THE CLINICAL INTERVIEW AND ASSESSMENT: GENERAL CONSIDERATIONS

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Abstract

The biopsychosocial model encompasses biological, social and psychological processes with the aim of offering a more holistic therapeutic approach. Good communication skills are vital for its application; they help to enhance the patient-physician relationship and can improve health outcomes. The clinical interview is a valuable diagnostic and therapeutic tool, but interviewing techniques are some of the most difficult skills to master and implement. The therapeutic alliance forged during the clinical encounter lays the foundations for ongoing patient care and education. The interview is usually the main source of information, but it is not the only one. Assessment scales, if used wisely, can strengthen the therapeutic alliance and promote treatment adherence. However, when psychological assessment tools are employed, care must be taken to avoid labelling patients with a mental health disorder. Professionals should avoid judgemental language and behaviour at all times.

Introduction

Dermatologists commonly see patients with underlying mental health problems and should therefore be correctly trained and prepared to manage and treat them. Patients often present comorbid symptoms that include depression, anxiety and social phobia. Some patients may even be at risk of suicidal ideation. Given these conditions, it is clear that carefully considered and effective mental health support should be provided whenever possible.

Some conditions are chronic, and in some cases they are kept secret by the sufferer (for example, Body Dysmorphic Disorder), as a consequence, they are frequently under-diagnosed. Some individuals are high-risk patients and early detection and treatment can be vital. When the dermatologist sees high-risk patients, they should be taken care of them until they are ready to be referred to a mental health professional or be treated by a qualified psychodermatologist (1).

Metaphorically speaking, the skin is a window through which physical and...
psychological problems and processes can be viewed; in order to understand the psychological consequences of cutaneous illness and to implement an effective treatment programme, the dermatologist must take a holistic approach that addresses the reciprocity of body and mind (2).

The interview: preliminary considerations

Basic preparation is essential: be familiar with the personal details of the patient before they come for the first consultation. Make eye contact, shake hands and introduce yourself. Put the patient at ease and ask open-ended questions. Listen attentively and encourage them to ask questions. Remember that empathy is a key component for developing good relationships.

Do not forget that patients may have suffered stressful emotional experiences which can lead to recurrent and intrusive negative thoughts and perceptions. Evidence suggests that when a traumatic or stressful experience is not emotionally resolved, there might be residual problems that manifest themselves in a variety of symptoms (3).

a. Communication skills

Communication is an indispensable clinical skill that has significant influence on treatment outcomes such as patient satisfaction, compliance and adherence to treatment (4).

Research has demonstrated that communication is central to the work of the physician: good communication improves the patient’s comprehension of their illness, reduces pain and physical symptoms, increases adherence to treatment and results in greater health care satisfaction (5).

The clinician must gain an understanding of the patient’s attitude to their illness. Patient concerns can range widely; patient values, culture and preferences need to be explored, whilst gender is another factor that should be taken into consideration. A judgmental demeanour must be avoided, as this will rapidly damage the lines of communication. The simple act of talking about the problem and discussing feelings and worries in a safe environment can be of enormous therapeutic benefit (6).

b. The patient

Patients are not simple recipients of care or subjects for research. Assume that they are active, informed individuals who wish to know more about their conditions and exert greater control over their treatment. The fundamental interaction in health care is the patient-physician dynamic.

Healing relationships can include friends, family members, patient advocates and other health care professionals. Physicians should acknowledge the roles of these individuals and integrate them into the treatment process.

The patient’s concerns about skin complaints need to be evaluated in a wider context, assessing potential interference in daily life. The evaluation should result in a list of treatment goals (1).

i. The “difficult” patient

Patients identified by dermatologists as ‘difficult’ are habitually those that are suffering psychiatric comorbidity. Approximately one in four patients seen by dermatologists are classified as ‘difficult’ (7). ‘Difficult’ is a label, an evaluation, a way of describing the patient during the consultation. People with severe personality disorders can provoke this response. With such patients, it is common for the therapists to emotionally distance themselves from the individual and their experience; difficult patients can challenge assumptions about identity (8).

