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THE PSYCHIATRIC INTERVIEW

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The psychiatric interview as practiced in most American psychiatric facilities has undergone a marked change during the past 60 years. Formerly a question-and- answer type of interview satisfied the requirements of psychiatric interviewing, as it did and still does satisfy those of medical history-taking with regard to exclusively physical illnesses. But the modern psychiatric interview, although it includes questions, puts much more emphasis on a free-flowing exchange between the psychiatrist and the patient. This alteration in our practice has resulted from changes in the kinds of information we want about patients and in our ideas of how we can best obtain this information. We also have learned the limitations of verbal communications. We now notice not only what the patient says but also his manner of saying it, for this may show what his words conceal. And we have learned that, when two people talk together, what they say depends not only upon what they want to tell each other but also upon what they think about each other. In what follows I shall discuss first the information a psychiatrist usually wishes to obtain in an initial interview, next how the psychiatrist's relationship with the patient influences what the patient tells him, then the

psychiatrist's optimal attitude, and finally some techniques that can increase the yield of an interview.

Both the theory and technique of psychiatric interviewing receive attention from American research psychiatrists, although not as much as they should. We may hope that from their efforts will emerge changes fully as great as those that the last 60 years have brought. This will require, among other things, that each of us challenge constantly his own habits and remain unwilling to practice, for the rest of his lifetime, only whatever his teachers have taught him.

I shall discuss the psychiatric interview chiefly with regard to the initial evaluation of a patient. Sometimes we can achieve this in one interview, but quite often we need several. Moreover, the initial interview or interviews should blend with the psychiatric examination. Chapter 54 discusses the psychiatric examination and the methods of including part of the examination in the psychiatric interview and of making a transition from the interview to the more definitive examination.

What the Psychiatrist Wants to Learn

The psychiatrist should obtain first what the patient usually most wants to give, namely, a description of his symptoms and the story of their onset and progress. After this the importance of life stresses in precipitating mental

illness requires a detailed review of the patient's current environment. The discussion of this can lead easily into talk about the patient's early environment and thence toward his family history. From this may naturally follow an account of the patient's own earlier life—his personal history.

Most psychiatrists understand the importance of eliciting this material in initial interviews, and only two items deserve further emphasis. First, much importance must be attached to a detailed account of the patient's symptoms. We should try to imagine what the patient has experienced and now experiences. We should try to see the world as he sees it, but we can do this only if we let him talk to us in great detail. Moreover, many psychological symptoms require study not only as direct experiences of the patient but also with regard to the purpose they serve the patient in adapting to other people or to other forces within himself. In short, we enter into detail so that we may know both what functions are disturbed and how these functions relate to others. Second, the study of the patient's current environment must be emphasized. Although we all recognize the importance of major life stresses in precipitating mental illnesses, we often neglect, to our and the patient's disadvantage, the careful study of how the patient lives. Only by entering into his daily life, as it were, can we come to appreciate the subtle but cumulatively powerful relationships between the patient and others close to him. And usually only such an appreciation will permit us to dissect the respective contributions of the patient and those around him to the strain he

experiences.

While listening to the history, the psychiatrist should not only attend to the bare facts of peoples, places, and events as chronicled by the patient; he must also study the meaning of these events for the patient and the attitudes that the patient showed to them then and, if those have changed, the attitudes he now shows toward them. In studying attitudes the psychiatrist must include, in addition to the patient's words, observations of the patient's emotions.

We have also another important reason for observing the patient's emotions as he talks. The psychiatric interview begins and includes much of the psychiatric examination. The patient's recital of his complaints and his history contributes valuable data about the illness. But that illness is a product (in most instances) of the action of stresses on sensitivities. The psychiatric interview should therefore study the special sensitivities and vulnerabilities of the patient. As the patient talks, the psychiatrist should scan him and his remarks for signs that certain events or topics are of special importance to him. The signals that reveal such events or topics deserve a brief review.

One may ask the patient directly about the events, people, and thoughts that bother him most. More often than is usually done, we should ask for this

information directly. At the same time we should remember the frequent, almost invariable, inability of patients to give a frank and complete answer to direct questions. In studying physical illnesses we can ask patients about the occurrence of nausea bloody stools, or swollen feet and usually expect reasonable and valuable answers. But we cannot ask a patient to tell us about his marriage, his parents, or his employer and expect that the words he returns us can alone contain all we need to know. Several factors are responsible for this difference. In the first place our society strongly emphasizes the importance of other persons having a good opinion of us. For psychiatric patients this becomes especially important, since they usually think poorly of themselves and have become doubly dependent upon approval by other people. When a patient finds himself in a psychiatrist's office, he has additional reasons for winning and preserving the favorable opinion of the psychiatrist. Consequently with his words he attempts to portray himself (unless he is very depressed or self-effacing) as a person who is in all respects lovable and "normal." Second, even the patient with the greatest candor has within himself large and important aspects of mind and behavior that lie quite outside his awareness. With the best will in the world he cannot tell us what he does not know about himself. And finally, even if he knew much more than he does, words would still furnish only a feeble channel for the communication of life's richest experiences, both of suffering and of happiness.

The psychiatrist needs to remember also that what the patient tells him about some past event or experience, even a rather recent one, may not correspond closely with the facts, if they could be ascertained, or the memories of other persons, if they are interviewed about the same events. Investigations of memories have shown them to be much less stable than was at one time thought true.' A person's account of his past given at one time may differ markedly from his account of the same events given at another time. And some events are remembered more accurately than others.

Despite these limitations of verbal communications and memories, the psychiatrist can use certain valuable clues provided by the patient to guide him toward at least some of what he wants to learn. These clues lie in the various signs of emotion shown by the patient as he talks, for our most important experiences become bound to emotions, or, more accurately, they become important because they affect us deeply.

Emotions show themselves in many and sometimes unexpected ways. The patient's arrangement and manner of presenting his verbal statements reveal much. The psychiatrist should note what the patient says first (both at the beginning of an interview and subsequently in response to questions), what he talks about most, what he returns to many times, and what he omits or glides over quickly. Thus the psychiatrist needs to learn what the patient especially wants to talk about and what he especially wants to avoid talking

about. Unusual speed of speech, hesitations, blockings, amnesias, and confusions all deserve attention as signs of emotion and, hence, clues to the significance of events or topics. The order of the patient's remarks deserves attention, and especially the connections of thoughts associated in one sentence or adjoining ones. Verbal associations betray affective links.

The psychiatrist should notice changes in the pitch and timbre of the patient's voice as he talks. Such changes express alterations in the tensions of skeletal muscles, of which many other indications can appear in the patient's face and limbs. Accordingly, the psychiatrist should watch for the play of emotion in the patient's face, in the posture of his body, and in the movements and gestures of his limbs.

