THE TECHNIQUE OF PSYCHOTHERAPY

THE INITIAL INTERVIEW

MAKING PRACTICAL ARRANGEMENTS FOR PSYCHOTHERAPY: TREATMENT PLANNING

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The Initial Interview:

Making Practical Arrangements for Psychotherapy; Treatment Planning

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The Initial Interview: Making Practical Arrangements for Psychotherapy; Treatment Planning

Before making any arrangements for therapy, it is advisable to give the patient a bird's-eye view of his or her problem in understandable and meaningful terms. The therapist presents a general statement of the problem, as the therapist sees it, and also what might be accomplished through psychotherapy. No interpretations are made; no outline of the dynamics are postulated; no promises of cure are extended; no pronouncements are expressed to the effect that the prognosis is bad. A possible statement might be, "Now I have a general idea of your problem, and I should like to give you some broad impressions of what might be done. Due to a number of factors, you have developed difficulties that 'tie you in a knot,' so to speak. You have some bothersome symptoms, and you are prevented from developing your potentialities. I think you need psychotherapy and can benefit from it."

Included in making of practical arrangements for therapy are choosing the therapist, choosing the type of therapy, deciding the frequency of visits, estimating the duration of therapy, arranging the fee, handling delays in starting treatment, and making final arrangements with the patient or referring him or her to another therapist.

CHOICE OF THERAPIST

By the time that the initial interview is completed, the therapist will usually have been able to evaluate whether he or she can, given the level of training and skills, handle the patient's problem. The therapist may, by virtue of training, be equipped to treat the patient. Whether or not the therapist decides to do so will be dependent on his or her emotional response to the patient, interest in the specific problem presented, and ability to make the proper time and financial arrangements with the patient. The therapist will also have to take into account the patient's own wishes.

The interviewer may not be trained to implement the kind of therapeutic approach best suited for the patient's difficulty. Thus, if formal psychoanalysis is decided on as the treatment of choice and the

interviewer is not analytically trained, he or she will want to transfer the patient to a psychoanalyst.

If a dangerous depressive condition necessitates electric convulsive therapy, (ECT), and the psychotherapist does not use this modality in practice, or if one is a non-medical therapist, a suitable psychiatrist will have to be found who can give shock treatment. If hypnotherapy seems indicated, a specialist in this field will be required. If behavior therapy, cognitive therapy, family therapy, couples therapy, or group therapy are what will help the patient most, arrangements for these will have to be made unless the therapist is familiar with these techniques.

The patient may possess a type of problem that the interviewer does not care to handle. For instance, some therapists do not like to work with adolescents, older patients, borderline cases, schizophrenics, alcoholics, drug addicts, obsessive-compulsive neurotics, severe anxiety hysterics, or psychopathic personalities. Moreover, the emotional response of the patient to the interviewer, and of the interviewer to the patient, may be such that it is obvious that they cannot work together. Finally, the patient may decide against starting treatment with the initial interviewer, even though the latter is willing to accept the patient for therapy. While this contingency is rare in a properly conducted interview, the therapist should still be prepared to meet it on occasion.

The question is often asked regarding the preferred sex of a therapist for the handling of certain problems. Experience proves that the personality and skill of the therapist are more important than whether the therapist is male or female. Nevertheless, some patients seem to do better with therapists of one sex than the other. Thus, if the patient has had damaging experiences of rejection, neglect, or harsh treatment from his or her father and has later never been able to establish a good relationship with a man, severe problems of a transference nature are apt to develop with a male therapist. If the ego structure of such a patient is furthermore weak, treatment may stir up anxieties that are beyond coping powers. Under these circumstances it is probably better to get the patient started in treatment with a female therapist. The opposite would be true if the prime problems were with a mother figure and were of such severity that the patient was uncomfortable with a female practitioner. Here a male therapist would probably be better for the patient. If, however, the ego of the patient seems strong, if reconstructive therapy is to be used, and if a transference neurosis is desired, the opposite choice might be indicated.

Certain kinds of syndromes seem to respond more readily in a relationship with a female therapist. Borderline cases and some types of schizophrenia, alcoholism, and psychopathic personality are often more easily handled by a female therapist, possibly because existing dependency (oral) needs are symbolically gratified and there is no potentially threatening masculine authority figure.

The age of the therapist may also influence the patient. Some patients are insistent upon an older therapist on the basis that age is an insignia of greater experience. An older female therapist is sometimes desired in cases where there is an urgent need for a mother figure, while an older male therapist may be sought by individuals who yearn for a relationship with a father figure.

There are specially gifted individuals who are remarkably ingenious, sensitive, and creative, and who, almost intuitively perceive the needs and potentials of their patients and are able to employ interventions and devise techniques that fulfill the requirements of any therapeutic challenge. Many therapists, however, are not so ably equipped. With adequate training, most aspiring practitioners, if they are not too handicapped by personality blights, can acquire adequate talents to do satisfactory psychotherapy. But there are some whose therapeutic ministrations leave much to be desired, and who manage to stay in business largely because of the placebo effect and the spontaneous remission rate.

CHOICE OF TREATMENT METHOD (TREATMENT PLANNING)

Treatment planning is a practice in which must be considered the immediate and ultimate goals to be achieved; the motivations of the patient to attain such goals; the intellectual and personality assets of the patient; the existing diagnosis; the flexibility, sophistication, and theoretical biases of the therapist; and many other factors. Lewis and Usdin (1982) have edited a book that constitutes a preliminary breakthrough on the subject. The future will undoubtedly witness additional contributions. Because emotional problems are so diverse and respond best to selective interventions, therapists wedded to monolithic approaches that work for some patients may organize a structured treatment plan around a modality that proves wholly unsuited for other patients. For example, a highly appropriate classical psychoanalytic treatment plan may be designed for a personality problem, and when applied to a borderline or schizophrenic patient will be as effective as shooting buckshot in the air.

