Mental Health Myths and Facts

	Myth	Fact
Mental health problems don't affect me		
Children don't experience mental problems		
People with mental health problems are violent and unpredictable		
People with mental health needs, even those who are managing their mental illness, cannot tolerate the stress of holding down a job		
Personality weakness or character flaws cause mental health problems. People with mental health problems can snap out of it if they try hard enough		
There is no hope for people with mental health problems. Once a friend or family member develops mental health problems, he or she will never recover		
Therapy and self-help are a waste of time. Why bother when you can just take a pill?		
I cannot do anything for a person with a mental health problem		
Prevention doesn't work. It is impossible to prevent mental illnesses		
People are born with a mental illness		
Only certain types of people develop a mental illness		
Mental illness is caused by a personal weakness		
People with mental illness are dangerous		
Mental illness is a form of intellectual disability or brain damage		
People with mental illness can 'pull themselves out of it'		
People with mental illness should be isolated from the community		

Sources: MentalHealth.gov & Government of South Australia/SA Health

Worksheet 1

Well-being Screening Tool

How did you fell in the last two weeks?

1. **I have felt cheerful in good spirits**

- All of the time
- Most of th time
- less than half of the time
- Some of the time
- At no time

2. **I have felt calm and relaxed**

- All of the time
- Most of th time
- less than half of the time
- Some of the time
- At no time

3. **I have felt active and vigorous**

4. **I woke up feeling fresh and rested**

5. **My daily life has been filled with things that interest me**

For scores of ≤50 is it recommended that participants also test themselves by using the PHQ-9 and GAD-7 questionnaires.

Note: this test is available online @ https://www.mymentalhealth.guide/get-tested/well-being-test-who-5

[Add PHQ-9 and GAD-7 in English and Greek]

Worksheet 2

Types and categories of mental illness

1. **Groups**
   i. **Depressive disorders** (aka mood disorders) (depression, bipolar disorder)
   ii. **Anxiety disorders** (generalized anxiety disorder, social phobia or social anxiety disorder, panic disorder, agoraphobia, specific phobias, i.e., arachnophobia, OCD, PTSD)
   iii. **Personality disorders (three clusters, namely Cluster A, Cluster B and Cluster C)**
      - Cluster A:
         - ✓ Paranoid personality disorder
         - ✓ Schizoid personality disorder
         - ✓ Schizotypal personality disorder
      - Cluster B:
         - ✓ Antisocial personality disorder
         - ✓ Histrionic personality disorder
         - ✓ Borderline personality disorder
         - ✓ Narcissistic personality disorder
      - Cluster C:
         - ✓ Avoidant personality disorder
         - ✓ OCD
         - ✓ Dependent personality disorder
   iv. Psychotic disorders (such as schizophrenia) (some may fall under the personality disorder group)
   v. **Eating disorders** (Binge eating disorder [BED], bulimia nervosa, anorexia nervosa, other specified feeding or eating disorders [OSFED}
   vi. Trauma-related disorders (such as post-traumatic stress disorder aka PTSD) (may fall under several categories)
   vii. **Substance abuse disorders** (drugs, alcohol, gambling, etc.)
2. **Categories:**
   a. **Common mental disorders** (depressive disorders + anxiety disorders)
   b. **Severe mental disorders** (bipolar affective disorder, schizophrenia, and other psychoses)

