. The consultant approached the bed, and said, "I am doctor Jones, the psychiatrist. Your doctor tells me that you have hallucinations and delusions and want to kill yourself. Is that correct?"

(What is wrong with this scene?)

6.2 Introduction

The psychiatric consultation interview that occurs in a medical setting often requires special techniques which distinguish it from interviews in other psychiatric settings. The referring physician, or sometimes a nurse, is more likely to recognize a psychiatric issue,

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and seek help, than the patient. As the consultation request comes from someone other than the patient, the consultant must first establish rapport with the patient, who might not have been aware of the need for psychiatric evaluation, then, assess the psychopathology if present in the context of the medical situation, and answer the particular referral question being asked or solve the underlying problem which may not be clearly stated or even recognized.

The psychiatric consultation interview generally consists of six phases: (1) Preparation Phase, (2) Introductory Phase, (3) History, (4) Mental Status Examination, (5) Discussion of findings and Recommendations, (6) Follow-up visits.

This chapter will focus primarily on phase 1, 2, 5, and 6, as well as the process rather than the content of phases 4, and 5, which are covered in detail in Chaps. 3 and 4.

6.3 Preparation Phase

It is a mistake to think that there is an advantage to interviewing the patient without any prior knowledge about the patient, ostensibly to avoid being biased. The consultation liaison psychiatrist needs to perform an assessment and make recommendations in a timely manner, keeping up with the fast pace of contemporary hospital care. In order to do this, the consultant must work as efficiently as possible, and this requires being well prepared going into the interview. Much of the work of the consultation, in fact, is done prior to seeing the patient.

The information that has been gathered from the referring physician, the nursing staff, the medical records, and sometimes from old records and family members or other interested parties should prepare the consultation liaison psychiatrist for what she/he is likely to encounter in the patient interview. The consultant should also plan the probable duration of the interview. The initial interview for the cognitively intact patient is usually allocated between 20 and 50 min. Before interviewing the patient, the consultant should obtain as much privacy as possible, such as drawing the curtains in a multi-bed room. The consultant should also plan for contingencies, such as what if the patient seems grossly confused or agitated? If there are visitors in the room, should the visitors be asked to leave? What if the patient is in the middle of a meal? What if the patient is asleep?

The rule of thumb for such contingencies to ask the question, “What would the primary responsible physician do under the circumstances?” When the consultant interrupts a meal or awakens the patient from sleep, he/she should apologize for doing so. “Ms. Jones, I am sorry to wake you up, but your doctor wanted me to speak with you in order to help in your care…” We discuss the visitor issue later in this chapter.

6.4 Introductory Phase

We will discuss the introductory phase separately for cognitively intact and cognitive impaired patients, and then discuss the issue of whether or not to include significant others in the interview.

6.4.1 Cognitively Intact Patient

The consultation liaison psychiatrist should introduce himself/herself with a brief statement regarding the reason for the consultation. It may also be useful to know whether the patient was expecting a consultation. For example, “Hello Mr. Jones, my name is Dr. Smith. I’m the psychiatric consultant that your doctor has called to see if I can be of help. Were you expecting me? "If the patient answers in the negative, the consultant might say, “Well, your primary doctor asked me to see you as he/she was concerned that you might be experiencing depression/anxiety/concerns.” At this point most patients will not be offended or be upset about to visit. Ideally, they were informed ahead of time, and even if not, and they may realize that the consultation is appropriate. Only a small percent of patients become distressed or resist the consultation at this point. This most often occurs with patients who are paranoid, or who are drug abusers who are afraid that the psychiatrist may cut off the narcotic analgesics or tranquilizers that they are demanding.

Notice that in the example above the consultant mentioned depression or anxiety. If the patient is in fact concerned about depression or anxiety, or is self aware of having a psychological problem, rapport will be established as easily as in any other psychiatric setting. If the patient issues are of a different nature, however, say a personality disorder, a somatoform disorder, a behavioral problem on the ward, or a communication problem with the doctor or staff, rapport will be much more difficult to establish. In this case, the following approach will often allow rapport to develop quickly.

The brief introduction need only mention that you are a psychiatric consultant whom the primary doctor asked to assist. Then it is very useful to immediately begin talking to the patient, providing information, rather than asking questions. For example " Mr. Jones, I understand that you hurt your back more than 8 years ago and subsequently have had two operations on it. You are in the hospital now for diagnostic testing because the pain has been getting worse." By reviewing the patient's pertinent medical history and reason for being in the hospital, you have established that you are interested in the same things that the patient is interested in. The patient quickly realizes that you have done your homework, are part of the medical team, and there will be the opportunity to talk in detail about their specific problems. In contrast, an opening such as "what kind of problems are you having?" is occasionally irritating to the patient, particularly the more difficult patient who is more likely to have a psychiatric consultation requested.

