

INTERVIEWING FOR ACUITY and the ACUTE PRECIPITANT

Jon Berlin, MD

MILWAUKEE COUNTY CRISIS SERVICE
MEDICAL COLLEGE OF WISCONSIN
10/30/08

References

Berlin J, Gudeman, J. *Chapter 10: Interviewing for acuity and the acute precipitant.*

(In: Glick, Berlin, Fishkind and Zeller, eds. *Emergency Psychiatry: Principles and Practice.* Lippincott Williams & Wilkins, 2008; 10: 93-106).

Disclosure & Background

- › No pharma industry ties
- › Medical Director of PCS since 1997
- › 120,000 visits

Questions

- › Other than eliciting risk factors, what is the role of the clinical interview in assessing risk?
- › Studies have not demonstrated its independent value, yet no one is willing to dispense with it.

Questions

- › Why is it that PES/ED patients who argue hardest for admission generally don't need it and those who argue hardest against admission generally do need it?
- › Why is that these patients have such a difficult time with the History of Present Illness and identifying an acute precipitant?

Questions

- › Why is the mental status exam regarding suicidal ideation with these patients typically so unreliable?
- › Why is it so hard to get a true estimate of their clinical acuity?

Questions about technique

- › Are there reasons for this resistance to genuineness and engagement with the interviewer?
- › Are there interview concepts and techniques that make it easier to draw these patients out?

Question

- › Why are the verbal associations of these patients often so devoid of metaphorical meaning common in psychotherapy patients? (Posed by Robert Langs MD)

Type of interview developed

- › Probing
- › Sensitive
- › Time-efficient

Stabilization 1st as needed

- › Medical conditions
- › Acute agitation, other extreme states

Sequence of discussion

1. Build rapport (pt comfort, safety, requests)
2. Explore Axis IV & V:
("Why now?" & "How bad?")
3. Clarify Axis I & II

Ms A: Exaggerating distress

- › Multiple PES visits
- › "I'm suicidal, and they don't know my diagnosis. I'm on an ED. You have to admit me."
- › "No reason why I'm feeling worse tonight."

Types of resistance

- › Discussion of diagnosis, past history, relationship with interviewer (transference as resistance), other components of psychiatric assessment
- › Prevalence of action language and extreme defenses, such as suicidal and parasuicidal behavior, substance abuse, aggressive acts, loss or reality testing

Reasons for resistance

- › Pain of the acute precipitant
- › Distrust
- › Discounting value of talking

Positive outcomes

- › More valid report of suicidal ideation
- › Improved History of Present Illness
- › Acute precipitant unveiled

Crisis Resolution

- › Acknowledging painful feelings
- › Accepting help in tolerating them
- › Promoting autonomy

Transform clinician-pt rel.

- › From adversaries to collaborators
- › Toward a therapeutic alliance

Risk management

- › Acute precipitant not severe
- › Increased ability to handle the precipitant
- › History of overestimated suicide risk
- › Good response to interview, suggesting outpatient therapy is a viable option

Mr D: Minimizing distress

- › “Fine” after medical hospitalization for overdose
- › Caused by a fluke alcohol relapse
- › Many reasons to live

Interviewing for acuity and the acute precipitant

- › S. Shea: “Behavioral incident”
- › Defenses and resistance against basic elements of psychiatric interview: HPI and MSE
- › Re-conceptualizing the chief complaint

4 elements of the “precipitant complex”

1. Acute precipitant, plus
2. Pre-existing diathesis or vulnerability
3. Leads to unbearable feeling state
4. Maladaptive response of conduct, thinking, and/or subjective distress

Similar outcome:

- › More valid mental status of crisis
- › Transform relationship
- › Mr D collaborates with risk management

Triage vs treatment

- › Ms A: slightly longer interview progressed to treatment model
- › Mr D: enhanced triage model

Allen MH. Definitive treatment in the psychiatric emergency service. *Psychiatr Q.* 1996;67(3): 247-262.

Countertransference (with minimizing individual)

- › Subliminal sensing of poignant or volatile feelings beneath the surface
- › Colluding with avoidance and naive hope
- › Acting out role of poorly attuned and ineffective parent

Countertransference (with exaggerating individual)

- › Negative emotions can be generated quickly
- › Feelings of being manipulated and trapped
- › Rush to end interview prematurely
- › Awareness of personal reactions gives insight into reactions of others in patient's life

False vs. more real self

- › In both cases, patient creates a false self to escape examination
- › Leaves examiner with a familiar but foggy sense of not connecting
- › Must respect defensive function of lack of authenticity while trying to overcome it

Mr Z: stabilizing before exploring

- › "I need hospitalization to get restarted on my meds"
- › Overtly calm

Outcome

- › Often, we are trying to avoid false positives in people seeking admission
- › With Mr Z, avoided false negative in someone asking for admission

Evaluator reenactments

- › Like performing surgery without anesthetic
- › Mr Z may have experienced the prodding and deferral of his request for hospitalization reenactment of goading and criticism
- › Need to stabilize before exploring

When no acute precipitant is found

- › With individuals who need admission: *"It's helpful to figure out what your triggers are and how to handle them better before returning home."*
- › With individuals who want hospitalization but don't seem to need it: *"I don't feel that I'm getting the whole story from you."*

No precipitant (cont'd)

- › May document "acute precipitant deferred" on Axis IV to encourage ongoing investigation regardless of level of care.
- › Acute precipitant may not always exist; biological factors may dominate.
- › But it is a tender and guarded psychic entity and not likely to be discovered if not pursued actively.