The Challenging Interview: A Basic Approach
October 4, 2002

Objectives
- Describe a basic process for identifying and addressing barriers to a successful interview.
- Describe and identify common barriers encountered in a clinical interview.
- Describe an approach to addressing these specific barriers
- Observe/Demonstrate interviews with standardized patients illustrating these problems.

“GET RIAEEL” : 6 steps to identification and resolution of barriers
- Recognize that barrier exists.
- Identify barrier.
- Acknowledge barrier.
- Explore barrier.
- Empathetically respond to patient’s feelings/beliefs.
- Legitimize patient’s emotional response.

Recognizing the barrier.
- Barriers to an effective interview include anything that can block effective communication, thus preventing fulfillment of the three purposes of the medical interview:
  - Acquisition of data.
  - Development of a therapeutic relationship.
  - Management of the patient’s problem(s).
- Barriers may be obvious (explicit), or not obvious on the surface of the interaction (implicit).
- The root cause and the resolution of both explicit or implicit barriers may be unclear initially

Possible Indirect Signs that a Barrier Exists
- Verbal-nonverbal mismatch - What the person says and what a person is feeling (as evidenced by nonverbal communication) are in conflict.
- Cognitive dissonance - The interviewer finds that the pieces of the story don’t “add up.”
- Unexpected resistance - The patient responds in an unanticipated, and unusual, manner to typical interviewing techniques and empathic statements.
- Physician discomfort - Presence of unexpected feelings on the part of the physician. May emanate from the physician’s own conscious or unconscious reaction to the
patient, but may also be a response to nonverbal communication of the patient’s emotional state.

- Noncompliance/treatment not working/exacerbation of chronic disease - These problems may arise from communication difficulties in the treatment phase of the interview, or they may arise from difficulties in the doctor-patient relationship, incomplete knowledge of the patient’s beliefs, values, etc.
- The patient has a label, or you have a strong desire to label the patient (e.g., “crock”).

A taxonomy of barriers
- Process problems
  - Technical impairments (uncomfortable environment, lack of privacy, etc)
  - Organic impairments (hearing impairment, dementia)
  - Language barrier
- Style impairments
  - Reticence – patient seems reluctant to provide information
  - Rambling – patient provides too much information, in manner that is often tangential and poorly organized
  - Vagueness – patient seems unable to describe illness and its effects in a precise, accurate manner
- Topical problems – issues that pose discomfort to patient or physician
  - Sexuality
  - Substance use
  - Positive review of symptoms
- Maladaptive patient interactive styles
  - Orderly, controlling
  - Dramatic
  - Long-suffering, masochistic
  - Guarded, paranoid
  - Superior
- Difficult emotions
  - Anger
  - Anxiety
  - Depression
- Somatization – commonly encountered problem in medicine. Patients who “somaticize” express emotional or psychosocial distress as physical symptoms.
- Patient’s and physician’s feeling about each other

Identifying the barrier
- Analyze the data: What do you know about the patient, their problem, their response, the interaction between you and the patient, and your response?
- If the problem is obvious, go on to next step (Acknowledge), if not -
- Generate hypothesis:
  - Is this problem arising from the patient, the interviewer, or the interaction?
– What sort of person is this patient? What problems (medical, emotional, psychological, social, spiritual) does this person have that might contribute to the problem encountered in the interview?

• Test hypotheses during the patient interview.
  – Explicitly: Share it with the patient (especially if the problem results from the patient or the interaction)

• Open exploration of a problem, if unable to identify a hypothesis.
  – Enlists patient’s aid in identifying potential barriers to the problem. Requires physician to share his/her perception that barrier exists, and asks for patient to help to identify and solve the problem.
    -- Brainstorm with patient – generate list of possible barriers.

• What if the problem belongs to you?
  – Must be careful at explicitly sharing this information with the patient. Dependent on nature of problem, and the doctor-patient relationship. Would it help to strengthen the doctor-patient relationship? If not, should not be shared.

