THE TECHNIQUE OF PSYCHOTHERAPY

THE INITIAL INTERVIEW
ESTIMATING THE PROGNOSIS

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e-Book 2016 International Psychotherapy Institute

From *The Technique of Psychotherapy* Lewis R. Wolberg

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The Initial Interview: Estimating the Prognosis

In textbooks of psychiatry there are many pages of index in closely packed fine print. Amidst the profusion of items there is, in most indexes, not a single entry under "prognosis." A search for synonyms of prognosis that would subsume similar prediction also yields nothing. This absence is probably not fortuitous; it indicates that the complexity of the problem is formidable and that reliable facts cannot be readily collated. A few bold authors have ventured opinions about prognosis, but on the whole little is available in the literature on this very important subject. An extensive study (the Penn Psychotherapy Research Project of Luborsky et al., 1980) found that not a single psychometric measure, demographic characteristic, symptom, psychological test, or interpersonal inventory was related to outcome. Among the crucial variables are the skill of the therapist and the nature of the evolving therapeutic relationship. These are merely a few of the factors that will affect outcome. The actual happenings in therapy cannot be predicted in advance. We might roughly say, however, recognizing that there are many caveats, that if a patient is highly motivated for therapy, has functioned well in the past, has had at least one good relationship previously, is uncomfortable with the symptoms or life situation, seems to be able to relate well with the interviewer, has a curiosity about personal psychological forces (psychological mindedness), and is reasonably intelligent, he or she has a chance of doing well in therapy with a good therapist.

No truly valid criteria have ever been designed that can serve as a basis of prognosticating the results in psychotherapy. Published material is not too helpful, and even simple studies on recovery rates with different psychotherapies pose more problems than they solve. Without a comparative assay of the standards used in rating reported results and without precise definition of the technical procedures employed, caution must rule in accepting the validity of any statistics on improvement and recovery.

If so seemingly uncomplicated a matter as success or failure in psychotherapy can be estimated with no greater accuracy than present studies reveal, it is obvious that the myriad intangibles involved make any estimates of prognosis an even more difficult task. One reason for this predicament is that irrespective of syndrome or any characteristics displayed by the patient, success in therapy is predicated

on the response of the patient to a therapeutic relationship in which there are two participants—the patient and the therapist. Unless it is known how the therapist will behave in the relationship, how objective and empathic he or she will be, only part of the equation is known. The other part, the activity and competence of the therapist, is the imponderable factor about which little is known but that will significantly influence the results.

If, however, the therapist aspect of the equation is accepted as a constant and we assume that the therapist can be therapeutically astute in all cases, it is found that some kinds of problems and some characteristics displayed by patients will make for a better response to therapy than other problems and characteristics. It is on these qualities that estimates of prognosis can be made.

In delineating prognostic signs it is necessary to qualify them in terms of the ultimate treatment goals. This is because some patients may successfully achieve the goal of stabilizing themselves at the level of their optimal functioning prior to the onset of their illness but may be unable to reach the goal of personality reconstruction. Prognostic estimates will, therefore, be different with these two objectives. For example, in a patient with marked disintegrative tendencies, who has manifested an acute emotional disturbance, we may perhaps prognosticate a recovery from, the immediate upset and restoration to the previous level of functioning. Yet the prognosis for eradication of the disintegrative potential, and for reconstruction of the personality, will be less favorable.

Prognosis may be approached by considering such factors as the age of the patient, the duration of the illness, the severity of symptoms, the diagnosis, the level of the patient's intelligence, the motivations for therapy, the depth of insight, the factor of secondary gain, the individual's ego strength or weakness, the current environmental situation, past therapeutic failures, and the response of the patient to the present therapeutic effort.

AGE OF PATIENT

Flexibility of personality is more important than the age of the patient in determining responsiveness to therapy. Because individuals become more rigid as they grow older, and their personality patterns and defenses become more inflexible, it is more likely that the average individual

can achieve extensive reconstructive changes with therapy before 45 years of age rather than after, other factors being equal. Responses to supportive or reeducative therapy, however, do not seem to be affected by age.

DURATION OF ILLNESS

The more chronic the illness, the poorer is the prognosis. Some ailments of more than five years' duration may be extremely resistant to therapy. The reason is that the problem has become highly organized over a period of time with defensive balances and counterbalances that tend to neutralize the therapeutic effort.

SEVERITY OF SYMPTOMS

The severity of symptoms seems to bear little relationship to how rapidly or how completely emotional problems are resolved. Thus, a mild phobia in some patients may be more resistant to treatment than a severe phobic condition in other patients. A person with an intense anxiety reaction may react more rapidly to therapy than one with a personality problem without disturbing anxiety manifestations. Indeed, the absence of severe symptoms may influence therapy in a negative way since discomfort and suffering provide many of the strongest incentives for getting well.

