REPORTS IN PSYCHOTHERAPY: INITIAL INTERVIEWS

formulated by
the committee on therapy

Group for the Advancement of Psychiatry

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REPORTS IN PSYCHOTHERAPY:
INITIAL INTERVIEWS

1. INTRODUCTION

This is the first of a series of reports on psychotherapy. Although subsequent papers will concern goals, processes, techniques and evaluation of therapy, the particular subject of this report is the initial psychiatric interview itself. We contend that the first consultative contact of a patient with a psychiatrist is an integral event within the total psychotherapeutic process. Some authors do indeed separate history-taking from the beginning of treatment, but we do not believe that this is in practice a valid dichotomy. On the contrary, we contend that the patterns and attitudes established during these first meetings are likely to have a substantial and abiding influence on the relations between physician and patient. Gathering data is of course necessary to an adequate diagnostic formulation and to a planned program of treatment but the initial interchange is inseparable from the whole psychotherapeutic process. Psychotherapy commences with the initial evaluative interviews.

This report concerns general principles not techniques. And it is based on a consensus of current clinical experience in psychotherapeutic practice. It is intended primarily for educational purposes. Education is different from training in that the former can be defined as instruction in general principles but the latter emphasizes technical devices. Specific techniques must be acquired in actual clinical situations, preferably under expert supervision, in which many diverse clinical problems are encountered. Many factors make this necessary: variation in the types of patients, the personality, life-experience and training of the particular therapist, the specific setting in which he works. Each of these requires subtle technical modifications of method and approach.

Speaking generally, however, we can say that the initial psy.
II. THE ESTABLISHMENT OF THE THERAPEUTIC ALLIANCE

Patients who come for psychiatric consultation are referred from a great many different sources. Physicians, social agencies, educational institutions, courts, friends, relatives, other patients provide the initial stimulus for the patient's first contact with the psychiatrist. Some patients seek consultation on their own initiative without an intermediary. Certain aspects of the doctor-patient relationship may be influenced by the source and the method of referral even before the patient arrives at the initial interview. The relation of the patient to the individual or institution that has advised the consultation (and the preconceptions that are intentionally or inadvertently transmitted to him) may have important effects upon the consultation. Potential sources of misunderstanding between doctor and patient can often be avoided by a knowledge of those influences which preceded the interview itself.

The Initial Contact

The first stages of the initial interview are concerned with the establishment of mutual understanding and with the greatest possible freedom of communication. Privacy, mutual respect and confidentiality are essential. A suitable setting is necessary, therefore, as well as the need to observe the ordinary amenities which usually attend a first meeting between two strangers. Indeed, these should take precedence over diagnostic interrogation. Even at this stage, however, the way the patient talks, his facial expression, his gestures in response to the interviewer, as well as the interviewer's reaction to him—all these convey valuable information. Some degree of confidence and trust on the part of both patient and interviewing physician is essential to obtaining relevant information, to the patient's subsequent acceptance of the psychiatrist's recommendations and to any therapeutic alliance that may be established. Initial interviews are shaped by the respective aims of the patient and psychiatrist just as in the treatment process the therapist and quitous. A large number of patients fail to keep their initial appointments at psychiatric clinics. In varying degree, every individual shares in a fear of mental illness. Embarrassment, shame and guilt are some of the other feelings that often accompany the patient's recognition that he needs psychiatric help. It is important to estimate in a particular individual, the degree to which the recommendation of psychotherapy will be felt as an emotional threat rather than as reassurance. This may determine the manner and the timing of therapeutic suggestions. The prospect of therapy may also mobilize an unconscious fear of change in the patient in contradiction to his stated wish to be different. Many apparently successful initial interviews, rich in information, have been followed by an unexplained disappearance of the patient whose anxiety about psychiatric treatment may not have been sufficiently recognized and alleviated during the interviews.

