12 Mistakes That Will Sink Your Oral Boards and How To Avoid Them!

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Preface

I wrote this book in order to introduce you to my approach on interview strategies and tactics. The concepts covered here are expanded upon and supplemented with further valuable information –such as techniques to control your performance anxiety—in the Beat the Boards! Psychiatry Oral Board Preparation course.

Whether or not you decide you need the further direction and skill-building that the course provides, I hope you find this book a useful addition to your exam preparation. I wish you much success. Feel free to call us toll-free at 877-225-8384 if we can be of further assistance.

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Introduction

Oral Board Exam Mistakes Fall into Twelve Categories

In this book I present the 12 types of mistakes that can trip you up when taking your psychiatry oral board exam. You will notice that some of the categories of weak approaches relate to the patient interview, some to the presentation to the examiners, and others to the vignette exam. In my experience as an educator I've witnessed thousands of psychiatric interviews and presentations by psychiatrists, psychiatric residents and medical students. Over the years, I've observed tens of thousands of errors and shortcomings committed.

Now if that meant that you as an oral board candidate were likely to commit dozens of mistakes out of a pool of thousands of potential errors, then your job of preparing for the oral boards would be daunting, verging on the overwhelming. It would also mean that I probably would not be very effective in helping you ace your oral board exam. Neither one of us would be able to track such a large number of errors, let alone have the wherewithal to be able to fix them.

But the good news is that there aren't hundreds or thousands of possible mistakes one can make. What struck me when observing all those psychiatric interviews and presentations was that all the various errors could be distilled down to just several major categories. I have even better news for you: If you make mistakes at all, they tend to primarily fall into only one or at most two of these categories. If I'm right, you should be able to recognize yourself in the mistake categories I outline.

During our Beat The Boards! Oral Board Prep Course when I present my assessment of a candidate's performance and show how even multiple interview or presentation weaknesses were simply several instances of a single category of mistake, it gives the candidate a great sense of relief. It turns a task that may have seemed daunting in its complexity and turns it into one of fixing just one or two of types of error!

Each Chapter Describes a Candidate Profile

Each of the first eight chapters in this book presents a profile of exam candidates who make a certain type of interview error. The next three chapters have as their focus profiles of errors in case presentations and the last chapter focuses on the Vignette exam section.

The type of mistake you make tends to repeat itself in various guises throughout the interview and presentation. As a corollary, you probably do not make many of the other mistakes because that is "just not you." In each chapter I explain specifically what makes interviews and presentations ineffective and label problematic styles to help you characterize and correct your errors. Once you understand the nature of your mistake(s), you can make the adjustments necessary to resolve it.

My Own Experience with the Oral Board Exam

I know I can see myself in two of the profiles. I tend to be an interview Perfectionist, trying to nail down every important detail. I am a thorough and compassionate interviewer when given the

45-60 minute diagnostic interview that is most congenial to me. Yet with the time constraints of a board-style interview, I fall apart. When practicing for my board exam I saw how my attention to detail –an otherwise admirable quality– derailed me. I was only "half way home" when time was up. I adjusted my approach and then committed the error of a "Scientist with his Specimen." When I saw in interview after interview that I was consistently running out of time, I just speeded things up. I didn't let the patient or the patient's negative reactions deter me from my appointed task of extracting information from them. I ran roughshod over my rapport with the patient. In the middle of one mock interview the patient actually said to me, "You ask questions like a machine gun." Do you think I adjusted my approach during the rest of this interview? No, I didn't. I was so desperate to complete the interview in my predetermined way that the patient's blunt and accurate statement made no impact on my behavior.

My interview anxiety made it difficult for me to remain flexible in my thinking and my behavior. I just bulldozed forward. Anxiety made my attention as narrow as if I were looking through a paper-towel tube. I once missed a patient's rather dramatic degree of tremor and stiffness because of my single-minded attention to my next question. Anxiety can narrow a person's focus and make it impossible to improvise. And yet the human interaction inherent in the oral board examination makes flexibility a must.

How To Use This Book

I recommend reading the entire book in the order it is written. First, because you do not know which profile best describes your interview and presentation style and you need to become familiar with all of them. Second, "Interview Rules" and "Presentation Rules" are interspersed throughout the text of each chapter. These rules may be useful to you even if you do not otherwise fit the profile under review. Third, I think it is helpful to understand the other types of errors that an interviewer and presenter can make in order to prevent you from "overcorrecting" and falling into another counterproductive profile. (As in my own sorry experience of trying to correct my original mistake by producing another one.)

Once you recognize which profile seems most like you, you can then focus on that chapter. The main points of each chapter are gathered into a summary page at the end of each chapter.

My Apologies

Let me preface the rest of the book with a small disclaimer. The candidate profiles I describe are examples of less than graceful performances. I don't really think that you act in the way presented; I am exaggerating in order to make my points. I give each mistake profile a name that is dramatic in order to act as a mnemonic device. And the names mostly have negative connotations. They are the names of failing approaches, after all. I hope that you can look past the caricatures and see how you might be making the same errors in less egregious ways.

The Sketch Artist

Being a Sketch Artist is the most common mistake committed by the oral board candidates who attend a Beat The Boards! course, accounting for about half of the inadequate examinations I've observed. The Sketch Artist tends to cover the requisite areas of assessment, but fails to fill in sufficient detail. While a half-hour interview will not permit gathering complete detail in every area of assessment, the Sketch Artist is satisfied with substantially too little information in areas of crucial interest.

Interview Rule: Get Sufficient Detail

A recent candidate interviewed a patient who stated he had "schizoaffective disorder." The interviewer asked a couple of depression screening questions, which the patient answered by stating in different ways that he had felt "down." The interviewer moved onto another subject. Later in the interview the patient mentioned that he had experienced manic episodes in his life. The interviewer nodded his understanding and queried for presence of psychotic symptoms, which the patient denied having.

The problem was that the interviewer did not obtain sufficient detail regarding the psychiatric symptoms. His questions did not touch upon the degree, duration, and variability of the patient's depressed mood, which was the patient's presenting problem, let alone query for the presence of any other depressive symptoms. Also, he did not assess for any history of manic symptoms even though the patient mentioned having manic episodes in the past. Further, the interviewer did not assertively query for psychotic symptoms. Given the fact that the patient stated he had been diagnosed with "schizoaffective disorder," a thorough and assertive assessment of the psychotic syndrome was warranted.

Additionally, the interviewer did not distinguish between past and present symptoms. Remember that even if you thoroughly assess the past, the NOW still needs to be explored. Assessing the patient's current mental status will permit you to make a judgment regarding the patient's current risk of suicide, homicide, or self-neglect and the adequacy of the current treatment regimen. I realize that asking these additional questions takes precious time in a short interview. However, this interviewer maintained a leisurely pace and insufficiently controlled the interview. He did have the time to have learned substantially more than he did. And besides, the syndromes related to the chief complaint should be assessed with the highest level of detail.

Interview Rule: "Trust but Verify"

The above patient stated that he had been diagnosed with Schizoaffective Disorder. The candidate seemed to accept the stated diagnosis without attempting to ascertain the nature of the symptoms. He was too trusting and did too little verifying. The motto of every psychiatrist should be "Trust But Verify." You must query the symptoms of the disorder under review in order to substantiate the diagnosis. The problem of accepting a diagnostic label the patient offers is a special case of the more general problem of obtaining too little detail.

Why is verification of the diagnosis important? First, because the board examiners need to see that you are a safe physician. It would be poor practice to base your entire treatment on the word of a patient who may have misunderstood his diagnosis or who may have received multiple

diagnoses over time while telling you of only one. As the present clinician – and for the purposes of the board exam, you are regarded as the present clinician – the "buck stops with you." Your thorough assessment may uncover a previous misdiagnosis allowing you to correct the possibly suboptimal treatment stemming from the misdiagnosis.

Second, obtaining details of the nature and degree of symptoms and dysfunction is important in more ways than just establishing diagnosis. These types of details can help guide treatment planning. For example, it is important to know when suicide risk is highest. Is it only during depressive episodes? Or does it increase also during manic episodes? You may be wrongly sanguine regarding suicide risk during mania, believing it is a time of unalloyed euphoria. Mania, even a typically euphoric one, still may have periods of despair leading to suicide attempts and other dangerous behavior. Knowing whether or not the patient had episodes of suicidal symptoms during mania can be ascertained only by asking.

Inconsistencies

Let us return to the mock exam I described above. The patient had stated that he had been diagnosed with Schizoaffective Disorder. The candidate proceeded to assess psychosis by asking if the patient heard voices, saw things that weren't there, felt paranoid, or thought the TV was talking about him. The patient answered "no" to this string of four questions. You may think that the candidate's screening for auditory and visual hallucinations and persecutory and referential delusions resulted in an adequate assessment. After all, the psychiatrist had little time due to the shortness of the interview. How in depth can you really get in a half-hour interview?

In my opinion these four questions may be adequate in assessing some patients, but with this particular patient they were not sufficient. Why? This patient stated that he had been diagnosed with Schizoaffective Disorder, which, if correct, necessitates longstanding psychotic symptoms of one type or another. Therefore, if the patient denied having these psychotic experiences, either in the past or presently, we have an inconsistency. (Note that many inconsistencies turn out on further assessment to be only apparent.)

This does not mean that the patient was 1) lying or 2) didn't know what he was talking about. These are two hypotheses explaining the inconsistency, but they are not the only possible or perhaps even the most likely ones. All that can be surmised at this point is that the history of illness is inconsistent with the patient's report of his diagnosis. The interviewer needs to clarify the source of the inconsistency. (Note that only inconsistencies that may substantially affect your diagnosis or treatment plan need to be pursued. Let other ones go. Remember that you have the option of pointing them out in the presentation to the examiners if you think they shed light on the patient in some way.)

Interview Rule: Hypothesize Possible Sources of an Inconsistency

The inconsistency of the patient's report of carrying a diagnosis of Schizoaffective Disorder and at the same time denying the psychosis screening questions may have several explanations. But a candidate must first recognize the inconsistency. This candidate acted as if he had no awareness that an inconsistency had occurred and proceeded to other areas of questioning. My suspicion was borne out during the question and answer session with me as mock-examiner when the candidate did not discuss or even mention the presence of the inconsistency.

A good interviewer must at all times be developing hypotheses of the sources of an important inconsistency in order to follow up with further questions that attempt to confirm or refute each hypothesis. This candidate, because of his lack of awareness of the inconsistency, was not in a position to do so.

What are the possible reasons for the inconsistency as described above? Let me list three to give you an idea of what I mean.

- Hypothesis 1: The patient had psychotic symptoms but other than the four symptoms that were assessed.
- Hypothesis 2: The patient had a history of the very symptoms queried but his understanding of them was different from the interviewer's phrasing of them.
- Hypothesis 3: The patient had no insight and believed he never had psychotic symptoms when in reality they had been present.

How can you proceed to confirm or refute these hypotheses? After all, you only can ask questions of the patient. You cannot read his mind. You do not have access to his medical records, his doctors, or his collateral sources. The solution, therefore, is to be as effective as you can be in your questioning. You can 1) query related symptoms that were not queried, 2) query these same symptoms but differently and 3) assess the patient's insight by pointing out the inconsistency to the patient, admitting to your confusion, and asking for clarification.

I would start out with the easiest approach, which is to query all the common psychotic symptoms. Query all first rank delusions. This was not done in this case. Also, attend to the presence of a formal thought disorder and disorganized behavior in order to rule out, at least in the present, these forms of psychosis. Remember that psychosis subsumes more than just hallucination and delusions.

If the patient continues to deny a history of the additional symptoms that you query, you can return to reassess the original four symptoms. They are, after all, the most common of the psychotic symptoms. It is not unusual for hallucinating patients to deny they are hallucinating. They may endorse hallucinations, but only if queried in a way that is consistent with their understanding of the hallucinatory experience. For instance, the patient may believe he is receiving telepathic messages rather than experiencing hallucinations. To address this possibility you can ask the patient if he receives telepathic messages, picks up radio waves or hears people whispering about him rather than simply asking him if he hears voices.

If upon more broad and in-depth questioning the patient continues to deny the presence of any psychotic symptoms occurring in either in the past or the present then the patient should be challenged to clarify. However, it is bad form to challenge a patient if the fault lies with the interviewer. That's why it is good to query for all common psychotic symptoms and to re-query the most common ones, such as auditory hallucinations and persecutory or referential delusions, in various ways. Note that by "challenge" I do not mean that I recommend badgering the patient. Challenging can and should be done respectfully, that is, with an attitude that shows that you care enough about the patient to actually try to understand the patient's life story and are unwilling to accept gaps or inconsistencies in his or her history.

Interview Rule: Nail the Chief Complaint / Presenting Problem

Is the level of questioning I suggested for psychotic symptoms necessary? I firmly believe it is with this patient because establishing the differential diagnosis is the very heart of the interview. If the patient states he has Schizoaffective Disorder, then it's likely that it or a related disorder is indeed the most likely disorder. However, it's hard to present a convincing formulation, problem list and treatment plan when the basis for your working diagnosis remains sketchy.

