THE TECHNIQUE OF PSYCHOTHERAPY

IDENTIFYING IMPORTANT TRENDS AND PATTERNS

THE USE OF THERAPEUTIC INTERVIEWING

LEWIS R. WOLBERG M.D.

Identifying Important Trends and Patterns:

The Use of Therapeutic Interviewing

Lewis R. Wolberg, M.D.

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In all forms of psychotherapy, except Freudian psychoanalysis, the focused interview is the chief exploratory vehicle. From material obtained in the initial interview and during the early sessions the therapist will have some idea of the sources and dynamics of the patient's symptoms. Of these the patient may be fully conscious, partially conscious, or, more rarely, completely unconscious. If our goal in therapy is at least some personality reconstruction, underlying causes and dynamics are investigated through such techniques as maintaining the flow of verbalizations, directing their course through selective focusing, and devices like accenting, summarizing, restating, reflecting, establishing connections, and maintaining tension in the interview. It is imperative to become thoroughly conversant with the principles of interviewing that have been described in Chapter 19, "The Conduct of the Psychotherapeutic Interview." For without a good understanding of interviewing, the therapist will be handicapped in carrying the patient through the middle phases of therapy.

In attempting to identify important patterns during the interview, the therapist may listen carefully for a dominant theme that tinctures the patient's verbalizations. Sometimes unexpressed feelings are as significant or more significant than the verbalizations themselves. The patient's nonverbal behavior also reveals many important clues. Slips of speech, hesitations, blocks, evasions and changes in content may furthermore give warning of conflictive areas. The therapist must constantly be sensitized to evidences of conflict in the various concerns of the patient.

The following excerpt is an illustration of how insight may be gained through focused interviewing. The patient, an associate editor on a magazine, interested in music as a possible profession, brings up an incident in her work with an orchestra that arouses in her a destructive neurotic pattern.

Pt. I was getting along fine, but then things started to go wrong, *(pause)*

Th. Wrong? (*repeating the last word to focus on the source of the difficulty*]

Pt. Everything went bad. My head hurt and my stomach kicked up badly.

Th. How long did this go on? *[attempting to focus the patient's attention away from symptoms]*

Pt. It all started vaguely about 2 days ago. *(pause)*

Th. Anything happen at that time? *[probing for a cause]*

Pt. Nothing unusual … I've been menstruating and have a lot more pain than usual. I listened to a recording of our orchestra last Tuesday, and it sounded very bad, particularly in parts where I came in. [*The patient advances environmental happenings that may or may not be causative.]*

Th. How did this make you feel? *[focusing on feelings]*

Pt. Well, I'm disgusted. I wonder why they have to have a group of inexperienced people with us. It makes me feel no good, too. *[What comes to mind at this time is, first, that the patient is resentful and cannot adequately express her resentment and, second, that she is blaming and devaluating herself.]*

Th. This disgusts you. *[repeating the patient's expressed feeling]*

Pt. Yes, I'm furious at them, but it's impossible to say anything. *[This sounds like suppressed or repressed hostility.]*

Th. That must be very frustrating *[expressing sympathy with how the patient feels]*

Pt. Yes, it is. How can they expect to have a good orchestra if they include beginners? *[The patient apparently seeks approval here for her resentment.]*

Th. It does sound unreasonable, *[backing the patient up in her feeling]*

Pt. I am so mad that I feel like quitting. *(clenches fists) [Apparently my encouragement helped to mobilize this aggression.]*

Th. Mm hmm.

Pt. But I know I won't, *(pause)*

Th. You must get something out of wanting to stay in the orchestra in spite of how bad things are. *[inquiring about positive values in here present situation]*

Pt. I don't think anything is worth what I go through.

Th. Then you may have the temptation to give up your place in the orchestra in spite of any possible good it does you.

Pt. But why should I be pushed out of a good thing? *[Apparently there are many positive values in her present situation.]*

Th. Yes, why should you? *[supporting the patient in her determination]*

Pt. (pause) You know, I ordinarily would get mad and then quit. I've done this about many things all my life—school, jobs, everything. I'd get mad and then blow everything up. It's awful. *[Patient recognizes a destructive pattern related to how she handles frustration and hostility. This insight should be of value to her.]*

Th. There must have been a reason why you did this, *[focusing her attention on causes]*

Pt. I'd get so mad, I'd be willing to blow everything up, including myself. I'm not going to let myself be maneuvered out of the orchestra though. I'm not going to be that silly.