DIAGNOSIS

Some types of emotional disorders seem to respond to therapy more readily than other types. Although certain conditions may rapidly be restored to stability with supportive therapy, they may resist vigorously the deeper changes wrought by reconstructive therapy. Among such conditions are organic brain disorders, schizophrenia, manic-depressive reactions, involutional psychotic reactions, chronic anxiety reactions, chronic obsessive-compulsive reactions, perversions, addictions, and a great many personality disorders, particularly those in which there is characterologic rigidity. The other syndromes, especially stress, anxiety, conversion, phobic, and psycho-physiologic reactions, are usually more amenable to reconstructive therapy, but coexistent factors of a destructive nature may possibly interfere with good results.

Neurotic symptoms occurring in the medium of a severe personality disorder and initiated, or sustained, by the disorder may not disappear until the personality problem itself is resolved. Thus, what may concern the patient most importantly, promoting the search for psychotherapeutic help, is the inability to enjoy sexual relations. The individual may ardently wish to get over the symptom. This, however, may not yield until the fundamental problem of detachment from women or men is corrected. Here the outlook is guarded, for the personality disorder will first have to be resolved before the sexual symptom disappears.

There are patients in practically all categories of illness who are sufficiently flexible to respond favorably to most therapeutic interventions. Diagnostic categories here, listed in DSM-III under Categories I and II, are said to have the best prognosis. Conditions of greater severity involve characterological and emotional problems that make for poor adaptation and include substance abuse or affective, anxiety, dissociative, paranoid, schizophreniform, schizoaffective, psychosexual, factitious (simulated), impulse control, psychophysiological, and personality disorders, as well as a variety of disorders of infancy, childhood, or adolescence as listed in Category III of DSM-III. Prognosis is less favorable here and requires therapy that is more prolonged and intensive. Even more incapacitating, and making for a worse prognosis, are bulimia, anorexia nervosa, atypical eating problems, Tourette's syndrome, pervasive developmental problems, intractable substance abuse, and paranoidal psychotic, affective, anxiety, somatoform, dissociative, psychosexual, impulse control, and personality disorders, listed in Category IV of DSM-III. These syndromes may require periodic hospitalization and biologic and psychosocial therapies. At the bottom of the adaptive and prognostic scale are such chronic and recurrent disorders as autism, schizophrenia, paranoid disorders, affective disorders, and personality disorders listed Category V of DSM-III, which may need and sometimes respond to hospitalization and biologic and psychosocial treatments. The most pessimistic prognoses are for such mental disorders, listed in Category VI of DSM-III, as chronic unmotivated severe schizophrenia and paranoid disorders, which resist treatment and require constant supervision and perhaps hospitalization. These diagnostic formulations are helpful in estimating prognoses in a general way, but other factors can override these estimates.

LEVEL OF INTELLIGENCE

High intelligence is not positively correlated with good results in therapy, although verbal skill and

the capacity for self-understanding are favorable ingredients. However, borderline or defective intelligence will make it difficult to use any other technique than that of supportive therapy.

MOTIVATIONS FOR THERAPY

Unless the motivation for therapy is present or it is developed, it may be difficult to treat the patient, or therapeutic goals may have to be rigidly circumscribed. Thus, an alcoholic may have no motivation for treatment whatsoever and may consult a therapist merely to please his or her spouse. As long as this lack of motivation persists, the prognosis with any kind of therapy will be poor. An individual with a psychophysiologic gastrointestinal ailment may seek rapid, dramatic relief of symptoms but may not be motivated to explore inner problems and conflicts to arrive at their basis. It will not be possible, under these circumstances, to employ deeper therapy with reasonable success. A woman with a personality disorder associated with, for example, aggression may not be motivated toward changing her way of life no matter how skillful the therapist. She may, for instance, rationalize her refusal to change on the basis that an alteration in personality would threaten her in the business world. She may believe that her livelihood is contingent on fierce competitiveness. She will, therefore, resist therapy that is aimed at reconstructive goals.

A patient, furthermore, may be motivated to find in the relationship with the therapist other things than emotional health. The patient may thus seek in it a means to power, success, or perfectionism. The patient may, out of loneliness or frustration, regard the relationship as a social experience. He or she may desire to convert the therapist into a parental figure to satisfy a dependency need. Or the patient may search for an idealized self-image in the therapist with which he or she can identify. Until these defective motivations are altered, the prognosis for sustained personality change will be guarded.

Among factors that support good motivation for therapy are suffering from symptoms, the realization by the patient that the neurosis is handicapping functioning, and a desire to be "normal" like other human beings. Among factors that oppose proper motivation are absence of symptomatic suffering, lack of handicap from symptoms, the fear of finding out something despicable about oneself in therapy, the reluctance to yield neurotic gains and values, the fear of exposing oneself to the unknown dangers of health, and the desire to be unique and unlike other persons.

