THE TECHNIQUE OF PSYCHOTHERAPY

The Initial Interview Collating Essential Data

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The Initial Interview: Collating Essential Data

Essential data will be needed to enable the therapist to fulfill the purpose of the initial interview. These must be obtained in an atmosphere of empathy in order to get a cogent understanding of the existing problem, to pierce resistances the patient has to treatment, and to assess existing and latent coping strengths. In collating data one must remember that the patient may withhold significant information for a number of reasons, such as (1) the patient may not know which facts are most meaningful and thus may stress the less important details; (2) may accept certain neurotic aspects as “normal” and environmental stress situations as inevitable and not consider them worthy of mention; (3) may have emotional blocks to revealing some incidents (anxiety here invokes suppressive and repressive mechanisms); (4) may have no respect for, mistrust, or fear the interviewer.

Because of these facts, it may be necessary to piece together tentatively whatever information can be obtained at the start and await resolution of the patient’s resistances during therapy before one can gather sufficient material for a correct evaluation of the problem.

Some interviewers believe a formal case history to be of advantage in getting pertinent data: others challenge the value of history taking for patients who are to receive psychotherapy. Those in favor of the practice insist that great gaps in information are present where reliance is placed solely on the spontaneous unfolding of historic material. Only a careful inquiry into the various areas of somatic, psychologic, interpersonal, and community functioning is said to reveal a complete picture of what has been happening to the patient. If adequate historic data is lacking, it may be months before the patient gets around to talking about an aspect of the personal problem that never was revealed at the beginning, and this may give the therapist an entirely different perspective of the situation.

On the other hand, there are many reasons why interviewers hesitate to take complete case histories. First, exhaustive histories are not considered absolutely necessary from a diagnostic point of view. Second, they are not believed to be therapeutically valuable. Therapy is regarded as a process not of collecting information but of helping the patient to develop a new outlook on life. Background material is felt to be not too important in promoting this goal. Third, it is argued that when the patient is asked to

reveal personal data, resistance may be mobilized and significant facts concealed. Fourth, the patient may assume that a report of personal history entitles a sitting back to await an automatic solution of existing troubles.

Table 24-1 Personal Data Necessary from Patient

Statistical Data	Complaint Factor	Etiological Factors	Assay of Personality Strengths and Weaknesses
Name	1. Chief complaint (in patient's words)	1. History of hereditary family illness	1. Level of maturation: physical growth, educational achievement and school progress, resolution of dependence, sexual maturity, marriage, parenthood, social relationships, and community participation
Address	2. History and development of the complaint	2. Family data: relationships with parents and siblings	2. Neurotic disturbances in childhood
Telephone number Age Sex Marital status	a. When did the complaint begin? b. Under what circumstances? c. What does the patient believe produced the complaint? d. What treatment has been given?	3. Significant events in the past history 4. Precipitating factors in present environment: assay of present environment to determine extent of stress on patient	3. Interests, hobbies, ambitions 4. Character structure: security feelings, attitudes toward authority, interpersonal relationships, attitudes toward self, and methods of handling conflict
Education	3. Other complaints or symptoms	5. Other factors, including inner conflicts as revealed by dreams and symptoms	5. Motivational factors and level of insight
Occupation Employment status and income	a. Physical b. Emotional c. Psychic d. Behavioral 4. Previous attacks of emotional illness a. As a child b. Later attacks c. Any hospitalization? d. At what period does the patient believe him or herself to have been completely free from emotional illness? 5. Effect of emotional illness on present functioning		

a. Effect on physical health, appetite, sleep, and sexual functions
b. Effect on work
c. Effect on family and other interpersonal relationships
d. Effect on interests and recreations
e. Effect on community relations

6. Evaluation of complaint factor

a. What evidence is there of adaptational breakdown, such as anxiety, depression, psychosomatic symptoms?
b. Are the defensive elaborations adaptive or maladaptive?
c. What are the patient’s ideas and attitude about the problem?

