
A health professional's assessment interview - abusive or therapeutic?

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Introduction

A health assessment can be a collection of data, obtained in an impersonal objective manner, an inquisition by *'the rapist'* that leaves the person feeling 'stripped' of dignity and information, or, a consultation by a *'therapist'*, who both obtains data and develops empathy, rapport and trust.

To be healthy, an individual is in a state of physical, mental and social well-being. (WHO) I have become concerned that more is being done *to people*, and not *with individuals* in need. My fears were aroused by my professional experiences, and by a conference report from 1996.

I have never forgotten a personal clinical experience in 1972, in a London teaching hospital. A group of trainee psychiatrists fired questions at a women patient. When they had their data, they dismissed her from the room. I would have felt "stripped, used, and abused", as if a monkey in the zoo. I forgot my anxiety as a newcomer, female, and from 'down under', and dared to speak. Then Consultant agreed to invite her to return, to be thanked, with respect for her own feelings and identity, and for her selfworth to be affirmed. Then she was encouraged to ask us questions.

Twenty-five years later, we are asked to collect clinical and statistical data and keep records on individuals, as specified by others, within limited time and finances. We are expected to provide treatments within the constraints of others' policies and procedures. Unique individuals do not fit into linear computer programs, statistics, benchmarks and a maximum number of treatments.

My paper aims to show that therapeutic assessments need to be a core competency for all health professionals. It encourages both the art of an individual approach, and the science of obtaining objective data. The desired outcomes include the person feeling heard, understood and respected, the diagnosis of any illness present, and participation in decisions on management

and treatment. It asks health service decision-makers to seek and respect individual patients' and carers' needs.

The Ministry of Health's Chief Medical and Chief Nursing Advisers described the skills and attributes needed by future health-care professionals in New Zealand. They did not include empathy, or its integration with clinical knowledge to establish rapport, arouse hope and trust, or to provide the care, compassion and therapy that are vital to promote healing, of body and mind.

Their CAPE conference paper referred to multiskilled health 'team-animals', who will have a broad-based general core education, with a training in business administration and economics. They will have a population focus to ensure that priority will be given to cost-effective interventions. They will gather, process and present information, and use analytical and statistical skills, (in order to) contract with public and private service providers, and be accountable for public money spent, and clinical services provided, as shaped by consumer demands.¹

We need to assist consumers to demand an individual therapeutic approach, to say that it works. They will have learnt from us that therapy develops hope, selfworth, and resilience under stress. When the individual's mind is positive, the body heals quicker. Relationships and society benefit.

Psychotherapists and other health professionals are asked to address possible medical diagnoses. And, each patient or client we see, relies on us to recognise any illness which requires treatment. Clinicians can study various interview techniques and content to develop what works for them.

Aims of a clinical assessment to make or exclude a medical illness diagnosis

1. To gain enough information on which to base treatment or management decisions:

- a) is immediate action needed? – e.g. bleeding, no airway, unsafe (suicidal, aggressive);
- b) is non-urgent treatment required, and if so, what? – e.g. advice, support, prescription;
- c) is referral indicated? – e.g. for admission, outpatient/service follow-up, to G.P, therapist?

1. Generic Substitution - only this time in the workforce. Reported by Vicky Tyler, *New Zealand GP Weekly*, 9 October 1996.

- d) to make sense of symptoms, and advice, to patient, and to a relative or carer if relevant.
2. To develop a professional relationship to promote healing and recovery;
 - a) with listening skills, empathy, respect, non-possessive warmth, compassion;
 - b) which develops trust, arouses hope, and facilitates the patient's full story (i.e., join patient's space, move at patient's pace; affirm feelings and actions);
 - c) which leads to the patient's understanding, participation in decisions, and a positive partnership in treatment and management, to promote recovery.
 3. To provide records, for current practical use, reports, and reference (personal/legal):
 - a) presenting symptoms & signs, their history, past personal and family history;
 - b) examination results, tests ordered/results, formulation, diagnosis, treatment, advice;
 - c) statistics & codes required, copies to send to appropriate persons/files/legal.

