Handbook of Short-term Psychotherapy

The Initial Interview

Common Questions

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A. Common Questions

The initial interview is perhaps the most vital of all sessions since in its conduct rests the fate of the therapeutic alliance and, even more importantly, the eventuality of whether or not the patient will return for further treatment. How much time should ideally be spent on history taking? Should the interview be largely diagnostic or therapeutic? What degree of confrontation can safely be employed? These and many other questions challenge the interviewer. In the present chapter some of the points mentioned in the last chapter will be expounded by presenting relevant questions (and answers) brought up in teaching and supervisory sessions with therapists of different theoretical persuasions.

Would you consider the first session therapeutic or diagnostic?

While the initial interview is conducted for the purpose of assessing the presenting problem and planning treatment strategy, it should be managed so that it registers a constructive impact on the patient. It must be stressed that a sizable number of patients, especially those that come to outpatient clinics, do not return for a second interview. Follow-up studies show that the initial interview can have a definite therapeutic effect and may even start the patient on the road to recovery. The therapist, therefore, should assume that the first interview will be the only opportunity to work with the patient and thus that enough work must be done so that the patient can leave the session with something positive to grapple onto. The initial interview should be conducted in such a way as to give the patient a better idea about his underlying problem and an assay of what he can do to help himself. Naturally, most patients will return for more sessions unless the therapist has failed to incite their confidence or has committed serious errors in approach (detachment, belittling attitudes, frightening the patient with depth interpretations, hostility, etc.).

How thorough should history taking be in the initial interview?

During the initial interview exhaustive, ritualistic taking of a history is unnecessary. All that is

required is the gathering of sufficient information to allow for treatment planning and perhaps for the making of a tentative diagnosis. In later sessions one may fill in this skeletal outline of history. More information will be revealed as the patient gains confidence in the therapist.

In appraising the degree of the patient's maladjustment at the initial interview, are there any criteria that can be applied?

There are a number of adjustment scales that are in use, none of which is perfect. It is helpful to view the present difficulty against the backdrop of previous maladaptations, particularly those during childhood. The data here is not entirely definitive since the patient could, in spite of a disorganized early life history, still make a reasonable adult adjustment under propitious circumstances. The second item one may consider is the quality of the present personal relationships, the adjustment to one's marital partner and children, the extent of creativity, and the values that mold behavior. Third, one may estimate the degree of anxiety that is manifest or that expresses itself in terms of such symptoms as depression and psychosomatic manifestations.

A fourth possibility is to examine the nature of defenses against anxiety, for instance, their ability to contain the anxiety and the effect that they have on the total functioning. Fifth, we ponder the extent of adaptational collapse. Here even though the patient seems to be making a good adjustment, we must ask at what expense. Thus, a detached person may show on the surface a fairly good adjustment. Consequently, it is essential to estimate how truly adequate this is in terms of what is happening to the inpidual as a whole. He may be escaping anxiety and working adequately only by the tactic of isolating himself from people. Or a dependent person may be functioning solely by attaching himself to a parental figure. The kind of adaptation helps us to determine the degree of support that will be required at the start of treatment, the amount of participation one may expect from the patient and how active the therapist should be in the relationship.

Is it advisable to spend more time on the initial interview than on other sessions?

If possible, yes. So much has to be done during the first interview that the usual 45 or 50 minutes of time allotted for a session may be insufficient. Extending the time, however, may not be practically possible. Hence, two sessions may be necessary in some cases to accomplish all essential tasks. An

experienced interviewer, however, may require no more than one session.

Is it possible to work with an unmotivated patient, and if so, can you give some examples of how this can be done?

