A Guide to the Psychiatric Interview for the Part Two Oral Israeli Board Exams

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Abstract: An approach to the psychiatric interview section of the Part Two Israeli Board Exams is presented in this three-part article. Part One presents pre-exam preparation and theoretical background to the psychiatric interview based on a comprehensive literature review, Cole-Cohen’s “Three Function Approach” and cognitive principles. Part Two is an in-depth analysis of the interview itself. Because psychiatric interviews are essentially uniform in their structure and function, a semi-structured approach is advocated. Part Three presents an approach to the differential diagnosis based on a DSM-IV multi-axial formulation. Management strategies are based on broad biopsychosocial principles and current standards of care. This article is aimed at both psychiatric residents preparing for their boards and psychiatric educators who teach interviewing courses.

PART ONE — Background to the Psychiatric Interview

Introduction

This approach to the psychiatric clinical interview aims to help residents preparing for Part Two of the Israeli Board Exams in psychiatry. It also serves as a primer for teaching the psychiatric interview during residency training.

The oral exam is similar to a semi-structured interview. Understanding the function and structure of the interview is the first step in writing a “script” that will allow you to navigate its intricacies. Practice examinations are a type of behavioral laboratory in which interview skills can be developed.

Theoretical Basis of Practice Examinations

The rationale for practice exams is based on a body of empirical research originating from study of the medical interview and cognitive behavioral theory.

Cohen-Cole’s Three Function Approach (1) is the most common approach to teaching the medical interview and is widely used in medical schools in the United States, Canada and Europe as the standard text for interviewing courses. It represents “an operationalized application of the biopsychosocial model to the medical interview” and advocates that medical outcomes are greatly dependent on the physician-patient relationship.

Interactions between doctors and patients are remarkably standardized — even complex and emergency situations are very similar (2). It is this basis that allows understanding of the function and the structure of the interview and forms the underpinnings for building a semi-structured interview script.

The first of Cohen-Cole’s “functions” is “gathering data to understand a patient’s
problems.” This highlights the centrality of the interview in obtaining the diagnosis. Ineffective data gathering may lead to time-consuming processes that impede understanding of the central issues that are bothering the patient.

The second function is “developing rapport and responding to the patient’s emotions.” This reflects the therapeutic quality of the medical interview. For example, it has been shown that patients who are more satisfied with their physicians have a greater adherence to treatment recommendations (3). Basic skills form the foundation for more sophisticated emotional interventions based on cognitive, supportive or insight-oriented psychotherapy skills.

The third function, “patient education and motivation,” reflects the treatment plan. Patient adherence varies from 22-72% (4). If outcome is an important goal of the medical interview then these outcome studies emphasize the need of crystallizing a treatment plan that is likely to be followed through by the patient.

These are the functions of the interview. Specific interview techniques will be discussed in section 2 where the structure of the interview is formally explored. This then leads us to discuss the scientific basis of practice examinations as a device for improving interview performance.

What evidence is there that practice exams improve performance in the actual exam and what are the theoretical underpinnings of practice exams? The largest study reported in the literature is that of Schubert et al. (5). They prospectively studied a program of 441 oral practice exams in anesthesiology. There was a positive correlation between performances in practice exams and the actual exam as well as internal institutional markers of residents’ knowledge and function. Practice oral exams marks were significantly associated with previous experience with practice exams, training duration, trainee preparedness and trainee anxiety.

Cohen-Cole (1) elaborates, “There is no substitute for practice. This holds true for any skill. Playing tennis, piano, surgery, etc., all require practice. Interviewing is the same.” However, the equation is not as simple as a certain number of repetitions guaranteeing success in the oral exam, just as playing a great number of tennis matches is no guarantee you will be a star.

Feedback is a cognitive technique (6) that facilitates efficient learning. The cornerstone of feedback is observation. Self-observation is encouraged by asking the candidate questions such as, “How did you think the interview went? What did you do well? What aspects would you like to improve?” (7). Other feedback techniques (8) include establishing mutually agreed upon and remediable goals for feedback, reflecting on observed behaviors, being non-judgmental, relating feedback to specific behaviors, offering the right amount of feedback and offering suggestions for improvement. It is preferable to give feedback during the actual practice exam rather than to wait until the end (9) and then hit the candidate over the head with a burst of sustained, and often overwhelming, feedback. Hodder et al. (10) used Objective Structured Clinical Examinations as a teaching tool and found that immediate feedback improved competency in the performance of criterion-based tasks when compared to controls.