There are cases that can induce feelings of aversion, anger, fear, guilt, frustration or anxiety in the health professional. Patient-doctor interactions are influenced by the expectations of both parties. A key to the treatment of ‘difficult’ patients is the drafting of a clear treatment plan and strictly enforcing compliance with that plan.

Research has been conducted into the identification of the common characteristics and problems of ‘difficult’ patients although pertinent cofactors in the domain of the care providers, the treatment and the treatment team have, so far, been underrepresented. It is the patients who are usually held accountable for evoking strong counter transference reactions or the stagnation of their treatment process (9).

ii. The delusional patient

Generally speaking, a physician who is empathetic and nonjudgmental should not find it difficult to develop relationships with delusional patients. It is important to remember that that skin problems are often a means for attracting and receiving medical attention without having to confront the possibility of a severe psychological problem (10).

The following techniques are recommended for use with delusional patients (11):
- Do not start by discussing the possibility of a psychiatric problem and the need to be seen by a mental health professional.
- Listen attentively and non-critically to the patient’s account and perform a thorough dermatological examination.
- If necessary, use several patient consultations on completely somatic issues before raising the possibility of a mental health problem.
- When the question of treatment is brought up, assure the patient that the goal is relief of symptoms.
- If patients continue to believe in a specific delusion, do not confront them; this will reinforce the delusion and may result in agitated and hostile behaviour.
- Remember that several consultations may be necessary to prepare the patient for psychiatric referral.

iii. Patient referral

Referral should be considered if the patient has a mental health problem that would benefit
from either medication or more intense therapy. However, a relationship of trust and confidence must be established before the dermatologist can recommend the patient to a mental health professional. When this occurs, it is important for the dermatologist to stay in contact with the patient and offer further consultations so that the patient does not feel abandoned. During these visits, the patient can talk about the experience with the mental health therapist and the dermatologist can offer support (12).

Patients may resent and even refuse a referral. Some will either abandon treatment or try ‘doctor shopping’. Some may fear the social stigma associated with psychiatric care and others may not be able to afford it. For patients who refuse to be referred to a psychiatrist, a pharmacological approach may be the most feasible option (11).

c. Types of interviews

Interviewing is one of the most difficult clinical skills to master. The demands made on the physician are both intellectual and emotional. Interviewing is often considered part of the ‘art’, in contrast to the ‘science’, of medicine. An empathic, patient-centred interview can bolster the patient’s sense of self-esteem and lessen the feelings of helplessness that often accompany an episode of illness. The therapeutic alliance forged during the clinical encounter can lay the foundations for ongoing patient care and education.

i. The patient-centred interview

In the patient-centred interview, the patient is encouraged to take the conversational lead, initiating discussion in the areas of their experience and expertise: symptoms, worries, preferences, and values. This type of interview operationalizes the biopsychosocial model and is associated with numerous positive outcomes for both patients and physicians (13).

Data gathering for diagnosis and treatment almost exclusively consists of eliciting information on symptoms, biomedical history and diagnostic tests. However, a full analysis of health or illness requires the additional consideration of the social and psychological dimensions of human existence. This necessitates the ability to ascertain personal or psychosocial data from patients, competent interviewing techniques and relationship-building capacities that nurture confidence and human understanding. The practical application of these skills is known as patient-centred interviewing (13).

ii. The motivational interview

This patient-centred approach has generated great interest in health care contexts: the main focus being the facilitation of behavioural change. An empathetic style is crucial and the underlying attitude must be one of acceptance. Patients are encouraged to contemplate their current state of happiness and to speculate on their future levels of satisfaction if they alter their behaviour in comparison with making no lifestyle changes (14).