Th. But your anger may be hard to control *[warning her of possibilities of repetition of her neurotic behavior]*

Pt. Yes, I know, but I won't let it—at least now I won't *[Her understanding of her resentment encourages more rational behavior.]*

The focus in interviewing may be on the patient's symptoms, feelings, environmental dissatisfactions, interpersonal relationships, past history, and slips of speech and on the therapist's intuitive understanding of the patient's problems.

FOCUSING ON SYMPTOMS

Concentration on symptoms is of primary concern in supportive and some reeducative approaches like behavior therapy. While some symptoms are surface manifestations of deeper problems, a careful exploration of their content and function and of the patient's attitudes toward

them may reveal important facts about past conditionings, reinforcing situations and people, repudiated impulses, as well as defenses against the impulses.

Focusing on symptoms in reconstructive approaches is largely for the purpose of demonstrating their relationship to underlying feelings. Sexuality seems to be overweighted in our culture and many patients concentrate on their disturbed or inhibited sexual life when they come to therapy. Since sex may preoccupy them, they may not be aware that this aspect of their functioning is only one dimension of their problem. This will be apparent in many of the interviews reproduced in this book. The therapist should at all times never be sidetracked by this focus and should attempt to place sexual and other symptoms into proper perspective. In order to do this, the patient's attention should be brought to undercurrent emotions whenever sexual and other symptoms are brought up. It is important also to explore the relationship of symptoms to definite life situations. If the therapist knows how to employ dreams, these may be used advantageously to establish the connections of symptoms with feelings and causal life situations.

A patient who had come to therapy because of depression following the rupture of a love affair started a session with the complaint of a skin symptom. Focusing on the symptom brought out the fact that it was a conversion phenomenon, resulting from certain conflicts of which the patient became aware during interviewing.

> *Pt.* Margaret was in my apartment no more than 2 hours when I noticed my arm itching. I took off my jacket. *[Margaret is the young woman with whom the patient is having an affair, after the violent rupture of a relationship with another young woman.)*
>
> *Th.* Where was the itch?
>
> *Pt.* On both arms, the round surface up here just below the elbow, like a band.
>
> *Th.* I see.
>
> *Pt.* It started in the left arm, and then it spread to this arm in the same place.

Th. Exactly the same kind of band?

Pt. Yes, and several hours after that I noticed a band about the size of 6 inches over the ankle on both sides. Almost like a wide bracelet.

Th. Mm hmm.

Pt. And immediately I thought, "Jesus Christ I'm itching." Funny I hadn't had it before. And Margaret said, "What are you so nervous about?" And then I started on her, "I don't know," I said, "I don't know what it is." *(pause)*

Th. Now suppose you talk about the things that happened to you just before you got this itch, *[focusing on possible causes]*

Pt. Well, I was coming home from work and I decided to walk on Harriet's street where she lives. *[Harriet is the young woman with whom the patient was in love and who broke up the relationship.]* I passed Harriet's house and looked up and saw the light on and figured what's going on there. I'm itching like hell now. There must be a direct connection. This proves it. This itching is bad. I scratched so furiously I drew blood. So I said, "Jesus Christ that's stupid." So I put some salve on. Then I went to sleep with Margaret. I went to sleep, and I dreamed about Harriet. I dreamed I was back with her and I was suspicious as to what she wanted from me. She seemed to want to screw me, that is, get physically in me. I don't know if she was on my back, on the side, or what. She was bent forward in what I suppose was her driving position. I asked her why she was back, but she gave me no clear-cut answer except that she wanted "to get laid." Then I realized that she wanted to reduce me to impotence. I played along with her even though I didn't trust her. Then, in another room another girl came into sight. I thought I can lay this other dame. Do I owe Harriet anything? No. I don't trust her. I'll do as I want. I felt, the hell with her. *(pause*) That's all. *(pause)*

Th. I see. What are your ideas about that?

Pt. Well, you see, Harriet did make me impotent. That is, I got impotent with her. She kept comparing me with the other guys she screwed. She'd say, "Be a man and fuck me like the others did." It would make me furious. I'd compare myself with them, and ask her about them. She kept telling me that I didn't rate much when it came to fucking.

Th. What do you think this did to you?

Pt. I got so I couldn't function with her and I got impotent.

Th. And then she threw you out.

Pt. That goddamn bitch. I hate her. Margaret is such a better person. Considerate and kind, but … *(pause)*

Th. But … *(pause)*

Pt. I shouldn't feel so dissatisfied with her.

Th. But you do.