DEPTH OF INSIGHT

The extent of insight may or may not exert some influence on prognosis. The patient may have no conception that one's symptoms are in any way related to basic conflicts within oneself and one's relationships with people. So long as this lack of understanding persists, reeducative and reconstructive therapy will proceed under a handicap. It is difficult to estimate how long therapy will go on before the patient develops this degree of awareness. On the other hand, the presence of such insight at the start of treatment, or its emergence during therapy, does not presuppose that the individual will be able to handle insight constructively or to utilize it in the direction of change. The patient will require considerable fortitude to help compensate for the spurious values arising from the neurosis, to master the anxieties related to the challenging of basic defenses, and to experiment with normal values and goals that have up to this time been held in contempt or been considered to be beyond reach. While it is difficult to predict how long it will take the patient to develop insight or to use it, the existence of intelligence, sensitivity, creativity, and flexibility are favorable signs.

THE FACTOR OF SECONDARY GAIN

Secondary gain elements include the use of symptoms and disorganizing personality traits as means to security and self-esteem. Every neurosis possesses a certain protective quality for the patient even though it vitiates the patient's productivity and sabotages happiness. Indeed, the patient may resent abandoning spurious values that accrue from a neurosis. Thus, a psychosomatic illness may inspire sympathy from people, absolve the patient from responsibility, and perhaps serve as a means of punishing intimates in the environment toward whom the patient feels resentful. In stress reactions (traumatic neurosis) the factor of monetary compensation may make sickness a real asset to the individual. Personality distortions may constitute the only means that the patient knows of relating to people. The patient may, therefore, conceive of therapy as a means of exposure to dangers or deprivations that have so far been avoidable.

The stronger the secondary gain, the less favorable is the prognosis. During therapy, however, secondary gain elements may be handled and worked through as forms of resistance.

EGO STRENGTH AND EGO WEAKNESS

The concept of ego strength is an empirical construct that is useful in estimating prognosis. The ego may be conceived of as an integrating force that permits mobilization of adaptive resources. The ability in insight therapy to face inner conflict, to tolerate the intense emotions and anxieties liberated in the relationship with the therapist, to recognize the irrationality of these emotions, to understand their genetic origin, to abandon the spurious values and secondary gains of a neurosis, and to establish patterns of behavior in line with mature goals calls for a relatively strong ego structure.

Estimates of ego strength may be made from data in the following areas: (1) hereditary influences, (2) constitutional factors, (3) early environmental conditionings, (4) developmental history, (5) present interpersonal relations, (6) methods of handling stress, (7) ability to gratify vital needs, (8) symptoms, (9) precipitating environmental factors, (10) type of previous adjustment, and (11) prevailing level of social maturity. Zucker (1963) has outlined test procedures to determine ego weakness, which manifests itself in disturbances in screening of external stimuli, fusion of different realms of cognitive experience, tendency to multiple identifications, fluctuating body image, inability to segregate the consequential from the inconsequential, and the extension of the ego field into other fields or entities.

Hereditary Influences

The significance of heredity in fashioning ego strength is unclear. It may be speculated that a "neuropathic predisposition" imposed on the individual by heredity tends to influence negatively biochemical and neurophysiological systems, and to weaken the ego, but how this operates and the extent of its influence cannot be described. A family history of mental illness, especially manic-depressive psychosis, schizophrenia, alcoholism, convulsive disorder, and drug addiction must always be considered seriously; nevertheless, a favorable early environment may neutralize some destructive hereditary factors. On the other hand, absence of hereditary history of mental illness does not mean that ego strength is guaranteed.

Constitutional Factors

Like heredity, it is difficult to assign to constitution a definite role in the molding of ego strength. A constitutionally abnormal stature or physique or endocrine disorder, however, may create problems for the person and, in this way, indirectly influence ego functioning.

Early Environmental Influences

Both behaviorists and psychoanalysts agree on the decisive role of early childhood in molding and establishing the patterns of adulthood, both good and bad. Some therapists have a fatalistic attitude about this, as if all that matters is a salubrious early life for the creation of a happy, adjusted adult. On the other hand, a disturbed childhood, it was once thought, presumably predisposes to an inevitable destiny of doom. These concepts have in recent years undergone some revision, as it has been proven that children are sufficiently resilient in their reactions so that, given a reasonably constructive milieu following a deprived and destructive upbringing, surprising reparative changes are possible (Clarke and Clarke, 1976; Rutter, 1972; Thomas and Chess, 1980). The degree of change will depend on the severity of early damage and the opportunities for growth offered to the child. An impressive number of studies has also cast doubt on "critical periods" of learning and even the so-called irreversible effects of imprinting in animals, whatever implications these have for humans.

