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The First Interview In Modern Psychoanalysis*

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An intial contact and interview between patient and analyst in modern analysis differs in many ways from an initial contact and interview in classical psychoanalysis. Some similarities also exist. In the following discussion these differences and similarities in theory and practice will be highlighted and a summary of a modern psychoanalytic first interview will be presented as an illustration.

The first rules laid out by Freud (**1912**, **1913**) for practicing analysts were based on his conviction that to take on the treatment of the schizophrenias or narcissistic disorders was a gross error of judgment. He believed that an analyst who undertakes to treat such cases "has committed a practical error; he has been responsbile for wasted expenditure and has discredited his method of treatment. He cannot fulfill his promise of cure." A less pessimistic view of the psychoanalytic treatment of severe mental disorders is now emerging (**Searles, 1965**; **Arieti, 1974**).

While the definition of psychoanalysis as "any line of investigation which takes transference and resistance as the starting point of its work" remains the same, the rules and advice of classical analysis, as gleaned from Freud's early papers, differ in several important instances from those of the present-day modern analyst. The

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following are some of the ideas expounded by Freud in his early writings:

1. "Select only suitable patients." (This precludes, in addition to the ones mentioned previously, patients who have been treated by other modalities, relatives, and those with whom the analyst may have had discussions about treatment.)
2. "Distrust and do not expect the return of any patient who puts off treatment."
3. "The treatment of friends and relatives guarantees the loss of friendship."
4. "Warn the patient that his favorable first impression of the analyst will be shattered."
5. "Tell him that his attitudes are his symptoms."
6. "Adhere rigidly to the principle of leasing a definite hour."
7. "See patients six times per week."
8. "It is a duty to let the patient know of the difficulties and sacrifices involved in treatment."
9. "The analyst forthrightly states the price he puts on his time."
10. "Give no free treatment—make no exceptions."
11. "Adhere firmly to the requirement of reclining on the couch."
12. "[The patient is to] say whatever comes to mind. Never censor."
13. "Remind the patient he has made a promise of absolute honesty."
14. "Refuse permission to deviate from any rules."
15. "Use properly timed interpretations as the method for resolution of resistances."

Although the ideas stated above became "rules" to many later psychoanalysts, the development from orthodox to classical to modern psychoanalysis was presaged by Freud. It is well documented that Freud was constantly breaking, modifying, and altering his theoretical views up until the time of his death. However, it is of historical interest to contrast the earliest rules regarding the onset of treatment with "suitable" patients to the current views of modern psychoanalysis.

Freud (1913) stated that he was "collecting together for the use of the practicing analyst some rules for the opening of treatment." He goes on to state that he brings them forward as "recommendations" without claiming any unconditional acceptance for them.

The exceptional diversity in the mental constellations concerned, the plasticity of all mental processes, and the great number of the determining factors involved prevent the formulation of a stereotyped technique, and also bring it about that a course of action, ordinarily legitimate, may be at times ineffective while one which is usually erroneous may occasionally lead to the desired end.

The following are representative of the rules and recommendations of the modern analyst **(Spotnitz, 1969)**:

1. Any patient with a psychologically reversible condition is considered treatable, at least theoretically.
2. Ask the patient when he would like to come. If the time the patient asks for is available, it should be given. If the patient rejects several alternative times, he may feel ambivalent about treatment and might be asked to call again.
3. Does the patient know where the analyst's office is? Ask him to repeat the time and address. Ask the patient to call again if he becomes uncertain later.
4. Once in the office the patient might be asked the following questions: How did the patient get to the analyst? With what problem does he want help? How frequently does he want to come? How much does he want to pay? When would he like to begin?
5. Do not volunteer information about possible duration, emotional difficulties or anticipated results of treatment. Do not promise a successful outcome.
6. Do not volunteer information about your credentials.
7. Do not ask the patient to free associate, but rather to say whatever he wants to say. There is no mention of honesty.
8. Use the couch if the patient is willing. Otherwise work to understand and resolve his resistance to the couch so that he can be helped to use it.
9. Use only those interventions designed to help the patient to stay in treatment.

Although Freud discussed the beginning of treatment, he made no reference to the manner in which the patient first makes emotional contact. Today we are aware that the analyst's response to the patient's first contact is essential in determining whether a treatment contract can be attained. The manner in which the patient contacts the analyst, the contact function, is a guide to

understanding what the patient needs. It helps the analyst determine what questions he may ask with genuine interest. Object-oriented questions, those that avoid thoughts and feelings about the self, are the preferred response when it seems likely that the patient has a fragile ego. Ego-oriented questions, questions relating to the patient's thoughts, feelings, and wishes, are often disturbing to him and experienced as attacks. Object-oriented questions avoid relating to the ego of the patient by referring to the analyst and the external world.