In designing a treatment plan, it must be considered that most patients are anxious for as quick relief of their symptoms as possible. They see no need for an exhaustive probing of their patterns. Satisfying the demand for succor through supportive therapy is justified in certain situations. Supportive measures may be considered necessary where the patient's symptoms reflect an alarming collapse of coping capacities in the form of excessive anxiety, depression, and disintegrative tendencies with shattered capacities for reality testing. They may be indicated also in patients whose ego strength is doubtful and in whom adjustment to the existing neurosis, using available assets to the full and minimization of liabilities, is all that can be expected. Immature, dependent, antisocial, borderline, psychotic, alcoholic, drug addictive, and some compulsion neurotic patients often fall into this category. The therapist may have no alternative but to use supportive measures in patients who have no real motive for self-growth and who extract from their neuroses elements of profound secondary gain that they refuse to give up. Finally, supportive approaches are helpful in patients with adequate ego strength whose adaptive capacities are habitually good but who have crumbled under the impact of extremely severe environmental stresses and want to reconstitute themselves as rapidly as possible.

Irrespective of diagnosis and severity of symptoms, however, the therapist has a responsibility to bring each patient as far along the path of maturity as possible by resolving resistance to the acceptance of more intensive help. This means that some form of at least modified reconstructive therapy will be indicated whenever feasible.

If the patient has a history of having made an adequate adjustment in early life and, until the onset of the present illness, has gotten along satisfactorily, the chances are that the individual can be brought back to previous levels of adjustment with an approach that is geared toward reeducative goals. Restoration of former status will generally not require a great deal of time. But where the patient has been seriously maladjusted since early life and later adaptation has never been adequate, therapy should be tried that is reconstructive in nature to promote in the patient a development of those capacities that have never previously existed. A less intensive form of therapy would achieve only abbreviated goals, which, of course, may be all that realistically can be approached in many cases.

For instance, a 48-year-old man successful in business, is referred for therapy by his physician because medications have failed to correct a painful gastrointestinal ailment that has persisted for eight

months. During the initial interview, it is tentatively determined that the patient was severely neurotic as a child and that he managed to adjust satisfactorily as an adult only by assuming a detached attitude toward people. A bachelor, the patient's relationships with women were sporadic, superficial, and largely centered around temporary sexual affairs. Despite the yearning for "a real woman," who would be a "real" wife and lover, no such personage had ever presented herself. However, one year previously, following a short affair, the patient, in spite of the fact that his paramour did not completely come up to specifications, decided to experiment with living together. Shortly after the young woman took up residence with him, he began to develop symptoms. His loss of energy and his "stomach upsets" caused him to confine himself periodically to bed, from which he issued orders to his lover. Violent rages at her incapacity to supply his demands for service and attention were followed by bouts with apologetic self-reproach.

The patient's history revealed that he had been brought up in an atmosphere of relative emotional deprivation. Following the death of his father, his mother was forced to go to work, assigning the care of the three-year-old boy to an aunt who was not too happy with her charge. The boy grew up as a tough, detached individual with a deep craving for maternal attention, a distrust of women, and what seemed to be compulsive needs for self-reliance and independence. As an adult he maintained his detachment and independence, and as long as he limited his relationships with women to superficial contacts, he seemed to get along quite well. He was a successful, respected businessman, with many male friends and a reputation of being "quite a lady's man."

It can be theorized that need for a mother figure, who would perhaps make up for the dearth of love and care he experienced in childhood, drove him toward finding an idealized female love object. The possibility of his paramour fulfilling this role both intrigued and excited him. He related to her as a child might to a mother, demanding bounties of constant affection and attention. In the process, his protective character drive of detachment was discarded. Anticipating the same kind of rejection that he experienced as a child, and, no longer capable of marshalling detachment and independence as security props, he became filled with catastrophic feelings of helplessness. He became more and more demanding of attention. His hostility toward, and distrust of, this new mother figure furthermore threatened his security. The anxiety liberated was apparently converted into somatic symptoms.

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In speculating on these dynamics for purposes of choosing the proper therapeutic approach, we may additionally theorize on the following:

1. It would be futile to treat the patient's symptoms with a supportive approach since he was living with conflicts that were stirring up symptoms. Attempting to remove or ameliorate his symptoms would be like blowing away smoke without smothering the flame.

2. Were it possible to remove the patient forcibly from his upsetting entanglement with the young woman, to restore his detachment, and to bring his relationship with her back to what it was before he got so involved, he would probably detach from his driving need for a mother figure and maintain his distrust of women, but he would feel secure again and be capable of functioning with his habitual character facades. He might be helped to sublimate his need for dependency, perhaps in an affiliation with some group such as one devoted to community betterment. But, by and large, his adjustment would, for better or worse, parallel that which he possessed prior to his illness. Unfortunately, the helplessness inspired by the abandonment of his customary characterological drives of detachment, isolation and compulsive independence, and his awakened dependency, would probably preclude a forceful removal of the young woman from his life. Anxiety might precipitate that was so intense that he could not tolerate her absence.

3. A better approach would be reeducative in nature, aimed toward understanding the depth of his frenzied search for a mother substitute and the futility of satisfying his dependency needs in his present relationship. During treatment he would probably automatically transfer part of his dependency needs onto the therapist. He would, however, be brought to an awareness of how his desperate desire for security had caused him to make an alliance with a woman who could not supply the insatiable tenderness and love he demanded. He would be shown how this disappointment had undermined him, filling him with hate and despair. His having isolated himself from his customary friends and removed himself from his usual pleasures would be revealed as contributing to his insecurity. The patient might even acquire some insight into the origins of his dependency needs. These measures might suffice for him to break out of the relationship that he had developed during the past year and help him to return to his former level of adapatation, with its attendant satisfactions and dissatisfactions. The time required for this restoration would probably not be too long since he was satisfying his dependency in contact with the therapist.

