THE TECHNIQUE OF PSYCHOTHERAPY

THE INITIAL INTERVIEW
THE FIRST CONTACT WITH THE PATIENT

LEWIS R. WOLBERG M.D.

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Lewis R. Wolberg, M.D.

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The Initial Interview: The First Contact with the Patient

The initial interview is probably the most crucial therapeutic session of all. Vital hours appear later during treatment when resistance and transference manifestations become rife. Errors in the handling of a session after the therapeutic process is well under way, however, are not nearly so fatal as mismanagement during the initial interview.

The primary goals of the initial interview are

1. *To establish rapport with the patient*
    a. by supplying the proper emotional climate for the interview
    b. by structuring the purpose of the interview
    c. by clarifying misconceptions about psychotherapy
    d. by dealing with inadequate motivation
    e. by handling other resistances and preparing the patient for psychotherapy
2. *To get pertinent information from the patient*
    a. by listening to the patient's spontaneous account
    b. by focusing on selective data
3. *To establish a tentative clinical diagnosis*
4. *To estimate the tentative dynamics* (in terms of inner conflicts, characterological distortions, mechanisms of defense and their genetic origins)
5. *To determine the tentative etiology*
6. *To assay tentatively the assets, strengths, and weaknesses of the patient, actually and latently*
    a. by estimating the areas of living in which the patient is succeeding and failing

b. by determining the motivations for therapy

c. by exploring the level of insight

d. by estimating the tentative prognosis

7. *To make practical arrangements for therapy*

a. by tentatively assessing optimal goals

b. by tentatively selecting a therapeutic method

c. by accepting the patient for treatment or arranging for another therapist

d. by making appropriate time arrangements

e. by making financial arrangements

8. *To arrange for essential consultations and psychologic testing*

HANDLING THE FIRST INQUIRY

The first patient-therapist contact is very important since it provides the patient with notions of the personality qualities and traits possessed by the therapist. Generally, the patient will have been referred to the interviewer by a physician, minister, teacher, friend, acquaintance, or relative of the patient. Sometimes the patient, learning of the work or reputation of the therapist, will apply for help without an intermediary.

If the therapist is working in a clinic, the intake worker will probably handle the initial contact. Under other conditions the referral source may communicate directly with the therapist. When the source is someone other than the patient, it is usually best, once it is ascertained that the therapist has time to see the patient, to advise the referral source that it is important to have the patient get in touch with the therapist or the therapist's secretary directly to arrange for a consultation. This puts the initiative in the hands of the patient and constitutes one more positive step that the patient has taken spontaneously in working out his or her problem. Under some circumstances, however, this will not be feasible, as when the patient is a child or when the patient is too ill or is intractably unmotivated for

treatment. Where a telephone call has been made for an appointment, this, if at all possible, should be given the same day especially where the patient is very upset. People generally hold off making the final plunge into therapy. Should a patient be rebuffed by the cold statement that an appointment cannot be made until some date in the future, motivation may be dulled. Even though the appointment is kept, resistance and resentment may persist on the assumption that the therapist is an unsympathetic person no matter how impelling the situation that necessitated the delay.

Should the therapist have absolutely no time for an interview on the same day, he or she should try to talk to the patient on the telephone, even for a few minutes, and attempt to extend some reassurance. By the tone of the conversation the therapist should try to convey an interest in the patient. An excerpt of a telephone conversation follows:

Pt. Doctor, I've got to see you today, I feel upset, like I'm going to pieces. Doctor___ told me to call you.

Th. This must be very upsetting to you. How long has this been going on? *[attempting to communicate sympathy]*

Pt. For a long time now, but it's never been so bad.

Th. Well, naturally, I want to help you, but we'll have to arrange for an interview. I'd like to see you today, but I could give you only a minute or two. This might be upsetting to you, and I'd rather see you when we can spend some time together to talk things over, *[conveying interest in the patient and attributing the delay in appointment time to a desire to help him more fully]*

Pt. Can't you see me today?

Th. Much as I'd like to, the amount of time I could give you wouldn't be helpful to you. Now what about Tuesday at 3:40 p.m.?

Pt. Yes, I can make that, but what shall I do in the meantime?

Th. I'd very much like to help you, but it is hard to do this without spending a little time with you. What have you been doing for this trouble up to this time? *[Instead of rejecting the patient's demand, a polite statement suggests that help will follow a short wait.]*

Pt. I've been taking some sedatives, some red capsules the doctor gave me. They don't help much.

Th. Why don't you continue doing what you have been doing that gave you a little relief, and then, when we meet on Tuesday, we'll talk the whole thing over? I'll be of more help to you when we go over all the facts.