In the sample interview which is presented later in this paper, the patient makes no emotional contact with the analyst. From this the analyst may assume a narcissistic state. In such situations, the analyst educates the patient to make contact by asking a few questions that are object-oriented. This approach is especially relevant for patients whom Freud considered untreatable—those suffering from severe narcissistic disorders.*

The first contact may come by telephone, letter, an unexpected appearance at the office, or indirectly, through a relative. The analyst often has to facilitate the arrival of severely disturbed patients at the office.

In the first interview, the analyst does not know his patient. Until an agreement has been reached, joining techniques are not recommended. Joining techniques refer to a variety of communications that have a maturational effect. They help the patient function cooperatively in the treatment session by removing the immediate obstacles to communication. They are used to deal with resistances (what Freud referred to as “stone-wall” resistances) that do not respond to interpretations.

During the first interview the patient's functioning is observed and tentative diagnosis is made. Medical reports are requested if indicated. No routine history need be elicited. An initial interview can be considered ended when a verbal agreement is reached. This may take several sessions.

Narcissistic disorders encompass a range of mental and physical disturbances which have fixations in the oral and anal phases of development. Increasingly, clinicians are including as possible causes, intrauterine influences, along with genetic and constitutional ones. Autism, schizophrenia, psychosomatic conditions, addiction syndromes and character disorders, as well as borderline conditions, fall into this category. In contrast, psychoneurotic disturbances relate to conflicts of the oedipal phase of development.

There is enormous richness, variety, and depth in the initiation of a therapeutic relationship based on patient and analyst dynamics, character, and personality. It can only be hinted at by the following brief excerpts. Responses which facilitate

communication are based on the analyst's feelings, knowledge, and judgment. For example:

Patient: My friend told me you helped him. Can you help me? I'm very unhappy.

Nonfacilitating: Yes. I have helped him and am sure I can help you, too.

Facilitating: What is the source of your unhappiness?

Patient: Dr. X. recommended me to you. I could not afford his fee. How much do you charge?

Nonfacilitating: My fee is ... I'm sure we can work something out.

Facilitating: How much would you like to pay? How often would you like to come?

Patient: What are your credentials?

Nonfacilitating: I am a graduate of...

Facilitating: What would that information tell you?

Telephone Call: My wife told me to call you. I don't believe in this stuff. She should see you.

Nonfacilitating: Why don't you make an appointment and we can talk about it?

Facilitating: Why not bring your wife in or have her call?

Patient: I'm here now but I have no problems.

Nonfacilitating: Well, that's a problem. Everybody has problems.

Facilitating: Who suggested you come here? Is there anything I can do for you right now?

Patient: I am looking for the right analyst but have not found one yet. You have been highly recommended to me.

Nonfacilitating: I am sure I can help you. Let me give you an appointment.

Facilitating: Would you like an appointment to determine whether we can work together?

Patient: The school (parents, court, etc.) says I have to be here or I will be sent away. That's the only reason I came.

Nonfacilitating: That is not a good enough reason for being here. You will have to want treatment for yourself.

Facilitating: Now that you're here what should we do about the situation? I am not so much concerned with what the school wants but with what you want.

Letter: The patient sends a letter requesting an appointment, gives some information about himself, and asks the analyst to call him to arrange for an appointment.

Nonfacilitating: The analyst telephones the patient, thanks him for the letter and arranges an appointment.

Facilitating: The analyst sends a letter in return, thanks the patient for the information, asks him to call and gives a telephone number and the times when he is available to receive calls.

The following is a summary of a modern psychoanalytic first interview illustrating some of the modern analyst's initial interview techniques:

I received a telephone call from Mrs. B. in which she stated that she had been referred to me by her former analyst and would like to start analysis. She volunteered that she was available at any time and knew where I was located. She sounded friendly, and the arrangements were readily made and kept. I was struck by, and felt somewhat suspicious of the “mature” manner in which she spoke, the absence of any uncertainty, and the clarity of her request. As a rule, patients initially show some hesitancy and anxiety on making contact with a new analyst. I speculated, however, that her manner may have been the result of her prior treatment experience.

Mrs. B. arrived exactly on time, greeted me, sat down, and began to talk volubly. She presented herself as intelligent, articulate, and well composed. She was attractive and appeared younger than her stated age. She immediately informed me of her familiarity with analysis, having been in treatment with her former analyst for eight years. She described her current life situation in an animated way,

characterizing herself as skillful, competent, and well organized. She talked on and on about her past history, her previous analyst and her life situation. She seemed totally oblivious of me—almost as if she were talking to herself.

