A Primer for Psychotherapists

BEGINNING THE THERAPY

Kenneth Mark Colby M.D.

A Primer for Psychotherapists

Kenneth Mark Colby, M.D.

e-Book 2016 International Psychotherapy Institute

From *A Primer for Psychotherapists* by Kenneth Mark Colby, M.D.

Table of Contents

BEGINNING THE THERAPY

Psychotherapy begins in the first interview, with the patient talking, the therapist listening. When he does speak, the therapist confines his remarks to questions and other interpositions, withholding interpretations for another time. This technique is the pivot of the initial fact-finding process around which future developments will swing. An illustrative clinical example follows:

After mutual introduction, a young college girl seats herself in a chair the therapist offers.

Ther.: How can I help you?

Pt. (*talking rapidly*): I'm not sure myself. All I know is I've decided I've got to do something about myself. I've been reading some of those psychology books, and I can see myself on every page. I just think it would be a good idea for me to see a psychiatrist and get myself straightened out. Mother would die if she knew I was coming, because she doesn't believe in psychiatry.

Even though the therapist has not received an explicit categorical answer to his first question, note how immediately the patient begins to give valuable information about her relationship to her mother. Since the patient keeps talking, there is no need to interrupt at this point. She continues:

Pt. (*animated*): It's not that she's old-fashioned or anything, but she just thinks everybody has problems and the only way to solve them is by leading a clean life. Get lots of sleep, take walks, and don't worry about things, she says. (*Stops.*)

It is not clear why the patient should suddenly stop here. Two courses are open to the therapist. He can wait in silence until the accumulation of anxiety prompts the patient to continue or he can stimulate her to go on by asking a question. Every patient has some anxiety related to talking for the first time to a psychiatrist and hence the therapist at the very beginning is more active in questioning and in encouraging the patient to talk until she can gain some ease. In this case the therapist asks a question which relates directly to the patient's last remark and which at the same time serves a direct investigative purpose:

Ther.: What things do you worry about?

Pt.: Well, I don't exactly worry, but things upset me. Not school, I'm doing fine there. To be honest about it, I guess it's boyfriends. I can't seem to hang on to one very long, and I always wind up being hurt. Then I get in a tizzy and get all upset.

Ther.: What happens to you?

The patient then describes anxiety symptoms of palpitation, severe restlessness, nausea and occasional vomiting which she has suffered for several months. They precede and follow dates with boys to whom she is attracted but who she fears will lose interest in her and not return. The therapist asks a few questions about the onset and details of these symptoms. In doing so, he notices that the patient is making shorter and shorter answers, limiting herself to the topic of the question and waiting for the next question from the therapist to provide her specific material. The therapist, to avoid accustoming the patient to the idea that psychotherapeutic interviews are solely a question-answer process, tosses the ball back to her by asking a general question which prompts her to be responsible for selecting the topic.

Ther.: And what else is bothering you?

Pt. (*after a pause*): I don't know how important it is, but in the last few years I've been having trouble with my mother. It seems we're always arguing about something or other. Like today, she was giving me a bad time about coming in late last night. She thinks a girl should be home and in bed by eleven o'clock. You'd think I'd committed a crime the way she carries on when I come home late. With her nagging at me on top of vomiting all night, sometimes I think I'm going crazy. (*Visibly upset, weeps.*) Do I sound crazy?

Frightened and in a turmoil she seeks support from an authoritative source or parent-figure. The portion of a patient's ego participating in the therapeutic interview consists of an observing and an experiencing component, the former reporting on, and at times stepping back to evaluate, the latter. When the experiencing component becomes flooded with affect and thus expands to overrun the observing component, direct reassurance by words and manner should be given to alleviate the patient's distressing feelings and to provide room for the renewed participation of the observing component. Hence, as is characteristic for initial interviews, the therapist interposes by giving what the patient seeks at the moment and then shifts the discussion away from the affect- flooding topic of mother:

Ther. (*sincere, definite*): Not at all. This sounds like a common enough problem between most mothers and daughters —the old battle between generations. Now you mentioned boyfriends. Do you have a boyfriend currently?

Pt. (*somewhat relieved*): Yes, I've been going steady now with a fellow for about two months.

Ther.: Is he a student too?

Pt.: He's a chem. major. He's graduating this year, and then he's going to grad school.

Ther. (*again asking a general question to give the patient free rein*): What's he like?

Pt. (*faint smile*): He's very intelligent. And a good sense of humor. I wouldn't call him handsome, but he's not bad. His name is George. We like the same things, books and concerts. He has a car, and we go for long drives into the country when he gets off his job on the night shift.

She goes on at some length about the activities they share and their common interests. Now that the patient has regained some measure of control of her emotions and is reporting freely, the therapist can again attempt an approach to the loaded topic of late hours and mother. Of course, if he had sensed that the patient was still so shaken that such a move would produce another emotional upheaval, he would postpone the attempt until later, perhaps even until the next interview.

Ther.: And it's these dates with George that keep you out late?

Pt. (*now able to speak more calmly*): Yes. When we go for drives I get home about one or two o'clock. Mother hears me come in, I guess, and then the fireworks start the next morning. She's all questions—"What did you do? Where did you go? Why can't you get home earlier?" and so forth.

Ther.: She knows George?

Pt.: Oh, yes. I've had him to the house for dinner a couple of times. I think she likes him all right. I don't know why she worries so. I mean about being out late.

In this manner the psychotherapeutic interview proceeds —the therapist for the most part listening, occasionally questioning, and at times taking active steps to stem the overflow of affects which distress the patient and interrupt the fact-finding process. During the first one or two interviews the therapist has two aims: (a) to formulate from the facts gathered a working clinical and dynamic diagnosis and (b) to acclimatize the patient to the interview methods and procedure of psychotherapeutic work. The first aim determines the suitability of the patient for therapy and roughly the type of therapy which will be undertaken, i.e., mainly covering or mainly uncovering. The second aim has the more long-range goal of preparing the patient for the roles he and the therapist will take in future meetings. Let us now consider the problem of diagnosis and later the aspects of educating the patient.

Diagnosing the Disorder

To establish a *clinical diagnosis* we utilize psychiatric knowledge of symptomatology and personality structure in deciding first whether the patient's difficulties result from an organic, a psychotic, or a neurotic process. If the therapist feels that there might be an organic disease present, the

patient is first examined by an internist or neurologist before any plans for psychotherapy are considered. If the patient is psychotic, one may wish to make other arrangements for him, or one may feel that his ego functions possess sufficient reality sense to make him suitable for psychotherapy, (cf. Chapter 9.) The diagnosis of neurosis can be further though not sharply subpided into the usual categories, anxiety hysterias, obsessive-compulsive states, depressions, etc. Suitability for psychotherapy is not so much determined by the clinical label as by the factors discussed in Chapter 2 and by the dynamic diagnosis.

A dynamic diagnosis consists of an evaluation of the patient's current dominant neurotic conflicts, of those ego areas failing to cope with the resultant disturbance and of the intact ego functions attempting to reinstate an equilibrium. The formulation of the neurosis in terms of decompensating and compensating ego processes serves as a guide for therapy in selecting what aspects of the patient's personality will be touched and whether mainly covering or uncovering maneuvers will be attempted. A few clinical examples follow to illustrate dynamic diagnoses.

1. An unmarried girl for the preceding three years has suffered acute anxiety symptoms preceding and sometimes during dates with boyfriends. The symptoms have been of the same intensity until a few months previous to the interview, when they became markedly worse for no apparent reason. At other moments in her life she has no difficulty. She holds a responsible job, has many friends, and takes an interest in social affairs.

   She had grown up in an atmosphere filled with the shouts of arguing parents, who were finally porced when she was twelve. From then on she lived with her mother, who missed no opportunity to warn her of men's sexual greed and animal nature. Despite this indoctrination, the patient in adolescence became interested in boys and went through several secret crushes. During college years, when she was away from home, her symptoms began on her first solo date. Since then she has had many dates with different boys without amelioration of her fears.