It is possible provided one deals with what is behind the lack of motivation. To do this the therapist may try to retrieve unexpressed or unconscious emotions that are acting, or will act, as resistances to therapy. Such emotions underlie the patient's manifest behavior. Very frequently these emotions cannot be expressed in words, and the therapist will have to make assumptions through observation of the patient's behavior. For instance, in the event that a delinquent boy is referred for therapy, the boy may sulk in his chair, fidget, be evasive, answer in a disarming manner, express disinterest, or show negativism. The therapist may gain the impression from observing the attitudes of the boy that the boy resents being at the interview. He, therefore, might say to the boy, "You probably resent coming here," or "Probably you feel that you ought not to have come here," or "I can understand that you feel kind of mad about this situation." Such a remark cuts into the emotion of the boy and may enable him to perceive that his feelings are understood.

Another example is that of a woman referred by a social agency on the basis that the agency believes she is suffering from an emotional problem for which she should get help. Even if she is not yet prepared to receive this help, she may still appear for therapy in order to appease the caseworker or as a means through which she can gain further aid from the agency. Her motivation, consequently, would be to give as little information as possible about herself or to be as evasive as she can without offending. Under these circumstances, once the therapist realizes what is going on, he might say the following:

> Th. I can very well see that you would feel resentful or uncomfortable about coming here. You probably do not feel that it is necessary and might believe that you could very easily do without therapy. I do not blame you for feeling this way inasmuch as you did not really come to the agency in order to seek help for an emotional problem.

This explanation probably would relax the woman considerably, since she would sense in the therapist a sympathetic person. She might then begin to express her feelings about the agency and at the end be willing to talk about herself and her problems.

A common problem is provided by the patient who views psychotherapy in the same light as

consulting an internist. The patient tells the doctor about disturbing symptoms, and the doctor prescribes a remedy. The patient, consequently, will bombard the therapist with a flood of symptoms and complaints with the hope that everything will then be taken care of in some mysterious way. The patient really has no means of understanding what is supposed to go on in therapy other than through experiences with previous health vendors. The disadvantage with such an attitude is that once the patient has elaborated the problem, responsibility for it is transferred to the therapist and a cure will be expected. Should the therapist become aware of this attitude, he may offer this interpretation:

> Th. It is understandable that you have suffered so long that you feel it is impossible for you to do anything about your problem yourself. It is natural for you to want somebody to step in and do for you what you haven't been able to do for yourself. But you and I have to work together as a team. I shall help you to understand what is happening to you, and you will find that you can do many constructive things for yourself. Together we should make progress.

The patient with a psychosomatic problem is often unconvinced that his physical symptom is or can be emotionally determined. The best way of losing such a patient is to insist that his problem is psychological. Since the patient may, at least temporarily, need his symptom, the therapist is wise at the start of therapy to allow the patient to retain the idea of its organicity. He may inform the patient that any symptom, even an organic symptom, creates tension because of discomfort or pain. The tension delays healing. What needs to be done is to reduce tension, and this can stimulate the healing process. Teaching the patient simple relaxing methods and allowing the patient to verbalize freely should soon establish a therapeutic alliance, and through this the patient may be helped to come to grips with his worries and conflicts.

A final example is provided by the host of patients who are shepherded into therapy against their free will, such as court cases, spouses of complaining mates, persons collecting disability payments, and inpiduals deriving strong secondary gains from their symptoms through avoiding hard work, supporting dependency needs, and getting attention and sympathy. Such patients cannot be forced to change. The primary task here, as in the case of the psychosomatic patient, is to first establish a therapeutic alliance. No hard-and-fast rules can be given since each patient will require innovative stratagems designed for their special situations. Patients receiving disability checks are particularly difficult to convince that anything psychological keeps them from returning to work. One tactic is never to imply that the patient is in any way psychologically manufacturing his symptoms because this will obstruct the establishing of a

working relationship. The approach at first may, as in the psychosomatic patient, be organized around tension reduction to help the patient assuage suffering. As tension is lessened, the patient will begin talking more about himself and perhaps about some family adjustment problems. The therapist may soon be able to inquire about the hopes, ambitions, and goals of the patient. Questions may be asked such as "What would you like to do?" "How would *you* like to feel?" "What do you enjoy most?" Very often when the patient realizes that the therapist does not expect conformity to standards that others set for the patient, a therapeutic alliance will begin. Reflecting the patient's anger without condemning it helps convince the patient that he is not bad for feeling the way he does. How the patient can go about fulfilling his own goals is then planned. An interesting article on techniques of dealing with such unmotivated patients has been written by Swanson and Woolson (1973).

