THE PSYCHIATRIC INTERVIEW

A structural guide to systematic data gathering, technique, and clinical reasoning.

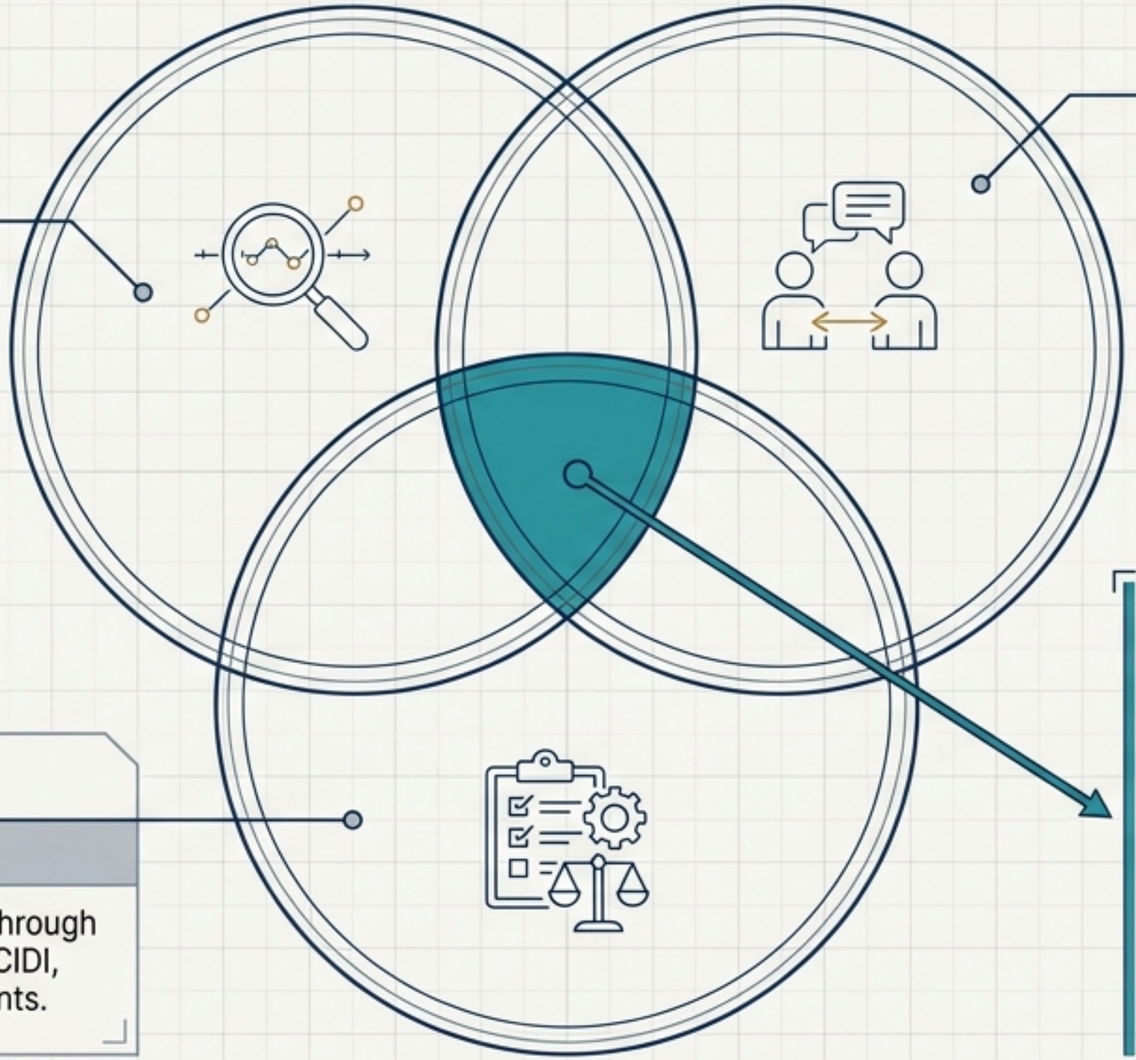
Based on The Psychiatric Interview: Structure, Technique, and Clinical Reasoning by Dr. Jerad Shoemaker (PsychoPharmRef).