Candidate Self-Assessment

The Sketch Artist often concludes the interview with a self-satisfied air. He generously and ostentatiously bids the patient farewell and good luck. He sits down heavily as if after a rich meal, ready to savor his after-dinner drink as soon as he disposes of the trifle of his presentation to the examiners.

What Really Happens

After the Sketch Artist's swift and confident start, the examiners begin interrupting him, asking for clarification and further detail on numerous points. For some candidates the dawning realization of the inadequacy of their interview, with its lack of detail, begins at this point. Other Sketch Artists never recognize their interviews were inadequate. They may leave feeling pretty confident of passing the exam. Still others may realize that the interaction with the examiners did not go well and that they may not pass the exam, but they feel that this outcome will occur through no fault of their own. They are convinced that they had the misfortune of getting teamed up with some stick-in-the-mud examiners who badgered them for an inordinate amount of detail. "Some people are just so anal," they think self-righteously on the trip home.

Corrective Action

If you are a Sketch Artist you can strengthen your patient interview, first, by being conscious of the need to obtain more detail. If the patient presents you with a diagnosis it is OK to use it as a strong lead but you do need to verify the syndrome. Remember: "Trust but Verify."

I think I can hear your aggrieved voice asking, "But who has the time to get all this detail and follow up on some fool dang inconsistencies?" (If you don't use the term "fool dang," then I apologize for my faulty imagined hearing.) In my experience many Sketch Artists are not pressed for time. Some candidates even end the interview early. Others ask the patient with five minutes to go, "Is there anything else you want to tell me before we end?" Of course the patient doesn't have anything else to tell you. It's your job to know what questions to ask. The patient-interviewees who participate in the oral board exam are not really your patients. They know it. They know that if they tell you more you will not be able to help them anyway. They are being paid to answer your questions. Who wouldn't want to get off work five minutes early? I have never had a patient-interviewee in a mock exam say "yes" and give a useful piece of information. Asking this question is signaling, "I have nothing else left to ask and I'm just filling up time to camouflage this fact." That's not a good thing.

Not all Sketch Artists run out of time early. Some keep asking questions until time runs out and still they end up short of the minimum information they need in order to have conducted a satisfactory interview. For some candidates the problem lies in the inefficient way they ask questions. Their questions may be hesitant, drawn out, unclear, or have other vices. Substantial

time can be lost by inefficient questions. The good news for those of you with this problem is that if a substantial amount of time is being squandered, then a substantial amount of time can be saved with the right techniques. Ask questions clearly and efficiently. Ask them one at a time, avoiding "series questions" which are confusing to many patients and can lead to invalid responses.

Second, you cannot accept inconsistencies in the history or presentation that can substantially affect your diagnosis or treatment plan without making an effort to clarify. Even if you run out of time before you have uncovered the source of the inconsistency, at least you will have shown the examiners that you are aware of the problem and have given it your best effort. Later when presenting the case to the examiners you can describe the inconsistency, your efforts to clarify its nature and source, the importance of obtaining clarification in developing a treatment plan, and what more you could have done if you had had more time. The worst thing you can do is to ignore a potentially important inconsistency. You might as well have a sign on your forehead flashing to the examiners, "I am oblivious."

Summary: The Sketch Artist

The Sketch Artist is satisfied with 1) substantially too little information and/or 2) inconsistencies in the information obtained.

Suggestions for the Sketch Artist:

- Remember always assess the NOW, the current level of symptoms and dysfunction.
- If the patient states his or her diagnosis, "Trust but Verify." Use the stated diagnosis as a lead, but assess as fully as you would otherwise.
- Do not accept inconsistencies in the patient's history that can alter your diagnosis or treatment.
- It is especially important to adequately follow up on the chief complaint or presenting problem.
- Hypothesize the source of an important inconsistency, then proceed to confirm or refute each hypothesis.
- If you can, get an independent opinion of your practice performances. Sketch Artists often have an overly positive self-assessment of their performance.
- Never stop the interview early.
- Get more detail!

The Gullible Candidate

The task of this chapter is to point out the most common and dangerous areas of gullibility. The Gullible Candidate may accept the patient's self-assessment in crucial areas of information and be blind-sided by an examiner who questions the validity of the patient's self-report and of the candidate's assessment based on that report. Note that the problem of gullibility manifests both during the interview and the question-and-answer session with the examiners. (FYI: I failed my oral board exam due to my gullibility.)

The Human Tendency to Minimize Unpleasant Events

Humans have a tendency to minimize many types of unpleasant events. These may be experiences that the patient has lived through or thoughts and feelings that he is having. If the patient has committed violent acts or had violent thoughts, whether towards self or others, he may be motivated to maintain a more benign self-image that is congruent with his expectations and self-definitions.

Even violent predatory criminals often self-justify their actions. Their violence is in response to provocations, in their minds. Or recurrently suicidal patients may see themselves as being more stable than they currently are. I have also seen this tendency in patients who have lived through a psychotic episode. When their stable mental state is re-established, they may minimize the extent of the psychosis. Perhaps this tendency relates to the forgetting of events occurring during a period of prominent dysfunction with associated impairments in memory and insight. Or perhaps, it is a psychological defense against a full realization of the trauma of having temporarily "lost one's mind" and of the possibility that it may happen again.

Interview Rule: Do Not Accept Minimizing Self- Reports

The oral board patients you interview and those you observe on videotape will have various levels of risk. You may have a patient who is currently hospitalized on an inpatient psychiatric unit. If so, the patient is probably there in order to minimize one of these three types of risk of harm: violence towards self, violence towards others, or an inability to care for self. After all, if the patient were not at substantial risk, she would probably be managed on an outpatient basis. In the United States we no longer frequently use psychiatric admissions as respites for family or to expedite diagnostic work-ups.

So hint, hint. If you have a hospitalized patient you need to do the following. During the interview, ascertain the type of risk the patient displayed that precipitated the current hospitalization.

So how do you spot an underreporting? Use your knowledge of the role of hospitalization in psychiatry today. If the patient tells you that she took "a couple of extra pills" because she had "real bad anxiety and just wanted to fall asleep," or had "a real bad headache and nothing else was working," you should be wondering why such benign or reasonable actions led the psychiatric team to hospitalize her. In fact, a good technique is to do such wondering aloud, "You said you were hospitalized for taking a couple of extra pills. So why did your doctor ask you to get hospitalized?" Pay attention to the patient's insight into her behavior and her handling

of the inconsistency between her benign report and the fact that she is now spending time on a psychiatric unit.

Interview Rule: Beware of Self-Reports That Involve Misunderstandings Or Over-reactions

Beware of patients' explanations for the reasons for a current hospitalization that involve misunderstandings or over-reactions on the part of family or treatment team members. Here are some examples.

- "My wife saw an empty bottle and thought I took all of the pills. But there were only 3 or 4 pills in there to start with. She called the doctor and made it sound worse than it was."
- "They thought I said I was going to kill myself, but that's not what I said. I said that if my pain didn't stop then I might do something. I meant like in a couple of years or something like that."
- "My doctor doesn't know me well and over-reacted. I've been getting into fights since I was in second grade. What's the big deal? He probably grew up in the suburbs."
- "My therapist is new to the field. She looks like she's right out of college. You look like you would have a mature understanding of people, but she's a kid. My previous therapist would never have hospitalized me."
- "When I said that the government wanted to kill me, I was speaking theoretically. I mean, the FBI killed all those people at Waco. You have to be a child to think that the government never does this sort of thing. But it's not like I think they're planning on going after me."

Why are these small areas of information so crucial that by mishandling them probably hundreds of psychiatrists have failed their exams? (My board exam patient's response was similar to the first example above.) The reason is that if a certain type of risk was great enough to land the patient in the hospital it must, first, be addressed and resolved before the patient can be judged ready for discharge and, second, it must be guarded against during future episodes of decompensation.

Thus, an inaccurate assessment of this "small area" may lead you to recommend the patient's premature release from the hospital and the application of outpatient protective measures that may be inadequate. Either way, the patient may get into harm's way. And we all know that mishandling an aspect of our assessment that may lead to the patient's demise will lead to our resolute failure.

Summary: The Gullible Candidate

The points to remember include:

- Patients are likely to minimize painful or uncomfortable events, thoughts and feelings.
- You cannot accept the patient's self-report at face value. Rather, assess it based on your understanding of the likelihood of minimization and of how psychiatric treatment works, that is, patients who are not at high risk are usually not hospitalized. Clearly, a clinician believed that the hospitalized patient you are interviewing was at high risk.
- Beware of answers that involve misunderstandings, over-reactions, or naïve clinicians. The report may be true, but it may be grossly distorted.

- The Present, The Past, The Future is a helpful mnemonic of the structure of your risk assessment.
- The future is available for assessment. Ask yourself, What scenarios is the patient likely to face in the near future that will place her at renewed risk? And what is her insight into how these scenarios renew her risk? And how capable is she in avoiding them?

The Perfectionist

The Perfectionist is on the opposite end of the spectrum from the Sketch Artist. Where the Sketch Artist accepts inadequate detail across multiple information areas and asks few follow-up questions, the Perfectionist obtains an overabundance of detail. Due to the time constraints of the board interview, however, the Perfectionist is able to cover only a few informational areas in detail while leaving others untouched. Since an open-ended interview this is not an option on the board exam, the Perfectionist often runs out of time.

Interview Rule: Be Good Enough, Not Perfect

I observed one psychiatrist with a perfectionistic streak who spent nearly twenty minutes obtaining the History of Present Illness. This candidate was interviewing a patient with a likely Schizoaffective Disorder, Bipolar type. Unlike the Sketch Artist, this doctor methodically queried depressive symptoms, then manic symptoms, and followed with a detailed evaluation of psychotic symptoms. She then obtained detailed information regarding substance use. She made strong efforts to understand the time relationships among the syndromes.

A detailed assessment, although unassailable in its approach under normal clinical circumstances, sometimes just takes longer than you can afford to give to it on the board exam. Most egregiously, in the above example, the interviewer did not assess the social history due to lack of time. Information regarding the patient's living situation, the parameters of his support systems, and his daily routine was not obtained. Why is this information so important? The short answer is that you'll fail your exam if you don't obtain it. The slightly longer answer is that you can not develop and institute an individualized treatment plan without it.

Interview Rule: Maintain Balance Across Bio-Psycho-Social Information

As you're all probably aware by now, a successful candidate needs to delineate problems and develop interventions in each of the Bio-Psycho-Social spheres. These are wide swaths of information to cover and there are several ways of falling short.

Some Perfectionists may see themselves as "diagnosticians" who are expert in nailing the diagnosis. They may remember with pride all the patients they've treated who had failed previous treatment with other clinicians. These patients responded to the Perfectionists' treatment because they, as Perfectionists, were able to correct a previous misdiagnosis. (Perhaps one made by a Sketch Artist.)

Some Perfectionists' attention to detail extends only to obtaining information needed to establish a DSM diagnosis on Axes I through III. Many important informational areas that are not assessed in the DSM-IV multiaxial system are nonetheless important in development of an individualized treatment plan.

Interview Rule: Know When to Let Go Emotionally

There's an important issue that Perfectionists struggle with that I've been skirting around and now wish to confront head on. A Perfectionist often feels a strong emotional pull to fill in every last detail. Many people, and probably a high percentage of physicians, have an unsatisfied or

even anxious feeling when informational details remain unassessed and unknown. Given the constraints of the 30-minute interview, there is not enough time to fill this emotional need.

If you are a Perfectionist I recommend that you look inward and assess the emotional pulls you experience that interfere with a fluid, wide-ranging and good, but not perfect, interview. After you learn to recognize when these tugs manifest themselves and their particular "flavor" you will be prepared. You can then counteract them in the interview through a conscious effort at staying on a schedule that, through practice, you feel capable sticking to.

Candidate Self-Assessment

Although Perfectionist candidates vary widely in their self-assessment, most are painfully aware of the information they could not obtain and the implications of these knowledge gaps. They have a keen grasp of the information needed to develop a good treatment plan. Other Perfectionists, such as "diagnosticians", do not fully realize the gaps in information left in certain areas, such as in social history.

Corrective Action: Finding Balance Between Too Little and Too much Detail

How do you walk the fine line between being a Sketch Artist and a Perfectionist? Too little detail will leaves gaps in your data big enough to allow a Mack truck to drive through it. Going after too much detail will leave you with whole informational regions unexplored because no time will be left.

Let me give you a few concrete examples to illustrate how to prioritize your questioning. Let's continue to use as an example a patient with Schizoaffective Disorder. This disorder is good to use as an example because it is challenging. It includes more than one syndrome (i.e., psychosis and mood disturbance); it is frequently associated with substance abuse disorders; patients with this diagnosis often have a complex treatment history; and the illness has both chronic and intermittent components.