4. For the patient to be more completely liberated, it would be essential to inculcate in him a deep feeling of inner security such as he has never had—a security bereft of dependency needs and involving measures of self-esteem and assertiveness. It would be necessary to promote the ability to establish warm relationships with people without desires to hurt

and to enslave, or to be hurt and to be enslaved. These reconstructive goals would necessitate long-term insight therapy that might last years. The patient would have to be motivated to accept this level of help with all the time and financial sacrifices that were entailed. He would also require sufficient ego strength to endure a certain amount of anxiety. Unfortunately, the patient may see no need for an extensive working out of his problems. He may be satisfied with the mere achieving of the adjustment that he had made prior to his collapse, even though he recognized its inadequacies. He may be unable to make the time or to gather sufficient funds for long-term intensive therapy. He may be unable to accept the treatment situation or the responsibilities that he must share in therapy. He may be incapable of tolerating the anxieties of transference or of withstanding an attack on his neurotic defenses and needs. He may be so rigid as to resist using insight in the direction of change, even though he has gained an intellectual understanding of his problem.

During therapy, this particular patient soon came to realize the operative dynamics involved. He then avowed a desire merely to return to his previous level of adjustment. Realizing that his paramour could not possible supply his dependency needs, he separated himself from her and resumed his previous activity. His adaptative equilibrium having been restored, the patient lost his symptoms and achieved as happy an adjustment as was possible with his underlying personality problem. This was considered an optimal goal in therapy since he had no motivation for more extensive change. Even with prolonged therapy there was no guarantee that personality reconstruction would have occurred in view of his age and the severity of his character problem. The kind of therapy employed was oriented around reeducative goals.

Once the category of therapy has been decided on—supportive, reeducative, or reconstructive—it may be wondered which of the many approaches are most suitable in a specific instance. Assuming, for example, that a patient requires and can use a reconstructive type of therapy, the best kind of reconstructive therapy is a questionable point. Should the therapy be Freudian psychoanalysis, organized around the establishment and analysis of a transference neurosis? Should it be a form of non-Freudian psychoanalysis, focused on the character structure and interpersonal relationships? Or should it be an active psychoanalytically oriented type of psychotherapy.

Since psychotherapy is a learning experience, one criterion of choice of therapies is the method best adapted to the learning aptitudes of the patient. Some patients are capable of learning rapidly in the

medium of an interpersonal relationship deliberately kept on a positive level by the therapist. In this medium they analyze their dreams and other unconscious productions and come to grips with their anxiety, without too severe resistances or too intense transference reactions. Here, psychoanalytically oriented psychotherapy may be remarkably effective. Other patients seem to learn better in a more formal analytic relationship, yet one that is not so intense as Freudian psychoanalysis. Such a non-Freudian psychoanalytic approach would concentrate on transference and resistance but avoid the setting up of a real transference neurosis. In other cases, particularly where repression is extreme, the only way that the patient can learn is through involvement in a transference neurosis, living through with the therapist important frustrations, anxieties, impulses, and feelings rooted in past conditionings with early authorities. Here a traditional Freudian psychoanalysis may be attempted.

Returning to the choice of categories of therapy, a rough index might consist of the following:

Supportive Therapy

Those who would benefit most from supportive therapy fall into seven categories: (1) patients who are in states of acute anxiety or depression or who have very severe disabling psychosomatic symptoms; (2) schizophrenics showing disintegrative tendencies; (3) patients with a history that points to good ego strength who have recently become ill and for whom the goal is merely a restoration to the previous adaptative level; (4) patients with problems in which a perverse environmental disturbance acts as the most significant stress source; (5) those who have severe character problems with obstinate dependency and immaturity; (6) those who suffer from severe obsessive-compulsive reactions; (7) those who suffer from especially obdurate habit disorders, alcoholism, and drug addiction.

Reeducative Therapy

Patients who will benefit from reeducative therapy are those with personality problems expressing themselves in difficulties in work, educational, marital, interpersonal, and social adjustment—especially those patients who have fairly good ego strength.

Reconstructive Therapy

Problems initiated by severe distortions in the individual's past relationships with parents and significant others, which have produced blocks in growth, may respond well to reconstructive therapy. Difficulties in which repression is the chief defense are most responsive. Included here are anxiety disorders, phobic disorders, conversion disorders, some obsessive-compulsive disorders, some personality disorders, and certain somatoform (psychophysiologic) disorders in persons with good ego strength.

It is essential to remember that the type of therapy required may shift during treatment. For example, the patient may be extremely upset at the start and require supportive handling. After stabilization he or she may be able to benefit from reeducative or reconstructive therapy.

Therapeutic Approaches in Different Syndromes

A systems approach recognizes the many interrelated units that must be considered in dealing with the specific problems of any person. These units may be visualized, as constituting a chain composed of interacting links—biochemical, neurophysiological, developmental as well as conditioned, interpersonal, social, intrapsychic, and philosophical-spiritual—that influence how a person thinks, feels, and behaves. Some of these interacting factors are intimately associated with the complaint that has led the individual to seek relief. The most effective help will be rendered by diagnosing the implicated links and targeting treatment toward these.

The different links are so amalgamated that feedback occurs throughout the chain when any one link is functionally disturbed. What probably concerns an individual most are the symptoms, which are usually the end product of this feedback. At the outset we would want to deal both with the consequences and sources of the patient's symptoms. But the person may be fully unaware of or may downplay sources. Thus an individual who seeks relief for depression and anxiety may not at all, or only indirectly, refer to marital discord. This is inspired by unsatisfied dependency needs, which promote hostility to the spouse when he or she fails to come up to the patient's expectations. The final result is hopelessness and depression. If the therapist focuses on the symptoms that disrupt the patient's well-being, e.g., depression and anxiety, and treats the disruptive biological link with an antidepressant, there should be some diminution of symptoms. But the intrapsychic and interpersonal links will probably be influenced only

minimally and will continue to promote trouble. It would be appropriate then to consider marital therapy and individual psychotherapy in addition to psychopharmacologic treatment. The matter of motivation is important. In our appraisal of the therapeutic focus we should consider which of the incriminated link systems the patient is ready to deal with and which is most amenable to alteration. There are some systems that are more difficult to change than others or that require more extensive therapy than the individual may be willing to sanction. Therefore, a compromise will have to be settled on and a link chosen that is susceptible to influence, the therapist hoping that through feedback other upset systems would undergo beneficial change. At the same time an effort would be made to create motivation for dealing with the most culpable link that is implicated in the patient's illness.