At this point the consultant can pause in the interview, giving the patient a chance to expand on the problem, or to correct what the patient considers to be misinformation on the part of the consultant. Then the consultant does an expanded history of present illness. A patient commonly will describe his/her experience and include his/her beliefs, reactions, and contextual issues around the symptoms. Another medical specialist may try to focus down the history to delineate the symptoms that are important to sort out the differential diagnosis. In contrast, for the psychiatric consultant, the goal is not so much the differential medical diagnosis, but to understand the patient's experience of what is going on in the patient's life and how this influences the presentation of symptoms, the experience of illness, the response to medical care, and the doctor–patient relationship. We not only allow this expanded history, but we encourage it. Often the patient appreciates this chance to tell the story, without too much interruption, and without being diverted from what she/he wants to say. If, as the patient tells the story, the consultant is attentive, empathetic, and facilitating, a positive rapport is likely, crucial in a short interview. Diagnostically important information is more likely to come out, and the interview is often therapeutic in and of itself.

6.4.2 Cognitively Impaired Patient

When the information obtained about the patient prior to the interview suggests that the patient may be confused, disoriented, or has an altered mental status, one must consider the probability that the patient might be delirious or otherwise cognitively impaired. Sometimes delirium or dementia has already been diagnosed, but in perhaps half the cases where this is ultimately found, this will not have been done. In such an instance, the stated reason for referral may be, for example, depression or agitation. Even in these cases, the nurses' notes often reveal that the patient is confused, at least at times. One must be careful not to uncritically accept the nurses' notation "A&Ox4" as being indicative of no cognitive dysfunction, however. This is sometimes seen in patients who are clearly delirious.

If a cognitive disturbance is suspected, the interview proceeds differently than if it is not. A delirious or seriously demented individual cannot give a reliable history. Attempting to obtain history from such a patient may stress the patient beyond his/her capabilities and may be a waste of time. Asking questions that are beyond the patient's capabilities of comprehending may result in a *catastrophic reaction*, in which the patient becomes anxious, agitated, defensive, and may even refuse to communicate. The interviewer may be in doubt as to whether the patient

is just being non-cooperative as opposed to having a cognitive disturbance.

A good way to start the interview when significant cognitive impairment seems to be present is by indirectly testing orientation. Instead of introducing oneself immediately, one might say, "Hello Mr. Jones, have we met before?" If that patient is disoriented to person he/she will not know that you are a doctor seeing him in the hospital. The patient may say something like, "Yes, I think I've seen you down the hall." A follow-up question might be, "How long have you been here now?" This question is testing for orientation to time but it does so subtly, in a manner that is not likely to antagonize the patient with a mild or no cognitive deficit. If the patient says "3 years" and she/he has only been in the hospital 3 days, one can conclude that there is disorientation to time. On the other hand if a patient in the intensive care unit has been comatose or under sedation for an extended period of time, they may well not know where they are or how long they have been there. Then the patient can be told, "Actually, you are in the Memorial Hospital, and you have been here for 6 weeks following a motor vehicle accident." Perhaps 2 min later the patient can be asked if he or she remembers the name of this place and how long he or she has been here. If the patient cannot remember this, he or she should be oriented again and asked once more only 1 min later. If the patient answers correctly, they could be asked again, say 5 min later. In this way memory span can be tested without having to bother giving three words to remember.

If the memory span is less than 30 s it is unlikely the patient will be able to learn and remember anything that the nurses say. The nurses can be informed, so they don't accuse the patient of being uncooperative when they fail to follow their instructions. If the memory span is a minute or longer, the patient should be capable of learning and remembering after multiple repetitions. If the memory span approaches 5 min, they are likely to have minimal cognitive impairment.

Thus, the interview for the suspected cognitively impaired patient consists primarily of a mental status examination that can confirm the diagnosis of delirium or dementia within a few short minutes. Of course if the cognitive abilities appear intact, the rest of the interview would go on as usual.

6.4.3 Visitors: The Presence of Family Members or Significant Others

When the consultant enters the patient's room, there may be visitors present, since visiting hours ordinarily have few restrictions in contemporary hospitals, and since the patient is likely to be seen at the consultant's convenience, not by appointment

What if a patient's spouse is present in the room? If the consultant ignores the spouse, and just begins to interview the patient, it will be awkward, let alone being impolite, and makes it harder to establish rapport with the patient. It is prudent not to identify yourself as a psychiatrist in the presence of visitors initially as some patients feel embarrassed about seeing one. For psychiatric interview to be conducted, the consultant must have the patient's permission for others, even the spouse, to be present. The consultant should introduce himself/herself to the patient, "Hello, Ms. Smith, I am Dr. Jones", then ask the visitor what the relationship of the visitor is to the patient. At this point, the interview can proceed in two ways, depending on the context of the situation and the inclination of the consultant. If the consultant suspects, based on his/her prior knowledge of the clinical issues, that it will be necessary or helpful for the patient to talk privately without the presence of significant others, he or she might say, "I am going to talk to your husband/wife for a while. Would you excuse us for a few minutes?" When the visitor has left the room, the consultant should introduce him/her self as a psychiatrist and might ask, "Would you mind my speaking with your wife/husband/relative/friend after we finish?"