The next steps - resolving the barrier

• Don’t forget basics -
  – open-ended questions, allow time for patient to respond, appropriate use of silence, summary, etc.
  – accept and respect patient’s feelings and coping style.

• Acknowledgement - open acknowledgement of barrier by the interviewer. Often accomplished during hypothesis testing. Should be stated as an observation – “you seem very upset.”

• Exploration - exploration of emotions/circumstances surrounding barrier. Are there any obvious causes of the problem? Some barriers are the result of either a patient’s or physician’s psychic conflict, and may be manifest by defense mechanisms such as projection.

• Empathy - interviewer attempts to share patient’s feelings, and communicate his/her understanding of patient’s feelings.

• Legitimation - validation of the patient’s emotional response or reaction as a reasonable one given the patient’s circumstances.

• Responding to strong emotions with empathy and legitimization is a very useful strategy to help build rapport and achieve a successful interview

• You may encounter situations where there are many barriers, or barriers that seem complex and are difficult to identify and overcome. Sometimes exploration of barriers with patients may be very painful or threatening - so much so, in fact, that the barriers should not be completely addressed, or addressed in stages, to minimize trauma to the patient. Exploring the patient’s willingness and readiness to work through barriers is important in these situations. Additionally, the physician/student must also be ready and capable of working through a barrier with a patient before plunging ahead. If the physician/student is not ready or capable of doing this, referring the patient to another
provider is a good strategy. It is important to do this in a way that assures the patient that they are not being abandoned.

Some specific examples of challenging interviews:

**The Rambling Man (or Woman)**
- Potential causes: Conversational style, anxiety, loneliness, histrionic personality style, thought disorder, particular beliefs regarding relationship of symptoms and events.
- Solutions:
  - Direct patient to the task at hand - be polite, yet firm.
  - Make patient aware of time limits.
  - Help patient to prioritize problems/complaints.
  - Acknowledge your confusion.
  - Use summary statements.

**The Quiet One**
- Causes: Personality, anxiety, depression, dementia, denial, and cultural distance from physician.
- Solutions:
  - Guide patient without using leading questions.
  - Try different types of open-ended questions, rephrasing of questions.
  - Use of menu or laundry list type questions.

**The Angry Patient**
- Causes: Patient’s situation, treatment by other health care providers (or you), poor communication, reaction to illness, depression.
- Solutions:
  - Recognize and acknowledge anger.
  - Accept patient’s anger, remain neutral. Acknowledge your role, if necessary.
  - Explore contributing factors and identify underlying feelings.
  - Be empathetic, and legitimate patient’s feelings.
  - Discuss ways patient can deal with anger-provoking situations.