The choice of therapeutic approach invites the examination of which syndromes are best suited for different therapies. Thus a scheme for some of the symptoms and syndromes might be formulated in a manner such as the following recognizing that other therapies may be coordinately used for special reasons:

1. *Affective disorders:* (a) major depressive disorder: tricyclic or other antidepressants, electroconvulsive therapy (ECT); (b) atypical depression: monoamine oxidase (MAO) inhibitors; (c) bipolar disorder-depression and mania: Lithium; (d) dysthymic disorder: psychosocial therapy, MAO inhibitors, Xanax (alprazolam);

2. *alcoholism:* inspirational groups (Alcoholics Anonymous), Antabuse;

3. *anxiety disorder:* anxiolytics (Valium, Xanax);

4. *attention deficit disorder:* stimulants (Ritalin, dexedrine);

5. *conduct disorder in children:* family therapy, behavior therapy;

6. *dissociative disorder* (hysterical neurosis): hypnosis, psychoanalytic therapy;

7. *educational problems:* counseling, guidance;

8. *enuresis:* behavior therapy (reconditioning);

9. *family problems:* family therapy, group approaches, hypnosis, behavior therapy;

10. *habit disorders* (food, smoking, nail biting, gambling): group, behavioral, and hypnotic

therapy

11. *marital problems:* couples therapy, marital therapy;

12. *obsessive-compulsive disorder:* behavior therapy, antidepressants (Clomipramine);

13. *opiate addiction:* Methadone, inspirational groups (Narcotics Anonymous);

14. *panic disorder:* antidepressants; behavior therapy

15. *personality disorder:* psychoanalytic therapy, group therapy, cognitive therapy;

16. *phobic disorder:* behavior therapy—in-vivo desensitization (flooding);

17. *psychosexual dysfunctions:* sex therapy;

18. *schizophrenic disorder:* neuroleptics, rehabilitative therapy, day hospital care;

19. *sleep walking:* hypnosis, psychoanalytic therapy;

20. *somatoform* (psychosomatic) disorder: relaxation therapy (biofeedback, relaxation hypnosis, meditation);

21. *speech disorders:* speech therapy, behavior therapy;

22. *substance abuse:* inspirational groups (e.g., Narcotics Anonymous);

23. *tension states:* relaxation therapy (hypnosis, biofeedback, meditation);

24. *vocational problems:* counseling, guidance.

The choice of therapies for different syndromes is largely oriented around symptom control and problem solving. Ideally, there would also be some reconstructive personality change, which may, in certain cases, allow the use of a psychodynamically oriented therapeutic approach.

Although there are major exceptions to the outline that follows, some use may be found for classifying approaches, especially when referrals are to be made to therapists with different training backgrounds.

1. *Guidance:* Educational and vocational problems when treatment goals are abbreviated.

2. *Environmental manipulation:* Financial, housing, recreational, marital, and family problems when goals are abbreviated.

3. *Externalization of interests:* Detached and introspective patients when goals are abbreviated.

4. *Reassurance:* Patients who require rectification primarily of misconceptions related to heredity, physical illness, sexual functions, mental illness

5. *Prestige suggestion and prestige hypnosis:* Habit disorders such as nail-biting, insomnia, overeating, inordinate smoking; hysterical paralysis, aphonia, and sensory disorders when symptom removal is the only goal in therapy.

6. *Pressure and coercion.* Patients who act out or endanger themselves or others in situations when the treatment goal is limited.

7. *Persuasion:* Obsessive-compulsive personalities when no extensive treatment goal is intended.

8. *Emotional catharsis and desensitization:* Patients who have gone through traumatic experiences that have caused them guilt, fear, or suffering and who have not allowed themselves to emote sufficiently.

9. *Muscular relaxation* (biofeedback, autogenic training, meditation): Tension states and psychosomatic muscular conditions when an adjunctive paliative approach is indicated.

10. *Convulsive therapy:* Major and bipolar depressions; insulin shock in early schizophrenia; subcoma insulin treatment in severe acute anxiety states, toxic confusional conditions, and delirium tremens.

11. *Drug therapy:* Used in schizophrenia (neuroleptics); depression, bulimia, panic states (antidepressants); anxiety (anti-anxiety agents); tension and insomnia (benzodiazepine hypnotics); alcoholism (Antabuse); and attention deficit disorders (energizing agents).

12. *Brain surgery:* Restricted to patients with severe disabling schizophrenia, chronic disabling obsessive-compulsive neurosis, and hypochondriasis who have not responded to any drug therapy, psychotherapy, or convulsive therapy.

13. *Inspirational group therapy:* Dependent and immature personalities, drug addicts, and chronic alcoholics who need social contacts and benevolent parental figures to help them function.

14. *“Relationship therapy”:* Personality disorders in which distorted attitudes and values are prominent.

15. *“Attitude therapy*Personality disorders in which there are cognitive distortions.

16. *Interview psychotherapy:* Various syndromes.

17. *nondirective or “client-centered" therapy:* Patients with relatively sound personality structures who require help in clarifying their ideas about a current life difficulty or situational impasse.

18. *Directive counseling:* Patients with personality problems who require a forceful parental figure to goad them to activity.

19. *Behavior therapy:* Phobias, habit disorders, obsessive-compulsive disorders; conduct disorders; lack of assertiveness.

20. *Semantic therapy:* Personality problems in patients whose difficulties in communication constitute a primary focus.

21. *Reeducative group therapy:* Patients with some degree of insight into their problems who need emotional catharsis and the experience of interacting with others while learning about themselves.

22. *Freudian psychoanalysis:* Personality disorders, anxiety disorders, phobic disorders, conversion disorders, obsessive-compulsive disorders, and some somatoform disorders (psychophysiologic reactions) in patients who have good ego strength, are motivated, reach for reconstructive objectives, and are able to establish and tolerate a transference neurosis.

23. *Non-Freudian psychoanalysis:* Personality problems are particularly helped, but other syndromes may be treatable.

24. *Psychoanalytically oriented psychotherapy and transactional analysis:* Various syndromes.

25. *Hypnosis:* Stress disorders, anxiety disorders, phobic disorders, conversion disorders, habit disorders, some types of alcoholism, antisocial personality, and somatoform disorders (psychophysiologic reactions)

26. *Narcotherapy:* Severe stress disorders, anxiety disorders, phobic disorders, and some somatoform disorders and conversion disorders.