The attempt to relieve anxiety about treatment is one example of doing something appropriate for the patient even at the first contact. There are also other ways of fulfilling a patient's realistic needs so that a feeling of trust can be established as soon as possible between the patient and his physician. Among those that we consider of particular importance are recognition of the patient's assets, appreciation of his accomplishments and support of his self-esteem. The constructive efforts which he had formerly made in trying to deal with his problems should be acknowledged. No therapeutic purpose is served either by criticism or condemnation or by condoning those activities that are symptoms of his illness. Such a non-judgmental approach may be the patient's first experience of a therapeutic attitude and may furnish an important initial source of emotional support. A phobic patient, for example, may assume that people would ridicule or despise him if they knew the fears which he has tried to conceal. Our understanding of his feelings does not imply that interpretations of the dynamics of his illness are given at this stage, nor that we have any more knowledge about his specific problem than we actually possess; but rather, that we are willing to try to help with the process of finding the reasons for his difficulties. The establishment of an alliance with the healthy part of his personality, vs-a-vis his illness, is the beginning of the collaborative therapeutic effort. Some clarification of the patient's presenting problems may be
his infantile wishes so that he can then try to satisfy mature desires in an appropriate fashion. The gratification of socially unrealistic desires increases the patient's inner conflict and thus harms rather than helps him. The therapist is confronted by a problem that is similar to that of a parent. He must find a balance between giving too much and too little—between spoiling and depriving. It may be necessary, in some instances, to help an actually deprived individual obtain aid essential for his well being. However, a patient's emphasis on actual deprivation may conceal unrealistic demands. In helping to solve realistic problems, the therapist may unwittingly promote a situation wherein the patient will remain intolerant of frustration and unable to distinguish between the feelings which arise from the frustration of realistic needs and those which are produced by the failure of his environment to gratify his infantile wishes. Patients who are too readily treated by this kind of direct intervention do not have their hunger appeased but rather their insatiability enhanced.

Often the patient is telling us about his present problem regardless of the tense in which he speaks. Whether the patient speaks of his present life, recent or past history, we are constantly alert to the probability that he is in some way revealing his present situation, his conflicts and unsuccessful methods of dealing with his underlying difficulties. The way he feels about the interview and the interviewer is also implicit in what he says and provides the perceptive consultant with a preview of the transference problems that are likely to emerge in any subsequent treatment.

Precipitating Events

Every individual reacts to crucial life experiences in his own characteristic manner. Many kinds of experience may serve as precipitating events leading to the failure of adaptation and to the production of symptoms. There may have been a meaningful change in the patient's life or in the life of some person who is important to him. The change may have been a tragic one, such as illness or loss of an important object, or a presumably happy event, such as the birth of a sibling. The precipitating event may appear trivial to the onlooker but have an important meaning for the patient. Events which threaten an individual's self esteem, security or established ideals and value systems, are especially fraught with traumatic potential. Somatic disease, an injury or an operation, may produce unforeseen emotional consequences. Each decisive phase of life, such as the beginning of school, puberty, graduation, marriage, childbirth, the entering upon a professional career, the climacteric and aging requires its own psychic readjustments on the part of the individual and increases specific vulnerability to psychological disturbance in those already predisposed. This is also true of certain special situations that are not part of the usual life expectancies, such as exposure to military combat. It is necessary to consider every variety of experience that may have a special significance for the individual involved.

Fluctuations in the level of sexual and aggressive tensions, for example, at puberty, during pregnancy or the menopause, are often precipitating factors. There are also a variety of situations to be considered in which the production of conscious or unconscious guilt is of primary significance. These may occur, and produce such a reaction, even when the patient himself has not
ration on test procedures and results permits the psychiatrist to deal more adequately with the patient, who may have questions about the results of the tests, within the total context of the diagnostic and therapeutic situation.

In some instances other members of the family may be interviewed to gain necessary information which is not available from the patient. This may also be helpful in enlisting their cooperation and aid in encouraging the patient to carry out the therapeutic recommendations. This may be essential in the case of patients who are grossly psychotic, elderly, delirious or suicidal and certainly when the patient is a child. Whether the psychiatrist elects to see the relatives himself or refers them to a psychiatric colleague or to a psychiatric social case worker depends upon many factors. These include the time that is available for interviews, their setting, their purposes and the availability of such auxiliary services. The attitude of the patient toward such interviews, as well as the attitude of his relatives, will have to be considered in such decisions. The preservation of the confidential nature of the doctor-patient relationship usually takes precedence over the more immediate advantages that such a step may gain. In most instances the preservation of the patient’s trust and the protection of the therapeutic alliance demand that such contacts be minimized. When they are clearly indicated, they should be arranged with the patient’s prior knowledge and consent whenever this is possible.

