



2022

How an intake conversation in mental healthcare nearly led to suicide

Lies Sercu
Katholieke Universiteit Leuven

Follow this and additional works at: <https://pxjournal.org/journal>



Part of the [Psychiatric and Mental Health Commons](#)

Recommended Citation

Sercu L. How an intake conversation in mental healthcare nearly led to suicide. *Patient Experience Journal*. 2022; 9(3):4-7. doi: 10.35680/2372-0247.1717.

This Personal Narrative is brought to you for free and open access by Patient Experience Journal. It has been accepted for inclusion in Patient Experience Journal by an authorized editor of Patient Experience Journal.

How an intake conversation in mental healthcare nearly led to suicide

Cover Page Footnote

This article is associated with the Patient, Family & Community Engagement lens of The Beryl Institute Experience Framework (<https://www.theberylinstitute.org/ExperienceFramework>). You can access other resources related to this lens including additional PXJ articles here: http://bit.ly/PX_PtFamComm

How an intake conversation in mental healthcare nearly led to suicide

Lies Sercu, *Katholieke Universiteit Leuven*, lies.sercu@kuleuven.be

Abstract

As a patient of mental health care, I want to share and reflect on an experience I had during an intake conversation. I had been dismissed from a hospital stay and my psychiatrist had arranged for an intake conversation for a program specialized in treating people with anxiety and depression in another hospital. Given the state of my illness, I was prepared to give this new program a try. My expectations were that I would be treated with dignity and respect as I had been treated in the hospital from which I had been dismissed. Yet, my experience turned out to be very negative leading me to consider suicide right after the conversation and when getting home. Below, I first provide my narrative of the intake conversation, after which I will share some reflections and recommendations. I now understand that achieving patient-centered care during intake conversations is not obvious, in part because the intaker has little time to get to know the patient, and in part because the patient may defer from speaking openly with the intaker. My conclusion is that, if the intaker and the patient manage to negotiate and work together from different but complementary points of view, one can achieve a patient-centered partnership in care, already during intake conversations.

Keywords

Mental healthcare, patient-centered care, patient account, transition of care, intake conversation

Introduction

As a patient of mental health care, I want to share and reflect on an experience I had during an intake conversation. I had been dismissed from a hospital stay and my psychiatrist had arranged for an intake conversation for a program specialized in treating people with anxiety and depression in another hospital. Given the state of my illness, I was prepared to give this new program a try. My expectations were that I would be treated with dignity and respect as I had been treated in the hospital from which I had been dismissed. Yet, my experience turned out to be very negative leading me to consider suicide right after the conversation and when getting home. Below, I first provide my narrative of the intake conversation, after which I will share some reflections and recommendations.

Narrative: My experience of the intake conversation

At 11:00 AM the door to the team meeting opens. The psychiatrist, a psychologist, and a couple of nurses. High heels. Hellish noise. Back and forth. Forth and back. The purple heels stop by my chair. "Good morning. I am the intern. You may come with me."

Four iron seats with orange cushions. A round coffee table. No coat rack. No place for my bag. Against the walls children's books and hand puppets. "The psychologist will be here soon," says the intern. "Shall we wait for her

then?" I ask. A teaching hospital. Interns, supervisors, supervisors of supervisors. Hurrying in and out. I feel myself shrinking at the idea of having to tell my story three times, each time condensing it a little more for yet another supervisor. They don't see that, that the summary is less and less true to me, shows me less and less. Do they even listen?, it goes around in my head.

"Well. We can start." I tell what I have prepared. Why I'm here. Who requested the interview for me. What I expect from them. The supervisor breezes in. Someone has followed her. She is flying out again. Next to her computer are two apples and a handbag. "Hmm," she sighs for the third time next to her apples that help me direct my attention away from my fear. The intern sums me up. "Hmm" and "Say." The supervisor takes over. From now on, the intern only notes things down, for her report later. It will go in her internship folder, another scrap of paper as proof of her education.

"What about your weight now? We only admit people here with a BMI of at least 18.5." "Somewhere between 18 and 18.5", I say. "We're going to measure and weigh you later. We need to be sure. We don't have an eating disorder program here." In my head, "not" and "none" linger. "When you say 'binge eating,' what do you mean? Self-induced vomiting?" Does she want to show that she is also an expert in this area by pushing the finger into the wound? Why doesn't she ask me if I am okay with being weighed? Why can't she be more sensitive? Doesn't she

realize how shameful I feel about showing my bony body to a stranger?

She jumps to yet another seemingly random item on her list. "What about your suicidal thoughts? We're an open ward here. If you think you need to be secured, you shouldn't be here." "Not" and "none." I feel my throat squeezed shut even more. "Two weeks ago they were very bad," I say. "I chose my method then. But now I don't want to commit suicide." She does not seem reassured. "You are speaking in the present tense." "Yes. I will not commit suicide now."

