

ORIGINAL ARTICLE

Towards an empiric theory of psychological interviews: A “first draft”

Ezio SANAVIO

Department of General Psychology, University of Padova, Padova, Italy.

Correspondence to: Prof. Ezio Sanavio, Department of General Psychology, University of Padova, Padova.
Via Venezia 8, 35131 Padova, Italy; FAX: +39 49 8276600; E-MAIL: ezio.sanavio@unipd.it.

Submitted: 2012-08-02 Accepted: 2012-09-12 Published online: 2013-01-11

Key words: **assessment; decision making; interview; therapeutic alliance**

Act Nerv Super Rediviva 2012; 54(4): 174–179 ANSR540412A04

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Abstract

The scientific and experimental approach influences behavior and cognitive therapy, including clinical interviews. The present paper stresses the active and intelligent processes that occur during interviewing.

The clinical interview is not simply a passive collection of information; it is an active process similar to problem solving and decision making. The therapist works intelligently throughout the initial assessment, generating many clinical hypotheses and reducing them by suitable questioning (or by other assessment modalities). The patient is also an active participant, and the resulting interview may be conceptualized as an example of social problem solving undertaken by an interactive dyad in search of better treatment strategies. Furthermore, clinical interviewing is not an inductive process and the detective metaphor is misleading. Behavior therapists mainly proceed by rejection of hypotheses (falsification) rather than their verification and use heuristics of the hypothetical-deductive type.

Finally, the clinical interview in behavior therapy is not an autonomous and self-sufficient technique, like in other therapeutic approaches, but a subset of the multidimensional assessment strategy.

We hope that a similar theoretical framework will stimulate empirical research, improve clinical interview models in behavior therapy, and take it ‘out of the realm of art and move to the realm of science.’

INTRODUCTION

Clinical effectiveness of cognitive and behavioral therapies is reportedly directly proportional to the degree of accuracy and depth gained during the initial assessment. Failures and relapses must be considered the most probable outcome of inaccurate or insufficient conceptualizations of the case. Clearly, therefore, the initial assessment sessions are crucial in the practice, research, and theory of cognitive and behavioral psychotherapy. Recognition of this essential point may often result in a simple *petitio principii*. The scientific literature is abound with somewhat “bitty” contribu-

tions (questionnaires for specific problems, interviews for specific populations, etc.), but it contains few properly based theoretical works on the overall subject.

Behavioral and cognitive therapy may be conceived as a general orientation toward clinical work in line with an experimental approach. It thus influences all the various moments of the therapeutic process, including the initial phases and the clinical interview. This is why I do not agree with those eclectic tendencies that attempt to shore up the fragility of this sector of behavioral and cognitive therapy with robust types of underpinning, often taken from DSM psychiatric diagnostics, sometimes from the legacies of Sullivan or

Rogers, and sometimes from idiosyncratic approaches of many CBT leaders – eclectic tendencies that elude proper attempts at reflection and theoretical growth. The aim of the present work is to propose a first draft of a clinical interview theory.

GENERAL MODEL OF CLINICAL ASSESSMENT

In cognitive and behavioral psychotherapy, an initial assessment is understood to mean a wide-ranging evaluation undertaken as the first step toward taking on a patient for psychotherapy or redirecting him to other, more appropriate treatment. This assessment aims at collecting all information necessary to “formulate” (conceptualize) the case, which allows the therapist to (1) identify as clearly as possible the patient’s main problems; (2) reconstruct the mechanisms and processes underlying the patient’s problems or disturbances; (3) identify and agree with the patient on both immediate targets and long-term targets after possible treatment; (4) identify appropriate methods of treatment to cope with the patient’s problems in an effective and lasting manner; and (5) deciding whether to treat the patient or not.

The initial assessment, therefore, clearly involves *hypotheses* as well as collection of *information and measures*. Assessment involves a relatively large number of measures that supply both the informational basis on which the hypothetical aspect of the assessment is based and the data required to construct one or more “base-lines” with which to compare the progress that (hopefully) will be made during therapy and will allow comparison with similar measures that may be repeated at the end of treatment and during later follow-up.

