THE TECHNIQUE OF PSYCHOTHERAPY

THE INITIAL INTERVIEW

SECURING ESSENTIAL CONSULTATIONS

LEWIS R. WOLBERG M.D.

The Initial Interview:

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Lewis R. Wolberg, M.D.

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The Initial Interview: Securing Essential Consultations

During the first interview, or later if needed, consultations with a number of professionals may be considered essential. When the therapist takes the time to explain the reasons for this, little or no difficulty will be encountered.

MEDICAL, NEUROLOGIC, AND PSYCHIATRIC CONSULTATIONS

It goes without saying that each patient under psychotherapy requires a thorough physical and neurologic examination to rule out organic somatic illness. If the patient has been referred to the therapist by a physician, the therapist may check with the former as to whether or not physical and neurologic examinations have recently been administered. If not, arrangements for these should be made with, or through, the patient's physician. A blank such as that in Appendix O should be filled out by the physician and filed in the patient's case record. For patients on whom a complete neurologic examination is done, a form such as in Appendix P may be found helpful.

Disorders of the cognitive, affective, and behavioral functions are usually psychologically caused but may be due to physiological disturbances whose existence, if suspected, should be ruled out. (See also the chapter on diagnosis.) Thus anxiety may be due to a certain tumor in the adrenal medulla (pheochromocytoma) or overactive thyroid (hyperthyroidism, Graves' disease). Conversion disorders (hysterical neuroses, dissociative disorders) may be mistaken sometimes for neurologic disease or gross brain disease; and somatization or somatoform disorders can be mistaken for actual physical disease. Depressions may be the product of (1) toxic substances (alcohol, sedatives, cocaine, antihypertensive drugs), (2) infections (viral hepatitis, infectious mononucleosis, tuberculosis, syphilis), (3) endocrine disorders (myxedema, Cushing's disease, Addison's disease), (4) neurologic illness (multiple sclerosis, Parkinson's disease, cerebral tumors, early dementia), or (5) nutritional problems (pellagra, vitamin B12 deficiency, collagen disorders, or neoplasms). Schizophrenia may be simulated by some organic disorders such as drug toxicity (amphetamine), brain disease (neurosyphilis), and some types of

hypothyroidism. Memory loss may be a product of early dementia (Alzheimer's disease, Pick's disease, multi-infarct dementia, infectious dementia, encephalopathy, sclerosing encephalitis, meningitis, or poisoning (lead or carbon monoxide). Amnesia may occur with cerebrovascular disease of the brain or lesions in the mamillary bodies and medial thalamus. Personality changes may develop with an expanding tumor of the brain or Huntington's chorea. Apathy, emotional lability, and various somatic symptoms (often considered a sign of hysteria) may be the result of multiple sclerosis. Impotence and inhibited sexual desire may be a manifestation of depression (expressed or masked), antihypertensive medication, psychotic drugs, diabetes, and some spinal cord diseases. Difficult or painful coitus (dyspareunia) may be a sign of suburethral diverticulum, retroflexion of the uterus, and pelvic inflammatory disease. When there are any signs of aphasia, apraxia, altered awareness of the body image (anosognosia), impairment of consciousness, syncope, or confusional states, there may exist lesions of the brain, epilepsy, diabetes, hypoglycemia, ingestion of exogenous toxic agents, or endogenous toxins and deficiencies (uremia, hyponatremia). A pain syndrome is sometimes psychogenic, but it may also be due to lesions in the thalamus. Vertigo may be a product of labyrinthine disease. Recurrent severe headaches necessitate a ruling out of expanding brain tumors, meningeal irritation (syphilis, tuberculosis), metastatic neoplasms, vascular disturbances, toxic states, hypertension, iritis, and glaucoma. Hiccups can be psychogenic but if prolonged may be due to irritation of the medullary centers controlling the diaphragm.

It may be seen from this that the list of maladies is long and discouraging because almost every symptom for which psychological treatment is sought may accompany certain physical conditions. When there are any doubts, consultation with a good internist or neurologist is important.

If organic illness is discovered on examination, the patient must be guided by the advice of the physician about required medical or surgical treatments. If no organic illness is found, the physician should be used as a consultant whenever physical symptoms of any kind develop during the course of psychotherapy. Insistence that the patient see his or her own physician is not only good medicine but also makes for good public relations. Even when the therapist is a psychiatrist who has not lost the medical diagnostic skills, the rules outlined will be found helpful. To do physical examinations or to prescribe medications other than psychotropic drugs may not be prudent, except perhaps in supportive therapy and in the more superficial reeducative therapies.