Mrs. B. was full of praise for her previous analyst; her face glowed as she spoke of him. She had contacted me on his recommendation that she secure further analysis. She would have preferred to return to him, but he strongly advised that she work with me. She was following his recommendation since there were some practical, financial, and geographic difficulties in seeing him and my office was convenient for her. I immediately felt on guard. A patient who had been as satisfied with an analyst as she indicated would not be so cheerfully willing to make a change; she would, in fact, have some feelings of resentment at being rejected.

During this initial interview she made no contact with me, but simply continued her monologue until, at what seemed a suitable moment, I asked her what situation had led her former analyst to recommend further analysis. Her voice became suddenly shrill as she began to tell of her chronic dissatisfaction with her husband and her overwhelming determination to secure the divorce she had wanted from the beginning of her marriage.

Her composure gave way and an angry, frustrated woman emerged. A divorce, she emphasized, was her only goal in seeking treatment at this time. A stream of invective against her husband poured forth:

I must get a divorce. My husband wants to kill me. He is committing crimes. This marriage must be ended. He is doing terrible things. One part of his mind doesn't know what the other part is doing. He is following me around. I don't feel safe on my job. He hires people to spy on me. He is crazy.

I felt uncomfortable and confused, and I recalled my skepticism at the time of her telephone call. My initial thought that I was dealing with a well-integrated woman with a marital conflict changed. Her emotional lability seemed bizarre. A warning signal had been triggered in me, and I had the feeling that I might be in the presence of psychosis. Nevertheless, I felt a desire to work with her.

When I asked Mrs. B. what problem she would like me to help her with right now, her tone changed and she plaintively and beseechingly asked me whether I could help her get a divorce. Because of her apparently severe emotional disturbance, I wondered to myself, but did not ask her directly, why she needed my help rather than a lawyer's. I asked if she would be willing to enter an exploratory period of treatment to see whether we could ascertain what had interfered and prevented her from dissolving her unsatisfactory marriage. This would also give her the opportunity to determine whether we could work cooperatively together and whether I was the right analyst for her. It would also give me the opportunity to better understand her situation and to know whether I could be of help to her. Following these communications, she was calm and controlled.

She readily acquiesced. When would she like to begin, how often would she like to come, and how much would she like to pay were the only other questions asked in this interview. She chose to begin immediately on a weekly basis and offered me a fee that I normally would charge. I considered it prognostically favorable that her responses were in keeping with my own thoughts, wishes and needs. She had no objections to the use of the couch. My tentative diagnosis, based on my observations, knowledge and the feelings induced in me, was paranoid schizophrenia.

Freud (1913) recommended a provisional period of treatment for the purpose of diagnosing the patient to determine his suitability for analysis as then "one is spared the distress of an unsuccessful attempt at cure." Thus the exploratory period was also an elimination procedure for patients whom he felt he could not cure. The modern analyst recommends an exploratory period for the purpose of better understanding the patient, giving the patient the feeling that he has the right to eliminate the analyst if he feels the analyst cannot help him, and for both to decide whether they want to work together. Thus, for the modern analyst only the conviction that this particular patient would be more effectively treated by someone else would be considered a reason for not working toward a treatment contract.

In the first sessions, Freud told the patient his analytic rules, including the need for daily sessions and the demand for honesty. He

gave lengthy instructions on how to free associate and would challenge a patient's inability to produce material, cautioning him that he is resisting. It can be assumed that a first interview was a test of ego strength.

In contrast, the assessment of the ego of the patient during the interview determines the modern psychoanalyst's communications. Mrs. B. was asked primarily object-oriented questions. At no time was she asked to talk about what she was thinking or feeling. It is assumed by modern psychoanalysts that most patients have some narcissistic problems and are to be responded to on that basis to guarantee against further narcissistic injury and ego attack. Thus caution was exercised in the opening interview with Mrs. B. She was asked what brought her there and what she wanted from treatment.

Freud (1913) considered feelings undesirable in the analyst and believed that they needed to be analyzed away when they extended beyond mildly positive and helpful ones. Initially he used as his model the surgeon "who puts aside all his own feelings, including that of human sympathy. The justification for the coldness in feeling in the analyst is that it is the condition which brings the greatest advantage to both persons involved" **(Freud, 1912)**. In contrast, it was the feelings induced in me by the patient during the first telephone contact and interview that gave me the clue that I was dealing with a very disturbed person who would require careful handling.