At times, however, the consultant may judge that the presence of a significant other may be of great advantage. If the consultant is confident in his or her ability to interview couples (and

families), he or she may directly ask, "Ms. Smith would you prefer Mr. Smith to be present while we talk, or would you like to talk with me alone? Most of the time, a patient will feel more comfortable in the presence of a loved one, unless there is something to hide.

The presence of a significant other is particularly helpful if the patient has dementia, severe psychosis, chronic illness, or drug abuse problems. The spouse/significant other can often revise or corroborate the patient's story. The history that is then obtained is often much richer and more complete. In addition, the consultant can assess the relationship for the degree of support that exists within it and how well a couple communicates with each other.

In order to bring the spouse/significant other into the conversation, the consultant may turn to him/her and say something like "I can see how difficult this illness has been for Mr. Jones—how has it affected you?" Another way to bring the spouse into the conversation, particularly with elderly couples who may be more reticent to talk, is to ask, "How long have you two been married?" When the answer comes back something like "45 years," the next question can be "That's wonderful. What is the secret of your success?" A couple that gets along well often responds with laughter, and the husband may say something like, "She's the boss and I do what she says". The couple usually enjoys this banter and this enhances rapport with the consultant. The consultant now knows that the marital relationship is one that provides significant support.

If there are significant problems of the relationship they are likely to come out at this juncture and the consultant can assess how much the marital conflict interferes with the medical care or the response to illness.

In general, interviewing the patient with a significant other involved in the interview is much more likely to give the consultant a good sense of what the patient is like as a person. On the other hand, some patients may be reluctant to reveal conflicts with the significant other if he or she is present. The consultant should make a judicious decision concerning whether to interview the patient with significant others. Sometimes it may be appropriate to ask the patient to invite the significant other to be there for a particular time when the consultant can interview them together.

6.5 Discussion of Findings and Recommendations

After the history has been obtained and the mental status examination performed, the consultant should share with the patient and significant other, if present, relevant findings and recommendations. This should be done in lay terms and with recognition of patient's and family's sensitivities. It is often useful to simply recognize the symptoms and signs that the patient has already told the consultant, e.g., "As you said, Ms. Jones, you have been feeling blue and depressed, and you have trouble falling asleep and sleeping through the night. You also lost considerable weight in the last several months. For these symptoms, I will recommend to your doctor an antidepressant medication called mirtazapine that you take at night. This medication is likely to help you sleep better, and increase your appetite, too. Do you have any questions?"

It is always a good idea to allow the patient to ask questions, and discuss any concerns or misgivings about psychiatric diagnosis and/or treatment.

For patients whose psychiatric condition is intimately related to the medical condition or its treatment, leaving the interview on a positive note is often very helpful and comforting to the patient. For example, the consultant might say, "I know it has been rough, but your blood tests show definite improvement. Your job right now is to be as patient as you can while your treatment (specify) continues. I expect that you will be feeling better soon." The more the psychiatric consultant has learned about the patient, the more they will be able to conclude in a meaningful, supportive manner. Patients are very sensitive to the words and nuances of their doctor's communications when they are sick. Many patients take great comfort in anything positive the doctor says.

6.6 Follow-Up Interviews

At least one follow-up interview is desirable for all consultations (if the patient remains in the hospital). As the initial consultation interview was a cross-sectional slice of the patient's state and behavior, it is necessary to observe them at another point in time. Quite often, the difference is astounding, especially when a patient is emerging from delirium. A visit from a family or friend sometimes dramatically changes a suicidal patient's mood.

As with the initial interview, the consultant needs to be prepared for the follow-up interview. The consultant needs to know how the medical treatment is proceeding, and what is being planned. The consultant should also know the patient's responses and behaviors since last interview. When the patient realizes that the consultant is knowledgeable and up-to-date about the medical course, further trust is engendered and misunderstandings or miscommunications, all too frequent, can be clarified and corrected.

6.7 Psychotherapeutic Aspects of Consultation Interviews

The purpose of the initial consultation interview is primarily evaluative, but any interview conducted by a psychiatrist has inherent psychotherapeutic aspects. By deliberately making the effort to form a rapport with the patients, the patients feel respected and valued, which is, unfortunately, not always what they experience in the hospital setting. In the course of history taking, the psychiatrist elicits information about the patient's emotions and emotional responses to important events that allows the patient to share and express pent-up feelings. By sharing with the patient, in a language that the patient can understand, the assessment and recommendations, the patient feels reassured that the consultant now has a handle on the emotional problem that was difficult to describe or express. Through follow-up visits, the patient feels that the consultant continues to be interested.