If a patient is referred who is unprepared for treatment, how does a counselor prepare the person to accept referral to a therapist when there is no incentive to receive help?

An example may illustrate the situation. A college student is referred to a counselor by her school advisor because she was becoming more and more of a recluse, avoiding social activities and even staying away from classes. On interview she is manifestly depressed. However, she has no desire for therapy and no idea that there is anything wrong with the way she is behaving. She insists indignantly that there is nothing wrong with her mind. Because she refused to go out does not mean she needs a psychiatrist. The question is how to get this girl to accept psychotherapy.

In handling this type of problem, the first thing the counselor would want to do is establish some sort of an incentive for therapy. Without this incentive, it would be useless to refer the patient to a therapist. How to create an incentive is the case in point. One way is to ask if she is completely satisfied with her present-day life and adjustment. If she says that everything is going along well, the therapist may say: "It is very gratifying to feel that you are completely satisfied, and understandably under those circumstances, you will want to do very little about yourself. There may, however, be certain areas that are not as pleasant for you as you might want. Are you satisfied the way everything is going in every area?" Should the adamant reply be that things now are perfect, the therapist may have no alternative than to bring out the prevailing adjustment difficulties, such as staying away from classes. At the end of the session the still unconvinced student is invited to return at any time she feels she wants to talk things

over.

On the other hand, the student may admit that while things are not too bad, there is the problem that she does not seem to have the energy to go out with boys though she likes boys. The counselor retorts: "If you really have a desire to get more energy, it may be possible for you to rectify this. Perhaps there isn't any desire to go out because there are fears of exposing yourself to some sort of contact." The patient may then deny this vehemently.

If the counselor has gotten the student to talk about herself, the chances are she will ask for another conference with the counselor. At the next visit she will perhaps say that she has thought the matter over and she does feel that perhaps she might be concealing from herself reasons why she does not want to go out. Under these circumstances the counselor may inform her that there are certain persons who specialize in handling problems of this type. In the past psychotherapists were looked upon as people who ministered to only severe emotional difficulties, but in recent years they have been handling both minor and major problems of normal people; people who could be much more happy within themselves and more efficient in their work or studies with some psychotherapeutic help.

Before referring a prospective patient to a therapist it would be important for the counselor (1) to establish the existence of a definite problem for which help is needed, (2) to deal with or to clarify whatever resistance there may exist that makes the person reluctant to consult a therapist, and (3) to correct any existing misconceptions about psychotherapy. How truly motivated for treatment the patient will be when a therapist is consulted will depend on how good a job the counselor has done. But, getting the patient to a therapist is the first step.

Since the presence of empathy is usually mentioned as the keynote to a therapeutic alliance, what happens if you simply cannot empathize with a particular patient? Does this mean you cannot treat that patient?

It often happens that a therapist does not like the kind of human being the patient is at the time he presents himself for treatment, nor may the therapist be able to condone the life the patient has led, nor approve of his attitudes, morals, values, or objectives. This does not mean one cannot work with the patient. Problems develop where the therapist because of intolerance, is hostile or judgmental. Particularly destructive to establishing a working relationship is repetition by the therapist of the same

kind of arbitrary and disapproving manner displayed by other authorities with whom the patient has come into contact. The patient has already set up defenses against these authorities that will block his developing confidence in a therapist whom he identifies with past authorities. If the therapist can exercise control over impulses to verbalize disapproval, and can avoid displaying criticism through facial expressions and gestures, aspects of the patient's personality will sooner or later come through that may kindle warm feelings in the therapist. Many patients at the start often try to test a therapist by displaying anger or by presenting the most shocking or disagreeable aspects of themselves. If the therapist does not fall into this trap, the working relationship may very well develop even in the first session.

How can you communicate empathy?