Once feedback is given, it is vital that the learner be given the chance to practice the skill again so that mastery of the skill can be demonstrated (1, 11). Repetitive practice will ensure honing of that skill.

The teacher can also use modeling of a distinct behavior to demonstrate a particular aspect of the interview. Cohen-Cole (1) suggests this should not take more than 4-5 minutes to be maximally effective. Standardized patients (actors), role-play, videotaping,
and live patients can all be used to refine interview skills. Role-play, in particular, is a very simple but versatile tool that facilitates immediate feedback, repetitive practice and modeling and has been successfully used by our group. A variation is rotating role-play or the rotating live patient interview. In these, each learner interviews the mock patient or real patient in turn for a period of about five minutes with “time out” in between for feedback and teaching (1).

Cohen-Cole suggests that interviewing skills be taught in small groups of no more than four to six so that individuals can receive appropriate individual feedback and guidance (1). Preparing for the interview examination with colleagues also facilitates peer feedback, a degree of healthy competition (12) and provides a network of support and encouragement.

When to start preparing
Ideally, psychiatric residents should be taught interview techniques as part of a well-integrated course from the earliest stages of their training. Cohen-Cole, for example, teaches interview skills to medical students in a 20-hour workshop divided into ten 2-hour workshops. The earlier a candidate starts to learn interview skills, the more time they will have to develop and test their techniques and, therefore, the more likely they are to approach the exam with confidence.

By setting out the goals one wishes to achieve in interviewing and the resources one has available to assist in this task, one can work out how many hours are needed to reach the target. For example, one’s aim may be to pass five live patient interviews with the toughest examiners in Jerusalem. Alternatively, the end-point may be to see two cases of each of the most likely diagnostic scenarios that will appear in the exam. Another scenario is that, in the limited time before the exam, one estimates that proficiency can be achieved by doing practice interviews three times per week.

Management of examination stress
Stress should be recognized and stress reduction strategies implemented. These may include regular exercise, relaxation techniques, adequate sleep, peer support and socializing. Benzodiazepines have sedative and amnesic side-effects making their use relatively contraindicated. Propranolol 10-20 mg. before the interview is effective in reducing the physiological symptoms of performance anxiety (13). If one decides to use propranolol, determine its efficacy and possible side-effects by taking it routinely before practice interviews.

One candidate described her experience with propranolol as follows:

“I suffer from examination anxiety. My heart starts to beat so loudly that drowns out the examiners’ voices; I end up panicking. I took 10mg of propranolol 1 hour before all of my practice exams just to make sure that there were no side-effects. Without the pounding in my chest I had more confidence to express myself in front of the examiners.”

What type of patient is likely to appear on the exam?
Hospitalized patients or day patients are often more available to appear in exams. An informal survey of 30 recent candidates revealed the following diagnostic spectrum: schizophrenia, schizo-affective disorder, organic psychosis, bipolar disorder types 1 and 2, panic disorder, PTSD, eating disorder, dementia, depression and borderline personality disorder. This information has no statistical significance — we present it as a reminder that patients seen in exams are representative of ward or clinic populations. Anticipation facilitates preparation and reduces anxiety.
Table 1: Modified examination marking scheme. Use this form in practice exams. Note the feedback from mock examiners in the right-hand column and alter interview script accordingly. Keep the forms to monitor progress as interview skills progressively improve.

<table>
<thead>
<tr>
<th>Breakdown of Exam</th>
<th>Candidates Score</th>
<th>Examiners Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% Interview Content</td>
<td>/20</td>
<td></td>
</tr>
<tr>
<td>20% Management of Interview</td>
<td>/20</td>
<td></td>
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<tr>
<td>20% Case Presentation</td>
<td>/20</td>
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<tr>
<td>40% Diagnostic and Therapeutic Considerations</td>
<td>/40</td>
<td></td>
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<tr>
<td>Total Score</td>
<td>/100</td>
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What are examiners looking for?

It is often difficult to establish formal reliability and validity in oral exams (14). Some countries rigorously select, train and monitor the performance of examiners (14) in an attempt to make the examination more uniform and fairer. In a similar manner, Israeli examiners score candidates’ performance using a standardized score sheet and undergo purpose-built training programs to maximize the reliability and validity of the exam.