Longitudinal studies indicate that it is impossible to predict the degree of competence and maturity in adults from the severity of confusion and disturbance during the childhood and adolescent years. Growth is possible at every stage of the life cycle from infancy to maturity. Yet it cannot be guaranteed that memory traces of a cruel and destructive early existence can be entirely eradicated by a propitious later environment, nor that these do not surface in dreams and in certain emergency reactions. Nor is there assurance that crisis situations in which mature modes of coping are shattered will not sponsor some catastrophic reactions reminiscent of an earlier state of disorganization.

The fact that an individual disrupted in growth during early development *can* change in later life sufficiently to overcome early handicaps does not guarantee that the individual *will* change. Among the reasons for this inability are the continued existence of inimical environmental circumstances, and the individual's inherent characteristics, creating stressful conditions that resemble the traumatic

happenings of the person's childhood, even though the milieu itself could be favorable in supporting constructive relearnings. We must remember that clinicians see a special subgroup of patients who have failed to change and that consequently false assumptions about capacities for change may be generalized to the population at large. On the other hand, most surveys and research studies have dealt with an unselected population and are more apt to present a more accurate picture of what happens. This may account for the discrepancy in ideas between clinicians and researchers.

Severely traumatizing influences in early childhood in some persons may have impoverished ego development so drastically as to limit the extent of its potential growth. Where historical material during early childhood reveals great stress, an attempt should be made to ascertain the effect on the patient's ego. Among traumatizing influences are disharmony in the home; intense conflict between the parents or parental separation or divorce; tendencies in either parent that make him or her markedly authoritarian, domineering, excessively punitive, cruel, intolerant, unstable, immature, cold, neglectful, rejecting, weak, sickly, superstitious, overprotective, neurotic, psychotic, or alcoholic; and great rivalry with, or jealousy and dislike of, a sibling. The absence of such influences is not necessarily a favorable prognostic sign.

Developmental History

By the same token, certain findings in the developmental history are indicative of a potential stunting of personality growth. They are often insignias of possibly extensive and even irreparable damage to the ego. Among important findings are the following:

1. *Birth:* (a) Patient an unwanted child, (b) premature birth, (c) birth injury.
2. *Feeding problems:* (a) Great undernourishment, (b) vomiting spells or colic, (c) bottle fed after 1½ years.
3. *Early care:* (a) Mother sickly after patient's birth, (b) mother not involved in early care, (c) care by a succession of nurses.
4. *Physical development:* (a) Delayed growth, (b) deformity.
5. *Habits:* (a) Retarded dressing and toilet habits, (b) enuresis, (c) improper sleeping habits.
6. *Intellectual development and school adjustment:* (a) Delayed talking, (b) started school when 7

years old or older, (c) got along poorly with teachers, (d) repeated grades, (e) got along poorly with schoolmates, (f) unhappy at school, (g) obtained low grades, (h) quit school before the eighth grade.

7. *Emotional maturity:* (a) Persistent temper tantrums, (b) continuing dependency, (c) unresolved sibling jealousy, (d) lack of assertiveness, (e) never self-supporting as an adult, (f) no effort to hold a job, (g) never married, (h) married, but divorced or separated, (i) no desire for children, (j) no group interests.

8. *Social development:* (a) Excessively selfish, withdrawn, timid, or seclusive, (b) no desire for friends or unable to form friendships, (c) unaffectionate and undemonstrative, (d) refusal to accept responsibilities.

9. *Sexual development:* (a) No sex education, (b) slept in parents' bedroom, (c) observed parents in sexual relations, (d) sexually stimulated by parent or nurse, (e) masturbatory intimidation, (f) intercourse before 16, (g) sexual seduction before 16.

10. *Illnesses and accidents:* (a) Convulsive disorder as a child, (b) "sleeping sickness," (c) poliomyelitis, (d) asthma, (e) fainting or dizzy spells, (f) migraine, (g) trouble with sex organs, (h) endocrine disease, (i) head injury, (j) several accidents, (k) several fractures, (l) cardiac disturbance, (m) stomach and intestinal illness.

11. *Neurotic traits:* (a) Peculiar toilet habits, (b) persistent thumbsucking, (c) nail biting, (d) easy crying, (e) persistent fears, (f) nightmares, (g) sleep walking, (h) speech problems, (i) tics, (j) compulsions, (k) excessive daydreaming, (l) cruelty, (m) excessive aggressiveness, (n) truancy, (o) hyperactivity, (p) runaway tendencies, (q) stealing, (r) fire setting, (s) detachment.