Some therapists have attempted to get around the arguments against taking a case history by having the patient fill out a questionnaire or by having some other person, such as a social worker, do the history taking. There is an advantage to be gained in this if the therapist needs as much information as possible in outlining a treatment plan. Even here, however, the presentation to the therapist of historical data at this stage may not be as helpful as one may imagine; the eliciting of these data during the ongoing therapeutic process tends to bring the patient and therapist more closely together, helping to establish a working relationship.

In clinics, the tendency is toward history taking, particularly where teamwork is employed. In private practice the tendency is away from formal history taking. Among psychoanalysts there is an inclination to follow Freud’s (1913) injunction to avoid the structuring of the initial interview, to abstain from “lengthy preliminary discussions,” and, in E. Glover’s words (1955), not to “repeat the emotionally strenuous experience of a prolonged anamnesis.” Gill et al. (1954) have recommended a spontaneous unfolding of the patient’s problems in the initial interview. V. Rosen (1958), on the other hand, while admitting that this is suitable for the experienced professional, believed it advisable to encourage a

traditional diagnostic interview for the inexperienced therapist.

Whether or not a case history is taken, the desirable data to be obtained from the patient are given in Table 24-1.

Kanfer and Saslow (1965) have prepared an outline for the gathering of information for use in approaches that are related to behavior therapy. The job of psychotherapy, they contend, is not the removal of intrapsychic conflicts but the utilization of a variety of methods that control the patient's environment, behavior, and the consequences of the behavior. Control of reinforcing stimuli "require that the clinician, at the invitation of the patient or his family, participate more fully in planning the total life pattern of the patient outside the clinician's office." Data collecting is concerned with identifying major variables that can be modified or controlled as well as with pertinent controlling stimuli in the environment. Toward this end the authors present a working model for a behavioral analysis: (1) problem analysis (categorization of behavioral excesses and deficits that are targets of the therapeutic intervention, along with the patient's behavioral assets); (2) clarification of the problem situation (which people and what circumstances maintain the patient's problem behavior and the consequences of such behavior); (3) motivational analysis (arrangement of a hierarchy of events, objects, and people that reinforce approach as well as avoidance responses); (4) developmental analysis (biological equipment, sociocultural experiences, behavioral development); (5) analysis of self-control (deficits and excesses of self-controlled behaviors and persons and situations that reinforce these); (6) analysis of social relationships (which people influence problematic behaviors or are being influenced by the patient); and (7) social-cultural-physical environment (norms in patient's environment and relationship to patient's idiosyncratic life patterns).

The above information permits manipulation of motivational controls for modification of the patient's behavior. Since, according to learning theory, behavior disorders are learned response patterns reinforced by definable environmental and internal stimuli, a delineation of the circumstances that control the patient's behavior output is at least as important as describing the pathology. Test findings, interview protocols, and referral histories must be supplemented by an account of the patient's behavior "*in relationship* to varying environmental conditions." Past history is important only in defining independent variables that control the current behavior. A verbal self-report is not equivalent to actual

events or experiences; these represent current behaviors in terms of verbal chains and repertoires that the patient has built up. The traditional interview techniques that are used are reinforced by role playing, free association, observation of the patient's interactions with other individuals, confrontations of the patient with tape recordings, material about the patient supplied by the patient's family and other informants, study of the patient's daily work behavior, responses to psychological tests, and other procedures for gathering pertinent information.

Obviously it will be impossible, due to the limited available time, to obtain all of the essential data related to the patient and the patient's problem during the first interview. Nor will information be in the order outlined. Therefore, material will have to be pieced together from various fragments of the interview. Some order in the eliciting of facts, however, will be helpful in obtaining as complete a picture as possible.

THE CHIEF COMPLAINT

Immediately after structuring the purpose of the initial interview and handling initial resistances, the therapist may attempt to get into the presenting problem with such a remark as "Suppose you tell me about your problem" or "Would you like to tell me about your problem?" Responses to such remarks are many.

1. The patient may proceed to detail the complaint factor.

Th. Suppose you tell me about your problem.

Pt. Yes, it's that I can't eat. My stomach gets upset, and I have to watch my diet. And then I get jittery all over for the slightest reasons.

