A Five-Minute Psychiatric Screening Interview

Mark Zimmerman, MD
Philadelphia, Pennsylvania

Recent studies indicate that as many as 30% of primary care patients have some type of psychiatric disorder. Although common, these disorders are often neither detected nor treated by primary care physicians. A brief interview is described that can be used as an effective screening tool to identify patients who require further evaluation.

Key words. Psychiatry; primary care; mass screening; interview. (*J Fam Pract 1993; 37:479-482*)

During the past decade much has been learned about the epidemiology of psychiatric disorders, especially depression, in primary care settings. Recent reviews estimate that 6% to 10% of medical patients have a major depressive disorder, and that 10% to 30% of patients have some psychiatric disorder.[1,2] Although these syndromes are common, research also indicates that they are often not detected and not treated.[3–5] Because as many individuals with psychiatric disorders receive treatment from primary care physicians as from mental health specialists,[6] several authorities have emphasized the importance of training primary care physicians in the diagnosis and treatment of psychiatric disorders.[7–9]

Efforts to increase primary care physicians' awareness of and knowledge about psychiatric disorders has taken three forms. First, more space in medical journals has been given to research and commentary on psychopathology, especially depression. In *The Journal of the American Medical Association*, for example, a MEDLINE search revealed that depression was the major focus of 31 publications during the previous 5 years (1988 through 1992), in contrast to only 18 publications from 1980 through 1984, and 12 publications during the 5 years before that. The emphasis on depression is understandable because somatic complaints are a frequent manifestation of depression,[10–12] and physical symptoms cause patients to visit medical rather than mental health providers. In the Epidemiologic Catchment Area study,[6,13,14] however, it is noteworthy that anxiety disorders were more frequent than depressive disorders, and that persons with phobias, panic disorder, or obsessive-compulsive disorder were also as likely to receive treatment from primary care physicians as from mental health specialists. In fact, across the entire spectrum of psychiatric and addictive disorders, patients were as likely to be treated by primary care physicians as by specialists in mental health.

The second method of improving detection of psychiatric disorders in medical settings has been the development of self-administered screening questionnaires for psychopathology. Again, there has been an emphasis on depression, and self-administered depression scales have been studied widely in medical settings.[15–20] Although these questionnaires are inexpensive, easy to use, and thought by primary care physicians to be helpful,[21] they have not achieved widespread acceptance by clinicians. Of note, no authoritative source or task force recommends the use of these instruments to screen for depression or for any other psychiatric disorder.[22–24]

The third method of increasing primary care physicians' knowledge about psychopathology has been the development of educational programs for trainees in family practice and internal medicine.[25–27] Preliminary studies have been positive regarding the acquisition of knowledge, although whether this will generalize to improved clinical practice has yet to be demonstrated. Anecdotal observations suggest that increasing numbers of family practice residency programs are providing training in psychiatry; internal medicine residency programs seem

Submitted, revised, June 22, 1993.

From the Department of Psychiatry, Medical College of Pennsylvania, Philadelphia. Requests for reprints should be addressed to Mark Zimmerman, MD, Medical College of Pennsylvania at Eastern Pennsylvania Psychiatric Institute, 3200 Henry Ave, Philadelphia, PA 19129.

© 1993 Appleton & Lange
ISSN 0094-3509

A Five-Minute Psychiatric Screening Interview

Major Depression/Dysthymia
Let me begin by asking about your mood. How would you describe your mood?
Have you been feeling sad, blue, down, or depressed?
Have you lost interest in, or do you get less pleasure from, the things you used to enjoy?

Mania/Hypomania
Have there been times lasting a couple of days or more when you felt the opposite of depressed, that is when you were very cheerful or high, and this felt different from your normal self?
If no: What about a period lasting at least a couple of days when you were unusually irritable and excitable, and quick to argue or fight?

Generalized Anxiety Disorder
What about feeling nervous or tense?

Panic Disorder
Have you ever had an anxiety or panic attack in which you had a sudden rush of very intense fear or anxiety?