One of the objectives of motivational interviewing is to identify and mobilise the patient’s intrinsic values and goals in order to stimulate behavioural change. The motivation for change is drawn from within the patient and not imposed from without. The patient’s belief in their ability to undertake and achieve specific goals must be reinforced. Motivational interviewing can therefore be seen as both a set of techniques and a therapeutic style (15).

iii. The psychosomatic interview

Whilst the medical interview generally focuses on illness and a diagnosis, the psychosomatic interview is a broader, patient-centred assessment that explores the unique elements of each patient from biomedical, psychological and sociocultural perspectives. The psychosomatic interview aims at more than the attachment of a diagnostic label; it attempts to correlate various factors within multiple domains. The patient’s level of interest and participation in the treatment process is also evaluated. The empathic alliance is neither paternalistic nor authoritarian; it seeks to be a partnership than can offer effective disease management. Through the utilisation of open-ended questions, observation of nonverbal behaviour and deliberation of illness perspectives, dimensions, behaviours and life stories, the clinician is able to form a more complete picture of the patient (16).

The clinical interview

The clinical interview does not simply comprise the task of collecting background information on the patient; it is the process of identifying the illness and understanding how the individual has been affected by it. Interviews can make up a large part, if not all, of a treatment process. Attention must be paid to the general behaviour of the patient, the content of the explanation and the manner in which the explanation is delivered.

d. Taking a history

In the first consultation, the objectives are: i) to understand the patient’s problem; and ii) to obtain information on how they cope with their condition. Take a psychomatically-oriented history. Try to draw out the patient’s explanations and beliefs regarding the disease and ask about subjective experiences; help to express the emotions associated with the illness. The physicians’ role is to accept the patient’s story, including the somatic and non-somatic problems. Sympathy for the patient’s suffering (even if it is exaggerated or without foundation) must be shown (17). Demonstrate empathy and give the patient complete attention: they should feel sure that they are being listened to. In some cases, the setting of limits is recommended as the patient may have
unrealistic expectations of the medical treatment and/or the physician.

The dermatological, medical and subjacent mental health conditions must be diagnosed. The patient should be given a biopsychosocial model of the condition with information on the problem and the influence of the psychosocial factors. Coping and self-management strategies should be fostered wherever possible (17).

Take a detailed history of the skin complaint so that the patient understands that their problem is not only thought of as a mental health disorder. This can be done in more than one consultation. It is important to have developed a good therapeutic alliance before a patient is referred to a mental health professional, and, in these cases, it is very important for the dermatologist to continue to see the patient to avoid feelings of abandonment (12).

i. Observation

Carefully observe patient behaviour during the consultation: pay attention to nonverbal communication, take note of how they are dressed, if they are accompanied, who talks first, etc. Record these observations in the patient's history; this information will be helpful in gaining a deeper understanding of the case (18).

Remember that first impressions count. Patients decide if they are going to feel comfortable with the doctor in a question of minutes, the decision is not based on what the doctor says, but how they say it and how they interact.

ii. The genogram

The genogram can prove useful for gathering data on the patient's family history. Patients construct their family tree by being asked to talk about family members, relationships, and significant life events such as deaths, births, illnesses, etc. The genogram can help to identify and understand patterns in the patient's family history that may be influencing their current functioning. A wealth of practical information can be garnered through the use of this technique (18).

iii. Attachment styles

The doctor-patient relationship can sometimes reproduce the type of attachment that patients developed with their parents as children. Patients who experienced a secure attachment consult the doctor with a feeling of trust and are usually positive after the visit. These people are normally self-confident about their ability to recover. An anxious/avoidant attachment may signify a lack of awareness of their condition as a consequence of over-regulation. Patients with an anxious/resistant attachment are often demanding, evidencing complaints or disorders that are impossible to treat. Finally, a disorganized/disoriented attachment can result in incongruous behaviour, emotional reactions and exaggerated responses to treatment (19).

e. Emotional responses

Affect is the visible and audible manifestation of the patient's emotional response to external and internal events – thoughts, ideas, memories, and recollections. It is expressed in autonomic response, posture, facial and reactive movements, appearance, tone of voice, vocalization and word selection (20).