27. *Art therapy:* As an adjunct in reconstructive therapy when the patient is capable of symbolizing problems in art productions.

28. *Play therapy:* As an adjunct in reconstructive therapy with children.

29. *Group therapy* Personality problems, preferably in conjunction with individual therapy.

30. *Couples therapy:* Marital problems.

31. *Cognitive therapy:* Depressions, some obsessive-compulsive disorders, adjustment problems brought about by faulty self-statements, values, and beliefs.

32. Sex therapy: sexual disorders.

Choice of therapeutic approach involves many considerations, including a consideration of ethics (Sider & Clamant, 1982). For example, is it ethical to insist on electroconvulsive therapy (ECT) in an extremely depressed person when the family is against it? By the same token, it may be argued that it *is* ethical to prevent suicide. This, of course, is an extreme example because in most cases of therapy choice, other issues than the loss of life are at stake, such as the rapidity with which symptom relief occurs and the selection of a circumscribed problem area of focus. Thus relief of one selected symptom may be considered a priority, with sacrifice of urgently needed behavior change. Is this an ethical or unethical choice? On the surface it would *seem* to boil down to values. But it is not merely a matter of values when it is considered that there are many practical reasons for the selection of a particular treatment. Further argument of this point would involve endless philosophical debate. Therapists must sometimes make an arbitrary decision about treatment choice, and many will select the standard of what is considered best for the patient, recognizing that this may entail sacrifice of certain functions and responsibilities. An example from medicine may elucidate this point. In severe hypertension there are now many effective medications that will lower blood pressure. A side effect is a lowering also of sexual function, which may affect, for example, a man's relationship with his wife. We may lower the man's blood pressure, but at the expense of incomplete marital fulfillment because of ensuing impotence. Is it an ethical choice on the part of the physician to save the patient at the risk of stirring up trouble in the bedroom? Obviously good medicine would dictate prescribing antihypertensives but also dealing with side effect contingencies, such as providing counseling for alternate methods of marital satisfaction. This would be better than forcing on the wife the resolution that an impotent husband is better than a dead one.

Speculation that the patient can best use a certain approach does not necessarily mean that he or she will respond well to this approach. For instance, if a woman shows symptoms of adaptive collapse, like anxiety and depression, and has what is considered a weak ego, the therapist may decide to use a supportive technique, at least temporarily, in order to bolster her strength. The patient, though yearning for a supportive relationship may, however, rebel against becoming dependent. Indeed, some of her current symptoms may be a product of her fear that the only way that she can function is through dependency. Use of an approach that makes her feel dependent may create more anxiety than it resolves.

Considering the case of another patient—with a fear of sexuality—the therapist may decide that only in using a reconstructive approach can the patient's essentially destructive attitudes toward sexuality be modified. As treatment begins, the therapist may discover that the patient is a detached, frightened individual who shies away from any form of human contact. A sexual relationship is particularly alarming to him since it is associated with fantasies of being trapped and injured. His impotency serves the important purpose of protecting him from imagined injury. So terrified is he of closeness that even a carefully regulated therapeutic relationship, with the mildest probing of his psyche, sets off fears of mutilation. His ego may not be able to tolerate the rigors of a reconstructive approach. The therapist may, consequently, have to employ a supportive technique that, while reassuring, will not bring the patient to the goal of adequate sexual functioning.

Therapists must, therefore, adjust the therapeutic approach to the patient's existing capacities. One cannot make a person with crutches run, no matter how earnestly it is wanted for that person to reach a desired goal without delay. The patient's legs must first be strengthened and not be forced to carry a load that is too great to bear. Working within the bounds of one's strengths and limitations, the therapist may gradually increase the burdens and responsibilities and help the patient to work toward a technique that will bring about the desired results.

Most people come to treatment with an incomplete or erroneous idea of the values inherent in different psychotherapies. They may have developed a conviction from newspaper or magazine articles or from listening to lectures or the accounts of friends, that there is only one kind of treatment that has any value—for instance, psychoanalysis or hypnosis. When the patient is informed that the interviewer does not practice these specialities or disapproves of such therapies or has something better to offer, the

patient may become stubbornly resistant and refuse to enter into treatment.

If a patient does ask for any specific kind of approach, the therapist may inquire why the patient desires this treatment and what the sources of information were. One must never depreciate or ridicule the latter sources, even though one may indicate that there are other treatment methods to be considered.

Ways of managing this situation are indicated in Chapter 23.

TREATMENT MANUALS

Several attempts have been made to standardize psychotherapy by preparation of treatment manuals, especially for purposes of research, e.g., Beck et al. (1978) on cognitive behavior therapy, Klerman et al. (1982), on short-term interpersonal psychotherapy, Strupp & Binder (1984) on time-limited dynamic psychotherapy aimed at reconstructive goals, and the impending new manual on psychotherapy published under the auspices of the American Psychiatric Association. The advantage of such manuals is that they enable judges to observe what therapists are doing and how closely the operations of a therapist are adhering to the form of treatment that is being prescribed. It is well known that what therapists say they do may only distantly resemble what they actually do with their patients and even more remotely how they follow the precepts of a designated treatment.

Putting aside the not so easily dismissed argument—in this day of epidemic lawsuits—that a treatment manual can provide a contentious lawyer with ammunition that impresses an unsophisticated jury with the defections of a therapist under fire, other cautions present themselves. No two therapists function exactly alike even when trained in the same school by identical teachers and supervisors or when primed by the same treatment manual. This is to be expected since psychotherapy like any other art is interpreted singularly by individual practitioners. Moreover, the personalities of therapists vary greatly. What they do with what they learn, how they relate to patients (the essence of therapeutic process), the patterns of establishing contact, the manner of exhibiting empathy, the form of communication, the mode of confrontation, and so on will vary. In exposing a trained therapist to a treatment manual, it must be kept in mind that following its directions precisely would cramp the therapists' style and spontaneity and put them into an operational straitjacket that defeats what the

treatment manual is trying to do. This does not invalidate the virtue of attempting to standardize the mechanics of a specified technique, but it points out the necessity of observing whether the technique unduly constrains therapists' patterns of therapeutic operation.

