THE VENEREAL DISEASE CONTACT INTERVIEW

A sensitive analysis of interviewing techniques used in social disease control as taught in the John Friend Mahoney Training Center for Nurses was presented during the Venereal Disease Seminar in Baltimore, April 29, 1959. A joint project of the Public Health Service and the Department of Health of New York City, the training center was founded in Brooklyn, N.Y., in March 1957 in response to the demand of public health nurses for more skills and knowledge in venereal disease control, a demand that mirrored rising rates of infection in these diseases. Participation in control activities by nurses in large cities had dwindled following the initial, spectacular success of antibiotic treatment and the innovation of interview-investigations.

The papers discussing the work at the center were delivered by Julius Buchwald, M.D., psychiatrist and consultant to the center; Josephine Omura, R.N., mental health consultant nurse with the Department of Health of New York City; Grace I. Larsen, R.N., senior nurse officer, Public Health Service, who is project director at the center; and Patricia I. Heely, R.N., director of the health department's bureau of public health nursing. Following is a compilation of these papers, in summary.

The Curriculum at the Center

With the aim of making venereal disease control an integral part of the public health nurse's services, the John Mahoney Training Center for Nurses gives a 2-week refresher course monthly, September through June, stressing epidemiological principles and contact interviewing. Among the topics are: recent advances in therapy, laboratory aids and their interpretation, casefinding methods, the social and emotional implication of venereal diseases, and the relation between their control and other community services. Emphasis throughout is on the adolescent. Nursing, mental health, and medical consultants of the city health department and the Public Health Service teach through group discussions, lectures, and demonstration and analysis of interviews. These experts are also available for student consultation.

During the first week, interviews are demonstrated by the project staff, and during the second, the nurses practice interviewing. Each interview is analyzed by the student group, under guidance of the staff and consultant psychiatrist. Evaluation of course components is constant for the purpose of improving teaching methods and program objectives.

The Indirect Interview

The indirect interview has provided a valuable communication tool in many areas of medical and social investigation. It was in the natural course of development that this tool was

applied to communication with patients suffering from venereal disease. Just as the microscope, based on understanding of lenses and light, opened a new pathway for exploration of a heretofore invisible world, so does the indirect interview, based on psychiatric understanding, open a new pathway for exploration of human behavior. It is the behavior of the carrier on which the spread of venereal diseases depends. Any attempt to curb the spread of these diseases must necessarily cope with the subtle shadings and nuances within the character of the human vector. While the indirect interview is helping us to understand the motives, fears, character traits, and defenses of the patient, it also lights the pathway to successful contact finding, education, prevention, and cure.

The indirect interview is a purposeful interaction between two people, a conversation which follows a seemingly circuitous path through emotions, eventually finding its way to a nucleus of facts ordinarily unattainable. The foundation of the interview is a positive relationship which can best be defined in terms of the patient's impression of the interviewer. Such an impression would ideally include such phrases as: "She is willing to listen." "She seems to understand." "Perhaps this is the place I can be helped."

There are no dark secrets to establishing a positive relationship. Grandmother used to say, "If you get a person to like you, he will give you what you want." We may prefer using such terms as "obtaining a positive transference," "developing rapport," "building a sense of respect and confidence," but it all amounts to the same thing. We want the patient to like us and work with us toward a mutually gratifying goal, the eradication and prevention of disease.

The materials that build a positive relationship are as obvious as they are elusive. Ordinary courtesy, including a friendly smile and handshake, will never be outmoded. An introduction in which the interviewer offers his name and explains his position and function in the organization can help dispel anxiety. Although adolescents and children frequently are called by their first names, it is a good idea to address young and older adults by their last names prefixed by Miss, Mrs., or Mr. The interview, other than the brief introduction, should not start or end in crowded corridors.

The patient's wish to maintain confidence can best be respected by starting the interview after the patient and interviewer are seated in a quiet, well-lighted, adequately furnished interviewing room. The walk to the room, however, does not necessarily have to be in stilted silence; an appropriate remark, such as "We can talk more comfortably here," can be made. This tells the patient that there will be talking and that the prying eyes and ears of outsiders are excluded. If the patient appears particularly guarded and cautious, it may help at the onset to say something like: "What we say here will be kept in complete confidence."