Current Interpersonal Relations

The nature of the patient's current interpersonal relations may yield some clues to ego strength. Human beings display an endless variety of interpersonal reactions. The intensity of such reactions rather than their quality is of pathological consequence. As a general rule, the personality distortions tabulated below indicate that long-term reconstructive therapy will be required to influence them significantly. They do not, however, indicate how the patient will respond to treatment. The quality of interpersonal relationships the individual possesses will determine the capacity to establish a proper working relationship with the therapist. Severe difficulties will interfere with treatment (Kernberg, et al., 1972). Some of the distortions are more serious than others, for instance, detachment or open aggression.

On the other hand, the relative absence of personality distortions is a good prognostic sign. The characteristics listed below must be considered of negative prognostic importance only when they appear in exaggerated form.

1. *Relationship with people in a superior or authoritative position:* (a) Dependency, (b) submissiveness, (c) shyness, (d) ingratiation, (e) fear, (f) dislike, (g) distrust, (h) aggression, (i) detachment.

2. *Relationship with friends and colleagues:* (a) Absence of close friends, (b) feelings of being disliked, (c) avoidance of people, (d) lonesomeness even when with people, (e) fears of people, (f) inability to mix, (g) fear of rejection, (h) dependency, (i) submissiveness, (j) distrustfulness, (k) aggression, (l) dislike of people, (m) inability to get along with women, (n) inability to get along with men, (o) fear of women, (p) fear of men, (q) feelings of difference from other people, (r) feelings of inferiority, (s) feelings of superiority, (t) jealousy of others, (u) suspicion of motives of others, (v) stubbornness with others, (w) insistence on having own way, (x) furiousness when crossed.

3. *Miscellaneous relationships:* (a) Dislike of younger, older, less attractive, or unfamiliar people, (b) suspiciousness, (c) self-consciousness.

4. *Group relations:* (a) Dislike, fear, and avoidance of groups, (b) shyness in groups.

5. *Attitudes toward self:* (a) Shyness, (b) lack of self-confidence, (c) avoidance of responsibility, (d) indecisiveness, (e) despising of self, (f) perfectionism, (g) meticulousness, (h) parsimony, (i) obstinacy, (j) self-dramatization, (k) narcissism, (l) grandiosity, (m) mysticism, (n) feelings of guilt, (o) need for punishment, (p) resentfulness.

6. *Emotional reactivity:* (a) Exaggerated, (b) limited.

Methods of Handling Stress

The adequacy or inadequacy of the defensive reactions of the individual may be of significance. Among the less favorable signs in relation to the handling of stress are physical withdrawal, emotional detachment, fantasy, acting-out, aggression, sadism, alcoholic overindulgence, excess sedation, intense dependency, self-punishment, self-aggrandizement, intellectual confusion, emotional shattering, physical sickness, compulsions, depression, feelings of unreality, and sexual perversions. Unfavorable also is an inability to face pain or to tolerate anxiety that will occur when the patient's resistances are

challenged.

Ability to Gratify Vital Needs

The ability to gratify, in conformity with the mores, important biologic and social needs without guilt, aggression, or self-punishment are signs of ego strength.

Symptoms

Prognostically unfavorable symptoms are stammering, homosexuality, exhibitionism, fetishism, sexual sadism, sexual masochism, psychomotor retardation, violent rages, euphoria, apathy, fear of blushing, fear of germs, fear of soiling, fear of contamination, fear of poverty, uncontrollable impulses, handwashing, ritualistic acts, hair plucking, self-torture, delusions of influence, delusions of persecution, delusion of "thoughts being stolen," grandiose delusions, delusion of "mission to perform," delusion of body organs rotting, delusion of having committed an "unpardonable sin," delusion of "having lost one's soul," ideas of reference, hallucinations, impaired reality sense, depersonalization, impaired judgment, alcoholism, drug addiction, criminality, and hypochondriasis.

Precipitating Environmental Factors

Emotional ailments occurring in the medium of severe environmental stress, and directly related to the stress factor, may have a favorable prognosis, provided that the environmental difficulty can be resolved or that the patient is capable of making an adjustment to irremediable circumstances. Illustrative are catastrophic life happenings, such as accidents, disasters of nature or those brought on by war, death of parents, mate, or children, abandonment, separation or divorce, and severe losses of prestige, position, or economic security. On the other hand, emotional illness developing in the face of a congenial environment has a less favorable prognosis.

An emotional problem brought on by severe environmental stress does not always indicate a good prognosis, even in the absence of maladjustment prior to the cataclysmic happening. In some instances the stress situation may touch off a residual neurosis by bringing into play repressive and regressive defensive techniques that persist long after the traumatic event has passed. Instead of recovering rapidly

with therapy, the individual may exhibit an obstinate reaction of helplessness, as if he or she no longer trusts the world that has so abruptly shattered all sense of personal mastery.