Changes in the patient's viscera deserve equal attention, for emotions affect the autonomic nervous system as markedly as the central nervous system. Physiological investigations have shown the occurrence of many important visceral changes during emotional disturbances. Not many of these lie exposed to the unaided eye of the interviewing physician. Nevertheless, he may notice changes in the patient's breathing and in his heart rate, observed perhaps in the beat of the carotid artery in the neck. He can notice flushing and pallor of the face and sometimes perspiration. The patient's mouth may dry up, or tears may glisten in his eyes. During an interview emotional changes may bring on (and sometimes remove) the patient's symptoms. Thus

palpitations may occur, or a headache may disappear. A patient with a psychophysiological skin reaction may scratch a tender spot on the skin when the conversation touches something tender in his mind. Each patient has his own special mode of expressing his emotions, almost as characteristic as his gait or his fingerprints. Some patients, for example, rub their eyes, others glance swiftly away from the interviewer, and still others swallow whenever they experience anxiety. The psychiatrist should watch the patient for characteristic traits especially in the early phases of the interview, partly because the patient is then usually most anxious and partly because the psychiatrist can use what he then learns to identify moments of anxiety later in the interview.

The identification of an important emotion only begins its study by the psychiatrist. With techniques described later he should try to open a further discussion of the topic that has evoked the emotion, although he may often defer this to a more appropriate time. In that discussion he wants to learn in what way this topic is important to the patient and how it became so. Exactly what thoughts does the patient have about the event, person, or topic that causes these strong emotions? The psychiatrist cannot consider that his study of an emotion is complete unless he has elicited from the patient the details of the accompanying thoughts. For this he returns again to the patient's words through which alone (outside art) the patient can communicate his thoughts.

The detection of emotion during the psychiatric interview contributes to the examination of the patient, which, as already mentioned, starts at the beginning of the interview and, indeed, cannot and should not be separated from it. During the interview the psychiatrist has ample opportunities to examine other aspects of the patient's mental functioning, as described in Chapter 54.

A final purpose of the psychiatric interview is the evaluation of the patient's readiness for psychiatric treatment and efforts to improve this when necessary. Since this properly belongs to psychiatric treatment, it is mentioned here without further discussion. But the psychiatrist should remember it during his interview. Although his assigned tasks may resemble those of a juggler keeping five balls in the air, unless the psychiatrist can include in his technique a study and strengthening of the patient's motivation for treatment, he may conduct a superb interview that leads to nothing.

The Physician-Patient Relationship

As mentioned earlier, the patient's wish to tell his story is frequently obstructed by his wish to win and preserve the psychiatrist's approval and assistance. This interference is experienced by all patients to some degree. But each patient varies from every other one in the experiences that have led to this shielding of himself and to other behavioral patterns. And each

psychiatrist differs from all others in his capacity to stimulate or reduce such patterns in his patients.

When the patient was a child, like everyone else he learned from experiences what to expect that his parents (and other people) would do. He then generalized many of these expectations, first learned with particular persons, to guide his behavior with other persons. Sometimes his generalizations guided him correctly, at other times inappropriately. A dog conditioned to respond to a sound with a frequency of 512 cycles per second may respond (unless carefully trained) to a range of sound, say, between 475 and 550 cycles per second. The more careful and prolonged the conditioning, the more discriminating will be the dog's response to different stimuli. But his discrimination may weaken under stress or without proper reinforcement. In much the same way humans may discriminate poorly as well as correctly. They may respond to physicians as if they were duplicates of their parents. Such misperceptions on the part of a patient never occur first with regard to the psychiatrist; on the contrary, they have happened often before and have contributed importantly to the patient's difficulties with other people. But the psychiatrist should especially notice how the patient perceives him, first, because he can study this directly instead of depending upon observations of other people and, second, because the patient's perceptions of the psychiatrist furnish important clues to his difficulties with other people.

The more closely the psychiatrist resembles the significant persons of the patient's earlier life, the more he will be likely to evoke the behavior in which they trained the patient. (The frequency of 512 cycles per second stimulates the conditioned dog, mentioned above, to the greatest extent, even though he may respond to a lesser extent to other frequencies.) Suppose that the psychiatrist, after studying in advance a portrait of the patient's father or, better still, a moving picture sequence, should carefully disguise himself in appearance and manner to resemble the patient's father. We could hardly blame the patient for responding to the psychiatrist-actor as if somehow his father had wandered into the psychiatrist's office and sat behind his desk. After a moment of initial surprise the patient would engage in conversation, so he would believe, with his father. Now suppose that the disguise has been arranged very poorly, that, in fact, the psychiatrist has put on a mustache like the father's but does not shave his head to a similar baldness or imitate the father's gruff voice or smoke cheap cigars. If then the patient still acts as if the psychiatrist is his father, the psychiatrist would have important evidence of poor discrimination.

By partially resembling earlier persons in the patient's life, the psychiatrist may stimulate the conditioned responses of his patients in many ways. Each deserves brief mention here and much attention in the interviews. First, as already mentioned, the psychiatrist's physical appearance influences the patient's responses. The psychiatrist's sex and age, especially, but other

features of appearance hardly less, strongly guide the patient's thinking about what it will be useful or safe to reveal. Second, the patient responds to the social role of the psychiatrist as he conceives it. In this he mingles his concept of the role of the physician. Two features usually blend. Physicians have authoritative roles in our culture, with power to recommend and execute drastic treatments or to commit to certain hospitals. This aspect of our work leads the patient to confuse us with policemen, sergeants, judges, teachers, and, most important of all, with fathers. But physicians also have a role of succoring the sick and weak; in this connection a patient frequently achieves a mental montage of a physician and his own mother. Third, our behavior may also stimulate in the patient patterns of behavior laid down in earlier experiences. Some of this behavior derives from our professional work. We ask questions and so we may remind the patient of his mother, who always asked her little boy pressing questions, sometimes requiring painful answers, when he came home from school. However, some of what we do our work does not require and may indeed be better off without it. Thus suppose we, like the patient's mother, have an inordinate preoccupation with sex, and we question the patient excessively about this. He may then react strongly, although not necessarily irrationally.

In all these various ways the psychiatrist may evoke behavioral patterns in the patient that can partly, or sometimes entirely, interfere with that part of him that perceives the psychiatrist as a helpful expert to whom he should

tell his story. Patients vary greatly in their capacities to see the psychiatrist as he is and to avoid confusing him with other people. If the psychiatrist is to study the patient's discrimination, he not only must attend to the patient's behavior but also must learn as much as he can about himself. If the patient falsely attributes a mustache to the psychiatrist, the psychiatrist can only evaluate the possible misperception in this if he can recall whether he himself has shaved during the last few days. He must know what he himself brings as stimuli into the interview. He must remember that the patient responds both to what the psychiatrist does and to what he is.