Suggestions on Prioritizing Details & Balancing Assessment Needs

Based on the above case permit me to give you some suggestions.

- Maintain balance in your questions between the patient's current and past episodes of illness. Before getting lost in a wilderness of details from past episodes, remember that you need to assess the patient's current state, the NOW. I have frequently heard candidates querying for past suicide attempts and risk factors but forgetting to ask the patient for the presence of current suicide risk factors. This seems to occur most often with patients who "look good" during the interview. The contrast between the patient's descriptions of his or her previous possibly dramatic and severe episodes and the patient's current coherent, pleasant and apparently unstressed demeanor can lull you into assuming that the patient is currently not at a high suicide risk. Thus, you may forget to assess for these symptoms in the NOW. Don't assume anything.
- Concentrate on only one or two past episodes. Pick ones that are recent, that the patient can recall clearly, and that are more severe.
- Query symptoms, dysfunction, and treatment at the height of the episode of illness. Many of the disorders we treat do not have an off/on/off course but increase in severity, reaching a height of disturbance, and are followed by a diminution of symptoms and dysfunction. Tell

the patient directly that you wish to understand his or her problems when the episode of illness is strongest.

- Understand the illness progression over the patient's lifetime without delving into details. For instance, are the episodes of illness becoming more severe, more frequent, less responsive to treatment, or more likely to result in hospitalization?
- Maintain balance in assessing for all five diagnostic axes. Do not slight information needed to establish Axis IV and V. Both may easily be missed by the interviewer who focuses too exclusively on psychiatric and medical symptoms. Axis IV requires that you understand the patient's psychosocial and environmental problems, such as family conflict, work or school problems, inadequate finances, barriers to health care, lack of supports. Axis V requires conducting a "Global Assessment of Function." Despite its name, the GAF is an amalgam of the patient's level of dysfunction and of symptoms. If you have not queried the level of function, your GAF may be quite inaccurate.

Summary: The Perfectionist

The Perfectionist obtains an overabundance of detail in some areas and runs out of time to cover others.

Suggestions for the Perfectionist:

- Maintain balance in assessing Axis I through V and not only Axis I through III.
- Maintain balance across bio-psycho-social informational areas, not slighting any.
- Spend substantially more time on the patient's current or most recent episode of illness than on past episodes.
- Concentrate on only one or two past episodes, preferably the more recent and severe ones.
- Understand the illness progression over time without delving into details.
- Remember to query current suicide risk, no matter how good the patient looks.
- Know when to let go emotionally.
- Be good enough, not perfect.

The Gentleperson Interviewer

The Gentleman or Gentlewoman Interviewer is a gracious person, treating the patient with deference and respect. The problem occurs when this sensitive interviewer's deference towards the patient interferes with gathering adequate information. The end result for the Gentleperson Interviewer is in many ways similar to that of the Sketch Artist in that enough detail is not obtained. The profile of the Gentleperson Interviewer differs, however, in that his or her motivation is to avoid giving offense or causing conflict with the patient rather than having low expectations for the amount of detail needed as is the case with Sketch Artists.

Interview Rule: Interrupting the Patient is OK

Some Gentleperson Interviewers do not obtain enough information because they find it hard to interrupt patients. A recent candidate was interviewing a woman with (I believe) Paranoid Schizophrenia. She was clearly an intelligent woman and had remarkably good insight into the course and consequences of her illness. She had many things to say, all of which were informative. She spent about ten minutes (one third of the interview time) describing the type of volunteer work she is currently doing. The Gentleman Interviewer at first listened attentively. Later, I could tell he was anxious to guide the interview into the many important areas he had yet to cover. His attempts at redirection were so slight they could easily have been missed. During the discussion period he admitted to the sense of urgency he felt in the interview with time running out and feeling at a loss of what to do when the patient did not respond to his gentle efforts.

Interview Rule: Challenging the Patient & Requesting Clarification is OK

Other Gentleperson Interviewers are more adept at interrupting the patient and have problems only when they need to challenge or confront the patient. These interviewers are able to use several techniques to guide the patient from one topic to another and know how to gently but firmly bring closure to an extended answer. However, the problem they confront is that they view a challenge or confrontation as rude and to be avoided. Thus, when interviewing a patient who provides inconsistent, illogical, unlikely, or confabulatory answers, the doctor does not ask for clarification.

My image of the Gentleperson Interviewer is that of a well-mannered person attending a reception or cocktail party. At these occasions you are required to be on your best behavior, yet it seems inevitable that sooner or later you'll become the object of the attention of the most boorish or strange guest you can imagine. What do you do in such a situation? Well, I think, you listen politely no matter how far-fetched or inconsistent the guest's anecdotes. It would be rude to point out lapses in judgement, clarity or sheer logic to a person who you don't know, wish not to know, and yet who may be a close friend or relative of the host. You concentrate on not glancing at your watch and on smiling until your face hurts.

Interview Rule: Do Not Treat Patients Like Guests at a Cocktail Party

I bet you never knew such a rule existed. But yes, it's a (soon to be) classic. The point is that you and your patient are not guests at a cocktail party. You cannot accept the same lapses in history, judgment, logic as you would from a strange guest. By clarifying and challenging, you can more fully understand your patient.

I believe that the Gentleperson Interviewer's intention is to remain polite and respectful. I strongly agree with this motivation and believe any other is unprofessional. I would argue, however, that you can remain respectful towards your patient without accepting everything your patient says at face value and while maintaining the ability to interrupt him or her if necessary.

I think that some oral board exam candidates inadvertently get themselves into trouble by being more deferential towards the patient-interviewee during the exam than they would be in their clinical practice. They may be acting on the mistaken assumption that being more forceful in the interview would backfire by giving the examiners the idea that they are disrespectful towards patients. These candidates bend over backwards to avoid the appearance of conflict.

Clarifying and Challenging Are Ways of Showing Respect For Your Patient

If you equate showing respect with avoiding clarification and challenging, I have two thoughts to try to change your mind. First, I approach my patients with the belief that my job is to understand them as accurately and completely as I can. I believe that if the patient says something that doesn't make sense to me or is at odds with previous statements, I show my respect for my patient's life story –and sometimes this is the most valuable possession they have– by really, really trying to understand. I feel that if I accept vagueness or inconsistency, then I have done my patient a disservice and shown disrespect for her story, like I'm willing to accept anything she tells me because I really don't give a hoot about her.

My second thought on this topic is that to be an effective psychiatrist you must be an investigator, a bit of a Colombo. Often patients are unaware or only dimly aware of the nature of their problems. If you are of a psychodynamic bent, you could say that patients are well-defended against unacceptable views of themselves or of significant others. If you subscribe to learning theory, you could say that they have developed certain cognitive explanatory models. Aspects of reality that are congruent with this model become more salient and other aspects that are cognitively incongruent lose saliency. However you wish to characterize it, I think the fact remains that what our patients tell us is often incomplete or inaccurate in some sense. By focusing on the important inconsistencies in history or incongruities in behavior, we often can begin to understand the world through our patient's eyes and how the less well known (or admitted to) aspects of their lives affect their behavior and contribute to their problems.

Types of Patients Who May Give Long Answers

Patients with different characteristics and psychopathologies may give answers that are too long (for our purposes). Even patients without evident psychopathology or who in no way could be considered hyperverbal may do so. Each type of talkative patient requires a different approach. (The type of patient you probably have most in mind is the most severe case and the one I discuss last.)

One type of patient with long responses is one who is simply being helpful to you, the nice doctor taking an important test. This patient wants to be as complete and informative as possible, even though in reality their behavior complicates your task. I think this scenario calls for some acknowledgement of the patient's "gift" of helpfulness to you, followed by an explanation of the interview parameters and a request for brevity.

Another type of patient who is too talkative may be one with borderline or narcissistic personality features, that is, a person who may have a history of being misunderstood or not adequately acknowledged and who wishes to avoid a recurrence of this fate. I can't remember encountering this type of patient in a mock oral exam, so this may be more a theoretical than actual problem. But I do have a couple of such patients in my clinical practice. One patient with these personality features speaks so quickly and loudly at the beginning of every session that she seems hypomanic. She is so overinclusive in details that she sometimes loses her train of thought. Only after about fifteen minutes of uninterrupted speech dare I direct the interview. Only then is she able to calm down, the more so as I become attuned to her pain and tribulations.

But gosh, what if she was an oral board patient? This difficult scenario has no easy or standard approach, but I would suggest these interventions. I would be apologetic at my intrusiveness but maintain my firm redirection. I would also explicitly acknowledge that this type of interview format is probably frustrating to her because I will be unable to really understand her life and predicament. I would avoid any superficial statements of "I understand" in response to her statements. She is likely to perceive them as empty and, probably, infuriating gestures. Remember that patients with Borderline features often have a history of invalidation and can be extremely sensitive to non-genuine platitudes.

Still another type of patient whose answers are longer than we can afford is a patient with a formal thought disorder. Patients who are overinclusive may have difficulty separating pertinent from inessential details. Tangential or circumstantial patients' answers can go on and on. When your interview patient has these types of problems then you probably need to more frequently redirect and restate the question. Also, keep your questions more concrete and close-ended. Break in when the patient drifts from the topic at hand.

The last type of talkative patient, the category of patient most of us have in mind when thinking of hyperverbal patients, is the hypomanic patient. In such a case I would use my voice AND my body to direct the patient. By voice I mean all those ways we have learned to interrupt and direct the interview. Often, however, this is not enough. When necessary be sure to make use of body language and gestures. For example, you can sit forward in your chair, make a gesture with your hands signifying to slow down, and convey a firmness in your voice. Do not raise your voice, however, because that can escalate the situation by agitating the patient.

Candidate Self-Assessment

Most Gentleperson Interviewers have an accurate assessment of their performance on the interview. While interviewing the patient they realize that they need to move the interview along to other fruitful fields. But they are at a loss on how to do this without appearing rude or insensitive to the patient. Their behavior with the patient has often betrayed to me that they are trying to control the interview but cannot. Interestingly, some Gentleperson Interviewers have fewer problems redirecting an agitated or hyperverbal patient than they do a higher-functioning or more stable patient who simply has a more leisurely pace of answering questions. It is as if when they are with the sicker patient, the Gentleperson Interviewer kicks into a different mode of behavior, the I-Have-To-Control-This-Agitated-Patient role. Whereas when they are with the more stable patient, the Gentleperson Interviewer reverts back to the Cocktail-Party-Polite mode.

Corrective Actions

The most general but also the most important point to remember is that you can be polite and respectful and at the same time maintain control over the interview. It's not what you do as much as how you do it. The following are examples of things you should be able to do when necessary to maintain the pace and trajectory of the interview.

- You should interrupt the patient who is still talking when you conclude that the patient's answer is leading to diminishing returns in communicating the information you need to complete an adequate interview.
- You should ask the patient to clarify important areas of vagueness or inconsistency.
- When a patient says something that you do not believe, you should, if appropriate, challenge the patient.

Here are some concrete ways to accomplish the above imperatives.

- Use your hands. When you are about to interrupt the patient, lift your hand gently in a gesture that signifies "stop" or "slow down." One caveat: Do not stick your arm straight out with your hand in the patient's face. Rather use a more gentle version with bent elbow and your hand at a 45 degree angle to the floor. Using such a gesture is equivalent to a road sign that warns of an upcoming stoplight. It signals to the person that you are about to interrupt and is less jarring than when a stop appears without warning.
- Use your hands some more. For particularly hyperverbal patients, such as a patient in a hypomanic state, it may help you to establish your hand gesture of "Stop" or "Slow Down" as a recurring theme whenever you need to interrupt the patient. The patient may begin to self-monitor whenever he or she sees your hand going up. I often find these gestures to be less intrusive and as effective as a verbal interruption.
- Be polite. Say something like, "I'm sorry to interrupt you, but I need to ask …"
- Don't hesitate. After apologizing, without further ado, ask the question. For example, "I'm sorry to interrupt you, but I need to ask, Do you ever hear voices or receive messages other people don't?" Do not pause after your apology in order to get an acknowledgment from the patient. I've seen many candidates lose precious time interrupting, apologizing and then hesitating long enough that the patient speaks, which in turn requires the candidate to answer. And pretty soon it's two minutes later. All due to hesitation.
- Tell the patient what you're about to do and then do it (again without hesitation). Telling the patient what you are about to do accomplishes two tasks. One, it can make for an easier interview since the patient knows what you are about to do and is more able to cooperate. Two, it is a way of keeping the patient in the loop. You give the message that you and the patient are working together and not that you are performing some procedure on the patient. For example, "I'm going to ask you a series of questions. Do you engage in repetitive behaviors? Do you…?"
- Be forthright. When you don't understand something, say so and ask for a clarification. It's rude and it doesn't lead to understanding when you have no idea what the person is saying and you just nod away.
- Challenge and get clarification when you need to. Be non-judgmental and specific. For example, "As you probably know, people who have a problem with alcohol often think they don't have one. Has anyone from your family ever thought that you have a drinking problem even though you don't think so?"