The expediency of psychiatric surveillance of certain patients being treated by non-medical therapists has already been discussed. The results of the psychiatric examination should be filed in the case record, using an outline or a form such as in Appendix Q. The psychotherapist then may be advised how to handle any emergencies that develop during the course of treatment, such as severe depression, suicidal attempts, and psychotic outbreaks. The therapist can, when necessary, administer or refer the patient for narcotherapy, hypnosis, electroconvulsive therapy, or drug treatments, such as tranquilizers, energizers, antidepressants, endocrine products, or antagonists like Antabuse. The therapist may also arrange for hospital admission or commitment when required.

CASEWORK CONSULTATION

The therapist may desire a consultation with a caseworker from a local social agency when any of the following difficulties exist:

1. Severe financial problems requiring supplementary help
2. Need for job placement or relocation
3. Need for rehabilitative services
4. Need for special health services
5. Need for better housing or for neighborhood relocation
6. Need for recreational facilities
7. Need for special schooling and training
8. Social security problems
9. Need for referral to special clinics or hospitals for the management of physical illness when resources are unknown or financial difficulties prevail
10. Aid in placement of a child in a foster home or institution.

In supportive and some types of reeducative psychotherapy the patient may be referred for adjunctive therapy directly to the caseworker or a special social agency that deals with the particular

problem. The caseworker helps the patient use the community resources best suited for the patient's needs. In reconstructive therapy this may also be done; however, the activity of a caseworker as an accessory helper may, in some patients, tend to disrupt the therapeutic relationship. Should such patients require casework services, the therapist may get the necessary information from the caseworker, such as the best available resources to meet the patient's needs. The therapist may then acquaint the patient with possible courses of action, encouraging the patient to make his or her own plans. The therapist handles therapeutically any delays or other resistances to effective use of the resources.

A caseworker may also be employed to deal with parents, mate, or children of a patient when such relatives require placement, hospitalization, counseling, or guidance as an aid in the treatment of the patient. Among the services rendered by the caseworker are the dispensing of information related to sexual problems, child-parent relationships, marital relationships, hereditary influences, budgeting, home management, housing difficulties, work problems, difficulties associated with alcoholism, and problems of old age. Premarital and marital counseling are other areas in which the help of the caseworker is often sought. Additionally, the caseworker may be used as a liaison between the patient and the patient's family, employer, teacher, and others when it is essential to interpret the patient's illness to them, to give them reassurance, or to enlist their active interest and cooperation.

In psychiatric clinics, caseworkers are often used for intake interviewing, to clarify the service of the clinic to prospective patients or to the referral source, and to determine if the service offered by the clinic is consonant with the needs of the patient. In addition, they are employed to take case histories and to prepare patients for psychotherapy by dealing with resistances to and establishing the proper motivation for treatment. When indicated, they help, directly or indirectly, to manipulate the patient's environment. Lastly, they serve to interpret the work of the clinic to the community and to enlist the cooperation of the community with the clinic. Caseworkers act as a liaison between the clinic and community organizations that are implementing community programs related to health, welfare, and social security.

PSYCHOLOGIC AND RELATED CONSULTATIONS

A consultation with a clinical psychologist may occasionally be necessary if the patient requires

intelligence tests, vocational tests, and tests for special aptitudes (Freeman, FS, 1962; Hoch & Zubin, 1951; Sundberg, 1962; Tallent, 1963; Cronbach, 1960; Schaefer, 1948; Anderson & Anderson, 1951; Abt & Beliak, 1959; Buros, 1953; Rapaport et al. 1946). These are used as an aid in planning a better environmental adjustment for the patient. Projective tests are also used as a rapid means of revealing important traits and tendencies. The test situation serves as a tiny segment of life, a kind of laboratory in which the individual divulges customary needs, hopes, impulses, and defensive drives. A trained, astute observer may analyze the strivings of the patient as they are projected into the test materials as well as the patient's defenses and may make remarkably accurate assumptions about the character structure and the unconscious conflicts of the person.