However, the assessment mainly supplies a quantity of hypotheses on the following four logical and

chronological levels: (a) possible relationships between the patient’s primary disturbances or problems; (b) etiopathogenetic hypotheses aimed at reconstructing the mechanisms giving rise to those problems and disturbances; (c) the therapeutic approach strategy and main goals; and (d) the most appropriate treatment techniques for the case in question. The degree of uncertainty connected with these hypotheses may, of course, be reduced by suitable questioning, but some uncertainty is unavoidable (according to some authors, for ontological reasons connected with the complexity of human beings and their freedom; according to others, due to current theoretical and technical limitations). The assessment thus concludes with decision-making processes at the lowest technically possible level of uncertainty, which is often undesirably high (Arthur 1966; Blampied 1999; Eifert 1996; Ward 1999; see also the whole Special Issue on ‘Psychological assessment and decision-making’ of *Behavior Change*, 1999).

Assessment is not simply the passive collection of information; it is an active process, very similar to problem solving and decision making. An initial assessment may be described as complex data collection and processing regarding the patient. As it gradually proceeds, uncertainty regarding the numerous clinically important variables and various hypotheses gradually decreases. Throughout the initial assessment, the therapist may be viewed as a powerful data processor. None of the questions he/she asks is independent of any hypothetical-deductive logic. It is also understood that the therapist works intelligently throughout the initial assessment, generating hypotheses and making decisions, and thus checking and possibly rejecting them. His hypotheses concern various aspects explicitly or implicitly inherent in the case in question. They are subordinate only to the constraint of being logically

compatible with the information already in his possession and with knowledge of the principles and laws of psychological sciences, which the therapist is able to exploit thanks to his scientific and professional background. Behavior and cognitive science now provides wider knowledge on decision making and social problem-solving processes, and the aim of “taking psycho-diagnosis out the realm of art and moving it into the realm of science” (Hersen 1976, p. 4) results in less distance than in the past.

Briefly, the clinical interview is one of the peculiar heuristics used to collect, select, and process clinical information to move from an initial condition of uncertainty to an acceptable level of uncertainty about the most appropriate strate-

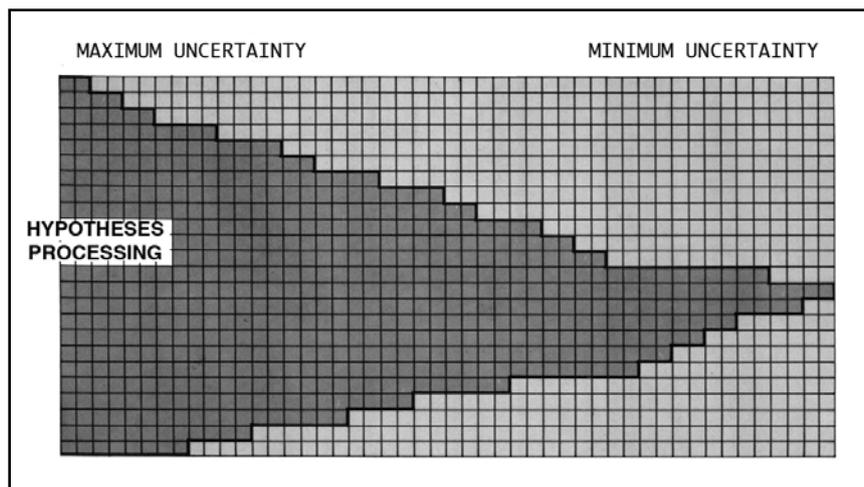


Fig. 1. Initial assessment as a process of information collection, selection and processing, and formulation and rejection of hypotheses. It can be described as an intelligent pathway to go from the initial condition (maximum uncertainty) to an acceptable level of uncertainty about the most appropriate characteristics of the psychotherapeutic treatment.

gies for managing the treatment of a specific patient. The wider the therapist's knowledge and experience is, the wider the range of alternative hypotheses that he/she may examine. Moreover, in the model presented here, assessment mainly proceeds by "falsification" of hypotheses rather than their "verification." This is not an example of paying homage to Popper-type epistemologies, but rather of exploiting semantically useful terms in order to illustrate how the funnel shape of figure 1 becomes narrower. In order to illustrate these concepts, I would now like to present an imaginary example, which I call "the story of little Peter."