Opening remarks should be brief but should stimulate the patient to talk spontaneously about himself and his difficulties. With experience comes a natural ease and ability to say the right thing at the right time. For example, an opening statement may be: "Well now, I'd like to get to know something about you and perhaps learn if there is any way I can be of help. Can you tell me what brought you to the clinic?" Or the opening remarks may be determined by what the interviewer notices in the waiting room or on the way to the office. For example, if the nurse notices the patient conversing with someone while in the waiting room, she may ask, "Someone with you today?" In one interview conducted at the Mahoney Center, this question led the way to learning about a patient's relationship with his uncle. What was learned about the relationship gave us considerable insight into the patient's fears and needs and directed the course of the entire interview.

Another patient, while accompanying the nurse to the interviewing room, revealed a mild limp. Here an appropriate start could have been, "Having some difficulty?" On the surface, the patient may merely be explaining the physical difficulty, but in doing so he is giving the interviewer a wealth of information regarding his handicap, his ability to cope with difficult situations, as well as his reactions to candid questions from someone who appears concerned.

Professional workers frequently avoid reference to an obvious physical handicap of a pa-

tient, especially when the handicap is chronic. Quite the reverse is true when a patient appears with his arm in a sling. In a professional setting, reference to any handicapping condition can denote interest and concern on the part of the interviewer and could well be used as a means of fostering a positive relationship.

The Expander Question

Expander questions during the interview offer another way of helping a patient talk spontaneously about meaningful and emotionally laden facts. The more a patient talks, the more he may want to talk, and the more he gets to like the listener.

An expander question differs from a direct question in several important ways. If you ask a direct question, you will get an answer, but that is all you may get. On the other hand, an expander or open-ended question opens a pathway to new facets of a patient's behavior and problems. Characteristically, a good expander question cannot be answered with one or even a few words. On the contrary, it forces the patient to probe, explore, confide, and learn. Where expander questions lead into emotionally laden material, they also uncover the most meaningful facts. Whereas the direct question usually takes its cues from isolated facts, the expander question takes its cue from feelings.

Examples of expander questions can be as numerous as there are varieties of situations which arise in the interview setting, but a question appropriate at one time, may be grossly inappropriate a few minutes later. Again, experience, intuitive capacity, and constant and full awareness of the patient's changing emotional tone are the best leads to the right questions asked at the right time. Opening questions such as, "Tell me about yourself," may be followed with, "What brought you to the clinic?" "Tell me more about that." "Are there other difficulties?" "I don't understand." "How do you feel about that?" "In what way?" "How does this show itself?"

Many times one or two words with the proper inflection and facial expression will do the job. For example, saying "Oh?" in response to a patient's statement may show interest and convey the message that you want to hear more. Simply repeating the last word or words of a patient's statement can indicate your interest as well as pave the way for further thoughts on a subject.

Nonverbal expander questions guide us and therefore play an important role. An appropriate change in the angle of one's head, a lifting of an eybrow, a well-timed smile, or an understanding expression of concern all can go a long way in helping the patient talk. Summarizing and clarifying what the patient has been saying can frequently focus a problem more clearly and aid in the exploration of new facts. For example, a patient talks of her problems in rearing four small children, meeting bills, frequent family illness, and the recent death of a relative. An appropriate expander at this point may be, "The going gets rough doesn't it?" Such a remark may lead the patient to further exploration of her emotional reaction to the events described, or, as sometimes happens, she may respond with, "Yes, but it's not always so rough." "Oh?" asks the interviewer; and, if the stage is set and the patient is ready, we may hear facets of the patient's life that are rewarding and make the "battle" worthwhile. The following example briefly compares the direct and indirect interview techniques. A patient has told the nurse that he recently came north to live. The direct interview would run something like this:

Nurse: When did you come north?

Patient: Six months ago.

Nurse: Do you like it up here?

Patient: Yes.

Nurse: Working now?

Patient: Yes.

Nurse: Do you like your work?

Patient: Yes.

Nurse: You have acquired your infection since you came up north?

Patient: Four weeks ago.

Nurse: What was the name of the girl?

Patient: I forgot.

The indirect interview may take this course:

Nurse: Then you have been living here only a short time?

Patient: Yes, I decided to come up 6 months ago.

Nurse: Oh? Tell me about that.