The most important tests employed by the psychologist are:

1. Measures of the ability to learn—Stanford-Binet Test (Terman & Merrill, 1960), Wechsler Intelligence Scale (Wechsler, 1955; Koppitz, 1963)

2. Personality questionnaires—Minnesota Multiphasic Personality Inventory (MMPI) (Hathaway & Meehl, 1952; Schofield et al., 1956)

3. Projective tests—Rorschach Ink Blot Test (Rorschach, 1942; Klopfer & Kelly, 1942; Beck, 1944, 1945, 1952; Ulett & Goodrich, 1956; Rickers-Ovsiankina, 1960; Thorndike & Hagen, 1961), Thematic Apperception Test (Murray, 1938; Tompkins, 1947; Anderson & Anderson, 1951; Beliak, 1954), Szondi Test (Deri, 1949), House-Tree-Person Test (Buck 1950), Man-Woman Drawing Test (Machover, 1948, 1951)

Sometimes there is an examination of handwriting (Lewinson and Zubin, 1942; Sonneman, 1951), art creations (Lewis, 1925), manipulated play materials (Erikson, 1939), and word associations (Jung, 1919), cognitive functions (Folstein et al., 1975), psychiatric disorders (Wing et al., 1974), and alcohol screening (Selzer, 1971). Among the items of information revealed are clues to the intelligence, originality, creativity, and sensitivity of the person; the severity of anxiety; the defenses employed against anxiety, such as inhibition, repression, phobias, compulsive reactions, aggression, acting-out, somatic preoccupations, fantasy, and retreat from reality; the intensity of hostility and defenses against hostility; the nature of interpersonal relations and current disturbances of character, such as dependency, aggression, sadism, masochism, detachment, and paranoid tendencies; the quality of self-esteem and whether there are distortions in narcissism, grandiosity, and self-devaluation; sexual

problems, inhibitions, fears, and perversions; masculine and feminine identifications; existing inner conflicts; schizoid and disintegrative tendencies; organic brain disease; and ego strengths and weaknesses. This helps in making a diagnosis and in differential diagnosis, in assessing personality, and measuring intellectual level.

The virtue of psychological tests is primarily in the diagnostic sphere. Attempts to evaluate ego strength and to predict the outcome of therapy by means of testing are usually speculative. If the clinical psychologist makes predictions about the quality of change that the patient will achieve in psychotherapy, estimates definite goals in treatment, and indicates the kinds of techniques to which the patient will best respond, he or she is straining the test materials, attempting to adapt them to areas for which they were never designed.

Prognostic estimates and predictions of what will happen in therapy on the basis of psychological tests are often fraught with disappointment. Although it is possible to determine customary responses to authority, and the habitual interpersonal reactions that emerge in a relationship situation, it is not always possible to guarantee that these responses will develop with the therapist. Therapy involves a special kind of a relationship, the uniqueness of which may prompt latent or new responses. Much, of course, will depend on the therapist, on whether he or she falls in line with the role the patient expects him or her to play. Similarly, it is difficult to anticipate the interpersonal potential of the patient, since it is unknown how the therapist will manage the tentative thrusts of the patient toward a different kind of relationship. Finally, it is not easy to predict what the patient will do with insight, whether he or she can acquire insight or use it, once it is evolved, in the direction of change. For these developments, too, are largely contingent on the nature of the therapeutic relationship and the skill of the therapist.

All psychologic tests are brief samplings of the patient’s reactions to a limited test situation, at a special time, with a specific test administrator. The patient may at another time, with a second test administrator and under changed conditions, respond differently. Test results must, consequently, always be correlated with clinical findings. The more experienced the therapist, the more the therapist will rely on clinical judgment and the less emphasis will be put on psychological test materials.

Beginning therapists usually feel more confident when they have in front of them a personality

survey that describes some of the patient's defenses and conflicts. The contribution that the test makes to the therapists' feelings of security more than offsets the disadvantage of having a preformed opinion about the patient. As the therapists become more experienced, they find that psychological tests are not accurate in all instances. They then regard them as tentative blueprints of neuroses that will require more or less extensive alterations as they delve into the patient's problems. Finally, they may, if their experience is sufficiently extensive, rely much more on their clinical judgment than they do on psychological tests. They may heed certain warnings sounded by the tests, such as the presence of disintegrative tendencies, which will make them gauge carefully the interpretive pressures that they apply so as not to overtax the strength of the patient's ego. They will still grant priorities to clinical "intuition," however.