- When your patient's answer is showing diminishing returns in terms of information you need, use natural breaks in your patient's speech to interrupt and ask your next question. I sometimes soften this interruption by nodding my head in understanding before I begin to speak, signaling that I have understood the point of my patient's response.
- Some Gentleperson Interviewers ask questions with a tentative air. Often their questions trail off, leaving the listener wondering if the question is completed.
  1. Practice asking questions that are grammatically simple, that is, without many dependent clauses.
  2. Speak in a clear and firm voice.
  3. Be sure your questions start and end as clearly as flipping a light switch on and off.

Summary: The Gentleperson Interviewer

The Gentleperson Interviewer shows excessive deference towards the patient and consequently cannot gather adequate information.

Suggestions for the Gentleperson Interviewer:

- Do not treat patients like guests at a cocktail party, that is, you must challenge them and ask for clarification when necessary.
- Learn to challenge your patient or request clarification in a respectful and nonjudgmental way.
- Be a Columbo (the TV detective), that is, try to investigate how and why your patient thinks and feels the way he or she does.
- Review the concrete ways that you can maintain control over the interview without being rude to the patient:
  - –Learn to interrupt gracefully.
  - –Use gestures to signal interruptions.
  - –Tell the patient what you will do, then do it without hesitation.
  - –Do not hesitate between questions.
  - –Ask questions firmly and clearly.
  - –Use simple grammatical structure.

The Scientist with Specimen

The Scientist with Specimen is an interviewer whose motivation is to obtain as much detail as possible. Although pursuing an admirable goal, the Scientist (for short) pays too little regard to the negative consequences of his or her approach on rapport with the patient. As illustrated by the cartoon the patient may end up being treated like a laboratory specimen, an object whose history is to be dissected, and not a partner in the quest for understanding.

The Scientist is at the opposite end of the spectrum from the Gentleperson Interviewer. Instead of being too deferential towards the patient, the Scientist is not deferential enough.

Like the Perfectionist, the Scientist gets much detail. The Perfectionist often takes too much time on a narrow aspect of the history, and yet for the most part maintains his or her pace and isn't a particularly aggressive interviewer. The Perfectionist is left at the end of the interview with large gaps in information as a consequence of the high level of detail desired in the context of a normal interview pace.

The Scientist, on the other hand, often proceeds at breakneck speed trying to squeeze every last question into the 30-minute interview. As I described in the introduction, I began as a Perfectionist. After seeing the shortcomings of that approach, I tried to be a Scientist. That was no more effective. I was able to fit more questions into my interview but at an unacceptably high cost. Again, you must find a balance in which you ask questions quickly and effectively, but avoid a breakneck pace and a consequent rupture in rapport with the patient.

Some Scientists are simply too fast, but avoid other interview pitfalls. They may interrupt too often and too early into patients' answers, but are otherwise respectful. For instance, they may pause when their patient reacts with emotional upset. They are likely to pick up on the patient's changes in interview direction and follow the patient's natural leads. These Scientists seem like thoughtful and organized interviewers with the sole vice of firing questions too fast, like a "machine gun."

Other Scientists, however, do not make a noticeable effort at maintaining rapport with their patient. Not only do they interview too quickly, but they may also engage in the following counterproductive behaviors:

- No matter where the patient leads they do not follow, instead rigidly maintaining their own predetermined interview trajectory. Even good interview techniques, such as maintaining control of the interview, become liabilities if overdone.
- They do not respond empathically towards the patient when the patient displays emotional upset, moving right ahead with the next question as if nothing unusual had occurred.
- They do not show restraint when querying areas of history that can be anticipated to be emotionally upsetting to the patient, such as episodes of abuse. I am not suggesting that an interviewer should not query for past abuse, but that he or she show restraint. For instance, when the patient acknowledges being abused, the patient does not necessarily access the pain of the full memory. However, if the interviewer plumbs for details, the patient may be triggered to relive the trauma. To use an analogy, at times you want to ask the patient for the title of a chapter as opposed to insisting the patient read from it. Also, keep in mind that in an

initial diagnostic interview, getting the details of the abuse history may be less important than finding out the ongoing consequences of the abuse and what forms of treatment, if any, the patient found more or less useful.

Establish Rapport

Find concrete ways to show your respect, convey empathy and establish rapport. At the start of the live-patient interview, introduce yourself to the patient and explain the purpose and structure of the interview. On my exam, I enjoyed this brief part of the interview. I was engaging in overlearned behavior. I took advantage of this time to center myself with my anxiety control approach.

To show your respect, always refer to your patient as Mr. or Ms. <last name>. Most chronically mentally ill people face a lifetime of low status, discrimination, poverty, and misunderstanding. Referring to patients by their last names, besides being a gesture of common courtesy, is a gift you give that costs you nothing yet may be more meaningful to people than you may imagine.

Also always refer to your patient as Mr. or Ms. <last name> when presenting to the examiners. It's a further sign of respect to speak of your patient as a person with a certain disorder, such as a person with schizophrenia, rather than as "a schizophrenic." The latter locution "essentializes" the person, making her or him little more than a walking disorder.

The other end of the spectrum, as an example of DISrespectful speech, is exemplified by this example. I recently mock-examined a candidate who I would have passed except for the fact that in the question-and-answer session he repeatedly referred to the patient as being a "Chronic Schiz." Yes, "a Chronic Schiz." This doctor seemed like a nice man and a competent psychiatrist. It was such an accepted term where he worked, I imagine, that he was surprised when I pointed out the inappropriateness of his description of the patient.

The Problems with Extensive Note Taking

Extensive note taking can also damage your rapport with the patient and needs to be moderated. Any candidate can take so many notes that problems arise. However, it seems to me to be most common among Scientists, so I address it in this chapter. Although true that writing down what you hear aids your memory retention even without further review, taking notes that are too extensive has serious drawbacks.

It may lead to the following errors.

- Your rapport suffers. You don't have time to maintain eye contact with the patient and are not focused enough on the person's expressions of emotion to be able to respond empathically as changes take place. You are thus cutting yourself off from a major source of information about the patient.
- You don't give yourself enough time to note abnormalities in the patient's physical features or behavior. Many, many candidates miss signs of, for instance, tardive dyskinesia because their eyes are fixed on paper.
- Your ability to attend to the content of the patient's answers suffers. You may be hearing 50% of what the patient says. You listen to the patient for ten seconds and then write for ten seconds. My boss at the University of Illinois and a board reviewer recently told me of a

candidate who completely missed the fact that a patient stated he had a gun and wanted to kill his coworkers. She was flabbergasted at just the possibility of such inattention. Although I don't know the reason for that candidate's failure to register such a provocative statement, in my experience such major gaffs are committed by interviewers who are too focused on writing rather than listening.

An important challenge many candidates face while interviewing a patient during the board exam is in knowing what to do when the patient shows emotional pain. You as the interviewer have many questions left to ask and you will not pass if you do not ask them.

On the other hand, it is unprofessional to ignore a patient's evident pain without communicating your empathy to the patient. Here are some sample statements that you can use to show empathy and understanding for your patient's pain without converting your interview into a psychotherapy session, which is not the task at hand.

- I can see this <issue> still causes you pain. Do you have anyone you can share your feelings about this with?
- I can see this <issue> still causes you pain. I appreciate your openness with me.
- I can see this <issue> still causes you pain. Because I won't be here to help you after our short time together, perhaps it's best if we don't dwell on this distressing topic.
- I can see this <issue> still causes you pain. [Pause] Are you OK? [Pause] Are you ready to answer some other questions I'd like to ask you?

Candidate Self-Assessment

Many Scientists complete the exam not fully aware that they lost points for lapses in maintaining rapport with their patient. Depending on how egregious the behavior, a Scientist can fail the exam even when he or she has done well in terms of informational content, formulation, and treatment plan. I have seen many examples of patients treated as if they were simply objects to be pumped for information. I have noted several Scientists displaying irritation when the patient was unclear, hesitant, circumstantial, overinclusive, contradictory, or lacking historical information.

Corrective Actions

If you consider the patient to be a partner in a process of discovery you will do OK. The patient is not to be seen as an obstacle to an imagined ideal interview. Begin the interview with a "Gathering Phase," a period of perhaps 3-5 minutes at the start of the interview in which you permit and even encourage patients to speak open-ended of their problems. Through this you will be more able to learn the breadth of the patient's problems, the understanding the patient has of them, and the concepts and words the patient uses to explain these problems. Through the patient's open-ended description you will also have a clearer understanding of the nature of the thought processes. Some of these are subtle enough that they only manifest during extended conversations. The time spent "gathering up" the patient's problems and identifying possible psychiatric disorders for later detailed assessment will help you establish rapport and a truer understanding of the patient. Throughout the interview you will need to maintain a balance between completeness of information and a fluid, sensitive, and empathic approach. By all means run a tight interview. Just don't overdo it.

Summary: The Scientist with Specimen

The Scientist with Specimen is an interviewer who tries to obtain as much detail as possible even at the expense of riding roughshod over the patient.

Suggestions for the Scientist with Specimen:

- Do not go so fast that you shoot off questions like a "machine gun."
- Do not treat your patient like an obstacle to obtaining their history.
- Make a noticeable effort at maintaining rapport with your patient.
- Be mindful of the damage caused when rapport with your patient is not maintained. If your behavior is egregious, you can fail the exam.
- Learn to show empathy with your patient's pain without turning the interview into a therapy session.
- You may not need to delve into the detail of a patient's trauma. Instead, focus on the ongoing effects of the trauma and the patient's approach to coping.
- Maintain frequent eye contact with the patient.
- Do not take such extensive notes that you lose contact with the patient, miss the history or inadequately monitor emotional responses.

Elephant in the Lap

In the scenario of the Elephant in the Lap the candidate misses what is most important about the patient. The candidate feels frustrated that she cannot conduct her interview with the patient because there is something, an elephant, blocking her view. The candidate has been trained to assess the requisite informational areas quickly and efficiently, but when she encounters a patient with an unusual feature, the feature goes unnoticed. The Elephant is seen as an obstacle to conducting the imagined ideal interview. The candidate responds with frustration or even anxiety, "Oh no! I'll never be able to assess the patient because of this stupid elephant on his lap."

Well, guess what. The Elephant IS the issue. The Elephant is any important feature of the patient or of his or her behavior that is so obvious that it is in danger of being missed. You should not try to look past the Elephant but figure out why it's there. How often do patients have an Elephant on their laps? Is it normal? Is it expected? Can it indicate an underlying, or not so underlying, problem?

Interview Rule: Never Ignore the Elephant

The concept of this mistake came to me when I was mock examining the following case. During a videotaped mock exam, the candidate was interviewing a middle-aged man who looked disheveled. When asked, the patient stated that he had been diagnosed with Schizophrenia. The interviewer spent much time attempting to ascertain the man's symptoms. Of course, this is a good thing. Remember the motto, "Trust but Verify." She was making slow headway, however, and even on the tape one could sense her frustration. What kept her information-gathering proceeding at a snail's pace was the fact that this man displayed a series of behaviors that made a linear question-and-answer sequence impossible to perform.

What were these behaviors? What was going on? I wish that the interviewer had showed some curiosity. Instead, she made no attempt to assess the behavior of the patient. During her presentation to me, my candidate made no mention of the patient's behavior or its lack of assessment by the videotaped interviewer. I can hear you asking, "What were the patient's behaviors?"

The patient frequently nodded off. He seemed to drift off into a somnolent state, placing his chin on his chest. The interviewer just spoke louder in order to rouse the patient. The patient also appeared to be distracted by stimuli outside the field of the video camera. The interviewer had to draw the patient's attention back towards her questions several times, yet made no assessment of these abnormalities. The candidate in the room with me also made no mention of these disturbances or the lack of any kind of assessment by the videotaped interviewer.

What is the Elephant on the Lap in this patient's case? I believe that the patient was mildly delirious. He had a decreased level of consciousness that waxed and waned during the interview. He was distractible and inattentive. I might be wrong. There are other, more benign explanations. He could have been somnolent from being awake the night before for some reason. He even could have been intoxicated during the interview. We'll never really know. The problem was that his behavior suggested the possibility of an urgent medical problem and it was not assessed.

The right interview approach with this patient would have been specifically and aggressively to assess his somnolence and distractibility. Perhaps the patient could have shed light on these disturbances. How long had they lasted? Was the patient even aware of the behaviors? Did he sleep last night? Was he intoxicated? Did this ever occur before? What medical problems does he have? Were any medications recently changed? Is he on any medications that could at toxic levels produce the mental state I witnessed? I could imagine asking these and many other questions.

"But you don't have time for this," you say. My answer is that there are situations, and this is one of them, that require you to move away from your imagined ideal interview. Throw your plan out the window and attend to the problem staring you in the face as baldly as an elephant sitting in a drawing room. If the patient presents with signs suggestive of delirium, then a safe physician focuses on this, the most acute problem. If the patient dies, it won't much matter what the quality of the other parts of the history you obtained.