Psychiatric residents can utilize a similar examination marking scheme (Table 1) in practice exams. This will assist in understanding what the examiners are looking for and give feedback on performance in an authentic manner.

Note that the presentation (20%), together with the diagnostic and therapeutic considerations (40%), constitutes 60% of the total mark. The exam is therefore weighted towards the synthesis of data and the treatment plan.

According to the Scientific Council guidelines (15), candidates must consider suicidal or aggressive tendencies especially in affective or paranoid patients. They must ask about physical illnesses, family history of mental illness, forensic status such as an involuntary admission or compulsory clinic treatment order, as well as detailing use of alcohol and drugs.

Will the examiner expect elicitation of every bit of information in the patient chart?

Examiners are blinded to the diagnosis. They will know as much as the resident does and therefore the clinical examination will be the focus for formulating a relevant multi-axial differential diagnosis, not the chart.

Dressing, time-keeping and note-taking

The examiners have come to see the resident and not the patient. One should dress like a serious psychiatrist. Examiners will spend the next hour looking at the resident. One does not want them to silently think, “Why are the candidate’s shoes unpolished? Why is he dressed from head to toe in black? Depression? Why is he wearing jeans — over-confidence?” If one smokes, one does not want cigarettes showing in one’s shirt pocket. Dress also reflects respect for the patient. Aldridge summed it up as “Blue is good, gray is good, sandals and socks are bad (13).”

The resident is expected to be in charge of time-keeping for the interview. If there is a clock in the room, it is most helpful if it is behind the patient. There is no need to ceremoniously lay your wristwatch on the table or bring in an alarm clock. One simply turns the watch face onto the anterior aspect of the forearm. One should be able to steal a
glance at the time, without the patient noticing, while one's hands are comfortably resting in one's lap. Patients are often exquisitely sensitive to rejection — a doctor looking at his watch may be interpreted as disinterest in the patient or being more concerned with his examination than the patient's needs.

Some candidates do not write during the interview. Others find it useful to have a pen and card handy to write down things that they might forget, such as a difficult name or the patient's age. Having a card or pad and pen may also solve the problem of fidgeting with hands. Writing down the start and finish times on the top of the card saves confusion under exam pressure.

Why Do Some Candidates Perform Better than Others?
It is generally agreed that no one flaw results in a candidate failing (13, 16) e.g., forgetting to ask about hallucinations. Rather, it is a combination of factors that leads the examiner to conclude — this candidate would be an unsafe psychiatrist.

Candidates who have failed commonly indicate inadequate preparation (16). Inadequate knowledge makes an unsafe psychiatrist. Examiners may fail candidates for more subjective reasons, such as insufficient empathy shown towards the patients or an arrogant attitude (16). Over-control of the interview (not allowing the patient to speak freely) is also viewed in a negative light by examiners. Arguing with the examiner is sure to cause irritation. It shows an inability to be flexible or to weigh different diagnostic considerations. This may be a subtle personality pattern (in which case the candidates are often unaware of their tendencies to argue) or simply a by-product of exam nerves. A candidate's ability to deal with his own feelings directly affects the manner in which he deals with emotions manifested by patients (17) or examiners.

The ability to deliberate is an important quality that examiners look for in candidates, rather than a right or wrong answer. It reflects a thoughtful psychiatrist who can think abstractly. Rigid, black and white thinking is often brought about by anxiety. In some candidates, crippling anxiety is so overwhelming that examiners are unable to assess the candidate's knowledge base (16). Self-efficacy (18), an individual's subjective estimate of his or her ability to cope effectively with different problems or issues as they arise, is a useful construct in this context. A confident candidate should have the ability to weigh up and analyze data produced in the exam situation and to deal with uncertainty.

Finally, a lack of organization or vagueness in the interview or presentation often defines a mediocre candidate's performance (16). Similarly, a crisp, well-organized presentation is always engaging and stimulating for the examiners.

The take home message of this section is that reasons for sub-optimal performance can be understood and addressed in a pre-examination preparation program. Feedback is of vital importance for the candidate who is struggling.

Psychiatric interviews have a repetitive element in their function and structure. Section 2 explores writing a "script" or a semi-structured outline for the interview. This will allow you to efficiently structure the interview while maintaining a spontaneous interaction with the patient.