Many physicians find dealing with patients' emotions more difficult than treating the symptoms of disease. As a result, when patients express an emotion, some physicians may unconsciously avoid these feelings by interrupting or changing the subject, others may preclude emotional expression by aggressively controlling the interview from the outset. Reasons for avoidance are deep-seated and may entail fears of causing the patient harm or losing control of the interview and their own emotions (13).

Alexithymic patients demonstrate deficiencies in emotional awareness and communication and show little insight into their feelings, symptoms, and motivation. Alexithymia is a deficit, inability, or emotional processing failure; it is not a defensive process. Alexithymia sufferers have difficulties in identifying and expressing their feelings. Patience, a good therapeutic alliance and a combination of open-ended and closed questions are necessary to engender emotion-laden communication (17).

Many individuals reveal emotional distress through their skin and a wide variety of personal and family problems may be reflected in a dermatological condition (11).

Repressed emotions are counterproductive to healing. Some people are better at writing than verbally expressing their emotions. The benefits of writing as an instrument of emotional healing have been well documented; therefore this therapeutic option can be considered with some patients (21).

It should also be born in mind that some patients use their 'medical condition' as part of their strategy for dealing with life. They come to the clinician not for a 'cure' but for support and the bona fide status of 'being under doctor's orders' and care. The removal of this emotional prop will see its swift replacement by another.

Illness can be a social condition for some people as it induces a caring response and admiration from peers; in these cases, medical attention is sought for confirmation, not for treatment, diagnosis is an end in itself. Doctors who believe that they are able to achieve great changes with these individuals will probably be disappointed. Once identified, the same senior staff should see these patients regularly, but not frequently.

Psychosocial assessment and psychometric evaluation

Symptom checklists, general health questionnaires, quality of life scales, as well as mental health screening and assessment tools can be used to complement the clinical interview.
However, prior to their use, the following questions should be considered:
- In what way is the information obtained from these self-report questionnaires going to prove helpful or improve the attention and treatment offered to the patient?
- Are the chosen tools user-friendly, as well as easy to correct and interpret?
- What information will be given to the patient prior to the completion of the tests? In other words, how are we going to justify their use?
- What type of feedback is the patient going to receive after the evaluation? Mental health issues need to be dealt delicately and professionally, care must be taken to avoid pejorative diagnoses.

Most of the information obtained from a psychometric evaluation can be asked directly during the interview. However, tests - if used wisely - can prove useful, valuable information can be ascertained in a short time frame, for example, screening for mood disorders; measurement of treatment outcomes; assessment of the impact of the disease on the patient; questions on delicate or sensitive issues.

While structured interviews are still considered to be the standard methodology for the classification of mental health problems, it must be remembered that individuals with dermatological problems often deny or hide their mental health symptoms. In such situations it may be easier for patients to acknowledge symptoms by means of self-rating scales than in a personal interview (1).

Screening tests used routinely in the clinic can save time in detecting difficulties that can be discussed in greater depth at a later date. For example, if a patient screens positively for anxiety or depression symptoms, further questioning can help determine the possibility of a referral or other treatment options, depending on the level of suffering and willingness to accept help.

f. Data collection
An assessment of the various aspects of the life of a person with skin-inflicted lesions involves consideration of a number of dimensions of their experience, using multiple sources of information and types of analyses. A complete assessment should include comprehensive interviews, psychological tests and behavioural observations.

It should always be remembered that people come from diverse backgrounds and have different personal resources and characteristics; these unique traits influence attitudes toward illness. Illness changes our sense of self and identity. In a society that places value on achievement and self-reliance, those that suffer illnesses can also suffer feelings of inadequacy. In most cases, patients will only talk about their feelings if the doctor shows empathy, understanding, and acceptance.

