CHAPTER 19

NOTE TAKING AND THE PSYCHIATRIC INTERVIEW

This chapter discusses the written record of the initial psychiatric evaluation and of subsequent therapeutic sessions. This written record is extremely useful for supervision and teaching because, unlike the prepared history that is organized around a more or less standard format, these notes reveal the process of the clinician–patient relationship as it unfolds.

The student is often distressed to learn that experienced psychiatrists vary considerably in their opinions concerning the optimal quantity and method of recording notes. The diversity of advice given the beginner is extreme. Notes are often suggested by a supervisor, thereby representing the intrusion of a third party into the interview situation. This may disturb either the patient or the interviewer. Therefore, a discussion of note taking requires consideration of the supervisory relationship. One supervisor may advise a student to make no notes whatsoever and instead to concentrate fully on what the patient is saying, relying on memory to reproduce the material. At the other extreme is the supervisor who recommends taking “verbatim notes.” The student is always confused as to the definition of “verbatim,” but in the spirit of cooperation, he writes frantically, trying to include everything said by both himself and the patient. The same supervisor may seem inconsistent, having a different approach for different students or for the same student with different patients or at different times in training. In order to understand this complex problem, it is necessary to establish some fundamental principles.

All interviewers make mental notes as they listen to the patient. One of the basic tasks in improving one’s interviewing skill is learning to lis-
ten to and register the implied message and not only the explicit content. Simultaneously, the interviewer must observe the patient’s behavior and affective reactions and his own responses to the patient. Furthermore, he is expected to note the correlation of specific topics with particular affective responses or body movements. Supervisors suggest that he learn to identify the “red thread,” or the unconscious continuity that exists among the patient’s associations. The interviewer is also expected to consider every remark that he will make to the patient and be able to recall his own comments, questions, interpretations, suggestions, advice, tone of voice, and so forth when reporting the interview. Since this is impossible, the result will be a compromise.

The pressure felt by the interviewer may be lessened by concentrating on one or more of the above-mentioned areas. Some emphasize historical data concerning the patient, whereas others direct attention to the interpersonal process that is taking place between interviewer and patient. Supervisors who emphasize historical data tend to be more demanding about note taking during the interview and usually want a precise record of the data concerning the patient in the order in which it was obtained. Those who emphasize the interpersonal process more often encourage a report of the interviewer’s statements, regardless of whether the notes are recorded during or after the interview. Note taking is thus part of a much broader question: Which aspect of the interview will occupy the attention of the interviewer and his supervisor?

This chapter concentrates on the more narrow issue of what kind of record is to be made and when it is to be done in relation to the interview. The need for keeping written records about patients is ubiquitous in healthcare. There is a legal and moral responsibility to maintain an accurate record of each patient’s diagnosis and treatment. Such requirements are quite broad; however, clinicians are subject to the policies of their particular institution. Although such policies undoubtedly influence attitudes, the precise manner in which the material is to be recorded is usually left to the discretion of the individual clinician. Another important purpose of record keeping is to aid one’s own memory concerning each patient. Therefore, each individual has to decide what type of information he has the most difficulty remembering and use this knowledge as a guideline in his own system of record keeping. Basic identifying data such as the patient’s name and address, the names of other family members, the ages of children, spouse, siblings, parents, and so forth should be written, because this information is not easily recalled. A concise description of the patient and his behavior during the initial interview along with initial diagnostic impressions often prove to be helpful later in treatment. Studies have suggested that ther-
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...ists who prepare a written case formulation are consistently more successful than are those who only organize the material in their minds.

The chief problem in making notes during the interview is the potential distraction from attending to the patient. With experience, it becomes progressively easier to make notes with a minimum of distraction, giving almost full attention to the patient. Furthermore, one may be more distracted by attempting to remember information and more free to listen and attend to the patient if one knows that the critical data are written and preserved for future reference. Many therapists make fairly complete notes during the first few sessions while eliciting historical data. After that, most record new historical information, important events in the patient's life, medications prescribed, transference or countertransference trends, dreams, and general comments about the patient's progress.