Social Phobia
Some people have very strong fears of being watched or evaluated by others. For example, a fear of eating or writing in front of others, public speaking, saying something foolish in a group of people, etc. Do you worry that you might do or say something that would embarrass you in front of others?

Simple Phobia
Some people have very strong fears or phobias of certain situations or things, such as heights, flying, bugs, snakes, etc. Do you have any very strong fears or phobias?

Agoraphobia
What about fears of bridges, tunnels, going outside alone, being at home alone, or other places or situations?

Obsessions
Some people are frequently bothered by silly, unpleasant, or horrible thoughts that seem unreasonable or do not make sense, but they keep repeating over and over. For example, repeated thoughts that you might hurt or kill someone you love, even though you didn't want to; that someone you love is hurt; that you will yell obscenities in public; that you are contaminated by germs or dirt; or that you just hit someone while driving. Has anything like this been a problem for you?

Compulsions
Some people are frequently bothered by having to do something over and over that they couldn't resist when they tried. For example, they wash their hands repeatedly, check whether the door is locked or the stove is turned off, or count things excessively. Has this been a problem for you?

Alcohol Abuse/Dependence
Now I'm going to ask a few questions about your use of alcohol. What are your drinking habits like?
Was there ever a time in your life when you drank too much?
Has anyone in your family, or friends, or a doctor, or anyone else ever said that you were an excessive drinker?
Has alcohol ever caused problems for you?

Drug Abuse/Dependence
What about street drugs? Have you ever used street drugs?
Did you or anyone else ever think you used drugs too much?
Did you ever use sleeping pills, weight loss medicines, or painkillers?
If yes: Did you ever get hooked on them or take more than was prescribed?

Bulimia
Now let me ask a couple of questions about your eating habits. Have you ever gone on eating binges when you ate an abnormally large amount of food over a short period of time?

Anorexia Nervosa
Has there ever been a time when people gave you a hard time about being too thin or losing too much weight?

Post-traumatic Stress Disorder
Earlier, I asked a little bit about recent stressors. Considering your entire life, have you ever seen, experienced, or been the victim of a traumatic event such as rape, assault, sexual abuse, combat, or any other extreme event?

Psychosis
And finally, does your mind ever play tricks on you so that you hear things that other people don't hear, or see things they don't see?
Do you ever feel like someone's spying on you or plotting to hurt you?
Do you have any ideas that you don't like to talk about because you're afraid other people will think you're crazy?

to have been slower to add this training to their curriculum. For many physicians, the major psychiatric training remains a 6- to 8-week clerkship in the third year of medical school. These clerkship experiences are usually based in psychiatric hospitals or on locked psychiatric units in general hospitals, where students predominantly see severely disorganized, psychotic, manic, or melancholic patients. Thus, the type of psychopathology seen during the clerkship bears little resemblance to the type of pathology seen in outpatient medical settings.

The Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R)[28] lists the disorders and specifies criteria for making specific diagnoses, but it does not guide the user in inquiring for these criteria. Because of this, I developed two guides to assist clinicians in evaluating psychiatric disorders.[29-30]

Not every patient visiting a medical office should undergo a detailed, hour-long psychiatric anamnesis. However, a brief mental health review of systems covering many of the major psychiatric syndromes could be routinely incorporated into a physician's initial evaluation. A single, all-encompassing, general question such as "How are your nerves?" or "Do you have any problems with your nerves or emotions?" is problematic. Some patients will not want to identify a particular difficulty as an emotional problem. Some will not know what to include under the rubric of "nerve problems." Others will be too embarrassed to describe their problem because they think it is unique to them and it means that they are "crazy."

Inquiring about specific symptoms is a more effective method of conducting a psychiatric review of systems because it eliminates the vagueness of broad, general questions, and it reassures the patient who thinks he or she is the only person with this kind of problem by implicitly indicating that others have experienced these symptoms. An example of a psychiatric screening interview that covers 15 areas of psychopathology and takes less than 5 minutes to complete is presented in the Table.