In this connection it is worth mentioning that even when different interviewers adopt a somewhat uniform approach in the conduct of an interview, they may have markedly different effects on different patients. In drawing attention to this fact, I am not recommending the adoption of a uniform style in interviewing. This would be as undesirable as it would be unfeasible. But I do exhort the interviewer to become as much aware as he can of his own behavior with patients and its differing effect on different patients.

A physician-patient relationship is clearly not fixed or capable of permanent description. It is a shifting complex of behavior that includes changes in both patient and physician. The patient does not necessarily continue in his misperceptions of the psychiatrist, and his speed of correcting

them furnishes an important point of prognostic value. During their further contacts psychiatrist and patient have the opportunity to correct their initial and frequently false categorizations of each other. If first impressions repel, they may discover— with the ever fresh pleasure this brings—that each is, after all, rather a pleasant person once one gets to know him a little. More often first impressions attract, because each shows socially conventional behavior. In a new situation our behavior at first tends to conform to the social roles we believe the situation assigns to us. Afterward, closer acquaintance may bring to the fore traits at first concealed. For with growing intimacy there emerge various patterns of behavior learned in the less uniformly structured experiences of the family. Thus it happens that after a time the psychiatrist does something or fails to do something that frustrates one of the patient's expectations of him, or he may offend the patient in many such ways. These events he must also study carefully.

The usual initial positive attraction of psychiatrist and patient for each other is largely sustained by their fantasies of what each can expect from the other. When the fantasies yield to closer inspection, and when at the same time intimate behavior begins to replace more formal behavior, the relationship may weaken. At this point one factor alone saves most physician-patient relationships from dissolving. In the time taken for the patient's irrational expectations of him to collapse, the psychiatrist has a chance to show, one should not say to display, his real professional competence. Then,

as the patient learns that the psychiatrist is not what he first thought him to be—perhaps a doting mother or an eternally patient father—he may discover that as a helpful physician the psychiatrist can now contribute even more than the mother or father. This transition from a tenuous relationship based on fantasy to a firm one based on an experience of competence demands that the psychiatrist offer the patient something considerably more than he can find in ordinary social intercourse. The following sections of this chapter offer suggestions concerning the content of this "something."

The importance of the physician-patient relationship in influencing what the patient will tell the psychiatrist and what the psychiatrist should tell the patient requires that the psychiatrist constantly evaluate this relationship. He should note how readily the patient talks and all other behavior of the patient toward him. Psychiatrists notice minutiae of social conduct—for example, punctuality, hesitancy in smoking, deference in going through doors —that would and should be overlooked or not noticed at all in other situations. But in an interview psychiatrists should observe all these items of behavior as clues to the attitudes that such behavior expresses. The psychiatrist should also help the patient to use any opportunity that arises to state what he thinks of the psychiatrist. In initial interviews most patients cannot achieve much candor in such comments. The psychiatrist can usually expect conventional formulas. But often, and even in guarded remarks, the patient may say something revealing and relevant. In drawing out the

patient's thoughts about ourselves, if we press the patient artificially we will usually only increase his conformity to socially acceptable platitudes. Natural opportunities will arise, however, that we can exploit. If the patient has referred himself or chosen the psychiatrist from among several of whom he has heard, we can ask him, "Why did you select me to consult?" If he generalizes about physicians or psychiatrists, we can say, "Are you including me in that?" I shall discuss later the special value and importance of discussing the patient's thoughts about the psychiatrist whenever the patient seems to become unusually anxious.

The Optimal Attitude and Behavior of the Psychiatrist

We should often ask ourselves in what ways we can be of more use to our patients than even their best friends can be. The difference may lie principally in the *degree* to which we show a friend's helpful qualities and, most of all, in the tenacity and patience that permit us (and the best of friends) to sustain a relatively stable relationship with another person over a long period of time. In addition, four other qualities for the psychiatrist—interest, acceptance, detachment, and flexibility—are recommended.

For his task the psychiatrist certainly requires interest in the patient and in his difficulties. This interest can include to a degree the biologist's curiosity about the wonders of living organisms, yet we cannot allow

ourselves to become so preoccupied with the details of morbid anatomy and physiology that we lose interest in the whole patient. Our specialty particularly concerns itself with the responses of the whole man. Our interest should be in the patient and for the patient; it should not pursue, disguised as diagnostic fervor, our own special predilections and curiosities. We rarely can entirely prevent these from interfering with our guidance of interviews, but we can at least strive to become aware of the ways in which our interest in ourselves may mingle harmfully with our interest in our patients. The interest we show in patients should include. and chiefly derive from, an attempt to understand them. Our limited success in this task may matter less than our efforts to try and to improve. We know that a fumbling medical student may learn much from a patient in a psychiatric interview. At present there is so little difference in skill between the worst and the best of us that we must rank the wish to understand as hardly less important than any understanding we achieve. At any rate patients respond well to both. Finally our interest should always include attention to the assets of the patient as well as to his deficiencies and difficulties. To this aspect of our interest patients also respond favorably, and with it we may help them to tell us more freely about their sufferings.

The psychiatrist should next try to reach a capacity for complete acceptance of his patients. Our profession does not ask that we approve all that our patients do or abandon our own ethical principles in favor of moral

relativism. But we do improve our skill when we can accept patients unreservedly, regardless of what they may say or do that would be quite offensive in another context. Just how offensive people can be, the psychiatrist has a better chance than anyone to learn. But he also can learn more easily just how important it is to all of us to gain and hold the affection of others despite our shortcomings. Here we can often be of more help than the patient's family and friends. Because they frequently have become alienated by his behavior or their own, so that the patient believes himself to be without the friends we all need, we should have the deepest reservoirs of kindness.

If the psychiatrist does surpass the performance of family and friends in this regard, he often owes his success to the cultivation of a third quality required in his work. We may call it detachment, separating this sharply from the aloofness with which it has sometimes been confused. Because we live outside the circle of the patient's family and friends, we are not so closely—and hence so emotionally—involved in the patient's difficulties as they are. What the patient does cannot affect us so much. It should affect us somewhat, or we would not want to help him or be capable of doing so, but it must not affect us to the extent that the strength of our emotions disturbs our judgment of the patient in the manner that the strength of his emotions has disturbed his judgment. His anxiety prevents him from thinking clearly. He needs a less troubled mind to help him correct his misperceptions and faulty

reasoning. Here again we can establish maxims more easily than we can follow them, and for this reason among many, psychiatrists should know themselves as well as they can.