FREQUENCY OF VISITS

The number of sessions conducted weekly will depend largely on the patient's needs, on practical contingencies of available time and finances, and on the patient's special response to therapy. Some patients do well on a once-a-week basis; others have such intense anxiety or strong resistances that they require more frequent sessions.

Sessions on the basis of once or twice weekly are often prescribed in psychoanalytically oriented psychotherapy, reeducative therapy, and supportive therapy. At the beginning it is sometimes advisable to see the patient as often as three times weekly and even oftener, for instance if the patient is in a panic state. A short period of such intensity may enable the psychotherapist to establish a working relationship rapidly and to stabilize the patient sufficiently so that the number of visits weekly may be reduced. There is generally little association between the frequency of visits and the length of time it takes the patient to get well.

In formal Freudian psychoanalysis five visits weekly are the rule, although some analysts may reduce this number to four. An interval between visits is believed to water down transference and to interfere with the establishment of a transference neurosis that is considered an essential prerequisite for therapy. Three visits weekly and sometimes fewer are considered adequate in non-Freudian psychoanalysis, perhaps because there is not so much emphasis on the transference neurosis.

Some general rules for increasing or decreasing the frequency of treatment sessions follow:

1. A small number of sessions each week (1 or 2) are indicated:

    a. In most forms of supportive and reeducative therapy.

    b. In many forms of psychoanalytically oriented psychotherapy.

    c. In dependent, infantile patients to prevent a hostile, dependent relationship.

d. Where a transference neurosis is to be avoided.

e. In patients who tend to substitute transference reactions for real-life experiences.

f. In patients who are not too disturbed and who seem to be able to discharge their responsibilities and to carry on satisfactory interpersonal relationships.

2. A larger number of weekly sessions (3-5) are indicated:

a. When Freudian and non-Freudian psychoanalysis are to be employed, particularly when a transference neurosis is desired.

b. When patients show signs of severe adaptational collapse—acute anxiety, depression, psychosomatic symptoms, and ego disintegrative tendencies requiring constant emotional support.

c. In patients with rigid character structures who have built a shell around themselves so thick that a concentrated attack on their defenses is essential.

d. When patients have no motivation for psychotherapy and when a consistent demonstration of therapy's value is necessary.

e. In patients who are intensely hostile.

f. In patients with a diminutive superego who need an ever present authority to check the acting-out of impulses.

The difficulty that arises in once-a-week therapy is that intense anxiety may be mobilized as patients come to grips with their inner problems. They may then use such props and devices as sedatives, tranquilizers, energizers, alcohol, acting-out, or escape from therapy to avoid coming to grips with the conflict. The problems inspired by very frequent sessions result from a perpetuation of dependency and a stimulation of a transference neurosis that is not desired.

ESTIMATING THE DURATION OF THERAPY

In a sense, all therapy is interminable in that once it is started, the process of self-understanding and growth can continue the remainder of the patient's life. However, the actual time spent in a therapeutic relationship may be relatively short, lasting until symptoms are relieved, abnormal character

patterns corrected, or blocks to maturation resolved. The time required to achieve these goals will depend on the nature of the patient's problem, how extensively the patient has worked through the difficulty independently, the patient's readiness for change, the flexibility of character organization, the intensity of resistance, the motivations for therapy, the astuteness and skill of the therapist, and the kind of relationship that develops in the therapeutic situation. It is difficult, therefore, at the start, to predict how long it will take for the patient to get well until his or her response to therapy has been tested. Nevertheless, a number of broad generalizations are possible:

1. When the patient's history reveals a good adjustment up to the time of the present illness, and when the latter is of relatively short duration, the chances of restoring the patient to the previous level of adjustment in a relatively short time are good.

2. When there is a long history of maladjustment and the patient's present condition appears to be an outgrowth of this, therapy will probably be prolonged.

3. As a rule, one is able to achieve with short-term therapy abbreviated goals— such as symptom relief—while more extensive goals, like modification of obdurate character patterns or expansion of personality growth, will require an extensive period of working through, ranging from 2 to 5 years in or out of therapy.

4. Some patients, such as those with borderline schizophrenic and dependent personality problems, may require therapy for five years, or even longer. Rarely, a patient may need a supportive therapeutic relationship the remainder of his or her life.

5. There are some therapists who believe that short periods of therapy that are focused on the immediate presenting complaints is the best model to follow. This philosophy follows the usual pattern of dealing with physical problems by consulting a physician for a period sufficient to control the symptoms. When there is an outbreak of the same or other symptoms, visits to the doctor are renewed. In dynamic short-term therapy this plan is sometimes also pursued, the patient being given home assignments to work through involving dynamic themes. When blocks occur, or when new problems develop, another interval of short-term therapy is arranged.

ARRANGING THE FEE

A frank discussion with the patient about the patient's finances and the expenses involved in therapy is very much in order. This is especially necessary when there is no insurance or reliable third-

party payer and therapy will last for more than several months. The patient may be apprised of the fee per session and then asked whether the payments will be manageable in the event treatment continues as long as is estimated to achieve a desired goal. If the patient is unable to raise the required sum with present income, it may be possible for the patient to arrange to supplement the income by borrowing. It is important that the sum spent on therapy be available to the patient without too great sacrifice since severe financial pressures may negate the effects of treatment.

Many therapists have a sliding scale of fees, adjusting these to the income of the patient. This practice is a commendable one, but some therapists may not be able to afford reducing their fees to patients of low income. It will be necessary for the prospective therapist to face the fact that the patient may require therapy for a long time. The therapist who resents treating a patient at a fee lower than he or she believes is deserved is not playing fair with the patient; the resentment will come through in some form, if only in disinterest, boredom, and relief when the patient does not show up for an appointment. A dialogue concerning payments is indicated, and if the patient is unable to meet the proposed fee, the therapist either has to resolve his or her resentment or else refer the patient to a less exasperated, less expensive resource. Moral and ethical values come into play here that each therapist will have to resolve individually.

