THE TECHNIQUE OF PSYCHOTHERAPY

THE INITIAL INTERVIEW

DEALING WITH INADEQUATE MOTIVATION

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From *The Technique of Psychotherapy* Lewis R. Wolberg

The Initial Interview: Dealing with Inadequate Motivation

Patients who come to the initial interview with inadequate, little, or no motivation for therapy require special handling because their mental set makes them refractory to the usual interview procedures. Among such patients are those with psychosomatic problems referred by physicians; delinquents, criminals, psychopathic personalities, sexual perverts, and other inpiduals involved in legal difficulties who are sent in by courts or correctional agencies; husbands and wives whose mates threaten porce unless their partners get treatment; clients of social agencies who have been inadequately prepared for therapy; alcoholics or drug addicts who are shepherded into the therapist's office through cajolery, threats, or exhortations; children with behavior and emotional problems brought in by parents or referred by schools; and psychotic persons out of contact with reality.

An inadequately motivated patient may utterly refuse to start therapy in defiance of the therapist and the referring agency. Or the patient may apathetically accept his or her plight, reporting as if to a parole officer, with no intention of cooperating or of conceding that help is possible. Accordingly, it is impossible to establish the kind of working relationship that permits the achievement of meaningful therapeutic goals. With proper handling, however, it may be possible to deal with defective motivation and to create the incentives essential for effective treatment. A general outline for the management of the poorly motivated patient follows;

1. Recognition and reflection of the patient's negative feelings about therapy and the therapist.

2. Indication of an understanding and acceptance of these feelings.

3. Display of a neutral attitude toward the patient's needing or being able to benefit from psychotherapy, until more facts are known about the patient's problem.

4. Expression of the opinion, when sufficient facts are known to the therapist, that the patient requires psychotherapy and may benefit greatly from it. Attempting to establish some incentive for therapy.

5. Sympathy with the patient's feeling, if negativism prevents revelation of facts but attempting to handle what is behind this feeling.

6. Dealing with the patient's misconceptions about psychotherapy, answering questions as directly as possible.

7. Refraining from "selling" the patient on therapy; respecting the verdict should the patient decide against therapy.

8. Accepting the inpidual as a patient even if the patient's decision has been made reluctantly.

RECOGNIZING AND REFLECTING NEGATIVE FEELINGS

Because the patient is defensive, evasive, inwardly outraged, and perhaps expressively hostile, little will be achieved until these untoward attitudes and feelings are resolved. Therefore, it is urgent to focus on them as soon as possible. This is relatively easy when the patient verbalizes readily or otherwise is self-revealing. Often, however, disturbed feelings are not openly apparent and must be perceived from how the patient talks rather than from what is said, or they may be recognized from random gestures, mannerisms, and facial expressions.

For instance, a delinquent girl referred for treatment sulks silently in her chair, fidgets around when asked a question, then answers in an evasive way with apparent disinterest in the proceedings. The therapist may make one of the following remarks:

"Perhaps you feel you ought not to have come here."

"Perhaps you're angry about being sent here."

"I can understand that you'd be annoyed about this situation."

These responses may immediately cut into the underlying mood and enable the girl to comprehend that her feelings are recognized. The result may be an outburst of hostile emotion toward the referring agency and an opening up to the therapist.

A woman, suspected of being emotionally disturbed, is sent to the therapist by her assigned social worker after she applies to a family welfare organization for help. The only reason that she accepts the referral is to please the social worker through whom she expects to secure supplementation of her income. Her lack of motivation causes her to withhold as many facts about herself as possible and to be as evasive as she can without offending. Under these circumstances, once conscious of her attitudes, the therapist might say, "I can very well see that you would feel resentful or uncomfortable about coming here. You probably do not believe that it is necessary and might feel that you could very easily do without it. I do not blame you for feeling that way inasmuch as you didn't really come to the agency to seek any emotional help." This may relax the patient considerably, for she senses in the therapist a sympathetic person. She may then begin to express her feelings about the agency and finally to verbalize her problems quite candidly.

A man with a character disorder expressed in petulant, querulous, and sadistic tendencies comes in for an interview on the insistence of his wife, who threatens to leave him unless he gets psychiatric treatment. After spending 10 minutes or so disarming the therapist with a genteel account of how well adjusted he is, the therapist interrupts:

Th. But there must be some reason why you came to see me?

Pt. I wish I knew why. My wife insists that I'm cracked.

Th. Cracked?

Pt. Yes. (*laughs*)

Th. Why does she make such a claim? *(The patient then irately expostulates on certain incidents in which he was unfairly treated by relatives of his wife. His responses, though retaliatory,*

were, he claims, tempered out of respect for his spouse. Yet she accused him of being cruel and irrational—tendencies he claimed, that were not an integral part of his personality.)

Th. Do *you* think that you have personality problems?

Pt. Not any more than anyone else.

Th. Then it must make you angry to have to come here to see me.

Pt. (pause) Well… she thinks I should go to you. I'm mad at her, not at you.

Th. Well, I would think you'd be as mad as the blazes to come here when you really don't see the need for it.

Pt. (laughs) I guess I am mad, but I don't blame you. Maybe I have been acting unreasonable at times. I suppose I'm hard to get along with sometimes.

Th. Everybody gets upset and acts unreasonable sometimes.

Pt. I don't know that I do any worse than anyone else.

Th. So that you'd resent being sent to a psychiatrist for no real reason.

Pt. Do *you* think there is anything wrong with me?

Th. From what you've told me, you seem to have a problem with your wife.

Pt. It's that she keeps picking and nagging and wanting to make me over. *[From this point on the patient's relationship with his wife is discussed and the patient participates enthusiastically.]*

INDICATING ACCEPTANCE OF NEGATIVE FEELINGS

By reflecting negative feelings, the therapist conveys an acceptance of them. The therapist, furthermore, may elaborate on the patient's right to feel the way that he or she does, demonstrating an understanding of the patient's mode of thinking. This is illustrated in the following excerpt of an initial interview:

(The patient stomps into the office with a swagger. She is a young woman with a short, cropped

haircut and a severely man-tailored tweed suit. She radiates an air of masculinity and is obviously disturbed and hostile.)