I did indicate the desirability of using the couch, but if she had objected I would have been prepared to work face to face until I resolved this resistance. I asked her to say whatever she wanted to say rather than to free associate. The purpose of this is to prevent too rapid a regression, which can readily occur when patients with ego fragmentation or already partially decompensated states are asked to free associate. Such patients may feel threatened and overwhelmed by such a request and are reassured when asked to talk about anything they wish.

I consider the treatment process to have begun from the first telephone contact. I was alert to any evidence of transference, countertransference, or resistance in myself as well as transference and resistance in the patient.

I elicited no history. I listened to what the patient said

voluntarily and asked only those questions which could lead to a treatment contract. At no times were conditions of treatment spelled out. Minimal information was offered. My attitude was one of interested study of what she communicated verbally and nonverbally. I assumed full responsibility for creating the conditions that would make it possible for analytic work to be accomplished. I did not require cooperation on the part of the patient.

A basic philosophical tenet of modern analysis (and a fundamental difference from classical analysis) is that unsuccessful treatment or inability to work out a therapeutic alliance is not considered the failure of the patient, but evidence that the analyst did not have the skills necessary to accomplish the job. This position is acknowledged regardless of whether the analyst is sufficiently trained and analyzed, whether he wants to work with the patient, or whether the present state of scientific knowledge is adequate. Since many patients suffer from a deeply held conviction that their difficulties stem from some basic deficiency in themselves, this attitude on the part of the analyst is helpful for effective work with them.

In order to facilitate entry into treatment of the more disturbed patient, the analyst responds to the manner in which the patient presents his characteristic narcissistic defense. The narcissistic defense is, in essence, predicated on the concept that frustration-aggression experienced in the first few years of life is released against the psychic apparatus of one's own mind and body as a defense against the danger of acting on impulses that might destroy the frustrating object. A full discussion of this may be found in H. Spotnitz, *Modern Psychoanalysis of the Schizophrenic Patient.*

It is important to keep in mind that narcissistic patients are unconsciously terrified of their potential for violence, and the prospect of being exposed to further hurt, rejection and humiliation. Their deeply held emotional conviction that there is something seriously wrong with them is not conducive to a commitment for treatment. Many are negatively suggestible and defiant. These mechanisms have helped them to survive. Often the compelling factor which precipitates a contact is unbearable suffering and a wish for some relief. The expectation and prospect for even further suffering does not enhance their wish for treatment. When the

analyst comprehends the narcissistic defense, he is able to make interventions that stir within the patient a vague hope that he will not be subject to further narcissistic injury or control and that the analyst is there for his benefit.

In modern analysis rules are generally spelled out as the occasion arises rather than in advance. Spelling out rules conveys the unconscious communication that the analyst expects a transgression against them, and the patient may feel the need to comply in order not to disappoint the analyst. It is recommended, therefore, that only suggestions that facilitate the onset of treatment be given. Thus, policies about lateness, payments for broken appointments, smoking and eating are preferably dealt with as they emerge in the treatment process.

In my opinion, an analyst should not attempt treatment with a patient with whom he does not wish to work unless he can work this problem through in his own analysis. It is important for the patient to get the feeling that his analyst is genuinely interested in helping him, regardless of the analyst's verbal communication. Narcissistic patients are acutely sensitive to what other people are feeling. If the analyst is not genuinely interested in the patient, it is preferable for the analyst to take the position that he is not the right analyst and that he cannot be helpful. This may be stated as the analyst's deficiency, not the patient's, e.g., “I am not adequate to deal with the problem you are presenting,” or, “My ability does not seem to make it possible for me to give you the help you need.”

A special problem arises when patients indicate that they have been in treatment with someone whom they find unsatisfactory. If the treatment has been terminated, it is advisable to find out the patient's idea of what the problem was. This often gives an important clue to the proper prescription for the patient. If the patient is currently in treatment, it is preferable for him to get agreement from his other analyst for a consultation. If the other analyst feels threatened, resentful or unwilling to let the patient go, that treatment should be terminated before a new one is begun. This becomes the responsibility of the patient. With both analysts' agreement, concurrent analyses may be conducted. Modern psychoanalysis accepts the idea that such multiple therapies can be beneficial to all concerned.

The modern psychoanalytic approach to facilitating entry into treatment for all patients has been described. Expanding knowledge and a patient population increasingly dominated by narcissistic problems have led to elaboration and modification of Freud's recommendations, facilitating the entry into treatment of patients formerly considered untreatable.

In contrast to the earliest Freudian practices, from the very first emotional contact, the modern psychoanalyst's theoretical

considerations are secondary to the primary objective of curing patients. While some practitioners hold the view that practice emanates from theory, the modern analyst's functioning is based on each patient's individual configuration. Ultimately, it is only the patient who can validate the psychoanalytic practice, from which may come a unified theory.

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