Patient: Well, my mother and father had

been separated since I was 13; I stayed with my mother until 6 months ago when she passed away.

Nurse: Oh! I see.

Patient: Yes, after she died I had no one else down there so I came up. I've been lucky. Got a good job, but it still gets lonely up here. I have no family here and do the best I can to make friends. I guess you have to take what you can get when you can get it. Seems its been like this a long time.

Nurse: Perhaps this feeling of loneliness is connected with the trouble that brought you to the clinic.

Patient: Maybe you have got something there. I have had this trouble before.

Nurse: Oh. Tell me about that.

Patient: Well, it was about 4 months ago. I was just kicking around and I met this fellow Joe who invited me to a party. When I got there . . .

This example, of course, is an ideal one. It implies that a relationship has been established and the patient wants to talk about himself. At the same time, it points to several problems that are characteristic of the indirect interview. First of all, this technique takes time. It is necessarily circuitous and brings in seemingly superfluous information. For that reason, time limits are necessary. We have found that setting a minimum time limit is as important as setting a maximum limit. Naturally, the maximum time you can spend with a patient depends upon the pressure of other responsibilities. Perhaps a 30- to 45-minute interview period can, for the start, provide an optimum amount of time for the exchange of thoughts. The minimum time limit can be considered as a margin of safety in coping with our own anxiety and tolerance of the interview situation. A resistant, provocative, hostile, or silent patient may frequently tempt us to terminate the interview prematurely. The patient, in spite of his outward resistance or hostility, will frequently view early termination as rejection and lack of concern on the part of the interviewer. Furthermore, it is frequently surprising and gratifying to find a seemingly fruitless 10-minute introductory period gradually evolve into a meaningful interpersonal experience.

The second problem raised by this technique is the mounting tension and anxiety felt by the interviewer. As the tools and rigid framework of the direct interview are dropped, the interviewer frequently finds herself on unknown territory, facing facts and feelings she didn't plan to meet. To listen to a patient struggling for the right words to express hidden emotions is quite different from receiving brief yes and no replies to matter-of-fact questions. No doubt, there are times when we would all like to revert back to the good old question-answer format, sidestepping the vital issues that remain uncovered. Perhaps the knowledge that good interviewing does provoke anxiety may make it easier to recognize our inner tension when it appears. The knowledge that the effort will be more than repaid by hitherto unachieved rewards can perhaps make it easier to cope with the anxiety.

Another contributor to the interviewer's anxiety may be the fact that the subject of sex and venereal disease has always carried with it many overtones of social and personal bias. The relatively free discussion of these subjects in the open-ended interview taxes the interviewer's ability to cope with these ideas in a candid and unprejudiced manner. This does not mean that the interviewer is expected to be able to, or should, strip herself of personal feeling and taste, based on a lifetime of experience. It merely asks that the interviewer be aware of her own personal biases. By coming to grips with how she feels about a patient who has acquired a venereal disease, the interviewer will be able to consciously refrain from imposing such biases upon the viewpoint and attitudes of the patient.

Let us turn for a moment to the frequently expressed concern over what to do with the patient who opens up too much. The fear that the dam will burst by an overwhelming flood of human emotions provoked by the indirect interview technique is a chronic source of anxiety to the interviewer, especially the novice. Yet, experience has shown that the dam rarely floods and personality structure tends to inhibit rather than to give free rein to emotion. At this point, many of you may think, "Yes it does happen rarely, but it's just my luck that it will happen to me; then what will I do? How will I handle such a patient?" To this let us say that most of us have the intuitive capacity to

recognize the severely disturbed patient, curb our probing, offer occasional reassurance, and shorten the interview. In 2 years of experience at the Mahoney Center, there has been no instance in which the interview got out of hand. On the contrary, a patient frequently remarks that he "feels good," at the close of an interview. Almost always, the patient will let us know when we are "stepping on his toes" by his silence, shifting to other subjects, as well as using other defensive maneuvers which help the patient retain an emotional homeostasis. Our major efforts with this technique of interviewing rest in handling rather than fearing the absence of the patient's resistance.