Every internist taking a history and performing a physical examination finds that he omits less if he follows a routine order of procedure. The psychiatrist's study of his patient should be equally thorough and usually must be longer. But the psychiatrist cannot afford to impose a rigid form on his interviews and examinations. Although careful to think and ask about everything that might relate to the patient's symptoms or difficulties, he should not expect always to learn things in the same order. Nor should he expect ever to learn the same things in every interview, for different symptoms require different emphases in the discussions. Lack of space prohibits a review here of some of the common variations in interviewing that occur with, for example, patients who have depressions, hypochondriasis, schizophrenia, anxiety states, and psychophysiological reactions. For these variations alone, flexibility becomes another desirable attribute of a successful interviewer, but he also needs this quality especially to reduce the resistances within patients that often prevent their talking freely about many important topics. Some patients can talk easily about their wives but dare not discuss their parents. Others may pour out a cataract of information about their parents and close up like a bank vault when the psychiatrist inquires about their wives. Many varieties occur in such

resistances, but the physician can nearly always count on finding some. Fortunately time helps the psychiatrist. Talking itself predisposes the patient to further talking. If the physician yields at first to the patient's reluctance to talk about certain subjects and lets him discuss others, he may thus prepare him eventually to return to the previously avoided material. This is not to say that the patient should be permitted to seize and retain control of the interviews. On the contrary, the physician should preserve guidance throughout and, if necessary, make his guidance explicit to the patient, but he should not use his skill and power to confront the patient prematurely with subjects that are seriously disturbing. This can trouble and even shatter the developing positive attraction of the patient for the physician. The flow of the patient's remarks is sometimes delicately balanced between the wish for help and the fear of injury at the hands of those to whom he gives his confidence. If he experiences painful emotions too much and too early, his expectation that he could be hurt may be confirmed (not unreasonably), even though the interviewer said nothing intended to hurt him. We all turn away, from pain and often also from those with whom we associate the pain, even when they have tried to help us. And so the psychiatrist should let things come gently and naturally, perhaps learning this lesson from skillful obstetricians.

The Technique of Interviewing

Arrangements for the Interview

In any interview stimuli reach the patient not only from the physician but also from the entire setting in which it takes place. The psychiatrist will find worthwhile a study of the setting of his interviews even if, and perhaps especially if, he cannot change the setting. Privacy and reasonable comfort for the patient and the physician are absolutely essential. A separate room best assures complete privacy, but not if telephones ring and secretaries run in and out. A public ward, with its chatter and other hubbub, gives more privacy than a semiprivate room. Bright precinct-station lights should not blind the patient as he talks. The physician and patient should preferably sit so that each can look at the other without having to do so continuously if they prefer not. The psychiatrist should reserve enough time for a satisfactory interview. In the present state of our knowledge anyone who does not keep at least 45 minutes or an hour for an interview identifies himself as practicing some psychiatric formula that does not include listening to patients. Brief interviews may have their place in medicine, surgery, and even in certain authoritative and directive psychotherapies, but they have no relevance to diagnostic and therapeutic psychiatric interviewing at its best. (A later section will discuss reasons for this.) Moreover, one interview, even of the length suggested, rarely suffices for a thorough exploration of the patient's difficulties, and the psychiatrist will usually have to arrange for several further meetings.

The psychiatrist should always make notes during or after an interview.

Apart from the value of having some record of the talk, the process of making notes passes the material through the mind of the psychiatrist again and thereby adds to his study of it. If he makes his notes during the interview, he should be reasonably certain that the note taking does not interfere with his own spontaneity. Some psychiatrists can pass this test, others cannot. And lie should also be certain that the note taking does not trouble the patient. About this he should not necessarily expect to hear from his patients, many of whom will communicate their objections indirectly rather than with words.

In connection with notes and records I shall refer briefly to the use of questionnaires in eliciting a medical history. Questionnaires can be filled out by the patient before an interview, perhaps in the waiting room. They often save time and they provide a valuable check for completeness of the survey of the patient's history and condition. They cannot, however, substitute for the interview, and this for at least two reasons. First, the psychiatrist cannot usually observe the patient's emotional responses as he fills out the questionnaire, and these provide important clues to the feelings and events of importance. (He may watch for signs of emotion as he discusses the questionnaire later, but this reduces the time saved, and in any case the strong emotions usually only come to expression during a fairly free conversation, not in response to questions.) Second, the psychiatric interview has other purposes than that of gathering information. It should provide the beginning of a trustful relationship in which psychiatrist and patient

collaborate for the improvement of the patient's condition. Since questionnaires cannot replace interviews their main value at present lies in research and sometimes in supplementing the interview by assuring comprehensiveness of the topics covered.

Starting the Interview

As patient and psychiatrist meet, the initiative lies with the psychiatrist. He should introduce himself, lead the patient to his office, offer him a chair, and start the conversation. One can begin well enough with a brief introductory statement such as, "I know about you only the little that Dr. X told me.

So it would be best for you to tell me in your own words what troubles you." After this the physician should usually remain silent until the patient's first responsive flow has dried up. He can soon tell whether the patient can talk freely or needs additional help. If the patient does need help the physician should give it promptly, not letting him bathe in the sweat of tense silences. Sometimes the patient does not know what he should give in the way of a history. Since psychiatrists do ask for kinds of information different from that required by internists and surgeons, the patient may simply need a little guidance. Sometimes the patient's anxiety mounts so high that it blocks his free expression. In that case the physician can channel the conversation into

something less painful to the patient. Often he can reduce the patient's anxiety by asking questions that free the patient of the fear that he will say too much and of the responsibility for giving emphasis to important topics. Later the patient may relax enough to talk freely. If such measures fail, often the psychiatrist should ask the patient about his anxiety and should suggest possible origins of it in order to encourage further expression. He can say, for example, "You seem frightened. Can you tell me what makes you so?" If the patient still blocks, the physician can suggest, "Perhaps you are afraid of how I will react to the things you may want to tell me about. Is that so?" The patient may then respond by verbalizing the origins of his immediate anxiety and can then continue with other parts of the interview.

Once the patient has begun to talk, the physician's task consists in helping him to talk freely and in guiding him to speak about the most relevant topics. These will be discussed separately, although in an interview they naturally intermingle.