Vocabulary of feelings and emotions

1. **Anger**
    - Disgust: Contempt, disgust, revulsion
    - Envy: Envy, jealousy
    - Exasperation: Exasperation, frustration
    - Irritation: Aggravation, agitation, annoyance, grouchiness, grumpiness, irritation
    - Rage: Anger, bitterness, dislike, ferocity, fury, hate, hostility, loathing, outrage, rage, resentment, scorn, spite, vengefulness, wrath
    - Torment: Torment
2. **Fear**
    - Horror: Alarm, fear, fright, horror, hysteria, mortification, panic, shock, terror
    - Nervousness: Anxiety, apprehension, distress, dread, nervousness, tenseness, uneasiness, worry
3. **Joy**
    - Cheerfulness: Amusement, bliss, cheerfulness, delight, ecstasy, elation, enjoyment, euphoria, gaiety, gladness, glee, happiness, jolliness, joviality, joy, jubilation, satisfaction
    - Contentment: Contentment, pleasure
    - Enthrallment: Enthrallment, rapture
    - Optimism: Eagerness, hope, optimism
    - Pride: Pride, triumph
    - Relief: Relief
    - Zest: Enthusiasm, excitement, exhilaration, thrill, zeal, zest
4. **Love**
    - Affection: Adoration, affection, attraction, caring, compassion, fondness, liking, love, sentimentality, tenderness
    - Longing: Longing
    - Lust: Arousal, desire, infatuation, lust, passion
5. **Sadness**
    - Disappointment: Disappointment, dismay, displeasure
    - Neglect: Alienation, defeat, dejection, embarrassment, homesickness, humiliation, insecurity, isolation, insult, loneliness, neglect, rejection
    - Sadness: Depression, despair, gloom, glumness, grief, hopelessness, melancholy, misery, sadness, sorrow, unhappiness, woe
    - Shame: Guilt, regret, remorse, shame
    - Suffering: Agony, anguish, hurt, suffering
    - Sympathy: Pity, sympathy
6. **Surprise**
    - Surprise: Amazement, astonishment, surprise

In Greek https://www.flowmagazine.gr/to_leksilogio_twn_sunaisthimatwn/

ΕΡΩΤΗΜΑΤΟΛΟΓΙΟ ΥΓΕΙΑΣ ΑΣΘΕΝΟΥΣ (PHQ-9)

Τις τελευταίες 2 εβδομάδες πόσο συχνά ενοχληθήκατε απ' οποιοδήποτε από τα παρακάτω προβλήματα; *(Υποδείξτε την απάντησή σας με ένα "✔")*	**Καθόλου**	**Αρκετές μέρες**	**Περισσότερες από τις μισές μέρες**	**Σχεδόν κάθε μέρα**
1. Μικρό ενδιαφέρον ή λίγη απόλαυση στις δραστηριότητές μου	0	1	2	3
2. Νιώθετε καταβεβλημένος(η), κατατεθλιμμένος(η) ή απελπισμένος(η)	0	1	2	3
3. Έχετε πρόβλημα να αποκοιμηθείτε ή να συνεχίσετε τον ύπνο σας ή κοιμάστε υπερβολικά	0	1	2	3
4. Νιώθετε κουρασμένος(η) ή έχετε λίγη ενέργεια	0	1	2	3
5. Έχετε λίγη όρεξη ή τρώτε υπερβολικά	0	1	2	3
6. Νιώθετε άσχημα για τον εαυτό σας ή ότι έχετε αποτύχει ή ότι έχετε απογοητεύσει τον εαυτό σας ή την οικογένειά σας	0	1	2	3
7. Έχετε πρόβλημα συγκέντρωσης σε κάποιες ενέργειες, όπως όταν διαβάζετε την εφημερίδα ή όταν παρακολουθείτε τηλεόραση	0	1	2	3
8. Κινείστε ή μιλάτε τόσο αργά που άλλοι άνθρωποι θα το παρατηρούσαν Ή το αντίθετο – είστε τόσο ανήσυχος(η) ή νευρικός(ή), που κινείστε πολύ περισσότερο από το συνηθισμένο	0	1	2	3
9. Σκεπτόσαστε ότι θα ήταν καλύτερα αν είχατε πεθάνει ή σκεπτόσαστε να προκαλέσετε κακό στον εαυτό σας με κάποιο τρόπο	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

Εάν επιλέξατε κάποια προβλήματα, πόση δυσκολία προκάλεσαν τα προβλήματα αυτά στη δουλειά σας, στις οικιακές εργασίες σας ή στην επικοινωνία σας με άλλα άτομα;

Καμία δυσκολία	**Μερική δυσκολία**	**Μεγάλη δυσκολία**	**Υπερβολική δυσκολία**
☐	☐	☐	☐

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, elevators, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

Please turn the page ☞

Reminder of rating scale:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

http://www.med.navy.mil/sites/NMCP2/PatientServices/SleepClinicLab/Documents/Beck_Depression_Inventory.pdf

APPENDIX II

Annotated Initial Interview (Direct Transcript)

Annotation:

Mr. Whitman (fictitious name) was referred to me by his outpatient therapist as part of an outpatient Veterans Administration (VA) program. He was an aging man, growing weary with life, particularly upset with VA doctors and administrators over a long-standing disability battle. His therapist informed me that Mr. Whitman had very little desire to see me, probably projecting that I would be "just one more pain in the butt." His therapist commented, "I think you'll like him once you get to know him (pause), that is, if he gives you the chance."