Interview Rule: If You Interview an Urgently Sick Patient, Do Not Ignore It

If I was interviewing this patient during my oral boards and, despite my best efforts, couldn't exclude delirium, then what would I have done? Ask yourself, "What would a safe physician do?" At this point I would need to break out of the exam mode. I would no longer necessarily function as a board candidate. I would shift into the mode of a physician confronted with a very sick patient. First, I would obtain as much history as the patient could provide. Since I would not have the capacity to further adequately evaluate this patient with suspected delirium, I would need to forcefully convey the urgency of the situation to the examiners.

In rare emergent cases, you may need to end the interview early. The examiners could intervene to make sure that a proper disposition of the patient was made. Remember that the board exams take place in large clinics and medical centers. Physicians and other staff are present on the premises and the patient-interviewee can be handed over to clinicians familiar with his case and in possession of his medical records.

Here are examples of features that seem obvious but that often end up not being assessed:

- Movement disorders, such as dyskinesias and extrapyramidal signs
- Signs of a medical illness, such as obesity, shortness of breath, wheezing, arthritic gait, etc.
- Emotional signs, such as great emotional distress or inappropriate affect
- Signs on the body suggestive of a psychiatric disorder. For example, the lack of eyelashes suggests trichotillomania. Light parallel scars on the forearms suggest self-mutilation.
- Agitation or behavior suggestive of aggression or impending violence

Corrective Actions

Notice what all my examples have in common. The common feature will help lead you to the answer to the mystery of why the most obvious abnormality often goes unnoticed. I'll let you think about it for a second. OK? The common feature of my examples is that none have to do with the patient's history. They either relate to the patient's behavior or to a physical feature of the patient.

Most of us, when conducting a psychiatric interview have the patient's history as our primary focus. The nature of a psychiatric interview is that of a long series of questions designed to gather information. For instance, how has the patient been feeling and acting over the past week or two? How has the patient felt, acted and thought in the past? What are the patient's current and past treatments? What medical problems does the patient have? And so on. This type of interview could be conducted over the phone or, more cumbersomely, even through an email correspondence.

I believe the solution to the Elephant in the Lap is to have a double awareness that notes not only what the patient says but also what the patient shows through his or her appearance and behavior. Through attention to the content of the patient's history, we learn what the patient knows and thinks of himself. In addition, we are able to maintain our interview organization and trajectory. This helps us complete our querying of depressive symptoms, for instance, before moving on to screening of manic or psychotic symptoms. It helps us remember to ask, for example, about current suicide risk factors.

For a successful psychiatric evaluation, we must also attend to the patient's behavior as seen during the interview. Some behavior is independent of the patient's interaction with us, such as a dyskinesia or, as in my example, signs of delirium. Other behavior is a reaction to you, the interviewer, such as an emotional display triggered by a question. We should monitor both types of behavior.

We should also be aware of the patient's physical features, such as injected conjunctiva, clubbing of the fingers, tobacco-stained hands, and obesity. The patient's accoutrements like a pack of cigarettes in the patient's shirt pocket or the nickel in the pinna of a manic patient's ear can also provide clues of the patient's mental state. As you see by my examples, we all regularly use our awareness of a patient's appearance and behavior in the mental status exam. We just need to remember to employ it during the oral board exam.

As discussed in the introduction to this book, the anxiety we experience during the board exam narrows our attention to a remarkable degree, usually to a single feature in the environment. By default we usually tend to track the content of the patient's history. We need to remind ourselves to use our skills of observation and our ability to take in multiple features in our environment.

To avoid missing the Elephant take these simple steps:

- In my oral board exam experience, I found that simply telling myself as I was walking into the exam room, "Note the Patient" was enough for me to notice any Elephant that may have been lurking before my very eyes. (OK, I admit it. I didn't say this just once. I must have repeated it about twenty times in a row walking up to the interview room.) In my guidance of candidates during mock exams, I have found that most people have a similar experience. Usually when I bring an Elephant to the attention of the candidate, it is enough to prevent recurrence of this problem.
- Use the unstructured time right after the greeting period during the first phase of the HPI to note the patient's physical, emotional and behavioral features. It is good to commence your "second awareness" early in the interview to establish it as an ongoing task.

Summary: Elephant in the Lap

The Elephant in the Lap occurs when the candidate misses what is most apparent about the patient.

Suggestions to avoid the Elephant in the Lap scenario:

- Never Ignore the Elephant! Find out what it's doing there.
- Learn to have a "double awareness," an ability to attend to the content of the interview while also noting the physical, emotional, and behavioral features of the patient.
- Pay attention to signs of movement disorders, emotional display, agitation, altered level of consciousness and medical illness, all of which are commonly missed or ignored by interviewers.
- If you interview an urgently sick patient, do not ignore it. In rare cases you may need to intervene.
- Tell yourself as you're walking to the exam room, "Note the patient."
- Take the opportunity of the "gathering" phase of the history of present illness to maintain this broad awareness.

The Scatter Artist

The Scatter Artist is a substantially disorganized interviewer. Most mock oral board candidates I've worked with have spent much time making sure that their interviews are organized. Their effort has paid off in making this problem less common and, when present, less severe.

The problem with conducting a "scattershot" interview is that examiners quickly note the lack of a predetermined systematic approach and give a low mark on interview organization. Also, and more importantly, a scattershot approach makes it easy for the interviewer to miss important informational areas. Probably every candidate who ends up conducting a scattered interview does so not from strategy but through a failure to maintain adequate interview organization or control.

Some Scatter Artists end up with a scattered interview because of difficulty in maintaining control over the patient's responses. They have a predetermined interview strategy but are unable to execute it under adverse conditions. These Scatter Artists do better with more cooperative and controlled patients and worse with patients who are agitated, hyperverbal, disorganized, overinclusive, circumstantial, or tangential. That is, patients who in one way or another will take the interview off-course for substantial periods of time if left to their own devices.

Other Scatter Artists have a more serious difficulty. They do not have an interview strategy. It is not the difficult patient that throws them off, but their lack of a mapping their interview.

Other interviewer profiles may also end up with disorganized interviews. For instance, Gentleperson Interviewers may have trouble maintaining adequate interview control. This failure may be related to a hesitation to interrupt due to fear of seeming impolite. Sketch Artists may zone out for a period of time in the interview and let the patient take the interview in the patient's own directions. This may be due to the Sketch Artist's belief that he or she has plenty of time to gather the amount of detail deemed adequate (which in reality it is not). The way a Scatter Artist differs from other profiles is that the fundamental deficit is in maintaining control over the interview and not from politeness (Gentleperson Interviewer) or belief that the interview can be conducted at a leisurely pace (as may be the case with Sketch Artists).

Every interview is less than ideally organized. I think this is true for all psychiatrists, no matter what the level of their experience. The interview is a fluid interaction between two people that evolves over a period of time. It is not and never should be like completing a questionnaire in which an interviewer asks the next question on a question-list and a patient answers each query succinctly and accurately. The interview should live and breathe and not seem a mechanical undertaking. I see an analogy to a duet of musicians. If their performance is too mechanical the music will end up with a synthetic quality. But equally importantly, the performance, even a highly improvised one, will not work if it is chaotic or disorganized.

By virtue of its breadth and complexity, the interview section that causes the most problems in maintaining a structured approach is the History of Present Illness (HPI) and the Past Psychiatric History. Thus, this chapter focuses on approaches these sections.

The Progression of the Interview

This is the order in which to progress through the interview.

- Introduce yourself to the patient.
- Orient the patient to the interview.
- Obtain demographic information (some interviewers do this later, which is acceptable).
- Ask for the chief complaint.
- Ask the patient to explain the chief complaint.
- Keep your questioning open-ended so that you arrive at an understanding (even though incomplete) of the progression of the patient's illness and so that you can gather leads to additional syndromes of psychiatric illness that may be present.
- You then move into a systematic assessment of each psychiatric syndrome. Then proceed systematically.

Even thought you have 30 minutes for the entire interview, you should be ending the psychiatric assessment a little past the half way point of the interview, perhaps at minute 16 or 18. Remember that you must still obtain information about the medical, family, and social / personal histories as well as conduct a screening cognitive assessment in the time remaining.

Let me now give you a tip on how to think about your HPI and your Past Psychiatric Histories. Knowing the point at which one becomes the other gives you THE most important anchoring point to your interview structure.

The "Wedge:" Demarcation Between the HPI and Past Psychiatric History

Start the HPI at the start of the patient's most recent or current episode of illness. Then assess how this episode progressed over time until you get to the present, the time of the interview.

Then consider the Past Psychiatric History as starting with the patient's initial decompensation and concluding when you get to the point in time in the patient's life at which the HPI started.

I try to structure my interview so that I obtain information about the most recent or current episode of illness (i.e., HPI) before moving to assess earlier episodes of illness. However, I do not always interrupt and redirect patients who veer between past and present histories because I have an interview map in my mind and an organized way of taking notes. Thus, even if the patient is disorganized, I am NOT.

Notice an important concept imbedded in the above paragraph. The concept is that you do NOT write down in your notes the pieces of information you learn from the patient in the order in which you hear of it. If you do you will have a big mess on your hands. For example, it is common that a patient with depression will mention facts related to his depression at all points throughout the interview. If you wrote the information in the order in which you learned of it, you would have depression-related facts all over your notes. What good would that do you? You would not only not be able to find the information, you would in addition get anxious as you looked for it and realized you could not find it.

So how do you do it? Keep all information about depression together in one section of your note sheet. And do the same for every other syndrome under review. Then when you present depression, you know where to look it up. When you present mania, you know where to find that information too. And so with all the other topics.

The Interviewer as His Own Worst Enemy

I have seen interviewers who have no one to blame for a disorganized interview but themselves. For instance, when a patient is speaking of her depressed and anxious feelings and happens to mention how she feels at work, the interviewer may ask what kind of work she does. This may have the effect of diverting the patient from a discussion about depression onto one regarding her job, her work history, conflicts at work, or plans for a job change. These are important topics, but you may not wish to head down this particular interview path at this time. Finish depression; then move on.

I understand the motivation to slip in these "off-the-topic" questions into the interview flow. The interviewer believes that he can get important information almost "for free," that is, taking so little time that it doesn't extend the time to finish the assessment of the main topic under discussion. But it does take more time. And it does get you and the patient off-topic. You are then left with a handful of half-assessed topics.

Interview Rule: Conduct a "Serial Monogamy" Interview

Especially when done repeatedly, off-topic querying backfires. It can decrease the patient's understanding of which topic is being discussed. Are we talking about depression or about work? Or is the interview one big Q-&-A salad in which anything goes?

I recommend that you minimize off-topic queries. Pick a topic and stay true to it. Assess it as completely as needed. Only then move on to the next topic. Keep it simple.

Return to Chief Complaint

If you ever get lost in the interview, you can always return in your mind to the patient's chief complaint and the syndromes suggested by it. Do you know enough about it? If no, then assess further. If yes, then consider what other syndrome leads you have that remain to be assessed.

And always assess the Big Four categories of psychopathology: Substance Use Disorders, Psychotic Disorders, Mood Disorders, and Anxiety Disorders.

Summary: The Scatter Artist

The Scatter Artist has substantially disorganized interviews. Some Scatter Artists become disorganized only with difficult patients while others have not developed an interview structure and have trouble even with compliant patients.

Suggestions for the Scatter Artist:

- Your interview should be flexible, but must have an organizational map.
- Learn to demarcate between HPI and Past Psychiatric History. The "Wedge" will help you keep your interview and presentation better organized.

- Note the information you learn NOT in the order in which you learn of it, but rather organized by syndrome.
- When in doubt, always assess the Big Four: Substance-Use, Psychotic, Mood, and Anxiety Disorders
- Be an interview "Serial Monogamist," that is, try to assess one informational area at a time.
- Keep it simple.

DSM Terra Incognita

The DSM Terra Incognita is the scenario encountered by the candidate who has not studied the DSM-IV well enough. This profile differs from the previous six in that performance in this area most closely reflects the candidate's knowledge base and less so his or her interview skills. This does not mean that the interview itself will be spared. After all, of what is the majority of the interview comprised if not questions and answers? Knowing the right questions to ask requires that you know the set of psychiatric disorders and their diagnostic criteria.

The majority of psychiatrists are general psychiatrists. The most common disorders in general psychiatric practice are Anxiety, Mood, Substance-Related, and Psychotic Disorders. It is not surprising that these are the disorders most of us know best from our daily work. Most of us have relatively detailed maps of these four major diagnostic groupings. Everything on the DSM-IV-TR pages before Substance-Related Disorders and after Anxiety Disorders, however, may seem like uncharted territory.

This chapter offers advice on how to approach your study of the DSM-IV-TR. To be brutally frank, I say there is no way around the need to engage in some old fashioned memorization of the diagnostic set and disorder criteria.