The transition from medical history-taking to the psychiatric review of systems could be awkward. One can lead into the psychiatric history by saying:

> One of the most important parts of a person's well-being is emotional health. Stress and nerves have a big influence on many of my patients' physical problems. I want to take a few minutes now to understand how you deal with life stress and whether anything is bothering you emotionally. I know that it's sometimes difficult to talk about these things. However, during the past few years doctors have learned that a large number of their patients are bothered by clinical anxiety or depression that never gets properly diagnosed or treated.

The interviewer then begins the psychiatric review of systems with an open-ended question about the patient's mood (Table). A patient with a mood or anxiety disorder may not use terms such as "depression" or "anxiety;" therefore, it is preferable to begin with an open-ended question about mood that can be followed up with questions to clarify the meaning of the patient's description. Most of the screening questions ask about the presence of specific symptoms; however, the questions are worded in patient-oriented language. It is preferable to ask if the patient has "fears" rather than "phobias," "unpleasant repetitive thoughts" rather than "obsessions," "repetitive behaviors that cannot be resisted" rather than "compulsions," and so forth. Illustrative examples of the pathology are also included in the questions. Transition statements are included to make the interview flow more smoothly.

The questions in the Table are to screen for DSM-III-R disorders. Thus, positive responses need to be clarified and followed up with questions assessing the full set of diagnostic criteria. Lists of questions for DSM-III-R disorders can be found in diagnostic interviews used in research,[31-33] and in more clinically oriented books on diagnostic assessment.[29,30]

It is perhaps controversial to suggest that a valid psychiatric evaluation and diagnosis can be achieved by asking questions from an interview schedule. This is how diagnoses are made in most psychiatric research, however, and there is little evidence to demonstrate the superiority of seasoned clinicians over trained research assistants (or computers) in making psychiatric diagnoses. Moreover, it is the underdiagnosis and undertreatment of psychiatric disorders in the medical setting that is the major problem. The 5-minute psychiatric screening interview and clinician-friendly diagnostic interviews should help physicians care for their many patients with psychiatric disease.

Acknowledgment

David T. Lush, MD, and Neil Farber, MD, provided comments and suggestions.

References

1. Katon W, Schulberg HC. Epidemiology of depression in primary care. Gen Hosp Psychiatry 1992; 14:237–47.
2. Schulberg HC, Burns BJ. Mental disorders in primary care: epidemiologic, diagnostic, and treatment research directions. Gen Hosp Psychiatry 1988; 10:79–87.
3. Keller MB. Depression underrecognition and undertreatment by psychiatrists and other health care professionals. Arch Intern Med 1990; 150:946–8.
4. Linn LS, Yager J. Recognition of depression and anxiety by primary physicians. Psychosomatics 1984; 24:593–600.
5. Rosenthal MP, Goldfarb NI, Carlson BL, Sagi PC, Balaban DJ. Assessment of depression in a family practice center. J Fam Pract 1987; 25:143–9.