Modern psychiatry requires a balancing act of three historical paradigms.

Descriptive Science

Emil Kraepelin (19th C.)

Focuses on descriptive phenomenology and longitudinal symptom observation without premature psychoanalytic interpretation. Separated dementia praecox from manic-depressive insanity.



Interpersonal Art

Harry Stack Sullivan (20th C.)

Focuses on the interpersonal theory of psychiatry. Treats the interview as a two-person interaction where the therapeutic relationship and rapport are inherently therapeutic.

Standardization

Modern Era

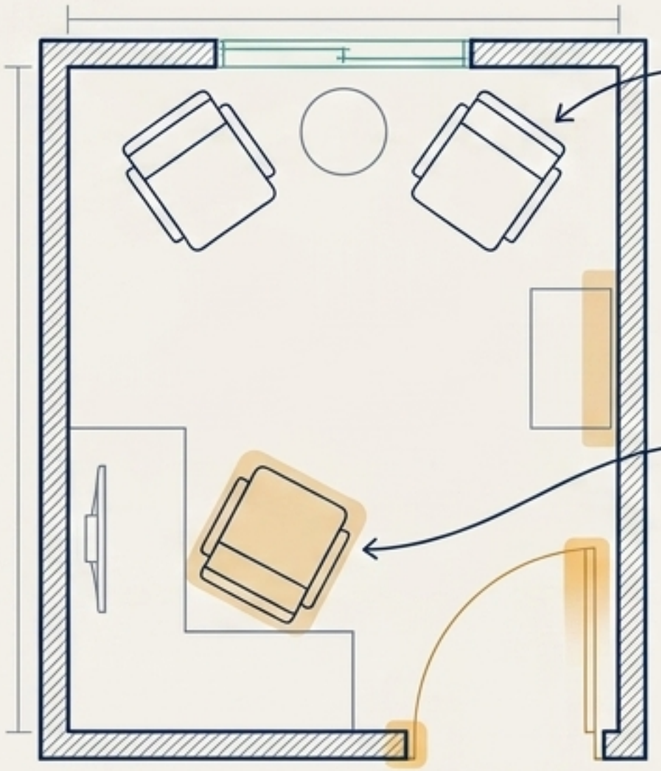
Focuses on reliability and validity through standardized assessments (SCID, CIDI, MINI) and rigid diagnostic constraints.

The Modern Interview

Blending Kraepelinian rigor, Sullivanian empathy, and **standardized** reliability within modern clinical time constraints.

Environment and open inquiry shape the crucial first five minutes.

The Space



No Barriers: Avoid desks that create clinical distance; utilize face-to-face seating.

Safety First: Ensure clear exit access for both clinician and patient; never position yourself between an agitated patient and the door.

The Timeline

0:00 - The Opening

Address stigma upfront: Psychiatry is medicine. I am only here to understand what you're experiencing.

Ask an open-ended anchor question: What brings you in today?

0:00

0:00 to 1:00

Allow 60 seconds of completely uninterrupted speech. Do not take notes. Maintain eye contact.

5:00

1:00 to 5:00

Begin gentle redirection and follow-up inquiry (e.g., When did this start?).