Th. Would you like to tell me about your problem?

Pt. (rapidly and angrily) The first thing I'm going to tell you is that I am against psychiatry completely.

Th. Why?

Pt. Because of past experience. I'm coming here against my will.

Th. I see.

Pt. Definitely against my will.

Th. Can you tell me about that?

Pt. In the year of 1970 I had two psychiatrists working with me. One was a society doctor who got me in and gave me 10-minute sessions, talking about nothing, and charging me 35 bucks; the other was a complete ass, who just sat on a chair, did nothing. He said he would try to work with me twice a week. He didn't help me one single bit and I am against it because of that.

Th. Well it does sound like you had some ungratifying experiences.

Pt. The first doctor wasn't really a psychiatrist, but he posed as one.

Th. How long did you go to him?

Pt. Just went a few times, maybe 10, I don't know offhand, but I felt it wasn't doing me any good.

Th. What was the reason for going to him in the first place?

Pt. I was kicked out of school.

Th. College?

Pt. Yes. They promised to let me come back if I had psychiatric treatment. I used to go to see the guidance woman, and she said that I had to see a psychiatrist. One of the teachers complained—a special narrow-minded, bigoted woman who had the same affliction I

did and that they had condemned me for. This was homosexuality, I guess. I don't know till this day. They got me into such a state that I was willing to do anything and everything. I had no psychiatric treatment; then I went to two of them. They were working with me, trying to get me back to school, and then after this year was up, the president talked to these doctors and everybody else. They started messing around, and then said they wouldn't take me back anyway, so that finished me up at college. That was the only reason I went for psychiatric treatment. I went in with an open mind. I said, "OK, if you can cure me and get me back to school," but it didn't work. And every since then, I mean, I don't particularly care for college; but I want my degree. I know what I want in life as far as a career goes. I am working toward it now. So I got to go back to college.

Th. So if you're antipsychiatry, why did you come to see me?

Pt. Well, that's not the point. I don't want you to cure me, as far as that's concerned. I talked to the guidance woman about the whole thing. She is a wonderful person and I adore her, except I think she is psychiatry conscious. She has been insisting on this and I am always trying to please her. In fact, it's not the homosexualism that bothers her, it's the way I dress and walk and things. I was a little out of hand at school.

Th. Is that what *they* say?

Pt. Well, no—that's what *I* say.

Th. What sort of trouble did you have?

Pt. Well, I don't smile enough; I look queer, I suppose; my mind is always a mile away, although I did good in school. I have an excellent mind and my marks showed it. I don't dress; I wear men's shirts; and I am always in this kind of an outfit, which is a little different from what the typical girl wears at college.

Th. I see.

Pt. Well, it looks different and my walk is terrific.

Th. You mean you walk with a swagger?

Pt. I do, definitely.

Th. Is that affected, or is that you?

Pt. I tried to calm it down, but it just doesn't work. You see, I was in physical education, and I am very athletically inclined, and the swagger does come, but it's not to the degree that I have. My voice is very gruff; in fact, my speech teacher gave me an E because he didn't like the way I spoke. And that's the lowest mark I ever got, and maybe I will be able to fix that up. It's just these little things—the way I smoke a cigarette. My behavior patterns that I have just don't qualify with the normal. I try to keep away from women 'cause I might be tempted, and as yet I haven't been.

Th. What do you mean as yet you haven't been?

Pt. Well, I haven't gone after women, to go to bed with me I mean.

Th. You never have had any homosexual relations?

Pt. Oh yes, but not at college.

Th. What they object to is just the fact that you dress in a certain way and talk in a certain way?

Pt. As this guidance woman puts it, they feel that in the state that I am in now, whatever that is —they have given me no definition of it— they feel that I am not a responsible person and that I may possibly forget myself and commit an act. Therefore, they feel I am not a good risk, but they don't know that I work well with children 'cause I have done a lot of field work, and I have done an excellent job. I have a good reputation at home. These college students and the professors, of course, can recognize the fact that I am queer I guess.

Th. Well, the business of working with children—your course is what?

Pt. It's educational sociology in group work.

Th. What would you like to do?

Pt. I thought about going back to physical education. In fact, I may start my graduate work in September.

Th. You don't see anything wrong with the things you are doing, do you?

Pt. Certainly I do.

Th. Well what's wrong with them?

Pt. Anything that doesn't conform to society is wrong in their eyes.

Th. But in *your* eyes—I'm talking about yours.

Pt. I got a conflict. I apparently have two personalities—one is the homosexual, the other is heterosexual. I can't make up my mind which personality I want to be. I think it's the homosexual because my relationships with men have been "snafu." I don't know. The guidance person thinks I hate women really. She has analyzed this thing with me, every time I talked to her. I always give the right answers as far as myself is concerned. I like women. I like to be with them, but I'm a very obvious homosexual and that's what's wrong with me.

Th. Well, when you are with them, how do you act with them, with the girls?

Pt. I'm aggressive, naturally.

Th. Do you ever take a passive role with them?

Pt. No.

Th. And what about your relations with men?

Pt. I am very much in love with one now, and he is also a homosexual. My only associations which are very satisfying are with gay boys. (*laughs*) If I talk to you much longer, you'll get my lingo. Isn't it awful?

Th. You seem to be ashamed of it.

Pt. I'm not ashamed of the fact that I'm a homosexual, but I am ashamed of the fact that I'm obvious.

Th. Well, would you like to change your being obvious?

Pt. Yes, that's the point. I don't particularly care about being cured as far as that's concerned. because a lot of great people were homosexual. If *they* could be homosexual, well *I* certainly can. I'm completely indifferent to that.

Th. Would you like to change some of these mannerisms that you talk about?

Pt. That's the point, if I can get out into society and work. In fact, my ultimate goals are to teach in a college.

Th. I see.

Pt. Now, I'm not going to do anything—inflicting my behavior upon my students—but it is obvious, and that's where the drawback is. And ever since I started in this work, it's not the students. The kids love me. In camping experiences, too, it was always the counselors or the teachers that jump on me because they see something.