THE STORY OF LITTLE PETER

This story, which takes place in a psychotherapist's studio/office, has the following five characters: (a) Peter, who is afraid of dogs (except for this, he is one of the happiest, healthiest, and well-balanced children around); (b & c) Peter's mother and father, who are presumably "near perfect parents"; (d) the psychotherapist; and (e) a first-year psychology student, who has a nasty habit of eavesdropping.

Little Peter has been brought to the psychotherapist because he is afraid of dogs. In the first five minutes, Peter, his mother, and father give a detailed account of how the child has been bitten several times by dogs, so he now has an exaggerated fear of them. On the other side of the door is the invisible student, with his ear to the keyhole.

What does the student think and do? He thinks that those boring laws of learning, which he was obliged to study against his will, are being incorporated into experienced facts on the other side of the door. He imagines himself in the place of the therapist and fantasizes. He sees himself confidently explaining that Peter's fear is a conditioned reflex, as in the famous case of little Albert, Watson's classic exemplification of conditioning the fear. Due to the phenomenon of stimulus generalization, Peter has extended his fear reaction to dogs that do not bite – he is frightened even when a dog in a TV cartoon barks or by soft toys in the shape of a dog. It is not surprising that, since he was last bitten, his fear has increased and not decreased over time. His parent's naive theory – according to which their child's fear should have disappeared with the passing of time – is incorrect; fears such as these increase according to the learning laws. His fear might have been expected to disappear after, say, occasional encounters with non-biting dogs, fear-free models of dogs, etc., but none of these ploys has been successful since Peter and his "near perfect" parents have carried out avoidance behavior, i.e., a course that offers maximum resistance to the extinction of Peter's fear. The essence of this story does not change if we refer to up-to-date models of fears and phobias.

In reality, of course, the student says and does nothing, but simply continues eavesdropping. What does the therapist think and do? He initially hypothesizes that Peter's fear is the result of his frightening experi-

ences with dogs and that things went more or less as described above. He hopes that this is so because, if it is, the action to be taken is simple and very promising. However, he certainly does not at once accept this hypothesis as correct, but sets it aside for the moment in order to evaluate alternatives. First of all, Peter and his parents may have far more important problems, and this story about dogs may be the least important of them and a pretext. An experienced therapist certainly explores the matter in depth.

Let us continue with this example and imagine that, at the end of his exploration, the therapist concludes that little Peter is indeed the most tranquil, balanced, and happy child on earth, apart from this question of dogs. So, the therapist focuses on canine matters and, setting aside the hypothesis "being bitten – classic conditioning – generalization – fear incubation – avoidance – phobia," he checks several alternative hypotheses that may explain the origin of Peter's fear of dogs. Are processes of operative conditioning at work? Does Peter gain attention and affection at the expense, for example, of a horrible little sister? Perhaps he hates school and this is a way of avoiding it for a few days? Is his fear sustained by some important "model?" Do his parents have divergent or conflicting views on how to cope with the situation? Why do they attribute such importance to their child's fear? Are they using this story about dogs in order to indulge in squabbling between themselves? Perhaps the pediatrician terrorized Peter's parents with talk of the "projection" and "displacement" of fear? Has his school-teacher, fresh from college, spoken to them about castration anxiety? What resources are available to Peter? How has he managed to avoid the thousands of other fears, which, like other children, he must have suffered from? How did his parents cope with his other fears? And with those of his little sister? What expectations do they and Peter have regarding ways to cope with his current fear?