   As a person she is intelligent, efficient, and businesslike. She is over-scrupulous about her personal appearance, becoming upset if a wisp of hair is out of place or her dress develops a wrinkle. Her friends tell her not to be so demanding in regard to punctuality, and they "kid" her about her rigid scheduling of all activities in both work and play. To her these qualities are not at all bothersome, in fact she is sure she would not like to be any other way.

The clinical diagnosis for this patient was anxiety neurosis in a moderately compulsive character. The dynamic diagnosis indicated the predominant conflict as centering around her sexual orientation to men. Though there was failure of her ego defenses in this area, the remaining areas seemed well compensated by reaction formations and other mechanisms. In therapy an approach would be made into the sphere of male relationships, leaving untouched her ego- syntonic compulsive character structure.

2. After serving for years as the mistress of a married man, a middle-aged secretary has become depressed when he finally said he could not marry her and returned to his wife. Symptoms of depression have continued for four years, with the patient losing interest in other men, hoping that one day her lover would return. This hope has been kept alive by correspondence with the man, who still likes her but feels that his first duty is to his wife and children. However, she realizes that her life cannot go on in this way, that she must seek new experiences if she is ever to marry.

Her childhood and adolescence had been characterized by a vigorous tomboyishness in an attempt to please both her father and her mother, who placed a premium on ruggedness and courage. In school she had competed successfully with boys academically as well as athletically. Only men who could outdistance her in every respect had had an appeal for her. She had met few of this type in her adult life until the married man who had had the affair with her.

In appearance she is quite feminine and alert. Though she often weeps, a smile at times shows up. She expresses no bitterness toward the man who left her; in fact she seems to admire him for his loyalty to his wife.

Clinically the picture is that of a neurotic depression. Dynamically the patient's conflict relates to the loss of a prized love-object, with a subsequent reversal of the repressed hostility. Instead of making a masculine identification to compensate for what she in childhood assumed to be a defect, she was seeking a certain type of man to increment her status. Therapy would first attempt to relieve the depressive symptoms by working in the sector of her reaction to the loss. Only much later, if the first maneuvers were unsuccessful, would a more extensive investigation of her conditions for love be considered.

3. A week before coming to therapy, a thirty-eight-year-old man had been discharged from the hospital after spending three months in recovering from an acute psychotic episode. His psychiatrist at the hospital had advised him to receive psychotherapy, and the patient is eager to prevent another breakdown. His memory of his thoughts and behavior in the

episode is vague, but laughingly he recalls one belief that he was Jesus Christ. In the hospital, another patient had interested him in a metaphysical cult whose ideas he feels are of great help to him.

Both parents had died while he was an infant, and he was raised by a grandmother until he was sixteen, when he began to support himself as a professional musician. As far back as he can remember he has been homosexual. All his affairs with men have ended after one or two experiences. He takes the passive role in the sex acts and enjoys the feeling of doing something for someone. He has no conscious conflict about his homosexuality, believing that it is the preferred way of life for a musician who is never in one place very long. His main interest is in philosophy and in systems of thought which explain the way in which people and the world behave.

The clinical diagnosis is schizophrenia. In a psychosis of this degree, with the shattering of multiple ego areas, it is difficult to isolate a predominating conflict, since so many wish-defense systems show severe disturbance. Certainly the patient's delusion and homosexuality point to his difficulties in a role as a man toward other men. If therapy (mainly covering; cf. Chapter 9) should be attempted in this case, it would cautiously endeavor to take advantage of his ego mechanism of intellectualization by encouraging his already roused interest in a religion, cult, or philosophical theory.

Acceptance and Declination

Upon establishing, usually after the first or second interview, working clinical and dynamic diagnosis along with an estimate of the patient's suitability for psychotherapy, the therapist proceeds to plan his future moves. Some patients he will at once decline to treat, some he will see for only a few interviews, and some he will select to treat for weeks or months.

Accepting a patient for psychotherapy presents few problems. Once the therapist decides to treat the patient, he makes some statement to the effect that he is interested in trying to help and outlines his plan as to appointments, hours, etc. An important principle at this point is that *the therapist does not promise the patient a cure.* In all honesty he cannot and should not make such a prediction. A psychotherapeutic working agreement is made on the basis that the therapist doesn't know yet whether he can relieve the patient but that he feels it is worth the effort to make an attempt. An example follows:

During the initial interviews a young artist whom the therapist intends to treat for a work inhibition asks:

> **Pt.**: From what you know so far, do you think you can get me over this inhibition?
>
> **Ther.** (*speculative but confident*): Oh, that would be hard to say definitely. Let's just work together for a while and see how it goes.
>
> **Pt.** (*wanting some assurance*): But you think there's a chance?
>
> **Ther.**: That I do. We agree the trouble is psychological, you want therapy, I'm interested in trying to help you. So let's start in with your painting. When did you begin painting?

The frequency of the interviews depends on factors in each inpidual case. Therapy which is mainly uncovering (dissolving defenses) requires interviews twice or even three times a week. Supportive and covering therapy (increasing defenses) can be accomplished at once-a-week or even less frequent intervals. As for the total duration of therapy, again such a prediction cannot reliably be made. The inquisitive patient is simply told this truth. Certain patients can be advised in general terms that therapy will be a long haul. For example:

Since the age of five a young man has suffered severe stammering. After trying all sorts of schools and speech methods, he seeks psychotherapeutic help. Intelligent, witty and of vigorous drive, he is eager to tackle and overcome his handicap quickly. However, the therapist realizes from other experiences that such problems require long and intensive effort.

> **Pt.**: How long do you think it will take before there are any results?
>
> **Ther.**: That's impossible to say. We'll have to see how it goes as we go along. But you should understand that it will be a matter of months and maybe even a few years. Don't let that discourage you. It's just that these things aren't solved in an hour or a week.

If the therapist is working in a clinic or on a service he plans to leave in a few weeks or months, he must in all fairness to the patient inform him of this fact when accepting him for therapy. Springing the news of departure two weeks before the event may be an unthinkingly cruel blow to the patient and needlessly complicate the work of the next therapist.

Declining those patients who the therapist feels are not suitable for therapy may involve a variety

of procedures. One is for the therapist to take the side of whatever conscious resistances the patient has to consulting a psychiatrist, as in the following examples:

1. A sullen and effeminate-looking man is referred by his physician after a routine physical examination. He sits silently and waits for the therapist to speak.

Ther.: And what brings you to see me?

Pt. (*somewhat annoyed*): I don't know. Dr. S. just told me I should see you.

Ther. (*acting puzzled*): But what for?

Pt.: I don't know. You'll have to ask him.

Ther.: What did you see him for?

The patient then gives an account of the physical examination he has taken in the process of obtaining a job in a restaurant. During the examination the physician has asked him if he is homosexual. He has affirmed this and been told flatly he should see a psychiatrist to get straightened out. He has obeyed the command, in order not to displease the physician and perhaps jeopardize his chance for the job.

Ther.: But as far as you are concerned, unless you had been told to, you wouldn't have consulted a psychiatrist?

Pt.: That's right. I don't think I need a psychiatrist. I'm all right the way I am.

Ther.: Well, I don't see any reason why you should come either. You're getting along all right. Why don't we leave it this way, that if anything comes up that bothers you, you can give me a ring? Otherwise let's let it go.

Pt. (*smiles with relief*): Okay by me. Thanks very much.

Ther. (*getting up):* You're welcome. Goodbye.

It was obvious from the patient's initial interview manner and appearance and from his referral story that he had a conscious unwillingness to see a psychiatrist. He wanted to keep his homosexuality intact. This was sufficient to make him at that time unsuitable for therapy. Hence the therapist simply agreed with the strong resistances and the declination was effected.