Mr. Whitman had thinning white hair. As he entered my office he avoided all eye contact and said nothing upon my greeting. He moved with an agitated quickness to his chair. As he sat down, he leaned forward, crossing his hands over his knees, his feet wiggling nervously.

Note that Mr. Whitman had already been versed on confidentiality before entering my office and had signed a standard confidentiality form used in our clinic. He had also signed a video release consent form. Also note the intermittent poor grammar, and occasionally disjointed quality to the dialogue, which is present because this is a direct transcript and both of the above qualities are typical of actual conversation.

Start of Interview

Dr. Shea: Well, we can go ahead and get started. Do you like to be called Mr. Whitman or Gary?

Patient: Gary. *(no eye contact)*

Dr. Shea: Okay, Gary, let me tell you just a little bit about what we will be doing today, and of course the main thing we are hoping to do is to help you. My name is Dr. Shea, and I am the psychiatrist who works with Phil, whom you have met, and he will be your therapist. I'll be doing a pretty thorough assessment to try to figure out if any type of medication might be of value, or if you are on medication, what we think of that. I also help with trying to decide what types of talking therapies would be most helpful. We always try to fit our work to your needs, because we find that it is the best way to help people. I won't be your therapist. Phil will actually be the person doing the therapy with you.

Our meeting today is probably about 50 to 60 minutes in length. What I am going to try to do is to understand what kinds of stresses and symptoms you are feeling and your perspective of what is working and not working. I also take background information about your family, stresses, and things that you are doing and medical history because sometimes our bodies really can influence what is going on mentally for us. At the end, I will share with you some of my thoughts and we will brainstorm a little bit about how we might be able to help. How does that sound?

Patient: *(nods, no eye contact, still no spontaneous speech)*

Dr. Shea: I want to thank you beforehand for allowing us to videotape. This will be used to help other professionals to be better clinicians and sensitive listeners. So, why don't we start, Gary, with your telling me a little bit about what brought you in to see Phil and what kinds of things you are dealing with. *(variant of a gentle command, see page 81, Chapter 3)*

Annotation:

We have already seen one of the reasons why I chose this interview as my illustration. It wasn't easy. Mr. Whitman is displaying some of the nonverbal characteristics of disengagement, as discussed in Chapter 19. At the time, I didn't know whether or not Mr. Whitman would actually display some anger or just be "hard to talk with." Of course, it is also possible that we are seeing the early warning signs of a shut-down interview.

As with any scouting phase, the single most important immediate goal was to engage Mr. Whitman. Specifically, I would need to develop a strategy for somehow transforming Mr. Whitman's hesitancy and resistance to seeing me. Right from the beginning, I was met with the need to focus on the most critical task of the initial interview, to ensure that the patient would return for a second appointment. At present, the patient could barely tolerate sitting still for the first one.

Patient: I have been depressed for quite a while.

Dr. Shea: Okay.

Patient: My kids don't like to listen to nothing. *(pause)* They're off in Arizona.

Dr. Shea: Far away. *(empathic statement with a moderately high valence of intuition, see Chapter 1, pages 21–23)*

Patient: We don't see them. We don't hear from them. I don't know where they are. What they are doing. If they are alive or what. We finally heard from them after a year, and it makes you think they don't give a damn about us. You know … we write to them. We send them stamps. We do this, we do that for them. They can't write back, and they can't do nothing. Then I tried to get a service connection because I got banged up while I was in the service …

Dr. Shea: Okay.

Patient: Like a fool I didn't go into it right off, and now I am having a hard time with that. Everything is just *(pause)* … nothing's working, nothing's working for me.