PART TWO — Structure of the Psychiatric Interview
Based on the cognitive behavioral principle of modeling, doctor-patient dialogues (in italics) appear throughout the next section, animating and illustrating various aspects of the interview.

It is recommended that one use the dialogues and this article as a basis to write
one’s own semi-structured script for a psychiatric interview. One should not mimic the template in a parrot fashion but rather use it to structure your own particular style and preferred way of interacting with the patient.

The interview is essentially the same as assessing a patient for the first time in the emergency department or clinic. This should provide a degree of confidence in the knowledge that the exam is essentially the same as daily work. By the same logic, if one interviews proficiently in the exam situation, these skills can be generalized to the workplace.

Engel (19), who first described the biopsychosocial model, emphasizes the importance of enlisting the patient as a collaborator in the interview and not simply an object of study. Engel suggests that it is important to ponder the difference between “encouraging narration” as opposed to “reporting.” In the former, patients will feel and appreciate that the resident is listening to them tell their story in their own words. He summed this up as, “Interrogation generates defensiveness; narration encourages intimacy.” A good candidate should establish an atmosphere of intimacy and trust despite the artificiality of the exam situation.

a. Introduce yourself to the patient, demographic information (5 minutes)

“Good morning, my name is Dr. Cohen. What is your name? Pleased to meet you, Mr. Levi. Please sit down here.”

Seat the patient at 45 degrees to you, close enough to just be able to touch his knee. Rearrange the furniture slightly if necessary. Ask specifically for the patient’s last name if he introduces himself using only his first name.

Establish the goals of the interview.

Check the patient’s understanding about the nature of the exam and the interview.

“What do you understand is the purpose of today’s meeting?”

Correct any misperceptions.

Should one introduce the examiners to the patient?

Not all candidates introduce the examiners. However, the patient may feel uncomfortable talking in the presence of two imposing strangers who exude an aura of importance. You can introduce the examiners formally by name or alternatively by function.

“These two doctors are examiners and they will be sitting in on our talk although they won’t be participating. Their job is to watch me and make sure that I do a good job!”

Obtain patient consent to interview.

“Would it be O.K. if we talk about yourself, your problems and your treatment for the next 40 minutes?”

Officially “between 35 and 40” minutes are allocated for the exam (15).

Establish patient comfort.

“Are you comfortable? Would you like a glass of water before we start?”

Elicit consensus.

“How does that sound so far?”

Non-verbal Communication

Non-verbal communication (1, 2) encompasses the amount of space between doctor and patient, the height of the doctor’s chair relative to the patient, the voice’s emotional quality, eye contact, posture, touch, and the amount of listening versus talking. This may be affected by age, gender, socio-economic status, ethnicity and education.

Doctors who pay more attention to non-verbal behavior are rated as more satisfactory by their patients. This measure was
independent of the patient’s rating of the technical quality of the care (20). In addition, reading of non-verbal behavior may be more accurate than verbal behavior (21).

Do not offer your hand to the patient if you do not feel comfortable doing so (1). Culturally, it is not common practice to shake hands with the doctor in Israeli society. Religious prohibitions against touching members of the opposite sex may be important. If the patient offers you his hand, courteously accept; simultaneously try to understand the meaning of the handshake. Is the patient desperately trying to gain approval of a harsh parent figure, for example? Are they manic? Is handshaking a reflection of their European upbringing?

Be aware of your posture. Leaning forward indicates a willingness to listen and has been associated with a greater degree of patient satisfaction (20). Try not to swing backwards on your chair, put your hands behind your head or rest your chin on your fist — it may be read as aloof body language. Avoid scratching your head or chin; instead find a comfortable position to rest your hands.

**How to start gathering information**

There are two approaches. One is to start with a few closed questions about the patient profile and the other is to launch into a series of open-ended questions immediately. Starting with specific closed questions may help to dissipate initial anxiety, establish a framework for the interview and build momentum and rapport. Closed-ended questions may be particularly indicated in patients with a psychotic illness as they are less threatening (1).

Examples of closed-ended questions that give identifying data include asking about marital status, occupation, disability benefits, psychiatric rehabilitation program, place of abode and other people living with the patient. You can ask if the patient owns the apartment or if it is a subsidized housing project, where they were born and when they immigrated to Israel. If you do not ask these questions at the start of the interview it often seems clumsy to do so at a later stage.