Anything which hampers communication may be considered to be resistance on the part of the patient. It may be a thought which is difficult to express, a feeling which demands suppression, or a generally guarded attitude which has become part and parcel of a personality structure strained by a lifetime of probing and prying at the hands of punitive authority figures. The manifestations of resistance are multiple and demand considerable flexibility and adeptness on the part of the interviewer. A frequent form of patient resistance is silence. It is amazing how 15 seconds of silence can seem to be 15 hours. The resultant anxiety frequently tempts the interviewer to break the silence by changing the subject. Yet, since the silence represents an important thought which the patient finds difficult to express, valuable information may be gleaned if the patient, rather than the interviewer, breaks the silence. If a period of silence becomes overly long and provokes too much anxiety, the silence may be terminated by the interviewer asking, "What are you thinking?"

One sometimes meets a patient who candidly refuses to talk about a particular subject. Here an explanation of why the patient refrains can frequently reveal hidden problems, fears, and needs. Blushing and obvious embarrassment may make it necessary for the interviewer to offer reassurance. For example, a patient may be helped through a difficult moment by a statement such as, "I know that some of this is embarrassing to you, but I have come across these difficulties before and the more you tell me about it, the more I can understand and help." Asking for contact information, a focal point of the interview, is more likely to meet with a successful response if it is introduced after a positive working relationship has been developed between the patient and the interviewer.

Workers at the Mahoney Center have encountered a strange, misleading form of resistance. We are referring to the patient who enters the interviewing room, hardly waits for any introductory remarks, and quickly spurts out: "I think I know what you want. I caught the infection 5 days ago by having intercourse with Jane Doe who lives at 10 North Street. If you don't want to bother sending her a letter, I'll bring her in myself so she can be treated. Can I leave now?" Since this is all usually said in one breath, we may not have the time to realize that under the guise of golden cooperation, we have met iron-clad resistance. The inexperienced interviewer may well be tempted to close the interview at this point, feeling, "Why go on? He has told me what I want to know. What do I have to lose?" In actuality, closing the interview at this point means losing a great deal, for again, we would lose the opportunity to form a relationship with a patient who could potentially carry our message out to the community. This type of patient further reflects a dangerous, though presumably submissive, attitude, which will be discussed further.

Education of the Patient

The indirect interview and the relationship it promotes set a flexible, useful stage for the education of the patient. Perhaps in recalling experiences with learning, even on the elementary school level, there are few who do not remember the so-called "born teacher" who lives on in our memory as a good and wonderful person whose lessons were a pleasure to learn. We seem to learn most things for three basic reasons:

- To satisfy an instinctive curiosity, the epistemophilic instinct to which Freud referred.
- To profit from past experience for the purpose of self-preservation and the promotion of a happier future.
- To please and receive praise from a teacher we have learned to like.

Many patients will express a healthy curiosity about venereal disease, a curiosity which has heretofore remained unsatisfied. However, the freedom to express such curiosity is directly dependent upon the nature of the relationship, the absence of personal bias and prejudice, and the presence of helpful and refreshing candor. In answering questions, it is necessary to know the specific thought behind the question, as well as what the patient already knows. It is helpful, therefore, to meet a patient's questions with the question, "Why do you ask?" For example, a patient asks, "I guess the only way you can get this disease is when a man and woman have sexual intercourse." The interviewer is tempted to answer with a brief "Yes," but instead pauses and asks, "Why do you ask?" The patient is embarrassed, but now finds the courage to state, "Well, I didn't want to talk about this, but I haven't had any girl friends." Further exploration of this difficulty may lead the patient to submit the names of homosexual contacts, and if a conflict in his sexual behavior is discovered, perhaps he can be referred to appropriate sources for further counseling and help. Thus, the exploration of a patient's question will help reveal hidden facts, and will often bring to light conflicting and anxiety-provoking fantasies which require airing and resolution.

That learning about venereal disease is necessary for self-preservation may be an accepted fact to us, but the patient may not appreciate this as readily as we do. The indirect interview, having given us a fund of background knowledge as to the patient's problems and meaningful life experiences, now gives us the opportunity to demonstrate to the patient a connection between past difficulties and his present problem. For example, a patient told how as a youngster he had lost a finger in an accident while working on his father's farm. The fact that the accident occurred in a careless split second, but left a deformity that would endure a lifetime, gave the interviewer an excellent opportunity to connect the patient's experience with his present problem with venereal disease, as well as with his proneness to act impulsively and cause irreparable damage. It is connections such as these that help make learning meaningful and memory enduring.