**“I Don’t Want to Talk to a Medical Student”**
- Causes: Uncertainty about medical student’s role; previous poor experience with medical student; desire to speak with his/her doctor; fatigue; pain; emotional distress; need for control.
- Solutions:
  - Recognize and acknowledge patient’s feelings.
  - Explore reasons for patient’s response.
  - Empathize and legitimate patient’s response.
  - Clarify your role, and address patient’s concerns.
  - Negotiate a solution.
<table>
<thead>
<tr>
<th>BARRIER</th>
<th>ADJUSTMENT EXAMPLES</th>
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<tbody>
<tr>
<td>Environmental</td>
<td>Ensure that the room is safe, comfortable, and private. Allow appropriate distance-closeness, maintain eye contact, keep at similar height. Keep to a minimum while interviewing.</td>
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<td>Room access, privacy, noise, cleanliness</td>
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<td>Body position</td>
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<td>Note taking</td>
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<td>Physical</td>
<td>Start interviews by asking how the patient is feeling right then; acknowledge and try to relieve discomfort; note and explore nonverbal expressions of discomfort.</td>
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<td>Pain or other discomfort</td>
<td>Identify the source of fatigue and consider limiting the visit. Identify and acknowledge early in the interview, and make specific adjustments to ensure effective communication and comfort.</td>
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<td>Fatigue</td>
<td>Carefully define through the interview, the mental status examination, or psychophysiologic testing, or a combination. Acknowledge and explore the accompanying frustration.</td>
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<td>Sensory deficit (deafness, blindness)</td>
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<td>Organic brain problems in processing, recalling, or expressing thoughts and feelings</td>
<td>Provide emotional support, including acknowledgement, exploration, legitimation, and empathy.</td>
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<tr>
<td>Psychological</td>
<td>Recognization, Acknowledgement, Exploration, Empathy, Legitimation</td>
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<td>Emotions</td>
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<td>Anger</td>
<td>Separate people from problem; Clarify the conflict; Brainstorm about possible solution; Focus on common interests, not positions; Use objective criteria when possible; Invent new solutions where both physician and patient gain</td>
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<td>Sadness (helpless, hopeless)</td>
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<td>Anxiety</td>
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<td>Fear</td>
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<td>Shame</td>
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<td>Attraction</td>
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<td>Euphoria</td>
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<td>Deprivation (sleep, sex, love, support)</td>
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<td>Cognitive and interpersonal</td>
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<td>Denial</td>
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<td>Prioritization of several intermixed problems &amp; feelings</td>
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<td>Dependency</td>
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<td>Responsibility or blame</td>
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<td>Uncertainty</td>
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<td>Lack of personal attention</td>
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<td>Personality style</td>
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<td>Mental disorder</td>
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<td>Sociocultural</td>
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<td>Other people involved</td>
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<td>Family</td>
<td>Adjust physician style to the patient’s personality++</td>
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<td>Appointment not self-made</td>
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<td>Translators, facilitators</td>
<td>Keep alert to possible co-existence of mental and physical disorders, to the unusual way psychotic patients may present physical symptoms, and to the high background prevalence of anxiety, depression, and alcoholism</td>
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<td>Insurance companies, HMOs</td>
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<td>Legal processes, disability determinations</td>
<td>Protect the patient’s privacy and confidentiality; obtain patient’s permission and assess the overall effect on the individual patient.</td>
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Conflicted physician roles
Personal physician as opposed to gatekeeper
Investor in tests, hospitals, forms of reimbursement
Physician’s own value judgments
Physician self-care as opposed to patient care

Ensure that the other physician roles do not interfere with the primary role as personal physician and patient advocate.

Physicians must take better care of themselves.

Socioeconomic
Rich or poor
Form of payment
Health insurance
Language
Technical terms
Translators
Labeling

Make reimbursement issues clear and explicit. Balance personal economic issues with societal obligations.

Avoid technical terms, check understanding and meaning of any diagnostic labels, and establish a shared language and understanding. Diagnostic labeling can resolve or create barriers.

Dress
Physician
Patient
Disrobing
Stigmatizing problems
All diseases to some extent, especially the acquired immunodeficiency syndrome, mental illness, and cancer
Disfiguring illness

Recognize that physician attire influences initial patient response. Power differences and vulnerability are exaggerated when patients are undressed.

Acknowledge, explore, and empathize with the feelings Of shame, worthlessness, and hopelessness often Associated with stigmatizing illnesses.

Openly explore when problematic.

General doctor-patient differences
Age
Sex
Race and culture
Education
Experience
Cultural differences
Beliefs about health and illness
Attitudes toward risk and uncertainty
Rituals, roots, superstition
Religion
Ethnicity
Transactional conflict
Problem-label
Goal-expectation
Method of diagnosis or treatment
Conditions of treatment
Doctor-patient relationship

Explore and understand these differences in order to Establish meaningful physician learning and a strong Physician-patient relationship.

Once properly diagnosed, try the negotiation strategies Noted above (Separate people from problem; etc…)

+For example, the adjustment for a deaf person might be to speak loudly and slowly, clearly enunciating to facilitate lip reading, or perhaps to use a translator if basic adjustments are inadequate.

++For example, allowing a patient with a Type A personality to exert more control on the treatment process than other patients who are more comfortable with dependency.

References

Coulehan, JL, Block MR. The Medical Interview: Mastering Skills for Clinical Practice, 4th edition.

Cohen-Cole, SA. The Medical Interview: The Three-Function Approach