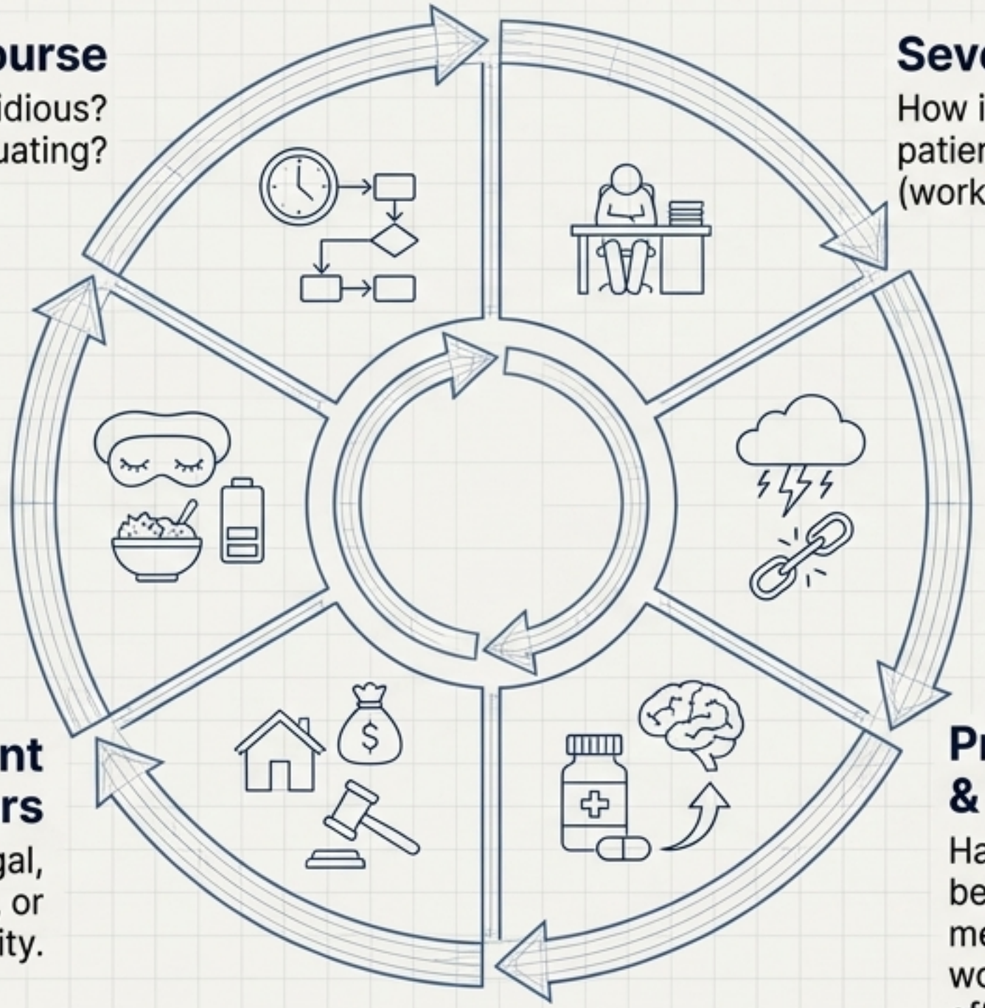
The core data structure is a systematic framework, not a straightjacket.

Important Note:
The flow of conversation will naturally overlap these topics.
The clinician's role is to gently guide the patient back to this framework, ensuring no domain is missed without resorting to rigid interrogation.

The psychiatric HPI tracks temporal and contextual narratives rather than anatomical symptoms.

Onset & Course
Sudden vs. insidious? Constant or fluctuating?

Severity
How impaired is the patient functionally (work, self-care)?



Associated Symptoms
Sleep, appetite, energy, anxiety.

Precipitants
What occurred in the weeks prior? (Loss, conflict, medical changes).

Current Stressors
Financial, legal, housing, or relationship instability.

Prior Episodes & Treatments
Have they experienced this before? Which medications/therapies worked or caused adverse effects?

Not That

Unlike a medical History of Present Illness (HPI), **do not focus heavily on symptom location, radiation, or physical quality.**

Focus on building a coherent, chronological narrative of the current illness and its context.

Medical conditions and substance use are the hidden drivers of treatment resistance.

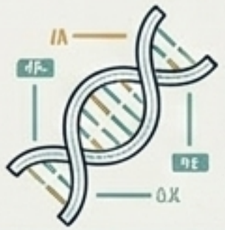
Substance Use

- **The Pitfall**: Often under-assessed due to time or clinician discomfort.
- **The Screen**: Use brief instruments like CAGE or AUDIT. Always ask about frequency, amount, route, and consequences.
- **The Approach**: Use motivational interviewing: I need to understand what you're using because it affects how medications work; I am not here to judge.