Th. Maybe you feel that if you expose yourself to therapy. I'm likely to try to change your preference for homosexuality.

Pt. Well, are you?

Th. I naturally won't change anything you don't want changed. As a matter of fact, you're the one that determines how far you want to change. Actually, I don't blame you for being mad at psychiatry, if you feel psychiatry is trying to force you to be something you don't want to be. But getting treatment merely to get into college may do *you* absolutely no good.

Pt. They don't exactly demand it; they haven't gotten to that stage. I don't want you to misunderstand. It was the guidance woman's idea, and she has been at me ever since I've known her. She has taken a keen interest in my work, and she feels that I'm good at it and that my future shouldn't be wasted because I am in this conflict. I am unhappy you see.

Th. What conflict are you in?

Pt. Whether I should go this way or whether I should go that way in sex.

Th. Well, maybe you'd like to work out which direction you'd really like to go, either the one or the other, as long as you are clear in your mind and convinced in your heart.

Pt. I think that I would be homosexual, *(pause)* because my whole environment as a child, and ever since I can remember, has been one that was conducive to homosexuality.

Th. Let's accept that; at least for the time being. Are there any other conflicts you might want to handle? *[attempting to discover some incentive for therapy]*

Pt. I sort of isolate myself, I'm afraid, and, as soon as I finish a class, I want to run home. Or I run down to the Village to this friend of mine, and I stay with him. What bothers me most of all is the way I look and walk and act. It upsets me.

Th. In other words, you feel the mannerisms and the gestures are not approved of?

Pt. That's right.

Th. And that's what bothers you more than anything else?

Pt. Yes.

Th. Would you like me to let us help you with *that* problem?

Pt. If you can; if not, I might as well go to the Bowery. Do you think you can? This problem of what I should wear, what I shouldn't wear. My sister is ultra, ultra feminine, and I have the clothes to wear, but I would prefer to be in this attire. *[The patient defines an area on which she wishes to work.]*

Th. I'll do what I can to help you understand yourself better. If you have the desire to work things out, I believe I can help you.

Pt. That's the whole thing except that there is this tremendous fear that I'm not myself. But, I'd like to get started if you can, as soon as possible.

MANIFESTING AN OPEN MIND ABOUT THE PATIENT'S NEED FOR THERAPY

Should the patient want to know whether the therapist considers the problem presented severe enough for psychotherapy, the therapist may say that a positive answer will have to be postponed until more information is obtained. Such an attitude helps convince the patient that the therapist is not an arbitrary authority. The patient may also be told that the therapist is not sure that the patient needs or does not need treatment, but that as soon as enough facts are available, the therapist will be better able to provide advice. The following excerpt is an example of this:

Pt. Do you think I need to get these treatments?

Th. I am not sure yet. Suppose we talk more about your problem; then I will give you an idea of whether or not I think you need psychotherapy.

CREATING INCENTIVES FOR THERAPY

When satisfied, during the interview, that enough facts have been gathered to justify a positive statement to the patient, the therapist may remark, "Now I know enough about the problem to give you one definite statement. I do think you can benefit greatly from therapy. Whether you want therapy is another matter; but it could be of help to you."

Should the patient demand a reason for the therapist's conclusion, the latter may frankly state that the patient is not as happy, or well adjusted, or creative as possible, or that the patient is being victimized by certain symptoms that are signs of neurosis. The therapist must respect the fact that only the patient can decide whether or not to pursue therapy, no matter how much it may be needed.

It is necessary sometimes to attempt the building of incentives for treatment. Illustrative is the following excerpt from the first session with a single, 24-year-old woman whose mother was insistent that she see a psychiatrist because of attacks of moodiness and spells of depression. The patient sat forlornly in the chair, replying to questions with monosyllabic answers and denying that her symptoms were bad enough to warrant treatment.

Th. Are you completely satisfied with your present life and adjustment?

Pt. Yes.

Th. It's very gratifying to be well satisfied. Understandably you wouldn't want any treatment if there is nothing wrong.

Pt. No.

Th. Your mother thinks you ought to get treatment. I wonder why?

Pt. I don't know.

Th. Maybe you're angry that she sent you here, if you didn't need treatment.

Pt. I'm not angry.

Th. Mm hmm. *(pause)* But there must be some area in which you aren't completely happy.

Pt. Well … *(pause)*

Th. Are you satisfied with the way everything is going in every area of your life?

Pt. *(pause)* No, not exactly.

Th. Mm hmm. *(pause)*

Pt. It's that I don't go out much, not much. I don't go out with boys.

Th. I wonder why?

Pt. I don't know. I don't have a desire to go out, I mean the energy. I get tired.

Th. Would you like to want to go out more? *[attempting to create an incentive for therapy]*

Pt. Oh, yes. I often wonder what I could do to make me want to go out.

Th. Well, if you really would like to work with me on that, maybe I could help you with it.

Pt. But could you do anything to make me want to go out?

Th. I wouldn't make you do anything, but if you were interested, we could explore this area and find out what it was that held you back.

Pt. I think I would like that, if you could do it.

To help promote motivation for therapy the interviewer may want to be alert to any of the following manifestations on which the patient's attention may be focused:

1. Distressing symptoms of failure in adaptation, such as tension, anxiety, and psychosomatic symptoms.

2. Incapacitation and inhibition of function produced by anxiety and defenses against anxiety, like phobic, conversion, obsessive, and depressive reactions.

3. Recognition by the patient that personal capacities are not being lived up to and that basic needs are being sabotaged.

4. Fear of the consequences of neurotic aims, such as retaliation for acting-out or detection of homosexuality.

5. A desire to be like other people.

ATTEMPTING TO DEAL WITH CONTINUED OPPOSITION TO TREATMENT

When the patient shows continued negative attitudes toward therapy and toward the therapist, it may be helpful to point out that many persons can be benefited by psychotherapy even though they do not see the need for it at the start. If the therapist, from personal experience, is able to relate in detail a case he or she has treated with problems resembling those of the patient, it may create a spark of incentive. Reciting a detailed history, such as the one described in Chapter 36, may give the patient an idea of how psychotherapy works.