How to Help the Patient Talk Freely

If the physician has a strong interest in his patients, he can influence most of them to talk freely, because everyone talks better to an interested listener than to a bored and reluctant one. The awareness of the psychiatrist's interest reinforces the patient's wish to talk and his conviction that the

psychiatrist merits his confidences. It may often be difficult to listen without interrupting. The psychiatrist's other medical training frequently impels him to intrude a question about a date or place so that he is sure to know all the data. Or something the patient says may infect him a little with the patient's anxiety or depression. Then he can quite unconsciously deflect the patient from such sensitive topics (for him more than for the patient perhaps) by asking the patient about something else. Each little interruption in itself may seem trivial, and usually is, but each adds to a cumulative effect on the patient that tells him, "The doctor wants something from me. What is it? How can I tell him what he wants to know?" When patients become occupied in giving us the information they think we want, they can easily forget to tell us what they want and need to say, of which we as yet know nothing. Every time we let the patient talk as he wishes, we encourage him to say something else that, perhaps up until that moment, he thought he ought never to confide in anyone.

In addition to deflecting the patient's line of thought, the interruptions by the psychiatrist also tell the patient more about the psychiatrist. There are advantages to the patient's knowing rather little about the psychiatrist; the less he knows, the less he can censor what he says in accordance with the assumed attitudes of the psychiatrist. This may make for a freer revelation of the patient himself.

Should the psychiatrist then always say and do nothing as the patient talks? Certainly not. He should say and do whatever becomes necessary to sustain the patient's flow and to guide it. Silence may suffice, or it may not. Sooner or later some further responses become necessary or additionally helpful. In offering these the psychiatrist may move from silence toward levels of increasing activity, each designed to emphasize to the patient a little more strongly his wish to hear more. Thus grunts of "uh-uh" and leaning forward expectantly stimulate the patient a little more, or sometimes much more, than silence. If such gestures prove inadequate, the psychiatrist can questioningly repeat the last word or phrase of something the patient has said. After this come gentle urgings such as, "What happened then?" "Go ahead," and "I'd like to hear some more about that." Should these fail, and assuming that the patient knows in general what he should talk about, his anxiety toward the psychiatrist has probably interfered too greatly. The psychiatrist should then bring this into the discussion directly, help the patient verbalize it, and, if necessary, apply appropriate reassurance. Thus he can begin by saying, "something makes it hard for you to talk to me about this matter. Can you tell me what it is?" Often the patient will respond satisfactorily to such leads. If not, the psychiatrist should suggest possible misperceptions of him by the patient, such as those mentioned above in connection with reducing initial anxiety.

He can say, for example, "Perhaps you are afraid of what I will think of

you?" If all such efforts to loosen the patient's tongue fail, the psychiatrist's task usually includes pointing out to the patient his share of responsibility for their difficulties in talking. The psychiatrist might say, for example, "We have to work together on this, I'm sure you know. It's a collaboration between us, and I can do little for you unless you can tell me more about yourself." At this point the psychiatrist may learn of the patient's distrust about the privacy of his communications. On this matter and other similar doubts, the psychiatrist should provide firm reassurance based on actual performance. He should not, for example, assure the patient that what he learns from the patient goes no further and then schedule an interview with the patient's parents without the patient's knowledge.

With this repertoire of techniques increasing serially in stimulating the patient to talk, when should the psychiatrist use his influence? I believe he usually needs to increase his activity in the following circumstances: to show his interest, to reduce the patient's anxiety, to encourage the patient's emotional expression, to control garrulity and irrelevance, and to channel the interview toward topics of the greatest importance. I will defer discussion of the last two of these to a section on guiding the interview, but the first three pertain to helping the patient talk freely.

Some psychiatrists have more interest in their patients than they show. I think young psychiatrists are especially liable to make this error when they

mistakenly apply in initial interviews the silence that is conventional and sometimes helpful in certain psychotherapeutic techniques. In attempting to stay out of the patient's way, a psychiatrist may say so little as to give the patient the impression he is mute. Patients have been known to leave some psychiatrists after one or two interviews because they do not understand these psychiatrists' unresponsiveness and become alienated by it. Most patients have already received training by internists and surgeons in the question-and-answer method of history-taking. They may misinterpret excessive silence on the part of the psychiatrist as simply incompetence. Moreover, previously important persons have often communicated aloofness, indifference, disapproval of, or even anger toward the patient by means of silence. The patient may confuse the psychiatrist with these persons, and if so the interview can perish, or it can become unnecessarily uncomfortable for the patient as well as less productive, since anxiety interferes with thinking and with expression. It makes sense, therefore, for the psychiatrist to remain silent if he can and needs to do no more, but also to offer freely whatever signs of interest the patient seems to require. He can easily insert such additional communications of interest often enough with nods of the head, with "Uh-uhs," or with simple words such as, "Surely," "Naturally," "Of course," and "I see." Words matter less than attitudes. With a friendly attitude we will find the right words, expressing them in a gentle speech and with a kind face. The psychiatrist should also offer, from time to time, more explicit

signs of his understanding of what the patient did or felt with remarks such as, “I can see how hard that must have been for you,” or “That must have made you feel better.” Remarks of this kind should articulate what the patient has rather clearly expressed and should not influence him to agree, against his own knowledge, with the psychiatrist’s interpretation of events. When the psychiatrist does not understand what a particular experience meant for the patient, he should usually inquire further, but when he does understand, if he will occasionally echo what the patient says he can lubricate the interview.

Experience will teach the psychiatrist the level of anxiety proper with each patient for a flowing interview. When a patient’s anxiety becomes too great, the physician should try to reduce it by some of the techniques mentioned earlier. As already mentioned, excessive anxiety during an interview usually derives from misperceptions of the psychiatrist as being more menacing than he is. Anxiety felt by the patient with regard to other persons drives him to talk, while anxiety felt toward the psychiatrist blocks his talking. The psychiatrist should generally try to reduce or keep minimal the patient’s anxiety toward him in initial interviews. Certainly he should note it and may subsequently wish to allow its full exposure, but if the patient becomes very anxious with regard to the psychiatrist before a strong attachment has developed, he may block harmfully or fail to return. Since the patient nearly always hungers for the psychiatrist’s approval, his anxiety toward the psychiatrist can often be easily reduced by encouraging and

praiseful remarks with regard to the patient's exposition of his difficulties. For example, the psychiatrist can say, at a moment when the patient hesitates and looks inquiringly at him, "Go ahead, you're doing very well. Keep going the way you were."

