

## **Student Interview Seminars: Guideline for Facilitators**

To maximize the value students receive from the interview seminars during the 3rd year psychiatry clerkship, we've put together these guidelines for instructors. We hope they'll promote a more uniform experience for students who rotate through different settings.

### **New for this year:**

**1. The first session will be attended by all of the students. The instructor may model an interview (especially at the beginning of the year) but it is preferable that the student(s) do the interview and all participate in the discussion.**

**2. After Week #1 each session will be attended by 1-2 students (different students each week but all should have attended session #1 – the days are pre-assigned to the students). The students should each have a patient prepared for the session and each student should do an interview and receive feedback. The students requested the smaller sessions to decrease anxiety that arises when interviewing in front of a large group.**

**Note: any student who did the interview during week #1 should still do an interview during their assigned small group session – it is an opportunity for even more practice and feedback!**

**3. Each student should have the attending fill out a written interview feedback form – the forms are handed out at orientation and available on Sakai to the students. The forms need to be turned in at the end of the rotation.**

1. Each student should have the opportunity to do a 30-40 minute initial interview of a psychiatric patient he/she does not already know. [This may mean, on some days, doing two patient interviews.] Note that the students have had an opportunity on their first day on service to witness and discuss a model initial interview done by a staff member or senior resident.

2. The first day, the facilitator might have to obtain a patient (from nursing personnel, who tend to be extremely helpful). Subsequently, at the end of each session, remind the students that *they* need to obtain a patient for the next week's session. Of course, to give a good initial interview experience, the patient should be someone the student interviewer has not worked with closely (usually, a patient from the other team). Responsibility for obtaining the patient could be assigned individually or by teams. Usually, the students themselves will work it out just fine.

3. In nearly every instance, the student should be allowed to complete the interview without interruption. At the end, and with the patient's acquiescence, encourage other students to ask questions they may have, after which the first student may have thought of additional questions. Finally, of course, the facilitator may wish to ask questions.

4. In no case should there be any discussion while the patient is still present. This can be confusing for the patient, potentially setting up issues that may complicate further treatment. The patient is participating as a volunteer, and should be treated as an honored guest, a willing participant in an exercise that is solely for the benefit of our teaching program.

5. Following the interview, after the patient has left the room, the student interviewer should be given a chance to state his/her impressions of the interview session. Especially solicit views on how comfortable the student felt in the role of interviewer, feelings of rapport, and any problems responding to what the patient says.

6. Go around the table, asking each student to evaluate his/her colleague's performance. Mostly, these comments will be something on the order of, "That was a really great job." Encourage each student to offer a constructive criticism. Most students will have real difficulty offering meaningful criticism of one another. It can help for instructors to praise meaningful criticism with something on the order of, "*That was a perceptive comment, Geraldine. Can you expand on that thought just a little?*" Or, "*How might you have phrased it, instead?*" It might also help to begin the first session by acknowledging how hard it is to criticize our colleagues, but point out that it all feeds the educational aspect of the exercise. You can also choose a topic from the outline (page 3) as a springboard for discussion.

7. After each student has had the opportunity to offer an opinion, instructors should do the same. Of course, it's always a good strategy to start with praise for parts well done. Use the page 3 facets of interviewing technique as a guide, offering suggestions for improvement.

8. Criticism can be tempered with statements such as: "All interviews are imperfect to one degree or another." "It will take dozens of interviews before you begin to achieve proficiency." "Every interviewer, even one as experienced as am I, forgets something."

9. Because psychiatry is where students must learn about the mental status evaluation, it might be helpful to ask each student to present just the MSE for his/her patient. It could help drill into the students the parts of the MSE—what's obtained by observation alone, what requires questioning, and to learn to determine when *experienced interviewers* can ignore certain aspects.

10. The focus of the discussion should be largely on the interview and interviewing techniques. During the last few minutes of the session, if questions pertaining to the interview itself have been pretty well exhausted, it will be OK to discuss the patient's diagnosis. However, many of these patients are well-known to at least some of the students, who will have heard (and participated in) discussions of diagnosis previously. Therefore, diagnosis is a *far* less-important topic for discussion in these seminars than is the interview itself. Interviewing technique is the main teaching goal of this seminar, its *raison d'être*.

11. For subsequent interview sessions, some instructors start by referring to the previous session, asking if there are questions. Others ask about what's happened to the patient from the previous week. All good.

12. It might stimulate interest to emphasize in the first meeting that interviewing pertains to every patient in every specialty—except, perhaps, pathology. Skills learned here should carry over to all areas of clinical medicine.

## **An outline of discussion topics pertaining to the initial interview**

How well did the interviewer:

Thank the patient for agreeing to be interviewed?

Address patient's comfort and dignity by using title and last name, maintaining appropriate physical distance (varies with situation)?

Elicit the chief complaint with a directive, but open-ended question?

Allow the patient time for "free speech" (to understand the breadth of patient's issues and learn something of the patient's flow of thought)?

Strive for rapport with body language, eye contact, appropriate encouragements?

For economy of time, use non-verbal encouragements (head nods, smiles)?

Use language appropriate to patient's age, education, and culture?

Provide honest reassurance when indicated?

Avoid talking excessively: State questions simply and in the fewest words possible?

Elicit patient's current feelings with open-ended questions?

Balance open- and closed-ended questions, increasing the latter in later stages of interview?

Consistent with rapport, maintain control of the interview throughout?

Was there any opportunity to deal with resistance? Did the student manage to maintain rapport?

Deal with sensitive questions (drug use, illegal activities, sex)?

When changing topics, use a bridge that was logical and graceful?

Acknowledge transitions that are more abrupt— "Now let's change gears and..."?

Avoid double questions and leading questions?

Limit "why" questions to patient's own experience ("Why did you leave your wife?")?

Cover each of the basic parts of the interview:

Chief complaint

Present illness: symptoms, prior treatment, consequences of illness (social, job, legal), suicide ideas/behavior

Past medical history

Psychiatric ROS: mood, anxiety disorders; psychosis; substance use; somatization screen (when appropriate); suicide behaviors; risk factors for AIDS; head trauma, loss of consciousness

Personal and social history:

Childhood, family constellation, school (last grade, academic and disciplinary issues)

Adult life: marital history, children, work history, military, legal problems, religion, current living situation, leisure activities, use of substances

Family history: relationship with relatives, occurrence of mental disorder

Mental status exam

Observational aspects: appearance and behavior, mood/affect, flow of thought

Aspects obtained by questioning: Content of thought, cognition, insight and judgment