In the hands of an experienced clinical psychologist who is conservative in test interpretations, psychological tests are valuable aids to the therapist, provided the latter does not permit the tests to interfere with the spontaneous planning and execution of the therapeutic approach. Therapy is more influenced by the skill of the therapist and by the capacity to set up a good working relationship with the patient than it is by the existing clinical syndrome. Thus, psychological tests may reveal strong schizophrenic tendencies. This revelation may frighten the therapist, and, on the basis of warnings by the psychologist that the patient cannot stand a reconstructive approach, the therapist may smother the patient with supportive props. Were the therapist to gauge the depth of therapy by the strength and quality of the relationship with the patient, there would be a much more accurate measurement of the extent of stress that the patient's ego could tolerate. On the basis of a good relationship, reconstructive therapy might be possible, and the patient might be able to endure and to resolve considerable anxiety.

Some therapists, who have had training in the administration and interpretation of psychological tests, prefer to test the patient personally rather than to send the patient to a clinical psychologist. By doing this they are able to observe the behavior of the patient and the manner of the patient's approach to, and execution of, the tests, which may give them valuable clues in addition to those revealed by the test responses. Often therapists do not score the tests but rely mainly on a qualitative analysis of the responses. Some therapists use test administration therapeutically, accenting certain responses to encourage the patient's associations (Harrower, 1956).

Apart from these traditional uses of psychologic tests, there are some psychologists who advocate the employment of projective materials to provide for a more objective measure of therapeutic progress (Piotrowski & Schreiber, 1952). By taking a test at the start, during, and end of treatment, it is believed possible to validate clinical impressions of changes developing in psychotherapy.

If the initial interviewer decides in favor of psychological tests, it will be necessary to prepare the patient for referral to a clinical psychologist. An explanation may be given the patient along lines indicated by the following excerpt:

> *Th.* I should like to get a psychologic examination. Would you have any objection to this?
>
> *Pt.* What is this examination?
>
> *Th.* Psychologic tests are like x-rays, they enable the therapist to see things about a person that would otherwise require many therapeutic sessions. In this way it helps to cut down the time of therapy.
>
> *Pt.* Are the tests expensive?
>
> *Th.* They cost more than a single treatment session, but they may save money in the long run.
>
> *Pt.* I want to do anything that is necessary, doctor.
>
> *Th.* All right, I'll make the arrangements for you.

Obviously the fee for testing must be within the financial means of the patient. Some patients may not be able to afford psychologic testing, and the therapist may then have to forego it.

The most common test employed in reconstructive therapy is the Rorschach. Sometimes the Thematic Apperception, the Szondi, and the Man-Woman Drawing tests are used. A complete battery of tests, which is the preferred routine, is prohibitive in cost for the average patient, although the therapist may be able to make special financial arrangements for this with the clinical psychologist. When only isolated tests can be afforded, the therapist should indicate to the clinical psychologist the special area of interest, such as diagnosis, dynamics, and so forth so that a proper selection can be made of the tests administered.

In recent years, divorce mediation has come into prominence and can be a productive alternative to adversarial proceedings in conventional divorce. The divorce mediator acts as a neutral party enabling

couples to negotiate with each other on important issues of distribution of marital property, arrangement of family finances, child support, custody, and visitation. Clients are also helped to separate emotional from practical issues, such as to recognize tax consequences of options. Specially trained counselors and lawyers may be found through local social agencies. Legal counseling in a variety of areas may be necessary and social agencies may also be of help here.

In addition to giving tests, psychologists are helpful when career planning and vocational and educational guidance are necessary as part of the treatment plan. Some psychologists are trained to do premarital, marital, adolescent, and old-age counseling. They also act as research supervisors in organizing and handling details of research projects.

Corrective work in the educational field, such as the treatment of reading and educational disabilities, may require the consultative services of special professionals such as remedial reading instructors. Rehabilitation workers may help in physical and sensory defects that interfere with the functioning of the patient. Speech disturbances may require the aid of a speech therapist.

The services rendered by such professionals as psychologists, remedial teachers, rehabilitation workers, and speech therapists are adjunctive to psychotherapy. Because prolonged contact may be required with adjunctive workers, it is essential that the workers be well-integrated individuals. It is important, too, that they recognize their limited role and not interfere with the therapist by giving the patient advice and interpretations that have nothing to do with their specific area of function. The therapist will always have to work out with the patient the matter of divided transference when consultants are employed. This need not constitute too difficult a hazard unless the consultants are themselves seriously disturbed emotionally.