If the patient has a problem that will require long-term treatment, it will be important to determine whether the patient will be able to make the proper time and financial preparations. The patient may be approached as in the following excerpt:

Th. Now in going over your problem, there are several approaches that we might use. In the first place, your present difficulty really goes far back in your life. As a matter of fact, it probably had its inception in your childhood. So, if you really want to untangle yourself more or less completely, it will take time. In other words, if you want to eradicate the basis of your trouble, it may take as long as 2 to 3 years.

Pt. Does it have to take that long?

Th. Well, it took you a long time to get tangled up. It may take you some time to get rid of your trouble.

Pt. I know it goes far back.

Th. Yes, and, therefore, if you want to untangle yourself, it will require time. As I said it may take as long as 2 years, and maybe even longer.

Pt. How often would I have to come?

Th. That would depend. In your particular case it would require two or perhaps three visits weekly. *[Should the patient have a problem that required fewer visits, he would be so informed.]* But, it may not be necessary to remake you completely. It may be possible to work on one aspect of your problem—the most disturbing aspect—so that you may adjust yourself better to life, making the most of what you have. In other words, if our goals are less extensive, it wouldn't take so long.

Pt. I don't like to do things halfways. I'd rather do a complete job.

Th. Of course, there is the matter of your being able to budget your finances to cover a long period of treatment.

Pt. How much would it cost?

Th. That would depend on who treated you. For instance, there are people who might be able to treat you for $25 a session, and others may charge as much as $60. But suppose you give me an idea of what you can afford to pay if you did have to come for a long period.

Pt. Well, I could pay the regular fee, but I would like to have someone experienced. What about you?

Th. Do you feel you can work with me?

Pt. Oh yes, I believe I can.

Th. Well, I do have some available time, and I believe I will be able to work with you. As a general rule, a three months' trial period is best, to see how we work together. That is, at the end of three months we would mutually decide how we get on, and whether I am the best person to help you. My fee is $50 per session for 45 minutes.

Pt. Good, that sounds good.

Th. All right, now when can you come? At what times?

Pt. Generally, doctor, mornings are best for me.

Th. Well, let's see. *(referring to schedule)* I can see you Mondays at 11:40 and Thursdays at 10. If we have to arrange another appointment hour, we'll do it later.

DELAYS IN STARTING THERAPY

Sometimes the interviewer will have no time for the patient. Consequently, it may be necessary to postpone starting treatments until time can be made available. This is possible if the patient does not need therapy immediately. When treatment is urgently required or where an emergency exists, it is obviously essential to start therapy without delay or to refer the patient to a therapist who does have time. It is highly desirable here that the interviewer make provisions for the patient and not send the latter out on a blind mission to interview other therapists who may also have no time for him or her.

FINAL ARRANGEMENTS

If the interviewer has decided to start therapy with the patient and an agreement has been reached regarding time and fees, final arrangements may be made with the patient and an appointment date set. It is advisable to inform the patient regarding the length of each appointment, the need for promptness in appointment times, the way payments of fees are to be made, and whether or not the patient will have to pay for broken appointments. The following excerpt illustrates these points:

> *Th.* Now I'd like to tell you something about your future appointments. They start promptly at the appointed time and last three-quarters of an hour. I'll send you a bill at the beginning of the month. Now, it's important that visits be consistent because it may set you back to skip visits. Of course, if emergencies arise or if you get ill, you can't help canceling one or more visits. If this happens, try to let me know at least 24 hours in advance. The custom is to charge for broken appointments where sufficient notice is not given, let us say 24 hours.

Some therapists demand a fee of patients who miss appointments for any reason, including illness and vacations that do not coincide with their own. Freud (1913) was firm about the "leasing" of an hour to a patient and the patient's financial liability for it even if the patient did not use the session. Many therapists accept Freud as a model for their business arrangements with their patients. Other therapists are more flexible and mindful of the patient's right to emergencies, illness, or vacations. In the former instance a full explanation of the rationale for the therapist's practice should be given to the patient, or resentments will be aroused about the patient's being exploited and treated unfairly. The image of the therapist may be damaged unless the therapist explains the accepted practice of charging for a "leased" hour. In most cases therapists are willing to forego holding the patient responsible for canceled individual appointments when sufficient notice is given in advance or for broken appointments in the case of emergencies. To forestall breaking appointments as a manifestation of resistance, the practice of charging for unjustified broken appointments may be advisable. In group therapy, patients usually pay whether they show up or not, and, since the fee is less, they are more likely to accept this without protest.

There is no standard length of a treatment session; the average time ranges from three-quarters of an hour to one hour. Practices of billing also vary. Arrangements for payment are usually made at the convenience of the patient. Some patients prefer to make payments at the end of each visit; others prefer a monthly billing.

REFERRING THE PATIENT

It is understandable that most patients will want to continue in therapy with the initial interviewer. Under certain conditions this may not be possible. Such instances occur when:

1. The interviewer may have no schedule time or available hours may not coincide with those that the patient can arrange.

2. The interviewer may not want to work with the patient because of the kind of problem the patient possesses or because of the patient's personality.

3. The interviewer may believe another therapist can help the patient more.

4. The patient may be unable to afford the interviewer's fee.

5. The patient may want to work with a therapist of a different sex, age, race, or orientation.

No matter how well trained and how experienced, the interviewer will be better equipped to handle some kinds of patients than others. With some persons, the therapist will feel very much at ease and will be capable of exercising that balance between sympathy and objectivity that makes for good therapy. With others, the therapist will feel less comfortable, more defensive, and less capable of exhibiting an adequate amount of interest. After acquiring a great deal of therapeutic experience and assaying the results, the therapist may come to the conclusion that it is not possible to work well with certain kinds of patients and problems. For instance, experience may lead a therapist to the conclusion of being unable to treat schizophrenics, or borderline patients, or compulsion neurotics, or individuals with strong phobias. One may get better results with women than with men, with young adults rather than with middle-aged persons. One may be unable to treat children or people in their later years. Another therapist may be inclined to select for patients those individuals to whom one responds positively and to refer others with whom a certain affinity cannot be felt. This selective process is to be encouraged since the emotional attitude toward the patient or the conviction that one is unable to do well with the problem presented may impose barriers on the relationship. This does not mean that the interviewer will not be able to work out difficulties in functioning; therapy will start out with an avoidable handicap, however, if there are other agencies to which the patient may be referred.