Medical Context

- **The Pitfall**: Attributing symptoms entirely to primary psychiatric illness.
- **Systemic Mimics**: Thyroid disease (causes depression/anxiety), cardiac disease (depression), neurological disorders (epilepsy, MS).
- **Iatrogenic Causes**: Beta-blockers can cause depression; steroids can trigger mania.

Context shapes vulnerability, resilience, and immediate clinical risk.



Family History

- **Genetics:** Accounts for 40–70% of psychiatric illness risk.
- **Mapping:** Track 1st-degree relatives (parents, siblings, children).

- **Predictive Value:** A relative's positive response to a specific medication often predicts the patient's response.

Social & Developmental

- **Early Adversity:** Childhood trauma has lasting neurobiological effects.

- **Function:** Track education, employment stability, and legal history (can reflect impulsivity, mania, or ADHD).

- **Support:** Relationships and housing stability predict treatment response.

Safety Assessment

- **Imperative:** This is not optional and cannot be deferred. Direct inquiry does not increase suicide risk.

- **Suicidality:** Assess frequency, intent, and access to lethal means.

- **Homicidality:** Assess intent and access to specific victims, particularly in psychosis or severe mania.

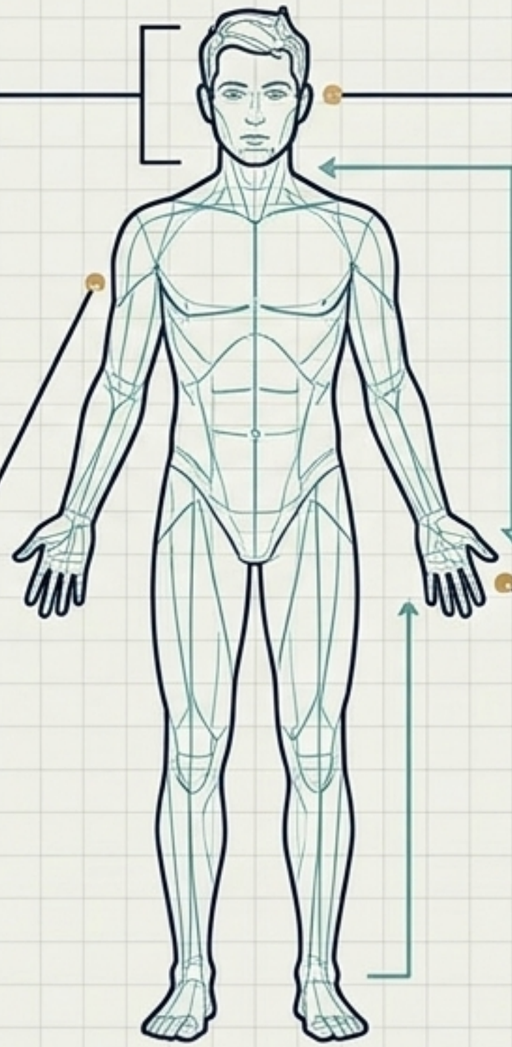
The Mental Status Exam is the psychiatric equivalent of a physical examination.

Overall Appearance

Concrete observations of grooming. Self-neglect suggests depression; flamboyant attire suggests mania; bizarre adornment suggests psychosis.

Eyes & Contact

Good contact indicates engagement. Avoidance reflects shame or depression; fixed, intense contact suggests paranoia or mania.



Speech Dynamics

Rate: Pressured (mania) vs. slowed (depression).

Latency: Delayed responses suggest depression or thought disorder.

Body & Psychomotor

Note restlessness, tremors, or tics.

Assess for catatonic features like waxy flexibility, mutism, or rigid posturing.

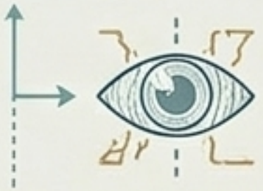
Differentiating the subjective experience from observable phenomena.