Dr. Shea: Okay.

Annotation:

At this point, I am just trying to let Mr. Whitman talk. What is interesting is the relatively large amount of talking he is doing. Despite his initial hesitancy, some part of Mr. Whitman obviously wants to talk. He has chosen early on to raise his problems with his kids and with his disability issues. These topics will prove to be core concerns for Mr. Whitman.

Clearly, we are not heading for a shut-down interview. Perhaps we can capitalize on Mr. Whitman's anger and his need to ventilate. Unlike most interviews, in which the clinician heavily emphasizes open-ended techniques during the scouting phase, in this type of interview it frequently pays to funnel the patient towards his or her affective charge. The hope is that once the patient has allowed the clinician into his or her world – a world perceived by the patient as unfair – the clinician will be able to ally with the patient with counterprojective statements (see Chapter 21, pages e169–e173) and empathic statements, thus transforming the patient's resistance towards the clinician. This "threading" of the patient towards his or her anger is often best accomplished with closed-ended questions and statements of inquiry (see Chapter 3, pages 81–83), some of which will double as counterprojective statements. It's a bit of a gamble, but let's see how it works. If it starts to fail, we can always move back into a more typical reliance on unstructured, open-ended techniques that are more typical of a scouting phase. The key is flexibility.

Also note the cognitive "overgeneralization" and "blackening," which are so common to depressive thinking and are illustrated by Mr. Whitman's comments, "… nothing's working, nothing's working for me." Although not apparent at this point, we will discover later that some of Mr. Whitman's comments about his children are also tainted by the destructive cognitive distortion of overgeneralization.

Patient: Like I told Phil *(Mr. Whitman's therapist)*, I said way back years ago I was ready to quit. I was ready to put myself out. When he asked me about that I didn't think about it. I was thinking about it the other night. I said it's so easy to just drive a car into a tree and say, "Hey, the hell with it." Let the world take care of itself. Everybody else will take care of them. A couple months ago I was going over the edge. I left the house in a huff, and I don't know why.

Dr. Shea: Okay.

Patient: Yeah. On the way home I went through the whole thing and actually, I don't know … but I was there. That was it, and on the way home, I almost put it off the road. I had that feeling I was all ready to go. I floored the car and I was just waiting to take the wheel.

Annotation:

To my surprise, suicide has been spontaneously brought up very early in the scouting phase, hinting at the immense amount of pain that Mr. Whitman is experiencing. This is not the type of man who goes around blithely telling people he is suicidal in a bid to get sympathy. Mr. Whitman is a "tough bug" who normally keeps things close to his chest.

This is an important window in the engagement process, but it is also a window potentially fraught with problems. Mr. Whitman is opening up, but is he opening up too early, necessitating a later retreat into his normal stance of keenly guarded privacy? More specifically, should the interviewer further open the window onto suicidal ideation now, when the engagement is in its birth, or defer to a later point, when the engagement may be a good deal more mature? From nonverbal cues, I intuitively felt that Mr. Whitman seemed almost embarrassed by his "admission" to suicidal ideation, so I decided to wait. My goal was to somehow make Mr. Whitman feel more safe with me, perhaps with some empathic statements and a movement towards a topic that he would feel more comfortable discussing at this early stage of the interview.

Dr. Shea: So you have been in a lot of pain now for months. *(empathic statement)* That was several months ago? *(statement of inquiry)*

Patient: Yes. Nothing seems to get better. I got a good wife. Wonderful wife.

Dr. Shea: Was that who I just met out there? *(closed-ended question)*

Patient: Yes.

Dr. Shea: She seemed very nice. *(an attempt at joining with Mr. Whitman)*

Patient: She is going through hell. She's got diabetes and everything else. Between that, my kids, and all of this stuff building up, I just can't go anywhere. These headaches are … I've had all kinds of treatments and everything else. *(second time that Mr. Whitman has spontaneously brought up his disability issues secondary to headaches)*

Dr. Shea: Just nothing under the sun is helping at all. *(this statement is a variant of a counterprojection)* You look like …

Patient: They give me Motrin and stuff like that. If I took it like I should, I'd be eating them like candy.