Our third basis for learning takes us back to the relationship between the interviewer and patient. It is our hope that knowledge acquired within a nonpunitive and helpful setting will be incorporated within the day-to-day living habits of our patients. Just as we tend to forget unpleasant experiences, we tend to forget facts that have been learned under unpleasant circumstances. Facts that have been learned as a part of a positive experience during a successful interview may more readily be used when new situations in the patient's life demand recall of past experiences.

Obtaining Contact Information

It is no accident that we ask for contact information toward the end of the interview rather than at the beginning. It is hoped that the positive relationship established during the interview will help the patient assume his responsibility in the situation by giving the information requested. Although it is not the purpose of the interview to offer psychotherapy, many patients have welcomed the opportunity to air their difficulties within the objective and nonjudgmental setting of the indirect interview. During the interview, the patient comes to recognize the interviewer as a helpful and responsible listener, a recognition which motivates the patient to assume the responsibility of providing contact information. Thus, we have tried to have the patient consider us as a source of help and to get him to like us. We have tried also to offer information of value to the patient, and we now expect that he will give us information that we need—contacts.

Finally, let us consider the matter of tactics and strategy in our war against venereal disease. Whereas the isolated casefinding, individual interview, and routine treatment of the patient constitute our tactical procedure, the strategy of our method must take into consideration an occasionally intangible but profoundly important attitude that has crept into the community and directly affected the potency of public health control efforts. At the Mahoney Center, we have had the opportunity to observe a community attitude that presents itself in subtle submissiveness, but rests on a hostile and fearful approach to authoritarian institutions.

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This is an attitude characterized, in a sense, by the patient described before, who quickly offers the name of a contact (a name, by the way, which frequently exists only in the imagination of the patient) and wants no further part of a relationship with the nurse or the services she represents. The furtive responses of some patients who have come to get that needed "shot of penicillin" reflect the fact that something, somewhere has gone wrong. Also, when shame and fear remain attached to treatment and illness, there is another warning sign that our strategy is in need of repair. The patient who timidly seeks to bribe us with the name of a contact so that he may get treatment must feel that he is stealing something which is rightfully his and which he should be able to accept with an uninjured sense of self-respect and human dignity.

Here, then, lies our strategic goal. At the Mahoney Center, we hope to improve our interviewing techniques so that the resultant positive relationship between nurse and patient may gradually be transferred to the relationship between community and social hygiene clinic. It is our hope that many individual interviews which provide a positive and helpful experience will lead the community to accept the clinic as a place where one can get help, considerate attention, and courteous guidance untinged by authoritarian or punitive demand. This is a long-term goal that requires continuous effort and study. It calls for hard work, but it is a goal that is well worth the effort.

Resolutions Passed on U.S.-Mexico Border Health

Marking another year of creative, binational action to lift the level of health along the common border, the 18th annual meeting of the United States-Mexico Border Public Health Association was held April 4–8, 1960, at Hermosillo in the State of Sonora, Mexico. The meeting offered an agenda of papers and panel and roundtable discussions on subjects such as environmental sanitation, venereal disease, maternal and child health, tuberculosis, and poliomyelitis.

Among resolutions passed at the close of the sessions were those concerned with:

- The association's approval of development projects such as community water supply programs.
- Continuation of the interchange of experience and knowledge by public health nurses in the United States-Mexico border area.
- Recruitment of all other interested agencies and groups to work with the association toward the early eradication of tuberculosis in the border States.
- Continuation and broadening of the close cooperation between border health agencies in venereal disease control in all border communities to further the training of health agency workers in venereal disease casefinding techniques and to increase the scope and efficiency of control programs.
- Further stimulation of specific training of nurses to aid in the early discovery and care of cases of infant diarrhea on the basis of oral rehydration and to assist in the promotion of local committees for the dissemination of information about these methods of controlling diarrheal disease.
- Encouragement of communities with a high occurrence of diarrheal disease to promote health and environmental surveys.
- Recommendations to officials along the border that they provide health workers with facilities for attendance and study at the association's annual meetings.
- Arrangement for joint publication of the proceedings of the association in the *Boletin* of the Pan American Sanitary Bureau, *Public Health Reports, Higiene,* and *Salud Publica de Mexico.*

A summary of other events of the meeting will appear in the December 1960 issue of *Public Health Reports.*