Pt. (slight cough, as if in relief) All right, doctor, I'll be there.

Th. Fine, see you then. Goodbye.

Pt. Goodbye.

If there is no time on the schedule and it is apparent that the patient needs help immediately, the patient may be given the names of several other therapists. Better still, the therapist may offer to see if these therapists have available time and then communicate this information to the patient.

PRELIMINARIES TO THE INTERVIEW

When appearing for an appointment, the patient should be greeted by name by the receptionist, if there is one, and made as comfortable as possible. If the therapist uses forms that the patient is to fill out for essential statistical data, these may be given to the patient (see "Personal Data Sheet," Appendix C) or blank sheets of paper on which to enter the initial interview data.

It goes without saying that the therapist should see the patient promptly at the appointed time. This sets the pattern of precision in appointment times, one of the necessary disciplines in treatment.

INSURING THE PROPER EMOTIONAL ATMOSPHERE

The average patient at the initial interview is burdened with great anxiety, harboring many conflicting emotions at the prospect of opening up pockets of guilt, of discovering fearsome secrets, of being exposed to the scrutiny and judgment of a strange individual, and of becoming the victim of unscrupulous practices. The degradation of consulting a "mind doctor" who may detect personal weaknesses, anticipating hurt in some mysterious way through probings of an unpredictable authority, yet hopeful that this new healer will achieve what others have failed to do, may release fantasies and expectations that know no bounds. This tangle of contradictory attitudes and feelings may mortify the patient until their reality is tested in the relationship with the therapist.

No better rule can be followed in the therapist's first contact with the patient than to heed the injunction to "be thyself." Artificial dignity, practiced pompousness, and professional poise will easily be penetrated by most patients. A studied, "deadpan," coldly analytic attitude and manner, advocated by some schools of psychotherapy, are particularly poisonous to a therapeutic atmosphere, which relies on honest communication. The patient must sense, from the behavior of the interviewer, that his or her

turmoil is appreciated and that adequate steps will be taken to help with the problem. At all times the interviewer must manifest as kindly and sympathetic an attitude as possible. Exhibitions of irritation, disgust, or disinterest or intimations that the patient's difficulties are hopeless or irremediable may prove to be irreparably destructive.

In the enthusiasm to get information the initial interviewer is apt to lose sight of the fact that it may be more important to establish rapport with the patient than to make a diagnosis. Many patients are lost during the first session because their emotional resistance to the acceptance of help has not been considered by the interviewer.

A good way of handling the initial contact is to greet the patient with a smile and introduce oneself. The patient is then invited to sit down. This casual way of approaching the patient is generally most reassuring.

> *Th.* (*smiling*) Are you Mr. Jones? I am Dr. Smith. *[If the patient extends his hand, the therapist shakes hands.]* Won't you sit over there in that chair so we can talk things over.
>
> *Pt. [The usual reaction is a smile and a polite comment of some kind.]*

STRUCTURING THE PURPOSE OF THE INTERVIEW

In structuring the purpose of the interview, the role that the therapist will play with the patient in the future must be kept in mind. If the therapist is merely seeing the patient in consultation in order to make a diagnosis and to refer the patient to another professional, this must somehow be conveyed to the patient. At the end of a well-conducted initial interview the patient will have established a feeling of confidence in the interviewer and will want to continue in therapy with that particular person. If not clear about the purpose of the interview, the patient, assuming that the interviewer will continue as therapist, will be frustrated, upset, and resentful at being referred to another professional who may bring to pass a realization of the fears somehow avoided with the present interrogator. The patient may be told, "Now the purpose of this interview is to get an idea about your problem so that I can find the best therapist to help you. It is important that you get treated by the very best available person, and I'll help you find such a person."

If there is available time and it is possible to accept the patient, the therapist may simply state, "Now the purpose of this interview is to get an idea about your problem so that we can decide the best thing to do for it." This leaves the door open in the event that the therapist decides to work with the patient.

If a resentful or unmotivated patient is being interviewed, the therapist must not convey an eagerness to get the patient into therapy. A statement such as this may be appropriate, "Now you've been sent here to talk things over with me. I don't know what I can do to help you, but if you give me an idea of the trouble you've been having, I'll see what I can do for you."

DEALING WITH INITIAL RESISTANCE

Most patients proceed to relate their problems to the interviewer without too great difficulty, following the structuring of the interview situation. As long as talk continues readily and spontaneously, the patient is not interrupted, being encouraged by the therapist's sympathetic facial expressions, noddings and subvocal utterances. After the patient's spontaneous account, specific information is obtained by pointed questions.