Previous Adjustment

If the patient has, at any period in life, made a good adjustment, the prognosis would probably be better than if maladjustment were present continually from early childhood. In appraising the character of the patient's adjustment, the therapist should consider whether this was maintained at the expense of vital aspects of functioning. One should determine what it takes out of the person to make the kind of adjustment that is being made, even though made successful. For instance, a schizoid personality disorder may not militate against a social adjustment, provided that the individual is capable of avoiding situations of environmental stress and is able to be detached sufficiently from people to prevent close interpersonal involvements. An aggressive obsessive-compulsive individual may be able to carry on satisfactorily, with a modicum of happiness, if the environment and close friendships can be controlled. Or adjustment may be contingent on the gratification of immature dependency strivings, maladjustment ensuing upon withdrawal of the host. Thus, the quality of one's past adjustment and the areas of functioning that must be inhibited for purposes of adaptation will determine whether or not they can be considered evidence of a strong ego.

Level of Social Maturity

Estimates of personality maturity in terms of physical growth, educational achievement, resolution of dependence, sexual maturity, marriage, parenthood, quality of social relationships, and group and community participation are possible indications of ego strength. However, an individual who has achieved satisfactory interpersonal relationships and a good social adjustment, satisfying accepted criteria of maturity, may still be a seriously sick person emotionally, who, upon succumbing to collapse in adaptation, may offer strong resistances to psychotherapy. Thus, a person may achieve social maturity by repressing powerful anxiety-provoking conflicts and by evolving a personality structure organized around perfectionism, obstinacy, meticulousness, repression of hostility, and a compulsive need for order and precision in the immediate environment. Therapy may be a prolonged and difficult task, even though the individual may have operated in life on an apparently high level of maturity.

On the other hand, evidence of immaturity (impaired physical growth, low educational achievement, continued dependency ties, sexual infantility or perversions, distorted life goals, inability to accept marriage or parenthood, inability to coordinate ambitions with aptitudes and the existing reality situation, disturbed social relationships, and lack of community participation) may, if prominent, be regarded as direct signs of ego weakness.

THE CURRENT ENVIRONMENTAL SITUATION

Serious lacks and encumbrances in one's environment influence prognosis negatively. Thus, a disturbed environment that the patient cannot alter, and in which he or she is expected to function, imposes a burden on personal capacities for adjustment. A wife assaulted periodically and unexpectedly by an alcoholic husband from whom she is unable to secure a separation or divorce, and a dependent child reared in the home of acting-out sexually perverse adults are examples. Among inordinate environmental influences are economic stress; bad work, housing, and neighborhood situations; abnormal cultural standards and pressures; discordant family relationships; and disturbed daily habits and routines.

1. *Economic situations:* (a) The patient is subject to desperate or poor financial circumstances; (b) is unable to afford adequate food, shelter, and clothing; (c) cannot support dependents, meet present indebtedness, or provide for appropriate education and recreation.

2. *Work situation:* (a) The patient is unemployed; (b) has made the wrong selection of an occupation; (c) is unhappy at work due to inadequate salary, inimical work conditions, and few opportunities for advancement.

3. *Housing situation:* The patient lives in an inadequate dwelling in terms of insufficient space, absence of privacy, and uncleanliness.

4. *Neighborhood situation:* (a) The patient is subject to malicious activities by delinquent or criminal individuals or gangs; (b) is exposed to racial, class, or religious discrimination; (c) is without neighborhood recreational and social facilities; (d) lives too far away from work and social activities.

5. *Cultural standards and pressures:* (a) The patient comes from a different background than people with whom he or she lives and associates; (b) feels discriminated against because of race, religion, color, or national background; (c) finds it difficult or impossible

to adjust to the standards of the surrounding people; (d) refuses to conform with current cultural patterns; (e) experiences a clash between personal and community standards.

6. *Family relationships:* The patient (a) is unhappy at home; (b) is "ashamed of," "afraid of," or "hates" certain family members; (c) disagrees violently with people at home; (d) feels a threat to personal independence; (e) experiences constant insistence to "obey"; (f) is subjected to interference with legitimate social life; (g) one is criticized for personal appearances; (h) is subjected to angry displays; (i) though adult, is unable or unwilling to live away from his or her family; (j) has a difficult problem with family members living at home; (k) is financially dependent on parents.

7. *Relationship with mate:* (a) If married, the patient is unable to adjust to married life or to get along with his or her mate; (b) is not in love with the spouse; (c) fights constantly with the spouse; (d) has unsatisfactory sexual relations;(e) has an adulterous or emotionally ill mate; (f) is mistreated by the spouse.

8.*Relationship with children:* (a) The patient is having a severe problem with one (or more) emotionally ill offspring;(b) regrets having children; (c) the children are experienced as irritating; (d) mutual dislike between parent and children; (e) the children quarrel constantly and are refractory to reasonable discipline.

