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EMPATHIC INTERVIEWING REVISITED

Dear Sir,

We read with interest the recent comments of Peter Maguire ("Psychiatrists also need Interview Training" *Journal*, October 1982, **141**, 423–24) concerning the training needs of both family practice (general internist) and psychiatric residents, specifically with regard to interviewing patients. This letter is to reaffirm some of his views and to report some of our own efforts in teaching interviewing techniques.

Each of the authors were third year psychiatric residents at the University of Pittsburgh when we undertook our community psychiatry placement at a local family practice residency program. The overall requirement was for us to become mental health consultants, and for two days per week for six months a year, learn the principles based on the work of Gerald Caplan and others. We went to rounds on an inpatient unit with the family practice residents, and the director of the residency, and advised in the outpatient clinic. The remainder of the time was used differently by each of us, on research projects, lectures, nurse's groups, seminar attendance, etc.

On the inpatient unit we were present at the bedside for some of the first encounters between patient and resident, and one day a week, for both resident rounds and attending rounds. On all these occasions we were free to comment on the interview to the resident, and to ask questions for own medical knowledge, and to volunteer information to the resident. On rounds we were also available for demonstration interviews. In the outpatient clinic, we were also available for first encounters, follow-ups, and for psychiatric resource purposes, i.e. pharmacotherapy, hypnotherapy, etc. Our consultation was supervised by a Board certified psychiatrist and a psychologist with specific expertize in mental health consultation.

The scheme of teaching included interviewing and the doctor-patient relationship, through Balint seminars, lectures, and supervised case management. This latter supervision is provided usually by a social worker as well as other staff family practitioners, while the Balint seminars are led by psychiatrists. Videotaped interviewing is rare and we are not yet fully equipped for its general use.

With regard to our role as teachers and observers, we noted the following, and have ranked them according to importance:

1. The different personalities of the residents (including how complexities of a case related personally to the residents) played an important part in determining how receptive residents were to our suggestions as well as the ease with which we were accepted into the room with the residents for the first encounter. Also, it was interesting to note that certain residents seemed to ask more insightful questions and were more open to suggestion. This pattern remained consistent over time and was not affected by the change in the teaching psychiatrist.
2. In general, first year residents were more receptive to suggestions, both psychiatric and medical, than the more senior residents.
3. It was easier for us to gain access to a room with a resident if his senior gave approval, and his sanction had different manifestations; the senior could give a suggestion to the resident that we accompany him, or could be asked to see a patient alone, or he could just be asked a general question in psychiatry.
4. The interrelationship of the behavioural aspects of a case was usually underplayed.
5. We, as psychiatrists, were continually amazed that the sensitivity to specific and often hidden behavioural issues seemingly acquired by clinical experience and demonstrated by several senior physicians, especially the residency director, could not really be taught. In addition, residents were more interested in emulating the medical knowledge than the behavioural science knowledge.

Residents and sometimes seniors are uncomfortable being watched, but we agree that the traditional method of sending the medical student or resident into a room and bringing back the data (the facts) is

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deficient. At our own institution videotaping is common and is quite a valuable teaching device for ourselves. But some of the resistance mentioned above and in Dr Maguire's comments also occurs.

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PUERPERAL AFFECTIVE DISORDERS AND RESPONSE TO LITHIUM

DEAR SIR,

We read with interest the report by Katona (*Journal,* 1982, **141,** 447–52) comparing puerperal and non-puerperal psychiatric illness and noted the high preponderence of affective illness in the puerperal sample. We were however surprised to observe that lithium was used less often in puerperal than in non-puerperal manic disorder.

For many years we have used lithium in the prophylaxis of recurrent affective disorders. Among our patients, 24 had puerperal affective illness and 19 of these patients had their first affecive episode post partum. This group was compared with a group of multiparous non-puerperal affectively ill patients in terms of clinical variables and response to lithium over one year. There was no differences between puerperal and non-puerperal patients in age, prevalence of family history of affective disorder, number of episodes prior to starting lithium and time on lithium prophylaxis.

Bipolar and unipolar puerperal patients had significantly lower mean age of onset than corresponding non-puerperal patients (see Table). Response to lithium was measured by an affective morbidity index (Coppen *et al,* 1973). Bipolar and unipolar puerperal patients had a similar response to lithium to corresponding non-puerperal patients.

First year response to lithium was shown to be a powerful predictor of long-term response. (Abou-Saleh and Coppen, unpublished observation).

The recurrence rate of puerperal affective illness in the present series was 57 per cent in bipolar and 53 per cent in unipolar puerperal patients.

These findings show the high morbidity of puerperal affective disorders and strongly suggest the need for lithium prophylaxis in these disorders.

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TABLE
Comparison of puerperal and non-puerperal affectively ill patients (results expressed as mean ± S.E.)

Group	N	Age (Yrs)	Age of onset (Yrs)	Affective morbidity index
Puerperal bipolar	7	57.1±2.7	24.8*±2.3	0.14±0.08
Non-puerperal bipolar	5	63.2±2.7	39.2±2.9	0.11±0.05
Puerperal unipolar	17	54.2±2.8	29.5**±2.3	0.19±0.05
Non-puerperal unipolar	25	60.5±2.1	46.2±2.4	0.19±0.08

* Significantly lower than non-puerperal bipolars P <0.01
** Significantly lower than non-puerperal unipolars P <0.001

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