The story ends a couple of weeks later, after Peter and his parents have spent at least three or four hours with the behavior therapist, who comes to his conclusions and tells them, more or less, what the student imagined. Once again, the student behind the door is listening, this time complacently.

A competent therapist would accept his initial hypothesis (being bitten-conditioning-fear) only at the end of a long "journey" during which he "visits" many different alternatives. His itinerary, i.e., the specific modes of assessment and interview, was suggested by a true process of exclusion: only after rejecting a myriad of alternative possibilities does our traveler give up and go back to his starting hypothesis. This is why it is better to speak of a process *ad excludendum* rather than one of confirmation, of a process of falsification rather than of verification. Conversely, our student, if left alone to act, immediately worries about collecting support for his initial hypothesis and, only when frustrated in this attempt, passes it on to others.

AGAINST INDUCTIVISM

The first interview is not a passive procedure simply involving collection and recording of information. Nor is it an inductive process. It is mainly hypothetical and deductive. From a general knowledge base (laws, principles, models, etc.) one passes through a process of selection/exclusion of hypotheses in order to arrive at a specific formulation or conceptualization of the case, allowing the array of hypotheses to be reduced to as few as possible. Of course, the amount of rational hypotheses that may explain a given phenomenon are infinite; the interview, like the wider assessment, ends because it uses a rule of simplification and assumes that there is a sufficient number of hypotheses, allowing the patient to receive an operatively valid response that can be examined and verified within a few hours.

The literature on initial assessments often uses the metaphor of the detective at work (Meyer & Turkat 1979; Turkat 1987; Wolpe 1977, 1980). This metaphor may be misleading unless we clearly think of a “hypothetical-deductive” and “falsification-oriented” detective like Hercule Poirot, and not ones following “inductivistic” or “verification” pathways like Sherlock Holmes or Lieutenant Colombo. The metaphor runs the risk of applying an inductivistic emphasis to the search for crucial clues and may end up distorting the idea of “conclusive formulation.” Conclusive formulation is not the dénouement of a detective story, complete with final proof and a confession on the part of the murderer, but a highly conjectural conceptualization of the case. This is why it is better to forget the detective metaphor and concentrate on that of a conceptual map and an interactive dyad faced with a common decision-making process.

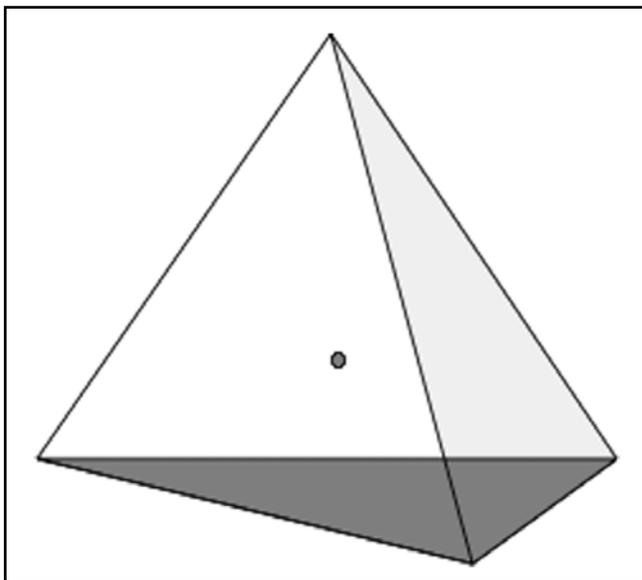


Fig. 2. Representation of the multidimensional model of assessment: a three-dimensional space defined along a cognitive-verbal, a motor-behavioral, and a psychophysiological continuum (adapted from Hugdahl 1981).

THE ROLE OF INTERVIEWS

Assessments generally *cannot* be reduced to an initial interview and a series of clinical questionnaires. Figure 2 describes a three-dimensional space, instead of the one-dimensional space confined to verbal information, self-reports, diaries, and questionnaires.