Yet we need to remember also that anxiety can run too low in an interview. Physician and patient can unwittingly exclude the patient's anxiety from expression and agree that he is much better than he (or a referring physician) thought he was. This comes about when the human wish to reduce human suffering urges the psychiatrist to offer reassurance prematurely. In doing this the psychiatrist deprives himself of the opportunity of tracing the patient's anxiety to its specific origins. For example, suppose a patient says, "Doctor, I think I am going crazy." To this the psychiatrist can immediately reply, "Oh, no you're not. You don't have the symptoms." More useful remarks would be either, "What do you mean by 'crazy'?" or "What makes you think you are going crazy?" To such questions the patient may then answer with details of his anxious thoughts. It then turns out, perhaps, that he thought he was going crazy because his memory has faltered recently and an aunt who died in a mental hospital also complained of this at one time. Further inquiries remind the patient that she was, as a matter of fact, an aunt by marriage. To such specific details the psychiatrist can then provide specific reassurance. The best reassurance comes from understanding and explanation. Patients can usually distinguish reassurance based on careful

inquiry and explanation from shallow statements to the effect that "everything is going to be all right." Their ability to penetrate our weaknesses in this respect provides another reason for avoiding premature reassurance. Such reassurance can seal off further exposures of the patient's anxiety. He may think to himself, "Why should I tell my troubles to someone who minimizes them all as my family does?" Moreover, premature reassurance, when the patient does accept it, tends to promote the patient's excessive dependence on the psychiatrist. If we say, "Everything is going to be all right" (and there may be times and places when we should), we should realize that we have thereby accepted responsibility for their being so. When we insist that the patient join us in a careful exploration of his symptoms and difficulties, we communicate firmly to him our expectation that he will also share responsibility for his getting well.

We can control the amount of anxiety in the patient rather well by changes in the amount of talking we do. As the patient talks more and the psychiatrist less, the patient's anxiety tends to increase, at least initially, although after catharsis it may decrease again. As much as possible the psychiatrist should talk to modify the patient's anxiety, not his own. To do this he needs to remember that patients often tolerate silences rather well and frequently use them to think before speaking. A patient occupied in telling his story may not even notice silences, and sometimes does not seem even to notice the interviewer. But if a patient uses a silence to delete some

repellent thoughts, he usually becomes aware of the silence, and his anxiety mounts. Then, if the psychiatrist has not prematurely spoken in order to ease his own tension, the patient will speak to reduce it in himself.

A common dissimilarity between the interviews of interested amateurs, such as sensitive internists, and experienced psychiatrists exists in the differing extents to which they permit, encourage, and facilitate the expression of their patient's emotions. This being so, we may ask why we psychiatrists encourage the free expression of emotions. We do it first because, as I mentioned earlier, emotions give importance to an experience and at the same time communicate that importance to other people. They should also communicate its importance to the person himself. And this they do when the emotions become strong enough. But often patients have not expressed themselves freely to other people. Consequently the related emotions may recede somewhat, and the patient may think himself untroubled by them. Talking brings the emotions to the surface, and if they become strong enough the patient may be astonished by the extent to which he has been affected. Patients frequently comment on this with remarks such as, "I never cry when I think about these things at home, but when I come here and talk I seem to cry all the time." This illustrates Sir Charles Sherrington's comment that in motor activity talking lies midway between thinking and acting. And it brings us to an additional reason for encouraging the patient's expression of emotions—the therapeutic benefit to him.

Although this subject properly belongs to therapy rather than to diagnostic interviewing, the psychiatrist can remind himself that initial interviews begin therapy by observing the simultaneous benefit for both diagnosis and therapy of the patient's freely expressing strong emotions. Moreover, the relief usually experienced by the patient cements his attachment to the psychiatrist and makes the patient eager to talk more at the next interview.

This does not always happen. Sometimes patients recoil in anger or guilt when they find they have talked too freely and shown some emotion they previously condemned and imagined they could not experience. A patient may resent the psychiatrist's hearing him criticize his parents perhaps for the first time, or seeing him cry, or eliciting the confession of some wickedness. One cannot easily predict which patients will react in this way. Fortunately the best safeguards lie within the patients, for those who are most likely to be hurt by too rapid a release of emotions are those who are most inhibited in the first interviews. They will require several or many interviews before they talk freely. But the psychiatrist should still observe the patient's reaction to the interview itself and notice whether the patient shows concern about the things he says and the emotions he displays. Within the patient's tolerance the psychiatrist should encourage the patient to express his emotions fully. Weak emotions, like mild pain, are often of doubtful significance, but strong emotions tell both psychiatrist and patient alike that they are working in relevant subjects.

Some of the chief techniques for encouraging the patient's expression of emotions have already been mentioned. The physician should sustain and show his interest over at least forty-five minutes or an hour. In brief interviews the patient rarely has time to overcome his almost invariable initial reserve. In a ten- minute interview discussion of the weather may take five; in a fifty-minute interview one can give five to the weather and still do much besides. In addition, emotions cut grooves for related thoughts of the same theme, which, in turn, bring stronger emotions to the surface. The longer one talks about a particular subject, the more emotion accompanies the evoked thoughts. Fully developed emotions usually occur only in longer interviews, because shorter ones do not permit this self-fueling of emotions to occur.

Beyond the requirements of showing interest and allowing plenty of time, the physician can further increase the patient's emotional expression by careful attention to some additional technical points. These are emphasizing detail in the patient's narration, reinforcing the patient's emotion by communicating understanding of his feelings, and naming the experienced emotion.

When we tell others about a past experience, we partially relive the events we tell and partially experience again the emotions we then had. The extent to which we feel again the old emotions depends upon the vividness of

reliving. Simple, uneducated people easily slip into a present-tense style of narration in which they seem almost completely to relive what they describe. More educated and more controlled patients, on the other hand, tend to talk in the past tense or to confine themselves to general statements. The psychiatrist should press the patient to provide specific examples of what he says. For example, if the patient says, "My father was always mean to me," the psychiatrist should ask, "Do you remember that? What do you remember?" He should frequently ask, "Can you give me an example of that?" or "Such as what?" Questions of this type oblige the patient to focus on specific events and, at least partially, to relive them. Moreover, the discipline of documenting general statements contributes to the patient's understanding of his own misperceptions. Once the patient has begun to tell about an incident, the psychiatrist can easily heighten the portrayal of detail by interjecting questions that ask for further details such as, "What happened then?" "What did your father say to that?" and "What did you do after you left the house?" After a little guidance of this kind the patient will continue to give detail on his own, partly because he knows what the psychiatrist wants and partly because he begins to experience the relief of catharsis, which usually only comes with vivid retelling.

Remembering the influence of the audience on any speaker, the psychiatrist can increase the patient's emotional expression by showing understanding of his emotions and attitudes in the events narrated. This does

not need to include or imply an endorsement of the patient's behavior; rather it implies an awareness that what he then did was natural for him at the time. Remarks (offered in a questioning way) such as, "So you felt no one was on your side," and "At that point you thought your father was trying to control you," can tell the patient that he at last has someone to talk to who can understand him, and so he will want to talk more.