These opening questions are in fact more than mere demographical questions. They provide critical information that is important to know at the start of the interview. The patient may state that he is the messiah or, with guarded suspicion, may refuse to give his name, thus hinting at the diagnosis. He may say that he never married after the Germans murdered his whole family in front of his very eyes — a very significant fact to know at the start of the interview. Immigration to Israel at the age of 15 from Moscow is a very different experience compared to a young married couple and their toddler from Uzbekistan.

*Make a point of using the patient’s name.*

“How old are you, Mr. Levi?”

**b. Chief Complaint and History of the Presenting Illness (10 minutes)**

“What problem brought you to the clinic/hospital?”

Use open-ended questions. Let the patient talk freely without interruption for a few minutes. Show that you are listening with empathetic “Uh-huhs” or “That must have been a difficult period for you.” Note whether disorders of thought process are present.

What is the main complaint? When did it start? Where there any triggers? Was the patient “non-compliant” with his medications? What was the patient’s level of functioning before the present exacerbation?

Your aim is to formulate a diagnostic hypothesis. This is done by defining the problem in its depth and breadth and comparing the pattern of the presenting illness to known psychiatric templates. Templates are
in essence criteria for psychiatric disease as typified by the DSM-IV (22). For this reason it is helpful to learn core DSM-IV criteria with a differential diagnosis for each.

By the end of the “history of the presenting illness” section, one should be able to state that the probable diagnosis is X, as the patient fulfills criteria A, B and C. The remainder of the interview functions, in a sense, simply to gather more data to substantiate the initial hypotheses.

One study showed that in 69% of standard medical interviews the doctor interrupted the patient after, on average, 15 seconds (23). Therefore, be aware of the timing and nature of the second question. Make sure it is open-ended and encourages narration.

“Tell me more about your depression, Mr. Levi.”

Checking is a cognitive technique that encourages a sense of collaboration (1, 6).

“Let me check to see if I understand you correctly...” or “Let me just check to make sure we are on the same page.”

It also conveys empathy and a clear message to the patient — that his doctor values understanding his problems and emotions fully.

Survey of problems
Patients may have more than one problem or, alternatively, the presenting problem may only be a calling card that legitimizes their coming to the doctor to talk about a more sensitive issue.

“What else bothers you, Mr. Levi?”

“Apart from the depression, I am worried about headaches that I have each morning.”

“I would like to hear more about your headaches...”

Probing to completeness: Once this has been explored it is important to continue “probing to completeness” (1).

“So I understand that you’re depressed and you are worried that your headaches may be due to a tumor. What else bothers you?”

“I am worried that my wife wants to leave me because I am always so down. I have missed a lot of work...”

“You have missed work and...”

“I cannot satisfy her sexually.”

(Note a different type of response is engendered by asking, “Is there anything else that bothers you?” A closed-ended question elicits a yes or no answer.)

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“Now I understand what brought you here, Mr. Levi. Perhaps you could tell me when your psychiatric problems first started?”

Or

“...I understand that you came to the hospital because you’ve been feeling down, you have no appetite and thoughts about death keep going around in your head. Have you ever had similar episodes in the past?”

c. History of Psychiatric Illness (5 minutes)
Ask when the patient thinks the problems began, when they first saw a psychiatrist or psychologist and when were they first admitted? How long was that admission? When was the next admission? What was the
treatment between admissions? How did the patient function between admissions? Are they compliant? Inquire about side effects of medication and the effect of the illness on the family.

**Rule: Respond to the patient’s emotions immediately.**

“When my family had me admitted to the nut-house, I thought that my life had come to an end.”

“That must have been a difficult time for you.”

It is vital to respond to emotions even though the exam situation is not strictly therapeutic. Eliciting the emotions behind the words is as important a part of the history as the words themselves.

“It was, but the worst was still to come. Then this young doctor waltzed in and in front of my family announced that I am schizophrenic!”

“Even though it was 10 years ago, I see that recalling these difficult memories still makes you angry.”

**Hint:** If the patient is a vague historian and you cannot figure out what is going on, then you may have to start the interview with the history of their psychiatric illness instead of the history of presenting illness.

“I’m not sure I understand exactly what brought you to the hospital. Perhaps we could go backwards in time to when your problems first started? When was the first time that you saw a psychiatrist or psychologist?”

