

THE CLINICAL INTERVIEW AND ITS PSYCHOLOGICAL NEEDS

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SUMMARY

The interest in the study of communication in real social contexts characterized, for several decades now, numerous researches conducted in theoretical frameworks and different disciplines. Communication is at the heart of everyday life, is present in every environment of human life, in every social group, and is the element of the plot of the relationship between people. It is characterized by a substantial condition of simplicity in regard to our relationship life everyday and distinguishes the possibilities we have to interact with others. Men cannot but communicate because every more or less conscious action of our life is an act of communication.

Key words: communication – social – disciplines – framework - human communication – relationship - verbal and non-verbal – metacommunicative – circularity – psychological – need – clinical - interview

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Human communication is essential at different levels and for a variety of reasons. First of all, it meets physical needs: it has been widely shown that lonely people with poor and unsatisfactory interpersonal relationships are more susceptible to disease and even premature death (Zani 1994). In addition, communication is the only way by which we learn who we are: our sense of identity is based on how we interact and messages and definitions that others send to us (Francescato 2002).

In every act of communication there are always present 2 levels, one relating to the content or news - the thing I want communicate, and one relating to the relationship between the partners - the interpersonal relationship. If the relationship between the interlocutors is "healthy", ie both communication partners see it the same way, the communicative aspect assumes a fair interpretive process, if the relationship is defined by the subjects in a dissonant manner it is possible to develop an interpretative conflict (Neisser 1981). Here are a few suggestions to develop "good" communication:

- be available to express your point of view in concrete form, avoiding generalizations, morality, and personal judgments. We should , educate ourselves to communicate with and not against our party;
- consider each party worthy of a story that we can not know if he does not to tell it openly;
- practice to make coherent use of verbal and non-verbal communication;
- build a competence or awareness of communicative and acts and their circularity.

Unfortunately, the possibility of implementing this transformation of perspective clashes frequently with a sort of "emotional illiteracy" (Contini 1973) that characterizes many interpersonal relationships and many social professions. In Western culture, the emotions and feelings have generally been considered as opposed to the rational, almost like two separate and distinct universes.

"Emotional illiteracy" refers to the inability of persons to understand their own emotional states, the

signals emitted by the other party and their inner messages. To struggle to understand the communication of the other deep words are not enough, since they may be in excess and even disguise and hide meaning. Communication needs to be investigated in the broad area of non-verbal behaviors, so one must observe spying attitudes, pay attention to the atmosphere of contexts and interpret the meanings; just so that one can earn some fragment of transparency within the opacity of the act and the communicative relationship. But not only that, a relational competence in social professions is centered on the ability to understand and recognize the emotions that the interpersonal relationship generates or exacerbates.

The difficulty of managing, that is, the feeling of anxiety and inadequacy linked to the perception of the problem and the ability to solve it is to affect, in fact, the emotional climate and communication established between the health professional and the patient.

Being able to communicate is being able to talk, to listen, to know how to overcome their cognitive-emotional egocentrism, decentralizing the situation of centrality and supremacy of our thoughts and our emotions, to open, receive and understand the message that comes from the other.

The helping relationship should be centered primarily on the quality of the encounter of the interpersonal and psychological relationship. Quality that is not necessarily a refined expertise of health care, but what must be managed by the ability of the "Nursing" has to build a direct personal relationship, founded on trust, willingness to recognize the patients' own feelings and the ability to live them.

Another element that is important in the interpersonal relationship between the nurses' and the patient's attitude is founded above all on respect and positive regard of the person and the recognition and unconditional acceptance of the variety and individuality of the life stories that will be told. The operator must be able to establish a deeply personal and subjective view; recognize first of all that the patient is a person who has

a personal worth, no matter what his condition, his behavior, his feelings. These conditions indicate a constructive relational climate; that enable the leap from an exclusively charitable and protective attitude, which assumes the liabilities of the assisted, to a relational climate capable of producing a process directed to an "authentic human relationship." Communication skills, willingness to change their traditional modes of care and attention sympathetic to the demands of the patient, are reflected in the nurse's relational competence. In fact, the communicative relationship is often distorted by the fact that in practice it tends above all to "not listen", presuming to know what the other wants to say or superimposing their thoughts to the interlocutor.

The ability to listen enables one to better understand the problems of the patient, to maintain a high degree of attention and motivation, and the activity that takes place in the patient, to recognize the dignity of the subject within the communicative relationship, to produce a significant change in the interpersonal relationship, contributing concretely to developing a helping relationship (Gergen 1990). The focus is primarily about listening, attempting to understand what is "behind" the acts and words of the patient, ie the real meanings which are not always corresponding to the words and the motivations that are often complex in nature and more hidden than it appears.

Rogers says, "it's really amazing how the simple fact of being heard by anyone give us the strength to accept moods and feelings otherwise unbearable (Rogers 1973). It is amazing how you can solve the problems which seem most difficult if someone is close to us and understands us and how things which appear most confused become clearer when one has the feeling of not being alone in having to unravel them.

Collaboration with the health of the patient is necessarily conditioned by an initial act of trust and total reliance. In fact, the patient may have significant problems and depend totally and without being forced on a choice between blind faith and idealization on the one hand, and desperation and despair on the other. The health care worker in this case should have the opportunity to discuss some of the fears, fantasies, suspicions and explain the realistic clinical situation of the patient; so that he can recover his own greater autonomy that he will otherwise lose. Coping with the patient and his anxieties and fears about the disease, the type of medical acts and commitments, the instrumental tests or surgery, enables the processing of events (such as a surgical operation) that may have connotations of self-aggressiveness at the unconscious level and a meaning of loss and mutilation which is both real and fantastic.

On the contrary, the use of inappropriate or premature reassurance, minimization, elusiveness when faced with questions, requests or concerns are many ways of hindering a collaborative work with the patient who asks to be given the ability to deal with their situation in a more mature and realistic way. This avoidance may be done to protect the health professional's psychic health (Trombini 2002).

Nursing should adopt a behavior that facilitates the construction of a working alliance, which helps the patient more responsibly decide the measures it intends to share and the degree of dependence that he feels gradually able to accept in view of a specific benefit or therapeutic program. It is in this area which is located the space to mature and to get that informed consent that meets not only the respect of ethical rules and the rights of the patient, but also the conditions for maintaining the therapeutic collaboration (Quadrio 1999). A sympathetic attitude towards the patient helps the professional to be in tune with the needs of the patient to express, give up or live with the symptoms. It helps to build a relationship with the patient which is relatively mature and adult. Time, emotional availability and genuine therapeutic intent are essential ingredients in this process; but their place is widely justified, both by humanitarian reasons and by the advantages acquired by the patient.

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