9.*Daily habits, recreations, and routines:* The patient is guilty of some of the following: (a) irregular meal times, (b) unbalanced diet, (c) excess coffee and tobacco, (d) improper body care and grooming, (e) insufficient sleep, (f) lack of exercise, (g) absence of interests, hobbies, or recreations, (h) few or no social or community activities.

Table 27-1
Summary of Positive and Negative Prognostic Signs in the Patient

Positive	Negative
1. The age of the patient is not too advanced	Patient has advanced to an age when learning is not so easy, patterns are set, and considerable rigidity exists.
2. Problems are of recent duration.	Problems date back to childhood or are of a long-standing nature.
3. Patient's symptoms or behavior patterns are incapacitating or inconvenient or arouse resentments in the patient.	Patient's symptoms or behavior patterns cause no inconvenience and are not incapacitating. Symptoms are strongly protective in nature and yield positive dividends, such as support, attention, and monetary compensation. Symptoms satisfy a masochistic need in the patient.
4. The patient is suffering from a stress, anxiety, phobic, conversion, or mild somatoform disorder.	The patient is suffering from an organic brain disorder, schizophrenia, manic-depressive reaction, involutional psychotic reaction, chronic anxiety reaction, chronic obsessive-compulsive reaction, drug addiction, sexual perversion, or severe personality disorder.

5. The patient has a normal or high intelligence.	The patient has a borderline or low intelligence.
6. The patient has a strong motivation for therapy. The patient applies for therapy and sees the need for it.	The patient has little or no motivation for therapy. The patient is brought into therapy by another person and does not see a need for it.
7. The patient has insight into the emotional nature of the problem.	The patient has no idea that the problem is emotionally inspired.
8. Elements of secondary gain are relatively lacking.	Secondary gain elements are present.
9. There is no hereditary history of mental illness.	There is a hereditary history of mental illness.
10. The patient has no constitutional abnormal stature or physique or endocrine disorder.	A constitutional disturbance is present.
11. The patient was not subject to severely traumatizing influences in childhood.	Severe traumatic influences existed in the patient's childhood.
12. Few or no distortions existed in the relationship of the parents with the patient.	There was severe disharmony in the home, severe difficulties between patient's mother and father, or severe distortions in the patient-parent relationship.
13. The developmental history shows no serious defects in physical development, habits, school adjustment, emotional maturation, or sexual development.	The developmental history shows a serious maladjustment during infancy and childhood.
14. Adjustment failures in childhood were minimal: childhood neurotic disturbances were absent.	There was failure of adjustment in childhood; patient had childhood neurotic disturbances.
15. Patient's relationships with people in general are good. There is plasticity in personality traits and defenses. The patient is able to establish a good relationship with the therapist.	The patient has severe disturbances in interpersonal relations. There is rigidity in personality traits and defenses. Transference elements are disturbing and interfere with a good relationship with the therapist.
16. Assertiveness is present, and self-esteem is good.	Assertiveness is lacking, and self-esteem is diminutive.
17. The patient's conscience is not too severe or too diminutive	The patient's conscience is excessively severe, is diminutive, or exerts an uneven pressure.
18. The patient is capable of handling reasonable stress or of enduring reasonable anxiety without repressive or regressive reactions.	The patient tends to handle stress or anxiety by reactions of physical withdrawal, emotional detachment, fantasy, acting-out, aggression, sadism, alcoholic overindulgence, excess sedation, intense dependency, self-punishment, self-aggrandizement, intellectual confusion, emotional shattering, physical sickness, compulsions, depression, and feelings of unreality.
19. The patient is capable of gratifying vital biologic and social needs in conformity with the mores of the group.	Patient is unable to gratify personal needs or does so in opposition to accepted mores.
20. The patient's symptoms consist of anxiety, tension, mild depression, or mild psychophysiologic reactions or phobias.	Symptoms consist of stammering, sexual perversions, deep depression, violent rages, euphoria, apathy, various obsessions and compulsions, ideas of reference, delusions, hallucinations, impaired reality sense, depersonalization, alcoholism, drug addiction, and criminality.

21. Immediate environmental precipitating factors are strong.	Immediate environmental precipitating factors are not intense.
22. The patient's adjustment prior to illness was good.	Maladjustment was present since early childhood.
23. The patient has achieved social maturity. There are no defects in physical growth, educational achievement and school progress, resolution of dependence, sexual maturity, marriage, parenthood, social relationships, and community participation.	The patient has been delayed in achieving social maturity. There are defects present in the patient's physical growth, educational achievement and school progress, resolution of dependence, sexual maturity, marriage, parenthood, social relationships, and community participation.
24. The patient has adequate interests, hobbies, and recreational pursuits.	Patient has few or no interests, hobbies, or recreational activities.
25. The patient's life situation will compensate for the abandonment of symptoms and reward the development of new patterns.	The abandonment of symptoms or the development of new patterns of behavior bring negative results or expose the patient to dangers of a strongly threatening nature.
26. Habitual environmental pressures on and responsibilities of the patient are average.	Habitual environmental pressures on and responsibilities of the patient that must be adjusted to are severe and irremediable. The patient will have to live in a disturbed or depriving environment (neurotic parents or mate, poor economic circumstances, harsh culture, and so on).
27. Ambitions are in line with aptitudes and the reality situation.	Ambitions are out of line with aptitudes or reality.
28. The patient has had no previous attacks of emotional illness.	The patient has had previous attacks of emotional illness.
29. The patient has received no psychotherapy in the past.	The patient has received psychotherapy in the past that was unsuccessful.
30. Therapy and the therapeutic situation do not impose too great hardships on the patient in terms of expense, time, travel, and so on.	Therapy and the therapeutic situation impose great hardships on the patient.
31. Patient has no problems in communication.	Patient has problems in communication.