One may show interest in what the patient is saying by listening carefully, by asking proper questions, and by displaying appropriate facial expressions. Sometimes communicating what must be on the patient's mind from clues given, verbally and nonverbally, can be helpful. The therapist may ask himself, "What goes on in the patient's mind as he sits there talking?" If one can penetrate beyond the facade of the patient's manifest verbalizations and get to the core of what he may actually be feeling, what fears, and anxieties exist, one may make a strong impression on the patient. When the patient first comes to therapy, he is usually quite upset, fearful, angry, or frustrated and he may anticipate counterhostility or disapproval. Typical ideas that occupy the patient's mind are these: (1) This is my last resort. If this doesn't work, I might as well commit suicide. (2) I feel degraded that I have finally had to resort to psychiatric help. (3) If anybody finds out about the real me, it will be too bad for me. (4) I will probably be blamed, rejected or hated. (5) I feel foolish to come here. It is silly for me to think I need help for my mind. (6) This must mean I am going insane.

The therapist should also countenance what may be going on in the therapist's own mind. These thoughts are very rarely acknowledged, let alone faced. They involve all sorts of formulations such as the following: (1) I wonder if I'm going to like this patient? (2) I wonder if he is going to like me? (3) I wonder if I'm able to help this patient or whether his kind of problem is the sort that I can treat? (4) I wonder if he can pay my fee and how am I going to handle the situation in the event that he is unable to afford treatment with me?

Assuming one can handle one's own feelings, the therapist may diplomatically ask the patient questions such as "I wonder if you are upset about coming here?" "Do you have questions about what I might be thinking about you?" "You may feel this is the last resort!" Other questions and comments will be suggested by observing the patient's reactions and reading between the lines of what the patient is saying.

Is there any way one can expedite empathy toward a person who comes from a socioeconomic group with which a therapist has little affinity?

In listening to a patient who belongs to a stratum of society with which one is not too familiar, one may try to understand the expressions and idioms the patient employs and to utilize the same language forms so that one can communicate on the same wave length. One may also try to find out if the destructive patterns the patient indulges are those common to or condoned by the patient's subcultural group, for example alcoholic excesses, dangerous drug usage, or delinquency. It is necessary to make sure at the start that one does not convey disapproval or disgust at indulgences the patient may consider normal. Later on, when a working relationship exists with the patient, it may be possible to point out destructive patterns that support the problems for which help is being sought. The therapist may also keep asking himself, especially when the patient comes from a disadvantaged group, how the therapist would feel and what he would do if he had to endure the intolerances and abuses the patient went through in the patient's past life. Would he be any different? The therapist may then better be able to empathize with the patient.

What do you do if a patient turns on you and attacks you verbally during the initial interview?

Many patients are inwardly very hostile when they come to the initial interview. The reasons for this vary. The patient may rightfully resent waiting for an appointment, the routine of a clinic, the fee to be payed, and other facts of life. Or hostility will stem from inner sources not at all related to reality. The therapist must accept this hostility and not act threatened by it nor respond in any adverse way. Hostility should be handled by bringing it out in the open during the interview, clarifying the reason for the disturbing reality situation if one exists. Or where hostility is not explicable, a casual statement may be made such as the following:

Th. It is understandable that you have suffered a great deal from your problem. People who suffer a great deal often are resentful of the suffering they have experienced and the ineffectiveness of the measures they have adopted to gain help. You may be angry at the fact that you are ill, or because of what has happened to you. Most people do feel resentful of what has happened to them. This is understandable. It is natural not to want to talk about one's feelings of resentment, too. The reason I am telling you this is that it is possible you may even feel angry at me or at the clinic as a result. If you do, do not feel guilty if you talk about it.

In spite of all the efforts you make to be tolerant, what do you do if you still find yourself being unsympathetic, even actually disliking the patient?

If your feelings interfere with your doing therapy, simply transfer the patient to another therapist. But, in all probability the patient will leave you first.

How would you show a patient you are tolerant of behavior about which the patient personally is ashamed and cannot or will not do much about?