Assessments traditionally use three classes of indexes, i.e., information coming from separate sources or “channels”: (1) subjective indexes, directly or indirectly obtained from the subject’s self-reported material (including information gathered during the course of the clinical interview and by means of questionnaires and inventories); (2) motor and behavioral indexes, gained by external observation of the subject (measures obtained from role-playing, in vivo observations, a video analysis of parts of interviews, or other procedures involving observation and recording of manifest behavior); (3) physiological indexes, obtained by means of recordings (polygraphic measures and psychophysiological responses, e.g., skin conductivity, breathing rate, blood pressure, and heart rate). Assessment theorists often believe that these channels correspond to three systems of relatively independent, non-isomorphous responses. It is well known that there are many psychopathological problems in which it is precisely the discrepancy between subjective, behavioral, and physiological assessments that takes on importance.

During recent years, multidimensional models were stressed in assessments. Previously, behavioral and cognitive psychotherapists used information belonging to several systems (cognitions, emotions, overt behaviors, psychophysiological reactions, recordings, etc.) and were aware that colossal discrepancies could emerge between, for example, a subject self-reporting and observations or reports from external sources. However, everything tended to be conceptualized inside a one-dimensional space. Thus, psychophysiological and behavioral data were invoked to convalidate subjective data. In the 1960s, during the first psychometric studies on Wolpe’s Fear Survey Schedule, the external validity of the schedule was sought by resorting to behavioral proof (approach-avoidance test) and measurements of skin conductivity (for example, Geer 1965; Lanyon & Manosevitz 1966). Today, nobody would dream of anything of the kind; the schedule measures the subject’s beliefs, the approach-avoidance test measures the overt behavior, and skin conductivity measures the level of the subject’s psychophysiological activation. None of the three indexes measures fear, but each measures one of the three sides of a three-dimensional construct (Lang 1968; Hugdahl 1981).

In conclusion, the clinical interview acquires meaning inasmuch as it provides a series of information (mainly cognitive-verbal) that interacts with information from other sources inside a multidimensional assessment. First, the initial interview (and the whole

series of initial interviews) is not something autonomous, but forms part of a multidimensional assessment. Second, the interview uses verbal material and explores the cognitive-verbal system. Third, it represents a specific and well-structured setting of observations, allowing (limited) exploration of the motor-behavioral system. Fourth, it is a significant example of interpersonal behavior, allowing analysis of the relational variables that come into being between patient and therapist.

AN INTERACTIONAL APPROACH TO THE INITIAL INTERVIEW

The various pieces of information that the therapist uses during an assessment come partly from interviews and partly from information that he and his subject collect together; this is already an embryonic form of that working alliance, which will later be essential throughout treatment. Although we customarily speak of an initial interview, a single meeting or a single session is the exception rather than the rule. It is more realistic to speak of a short series of clinical interviews: two or three in the course of the initial assessment are quite common. Moreover, as already mentioned, a certain number of structured operations for collecting information develop in the interval(s) between these interviews; for example, the patient is asked to keep a diary, make regular notes for a few days, complete questionnaires, and self-monitor emotions and automatic thoughts.

Although the main aim of the interview is to examine the patient's problem, its second aim is to establish a collaborative relationship with him/her. In my opinion, the initial interview goes beyond the simple dimension of listening, and the therapist does not limit himself to empathic listening. Empathy and identification are the results of what is constructed during the interview. An effective relationship – as Wolpe and Turkat (1985) call it – is established when the therapist can see things from the patient's viewpoint, when he can, as it were, slip into the patient's skin and imagine his life.

During the interview, the therapist should never forget that the patient's active role is equal to that of the therapist, although the latter is obliged to guide the "game" and to know how to guide it. It is therefore useful for the interview to be very clear and concepts should be sometimes verbally explained. Its essence is to have information in order to give information: "the therapist should remember that the purpose of the interview is actually twofold: to get information and give information" (Goldfried & Davison 1976, p. 39). Structurally speaking, the interview is a collaborative effort, an example of problem solving undertaken by an interactive dyad (Nezu et al 1997). It implies a working alliance directed toward analyzing problems – an alliance that may continue and develop during the course of treatment.