Patients frequently come close to the expression of strong emotions without quite permitting themselves to reach it spontaneously. Frequently fears of the psychiatrist's reaction to strong emotions inhibit them. When a tear moistens the patient's eye, the psychiatrist can profitably tell the patient he has noticed the emotion with a remark such as, "I can see it makes you sad to talk about this." Such a statement says to the patient, as it were, "It's all right to cry here. Go ahead." And frequently such little remarks will help the patient to cry or experience other strong emotions. The psychiatrist gains nothing if he runs too far ahead of the patient in using this technique. Many patients have great difficulty in acknowledging and showing anger. If the psychiatrist too rapidly confronts such a patient with a name such as "anger" or "rage" for these emotions, the patient may shrink back in horrified denial that he could house such feelings within himself. In that case, however, the psychiatrist does not need to retreat all the way. If he finds himself ahead of the patient and encounters denial, he could still say, "Well, of course, I could be mistaken, but I think nearly everyone in your situation would have been

annoyed at what happened to you." This provides the patient with a hint of the acceptability of some anger that he may later wish to use.

Although I have emphasized the importance of the patient's talking freely, the psychiatrist should retain general control of the interview. Free talking does not mean unlimited free association. The right of the patient to say what he wants does not convey also the right to babble on tediously about irrelevant matters. The psychiatrist has the privilege and even the duty of curtailing circumstantiality and garrulity. But before he does so he should first ask himself (and perhaps the patient) why the patient behaves in this way. There are many reasons, and it is worth finding out which applies. Sometimes the irrelevant chatter results from a long-standing inability to think clearly, a form of mental deficiency.

Sometimes it indicates failure of memory, with the patient substituting an appearance of remembering details for accuracy of recall. Sometimes the patient talks about something else in order to postpone talking about some more affecting topic, or to conceal it altogether. This commonly happens in the description of hypochondriacal complaints in which the patient, by focusing the attention of himself and everyone else on his heart or stomach, withdraws it from his marriage or disastrous financial predicament. Sometimes with such excessive talk the patient tries to communicate covertly something that he thinks about himself but cannot or dare not articulate

explicitly, or of which he may even be unaware. The patient who offers unnecessary detail may never have thought that his affairs seem less important to other people than to himself. Or when a patient recounts details of his previous illnesses and operations in uninvited detail, he may really want us to know in this way how much he has suffered and needs our sympathy.

Before cutting off the patient, or while cutting him off, the psychiatrist should usually inquire about the excessive talk. He can say, for example, "I notice you spend a lot of time telling me about your past illnesses. I can see that they are important to you, but I don't think I understand why. Can you tell me how they are important to you at this time?" If such inquiries prove futile to stem the flow of the patient's irrelevancies, the psychiatrist can then move gently, but if need be also firmly, to deflect the patient. He can say, for example, "Perhaps later we can come back to what you are talking about. But since our time is limited, I wish you would tell me about so and so." This brings us to the various techniques for channeling the interview toward significant topics.

Guiding the Interviewer Toward Significant Topics

As in his encouragement of the patient's talking freely, the psychiatrist should guide the interview covertly when possible and only secondarily with

more open directions. Often he can use the devices mentioned previously for showing greater interest in a topic of special importance that the patient only mentions. Thus he can channel the patient into another topic without the patient's becoming aware of his influence. But the psychiatrist should be aware of it. He should know that he is guiding the patient, and for a definite reason.

All psychiatrists should study carefully reports of experiments that have shown the profound influence on other persons of systematic utterances (by an experimenter) of such simple sounds as "Uh-huh." Such interjections have been found to influence the number of plural words spoken by a subject told to say all the words that come to his mind. As the experimenter gives an "Uh-huh" after each plural word, the subject, even without any awareness of being influenced, tends to increase the number of plural words he says. An even greater effect occurs when the subject judges that the experimenter means to communicate approval by his "Uh-huh." Similar experiments have shown that such interjected "Uh-huhs" can influence subjects to give more emotional responses during an interview and to vary the types of memories recalled. Now a patient always knows, or thinks, that the psychiatrist wants something, and he usually wants to satisfy the psychiatrist much more than experimental subjects want to satisfy psychologists. Consequently, if the psychiatrist interjects his "Uh-huhs" unconsciously and pursues his special interests in sex, religion, money, or something else, the patient will almost certainly go

along with him. Both may find the hour enjoyable, but it may be unrewarding because of a one-sided emphasis on their favorite topic.

If the psychiatrist's subtlest signs of increased interest do not guide the patient to talk more about some significant object, then he may direct the patient more openly. He should exploit as much as possible the associations and references already provided by the patient. For example, suppose the patient says, "My headaches are getting worse every day, and my wife says she can't stand it much longer." The psychiatrist can catch the patient's reference to his wife and inquire, "What does your wife say about your headaches?" This broaches the subject of the patient's marriage, and other inquiries and information naturally follow. Sometimes the psychiatrist should not interrupt the patient in order to pursue an association at that time. This can interfere with the patient's flow toward something equally important. But the psychiatrist can make a mental note of the patient's remark and return to it later. He can say, for example, "You mentioned five minutes ago that your wife couldn't stand your headaches. Will you tell me some more about that?" By using the patient's own references and associations, an experienced psychiatrist can sometimes conduct an entire and thorough history-taking interview without ever himself introducing a new topic. Since the patient seems always to be elaborating further on what he himself first brought out, he cannot reasonably believe that the psychiatrist has forced him to talk of things he did not mention.

Even with the most skillful use of indirect techniques, the psychiatrist will at times have to ask questions, bring up new topics, or inquire directly for further details. Although, as already mentioned, the psychiatrist should usually defer questions about dates, places, and details of events omitted in the patient's initial story, eventually he should ask for whatever facts he believes necessary to satisfy the requirements of a thorough history.

Before he does so, however, he should remember that questions frequently introduce errors into histories. It has been shown that spontaneously given accounts of events include fewer errors than accounts elicited with interrogation. This occurs for the simple reason that most people cannot bear to say "I don't remember" or "I don't know," and they are therefore inclined to answer questions with some information even when they are unsure of its accuracy. Patients, who are eager to obtain help and who often imagine that they must qualify for this help by pleasing the interviewer, have a special vulnerability to this tendency.