2. For many years a woman patient has moved from one mystical cult or esthetic fad to another in an

effort to find a viewpoint which would explain the meaning of life. Recently she has read of psychiatry and wondered if here she might fulfil her search. Also a friend has told her that she is neurotic and should see a psychiatrist.

Ther.: And do you agree with your friend?

Pt. (*a little ruffled*): No, I don't think I'm any more neurotic than anyone else. She's the one who ought to see a psychiatrist. My idea was only to learn more about psychiatry at first hand and compare it with semantics.

Ther.: It's really not my function to instruct people in psychiatry. My job is to treat people who are psychologically ill or upset. And this doesn't seem to be the case as far as you are concerned.

Pt.: I don't think I'm mentally sick if that's what you mean. I'm not so much interested in the treatment in psychiatry as in its philosophy, what it stands for.

Ther. (*frankly*): I couldn't be of much help to you that way. Your best bet would be to go to the various lectures being given around town and read some of the books on the subject.

Pt.: Where could I find out about them?

Ther.: Oh, you might try the Medical Center or get in touch with the Mental Health Society.

This patient's goal was not that of psychotherapy but of instruction. Her openly expressed resistance to the idea of psychotherapy was capitalized on in declining her for future treatment.

In cases such as the two just mentioned, the beginning psychotherapist should beware of trying to convince the patient that he needs therapy. It is a mistake, often a disastrous one, to break the patient down by showing him how badly off he is and thus frighten him into therapy. Also unwise is the attempt to lure the patient into treatment by promising him he will feel much better or get along with people more easily. Though there may be obvious clinical signs of a neurotic or psychotic disturbance in the patient, our knowledge of the personality as a labile equilibrium of checking and balancing wish-defense forces should correctly warn us often to leave well enough alone.

It may be more difficult to decline a patient unsuitable for psychotherapy who has no conscious resistances to treatment and who eagerly seeks help. Each case is an inpidual problem depending on its unique circumstances. Below are some examples.

1. Because he plans to marry a young woman who insists that he first overcome a sexual impotence,

a fifty-five-year-old man applies for help. He is intelligent, successful in his career and eager to do anything to prove to his fiancée that he will make a suitable husband. Impotent since his first attempt at intercourse at fifteen, he has always accepted it as an inevitable part of his nature. Though he has seldom felt much sexual desire, he has tried intercourse a few times in his life but has never been able to produce an erection. This handicap seemingly does not trouble him greatly, since he feels that the true test of a man comes in the business world, where he had proved himself more than adequate. Why he should decide to marry at this time is not yet clear.

His personality is that of a rigid and domineering compulsive character with extensive reaction formations and isolations. These defensive systems maintain his ego in excellent compensation, the only major symptom apparently being the sexual impotence.

The therapist feels that there is little hope of curing a forty- year symptom imbedded in such an inflexible personality structure and that it would be futile to attempt to dismantle such otherwise successful defenses. One possibility for therapy might be his decision to marry.

> **Ther.**: I really don't feel there is much chance of modifying your impotence. It's gone on for so many years now that it's pretty well fixed.
>
> **Pt.** (*disappointed*): I can see what you mean, but I want to get married and she won't have me unless we can have intercourse.
>
> **Ther.**: How is it that you've been unmarried all these years and now you suddenly decide to get married?

The patient with some hesitance tells of meeting his fiancée, a girl of twenty, in a bar about two months before. His friends tell him he is crazy to marry her, that she is after his money. He rejects this opinion, is determined to marry her, and even dismisses the therapist's remarks that he might want to discuss his decision further.

> **Ther.**: Well, I'm sorry I can't help you with the sexual problem. You might have some conflict over marrying this girl that we could work on but you say not.
>
> **Pt.**: No, I have no conflict. If you can't help the impotence, then I'll have to try something else.
>
> **Ther.**: Okay. Sorry I can't be of help.

2. When crossed by her husband, a woman patient who is no longer young has developed acute

anxiety attacks over a period of twenty years. During these spells she shrieks and moans, chokes up, fears she is going to die, and has violent heart poundings. After a small dose of phenobarbital and a few hours of solicitous bed care by the husband, she recovers completely. Her accusations that he has caused the attack by arguing with her produce sufficient guilt in her husband that he grants her some favor or gift. Although she is treated by her physician and husband as if she had heart attacks, she has always secretly recognized that these disturbances were psychological. A sister has convinced the patient that her attacks are psychological and has recommended psychotherapy.

After two interviews the therapist has gathered sufficient information to form the opinion that the patient is unsuitable for therapy. The secondary gains of the neurosis, an infantile personality, and a lack of psychological-mindedness combine to make the prognosis poor.

> **Ther.** (*doubting but not definite*): I'm not sure this kind of treatment will help you.
>
> **Pt.** (*protesting*): But don't you think that my trouble is psychological?
>
> **Ther.** (*agreeable*): Oh, yes. I agree with you on that, but I'm wondering if psychotherapy will relieve you.
>
> **Pt.**: Why won't it?
>
> **Ther.** (*now definite*): Well, there are several factors. First, your condition has been going on for a long time now, and it wouldn't be easy to get rid of. Then, this sort of problem takes weeks and months of work, and my feeling is that after a year we wouldn't be much closer to the root of your difficulty.
>
> **Pt.** (*upset*): But what am I going to do? I can't go on this way.
>
> **Ther.** (*reassuring*): Still, I think you do pretty well with these spells. You can get them under control with your medicine, and they soon pass. One suggestion I would have would be about these arguments with your husband. Maybe you could work on getting along with him and not let his stubbornness upset you. When you see an argument coming up, take a walk along the beach or go for a drive by yourself until you can cool down.

This simple advice was not given with the aim of changing her neurosis but (a) to reassure her that hers was not a hopeless situation and (b) to give her something to work on by herself by prescribing activities known to provide discharges of aggression and hostility. A psychotherapist must at times see clearly and admit to himself that there are irreversible psychological conditions which he can do little about.

3. A depressed and mildly paranoid woman of modest intelligence wants help for her spells of

gloominess and lack of interest. Her symptoms developed suddenly three weeks previously when her room-mate moved out to get married. As she looks around the apartment, happy memories of the room-mate crop up, accentuating her present loneliness. Though in the acute stage of a reactive depression, she does not appear suicidal. Her limited intellect and underlying psychosis influence the therapist to decline her for psychotherapy.

In the history he has noted that the patient has an older sister who has guided and comforted her in the past. Attempting (a) to get the patient away for a while from the actual scene which revives memories of the room-mate and (b) to provide a substitute source of a mother-child relationship, the therapist directs the discussion toward the sister.

> **Ther.**: At present I think what you need is to get away from here for a while. Didn't you say your sister lived in Los Angeles?
>
> **Pt.**: Right near there.
>
> **Ther.**: Why not go down and stay with her until you feel a little better?
>
> **Pt.**: I've thought of it but I'm not sure. She invited me to spend my vacation with her.
>
> **Ther.**: I'd go there. It will help you forget this trouble. In different surroundings you'll soon get some of your energy back.

Thus in declining to attempt psychotherapy with certain patients, it is often possible with the exercise of some resourcefulness to recommend environmental changes or to offer sensible advice. However, these suggestions should not relate to major decisions such as porce, having a baby, giving up a career, etc. If the therapist wishes to advise on such matters, he should have much more data than can be gathered in one or two interviews.

The Patient Learns

Previously I mentioned a second goal involved in the technique of the early interviews, i.e., accustoming the patient to the therapist's manner of working. This aspect of psychotherapy begins with the first meeting. If it is introduced correctly, the patient does not notice much difference between the therapist's role in the first diagnostic interviews and in the later hours of more specific therapy. The therapist may be slightly more active in questioning and in showing interest at first, later becoming more

of the quiet observer. Thus there is an easy transition from the initial diagnostic goal to the long-range goal of modifying neurotic conflicts.