Learn the DSM-IV-TR

You have no choice but to spend many hours memorizing diagnoses and the criteria for each diagnosis in the DSM-IV-TR. Make sure you are studying from the silver covered text-revised versions of the DSM-IV. The title includes a TR, as in DSM-IV-TR.

To make progress in this large task, incorporate the study of DSM-IV-TR into your daily routine. Carry the pocket version with you at work. Try the following suggestion: With every patient you see, review the patient's symptoms in greater detail and more formally than you probably usually do. Although it may be awkward for you at first, open the pocket edition and with the patient review the list of criteria for the patient's disorder(s). Before you scoff at this suggestion –I know how busy you are– try it for a couple of days.

I tested it in my own clinical practice and found it went increasingly smoothly over the first morning of my experiment. Using this approach seemed not to take much longer than not doing it. It was a matter of establishing a routine and of finding a way to present it to my patients.

So, how do you present this new approach to your existing patients? The following worked for me: While speaking with my patient, I would casually reach over for the pocket edition lying on my desk and flip to the right page. Then during a natural break in our conversation, I would say, "Today I'd like to more formally review with you any changes in your <disorder>? Then I dove right in, querying the criteria from top to bottom. My experience was positive.

If you fear that your patient will think you incompetent because you need to refer to a manual for the criteria, I can assure you that this is unlikely. Most patients have had the experience of completing clinical rating scales as aids to diagnosis or assessment of treatment response. I

would approach the formal criterion review with your patients in the same spirit. It conveys thoroughness and professionalism. I felt my patients appreciated my new approach.

What struck me, was how much I was able to refresh my memory for the criteria. Sad to say, but I thought I knew the criteria better than I actually did. Which led to the following thought: If I had to take a board exam in the near future, this type of formal review of criteria with the patient would have been quite a wake up call for me. I would have realized that I did not know them nearly well enough.

In addition to incorporating your study into your clinical work, you need to read, yes, actually read the full edition of the DSM-IV-TR. I'm often surprised at how resistant many people are to actually reading it. I recommend that you set aside 30 to 60 minutes daily before or after work to READ THE BOOK.

Reading the DSM-IV-TR can be a voyage of discovery. For instance, did you know that there is such a condition as "Psychological Factors Affecting Medical Condition?" Wouldn't that have been a useful diagnostic option to consider for that diabetic patient you tried to squeeze into an adjustment disorder? Also, did you know that there is an entire 12-page appendix devoted to "Decision Trees for Differential Diagnosis?" Are you familiar with the "General Diagnostic Criteria for a Personality Disorder?" Before you try to pin a specific personality disorder onto your board exam patient, you better know what it means to have a personality disorder. Having a difficult time interviewing the patient is not one of the criteria.

Understanding the DSM-IV-TR

The DSM-IV-TR is a diagnostic system of which we can all be proud. Each subsequent edition becomes more evidence-based. The clarity of the diagnostic criteria greatly increases reliability and guides research in existing and proposed diagnostic categories and criteria. The DSM-IV-TR is not perfect, however. The organization of the DSM-IV-TR makes it seem perhaps more complex than it needs to be. Begin your study by focusing on the major diagnostic groupings. Then proceed to learn the set of disorders in each group. Last, focus on the individual criteria for each disorder.

Fifteen Diagnostic Groupings

The DSM-IV is divided into fifteen Axis-I diagnostic categories. These are the largest topographic features like mountain ranges, deserts, shores on a map. Each category of mental disorder is listed with an abbreviated name when the full name is cumbersome. In those cases the full title appears in parentheses.

- Childhood Onset Disorders (Disorders Usually First Diagnosed In Infancy, Childhood, Or Adolescence)
- Cognitive Disorders (Delirium, Dementia, and Amnestic and Other Cognitive Disorders)
- General Medical Condition Disorders (Mental Disorders Due to a General Medical Condition Not Elsewhere Classified)
- Substance-Related Disorders
- Psychotic Disorders (Schizophrenia and Other Psychotic Disorders)
- Mood Disorders

- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Impulse Control Disorders
- Eating Disorders
- Sleep Disorders
- Sexual Disorders
- Adjustment Disorders

Disorders in Each Grouping

Memorizing fifteen major groupings is do-able, you think, but learning hundreds of disorders is another matter.

Learn the criteria of the most common syndrome(s) or disorder(s) from each grouping. Then compare and contrast the other disorders to your chosen one. Let me give mood disorders as an example.

The Mood Disorders grouping contains nine disorders, many of which have several Specifiers and different diagnostic codes based on severity and pattern over time. That seems like a lot. But consider this. There are only two syndromes in the mood disorders category: mania and depression. Every syndrome and disorder is a variation on the theme. Regarding syndromes, hypomania is a "little mania" and a mixed mood state is a co-occurrence of a manic and a depressive episode. Regarding disorders, to diagnose a Bipolar I Disorder the patient needs to have met criteria for a major depressive episode and a manic episode at any point in his or her life. To diagnose Cyclothymia the patient needs to have had a hypomanic and a minor depressive episode in his or her life while also never having met criteria for a manic or major depressive episode.

To make the relationships between the type of mood syndromes present and the diagnosis clear, you can learn to draw timelines. Time is represented on the horizontal axis and mood on the vertical. Manic or hypomanic episodes are represented as occurring above the horizontal line and, conversely, depressive episodes are represented below. The further below the axis, the deeper the depression and the higher above the axis the more severe the mania. The DSM-IV-TR includes such time lines to illustrate the longitudinal course Specifiers for Major Depressive and Dysthymic Disorder (see page of 425 of the large edition).

Organization of Individual Disorders

The DSM-IV camouflages the pattern of the diagnostic criteria, making it more difficult to see the similarities across disorders. If you take a look, you'll notice that most criteria are organized into the following categories. If you become aware of these categories you will have an easier time memorizing the criteria themselves.

- Symptom criteria
- Duration criteria
- Exclusion criteria

-Not Due to General Medical Condition
-Not Due to Substances
-Not Better Explained by another mental disorder
-Specifiers

I do not include a summary for this chapter. The work to do here is simply to get back to reading the DSM-IV-TR.

The Melting Candidate

Interview Rule: Never Say Die

Unless you are superhuman you will make mistakes in the interview and presentation. There are, however, few mistakes that by themselves are lethal to your chances of passing the exam. We all know that an inadequate (or absent) suicide and homicide risk assessment will result in a quick and unanimous decision by the examiners to fail you. Short of this conspicuous error, most failing performances are the result of multiple shortcomings that culminate in a negative evaluation.

Given that it is rare to fail due to a single flubbed interaction with either the patient or an examiner, the rule to follow is Never Say Die. If you realize that you are on the wrong track in your interview of the patient, you have time to take corrective action. The same is true for the Question-&-Answer session with the examiners. When you are in a section of the presentation in which you are relatively weak, you can live to see the interaction with the examiners break your way. We all have strengths and weakness in handling particular patient challenges and in areas of psychiatric knowledge. The examiners will query different areas of history, formulation, differential diagnosis, prognosis and treatment. They are looking for strengths and weakness and are sure to find both. No candidate is a perfect candidate. The question they ask themselves is, "Is this candidate safe and effective." Below I describe some scenarios that may interfere with your ability to maintain your Never Say Die attitude.

Interview Rule: Keep Your Attention in Front of You

Keep in mind that during a half-hour interview there are dozens if not hundreds of interactions between you and the patient. The Q-&-A session with the examiners "offers" a similar number of interactions. Since no interview or presentation is perfect, part of the impression you make on the examiners will be your handling of the problems that you encounter, even when they are of your own making. Let me explain in more detail the need to let go of mistakes and move on. You need to develop an ability to keep your attention in front of you instead of letting it lag behind you on mistakes or difficulties that might have occurred at some point in the interview or presentation. When your attention remains "behind you" you are permitting your most important capacity, the one on which all your other cognitive capacities depend, to leave you. You continue to move forward in time while your attention remains fixed on an event that continues to recede from you. I have had clients who remain preoccupied on some problem in the patient interview when they are now in the middle of the examiner Q-&-A. That means that the separation between person and their attention is 30 or more minutes.

I have an imagined scenario that may help you keep your attention right there in front of you. Imagine that you are a contestant on a new hit TV show, "The Celebrity Psychiatrist Challenge." In this show you wear a white jump suit and stand in the middle of an arena demarcated by lines on the floor similar to those on a volley ball field. On the other end of the field are two opponents. They are holding balloons filled with liquid. The object of the game is for them to nail you with these paint-filled balloons and your job is to avoid being hit. The contestant that gets hit the least number of times wins the game and a trip to Hawaii. Ask yourself, How would you stand? Where would you stand? And most importantly for our purposes, How would you deploy your attention? You'd probably stand with your knees slightly bent, ready to move either

right or left. You would probably move toward the back of the field of play to give yourself more time to react, and you would probably focus your attention squarely on your opponents and their movements.

Now let's imagine the game has begun. As the questions, sorry, I mean, paint-filled balloons come sailing toward you, you nimbly move out of the way and immediately resume your stance. Let me now ask you this question, If you were hit by a paint-filled balloon, what would you do? You'd let it go, both emotionally and attentionally. You'd resume your stance. After all, there are many minutes left in this game and you need to maintain a low score. I can tell you what you wouldn't do. You would not permit your thoughts to linger over that last paint balloon that hit you. You wouldn't be ruminating for the next 10 minutes, "Darn it, if only I had moved a little more to the right." You wouldn't have time. If you did ruminate you'd stand a good chance of having the next paint-filled balloon explode against the side of your head. And the next one and the one after that. Now that would be something to ruminate about!

So, during the exam, act as you would in the Celebrity Psychiatry Challenge Game. Go ahead, make your mistakes. Get hit with paint-filled balloons. It's bound to happen. Just don't let them capture your attention. You need it with you, right there in front of you.

Negative Self-Talk

On many occasions I have seen candidates get good traction early in the interview or presentation, then lose his or her place, hesitate, and then before my eyes, panic. Some candidates don't recover for the rest of the interview and/or presentation. Nothing terrible happened. Like all humans functioning under stress conditions, the candidate's focus lapsed and led to a break in his train of thought. Sometimes this happens when the candidate is interrupted by the patient (during the interview) or by an examiner (during the presentation). At other times the entire drama occurs internally. An extraneous thought breaks the cognitive train and precipitates an orgy of negative self-talk and anxiety.

The negative consequences are not due to this initial break in the train of thought, but rather to the individual's internal reaction to it. I can almost hear the catastrophic self-talk kick in at this point for some candidates, " Oh no! I'm lost. I knew it. I'm screwed!" This new intrusive train of thought leads to an autonomic anxiety response which, in turn, leads to a greater defocus from the previous task-oriented thought and an intensified focus on the new catastrophic self-talk. This leads to an even greater autonomic fight-or-fight response. These destructive self-talk / autonomic anxiety cycles seem to have the property of lightning quickness, with a cycle completed within milliseconds, leading a competent psychiatrist to act and feel like a blubbering idiot in a fraction of a second.

Darn, the sheer awful efficiency of these negative cycles. The solution to this heart-droppingly-painful scenario is to practice Cognitive Behavioral techniques on yourself. (Hey, if CBT is good enough for your patients, why isn't it good enough for you?) Going into the details of these techniques is beyond the scope of this chapter, but let me point you in the right direction. You can desensitize yourself to the anxiety of the oral board exam through doing mock oral exams. This is best done with someone you aren't close with. Ask a colleague if she can introduce you to an unfamiliar psychiatrist who can be the mock examiner. Choose wisely. At every one of the

Blue Tower Institute Oral Board Preparation courses there are psychiatrists who tell me of the incorrect things that they learned from uninformed colleagues. Also, don't fool yourself into thinking, "I'll just interview my new patients for 30 minutes and that will be like oral board practice." Yeah, right.

The other thing you can do is to learn your pattern of destructive self-talk and then work to change it. Negative cognitions are habits of thought that we probably learned decades ago. They are stubborn and ingrained but they are changeable. You need to note when they occur and what they "say", and learn to protect yourself against their sting. One CBT technique I particularly like because it is playful and effective is to give your negative internal voice an identity. These disparaging and anxiety-provoking thoughts all seem to speak in a single "voice," as if they were one person. You can take the sting out of this negative voice by giving it a ridiculous name such as "Scrooge" or "Scaredy Cat" or "Big Lame-O." Make the identity seem harmless and pathetic. When the negative thoughts start, you can say something like, "Oh shut up, you Big Lame-O."

Another change you can make is to have this negative voice speak in a ridiculous tone of voice. For example, give it an exaggeratedly whiny tone, to the point that it becomes hard for you to take seriously. Or perhaps instead of fighting off the negative content of the messages instead force the voice to sing its messages to you in the voice of a female lead in a Wagnerian opera. These playful techniques can pack a powerful punch, but trying them for the first time on the plane ride over or at the exam site won't give you enough time to internalize them. Start practicing now.