	Internal / Subjective World	External / Objective Expression
The Emotional State	**MOOD** **What the patient reports.** Document their exact words (e.g., Patient reports feeling "depressed and hopeless"). 	**AFFECT**  **What the clinician observes.** Assess Range (flat, blunted, full), Reactivity, and Congruence (does their face match their reported mood?).
The Cognitive Architecture	**THOUGHT CONTENT** **The "What" (Beliefs).** Includes delusions (fixed false beliefs), obsessions, phobias, and suicidal ideation. 	**THOUGHT PROCESS**  **The "How" (Form/Organization).** Includes tangential speech, loose associations, flight of ideas, and word salad.

Mapping perception, cognitive integrity, and clinical insight.

Perception

- **Hallucinations:** Perceptions without external stimuli (Auditory is most common in schizophrenia; Visual suggests delirium or substance intoxication).



- **Illusions:** Misinterpretation of real sensory stimuli.

Cognition

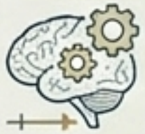
Orientation:

Person, place, time.

Attention:

Serial 7s or spelling "WORLD" backwards.

Memory:



Immediate, short-term (5 minutes), and remote recall.

Fund of Knowledge:

General information and current events.

Insight & Judgment

- **Insight:** A spectrum of awareness. Ranges from "Good" (I know I need treatment) to "None" (No awareness of illness, common in psychosis).

- **Judgment:** The ability to make reasonable, safe decisions based on reality.

Tactical adaptations for high-risk and challenging patient presentations.

The Agitated Patient

Posture:

- Ensure safe exit, maintain distance, avoid sudden movements.

Technique:

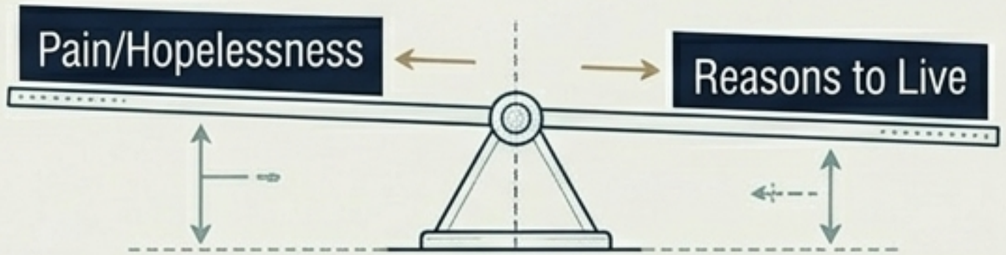
- Lower your voice, offer choices to preserve autonomy (e.g., Would you like to sit or stand?).

The Psychotic Patient

- **Posture:** Do not argue or challenge delusional beliefs directly; it alienates the patient.

- **Technique:** Validate the underlying emotion (e.g., I hear you believe they are after you. That must be frightening).

The Suicidal Patient (CAMS Framework)

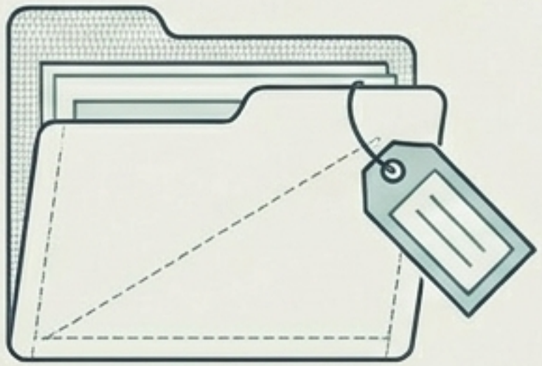


The See-Saw: Acknowledge the ambivalence—most suicidal patients have a part that wants to die and a part that wants to live.

Technique: Build a collaborative safety plan targeting the reasons to live. Do not rely on no-suicide contracts.