Once the patient is being seen regularly, he soon learns many of the therapist's everyday methods and tactics. An important one concerns the situation when the patient falls silent. The therapist usually does one of three things: (a) asks him what he's thinking about, (b) asks him some other direct question, or (c) simply waits for him to continue. The principle underlying the therapist's choice among these devices will be discussed later (cf. page 103). Clinical examples of the three techniques follow:

Inquiring About Unspoken Thoughts.

The patient opens the interview with a few random details about what she has been doing the past few days, buying clothes, sunbathing, etc. She then stops talking. The therapist waits about ten seconds and then interrupts the silence.

> **Ther.** (*encouragingly*): Just say what you're thinking about.
>
> **Pt.**: I'm not thinking about much of anything. (*Pause.*)
>
> **Ther.**: Say whatever comes into your mind.
>
> **Pt.** (*laughs*): My mind is really a blank.
>
> **Ther.**: It may seem that way to you at first, but there are always some thoughts there. Just as your heart is always beating, there's always some thought or other going through your mind.
>
> **Pt.**: Your mentioning the word "heart" reminds me that the doctor told my mother the other day she had a weak heart.

And she begins to talk freely again. There is no discussion of the resistance involved (cf. page 95). As this point the therapist only offers an explanation to acquaint the patient with his wish that she report the thoughts which occur to her during the interview.

In another interview the same patient again becomes silent and the therapist repeats his encouragement.

> **Ther.**: Just say what comes to you.
>
> **Pt.**: Oh, odds and ends that aren't very important.

Ther.: Say them anyway.

Pt.: I don't see how they could have much bearing. I was wondering what sort of books those are over there. But that hasn't anything to do with what I'm here for.

Ther.: One never can tell, and actually you're in no position to judge what has bearing and what hasn't. Let me decide that. You just report what comes into your mind regardless of whether you think it's important or not.

Here the therapist has taught the patient a little "free" association, instructing her not to censor or dismiss thoughts. He knows that there is always some censorship taking place in every patient, and his aim is not to completely eradicate it but to accustom the patient to her responsibility of continuously providing material for his examination and consideration.

Asking a Direct Question.—The question relates to some topic other than the silence. This device requires little illustration.

After talking at length about his father's death a few years ago, the patient stops.

Pt.: I guess that's about all there is to it.

Ther. (*after a short wait*): And then what did your mother do for a living?

The patient learns that at times the therapist does interrupt a silence to gather information on some point which interests him.

Waiting for the Patient to Continue.—This technique, the patient soon discovers, is the psychotherapist's stock-in-trade. In contrast to social conversations, the therapist does not seem to be made ill at ease by a silence. This may puzzle or annoy patients, particularly those who equate the therapist's words with his interest.

During the third interview a woman falls silent. The therapist waits quietly for her to continue. She acts as if she were waiting for him to speak, and when he does not she becomes curious.

Pt.: Why don't you say something?

Ther.: I'm waiting to hear what your next thoughts are.

Pt.: What I'm wondering is why you don't talk more.

Ther.: I have to know a great deal about you before I can say anything that will be of help. So my job is to listen while you do most of the talking. Don't worry, when the time comes, I'll talk.

Another situation where the therapist is more frequently silent occurs at the beginning of each interview. One waits for the patient to begin with whatever topic he chooses, and then his lead is followed. If he is silent at the start, after a short wait the therapist can ask him what he is thinking about. Anxious or depressed patients may be somewhat inarticulate in the early stages of therapy, and with them one must patiently adjust to their slow pace while encouraging them to keep on voicing their thoughts.

When the patient becomes silent and notes that the therapist remains silent also, he may attempt to ease his tension by asking a question which prompts the therapist to speak.

At times the therapist answers, but often he does not. Not receiving an answer to a direct question may confuse or irritate a patient used to the give-and-take of ordinary conversation.

Seeing that the therapist is not going to break the silence of the past many seconds, a lively and intense matron poses an interesting question.

Pt.: I've often wondered why anyone would go into this business. Tell me, how did you get interested in psychiatry?

In this particular case the therapist wishes to do two things at this point: (a) introduce to the patient the idea that questions are dealt with like any other material in the interview and not necessarily answered and (b) open up the area of the patient's transference thoughts which he feels might be at the root of her resistance to talking. He waits and says nothing.

Pt. (*a little affronted by the seeming impoliteness*): Why don't you answer? Isn't that a reasonable question?

Ther. (*agreeably*): It is. But this isn't a question-and-answer process. If your thoughts come to you in the form of questions, we look on them as any other thoughts. This doesn't mean you shouldn't ask questions if they are on your mind, but I don't guarantee to answer them. For instance, in this case it seems that what is on your mind are some thoughts about me.

Pt. (*accepting the explanation*): That's right. I do wonder about you. You don't seem the sort of person I'd expect to find being a psychiatrist.

Ther.: Why not?

Psychodynamic Role of the Patient's Questions.—Before discussing further the technical problem of handling questions directed to the therapist, we must briefly consider the psychodynamic role of these questions in the interview. In the case cited above, for example, the patient's question was a defensive attempt to avoid talking about her feelings toward the therapist by making him talk instead. To perceive the dynamic function of a question, the therapist must (a) note the time when it arises and (b) look beyond the face value of the actual word content. Here are examples to show some underlying meanings questions may have.

1. The mother of two small boys begins the hour with an account of how their perpetual activity and bickering rivalry run her ragged. She has read all sorts of books and tried all sorts of tricks, but she can't seem to relieve the drain on herself. The boys run to her for every little need, and each constantly complains about the injustices suffered at the hands of the other.

As she proceeds to elaborate on how she attempts to settle arguments between her sons, she speaks more hesitantly as if a little embarrassed. Finally, with some reluctance and expressed guilt, she admits that she secretly favors the younger boy because he is more obedient and friendly. One of her child psychology books states that one sibling should not be favored over another and she asks for corroboration from the therapist.

> **Pt.**: That's true, isn't it, that a child can be emotionally harmed by being given less affection than his brother?

Here the manifest question concerns an opinion on child development. But the question behind the question relates to the patient as a mother. At the moment, experiencing the sting of her verbalized guilt feelings, she is really asking the therapist, "Do you think I'm a bad mother for favoring one of my sons over the other?" The therapist can then choose, depending on what he wishes to accomplish at the moment, and where the patient is in therapy, which of the two questions (the manifest or implied) he will deal with.

Answering the direct question could take the form:

> **Ther.**: Sometimes yes and sometimes no. One never can pide something like affections into exactly equal portions anyway. What do you notice in the older boy that worries you?

Or handling the implied question by bringing it out into the open could be phrased:

Ther.: What you are really asking is, "Am I a bad person for favoring the younger boy?"

2. A superior physics student is being treated for a marital problem. He and his wife repeatedly engage in fierce arguments over political, esthetic, or philosophical questions. All his life he has been a very argumentative person and has enjoyed it, but now his wife threatens to leave him unless he tempers his combativeness. Also in college he is getting into difficulties with his professors by challenging their opinions. One of them has even told him that he is overly aggressive and should see a psychiatrist about it.

From the beginning and for several interviews the patient has been friendly and eagerly cooperative, perhaps even a little over- compliant. He comes early for his appointments, calls the therapist "sir," and often apologizes for the irrelevance of the material he presents. In this interview he begins to talk of his interest in the field of psychology. He has read and discussed the subject a great deal with friends. Once he has considered changing his major from physics to psychology. However, he finds he cannot agree with many of the concepts in psychology, especially those of a psychoanalytic nature. He asks:

Pt.: Take the unconscious mind, for example. What do you believe? Do you think there is really an unconscious?