Interview Rule: Don't Tie One Hand Behind Your Back For the Oral Board Exam

A recent participant of the Blue Tower Institute Psychiatry Oral Board Review course shared with me his experience during his oral board live patient interview. He walked into a room that was particularly small, "like a broom closet or something." The two examiners sat on a small couch that abutted the candidate's chair. His knee was almost touching the knee of the closer examiner who could easily see the content of the notes he was taking. The patient sat across from this huddled group but was positioned such that he, the patient, directly faced the examiners to whom he directed much of his answers. This candidate remained flustered throughout the interview by this uncomfortably tight arrangement. He did not perform well and was not surprised when he received a notice of failure from the ABPN several weeks later.

I asked my client to imagine the following, "Pretend that you are walking through your institution's inpatient psychiatric unit. A nurse pops out of one the rooms asking you to come and assess a patient in crisis. You enter the room, which turns out to be a small examining room. Aside from the examining table on one side there is not much free space left. The nurse who called to you sits on a chair between the examining table and the patient's therapist. The patient sits facing the two of them. You are forced to sit on a small stool wedged between the nurse and the examining table. In other words, I am asking you to imagine a scenario as tight and uncomfortable as the one at the board examination. Now, given this scenario would you have a problem assessing this patient?"

No, this psychiatrist did not think so. And neither do I. We are all used to interviewing patients after not sleeping for 36 hours, crammed into some broom closet because the ER has no other

rooms available, shouting to the patient to be heard over high ambient noise, or with frequent interruptions from housekeeping staff that decides this is a good time to empty the trash and mop the floor. What do we do in these situations? We do the best we can and usually do a damn good job. Many of these constraints, complications and annoyances become fairly irrelevant once we are in the midst of the interview. We are usually able to engage the patient to the extent that the patient also stops noticing these distractions. We have a job to do and we do it.

So why don't we more easily maintain this same can-do attitude during the oral board exam? You have a job to do, so just do it. My advice is don't let the type of situation that you deal with effectively every day of your work life throw you just because it occurs during your board exam. Be as effective during your oral board exam as you are everyday at work! Do not tie yourself up in knots with unverified assumptions, false ideas or unnecessary constraints. Do what you routinely and naturally do and do not let little things derail you.

Summary: The Melting Candidate

The points to remember are these:

- During the exam you will have dozens of interactions with the patient and then with the examiners. It is truly rare to have one flubbed interaction derail your exam. So the motto is Never Say Die. Even after you make an error, keep on trucking.
- Keep your attention ahead of you. Do not permit it to lag 20, 30, or 40 minutes in the past, chewing on some smaller or bigger mistake.
- If it helps you maintain your attention right ahead of you and take the sting out of making errors, which you are sure to do – no one is perfect – remember the Celebrity Psychiatrist Challenge. When you get hit by a paint-filled balloon (or a hard question), just resume your stance and prepare for the next interaction.
- If negative self-talk is a problem for you, practice some CBT techniques. Learn to disarm your negative voice by giving it a ridiculous identity or tone of voice.
- Behave in your routine and natural way. Do not let little things derail you.

The Interrogation

Some oral board candidates approach the presentation to the examiners as if it were an enemy interrogation. Each question an examiner asks is suspected of being a trap. The candidate protects himself by hedging his responses with painfully long series of "maybes" and "perhapses." No, this candidate won't be pinned down. He won't give up the secrets of his professional opinion about the patient no matter how harsh the lights or intimidating the examiners!

Interview Rule: Be Forthcoming with Your Professional Judgment

Some candidates are particularly averse to answering the examiners when confronted with questions requiring their professional judgment. These candidates may be adept at presenting the details of the case and answering questions of fact, but regard questions in which their opinion is sought as "trick questions." Thus, these candidates have no problem stating, for instance, the potential adverse effects of a particular medication, the diagnostic criteria of a certain disorder, or the details of the patient's social history. They freeze, however, on questions such as, "Which medication is best?" or "So why do you think the patient acted that way?"

Requests for your professional opinion during your interaction with the examiners are inevitable because they most directly show your ability to integrate and organize disparate data, gain an understanding of the patient, and think through the implications of clinical decisions. This is at the heart of your work as a physician. Sometimes it is hard to hypothesize about things for which you don't have definitive data, but you must do so. Sometimes it is hard to choose among diagnoses each of which seem not to ideally fit the patient's clinical presentation, but you must do so. Sometimes it is hard to speculate about how a patient may respond emotionally to a treatment intervention you are suggesting, but you must do so.

Below are some question types I have repeatedly seen candidates hesitate to answer when they needn't do so.

- Formulation. The Formulation has several parts: a brief case introduction followed by a discussion of etiologic factors, differential diagnoses, risks, and prognostic factors. Biopsychosocial aspects are discussed throughout. Most generally, the formulation answers the questions "What's wrong?" and "How did the patient get to be this way?" (The treatment plan goes on to answer, "What can I do about it?") At the heart of the formulation is your professional judgment on the nature of the patient's problems. You are required to reach judgments on, among other things, which factors seem to have contributed to the patient's decompensation, why these factors have had this impact, and what is the key to effectively addressing them. Some oral board candidates seem especially exposed when requested to share their professional opinion. Keep in mind that you are not Joe Shmoe being asked your opinion on the state of the economy. You are a highly trained professional asked to give a professional opinion. It's OK to do. You will need to speculate (or hypothesize, if you prefer); infer psychological mechanisms such as desires, motivations, and defenses; infer connections among thoughts, feelings, and behaviors; and in general go out on a limb with incomplete and perhaps unknowable information. So what? Give a disclaimer that you are speculating, hypothesizing, guessing, inferring, etc, then go ahead and do it. The examiners

need to see your ability to do so. The burden is on you. If you demur, they will assume a lack of perspicacity on your part.

- Working diagnosis. After you present your differential diagnoses, the examiners are likely to inquire regarding your "working diagnosis." The examiners wish you to choose the most extensive and most likely diagnosis in order to serve as a basis for further discussion. You will be presenting a treatment plan and your interventions need to reflect the ideal approach to treatment. Because this type of discussion takes time and time is short, the examiners wish to limit discussion to a single disorder. A working diagnosis does not imply that it is your definitive choice of correct diagnosis. It's a reasoned guess. It is understood that you are not in a position to be more definite in your judgment of diagnosis. You are working on the basis of a limited interview conducted without the benefit of collateral informants and medical charts. Let's look at a sample scenario. Your differential diagnostic list for the interviewed patient may include major depressive disorder, recurrent, severe with psychotic features and bipolar disorder, depressive episode, severe with psychotic features. The examiner says. "Please choose a working diagnosis." You can respond with something like this, "Given what I know, I believe that bipolar disorder, depressive episode is the most likely diagnosis. The depression is severe and is associated with psychotic features. Given this diagnosis I believe that a mood stabilizer is indicated." Clearly, choosing one diagnosis over the other will dramatically alter your treatment recommendation. Now that you have chosen the one disorder you need to present a treatment that addresses that disorder. The examiners wish to see how reasonable and broad your treatment recommendations for that disorder will be.
- Specific Treatment. Just as the examiners wish to pin you down to a specific working diagnosis to facilitate further discussion, they wish to pin you down to specific treatment interventions. It is insufficient to stop with, "I believe that a mood stabilizer is indicated." You also need to decide which mood stabilizer. I have seen candidates do OK up to this point but lose their cool when asked the dose and schedule. "What dose would you start with, doctor, and what will be your target dose?" is a reasonable question that may be put forth to you. However, some candidates begin to act as if they are being badgered or lured into a trap. They begin with delaying tactics such as, "Well it depends on the patient's weight." The examiners return with, "Well given what you observed of this patient, can you estimate the patient's weight and state a starting dose that you deem reasonable?" And on and on this cycle of "pulling teeth" continues. The examiners' intention is not to fool you. Remember that everyday in clinical practice you make very specific choices. You may choose, for instance, Depakote ER over Depakote. You may choose 500mg bid instead of 500mg tid. You may choose to increase the dose prior to getting a blood level. Etcetera, etcetera, etcetera. I like to point out to medical students that we are not professors writing a treatise. Rather we have live patients who will bear the brunt of our very real decisions. The examiners wish to gauge your ability to carry through on the most fundamental of your tasks as a physician. No tricks here.
- Psychotherapy. This point differs somewhat from the previous ones. Regarding psychotherapy, some candidates occasionally take the approach of hesitating to admit their relative ignorance and begin propounding points of detail that are way beyond their competence. Discussions on psychotherapy seem to see the most bluffing from candidates, perhaps because many of us are not well trained in it, and even for those of us who are, justifying its need and explaining the specifics of the therapeutic interventions is difficult. So my advice on this point is this: you know ahead of time that you will need to present a broad

problem and treatment intervention list. Your Biopsychosocial list will often include a recommendation for psychotherapy. So choose psychodynamic, cognitive-behavioral and supportive therapy and learn before the exam how to succinctly state their principles, indications, and something of the interventions themselves. You do not need to be an expert in this area. But as the physician team member, you need to know the range of treatment options open to you and the indications for prescribing them to your patient, even when you don't carry them out yourself. Think of MRIs. You should know under which conditions you would order one, but you are not expected to choose the MRI sequences or read the images yourself. A radiologist will do that for you.

Interview Rule: The Examiner is Always Right

You've heard that the customer is always right, right? Well, the same is true with the examiners. When they interrupt you it is because they want to interrupt you and it is their prerogative to do so. Your approach should be to stop your train of thought, to listen to the new question, AND THEN ANSWER THE NEW QUESTION to the best of your abilities. A good way to irritate an examiner, or any ordinary human being, is to stop your response long enough to let the examiner ask the new question and then pick up your previous response at the point where you left off before the interruption. Don't do it.

Take the Examiners' Point of View

The examiners' job is to examine your knowledge and skills. If an examiner interrupts you, it probably means that he or she has had enough of a response from you to assess your knowledge in that area. If your answer demonstrates poor understanding of a particular topic, the examiner rightly moves on. Just as you need to interrupt a patient when the patient's answer shows diminishing returns in terms of needed information, so too the examiners interrupt you when they have enough information to judge your base of knowledge on that topic. Although it is a negative situation to be found wanting, for the examiners to continue querying a topic you show weakness in would be cruel and not further add to their ability to adequately assess you. Under the opposite scenario, an examiner may interrupt you having concluded that your knowledge in the area under assessment is adequate. The examiner now wishes to move on to other topics in the short time that he or she has left. It would be ironic if you detracted from a positive assessment of your abilities in a certain area by fighting the examiners' need to control the session and move along to other topics.

Do you see how the presentation to the examiners mirrors your interview of the patient? They are both interviews. In one, you interview the patient and are at pains to control and guide the interview in order to meet your need to adequately assess the patient. The examiners interview you and are at pains to control and guide you in order to meet their need of adequately assessing you. And you both have only about half an hour! Remember, if conducting a half-hour patient interview is difficult for you, conducting a half-hour assessment of you is difficult for them. Taking their point of view for a moment will help bring in perspective approaches that may help you pass.

The examiners have half-hour to evaluate a career's worth of knowledge. They have to decide if you are ready to be "certified" by their organization. This seal of approval now lasts for ten years. If they do a bad job, they may inaccurately cause a worthy candidate the expense and

heart-ache of an inappropriate failure. Or they may certify a candidate who is not up to snuff, thus diminishing the value of certification. Help yourself by helping them. Cooperate as best you can: answer questions fully, speculate if asked to do so, listen carefully, and avoid pretending you know more than you do.

Interview & Presentation Rule: Avoid Premature Closure

Premature closure is the making of a decision prematurely, before you have obtained as much information from the patient as possible or before you have seriously evaluated all options. Although many premature closures become evident in response to an examiner's question, the error has usually occurred much earlier, often during the early part of the patient interview. It is at that time that you began to skew your questions towards the disorder you "discovered," perhaps to the exclusion of other diagnostic possibilities or of the general informational areas that need to be covered.

The examiners may not disagree with your "pet diagnosis" or "pet treatment approach." It's just that during the presentation they want you to consider alternatives. Their questions will try to guide you to other considerations. You may feel that the examiners are under-appreciating or frankly misunderstanding your insight through their limitations as psychiatrists. You might try harder to explain as patiently (patronizingly) as you can the reasons you are right. They may continue their interruptions until you start to get it or until they give up – and probably fail you.

You may already be doomed by the time your error becomes evident through a series of examiner questions. After all, a goodly part of your interview was spent substantiating the very disorder the examiners seem to be under-appreciating. You can't go back to re-interview the patient. You can however, thoughtfully respond to the examiners' queries that are suggesting you look more broadly. A usual question is, "Are there any other diagnoses you wish to consider?" If you say No while they believe Yes, they may follow up with, "How would you explain <some symptom that does not fit your hypothesis>?"