Sometimes assigned reading of informational books on psychotherapy (see bibliotherapy) may aid in the working out of the patient's blocks to treatment. Another helpful adjunct, available to the therapist who is acquainted with psychological testing, is to give the patient a projective test and then to discuss carefully and tentatively the test findings. Many patients open up remarkably when their problems are approached in this indirect way. Finally, if the patient is willing to risk personal exposure in an educational group, and if there is one available, the ensuing psychoeducational discussions in the group may resolve the patient's resistance.

CLARIFYING MISCONCEPTIONS

Throughout the interview it is necessary to clarify any misconceptions that the patient has about psychotherapy and to answer, as factually as possible, whatever questions the patient may ask.(See Chapter 34).

If the patient accepts psychotherapy but has spurious goals in mind in regard to what he or she wants to achieve from treatment, special handling will be required. For instance, a man

applies for therapy with the complaint of tension that prevents the development of his singing voice. His ambition is to become an opera singer. As he elaborates on his problem, it becomes apparent that he is really searching for success in terms of his father's conception of achievement. A music teacher himself, the father had trained his son to be a singer. The boy was driven to practice incessantly to discipline himself for a great vocal career. His coming to New York at the age of 20 had a twofold purpose: first, to study with a famous voice teacher and, second, to get an audition at the Metropolitan Opera Company. Upon leaving home, however, the patient's vocal ambitions began to ebb, and he found himself increasingly engaged in social and intellectual pursuits that perted him from voice exercises. Whenever he sang before a group, or even practiced singing for any length of time, he became uneasy, tense, and anxious. He came to therapy at the advice of a friend who was also receiving psychotherapy.

One might speculate that the patient was evidencing a delayed adolescent rebellion against his father that took the form of a desire for a self-appointed career. A reasonable objective in therapy, thus, would be the promotion of independence, even though this might mean an abandonment of singing as a profession.

Yet to tell the patient that his goal to be an opera singer was neurotic and that therapy would bring him to an independent course might drive him away from treatment. A preferable approach would be to accept the patient's motivation to acquire a better singing voice but to avoid any intimation that his voice might improve in caliber. He could be told that therapy may help him understand the source of his tension and the basis of any other interferences with his singing ability.

In the actual treatment of this patient it soon became apparent to him that his value system and self-esteem were dominated by the goals of his father. Attitudes of submissiveness and reverence masked deep resentment and desires for freedom. Breaking away from his father in coming to New York released his aggression. His refusal to practice singing was one sign of

rebellion. Tension and anxiety were the emotions consequent to this conflict. The patient was able to make a conscious choice of a career when he determined, in consulting with prominent critics, that his voice was not of operatic quality. He was surprised to find that his father accepted his decision benevolently after he had asserted himself and had insisted on giving up music in favor of a business career.

There are many neurotic goals that patients imagine will be realized from therapy, such as demands for power and perfectionism, a desire to endure hardships without flinching, and a yearning to remain poised under all circumstances. These motivations will not, of themselves, block entry into therapy, but they must be handled with determination at some point.

Among the most stubborn of inadequately motivated patients are those suffering from psychosomatic problems. Clinging to an organic etiology may be due in part to ignorance of how emotional factors can produce physical illness. In addition to the fear of being classified as a "mental case," the patient may consider that agreeing with a psychologic diagnosis is a sign that his or her suffering is regarded as "imaginary." When the patient is afflicted with disabling symptoms like blinding migraine headaches, intense gastric pains, or diarrhea, he or she may not be able to countenance any other but an organic cause. Applying to a psychiatrist for help is to the patient a sign of weakness, an indication of lack of will power, and an insignia of defeat. Deep fears of revealing repulsive personal secrets or of being unmasked as a contemptible, perverse creature reinforce the patient's antagonism. The possibility of embarking on a long and costly therapeutic adventure, the outcome of which is not guaranteed, is additionally unsettling. Because of these resistances, the referring physician has a formidable job in getting the patient to accept a psychiatric referral. As general practitioners have become more sophisticated in their understanding of mental health, they have been able to deal more adequately with many of patients' objections to receiving psychotherapeutic help. A few articles have appeared in medical journals that outline techniques of referring a patient to a psychotherapist, and these can benefit physicians effectiveness considerably.

In spite of good preparation, nevertheless, the patient may cling desperately to a conviction that the ailment is organic in nature and that a doctor will eventually be found who can locate the lesion and prescribe the proper medicaments. The patient may insist that the therapist become involved in this search, and, despite the patient's understanding that no medicines will be prescribed in psychotherapy, there is an almost frantic plea in the patient's manner, if not in verbalizations, for a remedy that will spell the renaissance of hope.

While the patient may intellectually be convinced of the fact that emotions can influence bodily processes, he or she may be unable to apply this information. The therapist may have to reiterate the thesis of how being upset can produce widespread disturbance in every part of the body, inducing even greater discomfort and pain than organic illness. The therapist must, however, always leave the door open to the possibility of at least a partial organic factor. To insist on its complete absence is an indication to the patient of the therapist's arbitrariness and prejudice. The fact is that the patient *may* have a concomitant organic condition; indeed, it is hardly conceivable that there is no physiologic correlate in every psychologic disorder. The physical disorder may be completely reversible once the patient's emotional difficulty is ironed out. Yet it may exist in fact and perhaps be demonstrated by laboratory and clinical tests.

A prolonged physical ailment may undermine the person and bring out associated emotional elements. The resulting turmoil will then accentuate the physical distress. As a matter of fact, a condition that starts out as physical may, after a while, incite emotional elements that persist long after the physical cause has disappeared. In the event that the patient seeks to know how emotions can cause bodily pains, the therapist may explain that the brain is connected to every organ in the body by nerves. When mental suffering occurs, the effects may be transmitted through nerves to the bodily organs, affecting their function and producing, for example, painful spasms. When mental or emotional relief eventuates, the organ may be restored to normal activity.