PAST THERAPEUTIC FAILURES

One or more long unsuccessful psychotherapeutic experiences is generally an unfavorable prognostic sign. Exceptions to this rule include treatment by an unskilled therapist, by one who was unable to handle transference or to control countertransference reactions, or by one whose approach lacked flexibility. Because previous treatment had failed, the patient may have lost confidence in the efficacy of psychotherapy. This may act as resistance to treatment.

RESPONSE TO THE PRESENT THERAPEUTIC EFFORT

Once therapy has started, it may be possible to prognosticate the outcome with greater accuracy than from the appraisal of the past history. If the patient has or develops strong motivations for therapy, enters into a good working relationship with the therapist, is capable of understanding and resolving transference reactions, masters resistances to therapy, exhibits an ability to face anxieties associated with external stress and inner conflicts, shows a willingness to abandon the spurious values of the neurosis and to vanquish the secondary gain element, a reasonably good prognosis can be predicted. Table 27-1 summarizes the positive and negative prognostic signs.

Table 27-2
Summary of Prognostic Signs Relating to the Therapist

Positive	Negative
1. The therapist is capable of understanding the dynamics of the patient's illness. The therapist is well trained and skilled.	The therapist is confused about the existing dynamics. The therapist is not well trained and lacks skills.
2. The therapist is sufficiently sensitive to perceive what is happening in the treatment process.	The therapist is insensitive to what is going on within the patient and within himself or herself.
3. The therapist is aware of his or her own feelings and is capable of remaining objective irrespective of the attitudes and behavior manifested by the patient.	The therapist is incapable of maintaining satisfactory objectivity.
4. The therapist is flexible in the approach used.	The therapist is rigid in the approach used.
5. The therapist has a capacity for empathy with the patient.	The therapist lacks empathy with the patient.
6. The therapist tends to treat the patient in a respectful and cooperative manner.	The therapist is domineering, pompous, and authoritarian.
7. The therapist is capable of being firm on occasion.	The therapist is too passive and submissive.
8. The therapist is capable of establishing a working relationship with the patient.	The therapist is detached.
9. The therapist is well adjusted and is satisfying basic needs.	The therapist tends to use the patient for the vicarious gratification of repressed or suppressed impulses, such as sexuality, the expression of hostility, and the gaining of prestige.

10. The therapist is capable of tolerating the expression of varied impulses in the patient.	The therapist is incapable of tolerating such impulses in the patient as sexuality, hostility, or assertiveness.
11. The therapist has no neurotic attitudes toward money.	The therapist's insecurity reflects itself in anxiety about fees and payments.
12. The therapist is able to tolerate the vicissitudes inevitable in therapy.	The therapist is unable to tolerate blows to personal self-esteem by the patient's acting-out tendencies, by manifestations of resistance and transference, and by the inevitable failures and frustrations in treatment.
13. The therapist feels personally secure.	The therapist has a neurotic need to be liked, a compulsive tendency toward perfectionism, inordinate hostility, lack of creativity, no sense of humor, an inability to take criticism, low personal integrity, a diminished respect for people, a failure to acknowledge self-limitations, a low energy level, or poor physical health.
14. The therapist is capable of giving the patient support in accordance with the patient's needs without overprotecting or dominating the patient.	The therapist rejects the patient or refuses to or is unable to extend to the patient measured support.

It may seem odd to include the therapist in a prognostic index. Since psychotherapy is an interpersonal relationship, however, the therapist's attitudes toward a specific patient and capacity to understand the patient and to provide a meaningful relationship for him or her are important in estimating what will happen in the therapeutic situation. It is difficult to predict from the general responses of the therapist whether it will be possible to establish a good relationship with a certain patient. The therapist may be able to relate better to some patients than to others. Furthermore, since empathy with a patient and his or her problems is mandatory for success in psychotherapy, the therapist may be able to work better with certain kinds of emotional ailments and not so well with others. Table 27-2 summarizes the prognostic signs for the therapist.