A sample scenario unfolds thus: you listen to a 68-year-old patient's description of his symptoms. He describes auditory hallucinations and a fluctuating level of paranoia that began years or decades ago. In the course of his description he mentions that his memory isn't so good anymore. Later, when discussing why he doesn't leave the house much, he ascribes it to the presence of his paranoid feelings and his poor memory. He adds that his "walking ain't so good anymore either." In a flash of brilliant insight you conclude that the patient has normal pressure hypdrocephalus. You spend two thirds of the rest of the interview asking questions to buttress this diagnosis. His answers are frustratingly vague but you continue to pursue this line of questioning, convinced that you have found the key to the man's problems

You find yourself eager to begin the presentation to the examiners to share your insight with them. They should have already surmised your diagnosis by the content of the questions you put to the patient, but these two old fogies probably don't know a thing about neuropsychiatry. When you start your presentation, the examiners seem to pick up on tiny, tiny inconsistencies, statements in your history that make the normal pressure hydrocephalus less likely than the patient's statements suggested. They may say, "Is that what the patient said?" when you describe the history. You get flustered. You think the patient said it the way you presented it. Who can

know anymore? "Why is this so hard?" you think. You're only three minutes into your history. During the formulation their doubting questions only intensify. "What do they mean did I note that the patient said he had arthritis? What does that… Oh! Maybe they mean as a possible explanation of the 'walking problem.' And their question about Cerebrovascular Disease? Well, I guess that could be a consideration. The patient did say he has hypertension. I'd really like to get back to the hydrocephalus idea, if these guys would only quit with their distracting questions."

What's the solution? Remember that you are working on very incomplete information, a short interview with a single informant. Remain humble in your insights. Present your ideas firmly but never as definitive. Remain open to the "guidance" examiners' questions provide.

Examiners Who Intimidate

Although the American Board of Psychiatry and Neurology carefully train their examiners on the standard and correct examination approach, examiners differ in their disposition. Despite instructions to appear neutral, the approach of some examiners is more intimidating than that of others. Examiners on the more intimidating end of the spectrum interrupt more, permit a tone of irritation to creep into their voices, or ask questions that are phrased in such a way as to suggest disapproval. An example of a question with a negative tone and phrasing from my own failing oral board exam was, "So, if the patient didn't tell you his diagnosis, would you have figured it out yourself?" This examiner sure seemed like he was asking, "So, how big of an idiot are you?"

I bring up this point to give you a heads up to the fact that your examiner may be (or seem to you) more negative or intimidating than the official line about examiners being neutral. If you get such an examiner, my advice applies all the same. Pay close attention to each question. Answer it as best you can. If the question is of the sort, "Would you consider…" or "Do you think the patient could have…" your answer should almost always start with a Yes. If you are interrupted with a new question, then it is the new question that becomes your sole focus.

Your own demeanor should stay calm and neutral. You are now in a war situation and your weapon is respectful attention to the question and to giving sensible responses. This is the way to win the war. If you act out by becoming defensive or argumentative, you increase your chances of failure. Remember that it often is not the mistake you make that leads to failure but your response to your mistake. You have a chance with your "post-mistake" behavior to clarify, expand, or correct your less-than-ideal initial response.

Summary: The Interrogation

The points to remember are these:

- The examiners' job is to assess you just as it was your job to assess the patient.
- When an examiner interrupts you, immediately stop your train of thought and listen to the new question. Then be certain to answer the new question.
- Examiners do not engage trick questions. If an examiner's question suggests you should consider alternative diagnoses or treatment strategies, then you should so.
- Avoid "premature closure," that is, making a decision before you have obtained as much information from the patient as possible or before you have considered the full range of options. Present your ideas firmly but never as definitive.

- Realize that the questions examiners ask can offer you guidance in considering possibilities that you hadn't. Regard them as positives and not as distracting irritations.
- We are professionals who are asked to make professional judgments. You will be asked questions about your opinions. Make clear that you are not in a position to make definitive statements, but do give your opinion, speculative though it may be. Avoid forcing the examiners to pull your opinions out of you like rotten teeth.
- Candidates most frequently hesitate when answering judgment questions. Since the formulation and the treatment plan most clearly require the making of a judgment, it is in these sections of the Q-&-A which candidates often stumble.
- If an examiner seems harsh or intimidating, you must keep your cool. Avoid becoming defensive or argumentative. Maintain your calm to the best of your ability and focus on the questions themselves.

Cookie-Cutter Presenter

I have heard examiners complain that more and more candidates give them "canned presentations." The problem arises when your presentation of a patient sounds like it could be a presentation of any one of many patients. Some candidates' presentations sound generic because they present too narrow a range of problems and / or treatment interventions. Other candidates are good at presenting a broad Biopsychosocial approach, but even then hew to stock formulations and treatment lists. A Cookie-Cutter Presenter describes patients in such a uniform and generic way that each patient seems to be cut from an identical mold.

Presentation Rule: Make Your Presentation Specific to Your Patient

The History

There are several ways to make the presentation of the patient seem genuine and rooted in the patient's unique experience. First, make the history specific. You should try to capture not only the events that led to the patient's decompensation, but also her reactions, her thoughts, feelings, ways of behaving. Many psychological and behavioral reactions have components of positive adjustments to difficult circumstances and prominent psychopathology, but also components of counterproductive adjustments. By highlighting both you will have more material to work with in your formulation and treatment plan.

Include the patient's understanding and explanations into your history. You are not only interested in the symptoms that the patient experiences but also in his conceptualization of them. Many behaviors become logical once the underlying understanding or definition is known. Also, intersperse the patient's own words in your history. This shows careful listening, a respect for the patient's concepts, and helps keep you closer to the "data" and less likely to substitute your own characterizations.

The Formulation

The Formulation begins with a recap of the patient's demographic information and presenting complaints. Then it moves to a presentation of the etiologic factors that have contributed to or maintained the psychopathology. The most common method of organizing and conceptualizing the etiologic factors is the Biopsychosocial one. Below is a (partial) list of Etiologic Factors for you to consider. The more factors that you take under consideration, the more likely you are to present a nuanced and patient-specific assessment.

Biological Factors

- Family vulnerabilities
- Patient's temperament
- Presence of medical illnesses
- Medications taken and presence of adverse effects
- Physical disabilities and impaired mobility

Psychological Factors

- Motivations and desires

- Internal conflicts and ambivalences (among incompatible desires)
- Emotions, e.g., shame and guilt
- Negative cognitions, e.g., catastrophizing, overgeneralizing, all-or-none thinking
- Limited self-regulating skills, e.g., in problem-solving, coping, stress management, or impulse control

Social / Environmental Factors

- Presence of major life events
- Interpersonal conflicts
- Limitations in social skills
- Cultural prohibitions and expectations
- Acculturation difficulties
- Religious / ethical conflicts, prohibitions
- Financial problems
- School / work problems
- Barriers to receiving medical or psychiatric care

The Treatment Plan

The Treatment Plan comprises a Paired Problem-Intervention List.

What are the problems should you include on your Paired Problem-Intervention list?

- Risk: Start with problems associated with risk, especially suicide and homicide risk. Danger of violence towards self or other takes precedence over every other problem start off with it. Define your problem and then provide the specific biopsychosocial interventions that address the problem under consideration.
- Working Diagnosis: Continue by presenting the interventions that address the syndrome or syndromes that are part of your working diagnosis.
- Axis I: Present the problem(s) with paired interventions for any other Axis I disorders.
- Axis II: Do the same for any Axis II disorders you believe the patient is suffering from.
- Axis III: Yes you are responsible for addressing Axis III medical conditions. You may not be the primary care physician but you still may need to order labs and review results, make referrals and maintain communication with other medical providers.
- Axis IV: We do not code disorders on Axis IV. Rather this is a list of psychosocial and environmental problems that the patient is confronting. And yes, you do need to develop an intervention plan for resolving or managing these problems. For instance, if the patient is homeless, referral for social work services may be indicated.

And remember that treatment interventions that you recommend and manage are NOT limited to the ones that you or your staff provides. For example, there are Twelve Step groups for almost every problem and disorder and many of your board patients may benefit from a physician's recommendation to attend one. A brief list includes:

- Alcoholics Anonymous
- Al-Anon
- Teen Al-Anon
- Debters Anonymous

- Gamblers Anonymous
- Incest Survivors Anonymous
- Emotions Anonymous
- Sexual Addiction Anonymous
- Overeaters Anonymous

There are support groups for families struggling with a family member with any one of many psychiatric disorders. There are many, many informational and support group websites for patients and families. Often web-based chat rooms, bulletin boards, and websites offer the latest in treatment options for patients. Don't be surprised if some of your patients will learn about the latest treatments before you do. There are psychosocial rehab programs and senior activity programs available in most cities and towns. You get the point. Keep your vision broad. If you tend to only consider SSRIs and a referral for individual therapy for most patients, don't be surprised if you'll start to sound like a cookie-cutter.

Summary: Cookie-Cutter Presenter

The points to remember are these:

- Take pains to describe your patient in a nuanced and unique way. Your history should take into account your patient's self-understanding and conceptualization of his problems.
- You can use the patient's own words to add specificity to your presentation and help keep you true to the data.
- You must maintain a broad awareness of different problem types, experiences and challenges your patient confronts that contribute to or maintain her psychopathology. Memorize the included list if you must.
- Present your treatment plan as a Paired Problem-Intervention List and organize it by axes, starting with any problems associated with suicidal or homicidal risk.
- Remember to keep your treatment interventions broadly based. Consider Biopsychosocial approaches to every problem under your consideration. You should know the repertoire of treatment interventions in all three spheres.
- Learn about all the self-help and support groups available to your patient and to family members. Know that the web offers much useful information.

Befuddled by the Vignette Exam Section

In 2006, the ABPN replaced the 30 minute videotaped interview exam section with the New Vignette exam section. Here are details about it.

- ✓ The new ABPN Part II Exam format changes went live at the May 2006 exam in Philadelphia.
- ✓ The live patient interview exam section remains unchanged. It comprises an approximately 30 minute psychiatric diagnostic interview followed by an approximately 30 minute examination session during which you present and discuss the case.
- ✓ The exam section consisting of a 30 minute videotaped case is now eliminated.
- ✓ Replacing it is a new "Vignette Exam" section which comprises 3 written vignettes and 1 video vignette.
- ✓ Individual vignettes are developed to test different parts of your knowledge base. Written vignettes are either focused on Diagnostic or on Treatment Issues and the video vignette either focuses on predominantly Axis I or on Axis II psychopathology.
- ✓ Each vignette is presented at its own station, which is located in its own examination room. Each station has a single examiner.
- ✓ The time spent at each station is approximately 12 minutes and is followed by a 3 minute transition period to permit you to move to your next station.
- ✓ You will spend your 3 minute transition period moving to the next station or seated in the hall in front of the examination room for your next station.

Details of the Written Vignette

- ✓ Written Vignettes are 300-500 words in length, which is between half and a three quarters of a single-spaced page.
- ✓ That station's examiner reads the case aloud to you. In addition, you are handed a copy of the vignette so that you may read along with the examiner.
- ✓ Before the examiner begins reading the vignette he or she tells you whether the vignette is focused on diagnostic or on treatment issues.
- ✓ You are not permitted to take notes on the written vignette sheet but may do so on a separate blank sheet of paper.
- ✓ Reading the written vignette will take about 3-4 minutes of time, so you will have approximately 8 minutes time remaining at the station for your Q-&-A period.
- ✓ The examiner begins asking you questions about the written vignette immediately after reading it to you. Thus, there is no interval of time given for you to gather your thoughts between the reading of the written vignette and the examination period.
- ✓ You will not be asked to present the case. Rather, the examiner will launch directly into a specific question regarding the written vignette.

Details of the Video Vignette:

- ✓ The video vignette is approximately 4 minutes long.
- ✓ The video vignette cases presented are of patients with either a predominantly Axis I or an Axis II disorder.
- ✓ The Q-&-A period is similar to the ones following the written vignettes. You are asked approximately 4 main questions about the case.

- ✓ The questions focus on 1) details of the case history 2) on visual observation, and on the interpersonal behaviors between the patient and clinician.

Vignette Examination Session & Scoring

- ✓ Scoring is done independently for each vignette and is completed by that station's examiner.
- ✓ The examiner asks you a series of standardized questions. The examiner may at his or her discretion ask follow up questions to clarify or extend the focus of the standardized questions.
- ✓ Your responses to the questions are rated on their comprehensiveness and accuracy.
- ✓ The examiner rates your responses based on semi-standardized guidelines of expected information included in your responses. For example, if the patient observed on the video clip has dyskinetic movements of a choreoathetoid nature, "Neuroleptic-Induced Tardive Dyskinesia" would be an expected diagnosis included in your differential diagnosis.
- ✓ Your examiner does not score individual questions. Rather the examiner scores your overall performance over the entire 8 minute Q-&-A session.
- ✓ Each vignette, as well as the live patient interview, is scored on a 1-8 scale.
- ✓ The Live Patient Interview section and the Vignette section of the exam carry equal weight in the scoring.

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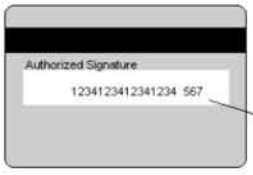

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