6. Narrow WE, Regier DA, Rae DS, Manderscheid RW, Locke BZ. Use of services by persons with mental and addictive disorders: findings from the National Institute of Mental Health Epidemiologic Catchment Area Program. Arch Gen Psychiatry 1993; 50: 95–107.
7. Lipowski ZJ. Is the education of primary care physicians adequate? Gen Hosp Psychiatry 1992; 14:361–2.
8. Schulberg HC, McClelland M. A conceptual model for educating primary care providers in the diagnosis and treatment of depression. Gen Hosp Psychiatry 1987; 9:1–10.
9. Pincus H, Strain J, Houpt J, Gise L. Models of mental health training in primary care. JAMA 1983; 249:3065–8.
10. Williamson PS, Yates WR. The initial presentation of depression in family practice and psychiatric outpatients. Gen Hosp Psychiatry 1989; 11:188–93.
11. Prestidge BR, Lake CR. Prevalence and recognition of depression among primary care outpatients. J Fam Pract 1987; 25:67–72.
12. Widmer RB, Cadoret RJ. Depression in primary care: changes in pattern of patient visits and complaints during a developing depression. J Fam Pract 1978; 7:293–302.
13. Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto US mental and addictive disorders service system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. Arch Gen Psychiatry 1993; 50:85–93.
14. Shapiro S, Skinner EA, Kessler LG, Von Korff M, German PS, Tischler GL, et al. Utilization of health and mental health services: three Epidemiologic Catchment Area sites. Arch Gen Psychiatry 1984; 41:971–8.
15. Koenig HG, Cohen HJ, Blazer DG, Meador KG, Westlund R. A brief depression scale for use in the medically ill. Int J Psychiatry Med 1992; 22:183–95.
16. Kathol RG, Mutgi A, Williams J, Clamon G, Noyes R. Diagnosis of major depression in cancer patients according to four sets of criteria. Am J Psychiatry 1990; 147:1021–4.
17. Craven JL, Rodin GM, Littlefield C. The Beck Depression Inventory as a screening device for major depression in renal dialysis patients. Int J Psychiatry Med 1988; 18:365–74.
18. Golden RN, McCartney CF, Haggerty JJ, Raft D, Nemeroff CB, Ekstrom D, et al. The detection of depression by patient self-report in women with gynecologic cancer. Int J Psychiatry Med 1991; 21:17–27.
19. Harper RG, Kotik-Harper D, Kirby H. Psychometric assessment of depression in an elderly general medical population: over- or underassessment? J Nerv Ment Dis 1990; 178:113–9.
20. Kitchell MA, Barnes RF, Veith RC, Okimoto JT, Raskind MA. Screening for depression in hospitalized geriatric medical patients. J Am Geriatr Soc 1982; 30:174–7.
21. Rucker L, Frye EB, Cygan RW. Feasibility and usefulness of depression screening in medical outpatients. Arch Intern Med 1986; 146:729–31.
22. Canadian Task Force on the Periodic Health Examination. Periodic Health Examination monograph. Quebec, Canada: Government Publishing Centre, 1980.
23. Frame PS. A critical review of adult health maintenance: part 4. Prevention of metabolic, behavioral, and miscellaneous conditions. J Fam Prac 1986; 23:29–39.
24. US Preventive Services Task Force. Guide to clinical preventive services: an assessment of the effectiveness of 169 interventions. Baltimore: Williams & Wilkins, 1989.
25. Cohen-Cole SA, Boker J, Bird J, Folks D, Raczynski J, Hain J, et al. Psychiatric education improves internists' knowledge: a three-year randomized, controlled evaluation. Psychosom Med 1993; 55:212–8.
26. Sivik T. Education of general practitioners in psychosomatic medicine: effects of a training program on the daily work at Swedish primary health care centers. Gen Hosp Psychiatry 1992; 14: 375–9.
27. Cohen-Cole SA, Bird J, Boker J, Freeman A, Hain S, Palmer R, et al. Psychiatric education for internists: a randomized, controlled comparison of two teaching models. Psychosom Med 1982; 44: 122.
28. American Psychiatric Association, Committee on Nomenclature and Statistics. Diagnostic and statistical manual of mental disorders—third edition, revised. Washington DC: American Psychiatric Association, 1987.
29. Zimmerman M. Interview guide for evaluating DSM-III-R psychiatric disorders and the mental status examination. Philadelphia: Psych Products Press, 1992.
30. Zimmerman M. Diagnosing DSM-III-R psychiatric disorders in primary care settings: an interview guide for the nonpsychiatrist physician. Philadelphia: Psych Products Press, 1993.
31. Endicott J, Spitzer RL. A diagnostic interview: the Schedule for Affective Disorders and Schizophrenia. Arch Gen Psychiatry 1978; 35:837–44.
32. Robins LN, Helzer JE, Croughan J, Ratcliff KS. National Institute of Mental Health Diagnostic Interview Schedule: its history, characteristics, and validity. Arch Gen Psychiatry 1981; 38:381–9.
33. Williams JBW, Gibbon M, First MB, Spitzer RL, Davies M, Borus J, et al. The Structured Clinical Interview for DSM-III-R (SCID) II: Multi-site test-retest reliability. Arch Gen Psychiatry 1992; 49:630–6.