Some patients will expect you, perhaps even want you to disapprove of their behavior. If you comply with this wish, it may temporarily be stabilizing by furnishing the patient with an outside control. The improvement, however, will be short-lived as long as the patient has a stake in destructively acting out patterns. The patient will then defy you or deceive you by perpetuating the patterns secretly at the same time that anger and guilt accumulate. The therapeutic alliance will, therefore, suffer. The best way to manage any revelation of conduct about which the patient seems guilty is to remark that the patient appears to be guilty and ashamed of what he or she is doing. The following excerpts illustrate how I handled two such cases:

Pt. I want you to know that I am homosexual.

Th. So what?

Pt. (*pause*) Well?

Th. Well what? Is that what you came to see me about?

Pt. No, but how do you feel about it?

Th. You must feel that I disapprove or should disapprove.

Pt. Don't you?

Th. Why should I if it's something you want to do. You told me that you were depressed and anxious a good deal of the time. Isn't that what you came to see me about?

Pt. Yes, it is.

Th. So let's work at that. Now, if your choice of a sexual partner has something to do with these symptoms we'll talk about that.

Pt. [*obviously relieved*] Fine, I knew you were liberal about these things.

A patient in her middle 60s came for help to relieve pain following a breast amputation for cancer.

Pt. I have to tell you, doctor (*laughs*) that I have a little habit that I am ashamed to tell you about.

Th. Are you afraid of what my reaction will be?

Pt. No, I guess I don't like it myself. It's that whenever I go into a store, I lift-sneak a little thing in my purse or bag.

Th. How do you feel about it?

Pt. I guess I do it for the excitement. I usually don't need the trinket. I guess you'd call it kleptomania. I read about it.

Th. You must disapprove of it, or doesn't it bother you?

Pt. My heart trembles for hours afterward. What if I'm caught? The disgrace.

Th. If it does bother you enough, we ought to take it up in our talks here.

Pt. Do you think I can get over this habit? It started shortly after my husband died.

Th. Perhaps you felt deprived. But if you really want to get over it, that's nine-tenths of the battle.

Are reasons for seeking help at the time of coming for help a good thing to focus on?

Harris et al (1964) describe a 3-year project at the Langley Porter Neuropsychiatric Institute in San Francisco where a method of up to seven sessions was designed around the focus of the factors that enjoined the patient to come to the clinic. The questions explored were why the patient was seeking help *at this time* and what he or she expected out of the contact with the clinic. This approach served not only as a satisfactory intake method, but also produced a return to adequate functioning in a significant number of patients. For the remaining patients the brief experience helped delineate the problem, clarified the extent of motivation, and acted as preparation for continuing help or intensive treatment. Focusing on the help-seeking factors is nothing new. Social-work agencies have for many years employed it in casework on a short-term basis. Similarly some counseling approaches have operated around a

similar exposure of the immediate complaint factor. Both casework and counseling have often substantiated improvement beyond the mere alteration of the environmental disturbances or symptomatic upsets that initiated the consultations.

How does a therapist know whether his appraisal of a chosen focus is the correct one?

A therapist's judgment concerning existing core problems involves speculations that are not always consistent with what another therapist may hypothesize. Given the same data, different therapists will vary in what they consider is the most significant area on which to focus. In a small experiment that I conducted three experienced therapists trained in the same analytic school witnessed the first two sessions conducted by a fourth colleague through a one-way mirror. Each therapist had a somewhat different idea of what meaningful topic was best on which to focus. In my opinion, such differences are not significant because multiple problems can exist and these are usually interrelated. Even where one strikes the patient's core difficulties tangentially, one may still register an impact and spur the patient on toward a better adaptation. After all, a reasonably intelligent patient is capable of making connections and even of correcting the misperceptions of a therapist where a good working relationship exists and the therapist does not respond to being criticized too drastically with a display of wounded narcissism. From a pragmatic standpoint, the focus is an accurate one if the patient responds positively to it.

Can a person get well without needing to work on basic nuclear conflicts?