2. The patient may hesitate on the basis of an inability to gather his or her thoughts or because of unclarity as to the nature of the difficulty. Here, a rephrasing of the question may help.

Th. Would you like to tell me about your problem?

Pt. *(pause)* I just don't know where to begin.

Th. Well, what bothers you most? *[rephrasing the question]*

Pt. Well, my worst trouble is how I get along with my wife. We've been married now going on 10 years, and we've

never gotten along well.

3. The patient may be completely blocked in voicing the chief complaint. Asking repeated questions may be necessary.

Th. Suppose you tell me about your problem.

Pt. *(pause)* I just don't know what it is.

Th. Would you rather that I asked you questions?

Pt. Yes, I'd rather you did.

Th. What bothers you most?

Pt. I don't know.

Th. Do you have any special trouble with anything?

Pt. Nothing seems to stand out. I feel upset all over.

Th. Physically upset?

Pt. Yes, I get the shakes and my bowels are upset when I get tense.

Th. Anything else?

Pt. You mean physically?

Th. Yes, or otherwise.

Pt. Well, I can't think clear. My mind is in a fog. I can't remember things.

Th. Mm hmm. *(pause)*

Pt. And I can't work because I just feel so weak I can hardly sit. *(Patient continues to elaborate on his problem.)*

The chief complaint may not be the most important problem for which help is needed. As a general rule, the patient voices the complaint in terms of manifest disturbing symptoms. Here one symptom may be focused on to the exclusion of others. Thus, the patient above may present as a chief complaint the fact that he is depressed. As he describes his problem, it is evident that he is also detaching himself from people, that he has a gastric ulcer, and that his inability to work has jeopardized his economic security.

Statements by the patient of the most important difficulties as the patient sees them should be

recorded verbatim if possible. The initial interview form in Appendix C in Part II is excellent for this purpose and for the recording of other data during the interview. The use of a form to tabulate highlights of the interview relieves the therapist of much writing and frees the therapist to interact with the patient.

HISTORY AND DEVELOPMENT OF THE COMPLAINT

The patient, immediately upon mentioning the complaints, may spontaneously begin discussing how and when they originated. If this does not occur, pointed questions may be asked, such as:

1. *Onset:* “How long ago did your troubles begin?”

2. *Circumstances under which the complaints developed:* “At the time your trouble began, what were you doing?” “Were there any changes in your life situation?” “Were you happy or unhappy at the time?”

3. *Progression from onset to the beginning of the initial interview:* “Once this trouble started, what happened?” “Did your difficulty get worse as time went on?”

In revealing the history and development of his or her complaint, the patient may elaborate on the current environment, daily habits, and routines. The description of the patient’s present life situation involves judgments by the patient that must be carefully scrutinized. Depending on emotional needs, some persons will react catastrophically to even average vicissitudes, while others seem capable of tolerating very severe environmental stress. The patient may consequently exaggerate, distort, or minimize life difficulty. There may be a need to blame inner turmoil on environmental factors that were self-created. On the other hand, the patient may be unaware of how disturbed the situation actually is, accepting it as an inevitable consequence of living, yet reacting to it with untoward emotion. The interviewer must, therefore, never accept the patient’s statements at face value and must later validate the account given.

The unfolding of the historical development of the complaint may be accompanied by the introduction of many tangential and perhaps irrelevant elements. It will be necessary constantly to focus on pertinent aspects of the patient’s problem since many points will have to be covered to fulfill the purpose of the interview. Generally, if more than 15 minutes or so are consumed in discussing the history and development of the complaint, the patient may be interrupted.

STATISTICAL DATA

If the patient has not filled out a Personal Data Sheet (see C). Assuming that the patient has discussed sufficiently the development of the complaint, the therapist may interrupt this and proceed, as in the following excerpt:

Th. Well now, I'd like to ask you a few questions about yourself, and then we'll go ahead discussing your problem.

Pt. Fine.

Th. Your full name is?

Pt. George Dickens. *[The patient's name and other identifying details have been changed to conceal his identity*.]

Th. Your address is?