The patient will probably repeatedly have to be told that a reciprocal relationship exists between mental and physical processes—that nerves influence organs and vice versa. Sometimes a physical ailment touches off worry and other disturbing feelings, and the emotional disturbance then exaggerates the ailment. It would surely be remarkable if suffering from pain and other uncomfortable symptoms did not promote worry. Once anxiety is mobilized, a chain reaction begins, and the physical condition becomes more and more aggravated. Treating the physical condition with medicines or surgery may not remove the nervous component. Treating the nervous component, on the other hand, helps the organ return to its normal condition. This is why the treatment of the emotional part of the patient's trouble may restore physical health.

Because the patient may require the preservation of psychic integrity through a psychosomatic symptom, one must always cautiously and tentatively advance the possibility of emotional causation, always respecting the patient's need for refuge in a physical cause.

If the patient accepts the sincerity and authority of the therapist, he or she may be willing to explore the emotional aspects of the problem. Sometimes the patient will listen in a polite manner and then will insist on further medical consultations and tests before submitting to psychotherapy. The therapist here should respect the patient's wishes and refer the patient back to the physician, with the comment that the patient is unwilling at present to accept psychotherapy. Often this tolerant and open-minded attitude evidenced by the therapist will inspire the patient to return, motivated for treatment, when an additional excursion for diagnosis has proven futile.

These principles may be illustrated by considering the case of a man who, because of a disabling gastric complaint, consults his family physician. A series of laboratory tests, clinical examinations, and x-rays reveals no discernible organic lesion. Alkalis, antispasmodics, vitamins, and sedatives are to no avail. In desperation the patient consults a number of specialists, and finally he makes the rounds of medical clinics but with no abatement of his symptoms. His

suffering eventually drives him back to his original family doctor, who had intimated, to the dismay of the patient, that there might be psychological factors responsible for the patient's trouble. This indicated to the patient that the doctor considered him insincere and somewhat of a faker. But, having exhausted every possible avenue of traditional medical help, he finally is willing to listen to his physician and to consult a psychotherapist.

His approach to the psychiatrist at the initial interview is one of mingled disdain, fear, frustration, and hostility. Secretly he hopes that the therapist will produce some kind of magic pill that will allay his suffering. He has been willing to try something new, but he comes to treatment with his "tongue in his cheek." He is willing to give this strange doctor a chance to do something that the other doctors have not been able to do, but naturally he has his doubts. The slightest intimation that there is a psychological aspect makes him fear that his pain may be considered imaginary.

The following is an excerpt of part of a session with a patient of this type who has no wish for therapy, but whose lack of motivation is dealt with successfully by the therapist. After the patient discourses on his doubts that he has a psychological problem that requires psychotherapy, the interview proceeds:

> *Pt.* But how can stomach trouble be caused by the mind?
>
> *Th.* The brain is connected to every organ in the body, and when a person is disturbed, it is understandable that the disturbance or worry or conflict can get into every organ of the body through nerve channels. And then the organ gets upset.
>
> *Pt.* But there's nothing wrong with my mind. I'm not worried about anything except this pain and how to get rid of it.
>
> *Th.* Perhaps that's right. As a matter of fact, you *may* have something really wrong with your stomach. Have you satisfied yourself that there is nothing wrong? [*Since patients are suspicious that the therapist will bend backward to label a condition psychological, this remark is intended to show the patient that the therapist is not eager to come to this conclusion without good evidence.]*

Pt. Well, the doctors all say that there is nothing wrong. They've given me all the tests. But I feel there is something. *[This conviction of the patient against all of the evidence may be obdurate resistance to his accepting psychotherapy.]*

Th. You've had all of the tests?

Pt. Yes, and they all add up to nothing.

Th. Perhaps you wouldn't be satisfied until you find someone who tells you there is something wrong. It certainly seems reasonable to exhaust every possibility to your satisfaction, that is, get the best doctors to look you over, before you get psychiatric help, *(pause) [This lack of eagerness on my part to accept the patient until he is convinced he wants psychiatric help may spur him on to accept it.]*

Pt. Do *you* think there is nothing wrong with my stomach?

Th. There *must* be something wrong; otherwise you wouldn't have pain. The question is whether the cause of the pain is emotional, or organic, or both. Frankly I don't know which it is, since I'm not acquainted too much with your condition. But from your account, nothing organic has been found. And you've had good doctors. Dr. _ is a good doctor; he's conservative, and he sent you to see me, which shows he feels there is at least the possibility of an emotional factor.

Pt. But what could it be, if it isn't my stomach?

Th. You mean what would the emotional factors be if your stomach trouble was not organic?

Pt. Yes.

Th. That's why you were referred to me. Perhaps we might be able to find out. You know, emotional trouble can give you a bigger bellyache than physical trouble.

Pt. As bad as mine?

Th. I don't know how bad yours is, but it can be mighty bad, even worse than organic trouble, *{pause)* Apparently you can't accept this fact as applying to you. Maybe you think it's disgraceful to have emotional problems?

Pt. Well, if I were that much out of control ... Well, maybe it's so, but I don't, can't see how. Wouldn't I know if there is something wrong, with my mind, I mean?

Th. With your emotions, you mean? Well, usually not. But I don't know that there is anything wrong either. We'd have to give ourselves a little time and begin exploring, (*pause*)

Pt. Doctor, do you think *you* can help me?

Th. If you have an emotional problem that is causing this trouble, yes, that is, if you really wanted to be helped.

Pt. But I do want to be helped. I've spent a fortune of money, and nothing has been done.

Th. Maybe you'd rather wait and keep trying other internists until you're convinced the organic factors are the most important ones.

Pt. But I've tried and tried.

Th. Yes, but you are still not convinced. Why don't you think things over, and, if you'd like to give this a try—with an open mind, I mean—call me and we'll get started. *[Throwing the choice squarely on the patient's shoulders.]*

Pt. I get the pain over here, *[points to his abdomen)*

Th. It must be very distressing [*showing sympathy]*

Pt. Yes, doctor, it drives me practically out of my mind.

Th. You know, a person with even a real organic problem involving his stomach can get very upset. And his emotional tension can in turn stir up trouble for him.

Pt. This pain does upset me and I think it does make my stomach worse.

Th. So you see, emotional trouble, worry, and tension can upset your stomach.