An assessment to integrate psychiatric data collection and therapeutic interactions

On meeting, I make eye contact, and move to shake hands, but I am ready to stop – if he looks fearful, paranoid or aggressive – if she is shy, suspicious, or withdraws, or may have been abused. I say that he/she is welcome to be accompanied, or to see me alone, for part or all of the time. Some need my 'permission' to say "no" to a partner, a child, a friend, counsellor, volunteer. I point to a chair, but add that he is welcome to move around, and ask for a drink of water. The shy person sits as if stuck to the chair; a paranoid or agitated person may move around. I explain that I am a medical specialist, in mental health, but cannot read anyone's mind. I note that it is not easy to tell a stranger personal things, and especially a psychiatrist. I ask if there is anything they would like to know about me, and the interview?

I may be asked if we are being tape-recorded, who will read the notes, or is everyone crazy if asked to see a psychiatrist? I may be told they do not need to be there, and who they blame for it.

I compliment him on the stressful decision to seek help, and to make any changes needed. Motivation for anything requires recognition, respect and rewards. They help our clients too.

Basic details are sought & recorded; i.e. name, address, birthdate, referrer, reference number. This 'neutral stuff allows time to settle, and introduces a professional framework. It is like making contact at the bedside by saying the patient's name and feeling his pulse.

I ask what is the most important for me to know? Why are they here, and why now? I ask about any concerns. I ask what are they hoping for by the interview's end?

I may learn about their motivation, comprehension, word use, relationships, anger, despair, delusions, hallucinations, attitudes to doctors, and to medication, and about past reactions.

After talking about fears and feeling heard, a person is finally ready to listen and to think. A woman responds to affirmation of her feelings first. A man appreciates affirmation of actions.

I say that each person has an unique life-story, and that it would help me to understand if I knew some of it. I ask standard questions, to gently guide the assessment to finish within an hour. I look for patterns of triggers, problems, emotional reactions, defences, strengths, and supports. I elicit details of each symptom: specific duration, history, triggers, impact, treatment responses.

Is their central nervous system functioning more slowly, faster, or in a confused or agitated way?

- sleep? - from and to when, awake in night, tossing, overactive mind, nightmares, flashbacks?
- appetite changes? - when, why, weight change from and to what, when, vomiting, body image?
- attention/concentration changes? - TV, newspaper, cooking, shopping, work, conversations?
- energy? - different in morning, afternoon, evening; tired, restless, agitated, overactive, rituals? thoughts & talk? - logic, speed, content (pessimistic, guilt, suicidal plans/attempts, hopes)?
- perceptions? - "sees/hears" others judging or hostile, thoughts are influenced, e.g. by TV, Devil.

- alcohol & drugs? - since when, why, where, dollars spent, family history/ use, plans to stop?
- feelings? - How long have you felt like this? What was happening before you first felt like this? What might help you feel less sad, scared or irritable? What or who makes you feel more so? Any similar feelings in the past, and when? Has any family member had similar problems?
- For Post-traumatic stress disorder, I explore a typical day's feelings, activities and reactions. I start with going to bed, sleep, flashbacks, washing, dressing, food, telephone, travel, shopping, children, social, work, relationships. I have learnt so many traumatic details as I have listened to hundreds of sufferers, female and male, children and adults, since 1982, in hospitals, prisons, Department of Social Welfare, and for Accident Compensation. Each survived so much pain. For reports, I quote from their answers for examples of the avoidance, re-experiencing and hypervigilant symptoms of PTSD as described in DSM-IV 309.81
- relationships? - feel heard, understood, supported, ignored, unwanted, denigrated, hostility?
- physical? - headaches, vision, smell, heart, blood pressure, thyroid, diabetes, liver, infections?
- medication? - refused? - current type, dose, duration, response, problems, past experiences?

I make links for them as I learn about their birth, childhood, school work, and social life, including illnesses, relationships, problems, traumas, fears, and their achievements, interests and hopes. After facilitating delivery of 'ah ha' links I can feel as if I have been a 'midwife' to deliver insight. I ask their idea of their problems, their strengths, what changes are wanted, how and by whom?

I am aware if I feel sad, depressed, scared, angry, puzzled, or have concerns for anyone's safety.

I formulate my ideas on the predisposing, precipitating and perpetuating factors in their problems. i.e.: what makes that person 'tic'? What was stressful? Why? Is there an illness, mental, or physical?

Predisposing vulnerabilities include family history of personality traits, mental illness or substance abuse, personal nervous system injuries or infections, family dysfunction, neglect, abuse or loss.

Precipitating triggers include stress from a loss of security, self-esteem, health, work or support.