The face value of the question concerns the validity of a scientific concept. Its true psychological meaning concerns the patient's relationship to the therapist. We see in this intellectualized provocativeness the beginning emergence of the patient's competitiveness with the therapist. Cautious at first, he is now sounding out his rival's ground in preparation for the eventual struggle so typical for his personality.

3. A combat veteran one day begins the hour by asking the therapist at what ages cancer occurs. Offhand the therapist cannot in his own mind connect the manifest question with anything specific he knows about the patient and hence cannot immediately arrive at the implied question. He proceeds:

Ther.: Cancers occur at all ages, but mostly in older people. Why do you ask?

Pt.: My mother wrote me last week that a friend of mine, only thirty-eight, died of cancer. We grew up together and were in the army overseas together. A swell guy. It seemed awfully young to me to be dying from cancer. She

said he had a cancer of the intestines.

Now the therapist suddenly recalls that for many months after his discharge from the army, the patient suffered symptoms of a recurrent amoebic dysentery. Occasionally nowadays he has slight diarrhea. Behind the request for factual information, perhaps he has a fear that he has or will get cancer.

Ther.: Have your bowels been acting up recently?

Pt.: Not especially. But you're on the right track. When I had that dysentery, I used to think maybe I had cancer. Sometimes nowadays when I get an ache or pain, it flashes into my mind: "Maybe I've got a cancer."

The implied question, guessable but obscure at first, now becomes clear. He is really asking, "Could I have cancer at my age?"

Returning to the therapist's ways of handling questions which become familiar to the patient, it is obvious that the therapist shows elasticity, at one time answering the manifest question, at another time remaining silent or touching on the implied question. Speaking generally, in a mainly uncovering therapy the therapist is more often silent or refers to the implied question while in supportive or covering therapy direct questions are more often answered or dodged. An example of the latter follows:

It is characteristic for this determined though phobic school teacher to flood the interview hour with a Niagara of direct questions. As therapy has proceeded, she has become accustomed to having a few of them unanswered, but she insists on responses to the majority of them. The therapist has learned that unless her desires are followed in this respect, she feels mistreated and lapses into an angry silence which is difficult to overcome. Wishing to avoid these silence barriers, the therapist answers and dodges until he can direct the discussion into other channels.

Pt.: And then I worry about getting pregnant. You're a doctor, you should know whether a diaphragm is safe. Do you think I have reason to worry?

Ther.: From all that I know a diaphragm is supposed to be the best contraceptive. But I'm really no authority on these things.

Pt. (*rushing on*): Well, could someone get pregnant even when they used a diaphragm? Supposing it didn't fit any more? Are you sure a diaphragm is all right?

Ther.: No, don't take my opinion as the most reliable one. If you have all these doubts, why don't you see your regular doctor?

Pt. (*ignoring advice*): Why can't you tell me? This isn't a silly fear like some of my other ones. You know once I did get pregnant and had to have an abortion. Boy, that was a rough time, I don't want to go through that again.

Ther. (*quickly*): What happened?

The therapist sees a chance to switch the patient's attention to a historical event, thus escaping temporarily from the barrage of questions and also exploring some of the patient's past experiences connected with her pregnancy fears.

Handling Personal Questions.—One type of direct question the patient may learn to give up (again there are always exceptions) is that referring to the therapist's private life. In this area perhaps more than any other, the therapist, wishing to allow transferences to develop on a minimum factual basis, is silent or evasive. However, beginners in psychotherapy often have difficulty in gracefully meeting such direct personal questions. For that reason the more common personal questions and possible ways of handling them are listed below. As with other questions, the therapist first takes note of their timing and of their underlying implication.

Age. Patients often are curious about the therapist's age, especially if he appears younger than they. Thus a typical question early in therapy is:

Pt.: Doctor, how old are you?

Again we have (a) the manifest question requiring a numerical answer and (b) the implied question requiring some statement as to the therapist's experience. Suggested answers are:

a) **Ther.**: Twenty-eight. *(Waits tor the patient's response— disappointment or satisfaction.)*

b) **Ther.**: Old enough to assure you you won't be a guinea-pig. [or] Perhaps you're worried about whether I've had enough experience to treat you.

With personal questions the therapist may decide simply to answer a few of them and then wait to see what the patient's next remark will concern, as in the next category.

Training. As in the situation with age, the patient is often asking about your ability to help him or measuring you by the places you have been:

Pt.: Where are you from, doctor?

Ther.: Chicago.

Pt.: Is that where you went to school?

Ther.: No. I went to college and medical school in New York.

Pt.: And where did you get your psychiatric training?

Ther.: In Boston and here in San Francisco. But it seems you are very curious about my background. Why do you think that is?

Pt.: I guess I want to make sure I'm in good hands. My father once had a doctor who knew from nothing and as a result now one of his legs is shorter than the other.

Ther.: How did all that happen?

Here we see that an important event in the patient's life is connected with his question.

Marital Status. A favorite question of women patients who consciously or unconsciously see the therapist as a potential mate is the following:

Pt.: Are you married?

Ther.: Why do you ask?

Pt.: Just curious. You don't have to answer if you don't want to. (*After the therapist remains silent.*) My guess is you're not married. Because if you were you'd say so. Since you're being defensive about it, it means you're not married, but afraid to say so.

Ther.: And if I'm not married, what then?

Pt.: Oh, then I begin to wonder why not. Maybe you're shy with women. Or maybe some woman gave you a bad time.

It is noteworthy in this example that the therapist in reality is married but allows the patient to continue her guess that he isn't in order to investigate her subsequent transference fantasies.

Political or Religious Beliefs. Patients often want as a therapist someone whose opinions in political and religious matters come close to their own. If the therapist is like them, they feel strengthened and reassured. If not, they may use the difference to block or interrupt the therapy.

Pt.: Now before we go any further with these treatments, doctor, I'd like to know whether you believe there is a God.

Ther.: Why?

Pt.: As I've told you, I'm an Adventist, and I wouldn't feel right about bringing my troubles to a psychiatrist who's an atheist. I don't care what your religion is as long as you're not Godless. Just tell me if you believe in God, in a Supreme Being.

Ther. (*candidly*): No, I don't.

Pt.: Well, then, I have no choice but to see someone else. Is that all right with you?

Ther.: Sure, in fact I think it would be better for you to see someone you had more confidence in.

In such situations, infrequent as they are, the therapist comes to a point where he must face the issue of the direct question, answer it, and await the consequences.

How Patient Regards the Therapist's Questions.—While on the subject of questions, let us consider how some of the questions the therapist asks may ring in the patient's mind. When the therapist poses a question, two sets of ideas often occur to the patient. First are those thoughts which specifically answer the question and second, wonderings about why that particular question is asked at this time, i.e., what line of thought the therapist is taking. This line of thought, once understood, becomes very important for the patient because he assumes (and by and large correctly) that this direction is psychotherapeutically a worth-while one, promising in the long run relief of symptoms or an increased understanding of himself.

1. A lively young woman is being treated for an obsessional murderous thought and frequent migrainous headaches. In the third interview she has spent much of the time describing events of the week end. Saturday she lunched with friends and spent the afternoon shopping. That evening she went to a party but soon after arriving noticed the typical beginning of a headache It didn't turn out to be very severe and was gone by the following morning.

She then changes the subject to her plans for the following week end, when she intends to go to the mountains. As she prepares to describe this trip, the therapist interrupts:

Ther.: You mentioned a few minutes ago that Saturday afternoon you felt fine, but at the party in the evening you had a headache. Tell me what happened between those times.

Pt.: Nothing special that I can think of. I went home, talked to my girlfriend for a while, got dressed. Oh, yeah. Here's something. Jack was late in picking me up that night, and we had a squabble about that.

Ther.: Could you enlarge on the squabble? Give me the details.

By the use of interpositions the therapist focuses attention on an interval between states of well-being and a pain, with the implication that perhaps something occurred which could be connected with the development of her headache. Once a significant event is discovered, he holds the patient in this area by showing interest in it and requesting further information.