Alternatively, ask about medications at an earlier stage in the interview. This can then be used as an anchor point for exploring the past psychiatric history. For example, a patient receiving lithium is likely to be suffering from bipolar or schizoaffective disorder.

d. Medications, Drugs and Medical Problems (5 minutes)

List all of the prescribed medications including the patient’s last lithium, carbamazepine, valproic acid or tricyclic antidepressant serum level. Note past medication trials.

“How is your health generally speaking? Do you smoke cigarettes? What about alcohol? Have you ever used grass or speed? Ecstasy? Have you ever used IV drugs? Heroin?”

A thorough drug and alcohol history is always important. Differentiate substance abuse from dependency. The CAGE criteria (24) are useful for alcohol abuse (Ever tried to Cut down? When people tell you to cut down ever get Angry? Ever feel Guilty about your drinking? Ever start the day with an early morning Eye-opener?)

e. Family History and Personal History (10 minutes)

“How does anyone in your family suffer from a psychiatric problem?”

This section helps to gain an understanding of pre-morbid personality, Axis 2 diagnoses and the impact of the illness within the frameworks of personality and family. It identifies positive and negative outcomes such as social supports as well as stressors and socio-economic factors that may impact on the formulation and management.

Asking how a patient received their name, especially an unusual one, is rewarding, often revealing family expectations. Ask about siblings, birth, breast-feeding, milestones, and difficulties separating from the mother. Was the patient an “A” student or was he in a remedial class because of problems with hyperactivity and a decreased concentration span? Gain a sense of the patient’s social abilities — how many good friends did he have? How did he fit into team sports? Was he a youth movement member? In particular,
inquire about army service, army profile (past and current) and reserve duty. Ask about university, sexual experiences (if appropriate), marriage, children, job satisfaction and economic stability. Finally explore how the illness has disrupted the patient’s life, interpersonal relationships and work.

f. Last five to ten minutes
Finish off the examination with a series of closed questions. This is the most structured part of the exam. **Do not leave any of these questions out.** If the potential risk posed by the patient to his or herself and others was not assessed previously, then do so in this section.

Even patients with a suspected personality disorder should have their orientation checked, as personality changes may be a manifestation of an underlying illness such as herpes encephalitis. Introduce this section concisely:

“In the time remaining, I would like to ask you a few questions that check your memory and concentration.”

Orientation, Registration and recent memory — “I want you to remember three things...”; long-term memory — “When was the Six Day War?”; concentration (serial sevens), “What were the three things that I asked you to remember?”

Abstract thought — interpretation of proverbs. In the Israeli context, it may be worthwhile preparing proverbs that would be understood by, for example, an ultra-orthodox Haredi or a new immigrant.

Judgment: “What would you do if you were at the movie theater and smelled something burning?”

Insight: “Do the medications help? Should you have been admitted?”

g. The Last Question
Think about this carefully. Note this is an open-ended question. Possible examples include:

“Thank you. You have been very helpful. Before we end, is there anything else you would like to mention or think that I should know?”

Or

“Is there any aspect of the treatment that concerns you...? How did you feel about our discussion today?”

See the patient out to the door.

“Thank you again for coming here today.”

Understanding the structure and function of the interview allows you to gather relevant data that will be analyzed in the final section of this article, Part Three, where the case is presented and formulated and management plans discussed.

**PART THREE — Case Presentation and Treatment Plan**

**Case Presentation**

The examiners will allow 5 to 10 minutes to write up and organize one’s thoughts. If they do not, then politely ask for a few minutes. Write down relevant positive and negative findings in point form on small white cards. Write down formulation and differential diagnosis but do not become over-absorbed with writing out the treatment plan as this is very standardized and one should be able to talk your way through it.

An important technique to bear in mind is the narrative thread (1). This refers to the way that the illness fits into the overall timeline of the patient’s life. The most elegant presentations dramatically capture a sense of telling a story about a person and his illness, unfolding precipitously within a time frame filled with the characters that populate the patient’s life.