"Say, and what's the difference for you between burnout and depression?" Another condition for admission to the program is checked off. The psychologist forgets to add that they don't offer a program for burnout.

"You're dry, right? People who are not dry can easily spoil the program for all of us." At the word "dry," my last bit of credit for her snaps. I'm not wearing diapers! I am not a child anymore, failing to see the connection between being "dry" and alcoholism.

How negligent someone's language can be! The whole setting is so uncaring! I'm pretty used to this kind of barrage-like conversations, but this beats everything. My heart screams. I am wearing my hauberk, even today, to armor myself, against the sadness that keeps coming up during conversations like this. Yet, touché! I feel myself shrinking.

The final condition for admission to the program is mentioned in a casual way: "If you get into the program, you have to stop all your other counseling." I don't know what I'm hearing. Discontinue? Abandon what has kept me going so far? Discontinue my aftercare program? Put an end to the course I'm on with the dietitian? Stop seeing my psychiatrist?! I am not willing to leave behind what I have built up so carefully in order to start a new program that seems increasingly flawed and insensitive.

I try one last time, not wanting to give in completely. "What, specifically, might a program have to offer me?" "We are your programs for anxiety and depression." I urge: "But specifically, what might the program have to offer *me*?" The psychologist's arrogant authoritative mask does not fail to fall off now. The examples she gives are themes they offer in the program, not themes that came up during our conversation. "A fail mark for personalization," my professor's brain thinks. "A lack of listening and empathy."

"Here's our brochure. Read it. You can then request a second interview. That's how we work here. At the time of the second interview, you must have formulated your objectives. We work with objectives here." A little bundle

of A4s is handed over. I notice two typos. Degraded language. That too. When the supervisor asks too amicably whether I am from West Flanders, I reply, "You obviously are too," using the one little weapon I have, pointing at her off-putting accent. I stand up and think: Never come back here again. A major unhelpful, disruptive disappointment. No empowerment. No shared decision-making. No comforting. No connection. No therapeutic relationship.

The stairs now, not the elevator. Clinically white. Fluff on the floor. My hands are shaking. I struggle with my bicycle lock. I ride home in a daze. In the garage, my rope. A noose around my neck. The noose tightened. This is what it would feel like. I shiver. Just for a moment. "Don't give in now. Be strong. There must be better times ahead. Not with the ropes of the children's hammock"¹.

Reflections and recommendations

At the time of the intake interview, I was suffering from a major depression, even if I was passed the worst stage. The intake conversation was stressful, and the surroundings in which it took place did not help. The room where I was received was not welcoming. When looking back at it, it was as if I was one of the objects that were additionally stacked into an already overfull room.

In my experience, intake conversations are among the most stressful ones. Complete openness regarding anything that is wrong is expected of you, even during a first-time meeting, whereas the interviewer holds the power over your care trajectory and your mind's recovery, assessing and judging you and deciding on the next steps to take. This is far more frightening than in somatic care as your brain and mind are not concerned there. The way I was treated felt dehumanizing and debilitating. It did not feel morally right. Being deeply depressed at the time, my attachment system was anything but secure, and my capacity to mentalize was negatively affected. Yet, this was not picked up by the interviewer. Surely, I myself must have been very successful at hiding my extreme lack of energy and my stress, putting on my academic face as I was being seen in an academic hospital by academically trained staff.

At the time of the interview, I had the expectation that I was going to be admitted to the program since my psychiatrist had made a phone call and I had an appointment. Yet, these expectations based on trust in my psychiatrist had blinded me to the hints the intaker may have given me: you are not getting in. At the time of the interview, I had not had the same experience with doors that remained shut or waiting lists. I expected to be admitted. My expectation had also been to be received by people who keep believing in the possibilities of mentally-ill people, who keep searching for means to regain power. I was used to good therapeutic conversations with my

psychiatrist, someone who understood that I had been deeply shocked in my trust in people and tried to meet me where I was with this lack of trust, with empathy and warmth. Also, as an academic, I wanted explicitness, explanations, and education. Yet, when asking what the program had to offer me specifically, and the intaker could not answer this question but kept repeating what the program had to offer, I again felt debilitated and left alone.

Before meeting the intaker, I had worked with many different clinicians and had experienced differences in diagnostic and therapeutic sensitivity and skills. I had come to realize that conversations with mental health patients can be very challenging and require patience yet directiveness, something at which some clinicians are more skillful than others. In retrospect, the conversation I had was very directive. My file, which had been read by the intaker, was used to make it clear to me that the program was not going to admit me unless I had overcome all my previous difficulties.