Diagnostic Formulation

From the data obtained by these procedures, a provisional clinical and psychodynamic diagnostic formulation is made. This formulation should include the nature of the current problem, the patient’s physical condition and environmental situation, the nature of the precipitating stresses, the patient’s habitual methods of coping with stresses and the efficacy of these methods. An attempt should be made to reconstruct the historical determinants of the current conflict and to estimate the strength of the forces predisposing him to his current illness. The formulation should include a description of the patient’s personality, his characteristic methods of adjusting to his environment and to the people with whom he is most frequently in contact. It should also include a description of his concept of himself, his feelings of identity, and his usual

IV. EVALUATION OF THERAPEUTIC POSSIBILITIES

The third aim of the initial interviews is to decide upon the appropriate treatment for the particular patient. This will include an assessment of the indications for, and his accessibility to, psychotherapy. It will also include consideration of other treatment measures or referrals. It may be necessary to consider urgent action, as for example, the hospitalization of a depressed, suicidal patient. Certain types of organic brain disease, addictions or psychotic behavior may require some immediate intervention in order to protect the patient or the community. Anti-social behavior may require special referral to an agency or institution within whose competence it properly lies.

In estimating the patient’s accessibility to psychotherapy, his motivations, willingness to change and awareness of responsibility for his difficulties will play a most important role. Other factors to be considered are his physical condition, his intelligence, his capacity for psychological awareness, his ability to verbalize his problems, his ability to tolerate frustration, his resiliency, flexibility and his capacity to substitute the satisfaction of healthy activities for the secondary gains of illness. Lastly, the decision will be influenced by the psychiatrist’s estimate of the patient’s capacity to relate to others, including himself.

The consulting psychiatrist is called upon to make certain realistic appraisals, as well as prognostic predictions, in evaluating psychotherapeutic possibilities. Some patients who fulfill all of the criteria of accessibility may live in communities where psychotherapy is unavailable in a clinic or they may not be able to afford private care. The patient may be financially ineligible for clinic treatment and yet, in such an economic situation that the expense of private care would cause greater unrealistic burdens than the illness itself. Sometimes a patient’s working schedule or location may put such obstacles in the way of a therapeutic schedule as to
V. FORMULATION OF THE TENTATIVE OBJECTIVES OF TREATMENT

The next aim of the initial interview is to establish tentative goals of therapy. These will probably change during treatment as the patient’s problems become clarified. Since a systematic discussion of the goals of psychotherapy will be the subject of a separate report, we will restrict ourselves here to briefly mentioning them. The psychiatrist may envisage goals which range from the strictly palliative, aimed only at amelioration of symptoms, to attempts at major personality reorganization. Between these two extremes he may attempt to bring about varying degrees of change in personality functioning. From the point of view of the therapist, apparently superficial change may be the only practical possibility that presents itself. From the patient’s point of view, however, such a change may have profound significance and occasionally may even represent the difference between life and death. For example, a psychotherapeutic intervention which reduces the severity of diarrhea, may be far from superficial to a patient with ulcerative colitis.

Other examples of limited goals would be helping a family to accept a patient’s irreversible illness, helping a patient to accept the threat of loss or actual loss of a loved one, or even to face his own imminent death. Limited functional goals include the amelioration of the severity of a patient’s symptoms or the modifications of his social adjustment.
REFERENCES


Group for the Advancement of Psychiatry

The Group for the Advancement of Psychiatry has a membership of approximately 185 psychiatrists, organized in the form of a number of working committees which direct their efforts toward the study of various aspects of mental health and human relations. GAP is an independent group and its reports reflect the composite findings and opinions of its members only, guided by its many consultants.

Collaboration with specialists in other disciplines has been and is one of GAP’s working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisions a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health and human relations;

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