2. The therapist knows that a major childhood experience of an intelligent though wayward adolescent boy was the death of his father when the patient was eight. In the fifth interview the patient describes his feelings of inferiority in competitive sports, especially baseball, which his friends play and follow enthusiastically. He is puzzled about the lack of ability, because in other physical activities he is well coordinated. His main difficulty in baseball is ball-shyness, fearing a hard ball coming directly at him. As far back as he can remember, he was frightened of a ball approaching him. The therapist asks:

Ther.: As a boy, did you play catch with your father?

Though at first this might seem to the patient to be an irrelevant question, it is of a nature which will arouse his curiosity as to what the therapist is driving at. Evidently the therapist by his question is linking "father" with "ball fear." The question implies, "Let's look here, maybe we will find something to help you."

The Psychotherapeutic Atmosphere.—Finally, the way questions, both those of the patient and those of the therapist, are handled in the interviews gives psychotherapy an atmosphere unique in human relationships. The patient gradually learns that his therapist is interested in examining and studying his mental processes without formulating whether they are good or bad, right or wrong, normal or abnormal. Even though in his own mind the therapist may deem some thought or behavior as psychopathological, he seldom says so, realizing how often nowadays "neurotic" means "bad" and that because "bad" means punishment, it is hidden or censored. The therapist wants the patient to present as much as possible about all of his thoughts and behavior and not select them for scrutiny on the basis of his own value systems.

In the beginning of therapy a housewife mentions that she does not like to stay at home alone at night. If her husband is away for a few hours, she visits friends or has friends visit her. Too, if she must be alone in the house she makes sure that the doors and windows are locked. This problem interests the therapist, who wishes to explore it further but meets resistance phrased in a manner common among contemporary patients.

Ther.: And what do you feel it is that makes you uneasy when you're alone?

Pt. (*evasive*): I don't know. Some sort of vague anxiety.

Ther.: But about what?

Pt.: Well, that someone might break in.

Ther.: A man?

Pt. (*lightly*): Sure, that's it. But I don't see anything abnormal about that. All the women I know don't like to be alone at night. I don't think I'm different from anybody else in that respect.

Ther. (*explaining*): But you see, here we're not interested in whether it's normal or abnormal, common or uncommon. We're trying to understand how your mind works, regardless of whether it's like others or not. For instance, sure, lots of women have this fear, but let's see what it means to you. What are you afraid will happen if a man breaks in?

This patient makes a pision between what is normal (like others) and what is neurotic (unique) about herself. She then feels that whatever is neurotic should be discussed in psychotherapy, while what is normal can be pushed aside as nonsignificant. By his questions and remarks, the therapist attempts to teach the patient that in their meetings he wants to hear every aspect of herself, whether she feels it is pertinent or not.

When the therapist successfully communicates this non- judgmental attitude, the patient can become accustomed to the idea in therapy that to discuss, study, and understand something in him is not synonymous with condemning it. Once an attitude of his is worked through in this manner, he is free to choose then whether he wants to change it or keep it.

The Therapist Learns

In the beginning stages of therapy, while the patient is getting used to the various educational

conditions of the interview, the therapist is busy learning as much as he can about the patient. The therapist allows him to talk freely about whatever he is interested in telling. Once working clinical and dynamic diagnoses are established, the therapist listens for further data on those leading neurotic conflicts which he will eventually make the main precinct of interpretations. He tries to get a clearer picture of the patient's presenting difficulty in reference to past and present interpersonal relationships and in terms of compensating and decompensating ego functions.

Much of what the patient says at first may be a mystery in that you can't immediately see its relevance to his symptoms or problem. But this is quite natural and happens to veterans as well as to beginners in psychotherapy. "No man can hope to understand all that he daily beholds." This is because the patient never states the conflict directly or in so many words. Part or most of it is hidden from himself. It is only from the patient's verbalized allusions and approximations to his un- or preconscious conflicts that the therapist is able gradually to formulate their nature and extent.

In selecting the sector intended for therapy, the therapist pays particular attention to certain data, e.g., the situation coincident with the onset or exacerbation of symptoms, transference references, fantasies, dreams, and the patient's characteristic resistances. Each of these areas is a key source of information providing material enabling the therapist to understand and eventually interpret the underlying processes. Since we choose a sector of what the patient produces and let the rest go, the subsequent interpretations will be planned in the main to pivot around this sector.

Rather than having difficulty in clarifying the interpretable sector, the beginner may have more of a problem in restraining his eagerness to interpret something the moment it is glimpsed. That something is seen by the therapist does not automatically render it fit for interpretation. As is shown by the clinical examples thus far mentioned, the therapist's remarks in the beginning stage consist of interpositions (questions, explanations, advisory suggestions, etc.) rather than interpretations (confrontations with what is being warded off).

Also one must guard against a tendency to squeeze the patient into a prematurely formulated theory or even sometimes to fit the patient into a theory one is currently reading about. The chief activities of the therapist in these early interviews are listening and occasionally questioning. Even the

questions should be limited and not too numerous, so as to avoid muzzling the patient's spontaneous remarks. It is true that at times the therapist must give reassurances or perhaps point out something to the knowledge-hungry patient just to keep the therapy going for a few more interviews until more extensive interpretations can be made.

Finally, beside learning of the patient's life experiences and how they bear on his central conflicts, the therapist soon gains an acquaintance with how the patient describes things. His typical words and phrases used in communication give you an opportunity to develop a common, quasi-private language together. This shared idiom allows the therapist short-cuts in phrasing interpositions and interpretations by knowing what certain words and images convey to the patient.

Drugs and Relatives

Among the manifold problems requiring direct action on the part of the therapist, two situations occurring most often in the beginning of therapy merit attention. They are (a) when the patient requests a prescription for drugs and (b) when friends or relatives wish to consult the therapist.

Drugs.—Some patients entering therapy are already taking drugs, usually Benzedrine or barbiturates, prescribed by another physician. Others ask for drugs from the therapist to relieve their symptoms. In supportive or covering psychotherapy, small doses of drugs may be an expedient aid to the rallying of old healing defenses (repression, isolation, etc.). But in a mainly uncovering therapy, drugs must be avoided unless some pressing emergency arises. The therapist can frankly indicate his stand to the patient.

Losing sleep because he fears that when he lies down at night his throat might close off, a young patient with an anxiety neurosis has been taking Nembutal occasionally. In the third interview he asks for a prescription.

> **Pt.**: Dr. T. gave me a prescription some time ago for sleeping pills, and now I've run out. I was wondering if you could give me another one.
>
> **Ther.**: How often do you take them?
>
> **Pt.**: Once or twice a week my fear will keep me awake for a couple of hours, then I take one. It usually puts me right to

sleep.

Ther.: I'd rather that you try to get along without them.

Pt.: Why is that?

Ther. (*definitively*): We agree that your anxiety is something purely psychological. For a psychological illness the best treatment is purely psychological. These sedatives are only a temporary crutch. Let's try it without them. If it doesn't work out we can always reconsider it.

Most patients taking drugs before therapy, except the true addicts, of course, can soon abandon them. Sometimes at the beginning of psychotherapy when the patient genuinely suffers from prolonged painful tension or severe insomnia, sedatives can be prescribed as an emergency measure. In the course of therapy drugs should not be given unless the therapist feels there is a real crisis at hand.

Relatives.—Friends or relatives of the patient can be a mixed blessing. In supportive work they may be vital factors in manipulating situational improvements. At other times they may consciously or unconsciously undermine therapeutic efforts.

No friend or relative of the patient in therapy should be seen by the therapist without the spoken knowledge and permission of the patient. If the patient objects, then the relative cannot be allowed a visit. If the patient agrees, then the relative should understand that his conversation with the therapist will be reported to the patient. These requirements often are sufficient to discourage potential meddlers. The following telephone conversation between relative and therapist is typical:

The pleasant voice at the other end of the line belongs to the mother of a thirty-two-year-old man who has often bitterly complained to the therapist that his mother always tries to interfere in his affairs.

