THE TECHNIQUE OF PSYCHOTHERAPY

THE INITIAL INTERVIEW

IMPORTANT "DON'TS" DURING THE INITIAL INTERVIEW

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The Initial Interview: Important "Don'ts" during the Initial Interview

1. **Do not argue with, minimize, or challenge the patient.** If the patient presents a point of view that is obviously prejudiced or distorted, one may be tempted to argue with or challenge it. These tactics are ill advised since the patient probably needs to maintain a distorted point of view to bolster defenses. Criticizing the viewpoint or theory may seem logical but, since there is no close relationship with the therapist, the patient may be unable to tolerate an attack on his or her defensive system. When the patient presents a fallacious idea and insists it is true, he or she may be told, “Understandably you may feel this way, but there *may* also be other ways of looking at this situation.” Should the patient keep probing this point, the therapist may say, “I do not yet know enough about the problem to make positive statements.”

2. **Do not praise the patient or give false reassurance.** Because the patient’s self-esteem is so damaged, he or she will probably be unable to accept any praise even though it is sincerely offered and realistically justified. Actually, there is little reason for praising the patient for any virtues, such as appearance, poise, or accomplishments, since the patient is undoubtedly aware of these and has discounted them. Reassurance may also be a futile gesture, although some reassurance may be attempted when the patient shows symptoms of adaptive collapse and grossly minimizes chances for recovery with psychotherapy.

3. **Do not make false promises.** These will boomerang, and the patient will use them deftly in resistance. The interviewer has no way of knowing what the course of therapy will be, and to pledge results before observing how the patient works is folly. The same holds true for promises of special privilege. To make these hastily to lure the patient into therapy and then to withdraw them because they cannot possibly be fulfilled can be greatly damaging to the patient’s trust in the therapist.

4. **Do not interpret or speculate on the dynamics of the patient’s problem.** The patient is obviously unprepared for interpretations until a working relationship has been established with the therapist. To assault the patient with explanations at the start is like attempting to plant a seed on untilled soil. Not only will interpretation not take, but its effectiveness will have been vitiated when an attempt is made to interpret later. Similarly, to speculate on the dynamics of the patient’s problem is to bombard the patient with concepts that will do little except to mobilize resistance. If the patient asks for interpretations or wants an outline of the involved dynamics, the therapist may say,

"It will be necessary to find out more about the problem before I can offer you a really valid opinion of it."

5. **Do not offer a diagnosis even if the patient insists on it.** This is because a diagnosis is often employed as a masochistic torture weapon. The therapist may provide an importunate patient with the explanation that an emotional problem is present that can be approached through psychotherapy. The type of problem is not important from a practical standpoint. Actually, it is impossible to make a complete diagnosis without studying the patient over a period of time.

6. **Do not question the patient on sensitive areas of life.** It is important not to interrogate the patient on sensitive points, particularly appearance, status, sexual difficulties, and failures in life. An opening may be given the patient to talk about these, but if blocking occurs, it should be respected until some later date when the relationship is sufficiently firm to countenance greater tension and anxiety. It is necessary in the initial interview, and indeed throughout the first phase of therapy, to avoid all comments that are offensive or humiliating to the patient. In fact, this should be the rule throughout therapy.

7. **Do not put the patient on a couch for the initial interview.** The establishing of rapport and the eliciting of important data are best accomplished in face-to-face interviewing. A great deal of anxiety is apt to be mobilized in a patient if the interviewer insists on the couch position.

8. **Do not try to "sell" the patient on accepting treatment.** Once the facts are presented to the patient, the choice of whether therapy is pursued must be the patient's. To force the patient into therapy may create insurmountable problems for both patient and therapist.

9. **Do not join in attacks the patient launches on parents, mate, friends, or associates.** Because the patient feels ambivalent about people he or she attacks, the therapist's criticism of these people may be resented. The patient may consider the therapist impulsive, naive, or judgmental to join in an attack with as little information as has been revealed. The therapist's best response is sympathetic listening, not defending, condemning, or condoning the person attacked. If the patient complains about a remark that was made to him or her that was upsetting or about a bad situation, the therapist may say, "A remark like that would be disturbing to you," or "This situation must have upset you," or "Actions of this sort can be disturbing to a person." Examples of unsuitable and suitable responses follow:

Pt. My wife is impossible. She's always been this way—nagging, yelling, disagreeable. Nothing satisfies her.

Unsuitable responses:

Th. That's terrible. Doesn't she know what it does to you?

Th. That's bad. She's a destructive person.

Th. Maybe you're prejudiced against her.

Suitable responses:

Th. This must upset you.

Th. It must be difficult for you.

Th. A situation like this could be disturbing to any person. Do you think you get unduly upset by it?

10. **Do not participate in criticism of another therapist.** Even if the patient presents accounts of unprofessional behavior, it is bad practice to criticize another therapist. No matter how strong the evidence may be, one never knows how much of the patient's story is colored by misinterpretation or transference. In the event the patient complains that there was no progress with a former therapist, one must also not agree. Often, significant inner changes have occurred that are blocked by transference. A resolution of hostility toward the former therapist may bring out the fact that considerably more progress was made than the patient had estimated. It should be remembered that should the interviewer fail to help the patient, one may become the victim of accusations that are made to the next therapist whom the patient consults. An example of how criticism may be handled is given in the following excerpt:

Pt. When I say that for three years I wondered what the hell went on, it's true. I don't know what—I can't summarize what I learned or what happened for three years with Dr._____ I just didn't get anywhere, and I'm at a loss to say just what transpired all that time.

Th. You feel it was a waste of time?

Pt. Yes. I … I … I do feel that it was mishandled, and I do feel that it was time wasted, and in many ways.

Th. Perhaps certain problems came up in your relations with Dr.__

Pt. Yes, I know I'm as slippery as the next patient as far as being treated goes.

Th. Slippery?

Pt. Dr.______ always complained I just didn't catch on, didn't do the right kind of associating.

Th. Perhaps the situation just didn't progress for many reasons. At any rate we may be able to discuss your feelings about your past treatment in greater detail later on.