Pt. 211 Thorton Street.

Th. Home telephone?

Pt. 677-4228.

Th. Business telephone?

Pt. Well, I'd rather you didn't call me there.

Th. Yes, of course. If I do call to change an appointment or the like, when can I call you?

Pt. After six o'clock.

Th. Would you rather that I wouldn't mention my name if I do call? *[This is to reassure a patient who is fearful that others will find out he or she is consulting a therapist.]*

Pt. It really doesn't matter. It'll be all right.

Th. What people are living with you at present?

Pt. My wife and child.

Th. How old are you?

Pt. Thirty-two.

Th. You are married you say?

Pt. Yes.

Th. How long have you been married?

Pt. Three years.

Th. I see. Any previous marriages?

Pt. No.

Th. How old is your wife?

Pt. Thirty.

Th. Does she work other than doing housework?

Pt. Yes, she writes copy for an advertising company part time.

Th. Mm hmm. About what is her salary?

Pt. Well, I don't know. I'd say about $5000 yearly.

Th. What about children; how many do you have?

Pt. Just one; she's two years old.

Th. How far through school did you go?

Pt. Two years of college.

Th. And your occupation?

Pt. I'm a linotype operator.

Th. What do you earn?

Pt. About $15,000 a year, take-home pay.

Th. Were you in the armed forces?

Pt. Yes, for three years.

Under some circumstances, this statistical data may be obtained at the beginning of the interview before the patient talks about the complaints and symptoms. It is recommended, however, that the procedure outlined be followed, since the average patient is under considerable tension and considers the giving of statistical information about oneself a diversion. If the patient has filled out a Personal Data Sheet (Appendix D), it is unnecessary to burden him or her with the above questions, unless there are

points that have been omitted or that need clarification.

OTHER SYMPTOMS AND CLINICAL FINDINGS

It is helpful to get a general idea of other symptoms besides those discussed by elaboration of the complaint. Due to the limited time available in the initial interview—45 minutes to 1 hour is the usual time allotted to a session—pointed questions are necessary. Suggested areas of questioning are indicated in item 3 of the Initial Interview Form (Appendix C). Continuing with the interrupted interview above:

Th. Now, I'd rapidly like to ask you about other symptoms you may have. What about tension; do you feel tense?

Pt. Oh yes, all the time.

Th. Mm hmm. What about depressions; do you get depressed?

Pt. Yes, now and then.

Th. You snap out of it, though?

Pt. Yes, I do.

Th. How about anxiety?

Pt. I don't know what you mean.

Th. Well, spells when your heart palpitates and you get panicky.

Pt. Yes, when I am in the company of people.

Th. Any other time?

Pt. When I'm asked to do something, like make a speech.

Th. I see. What about physical symptoms; do you have those? [*It will be noted that questions are not asked in reference to suicidal tendencies, hallucinations, delusions, and dangerous and excited tendencies. The therapist should ask these questions only where the clinical condition of the patient warrants it. To ask them when they are not indicated may be upsetting to the patient or may be productive of resentment.*]

Pt. (pause) I don't know.

Th. Well, for example, what about fatigue and exhaustion?

Pt. Oh, yes, all the time.

Th. How about headaches?

Pt. No.

Th. Dizziness?

Pt. No.

Th. Stomach or bowel trouble?

Pt. Yes, when I get nervous, upset, they come. Butterflies in my stomach.

Th. Diarrhea?

Pt. Sometimes.

Th. Do you have any sexual problems?

Pt. I wouldn't say so.

Th. Your sex life is satisfactory then?

Pt. Yes. [The patient's evaluation of this and other aspects of his functioning should not be accepted at face value. As he explores his problem, he may find that what he considers "normal" may not be good functioning. In this patient, for example, sexual frequency was once every 3 weeks with no true enjoyment.]

Th. Any phobias or fears?

Pt. Of talking in front of groups, of meeting strange people.

Th. Mm hmm. Any other fears?

Pt. I don't think so.

Th. Any thoughts or obsessions that crowd into your mind and frighten you?

Pt. No.