At the time of the interview, I did not understand what financial or policy reasons may have lain behind the recommendation to cut off all my other helplines before I could enter the program. I could not understand why it could be so difficult to pick up the phone and make appropriate arrangements so that both parties could take responsibility for part of my care trajectory. I still cannot see why patients would have to bother about competition between hospitals or healthcare professionals, or about financial incentives for hospitals and their repercussions on patient care.

I also could not see how the intaker's workload may have affected the way in which she treated me and the way in which she conducted the interview, namely as a routine rattling off of a preset batch of intake questions as mentioned in the intake form for new patients. I now feel she may have been caught in-between professional values, standardization, and busyness, and that this reveals the complexity of hospital-based psychotherapeutic practice and a diversity of ethical dilemmas regarding how much time to spend on which case and what results to come up with in order to live up to hospital expectations.

Yet, despite these conditions, patient-centered care requires taking account of patients' emotional reactions at all times, also and particularly when imparting bad news. I feel today's psychiatry is characterized by some chilling. In my eyes, empathy is anything but for wimps. It is the most important tool psychiatry has. With empathy, intakers can start the healing and recovery process. Empathy helps understand and helps heal. I believe many of us have experienced what it feels like to be empathically understood in a stressful situation and know how the sigh of relief that may follow from this can calm the nervous

system. It is my hope that psychiatric intake conversations can help patients to experience exactly this relief.

The personal report I have presented shows a patient who is deeply involved emotionally yet is able to consider her experiences with a certain degree of distance. Throughout the conversation, I felt a tension between the intaker and myself. The intaker appeared to perceive her role as gatekeeper to the program, whereas I wanted to enter it. The intaker's attitudes towards patient-centered care appeared not wholly favorable, making it difficult for me to become an active participant in the care planning process. It also seemed that she did not have the skills to engage in conversations that can lead to shared decision-making, using a by-the-book directive style of interviewing. When I presented my own medical file in an academic way and asked about what the program could bring me specifically, the intaker retained an impersonal stance and did not meet my attempts to become a participant in care decision-making. The intaker wanted to remain the expert on the program and the one in charge of the intake conversation, affirming her power over mine, and continuously reestablishing the power imbalance.

The philosophy of the patient-centered intake model implies that a proposal of treatment is not a take-it-or-leave-it proposal and that compromises can be sought.^{2,3} Yet, in this case, the program was to take or leave. Even the caregivers from previous programs were to disappear from my life. The intaker believed the program for fear and depression was evidence-based and therefore would be helpful as such. This unwavering faith in evidence-based medicine seems to have taken away any room for respectful human contact in which I felt safe and in which I did not feel reduced to my problem but felt seen as a whole person.

The philosophy of the patient-centered care model also demands that hope, even only a spark of it, is instilled in people. Mental health patients who have hope can see a bright spot to work toward. Offering hope starts with warmth and love for the patient, something that appears missing from the described intake conversation. I had hoped to meet an intaker that would show the same warm characteristics as some of the other caregivers I had met before. For me, continuity of care also meant feeling welcome, albeit in a new psychotherapeutic group or center, next to meeting people who had read my file and were knowledgeable about my mental problems. That the intaker had not instilled hope in me becomes clear from the end of my narrative where I report my suicidal thoughts. The intaker had failed to get in touch with me, to create rapport. She had not listened carefully enough, not shown enough understanding, not formulated carefully enough what she thought she heard me say. She had left me alone.

Conclusion

I now understand that achieving patient-centered care during intake conversations is not obvious, in part because the intaker has little time to get to know the patient and in part because the patient may defer from speaking openly with the intaker. Even when patients speak openly, as I did, the intaker, suffering from a heavy workload and holding attitudes that may not be wholly in favor of patient-centered care, may fail to establish sufficient rapport with the patient or instill hope.

In intake conversations, the intaker may well be the expert on the program offered and the possibilities offered by psychiatric and psychotherapeutic science, but the patient is the expert by experience because only she knows what certain aspects mean for her well-being. Both points of view are complementary and could complement each other perfectly if only caregivers allow patients to participate in the intake conversation. If the intaker and the patient manage to negotiate and work together from different but complementary points of view, one can achieve a patient-centered partnership in care, already during intake conversations.

References

1. Sercu L. (2022). You're not getting in. *Patient Education and Counseling*, 105(7), 2617–2618. <https://doi.org/10.1016/j.pec.2021.09.032>
2. Picker Institute. (1987). Principles of patient-centered care, 1987. <http://pickerinstitute.org/about/picker-principles>. Accessed June 9, 2022.
3. De Pinho L.G., Lopes M. J., Correia T., et al. Patient-centered care for patients with depression or anxiety disorder: An integrative review. *J. Pers. Med.* 2021;11,776. <https://doi.org/10.3390/jpm11080776>