Getting well embraces many degrees of improvement. Most people make a fairly good adaptation while retaining some aspects of their deepest conflicts. In short-term therapy we usually deal with secondary derivative conflicts because of the lack of time for depth probing and the working-through of resistance. However, personality changes can result over a period following therapy if the patient consistently works on himself and his problems. Apparently nuclear conflicts may sometimes be influenced through resolution of their manifestations in secondary conflicts. Hitchcock and Mooney (1969), for example, have written how in mental health consultation dealing with the consultee's work-ego function alone can have a more than superficial effect. D. Beck (1968) has also written an interesting article accenting the value of working on derivative conflicts. In many types of short-term therapy opening up a "bag of worms" through blunt interpretation of a nuclear conflict may create more problems

than it solves. The therapist must judge how ready the patient is for an interpretation—that is, how conscious the patient is of an existing conflict—before exploring it. Where the patient has such an awareness and wishes to deal with his conflict, there is no reason to avoid it.

Suppose, in evolving a working hypothesis of the problem, that the therapist happens to be wrong. Would it not be better to wait until more facts are available before speculating about what is going on?

While the therapist will want to develop a working hypothesis of the problem, he must consider it tentative at best. Not all of the facts may be available during the first few interviews. Even if the therapist is wrong or partially wrong in the initial analysis, he will be able to correct or modify his ideas later on. If a connection with personality factors or inner conflicts is not apparent at the beginning, or if the patient is not ready to countenance the implications of such connections, interpretations may be confined to the immediate environmental precipitants while waiting for more data before linking these to underlying inner difficulties or more obscure external events.

How would you account for the fact that even though few or no psychodynamics may be apparent during the first interview, the patient still may experience a good deal of relief?

There are many reasons for this. First, the empathic understanding of the therapist enables the patient to unburden himself or herself in an atmosphere shorn of blame and authoritative pressure. Simply relieving oneself of painful thoughts reduces tension. But more importantly, putting into words feelings that float around in a nebulous way tends to identify them and helps the patient gain control over them. Moreover, revealing ideas and experiences to an authority who does not respond the way other past authorities have acted, or the way the patient imagined they would act or should act, softens the introjected parental image and relieves guilt. Faith and trust are kindled. The placebo element to the effect that something is available that can help and that matters are not hopeless, and the impact of direct or indirect suggestions made by the therapist may inspire the patient toward taking a corrective path of thinking and behaving. Of course, the extent of the patient's taking advantage of these positive elements will depend on his readiness for change. Where a readiness for change exists in good measure, the impact of the first interview can be dramatic even though basic nuclear conflicts are not touched. And the patient may be able to achieve an emotional equilibrium at least equivalent to that which prevailed prior to the onset of the present illness.

Can one prognosticate from the severity of symptoms or the sickness of a patient the possibility of improvement or cure?

No. Sometimes the sickest patients, even hallucinating psychotics, recover rapidly, while what seems like a mild depression, anxiety, or character problem will scarcely budge. Many variables obviously exist other than the current symptoms, which are related to the patient's latent ego strength, flexibility of defenses, readiness for change, secondary gain, selective response to techniques, capacity for developing a therapeutic alliance, skill and personality of the therapist, and many other factors. These will all influence the outcome. The effect of these variables cannot be anticipated in advance since they display themselves only after therapy has started.

Is there one factor you would consider the most important of all in insuring good results in therapy?

There are many factors that are operative, but I would consider the quality of the relationship between the therapist and patient the most important of all factors.

How much confrontation can be utilized during the initial interview?

There are varying opinions. Where the first interview is employed as a screening device to determine the suitability of a patient for an anxiety-provoking type of therapy, such as practiced by Sifneos, confrontation is part of a selection procedure. As a general rule, however, with the average patient, confrontation is best delayed until a good therapeutic alliance has been established to sustain the patient's hostility and anxiety. Otherwise the patient is apt to drop out of treatment prematurely, either because he mistakes the therapist's manner as an attack or because he is unable to handle the emotions stirred up in himself as a result of the pointed challenges. In some cases, however, the therapist is capable of setting up a working relationship rapidly in the first session, under which circumstance careful empathic confrontation may be gainfully employed.