Several studies have examined associations with traumatic events in childhood, particularly in cases of borderline personality disorder. These studies have reported a high number of traumatic experiences during childhood, particularly sexual and physical abuse (22). Successful psychological assessment and treatment typically involves a strong patient-therapist alliance. Unfortunately, victims of traumas such as child abuse, rape, torture, or partner violence may interpret any relationship with an authority figure as potentially dangerous (23). The health professional should always show compassion and respond with empathy. If possible, put the experiences into perspective and instil feelings of hope.

Some common psychopathologies underlying dermatological disorders are anxiety, depression, delusion, and obsession-compulsion. For example, poor self-confidence and obsessive traits may be risk factors for self-excoriative behaviours in patients with facial acne vulgaris.

In some cases, patients can be asked to keep a record of certain behaviours, for example: the frequency and the intensity of the problematic behaviour (mirror checking, self-excoriating, picking, cutting, etc.); the distress caused by or associated with the problem; the degree to which the problem interrupts or prevents more preferable activities; the extent to which the problem disturbs satisfactory personal relationships. This valuable information can motivate patients to set realistic treatment goals with the help of the health professional.

g. The use of mental health assessment tools
As already mentioned, the use of assessment tools should be clearly explained to the patients. Instruments, such as quality of life questionnaires or screening scales for anxiety and depression symptoms are used on a regular basis by some clinicians. If they are used for research, signed informed consent is obligatory. Patients should also be offered feedback on the results. With children and adolescents, parents should be kept informed at every stage of the assessment and treatment.

All assessment instruments employed must have suitable psychometric properties, such as reliability and validity. Tests should be translated, culturally adapted, and standardised (24).

Ideally, the instrument should be simple and quick to implement. The instructions must be adhered to and if there is doubt with regards to interpretation, expert opinion should be sought (24).

When offering feedback on psychological assessment, adopt an optimistic approach towards the patient and in addition to explaining the difficulties, try to highlight and emphasise the positive aspects.

Final considerations
Enduring psychological characteristics associated with self-harm include hopelessness and poor problem-solving abilities. Repeated self-harm is also associated with difficulties of emotional and
behavioural control. Self-harmers typically suffer low self-esteem, lack confidence, feel inadequate and are socially withdrawn. They may present disorganized and confused thinking, unstable and inappropriate emotions, bizarre behaviour and impaired judgement. Subjective feelings of irritability or anger are also common. These patients are usually emotionally fragile and must be treated with warmth and respect (25).

Having a positive outlook and being optimistic appear to benefit the process of adjusting to illness. The importance of a health care professional who is willing to listen and show respect for the needs and wishes of the person cannot be understated. The perception that the patient is working together with the health care professional seems to facilitate the process of adapting to the illness.

Problems in the interview often result from the patient’s reactions to illness and the medical consultation. Most people experience anxiety when they are ill and have to see a doctor, some harbour feelings of anger or helplessness. Responses vary in accordance with the severity of illness, past experiences, personality, stress and support. The patient who appears reticent to talk may need emotional support. Active, non-judgmental listening demonstrates the physician’s interest and concern and encourages the patient to talk.

If psychological assessment tools are used, care must be taken to avoid labelling patients with a mental health disorder. Positive aspects and personal skills should be emphasised and coping strategies reinforced.

Psychological tests alone cannot determine a diagnosis, but they can reveal important information about many aspects of a person: self-image, self-esteem, motivation, values, relationships etc. Before implementing a test, the clinician needs to advise the patient on its purpose and the type of information it provides.

The process of learning to manage illness can be overwhelming; the support and understanding of family and friends has a significant influence on the response. The condition is more manageable when the sufferer knows that they are supported and understood by significant others.

Health problems cause worry and distress. The stressfulness of an illness depends on the patient’s perception of that illness. People react and cope in different ways, but given time, most develop adaptive methods to confront the challenges of their conditions.

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