- Identifying details
• Presenting illness (note if involuntary admission)
• History of psychiatric illness
• Family history and personal history
• Medications and drugs
• Medical problems

Mental state examination:

Appearance: Bring the patient to life with description! Note clothes, eye contact, mannerisms, cooperativeness, psychomotor retardation or excitement, orientation in time, place and person, speech,

Affect: anxious, flattened, constricted, monotonous, labile, appropriateness,

Thought processes: loosened associations (positive formal thought disorder), alogia (negative formal thought disorder or impoverished thinking), flight of ideas, circumstantial, tangential, perseveration, goal-directed,

Thought content: What concerns the patient? Describe the patient’s self-perception, view of others and the world and his or her view of the future (the cognitive triad). Is there typical depressive or anxious ideation or evidence of delusions, suicidal or aggressive thoughts?

Perception, interpretation of proverbs and abstract thinking, concentration, memory, intelligence, judgment and insight.

Multi-Axis Formulation
There is no one correct way to present your findings, but the DSM-IV multi-axial formulation provides a neat and concise way to consider biopsychosocial interactions.

“I would like to discuss diagnostic considerations using the DSM-IV multi-axial formulation.”

AXIS 1
Work out the differential diagnoses for every major diagnosis, e.g. schizophrenia: schizophreniform, delusional disorder, drug induced, organic psychosis, and paranoid personality disorder.

“I think that Mr. Levi has schizophrenia because of the positive signs a, b, c, and the negative signs d, e, f. His illness started at least 1 year ago so ruling out schizoaffective disorder. I could not elicit a history of affective symptoms so schizoaffective disorder is unlikely. He started smoking marijuana after he developed symptoms and their bizarre quality discounts delusional disorder.”

AXIS 2
Personality disorder or mental retardation. Take care not to diagnose a personality disorder after 35 minutes! An alternative is to speak of personality traits.

AXIS 3
Medical problems

AXIS 4
Stressors, economic and social problems

AXIS 5
Current GAF (1-100), Best GAF past year

Hint: Candidates may feel pressured by an examiner who demands to know why they did not ask about a specific detail, X, in the history taking. One can explain that usually one asks about X, and recall the limitations and the pressure of the exam situation, explaining that sometimes more time is needed with patients to fully understand their complexity. One can even pre-empt the “Why didn’t you ask about...?” question by stating:

“Usually I would complete my history taking by
• Serial interviews if necessary — I am aware that a single interview is only a
Treatment Plan

The function of the treatment plan encompasses education, negotiation and motivation (1). Bear in mind the high percentage of non-adherence to medical recommendations mentioned previously. It should reflect a broad biopsychosocial approach (13).

Like the interview, the structure of the treatment plan is predictable and repetitive in nature. It too can be approached as a semi-structured construct and it can be tested empirically in practice examinations and modified accordingly.

1. **Provide a diagnosis. Educate the patient about the illness. Enlist family support:** Engage the patient within a treatment framework and establish a therapeutic relationship. Cementing a firm therapeutic bond is independent of the diagnosis, i.e., it applies equally to all patients, and has prognostic significance (25).

   The patient should first be asked how he perceives the problem before telling him the diagnosis. Providing a diagnosis (e.g., you have schizophrenia) will cause an emotional response and this needs to be addressed before going on to educate the patient about his illness in clear, non-jargonized language (1).

   A patient’s main supports are usually family. Enlist the family’s cooperation as a partner. Provide family members with verbal or written information about the illness. Explain signs of the illness, triggers and prognosis. Channels of communication with psychiatric professionals should be clear and reliable. In this context the doctor can be seen as both an expert and a teacher (2). Research shows that patients want as much information as the doctor is willing to provide. They also want to work with physicians in a collaborative manner to make health care decisions (2) rather than have decisions made for them in a paternalistic manner. This has implications for patient satisfaction, distress, sense of control and adherence to treatment (26).

2. **Where should the patient be treated?** This is the first decision to be made. Should the patient be admitted or treated as an outpatient or day patient? If there are no grounds for involuntary admission, the best strategy is to check the patient’s expectations of the treatment and his motivation for treatment. A period of observation to wash out the effects of drugs or previous medications and to gain a better understanding of the patient is an acceptable first step. All this should be negotiated with the patient, eliciting his or her cooperation as a partner.

3. **Diagnostic work-up:** An examiner may ask, “What would you do in order to exclude organic pathology?” The most important way of doing this is with a thorough history (2) and physical examination. However, a variety of investigations can be ordered based on clinical suspicion. Ordering tests blindly, without a clinical basis, statistically has a low likelihood ratio of yielding positive results. For example, ordering 5-HIAA and VMA levels routinely in panic disorder has a low probability of success (27). Table 2 lists tests one may wish to consider, after a comprehensive history and physical examination have been conducted.