Pt. Well, I do know there are some things my wife does that upset me. *[This is the first indication of the patient's desire to work with his emotional problem. He talks about his difficulty at home and then makes arrangements to start therapy.]*

Because the patient with a psychosomatic problem is often unconvinced that a physical symptom is or can be emotionally determined, the best way of losing such a patient is to insist that the problem is psychological. Since the patient may, at least temporarily, need the symptom, the therapist is wise at the start of therapy to allow the patient to retain the idea of its organicity.

The therapist may inform the patient that any symptom, even an organic symptom, creates tension because of discomfort or pain. The tension delays healing. What needs to be done is to reduce tension, and this can stimulate the healing process. Teaching the patient simple relaxation methods and allowing the patient to verbalize freely should soon establish a therapeutic alliance, and through this the patient may be helped to come to grips with worries and conflicts.

It is sometimes expedient within the first few minutes of the interview to try to get the patient to convince the skeptical therapist that a psychological problem exists in his case. Thus a patient appears for an interview arranged by his physician. After the usual opening formalities he states:

Pt. Dr._sent me to see you.

Th. Yes.

Pt. He thinks my trouble is in my head.

Th. Mm hmm.

Pt. This pain in my head. Migraine.

Th. What makes you think it is psychological and not physical?

Pt. I'm not sure. In fact I don't think its psychological because I'm pretty well adjusted.

Th. Perhaps it is physical.

Pt. I've tried a lot of doctors and the only thing that helps a little is ergotamine.

Th. It still may be physical. Tell me who you have seen for this and what they said. *(The patient enthusiastically for the next 10 minutes details his futile adventures with doctors. After this he pauses and asks a question.)*

Pt. Could this be psychological?

Th. I am not sure. But I can tell you one thing. Even if it is organic, and it may be, the pain and tension you have suffered can spark off attacks and prevent healing.

Pt. I do get tense sometimes.

Th. Tell me about this. *(The patient then launches off into various troubles he is having in his work and with his wife.)*

Th. I'd say you have enough trouble to spark off migraine. But the basis may still be organic, although you've seen quite a number of good doctors.

Pt. Do you believe I can be helped?

Th. The best way to find out is to get started.

Pt. I'd like to do this.

Patients receiving disability payments for an injury are particularly unmotivated to give up psychological pain and other symptoms that complicate their problems. Here the factor of secondary gain appears through avoiding hard work, supporting dependency needs, and getting attention and sympathy. Such patients cannot be forced to change. The primary task here, as in the case of the psychosomatic patient, is to first establish a therapeutic alliance. No hard-and-fast rules can be given since patients will require innovative stratagems designed for their special situations. Patients receiving disability checks are particularly difficult to convince that anything psychological keeps them from returning to work. One tactic is never to imply that the patient is in any way psychologically manufacturing the symptoms because this will obstruct the establishing of a working relationship. The approach at first may, as in the psychosomatic patient, be organized around tension reduction to help the patient assuage suffering. As tension is lessened, the patient will begin talking more about himself or herself and perhaps about some family adjustment problems. The therapist may soon be able to inquire about the hopes, ambitions, and goals of the patient. Questions may be asked such as, "What would you like to do?" "How would *you* like to feel?" "What do you enjoy most?" Very often when the patient realizes that the therapist does not expect conformity to standards that others set for the patient, a therapeutic alliance will begin. Reflecting the patient's anger without condemning it helps convince the patient that there is nothing wrong with feeling the way he or she does. How the

patient can go about fulfilling personal own goals is then planned. An interesting article on techniques of dealing with such unmotivated patients has been written by Swanson and Woolson (1973).

The therapist's handling of the patient's denial tendencies is crucial. Blank unbelief often operates as a primary defense to insulate the patient from the implications of the illness (Lindemann, 1944). Such denial, interfering with the true assessment of the reality situation, constitutes a great danger for the inpidual. In coronary illness for example, the patient may engage in dangerous overactivity, neglect of diet, and absentmindedness about taking essential medications. It is, therefore, important to review with the patient his or her ideas of the illness and attitudes toward it, especially hopelessness. By careful clarification coupled with reassurance existing misconceptions and cognitive distortions may be corrected. The relationship with the therapist can greatly help the patient to accept a factual assessment of the patient's situation. The therapist here serves "in a role similar to the protecting parent who makes painful and threatening reality less intolerable to the child, thus enabling the child to accept and face reality, with its hazards, rather than having to deny and 'shut out' " (Stein et al., 1969).

Sometimes lack of motivation for treatment is predicated on a need to retain the boons bestowed by a neurosis. Thus the cement that holds a marriage together may be agoraphobia in a wife whose symptom binds the husband to the wife out of guilt and sympathy. Fear that the marriage will break up should she get well will be a formidable obstacle to a proper response to treatment. Here couples therapy may be mandatory before a good response to behavior therapy, inpidual psychotherapy, or group psychotherapy can be expected. This type of motivational lack may result in acceptance or indifference to one's symptoms, a patient going through the motions of exposure to treatment, even demonstrating interest in the dynamics without any impact on his or her dysfunctional behavior patterns.

Treatment guidelines using psychoeducation, family intervention, psychodynamic interpretations, paradoxical intention, and assertiveness training for the behavioral treatment of resistant anxiety-disorder patients have been suggested by (Hanrahan et al., 1984) to help patients learn new skills, to understand resistances, face anxiety-provoking situations, and complete essential homework assignments. A program to acquaint students with modes of managing unmotivated patients has been developed by Swanson and Woolson (1973).

AVOIDING THE 'OVERSELLING' OF THE PATIENT

Lack of on the part of the patient motivation may persist no matter how expert the therapist. The patient may cling to the notion of self-reliance, believing that it is threatening to have to depend on the therapist. The patient may harbor a deep masochistic need for suffering and refuse to relinquish the symptoms. In addition, the patient may possess a contempt for normal values in life that he or she anticipates will be the outcome of therapy. The patient may suspect the intention of the therapist. Common fears are that creativity, talent, and uniqueness will be exterminated in treatment, that therapy sometimes wrecks marriages leading to separation or porce, that life may become bereft of pleasures that are now derived from neurotic indulgences. He or she may fancy that getting treatment constitutes a hostile act against the family, which actively or indirectly opposes the therapy. The patient may contemplate with dread the overcoming of any ostensibly symptomatic handicap since this has justified failure in adjustment. There may be many other reasons for the patient's refusal to cooperate that will nullify the therapist's efforts to guide the patient into therapy.