The anxious or uncomfortable interviewer may find note taking a convenient refuge from emotional contact with the patient. It allows him to avert his eyes and occupy his thoughts with other matters. His note taking may fall a sentence or two behind the conversation. The interview fades into the background and whatever was making him anxious becomes less disturbing. When this occurs it is an indication that the notes should be put aside and the countertransference problems explored. As an example, a psychiatry resident told one of us that he had been particularly impressed by an article he had read that likened the maneuvers between beginning male therapists and female patients to the dating or courtship interaction. The resident felt that note taking helped him establish the feeling of having a professional identity and that he was relating to the patient in the proper and appropriate manner. Here, note taking functioned to reinforce a professional identity and to help provide a distraction so that the therapist could be more involved with the notes than with his feelings of attraction toward the patient.

There is a business-like quality to any note taking, and this can be used therapeutically. The clinician can establish a sense of heightened intimacy by putting his pen and paper aside. This is customary in discussing material about which the patient is expected to be reticent—his sexual life, his transference comments, or his negative feelings about a previous clinician.

In presenting material to a supervisor, the obsessive supervisee takes comfort in bringing copious notes. He is uncertain about what material is most important and is concerned that, if left to his own judgment, he is liable to bring the wrong data. He compensates for his inability to discriminate by attempting to bring everything. Invariably, he
leaves out the most important things, those that took place on the way into the office or at the end of the interview when he had already put the notepad away. Since it is more difficult to write while talking than it is to write while listening, there is a tendency for the notes to be more complete and accurate concerning the remarks made by the patient than those made by the interviewer. Often when a supervisor suggests that the student might have said such-and-such or asked the patient about so-and-so at a certain point during the interview, the student quickly assures the supervisor that he did, in fact, say that, only he did not have a chance to write it down.

"Verbatim" notes are not actually verbatim. In fact, there is no such thing as a complete record of a session. Even a videotape is not a total report of all that transpired during the interview, as it contains only the externally observable behavior. Furthermore, many of the subtle verbal innuendos may be obscured by the recording equipment or completely missed if they are separated from the nonverbal cues that accompanied them. The crucial data of the interviewer's subjective feelings and responses cannot be directly recorded by any means. The quality of the relationship between the supervisor and the supervisee determines how much of the important material of the session is reproduced during a supervisory hour. If the supervisee respects and trusts his supervisor and does not perceive him as someone out to damage or weaken the trainee, more will be communicated. If the supervisee is frightened, the supervisor is not likely to learn many of the important things that transpired during the session, even though there are copious notes.

Audio- or videotapes are a kind of note taking that modern technology has made increasingly popular. When these methods are employed, one must consider the effect they have on both the patient and the clinician. The clinician's concern about the patient's rights and privileges is revealed by the manner in which he introduces these procedures to the patient. In the author's experience, it is uncommon for a patient to object to a recording, but every patient should have the procedure explained in advance and permission requested. The equipment should be started only after the patient knows about it, has given his permission, and understands who has access to the material and for what purpose. The patient is far more concerned with the clinician's attitude about invading his privacy than with the content of what might be revealed.

The interviewer, on the other hand, is often quite concerned about scrutiny by his colleagues and supervisors. This will stifle spontaneity and lead him to conduct a "safer," more stereotyped and more cognitive interview. In addition, his responses to the recording equipment
are often projected onto the patient, and he may pursue the patient's anxiety about recording even though the patient is, in fact, relatively indifferent to it. One of the authors began his first interview on videotape with, "I imagine you're wondering about the television equipment," only to hear in reply, "Oh, don't you always do that?" On some occasions the doctor's exhibitionism will take over, and he will attempt dramatic maneuvers. In any event, he is responding to an unseen audience rather than to his patient.

Thus far, we have considered note taking largely from the point of view of the therapist and its effects upon him. Note taking also has effects on patients.

The paranoid patient is likely to be upset by note taking, and particularly by audio or video recording. He feels that the records represent damaging evidence that may later be used against him. In working with such patients, it is generally wise to confine note taking in the patient's presence to basic historical information. The interviewer should answer suspicious patients' questions about who has access to the notes. It is important to explore such patients' concerns and assure them that the interviewer will be discreet in his recording. Making notes at the end of the session will minimize some of these problems, but is often impractical.