Mother: Doctor, I'd like to have a talk with you about Peter.

Ther.: Yes, I could see you. But I would have to talk it over with him first to see how he feels about it.

Mother: But that's just what I don't want. If he knew about it, he'd have a fit. Couldn't I see you without him knowing about it?

Ther.: I'm sorry, no.

Mother (*voice now not so pleasant*): Well, I must say that's a rather high-handed attitude. After all, I'm his mother and not a stranger.

Ther.: I'll discuss your call with Peter next time.

Mother: I know he won't agree, so let's forget it.

Even such phone conversations should be mentioned to the patient. If a relationship of trust is to develop between patient and therapist, the therapist must be prepared to demonstrate that he is straightforward and honest in his attempts to be of help to the patient.

An Illustrative Series of Interviews

A condensed account of the first four interviews of uncovering psychotherapy in a clinical case is now presented to illustrate some of the principles outlined in this chapter. The therapist's thoughts and observations accompany the patient's remarks.

First Interview.

The patient is a twenty-six-year-old businessman referred to the psychotherapist because of anxiety symptoms. After the introduction and seating, the therapist begins:

Ther.: Well, where shall we start?

Pt. (smiling but uneasy): I'm not sure. Perhaps I should go back a little to when I got these stomach things. They came on about six months ago. I was working hard and had a lot on my mind. I began to notice sort of a clutching sensation in the pit of my stomach, like something had suddenly clamped tight. I went to the doctor and he advised X-rays to look for an ulcer. The X-rays . . . .

The therapist allows him to tell his story. He begins with his physical symptoms, describing at some length the medical processes involved in establishing that he has no ulcer or other physical disease. In appearance he is an alert, friendly young man in a good humor.

Pt.: . . . so then I realized it was all emotional. I half suspected it at the time because I was under a lot of pressure. (*Stops.*)

Ther.: From what?

Pt. (*face serious*): The job, for one thing. There's a lot of politics in that office. I'm trying all the time to keep the different factions happy. And one or the other side is usually mad at me, thinking that I'm favoring the other one.

Ther.: What do you do?

This is a general information question. The therapist postpones for the time being further investigation of the "pressure" the patient connects with his symptoms. For a while the patient's job is discussed. He is able, successful, and ambitious. He had a college education before he entered the firm he now works for and has enjoyed several promotions. All this the patient reveals freely, at times laughing and joking. Now he is a little more at ease in the interview, perhaps because the topic is one he likes to relate and the therapist seems interested. But looking for data more directly pertinent to the symptoms, the therapist switches back to the earlier point.

> **Ther.**: You said you were under a lot of pressure when this began. Anything else besides your job?
>
> **Pt.** (*immediately loses some of his gaiety*): Yeah. I think even more important than the job is the trouble at home. My wife and I have our little spats like any other couple. But it's more than that. We can't seem to get together on our sex life.

He then tells of his marriage three years ago. His wife is from a similar New England background hut seems never to have overcome many of her fears and dislikes of intercourse. He feels he is of an affectionate nature and likes to have intercourse every day while her desire emerges only two or three times a month. It is when they argue over this matter—she accusing him of being oversexed and he accusing her of being frigid—that his stomach spasms and anxiety develop. During this account he looks angry and bitter. The therapist notes to himself for future reference (a) the wife as the important object relationship, (b) the high frequency of the patient's desired sexual activity, and (c) the stomach as the organ most affected by his anxiety.

> **Pt.**: . . . and I'm convinced that unless we can work this out I'm going to leave. Maybe she should see a psychiatrist, too. I don't want to leave her, she's everything I want in a wife outside of this sexual thing. She's attractive, intelligent, on the ball. But we can't go on this way.
>
> **Ther.**: How did you meet her?

Now gathering historical information on this important interpersonal relationship. The therapist does not subject the patient to the "routine psychiatric history" process but takes each item as it arises and, if it appears significant, explores it briefly.

In telling of meeting his wife and the courtship, an interesting fact comes to light. Before he was married, he was a heavy drinker but only after working hours. Each night he would go out with friends

to bars or night clubs and get drunk. He told his girlfriend, later his wife, that he didn't want to get married just yet. But one night he passed out and on coming to found himself in jail charged with disorderly conduct. This scared him so much that he decided he must settle down with a more stable life and hence the next day he proposed marriage.

Ther.: And was the sexual problem present from the first?

Pt.: Oh, yes. Even before we were married we tried intercourse and I knew she had trouble enjoying it. But I thought she would get over it as time went by.

Thus it becomes evident that there is more to this situation than sexual incompatibility. He married her, knowing fully about her frigidity, in order to solve some internal problem till then being warded off through alcohol.

By this time the end of the hour is drawing near and the therapist wishes to arrange further appointments.

Ther.: Well, our time is about up. You understand I can't say very much about all this right now.

Pt.: Do you think you can help me?

Ther.: (*smiling*): I'll certainly try. But let's work along a little further to see how it goes. Could you come again Friday at this time?

Pt.: Okay. Fine.

Ther.: For the time being let's talk Tuesday and Friday at this time. If these times don't work out we can consider some other arrangement.

The tentative clinical diagnosis is anxiety neurosis. There is no evidence of a physical disease or psychosis. As yet the information is too meager to clearly formulate a dynamic diagnosis, but the therapist already feels that the patient is suitable for psychotherapy because of his age, intelligence, reliability, interest, and psychological awareness of a connection between his symptoms and a life problem which he is able to verbalize.

Second Interview.

He arrives early. The interview begins with the therapist waiting for him to speak.

Pt. : Where shall I start, doctor?

Ther.: Anywhere you like. (*Immediately leaving the patient to choose the topic.*)

Pt.: I like this idea of talking over my problems. During the time I was telling you about, when I drank so much, I sometimes thought to myself, "You're all screwed up, you should see a psychiatrist." But I guess I didn't have the courage.

Ther.: Now that you can look back on it, why do you think you did drink so much during that period?

Pt.: You've got me there. One thing it does is relax my stomach.

Ther. (*interrupting*): You mean your stomach spasmed at that time?

Pt.: Off and on. I guess it's come and gone for years. Nowadays it's the worst it's ever been. In those days I didn't know why it was acting up. Didn't even know my wife then. H'mph (*surprised*). That's odd, never thought of it until just now. I had stomach trouble six or seven years ago when I was going to school. That's when my drinking began. I started going out with the boys for a beer, and soon we were getting blotto every week end.

Here the therapist finds partial confirmation of his conclusion in the first interview that something was upsetting the patient before his marriage.

Pt.: I enjoyed those times. It was the feeling of freedom, or doing whatever the hell I wanted to. For the first time in my life nobody was checking up on me. That's what I couldn't stand about home, a feeling of restriction.

Ther.: Your parents kept close watch over you?

Pt.: (*vehemently*): And how! When I was seventeen they still treated me like a child. I couldn't go out at night unless I told them where I was going, who I'd be with, etc. My mother especially, my father didn't care too much.

With the introduction of home and parents into the discussion the therapist then asks a few questions about them. Summarizing, both his parents were teachers and he was their only child. Of moderate income and social position, the family lived comfortably and quietly in a large city As he talks now, he emphasizes his father's fanatical pursuit of physical culture and his mother's peevishness. The therapist returns to the patient's drinking, seeking further information for a dynamic diagnosis. He restates the patient's own judgment.

Ther.: So one thing in the drinking was feeling independent?

Pt.: And the comradeship. It was fun. We'd have big bull sessions and talk for hours.

Ther.: What do you connect your stomach troubles with at that time?