Some patients, however, may be too upset to proceed with an account of their problems. They may feel helpless and insecure and believe themselves to be at the mercy of forces that they can neither understand nor control. Often they resent the circumstances that forced them to apply for psychotherapeutic help, the efficacy of which they unreservedly doubt. Ashamed at being unable to handle their problems personally, they consider themselves to be weak and stupid. Unsure of the therapist's designs, uncertain of whether they will be exploited, humiliated, subjected to hospitalization or to other forceful measures, they may respond with resentment. They are apt to express their anger in the form of open defiance. Sometimes, they may handle themselves by acting apathetic or by displaying a kind of braggadocio that conceals their underlying turmoil. They may resort to a clinging dependency, plaintively appealing for succor and support. These reactions have to be handled carefully. One way of doing this is by calmly and sympathetically verbalizing how the patient must feel, indications being gathered from verbal and nonverbal clues. Putting feelings into words does much to help the patient accept the fact of the interviewer's understanding and non-punitive role.

The interviewer will have to display relatively great activity at the start of the interview under the following conditions:

1. If the patient is manifestly upset emotionally.
2. If the patient talks about attitudes toward therapy and toward the interviewer, rather than about the problem.
3. If the patient cannot seem to get started talking or does not know what to say.
4. If the patient pauses or is silent too long.
5. If the patient shifts the trend of talk from relevant to irrelevant material.

The handling of a patient who is upset emotionally will depend on the kind of affect involved and on the intensity of response. If the patient is depressed, agitated, and tearful, a display of warmth and understanding may stabilize the patient sufficiently so that he or she can verbalize freely. For example, one patient, following a structuring of the interview, broke down into tears after uttering a few words:

Pt. Oh, oh ... I don't know what to say. ... I feel lost ... completely lost ... *(cries)*

Th. I know how difficult this must be for you. *[communicating sympathy]*

Pt. Oh, oh, oh ... *(continues crying)*

Th. You have suffered a great deal and understandably are upset. But I am going to do everything I can to help you.

Pt. Thank you, doctor.

Th. Now if you will tell me about your trouble, I will see how I can best help you.

Pt. (relates problem)

If a patient is tense and fearful, he or she may be approached as in this excerpt.

Pt. I just can't think of anything to say. I'm so scared to death.

Th. What do you think is going to happen?

Pt. I don't know. I've read so much about psychology. I'm afraid I'll find out something about myself that will be terrible.

Th. Most people feel this way when they start treatment.

Pt. Yes, but, I'm afraid I'm different than other people are.

Th. I see, in what way?

Pt. I get so keyed up about nothing. (*Patient gets into the problem from this point on.)*

In the event that the patient is excessively hostile, one must refrain from responding with counterhostility. A man referred by a physician arrived for his appointment 10 minutes late. While the interview was being structured, he angrily stared at the interviewer. The following conversation took place:

Pt. Dr. B_ sent me here for these headaches. He thinks it might be mental. I really don't think it was necessary for me to come.

Th. Do you believe it's mental?

Pt. Good Lord, no! I think I need something that will ease this pain. I've been told a million different things of what's wrong.

Th. Perhaps you are right. It may be entirely physical. What examinations have you had?

Pt. (Patient details the many consultations that he has had.)

Th. Then it perhaps made you angry to come here?

Pt. I was angry. Not now though. Do you think you can help this headache?

Th. I'm not sure; but if you tell me about your trouble from the beginning, I might be able to help you with any emotional factors that can stir up a headache.

Pt. How can that do it? I know I have been emotional about it. *(The patient proceeds now with an account of his difficulty.)*

In the event that the patient is preoccupied with feelings about the interviewer and does not wish to discuss any problem, it is important to explore such feelings as thoroughly as possible before proceeding with the interview. How the patient was referred to the interviewer is important. The patient may have been forced into treatment by an actual or implied threat, may have been told that he or she is a nuisance and deserves to see a psychiatrist, or may have been promised a cure in a few sessions in view of the presumably rapid strides psychiatry has made in recent years. Under these circumstances the

person will possess a certain mental set that will have to be rectified before the proper therapeutic situation prevails. Misconceptions about psychotherapy are rampant and will require clarification. Examples and methods of handling these are detailed in Chapter 34.

The management of difficulties in verbalization, and of pauses, silences, and shifts from pertinent material may be along the lines indicated in this Chapter.