When the interviewer does ask questions, his attention to careful phrasing of them proves rewarding. Slight differences in wording can greatly influence the patient and his responses. If our "Uh-huhs" can tell the patient what we want to hear, our explicit questions provide a much more forceful and sometimes harmful guidance to the patient. The questions asked should provide the fewest possible clues to the answers expected and the least

possible channeling of the answers. Most desirable are “open” questions that ask about a topic in general and to which the patient must reply with one of several sentences. The least desirable questions are leading questions to which the patient can answer “Yes” or “No” and then remain silent. Compare, for example, the differing values of asking the patient, “Do you and your wife quarrel often?” and “Tell me about your marriage.” The first question, apart from its abruptness, which can offend, may evoke a simple “No” from the patient and nothing else, unless irritation. The second question invites and almost obliges the patient to reply with a sentence or more. Moreover, it does not confine the patient in his reply to the present time. The psychiatrist can learn much from noting what the patient selects to talk about first in answer to such a question. To illustrate this important principle further, an exercise for a psychiatrist who wishes to improve his technique is to arrange opposite each other in a list closed questions and more valuable open ones. For example, one can ask a patient “Was the pain severe?” but a better question would be, “What was your illness like?” “Did you miss your daughter when she married?” will yield less than, “How did you feel when your daughter married?” We can ask, “Do you have a bad temper?” but we can improve on this by saying instead, “How is your temper?” I do not mean to proscribe all leading questions focused sharply on a specific point, but these should come after more general open questions have given the patient an opportunity to answer freely without the suggestions and guidance of leading questions.

In asking questions that broach new topics, tact and timing reward the interviewer for the extra care they require. Careful phrasing of questions can greatly improve their yield. For example, in talking to an unemployed patient one should avoid asking, “Have you been on welfare often?” Instead, one can say more usefully “Have you had much trouble finding work?” Or, to illustrate further, one can unnecessarily offend a patient by asking, “Have you quit many jobs?” The patient would give the same and more information if asked, “What has led to your various changes of jobs?”

The state of the physician-patient relationship should influence our timing of questions and opening of topics to which the patient may be sensitive. As the patient and psychiatrist become more attached to each other, the patient feels freer to disclose more of himself, and the psychiatrist feels freer to ask him to do so. We can ask questions in the last five minutes of an interview that we could not ask in the first five, and we can ask questions in the fifth interview that would have been inappropriate in the first.

We can make many questions less painful by embedding them, as it were, in a matrix of other questions to which the patient is less sensitive. Thus one can lead a woman patient fairly easily to talk about sexual intercourse if one inquires about this at the end of a series of questions on pregnancies. In asking about further pregnancies the physician may naturally inquire whether the patient’s sexual relations have been satisfactory and, if

not, why not. Similarly one can ask questions about impairment of memory right after asking about the effects of the patient's illness on his vital functions such as sleep and appetite. With the question placed in this context, the patient is much less likely to believe that the psychiatrist thinks he is "crazy" than if a question about memory confronts him abruptly as a new topic.

Do not, however, confuse tact with timidity. The psychiatrist should never hesitate, out of feeling for the sensitivity of the patient, to ask a question that is necessary for thorough evaluation. In talking to a depressed patient, for example, the psychiatrist should discover whether the patient has had suicidal thoughts and the likelihood of his acting on these thoughts. Often he can learn about such thoughts indirectly, but when he cannot, then he should pose questions directly. A question firmly asked will usually elicit a more direct answer than one offered hesitantly.

The psychiatrist should try to avoid offering gratuitous comments and interpretations that can trip the patient as he tries to tell his story. Instead, he should try to offer simple questions that, while asking for more information, encourage the patient to talk further. For example, suppose the patient says, "I feel I need affection and can't get it." One might respond to this with, "Well, we all need affection, and you're not alone in this." A much more useful response would be, "What interferes with your getting affection?" This second comment reassures the patient that he needs affection, but it also inquires

further about what he himself may do to deprive himself of it. Or again a patient may say, “I’m afraid I may lose control of myself.” To this one could reply with, “Would that be bad?” but an even better response would be, “What do you think would happen if you did?” Or as a final illustration, suppose a patient says, “I was afraid of my parents as a child.” The psychiatrist could answer reassuringly, “Yes, many children are afraid of their parents.” A more productive answer, however, would be, “What about them made you afraid?”

Ending Interviews

When patients do express emotions freely, we should give them some warning of the end of an interview before it closes. This permits the patient to regain some calmness before leaving the office. About five minutes in advance one can say something like, “I can see that all this is extremely important to you, and we need to talk about it some more. But our time for today will soon be up, and we will have to postpone the rest.”

I find it helpful always to ask the patient at the end of diagnostic interviews if he has anything further he would like to bring out or has any questions he would like to ask. In these final moments patients frequently reveal some matter of great importance to them. Previously anxiety prevented their reaching these subjects, but as they see the interview closing, they often decide to risk the exposure. Usually time does not then permit a

full discussion, but the psychiatrist can defer this until the next interview.

Much of the best work of interviews occurs after psychiatrist and patient have separated. The patient (and a good psychiatrist also) goes on thinking about the subjects of the interview. New associations and often new emotions come to the surface and provide additional material at the next interview. The psychiatrist can usefully ask patients on parting to think further about the things discussed and to note these additional thoughts. Such instructions often stimulate patients who have shown marked resistance to psychological explorations. In the interview itself their great anxiety frequently prevents their talking or even thinking freely, and they often present defensive and obviously incorrect denials of symptoms and attitudes for which abundant evidence exists in other signs. After the interview and away from the psychiatrist, many of these patients relax and then begin to think constructively about the topics discussed. At the same time the image of the psychiatrist becomes less awesome. After a few hours or days of rumination the patient may eagerly welcome a second interview and may talk much more freely.

At the end of any initial interview the psychiatrist should discuss with the patient plans for further interviews or for treatment. Often the patient will press him for an immediate diagnostic opinion. The psychiatrist may then have to explain that he will need further interviews and perhaps other

examinations and tests before offering an evaluation of the patient's illness. He can usually include some initial reassurance covering what he knows up to that point. He should avoid blanket reassurance that he may afterward have to revise, and he should avoid offering prematurely a diagnostic opinion or recommendations for treatment. But always he should tell the patient what he plans to do next. Attention to such details of courtesy and cooperation greatly aids the transition from initial and diagnostic interviews to treatment.

Few single interviews sufficiently reveal the patient's difficulties for the purposes of the thorough evaluation that sound practice requires. Not many healthy people can pass from strangership to intimacy with another person in any hour, or even in several. So we should not expect this of anxious or otherwise troubled patients. Therefore, we must turn to additional interviews and to additional informants, both of which are nearly always desirable. With the patient's consent (rare exceptions to this occurring in the cases of irrational, psychotic patients or young children) we should interview important relatives of the patient, so that we may benefit from their often quite different perceptions of the patient and his illness. The discrepancies between the patient's account of himself and that of a relative frequently astonish us and also show us how differently people appear to different observers. Our psychiatric interviews can improve if we frequently remind ourselves of their significant limitations in giving us the information we need.

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