Should not the therapist choose as a preferred focus the relationship between himself and the patient?

Effective learning can proceed only in the medium of a good interpersonal relationship. The latter serves as the matrix for whatever theoretical and methodological structures fashion the treatment maneuvers of the therapist. One usually assumes that the patient comes to therapy with some basic trust

in the therapist as a professional who can help. Naturally, there are always latent some elements of fear and distrust, the degree dependent on previous experiences with irrational authority and with incompetent professionals. It is usually not necessary to focus on the relationship unless there are evidences, from the behavior and verbalizations of the patient, that the relationship is not going well or that transference exists that is acting as a resistence to treatment. As long as the relationship appears to be good, there is no reason to probe or challenge it.

Does not the relationship itself sponsor reconstructive change where the therapist is accepting and tolerant?

An assumption is often made that everyone has within oneself the capacity to achieve therapeutic change, provided there is a non-judgmental, nonpunitive atmosphere in which to express feelings without fear of retaliation or censure. Growth is said to be contingent on the constructive relearning that comes about as a by-product of a nontraumatic relationship. The inpidual has an opportunity here to revise inherent concepts of authority out of a new experience with the therapist who operates as a different kind of parental symbol. In practice this happy result does not often follow because the inpidual, even in a completely noncensorious environment, will usually perpetuate personal problems by clinging to unjustified and unjustifiable assumptions. Even though the therapist does not repeat the parental attitudes or display their intolerance, the patient may react as if the original authorities were still present. This is because the problem has been internalized and forces the patient to operate with a sense of values that, merciless as it is, is uncorrected by reality. Indeed, the patient may even become indignant toward the therapist's tolerant standards and behavior as offering temptations for which one will later pay dearly. This serves as resistance against altering one's values. We, nevertheless, try to promote change by detection of negative attitudes and transference feelings and by their interpretation and working-through.

How important are optimism and enthusiasm on the part of the therapist?

Very important. Optimism and enthusiasm inspire faith and trust and tend to neutralize despair and hopelessness. The therapist's belief in himself and in his techniques must, of course, be real, since simulated optimism will easily be detected and will damage the relationship.

There is some controversy about the role of positive expectation on the part of the patient in promoting change. Does expectation influence short-term therapy?

As is usual in some questions, the answer is yes and no. Expectation that one will change acts as a placebo enhancing the patient's faith in the therapist and in the operative techniques. The therapeutic situation itself is a suggestive arena that promotes expectations of change. On the other hand, expectation may be bridled to certain assumptions about the therapist's power and invincibility that can be unrealistic. When the patient learns that the therapist has no magic and that the patient himself must work to achieve change, his expectations may dwindle to nothing and may even act as a negative placebo.

Is your immediate impression of whether you like a person or not a good gauge of how the relationship will develop?

That depends on whether the therapist is able to analyze his own countertransference and prejudices. Initial impressions are often the products of past experiences with a person or person whom the patient resembles or of intolerance related to the patient's race, religion, sex, age, facial expression, manner, speech, and the like. Misconceptions can abound, but a mature therapist keeps analyzing his own reactions to see whether they are the result of countertransference or prejudice, and he accordingly tries to correct attitudes that will interfere with establishing a therapeutic alliance.

Should the therapist prepare the patient for termination of treatment at the first interview?

Proper preparation of the patient for termination is an extremely important, yet the most grossly neglected, aspect of treatment. The therapist should be alerted for signs, even in the first interview, of impending problems with termination since the ending of treatment can be extremely difficult and disturbing for some patients. Moreover, the therapist will need to be aware of his own guilt at discharging some patients, particularly those who have become dependent on him. The therapist may consider the termination of treatment a form of abandonment. On the patient's part, termination may kindle previous upsetting reactions with experiences of separation or loss even as far back as childhood. The patient may interpret termination as a sign of the therapist's irresponsibility or lack of concern and this will activate a devalued self-image. If at the first interview the therapist discusses with the patient that some patients respond to termination of treatment with resentment and feelings of loss, this may ease, though not entirely dissipate, the patient's eventual reaction of anger and disappointment.