A source of great initial resistance is the patient's disappointment in the therapist. Patients usually come to treatment with a stereotype in mind of the kind of individual whom they want as a therapist. This is generally a kindly and wise middle-aged male psychiatrist. Such an image is partially the product of the universal need for an idealized father figure and partially the popular movie and magazine conception of the "mental healer." Other notions of an ideal therapist are nurtured by desires to fulfill, through special qualities in the therapist, impelling neurotic needs. For example, masochistic patients may yearn for a powerful and cruel individual, who will deal with them firmly, and they will try to seek out a therapist who possesses punitive potentialities. A frustrated middle-aged woman may have a longing for a virile, handsome, male figure through whom she may sublimate her unpropitiated longings. A passive, dependent male may desire a strong female therapist who can dominate him and mother him. If the patient is aware of and verbalizes disappointment, this will have to be handled in a therapeutic way. Examples of managing such situations follow:

1. *Questions about the age of the therapist*

Pt. I expected to see an older person.

Th. You are disappointed that I'm too young?

Pt. I really wanted an older man than yourself to treat me.

Th. I see. Perhaps you feel you could have more confidence in an older man. *[Reflecting possible attitudes behind the desire for an older person]*

Pt. It isn't personal, doctor, it's just that I've had this so long, I wanted a person with lots of experience. Dr. J told me you had a great deal of... well, but I thought you'd be at least 55 or 60 years old.

Th. Yes, it's natural for you to want to get the best kind of help for your problem, and you might feel that an older person has had more experience. If you'd like to tell me what your difficulty is, perhaps I could help you locate such a person *(accepting the patient's desire)*

Pt. Well, it goes back a long way. *(Patient discusses the problem.)*

2. Questions about the experience and training of the therapist

a. The extent of experience

Pt. I'd like to ask you about your training.

Th. Mm hm. (smiling) what would you like to know?

Pt. Well, how long have you been doing psychiatry?

Th. You must have some question about my qualifications. What kind of a therapist do you believe you would be able to work with best? *[reflecting possible attitudes behind the question]*

Pt. Well I wanted someone, someone who had a lot of experience.

Th. I don't blame you for that. Certainly you would want someone who would really know how to handle your problem, *[again accepting the patient's wish]*

Pt. Yes.

Th. Suppose I tell you that I have had enough training and experience to have helped many people. Now whether I am the best person to help you, I don't know. But why don't you tell me about your problem, and then we'll decide on the best kind of a psychotherapist for you. If I'm not the best person, then I'll help you find someone.

b. The kind of experience—sometimes the patient seeks a specific kind of psychotherapy and questions the orientation of the therapist

Pt. Do you do hypnosis and hypnoanalysis?

Th. Do you feel you need hypnosis?

Pt. Well everyone tells me I should get that. I read about it.

Th. Certainly if you need hypnosis, you should get it. But I'd like to go into your problem and then we can decide whether hypnosis is the best treatment for you. If you need hypnosis, then we can decide on the best person for you.

c. The kind of training

Pt. Could I ask you a question? Where did you get your training?

Th. You must be wondering whether I'm adequately trained enough to help you. *[reflecting possible attitudes behind question]*

Pt. I'm wondering what kind of therapy you do.

Th. I see. Do you have an idea of the kind of therapy you feel you need?

Pt. Well, no, but I know training is important.

Th. I think you have a right to know that the person treating you is adequately trained. [At this point the therapist may outline his or her training, and, if the patient is not satisfied, the patient may be told that after going over the problems, referral will be discussed.]

3. *Questions about the sex of the therapist*

Pt. Somehow I pictured being treated by a woman.

Th. Do you have any feelings about working with a man?

Pt. No, but I think a woman would be better for me. I could talk easier.

Th. I see, well perhaps what we might do is talk about your problem, and then we can decide on the best person to treat you.

4. *Questions about the religion of the therapist*

Pt. Are you Catholic?

Th. No. Do you feel that makes a difference?

Pt. I think a Catholic doctor might understand my problem better. You see, I'm Catholic.

Th. Yes, it's possible that a therapist with a background similar to yours might do better with certain kinds of problems. But suppose you describe your problem, and then we'll decide on the best person who can treat you.

5. *Questions about the professional identification of the therapist*

Pt. I was told to see a psychologist because I'm failing in my studies.

Th. Does it make a difference to you if I'm not a psychologist?

Pt. Well I don't know. You see, my sister called you about me when I told her I should see a psychologist because of how I was doing in college.

Th. It's true that psychologists do deal with educational problems, but other trained persons can do that too. Now, I'm a psychiatrist and I think I can help you, but suppose we talk about your problem, and then we will discuss whether a psychologist would be better for you. I'll then find the best one who can help you.

The principle outlined in these interviews is to *join the initial resistance* rather than fight it. The object is to get the patient to verbalize and ask more questions if desired.

Once these questions are answered, the patient will, as a rule, talk freely about the problem. It is rare, in a properly conducted interview, to encounter a desire to change therapists. The patient will usually have found the interviewer sufficiently discerning and empathic to want to continue in therapy with that therapist.