From a strategic point of view, it may be argued that irrespective of how resistive the patient may be at the start of therapy, the developing relationship will eventually undermine such resistance. This is probably correct, and many patients who are initially unmotivated do eventually accept therapy. The great problem is to convince the patient to continue in treatment in spite of doubts. This is easier said than done, and the therapist may, in the eagerness to help the

patient, try to "oversell" psychotherapy. The best practice is to present the facts frankly to the patient and then leave the choice of therapy entirely up to the patient. Under these circumstances the patient may decide not to start treatment but later may return motivated, having spontaneously worked out the resistance in the interim period.

The following case illustrates this. It is part of an initial interview with a patient with physical symptoms who was referred by a physician. An unsuccessful attempt is made to bring him to an awareness of possible emotional sources of his illness. Also unsuccessful is an effort to convince him to accept therapy for a potential psychological problem. Throwing the choice back at the patient makes him decide to get a further physical checkup. He is encouraged to call the therapist when he is ready to accept treatment.

Pt. I'm here because I've been working very hard, sometimes till 11 o'clock at night. I was so tired that I thought something was physically wrong, but I was told that there was nothing wrong with me. No matter what reassurance I get, I am still depressed. When I was coming to your office, I felt sort of a fear. I can't explain it, but if I was with my wife, I know that I wouldn't feel that way. When I walk by myself, I get that feeling and I can't reassure myself, but, no, I do reassure myself. I say to myself that this is silly and I have no reason to feel this way. I don't tell this to anyone, just you now, doctor. *[The patient has symptoms of somatic disturbance, depression, and anxiety—manifestations of a collapse in adaptation.]*

Th. You feel fearful? *[focusing on his anxiety]*

Pt. Yes, fearful; that's it. *(pause)*

Th. How long has this fear been going on?

Pt. Well I guess … I get up at night, and, and that's why my wife came here to explain what goes on at night. *[Patient's wife is in the waiting room.]*

Th. What goes on at night?

Pt. Well, I get up at night. I don't know what food I eat the night before that gives me a full night's sleep, but certain days I do get a full night's sleep, and I get up in the morning, and I still feel that jittery fearful condition. But if I get up during the night, and open up

my eyes any time during the night, and I feel the taste in my mouth; if I feel that I'm nauseous, I'm nauseous—if I feel that I want to take an Alka Seltzer, first thing I wake her up out of her sleep. First thing I wake her up. Really, I shouldn't, shouldn't do it, but I know I shouldn't do it, but, if I do, for some reason I feel reassured if she's up. I tell her I don't feel good, and she says, "All right just forget about it, and just lie down on your stomach and force yourself to go to sleep." *[Feelings of anxiety and helplessness make him apply to his wife for succor and reassurance.)*

Th. Do you feel physically sick?

Pt. See, Doctor, the trouble is I still feel that I'm physically sick, in spite of the fact that I had an x-ray taken about a year ago. Dr._____ in the Bronx told me at the time, and he showed me the pictures right in front of me too. He says the x-ray shows that there's nothing wrong physically. However, year, maybe less than a year, I believe you can find out exactly just when it was, I was told by the doctor there was nothing they could find out about my condition, there was nothing there. You could call Dr.__ You see, he'd probably have pictures and he could explain it better. But that's the way he explained it to me.

Th. Now this has been going on for how long?

Pt. Well, it isn't so very long. I'd say 3 or 4 years—I mean on and off; but the conditions, well from medical doctors I got examinations. They never found anything wrong during all those years. I did feel during that time, and I still feel during the present day, that it isn't mental, that it is something physical that I feel. I don't know how. I get reassured and reassured and reassured, and the only thing is that people confide and talk to me in a certain sense, and it immediately disappears. And then it comes back again almost right away.

Th. Anything else wrong?

Pt. No, everything is very, very nice. When I'm at home, we got a television set 9 or 10 months ago and I feel reassurance—we, we— the recreation, I mean. I feel wonderful at home, too, but I can be looking at the television, and if I distract my attention from the television, I still feel that feeling. I would say that 3 years ago, 3J, 4 years ago my boss says, "Joe"—well, they call me Joe for short, he says instead of Joseph—"Take 2 weeks this spring, take 3 weeks." I mean. I felt kind of run down, and I always felt that when I'm run down, you know, from continuous work, I should rest up more.

Th. What do you think this is all about?

Pt. Well I don't know. That's why I don't know whether it's my physical condition or whether

it's my mental condition. I still feel that it's my physical condition for the simple reason that no matter how I feel, I always snap out of my mental condition. Because if I feel too depressed to a certain degree, I don't try to fight deeply against it. I try to get the help of people whether it's in the business or anywhere else. Or else I just cry it out and get the tension off my chest. I mean I don't try to fight it to the extent that it should get the best of me. You see, I got—to get it down to brass tacks, doctor, I have everything to live for. I have a wonderful, I've got a wonderful family, a wonderful family from my side, I mean my brother and my sisters, and my wife on her side, her brother, her father. My father-in-law lives with us, my daughter and her husband live with us. We have a pleasant environment. I enjoy coming home. I got everything to fight in the direction of health. And so it, that's really the root of it, it gives me the power to fight because I know that everybody is with me.

Th. You feel that there is a physical condition that's undermining you, that makes it hard for you to do things, particularly to work?

Pt. Yes, but when I get that mental condition, I do feel that it comes from something, something physically wrong. I don't know what it is. It might be, it might be the smallest thing, but still the smallest thing might be … *(pause*)

Th. Do you think there is anything seriously physically wrong with you?

Pt. I never feel that pain as I—I never feel any pain. The only pain is the usual condition.