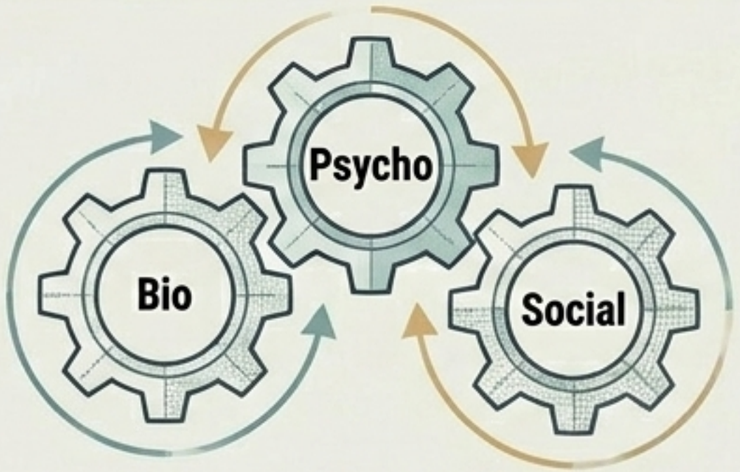
Moving from a categorical label to a synthesized, causal narrative.

Diagnosis (The "What")



- Categorical assignment based on strict criteria (e.g., DSM-5 Major Depressive Disorder).
- Crucial for medical records and billing, but lacks individual context.

Formulation (The "Why")



- An individualized understanding of why this patient, at this time, has developed this condition.
  - **Biological Gear**: Genetics, neurobiology, medical conditions, substances.
  - **Psychological Gear**: Defense mechanisms, attachment history, emotional patterns.
  - **Social Gear**: Current stressors, support systems, socioeconomic status.

The 4 P's Framework organizes a chaotic history into an actionable treatment strategy

Predisposing (Vulnerability)

Genetic loading, childhood trauma, baseline neurobiology, and personality traits that set the stage.

Precipitating (The Trigger)

Time-linked events that trigger the acute episode (e.g., grief, job loss, new substance use, medication change).

Perpetuating (The Anchor)

Factors maintaining the condition (e.g., social isolation, ongoing stress, avoidance behaviors, sleep disruption).

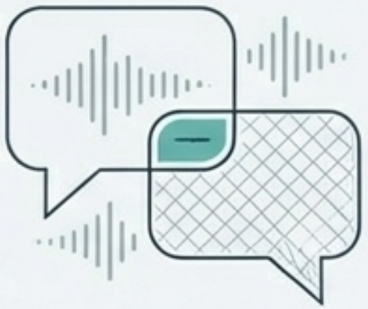
Protective (The Buffer)

Elements that promote recovery and buffer against illness (e.g., resilience, social support, faith, employment).

Unified Clinical Presentation & Tailored Treatment Plan

Translating the fluid interview into concrete psychiatric documentation.

Raw Data



The Patient's Narrative

The Process

Clinical Synthesis & Filtering

The Output

The Psychiatric Note

- **HPI:** A narrative integrating patient understanding and clinical observation.
- **Safety:** Must document specific denial or presence of intent, plan, and means.
- **MSE:** Systematic documentation of appearance, mood/affect, and cognition.
- **Assessment & Plan:** The diagnosis, formulation narrative, and concrete next steps.

The Golden Rule of Documentation: Use concrete observations, not interpretations.

Instead of: Patient is paranoid.

Write: Patient believes neighbors are monitoring him through the walls; belief is fixed despite reassurance.

Top Clinical Pitfalls in the Psychiatric Interview

Triage Matrix	✕ Not That	✓ Do This
Diagnosis	Premature closure or anchoring bias on the referral diagnosis.	Maintain a differential diagnosis; actively seek disconfirming evidence throughout the interview.
Substances	Skipping or underestimating substance use due to time or discomfort.	Ask directly every time; use CAGE/AUDIT screens as routine medical necessity.
Documentation	Vague MSE entries or confusing subjective mood with objective affect.	Quote the patient's reported mood directly; use concrete language to describe their observed physical affect.
Assessment	Over-relying on screening tools (GAD-7, PHQ-9) to diagnose.	Use screeners strictly as adjuncts to prompt deeper clinical inquiry, not as replacements for the interview.