Perpetuating stresses are abuse, illness, inadequate support (housing, food, money, relationships).

Genetics can leave a person vulnerable to depression, schizophrenia, obsessional-compulsive and other anxiety disorders, some types of alcoholism, personality traits, and to physical illnesses.

Early nurturing, in rat studies, influences the growth of the number of post-synaptic receptor cells, both para-sympathetic (nor-adrenaline), and sympathetic (5 HT/serotonin) in the nervous system.

Early childhood experiences influence a child's trust/mistrust, beliefs about self and others, independence/dependence, intimacy or hostility, initial reactions under stress and coping style, (e.g. abandonment depression, general suspiciousness, poor self-esteem or resilience in adversity)

Dr Michael Rutter, Child Psychiatrist, researcher and author, wrote that by the time of starting school, a child needs to feel that it can trust at least one adult to love and care for him or her. That child then feels empowered to cope with challenges in the schoolroom and the playground. He added that before leaving school, the adolescent needs to have achieved in at least one area; e.g.: studies, sport, art, music, or friendships. That person will then be able to persist and be resilient under adversity, as he/she feels loveable, and knows that success is possible and worthwhile.

Severe stress, such as physical, emotional or sexual abuse, accidents, illness or feeling helpless and hopeless, after a loss or in domestic violence, can precipitate and perpetuate excessive use of mental defence mechanisms to defend against overwhelming anxiety. Depending on an individual vulnerabilities, a person may use excessive intellectualised explanations, or paranoid projection onto and blaming of others, or introject and blame themselves and become depressed, or deny reality and become psychotic, or access to awareness is blocked at that time, until are less fearful.

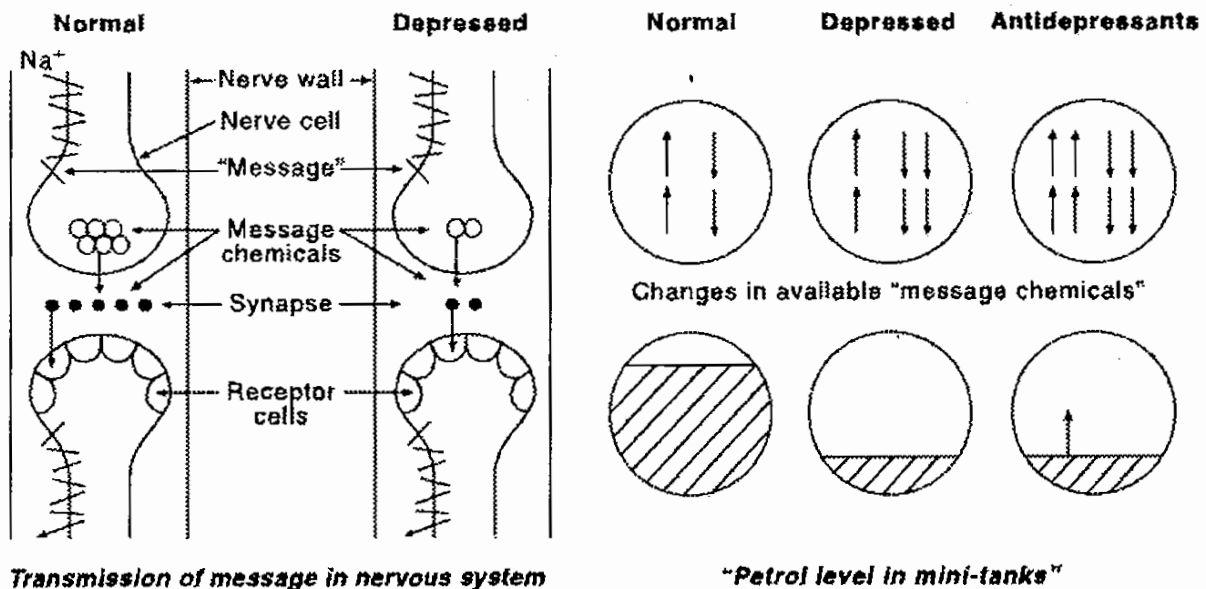
Depression provides a good example of the formulation, of a differential diagnosis of these three 'P's', of biological and environmental factors. It shows the value of integrating them in the dialogue with the patient, for each to understand, to make links between past influences, current stress and problems, and to participate in treatment decisions to aid their recovery overall.