4. **Medications for the chief complaint:** Decide, in conjunction with the patient, if
oral medication is appropriate or would an intra-muscular formulation be more suitable? Encourage compliance by once-daily dosing, explaining the rational for treatment and stating possible side-effects. Medication may function as a type of transitional object (25), and so a patient may be much attached to the old medication that his trustworthy doctor has been giving him for the past 20 years. Explore resistance to taking medications such as a fear of dependence on transference figures.

5. **Secondary medication strategies**: Are there any other medications that can help my patient? Will a sleeping tablet or anxiolytic help him in the initial phase of therapy? Side effects of anti-psychotics or lithium are appropriately treated with medications such as anticholinergics (e.g., biperiden), amantidine, propranolol, etc.

Check serum levels of medications as appropriate.

**Hint:** Do not rush to change the patient’s medications to the “next generation drug” in an exam situation. Rather, provide pharmacological options to the examiner in the same ways one would provide different options to a patient.

6. **Assess the patient’s family**: It is important to assess how the patient’s illness affects the family. Are there children in distress? Are there other psychiatric patients in the family? Often involvement of a social worker and other members of the multidisciplinary team are important first steps in understanding how patients function in the community.

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**Table 2: Useful investigations to consider in patients presenting with psychiatric complaints if indicated by history or physical examination (organized to maximize recall in an exam situation).**

| Blood tests — | Full blood examination, ESR, urea and electrolytes including calcium, HIV, HBV/HCV, B12/folate, TSH/T4, CPK (Neuroleptic malignant syndrome), |
| Blood tests — | Alcohol / lithium/ valporate / carbamazepine serum levels, salicylate/pareacetamol |
| specific | levels (overdose) TPHA/VDRL, copper/ceruloplasmin (Wilson’s Disease), ANA and anti-dsDNA (SLE), |
| Urine | B-HCG (pregnancy test), drug screen, 5HIAA (carcinoid), VMA (pheochromocytoma) |
| Invasive tests | LP, biopsies (e.g., brain in Creutzfeldt-Jacob disease) |
| Electrical | EEG, ECG (if over age 40), VEP/BAEP (multiple sclerosis) |
| Imaging | Chest X-ray, CT/MRI, SPECT (dementia), carotid Doppler (multi-infarct dementia) |
| Psychological tests | Dementia screen/mini-mental, Bender, Wechsler, projective tests |
7. Psychotherapy: There are a variety of psychotherapies available, e.g., supportive, insight oriented, group, cognitive, interpersonal therapies. Choice of therapy depends upon the patient’s illness, indications and contra-indications, his motivation, financial constraints and local expertise. For example, cognitive behavioral psychotherapy may be particularly indicated in the treatment of depression, panic disorder and obsessive-compulsive disorder (6).

8. Rehabilitation: Psychosocial rehabilitation may be in an inpatient or outpatient setting, and may focus on social or occupational issues. Models of rehabilitation include intensive case management (28) and assertive community treatment (29, 30). Family psycho-education (31) has a proven efficacy in relapse prevention.

9. Living arrangement: Does the patient require temporary or permanent social benefits, subsidized housing, a hostel, etc.?

10. Support groups A variety of self-help, clubhouses and consumer groups may promote independence and improved self image e.g., Enosh, AA, Elsam.

Conclusion
Research points to the value of developing interview skills through practice exams to improve performance in the live interview section of the psychiatric board examinations. These interview skills can be generalized so that psychiatrists perform better at their work — this in turn affects patient satisfaction. If the function and structure of the psychiatric interview is broken down and understood, the exam is rendered largely predictable. Through planning, practice and feedback, candidates can develop a standardized, semi-structured approach to the psychiatric interview while fine-tuning their ability to think laterally under stress. Ultimately, the psychiatric interview should be taught as part of an integrated residency training program, possibly in a “block curriculum” that facilitates group process, as emotional development enhances and refines clinical interviewing skills (17). It is unfortunate that the live patient interview is often misperceived to be arbitrary with a low reliability by candidates (32). Educators should also aim to address these distorted beliefs in their training programs as negative anticipation is frequently linked to negative behavioral outcomes.

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