CONCLUSION

By definition, the clinical interview is a very flexible tool for psychological investigation, covering a wide range of applications. First, the theory of the initial interview is not autonomous and self sufficient. In my opinion, clinical interview theory should be collocated inside a general assessment theory. The first interview (like all first interviews) falls temporally and conceptually inside the more ample context of the initial case assessment, i.e., an essentially active process of information collection, selection, processing, and then hypothesis formulation and analysis. The first interview is a subset of the assessment and has its own procedure and internal logic, which develop according to heuristics similar to those found in decision-making processes.

Second, we have seen that the first interview is an essential, but not exclusive, source of information. In my view, it is the keystone of the more general and multidimensional process we call assessment, a source of mainly cognitive-verbal information that interacts with other information from other sources. The decision made by some CBT therapists to reduce the phases of an initial assessment to the interview alone is perplexing. To use a metaphor, when a very young child draws a human figure, he simply uses lines to indicate the body, arms, and legs, but an older child draws two- and then three-dimensional figures. The fact that constructive and 'third wave' concepts may be used in clinical interviews does not mean that we are dealing with a person reduced to only one of his/her multiple dimensions.

Third, I suggested above that the metaphor of the detective should be abandoned. A better metaphor would be that of two travelers about to set off on a journey without a map. They first aim to exchange information and construct a map. This was why the word "topography" has been proposed to describe the several phases by which they construct it (Sanavio 1998).

Fourth, another characteristic of the model presented here is that the technique used to conduct the interview cannot be acquired by mere experience and modeling. It may become more refined over time, as the therapist studies his own transcriptions and those of others. In training programs for therapists, while rereading interviews transcripts, one must hear the buzzing of two brains thinking and must learn to understand what that buzzing means. The question that the therapist asks instead of another, one question that comes into his mind but he does not ask, the formulation of one question instead of another, a moment's silence, a change in tone of voice, and movement of the head are all examples of those tiny noises that indicate that a brain is at work and that it has given priority to one line of analysis and a series of hypotheses rather to another.

Last but not least, the clinical interview is in itself a process of search, analysis, and processing of informa-

tion through an interactive dyad to find a solution to a problem.

By definition, behavioral and cognitive therapy refers to general psychology. In clinical interviews as well, it may be useful to refer to general psychology and basic research. The essence of the present work is that the initial clinical interview may be conceptualized as a decisional problem. Faced with the need to carry out complex tasks, individuals resort to strategies (called heuristics) that have been long studied and used in problem-solving situations. These lines of conduct do not guarantee solutions to problems, but they do allow the solver to approach his/her goal. In the interview, as in problems studied by decisional psychology, we find it impossible to treat and manipulate information from multiple sources, meaning that the decision-maker must use heuristics, which aim at simplifying the problem and reducing the array of possible options (hypotheses).

In decision-making psychology, *uncertainty* indicates situations in which the individual knows what the outcome of his choice will be, but does not know its probability. *Risk* indicates that an individual knows the outcome of a given decision and the probability associated with it. The initial interview and assessment deal with decisions in both uncertainty and risk conditions. Unlike humanistic and psychodynamic psychotherapies, the behavioral and cognitive approach has a sufficiently wide and sophisticated empirical base and a corpus of scientific research for analysis of the probabilities connected with various outcomes. That is, we work inside a decisional context, which – although complex, multidetermined, and partially unknown – does not produce situations very dissimilar from those we find in other disciplines such as economics or medicine. The indications given here may be considered the “first draft” of the heuristics of the first interview and stimulate empirical research.

This “first draft” of a first interview theory lacks the systematic completeness we normally require of a theory. In my opinion, the construction of a good theory and its relative praxis is the result of collective effort. I simply wished to set down in writing the theory underlying the interview practices adopted by myself

and the colleagues with whom I am in frequent contact, in the not overly-modest conviction that a bad theory is still better than no theory at all, and any colleague who wished to read and criticize it may find a basis for constructing a future and better one.

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