Th. Any compulsions—the need to do things over and over?

Pt. No.

Th. What about sedatives; do you take sedatives?

Pt. No.

Th. Do you drink alcohol excessively?

Pt. Well, I have an occasional drink.

Th. Get drunk?

Pt. Oh no.

Th. What about insomnia; how do you sleep?

Pt. I sleep fine.

Th. Any nightmares?

Pt. No.

DREAMS

The recording of a nightmare, of a typical dream, and of repetitive dreams are helpful to the analytically trained therapist in gaining clues as to unconscious foci of conflict. Continuing the interview:

Th. Do you dream a lot or a little? *[This question is phrased this way because patients are apt to think, if they are asked merely whether they dream, that dreaming is abnormal.]*

Pt. Oh, a little.

Th. Remember your dreams?

Pt. Sometimes.

Th. Suppose you tell me a dream that you had recently.

Pt. I can't seem to remember any right now.

FAMILY DATA

Briefly recorded family data are valuable to the initial interviewer in appraising the quality of the patient's relationships and in anticipating responses to male or female therapists. The interview continues:

Th. Now, I'd like to ask you a few brief questions about your parents. You mother, is she living?

Pt. Yes, very much so.

Th. What kind of a person is she?

Pt. Well, a nice person; she did what she thought was best. She was a nervous person, self-centered, always fighting with my father.

Th. How did that make you feel?

Pt. Well, I don't know. My mother and father were divorced when I was eight years old. He left. I saw him rarely.

Th. How did you feel about that?

Pt. I don't know; all right, I guess. My mother thought he was a heel.

Th. Did you?

Pt. No, he was all right. I guess he took quite a beating from my mother. She was the smarter of the two.

Th. What sort of a person was your father?

Pt. A quiet fellow. I didn't know him well.

Th. How did you feel about him?

Pt. I liked him.

Th. Any brothers or sisters?

Pt. Only one older brother. He's 36 years old.

Th. What about him; how did you get along with him?

Pt. Well, when we were small we'd fight a lot. He didn't like me. But we see each other now. (*laughs*) I guess we learned to tolerate each other.

Th. How do you feel about him now?

Pt. (*laughs*) O.K., I guess. We like each other.

Th. Now how about your wife; what sort of a person is she?

Pt. Nice, patient with me. She's got her troubles. Her mother hounds her.

Th. How do you feel about her?

Pt. Fine. We get along better than we ever did.

Th. Like her?

Pt. Oh, sure.

Th. What about your daughter; what sort of a youngster is she?

Pt. Oh, she's a devil, all right. Gets into everything.

Th. How do you feel about her?

Pt. Oh, fine; I like her.

The patient's evaluation of his family and his expressed attitudes toward them do not always indicate his true feelings. Guilt may cause him to conceal or to repress important attitudes that may come up later in therapy when he has developed the strength to tolerate the implications of his suppressed or repressed emotions.

PREVIOUS EMOTIONAL UPSETS

The patient should be asked questions about any previous emotional disturbances that were experienced. This will give the interviewer clues as to the severity of the patient's disorder and how far back in one's life it goes. The interview continues:

Th. No.w, what about nervous problems previously; any previous attacks of the same kind before?

Pt. No, not exactly like this.

Th. Well, any other kind of nervous upsets?

Pt. I've always been nervous.

Th. How far back would you say your nervousness goes?

Pt. As a kid, I was afraid of other kids. I didn't like to fight.

Th. Did you have any nervous troubles for which you needed help?

Pt. My mother was always concerned. I was a sickly kid, always had one thing wrong with me or another. I had ear trouble a good deal.

PREVIOUS TREATMENT (INCLUDING HOSPITALIZATION)

Any previous therapeutic efforts should be recorded to discern the problem for which help was sought, the progress achieved, and the patient's response to all former therapists. Unless indicated by the

severity of the problem, questions need not be asked about hospitalization. Continuing the interview:

Th. Have you ever had treatments for your condition from a psychiatrist or any other person who gave you psychotherapy?

Pt. No. I've read some books but never gotten treatments.