If they remain, or still become severely anxious, or suffer from Post-Traumatic Stress Disorder symptoms, they often become depressed with exhaustion. I liken their body to a car with a flat battery or an empty petrol tank. It is as if they have been driving their car at 400 km/hour for a long time, using up more petrol and faster than they can refill, Then only a few messages can pass from one nerve cell to the next, as there are too few message chemicals ('petrol') for the demands on them or poor functioning receptor cells ('dirty spark plugs').

One in four women and one in six men suffer a depression episode at least once in their life. Most are not diagnosed or are inadequately treated. Depression precedes most suicidal feelings.

In the beginning, 'the car driver' needs 'a tow', joined by an empathic 'tow-ropes', to borrow the therapist's caring energy, hope and skills, to even want to 'stay on the road and in gear'. But, communications need to be simple and psychotherapy to be supportive, until there are enough chemical 'messengers'. I add diagrams of the nerve's message and antidepressant functioning.

Usually after two or more weeks of taking an antidepressant medication, the 'driver' has a 'car' that will go where directed, and personal control and skills can be enhanced by psychotherapy.² It takes six to twelve months of antidepressants before the 'car can climb uphill and not stall'.



2. Hewland, Robyn. *Psychotherapy in Depression*. NZAP Conference paper, 1975

Early paranoid psychotic suspiciousness, beliefs and reactions may be difficult to separate from substance abuse effects, and from post-traumatic flashbacks and fears of abuse and authority. It is easier if the psychotic person is receiving 'messages' on TV or radio and is very illogical. The teenagers' 'voices' after PTSD relate to feeling abused, and differ from in schizophrenia.

Physical illnesses with psychiatric symptoms include an over/under-active thyroid, diabetes, an infection or cancer, poor renal or liver function, anaemia, and inadequate oxygen to the brain.

We discuss a diagnosis and work out a treatment plan for recovery. It integrates any tests needed, medication, therapy, and life changes, and protective factors against relapse. Medication may have been refused before. Diagrams can explain why, if medication is needed. Reports are discussed.

Dr Richard Tillett³ carried out medline and manual literature searches and over 1000 personal psychotherapy assessments. He found "substantial evidence for general efficacy of psychotherapy. Differential benefits were identifiable. Short-term treatments are appropriate and effective in a wide variety of situations, but chronic/complex psychopathology is likely to need longer term therapy".

"Assessment of the individual patient and their problems enables both to answer the key questions:

- a) is treatment of any kind required?
- b) if indicated, what are the relative merits of medical, psychological and social interventions?
- c) if psychological is indicated, which types of approach might be appropriate, what depth of therapy is needed, and who should therapy involve?

He outlined the information required about personal, family and problems. He notes "the need for the experiential assessment of the person's psychological functioning". That includes: "an assessment of personality type, of the depth of emotional contact achieved, the patient's use of psychological defences, and the response to provisional formulations and interventions." He added that "it is unwise to recommend psychotherapeutic treatment unless it is based on a clear and appropriate formulation, which includes an evaluation and discussion of both dynamic and systemic factors."

3. Psychotherapy Assessment and Treatment Selection - a Review Article. *British Journal of Psych.* no 168, 1996, p 10-15.

He concluded:

“Sound assessment provides a secure foundation for effective psychotherapy. It requires not only knowledge of the range of available psychotherapies and the research evidence of their differential efficacy, but also a careful evaluation of the patient presenting for treatment, both in terms of the problems presented, and the person presenting them. A number of different treatment approaches may be possible, and these options need to be discussed fully with the patient, who can then make an informed decision about treatment. This requires a logical and collaborative approach to assessment and treatment planning.”

In summary, health professionals, in their assessments, need to combine the art of a therapeutic approach and the science of objective data, to respect each individual's dignity and feelings. They need to encourage the individual's participation in decisions as to how to address the assessed clinical needs, to promote healing and recovery, of body and mind.

Professionals and their patients and clients need to advocate for individual therapeutic needs, and show how these consumer demands are cost-effective, to the individual, the family, and society.

The New Zealand Association of Psychotherapists has fifty years experience in mental health. It knows the influences, links, problems and interventions, from birth to death, which contribute to the health of individuals, families and society. It can demonstrate and advocate for therapeutic assessments to be a core competency for all health professionals.