Dr. Shea: They want you to eat a lot of … *(This is the beginning of a counterprojection, but Mr. Whitman cuts me off again, which is not necessarily a bad sign. I actually think that he is cutting me off because he is so intent on venting his frustration. Notice that there is no anger being shown towards me. Our strategy may be paying off. We are being brought into Mr. Whitman's world. As with most scouting phases, there is no structuring occurring into diagnostic regions, and so forth, other than an effort to stay in topics that Mr. Whitman, himself, wants to talk about.)*

Patient: He said take them when it gets bad. Well I wait until I just can't take it any more, then I take them. I lied.

Dr. Shea: Do you think they are migraine headaches or …

Patient: No, I blame it on the service.

Dr. Shea: Okay.

Patient: Back when I was in the service, I got hurt three times. I got hit three times in the head. Four years of service and when I came out of the service I was having the headaches. So I went to the doctor and asked him about it and he said well, your blood pressure is up. He said blood

pressure will do that.

Dr. Shea: Causes headaches.

Patient: So, I said okay and let it go that way. All this time the headaches kept coming and coming, and I kept taking the blood pressure medicine like the doctor said.

Dr. Shea: So you have been having headaches for decades?

Patient: Yes, and I didn't push it. That's where I made the mistake. Because I was stupid and didn't say well maybe I should go do something.

Dr. Shea: For benefits or something?

Patient: I went to another doctor. He told me the same thing. I went to three different doctors. So I said well they must know what they are talking about. So I took aspirin and stuff like that and then when I got up to Veterans Health, I talked to Dr. Canton *(fictitious name)* and he said no. It can't be your blood pressure. So …

Dr. Shea: So you are seeing Dr. Canton now about this?

Patient: Yes.

Dr. Shea: So he is trying to investigate this? *(I've used a series of closed-ended questions and statements of inquiry to keep threading Mr. Whitman into this rich arena for the venting of his frustrations and for joining with him regarding his frustrations.)*

Patient: Yes.

Dr. Shea: Well I hope they can sort it out.

Patient: I have had all different kinds of medications and everything else.

Annotation:

At first glance, this might look like the right time to carefully expand the region of medications. But we are still in the scouting phase, and there is no need for structuring just yet. I would prefer shoring up my alliance with Mr. Whitman first, as shown by the use of an empathic statement.

Dr. Shea: Sounds like you have been going through a rough time. *(empathic statement with a high valence of intuition, a type of empathic statement that can be quite engaging)*

Patient: I went for a hearing on the disability. And I been wanting to get service connected so that if anything happens I can take care of her. We can save some money to go to the commissary and things like that. I think I am entitled to it because I got banged up. I've got a record … *(Mr. Whitman pulls out a piece of paper and starts to look at it)*

Dr. Shea: Can you show me that? *(clinician begins to read)*

Patient: The thing right there is that I wrote out what happened. I got looking at the hearing thing the other night and when I read that I got so mad … if that man had been there, I think I would have punched him out, because the hearing papers are wrong.

Dr. Shea: So it's just like nobody is really in your corner here on this thing.

Annotation:

Here is another example of a counterprojection. I'm trying to do everything I can to get Mr. Whitman to view me as an ally, who is here to help him. Perhaps my most effective engagement strategy was the effort I made to read his letter, thus demonstrating a genuine interest in his problems. Although this action is time consuming, I believe it paid off very well.

By the frequent raising of his headaches, Mr. Whitman has made it plain that the headaches are a

major framework for meaning for him at present. It is a topic that he feels physicians have ignored. So as not to be unconsciously clumped with the "bad guy" physicians, I go out of my way to show an interest, even to the point of taking the time to read the letter. Notice that this entire opportunity for significantly enhancing engagement might have been lost if I had prematurely shortened the scouting phase by exploring medications earlier.

Patient: I got the DAV, what the hell, and the hearing, to me, was a joke.

Dr. Shea: Yeah. Well, I'm struck by the … *(clinician is pointing down into the letter)* steel cover coming down and hitting you on the neck, that's the problem. It could have really done something bad.