Another reason for referring the patient is that the specific training or experience of the interviewer does not permit the kind of therapy that the patient could best use. Thus, many therapists

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who do supportive therapy well are not equipped to do reeducative or reconstructive therapy; those who have been trained in reeducative approaches may not know how to implement supportive or reconstructive treatment; those who are trained to do reconstructive therapy may not know how to handle problems that require supportive or reeducative measures. Certain aspects of the patient's difficulty may be tackled by any of the three approaches; however, when the therapist recognizes that the particular method practiced is not suited for the patient, the patient should be referred to someone from whom more appropriate treatment can be obtained.

When, for any reason, a referral is to be made, the patient is acquainted with the reasons for this in such a way that the referral is not interpreted as a rejection by the interviewer. If opening statements have been made to indicate that the purpose of the interview is to determine what approach would be best for the patient, with an implication that the interviewer may not continue as therapist, the patient will usually accept the referral without too much difficulty. When the possibility of another therapist has not been mentioned and it is felt the patient should be treated by someone else, the interviewer must carefully present to the patient positive reasons for the referral. For instance, if the interviewer believes that the problems of the patient can be more advantageously managed by a therapist of a different orientation, the following may be said:

> It will be important for you to be treated by a specialist who is best capable of handling your problem. I would like to refer you to someone who has had a good deal of experience with problems such as yours. I shall telephone several therapists who I believe can help you in order to make sure they have the lime. Then I shall telephone you, and you can make an appointment.

In the event that the interviewer simply has no time at present for the patient, remarks such as the following are appropriate:

> Unfortunately, I do not have time on my schedule right now, and I do not expect to have time for some period in the future. I believe you need therapy right away and since I know the facts in your case, I shall be glad to refer you to a therapist who can handle your problem adequately.

Referral to a low-cost clinic or psychotherapeutic center may be made when the financial condition of the patient precludes getting therapy on a private basis. Here it may be necessary to spend a little time preparing the patient for the routines of the clinic, which may otherwise be threatening.

In making a referral, the patient should also be told that the most important element in treatment is

the relationship with the therapist. It is possible that the patient may not respond completely to the therapist to whom he or she is being sent. If, for any reason the patient does not have confidence in, or feels a block in, working with the therapist, it will be important to discuss these attitudes openly; if the patient cannot remedy these feelings, it might be necessary to find another therapist. The following excerpt illustrates these points:

> *Th.* Now I believe Dr. _ can help you, but your response to him will be important. Therapy is most successful where you have confidence in your therapist. If, after several sessions, you don't feel you can work with the therapist, it may be necessary to get someone else for you.
>
> *Pt.* I see.
>
> *Th.* But before that happens, it will be important to discuss your feelings about Dr._ with him. He will understand your feelings, and if you continue to feel that somehow he isn't the person for you to work with, he will help you find another person. Or you can call me, and we can discuss this matter further.

Unless one forewarns the patient that he or she may not "hit it off" with the therapist, the patient may become discouraged and discontinue treatments indefinitely. Moreover, the admonitions voiced may embolden the patient to discuss and to work through with the next therapist attitudes that are rooted in transference.

ANTICIPATING EMERGENCIES AND OTHER DIFFICULTIES

Plans may have to be made in advance for dealing with emergencies, should these arise. For example, an alcoholic patient may get into various difficulties and require hospitalization. A drug addict may need careful observation to detect a stealthy resumption of the drug habit. A psychopathic personality will constantly tend to act out personal problems and may get involved in difficulties with people and with the law. A patient who is seriously depressed must be considered a suicidal risk. One who has had a previous psychotic break may relapse into a psychosis. Patients with sexual perversions may get into serious legal and interpersonal conflicts. By anticipating emergencies the therapist may avoid serious trouble later on. An alarming recrudescence of symptoms is also to be predicted in certain conditions. For example, patients with anxiety, phobic, or obsessional reactions will probably have bouts of anxious emotion that will disable them for a time and may undermine their faith in therapy. Patients with psychosomatic problems will repeatedly experience an upsurge of symptoms, which will tend to divert them from thinking about the dynamic factors that underlie their complaints. Thus, it may be

necessary, in the early states of therapy, to prepare the patient for a possible relapse in symptoms.

ESSENTIAL CORRESPONDENCE

A brief letter to the individual or agency who referred the patient to the initial interviewer, or to the organization that the referring individual represents, is a courtesy that is usually much appreciated. It is generally unwise to discuss too many details of the case or to outline the tentative dynamics. Nor is a diagnosis indicated, except perhaps when the referral source is a physician. The disposition of the patient should, however, always be mentioned.

The following are typical letters, the first to a social agency, the second to a physician.

Dear_____,

> I have seen Mr. _______ whom you referred to me for consultation and find him to be suffering from an emotional problem for which psychotherapy is indicated. I believe he would do best with an analytically trained therapist and consequently have referred Mr. ______ to Dr. _______, who has been able to make time available for him at a fee satisfactory to Mr. ________. Mr. ______ responded well to the consultation, and there was no reluctance in accepting the referral to Dr. ________. I should like to thank you for sending Mr. _______ to me.

Sincerely yours,

Dear Dr.__:

> I have seen Mr. ______ in consultation and agree with you that a strong emotional element is involved in his present somatic complaint. I believe psychotherapy definitely to be indicated; but I am not, at the present time, able to prognosticate the outcome due to the incomplete motivation that exists for treatment. Mr. ______ responded satisfactorily to the interview and expressed a willingness to start therapy with me. I should like to thank you for the referral.

Sincerely yours,

Correspondence may also be required when it is necessary to get further information about the patient from former therapists, from clinical psychologists who have administered tests, from physicians who have rendered recent examinations, and from institutions in which the patient was hospitalized. A “release” form, such as in Appendix R, signed by the patient, will usually be required when requesting

such information.