The obsessive-compulsive patient may feel that the interviewer is getting the goods on him, but he is more prone to view the note taking as a cue to the significance of what he has said. The patient may also indicate his awareness of the importance of the notes by pausing periodically to facilitate the recording. The patient is usually unwilling to acknowledge that this behavior is motivated by his resentment that the interviewer shows more interest in the notes than in him.

Patients who are being treated by trainee therapists in academic training centers often have some awareness of the teaching role of the particular institution to which they have gone for help. They often do not ask directly about supervisors or supervision, but they will very frequently couch such curiosity in questions about the note taking. A common question is, "What do you use those notes for?" The trainee often senses that the inquiry is really directed at the supervisory process and represents a potential expose of his inexperienced status. Therefore, he may be tempted to reply with a mild degree of dishonesty, offering such answers as "The notes are an important part of your treatment record" or "The clinic requires that treatment records are kept." Prominently concealed in such inquiries is the patient's fear that the clinician will breach his confidence. The evasiveness of the beginning therapist may also stem from guilt or discomfort at the idea of revealing his
patient’s confidences to a supervisor or at a conference. It is helpful to answer such inquiries by asking the patient if he has some specific idea concerning the purpose of the notes. The interviewer may uncover thoughts that the patient has concealed. Pursuing this point may lead to direct questions about the therapist’s supervision. Such questions may be threatening to the novice, but he is surprised to learn how frequently the patient is reassured at the idea that his inexperienced therapist is being aided by a more experienced supervisor. At other times the patient already knows the answer to these questions and is relieved and impressed that his therapist is open and honest about his status.

On occasion a patient may ask, “What did you just write down?” or “Why did you write down what I just said?” Such questions indicate either the patient’s search for some magical answer to his problem or his fear and mistrust of the clinician. The interviewer will gain more understanding of the underlying process if he does not answer the question directly but rather replies, “What do you think I wrote?” or “What is it that you are concerned about?” Uncovering the covert meaning of the question will shift the focus of the patient’s interest from the notes to his own anxiety. Other variations of this situation occur when the patient tries to read the notes upside down while they are being written. This behavior may be accompanied by comments from the patient indicating that he has just read something. The interviewer might put down his pen at this point and explore the meaning of the patient’s interest as suggested earlier.

Obsessive-compulsive and schizophrenic patients will frequently become concerned about the ownership of the notes. A common statement is “Those notes are about me so they must be mine.” The clinician inquires about the patient’s concern and may point out that the notes are really about their work together. Patients sometimes ask if they can read the notes or if they can have a copy of them. They may feel that the notes contain the magic answer that will immediately provide a solution to their problems, if only the clinician would share it with them. The interviewer should determine to which aspect of the note taking the patient is responding, rather than providing the notes to the patient. Once the interviewer has explored the basis of the patient’s interest, the concern with the notes will be forgotten.

Ownership of the notes may also become a problem with patients who have a disturbance of impulse control. A typical patient might ask, “What would you do if I were to run over and grab those notes?” Interpretations about the patient’s concern over loss of control are important. Such comments may be unsuccessful with very literal-minded patients, making it necessary for the interviewer to tell the patient that
the notes belong to him, not to the patient, that the patient may not look at them, and that he will not allow the patient to take the notes away from him.

Histrionic and depressed patients tend to resent note taking. These individuals want the undivided attention of the therapist, and any interference provokes their anger and makes them feel deprived. Often their resentment about the notes is revealed in dreams long before they openly complain during the session. As with other patients who are disturbed by note taking, one can avoid the problem by making notes after the session. However, there may be a diminution in the quality of the notes. As with other transference cravings of such patients, the important issue is not whether the therapist accedes to the patient's desire but whether the desire is articulated and explored and whether this exploration contributes to the patient's self-understanding.

Like any other phenomenon that changes the frame of the interview situation, note taking will reflect transference and countertransference issues. When its impact is examined, note taking can usefully illuminate both the clinical and supervisory situations.

The supervisor's management of the student's note taking, including the exploration of the supervisee's transference to the supervisor that is reflected by these notes, often becomes an important educational experience in which supervision provides a "parallel process" to that of the therapy being supervised.