Patient: It hit me on the head. I got hit right across here, and there was a scar there. There was a steel handle that weighs about 5 or 6 pounds. That knocked me down and split me open. I got back up and went on, and it wasn't even my job. *(in a healthy way, Mr. Whitman prides himself on a committed work ethic)*

Dr. Shea: There are 24 stitches there. You are sort of a tough guy aren't you? I mean you just keep on going.

Annotation:

Here is my response to "Sullivan's question," a question that interviewers *ask themselves* during the opening phase along the lines of, "What does this patient most want to hear me say that will make him or her feel comfortable and safe?" I am directly addressing his work ethic and past history of psychological strength and grit. I felt that one of the major blocks to powerful engagement for Mr. Whitman was the fact that he felt uncomfortable asking for help in the first place because, in his mind, such an action, combined with his admission regarding suicidal ideation, might make him appear weak. I believe that the one thing he most wanted to hear from me, which might increase his sense of safety (answer to Sullivan's question), would be something that told him that I was not seeing him as weak. From his subsequent response to my comment, one gets the feeling that this intervention was "on the mark."

Patient: I mean, I have to keep going. I can't, I raised six kids and I worked every day. I never missed a day. I took all the hours I could work. I worked and worked and worked and it didn't make any difference. I went to work days when I thought I was going to die, but I thought I gotta feed my family and … all this … gets to me. *(tears are welling up, and his voice is wavering)*

Dr. Shea: Yeah, I bet it does.

Patient: I mean I've done everything I can do to take care of my family. Now I want somebody to help me and I can't get it.

Dr. Shea: Yeah, you look like you are almost close to tears. *(An example of an "observed gate," used to enter his painful affect. At this point Mr. Whitman began to cry. His tears, ironically, show us that our interview strategy has been a success. Instead of anger, which easily could have been projected onto yet another "uncaring doctor," we are seeing pain. Mr. Whitman has opened the door to his world, and it is unlikely that we will be ushered out, unless we make a subsequent engagement error of some sort.)*

Patient: It gets you upset …

Dr. Shea: Yeah, I bet you're hurt. Putting all those years of helping and, now, you are just looking for help. Let me get you a Kleenex. By the way, would it be alright if I could put a copy of this in my chart later, after this, because I think it is important. *(Good cementing of the alliance by continuing to emphasize a sincere interest in Mr. Whitman's headaches through actions not just words.)* Well, you are really going through a lot.

Patient: … crying like a baby. *(looks and sounds like he feels a bit embarrassed)*

Dr. Shea: No, no, no. This is just natural, all of us cry. Trust me. I've cried. You know all that means is, sort of, our souls are telling us that we are in pain. That's all that is. It's like getting a

temperature when you are sick. But you have just about had it, huh?

Patient: Yeah.

Annotation:

It seemed important to once again reassure Mr. Whitman that his opening up of his emotions was "okay." I also decided it was time to end the scouting phase, and I next moved into the history of the present illness via his recent medication history.

The main task of the scouting phase has been accomplished – the active engagement of Mr. Whitman. Not only is he no longer wary, but also he has actually become fairly open. I think that he senses the presence of a potential ally. For the first time, an element of "hope" may be stirring in this, our first encounter.

The upcoming switch of topics will also give Mr. Whitman a chance to distance himself from his pain for just a bit, because I sensed he needed a break. As you will see, the transition here is somewhat awkward and abrupt. Frankly, a natural gate into the topic of depression probably would have been a smoother and more conversational transition, but I didn't see it.

A second potential problem for this interview, which actually transformed into a real problem later on, is worth mentioning here – length. This scouting phase was almost 10 minutes in length as opposed to a more typical 5 to 7 minutes. Because of the complicated nature of Mr. Whitman's early disengagement, I believe that this amount of time was warranted; indeed, it was probably necessary to ensure his return.

The problem was that, as the interview proceeded, I needed to consciously eliminate some of my standard data gathering in order to keep this interview within 60 minutes. As you shall soon see, I subsequently forgot to do this winnowing and hence ran overtime. In any case, let's watch the movement out of the scouting phase.