Pt.: Another thing that relaxed me at times were day-dreams. One especially about meeting a woman somewhere and getting together with her.

He avoids the question as if he hadn't heard it. Why this reluctance? His anxiety related to being with other men? His mind jumped to having an affair with a woman. His heterosexuality exaggerated as a defense? The therapist lets this evasion go by without comment. Now comes a fantasy, always a fruitful source of revelation.

Pt.: . . . though actually I don't know if I'd carry it out. I've had chances to shack up with several women but somehow it never works out.

Ther.: What sort of woman do you think about?

Pt. (*laughs*): Well, that's an interesting thing. It's always a large, big-breasted woman-of-the-world type—a little older and more experienced. She would be my mistress, though, not a wife. She's just the opposite of the way my wife is. She'd be sort of motherly. My wife isn't at all affectionate that way. She's a cold fish. When I come back from a business trip, she says hello as if I'd just gone down to the corner to mail a letter. That's why I like to get away at times. Escape both the office and home. And I enjoy traveling. It gives me a feeling of importance to travel on some important job. I know things center around me, that I can do a good job.

The fantasy and his associations to it show in terms of object relationships, his wish for a mother, and the frustration of this wish in his relationship to his wife. In structural terms, his ego fails to successfully deal with passive-receptive wishes, though the sublimations and compensations found in his work do bring gratification. At this point then, the dynamic diagnosis would formulate his chief neurotic conflicts as revolving around dependency on wife and mother and possibly fears of this passive orientation in relation to men. Since the symptomatic process is only of a few years' duration and the patient is young, pliable, and "psychologically minded," it is worthwhile to attempt an uncovering therapy which will endeavor to make conscious some of these unconscious factors.

Since the time is up:

Ther.: Okay. Let's stop there for today.

Pt. (*arising*): Should I write down things during the day for you to read? Maybe you could find out more about me than by just what I say here.

Ther.: No, that isn't necessary. See you Tuesday.

Third Interview.

As the patient enters he takes off his suit coat and hangs it on the back of his chair. This is an important observation for the therapist, since he himself does not wear a suit coat while working. The patient's first remarks also constitute a transference reference.

Pt.: Is this psychotherapy I'm getting?

Ther.: Yes. What interests you in that regard?

Pt.: The other night I was talking with my friends about the difference between psychotherapy and psychoanalysis, and none of us could get it very clearly. I know in psychoanalysis the patient lies down. And I see you have a couch. Do you want me to lie down?

Ther.: No. We can work along this way for the time being.

Perhaps he wants to lie down (be in a more submissive position) and in preparation for it took off his coat. The therapist awaits the common question as to whether he is an analyst or not.

Pt.: Do you use psychoanalysis in this clinic?

Ther.: No, but we call it psychoanalytic psychotherapy. That is, we look at things from a more or less psychoanalytic viewpoint.

In answer to the testing-out questions, the therapist gives simple explanations, by-passing the underlying significance of the questions. The patient returns to describing his symptoms.

Pt.: My stomach is just about the same. The other day on the bus I really noticed it. Like a vise gripping me in the pit of the stomach. I was sweating a little and felt uneasy. Nothing I could think of on the bus upset me. It comes on like that sometimes, out of the blue. What do you think it could be?

Ther. (*shrugging*): Oh, I don't know. It sounds like a little spell of anxiety that comes and goes.

Pt.: I know I feel anxious during it. Sometimes I can feel my heart beating, too. What scared me at first was the idea that I had something really wrong. Like an ulcer or maybe appendicitis.

At this stage in the interview the patient seems preoccupied only with his bodily symptoms and in elaborating on them. He does not continue into his past or present life experiences. That plus the glimmering of transference phenomena indicated at the start of the hour signify to the therapist the presence of a force beginning to impede the desired course of therapy (cf. page 95 for further discussion

of resistances). Again this is not pointed out to the patient. The therapist waits until a key word or phrase appears in the patient's comments which will serve as a springboard to a topic away from symptom-rumination.

> **Pt.**: . . . but when I told my wife that I had an ulcer, she just laughed. I looked up ulcers in a medical book and found that there was some comparison.
>
> **Ther.**: Your wife didn't take you seriously?
>
> **Pt.**: She never thinks I'm sick. If I tell her I have the flu or don't feel well, she passes it off as if I were just complaining. But when she's sick you'd think she was dying. She's always getting sick with this or that.

Now the patient's attention is away from his symptoms and on his major interpersonal relationship. The therapist holds him there by asking several more questions about his wife, helping the patient to unfold more and more of his feelings about her. Soon the intercourse problem enters the discussion and something of the patient's past sexual life is learned. In late adolescence he began sex play with a girl his own age. For several months they met three and four times a day for kissing, petting, and mutual masturbation. Fearing pregnancy, she would not permit intercourse. This high frequency of sexual activity gratified him immensely. He had several ejaculations a day and never seemed to tire of it. During the sex play his accompanying fantasies were of intercourse, mostly with the girl but often with the worldly woman of his day-dreams. Wondering about a temporal sequence, the therapist asks:

> **Ther.**: And is this when your heavy drinking began?
>
> **Pt.**: No, the drinking came later. I fooled around with this girl when I was eighteen. The drinking started when I was nineteen or twenty.

The therapist has in mind that the hyper-sexuality, being not truly on a genital level of development, not only gratified some impulses but also served defensive purposes similarly to the heavy drinking.

Fourth Interview.

Today he looks a little more uneasy than last time. He immediately lights a cigarette.

> **Pt.**: Tell me, what did you think of the Kinsey report?

Ther.: Or of more interest, what did you think of it?

Pt.: It was a comfort in one way. Especially the figures on masturbation. And the part about homosexuality. I never realized how many men had such an experience. I must admit I've worried whether I've had any homosexual trends. (Voice shaky.)

Ther. (*matter-of-factly*): Why?

Pt.: I've read about men who become homosexual when there are no women around—like in prison. I've thought that, since my wife wants so little sex, maybe it would drive me in that direction. I knew a guy once who was homosexual. lie was a classmate in college, brilliant guy. He was very open about it. We used to talk about it a lot. He claimed homosexuals were a persecuted minority' and someone should go to work on this prejudice like the work being done on anti-Semitism. That's something I have fights over with my father. He's a real reactionary. Why, he even thinks that labor leaders should be shot.

Having for a moment faced his anxiety about homosexuality, he now skitters away to a less tension-evoking topic, though the therapist notes that it concerns his difference from his father. It is too early in therapy, with the transference undeveloped and the patient too scared by the subject's significance, to force prolonged exploration of homosexual pathways. The topic will crop up again directly or indirectly in subsequent interviews.

Continuing to relate his father's social and political views, he soon approaches his struggles in breaking away from what he felt was a severe parental constriction and domination. The clash of children and parents is a subject the therapist listens to very attentively, knowing that this is stuff out of which transferences are fashioned, especially in the case of male patients.

Pt.: When I visit them nowadays, I still feel some of that old oppression. Like at the table my father will say, "All those guys in Washington are a bunch of crooks. Roosevelt was a crook." It burns me up, but I don't say anything. What good would it do?

Ther.: Maybe he's trying to get a rise out of you.

Pt.: No. He's just making flat statements as if he were telling us this is the way it is and there's no question about it.

And so it goes. Let us now turn to the middle course of psychotherapy, characterized by the actual work of interpretation designed to modify neurotic conflicts. For discussion purposes we can designate the middle period of therapy as ranging from the first interpretations on to the very end of therapy. With the first interpretations the bulk of therapeutic work begins. In theory this work will consist of freeing the ego of a symptom-producing neurotic conflict. In practice, the chief technical tools for the task are the

therapist's remarks, which fall into two groups, (a) interpositions and (b) interpretations. The preceding chapter has already considered the rationale and use of interpositions. They continue through the course of therapy. Interpretations, more characteristic of the middle period, will now be examined and discussed.