Th. A physical condition, like you say you have, may still be there and undermine you emotionally. Also on the basis of your worrying, the emotional state may aggravate the physical state. It's a vicious cycle. It may be important for you to get physical treatment and also important for you to get treatment for your emotional state. *[This is a tentative attempt to soften the patient's resistance to psychiatric treatment.]*

Pt. Well I do feel, doctor, that all this condition is, is because of the continuous years of work I put into a career, like. Well, I've been working since 1919. In all the years I feel that 50 percent of that time I put two days in 1. Let's see, I've been working since 1917, which is 33 years. I put 2 years in 1, probably 10 years of it, so that 10 years I put in approximately 20 years of work. And I do know I have because I've been working at times 13, 14, 15, hours a day. I mean, not these last couple of years, but in this trend before. Because after all your machine is working, and if you put twice as much as you should, you pay for it. *[The patient is trying to justify his condition on the basis of overwork.]*

Th. Now look, do you feel that you want to get psychiatric help for this condition of yours.

What do you think?

Pt. Well, I think I feel that when I go to my place of business, I have the desire to go, I have the desire to work, and I know that I have obligations. I've got to work to make a living for the family and to keep the respect of the people I associate with. I know my obligations and all that, and I know that if I don't work here I've got to work somewhere's else.

Th. Would you like to get some sort of help for this trouble of yours? *[Repeating my question that the patient dodged.]*

Pt. Well, the first thing I feel that if I got reassurance as to my physical condition, I'd be all right.

Th. The reason you were sent to me was Dr. _felt that there was perhaps an emotional problem in addition to any possible physical problem that existed. Now let's assume that you have a physical problem such as you say you have, there still might be an emotional condition superimposed on it. But you won't be able to benefit by help for an emotional problem unless you really want it. That's why I ask you, do you want help, do you want me to arrange for help for you? What do you think?

Pt. Well, I'd rather think it over a little. *(pause)*

Th. I tell you what I will do then. You think it over a little and I will get in touch with Dr._____ I will tell him what I feel. And then after you talk it over with him, and you decide you want help, call me.

Pt. You see, I don't know whether it's psychological or physical. You see I say that because I'm not convinced.

Th. Are you interested in what I think?

Pt. But, first, if I can be reassured as to the physical, then probably that can loose up the tension.

Th. Do you feel that that would be enough once you are reassured?

Pt. Well, I don't know. I just don't know.

Th. You know from your experience you've tried that over and over again, and it hasn't worked.

Pt. I've tried, but I still feel that in the physical, I feel there's so many other things that just an x-ray or that—it's just a complete checkup as to every extent of the inpidual—I haven't had a complete checkup for a long time.

Th. Do you think that the best idea is to go ahead and make arrangements for another complete checkup? Then when you are assured through that complete checkup to your satisfaction that there might be a good reason for you to get psychiatric help, give me a ring.

Pt. That's what I'll do.

Th. All right then. You may call me when you decide.

Pt. Yes, goodbye, doctor.

The contact with the patient was terminated at this point. The referring physician was told that the patient undoubtedly could use psychotherapy, but that he was not ready for it, not being convinced that there was a psychological factor in his ailment. Without a desire for treatment it was doubtful that the patient could derive any benefit from it.

Six months later I received a telephone call from the patient asking for an appointment. He was ready, he claimed, to start therapy. Treatment was started and carried on with satisfactory results.

TREATING THE UNMOTIVATED PATIENT

The unmotivated patient who feels obliged to continue in therapy because of external pressure or who is willing to experiment with treatment against his or her own judgment should be accepted without question. The best way to motivate such a patient for therapy is to start a good relationship immediately—one of frankness and sincerity. The patient, finding value in this relationship, may eventually accept therapy, using the therapist to bring some objectivity into his or her life.

This may be illustrated in the following excerpt of the fifteenth session with a woman of 30

whose husband had forced her to accept treatment under threat of porce. The patient suffered from a phobic reaction that restricted her movements and caused her to cling fearfully to her husband. She resented his insistence on her getting psychiatric help, and the first sessions were spent accepting her resentment and pointing out to her that her disabling symptoms might provide an adequate reason for her personal acceptance of therapy irrespective of the wishes of her husband. Gradually she concurred with this idea.

Pt. Well, I feel that I am learning a lot. I don't know how it happened. It's been very subtle. I just don't know how it happened, but I don't think the way I used to. That's the only obvious thing that I can see. I think that I'm getting my feet on the ground; I'm thinking more realistically. I know that I did come here because somebody else wanted me to. I'd be telling a big lie if I didn't admit that. But I had absolutely nothing to say about coming here in the first place, not a thing. And the only reason that I didn't like to come here, I thought of the stigma of having anything wrong with my mind. I'm reminded of it, and John *(her husband)* reminds me of the fact that I'm neurotic all the time, and I know it myself. I think that that has been my phobia, more than some of the other things.

Th. Don't you think you would have thought the same way about treatment if there was something medically wrong with you?

Pt. No.

Th. In other words, you put a special stigma on being neurotic as compared to having any other ailment.

Pt. Well, any other thing, I don't know. But Dad taught us ever since we were children about people being mentally off and that whenever we got married, that the one thing to be sure of always was that the other person was well balanced and didn't have any queer strains in him. That idea has kept on so long, that it has always seemed to me there were cures for physical things, but that something wrong with your mind you had with you until you died. If you think that for a long, long time, and then someone starts telling you you're queer, it accumulates like a snowball.

Th. Well, that made it difficult for you. You then came not of your own free will, but because your husband insisted on it. But you are beginning to see that coming here does not imply that you are seriously mentally ill. Many people come to therapy not because they have symptoms but because they want to improve on their potentialities.

Pt. I realize that they go because they themselves feel that, *(pause)*

Th. Because they themselves feel that.

Pt. And it isn't because someone else says they are queer.

Th. Precisely. If you continue to come to see me on the basis that somebody thinks you're queer, you won't get much out of coming. If you don't come of your own free will and feel that this is your project, that there are problems that *you* have, emotional conflicts that *you* want to work out, your treatment will be delayed.

Pt. No, I don't have that attitude, and you have gotten me over that feeling. I guess it's because of you. Well, your attitude isn't the kind that reminds me that I'm queer, nothing like that at all. It's entirely different. I think that I want to do things about myself.

From this point on therapy proceeded satisfactorily.