Dr. Shea: Yeah. Okay. Now, have you been getting some care, have you had a lot of psychiatric care, I mean have they been using medications?

Patient: No, no, I just got it. I tried to get it before and … it never worked out. And finally Rachel helped me to get it. And I've been on it now since about the first time I come down. I went to a stress clinic.

Dr. Shea: Okay.

Patient: And it relaxed me but it didn't do any good. Well I can't say it didn't do any good. It had to have done some good.

Dr. Shea: Helped calm you down. A little bit of a Band-Aid compared with how much pain you are in. I'll tell you what I would like to do now, Gary. *(beginning of an introduced gate, see Chapter 4, page 145)* I would like to get a better handle on what this depression is like, because it is a unique thing for each person. The better I understand it, the better I might be able to figure out how we can help. When do you think that you first started to become depressed, just roughly?

Patient: Well I probably have been for a long time, but basically the worst part hit me now with all of this stuff coming together, then I try this and there is nothing there and …

Dr. Shea: When did it start getting worse for you? It might be hard to remember. Let me ask this question, were you depressed at Christmas time? *(Holidays can function as good timeframes for pinning down the earliest onset of symptoms. This an example of one of Carlat's validity techniques called an anchor question, as delineated in Chapter 5, see pages 153–155.)*

Patient: I didn't have a Christmas to speak of.

Dr. Shea: Okay. Were you depressed at that period of time though?

Patient: Yeah, because I didn't see my kids.

Dr. Shea: Okay, and were you depressed at Thanksgiving?

Patient: I mean, I had some kids in Massachusetts that I go and see … *(Patient is starting to pivot out of the region of depression here – see Chapter 4, pages 132–134 for a discussion of "pivot points.")*

Dr. Shea: Okay.

Patient: And my other kids I can see, but these kids I can't see.

Dr. Shea: The ones out in Arizona.

Patient: Right.

Dr. Shea: Okay now what about Thanksgiving … had the depression started by then? *(Good focusing! It would have been very easy to let Mr. Whitman start to ramble on about his relationship with his kids here.)*

Patient: It's been going on for I don't know how long.

Dr. Shea: Years?

Patient: I see my youngest son once a year *(still starting to wander off the topic of depression itself).* Of course he calls and everything. He uses the telephone. I see him up here in Chester every year so … he calls us and lets us know.

Dr. Shea: Has it been going on for a year at least? *(Good, simple focusing question. We will come back to the role of his children later, perhaps using a well-timed referred gate.)*

Patient: Oh yeah.

Dr. Shea: Okay. Has it been going on for several years?

Patient: *(nods)*

Dr. Shea: Okay. When did it start to get the worst for you? *(By the way, you are seeing an interviewing habit that I'm trying to get rid of in my style – of saying "okay" too frequently. These are meant to be facilitatory statements but are probably best replaced with a simple head nod or "Uh-huh." Done too frequently, as I am demonstrating, they may sound almost like a cut-off of some sort. Believe it or not, I had almost eliminated this habit from my interviewing style and was rather shocked to see its return in this transcript. One must always keep an eye out for one's bad habits.)*

Patient: Maybe 2 years ago.

Dr. Shea: Two years ago the depression really started to worsen?

Patient: Right, and I decided I was going to … 2 maybe 3 years ago … and I decided that I had to do something. I got to try …

Dr. Shea: So you began having depressed feelings almost 3 years ago? That's a long time. Okay.

Patient: I sit there some nights and I can't sleep. I get up, *(pause)* I just get up and want to get in the car and go somewhere or do something. *(pause)* I can't sleep. *(pause)* I went out and bought a computer figuring that would take my mind off of everything. You know?

Dr. Shea: Okay. Now your depressed symptoms, like your sleeplessness and things like that, have they reached a point now where they are basically with you all the time, day in and day out? And did that start a year ago, 2 years ago? *(This is a cannon question, see Chapter 5, page 173, and may be confusing to the patient. Which question is he to answer? It is better to phrase them as two separate questions and wait for the answer to each question before going on.)*

Patient: I started getting ticked off at everything.

Dr. Shea: But did the symptoms start to be persistent like that as long as a year or 2 ago? Or is that