Where the history reveals an early loss of, separation from, or abandonment by a parent, the therapist must be triply mindful of the need to prepare the patient for termination and to watch for early signs of anger, depression, and grief. The patient, as part of treatment, should be encouraged to talk about developing separation reactions as well as past separation experiences. Among the emerging separation reactions will be a return of old complaints and the development of new symptoms such as anxiety, depression, and psychosomatic complaints. Some patients respond to termination by denial; where there are signs of this, the therapist must actively interpret the response. Vastly important is the need for the therapist not to consider the patient's hostility as a personal affront.

Are psychological tests necessary in short-term therapy?

Generally, no, A rapid exposure of the patient to the Rorschach cards and to a man-woman drawing, though they are strictly speaking not tests in the formal sense, are sometimes helpful diagnostically and toward spotting a dynamic focus. The same can be said for the Thematic Apperception Cards.

What about the Minnesota Multiphasic Test?

A great deal of information can be gotten from the MMT, although a good interviewer can get sufficient material to work on through ordinary history taking. Most therapists do not give their patients routine tests like the MMT, intelligence tests, and the like, unless there are special reasons for testing.

Is it advisable to make an initial diagnosis on every case?

Yes, for many reasons. The initial diagnosis, however, may have to be changed as more information is obtained during therapy.

Are past dreams important to explore in the initial interview?

Very much so. Dreams often reveal the operative dynamics not obtainable through usual interview techniques. Repetitive dreams and nightmares are especially important. Asking for dreams that the patient can remember from childhood may also be valuable.

It has been stated that patients who were interviewed and put on a waiting list did almost as well on their own as those who were accepted for formal treatment. If this is true, is not therapy superfluous?

Some skeptics downgrade psychotherapy by pointing out that there is no advantage in formal treatment to simply being placed on a waiting list after an initial interview. For example, in one study (Sloane et al., 1975) 94 patients were seen initially by experienced therapists and then randomly assigned to (1) a waiting list, (2) short-term behavior therapy, and (3) short-term psychoanalytically oriented psychotherapy for 13 or 14 sessions. Follow-up after 4 months by assessors showed that target symptoms in all three groups improved, but somewhat more so in the treated groups. Work and social adjustment showed no differences. *All three groups* 1 year and 2 years after the initial interview had improved significantly "regardless of whether or not further treatment was received during this period." We might conclude from this that with the notreatment group doing almost as well as the treated groups after 4 months and fully as well after 1 and 2 years, formal psychotherapy was dispensable.

The fallacy of this assumption is that we fail to credit the initial interview with the therapeutic impact that it can score by itself even where no further professional help is secured. Nor is it true that a patient on a waiting list languishes without exploiting other helping resources. Often after a good initial interview the patient will have obtained sufficient support, reassurance, awareness, and hope to muster latent coping capacities or to find suitable helping aids outside of formal treatment. We should, therefore, consider even a single intake interview a form of short-term therapy.

That even one or two sessions have on follow-up registered themselves therapeutically on patients has been reported by a number of observers, such as Malan et al (1975). Not only had symptomatic improvement occurred, but in some cases the solitary interview appears to have released forces producing noticeable, and in some cases significant and lasting dynamic, changes. At the Beth Israel Hospital in Boston a sizable group of patients were given a diagnostic interview in the form of a two-session evaluation. No other therapy was administered. A follow-up interview 1 month later revealed a subgroup who improved with no other therapy. The results "confirm the conception of the diagnostic interview as a dynamic interpersonal process and adds support to the evidence that brief psychiatric contact during times of stress can produce significant changes in affect and behavior." Whether patients who improve will sustain or continue their improvement will probably depend on the nature of their transformation, their prevailing motivation to change, their ability to release themselves from their

maladaptive coping patterns, and whether or not their environment reinforces or discourages the developing alterations.