Pt. I must. I keep on thinking about Harriet. The other days when I walked by her house—I do that now a lot—I would look up at her room and feel relieved that the place was dark. Then I'd figure where else is she, and I'd say that she must be screwing in somebody else's apartment, not her own. But I'd push that out of my mind. This time when I saw the light, I felt very upset. I said to myself that she is half undressed or she's all undressed. She's in bed with a guy. He's undressing her or she's undressing him. I don't know who the guy is. He's probably a son of a bitch who doesn't look anything like me.

Th. What emotional effect did it have on you?

Pt. I thought to myself, it's amazing how little it concerns you: you have no reaction.

Th. It astonished you?

Pt. Where is the reaction there, I said. I'm going with Margaret. I've got a better girl. I thought I'd go home and make love to Margaret. So when I got home, there was Margaret, and then I got that goddamned itch.

Th. Mm hmm.

Pt. I kept thinking about what time this man with Harriet went home. Then I began to resent Margaret. I felt why can't Harriet be with me.

Th. In other words, Harriet still has more value to you than Margaret.

Pt. (scratching his arms) This itch is awful. I gradually moved into the position of asking Harriet to marry me. Every time I built up to the point she greeted me with complete silence.

Th. How do you feel about being with Margaret now?

Pt. I feel like I've got chains on.

Th. What kind of chains?

Pt. Tying me down, *(touches itching area of arm) (pause)* You know I just thought of something. I thought of chains in Egyptian times used to tie down slaves. You've seen pictures of them. I have seen pictures of them.

Th. What do the pictures look like?

Pt. Either there or here—bands of iron with the chain between them and anklets governing the size of the step. And, you know, the bands of irons on the arms and legs are like, in the same position as the areas of my itching!

Th. So the conclusion would be what?

Pt. That I'm wearing chains.

Th. And the scratching?

Pt. (excitedly) I want to tear them off.

Th. But these emotional chains you're wearing are what?

Pt. Jesus Christ, I feel a defiance. This thing is building up with Margaret. I was getting to think I was comfortable, but I resented the comfort. She's giving up her job, fluttering around, looking for this, looking for that. Basically she's here to stay because she wants to be with me. I feel as if I'm in chains with her. I don't want to marry her.

Th. So Margaret is your chain and you want to get rid of her. [*interpreting]*

Pt. But I know what is enslaving me. I don't want chains on me so I can go back to Harriet. But, shit, I don't want to go back to her; she's chains for me too. *[We thereafter discuss his masochistic need to he dominated and hurt by women.]*

FOCUSING ON FEELINGS

Feelings that are openly manifested or that lurk unexpressed behind verbalizations are extremely important aspects of the inner life of the person. Feelings cannot be isolated from

intellectual and behavioral components, although anxiety may cause a dissociation. By constantly focusing on feelings and encouraging verbalization, a reunion of dissociated elements may be effectuated. Awareness of feelings and their meaning brings patients to an understanding of their relationships with people and to some of the basic sources of their symptoms.

Thus, patients may talk about their work situation. Sympathizing with their employer, they present an account of how difficult things must be for their employer. The responsibilities that confront the employer are so pressing that they would make anyone irritable and hard to approach. They feel sorry for their employer on this account, and they forgive the employer's rudeness. The therapist, legitimately suspecting that patients feel resentment they do not dare to express, or of which they are unaware, may decide to focus on latent hostility by saying, "Doesn't such behavior on the part of your employer irritate you?" or "I should imagine that your employer's attitudes would sometimes make you angry." This may liberate an acknowledgment of resentment and a more precise investigation of attitudes toward the employer and toward other authorities.

Other patients may be aware of strong sexual feelings in relation to a teacher. Such feelings preoccupy them a large part of the day. They have no idea of why the teacher has made so vivid an impression on them. The therapist, in order to help patients connect their feelings with attitudes toward the teacher, may say, "The teacher arouses certain feelings in you. Have you had similar feelings toward other people?" A description of previous situations in which sexual feelings were intense may reveal a succession of men or women with certain qualities. Asking patients what all of the men or women have in common may bring out the fact that they all resemble their older brother or sister of whom they were enamored as a child, and toward whom they had strong sexual feelings, which made them feel guilty.

> During the treatment of a patient with a psychophysiologic intestinal disorder, a session was occupied listening to explosive outbursts directed by the patient at her children who were going through a recalcitrant, defiant stage in their development. She brought out several incidents in which one of her children demanded attention

and she pushed him away. The patient berated herself for acting so heartlessly. As she spoke, I noticed what seemed to be a frightened expression on her face. Bringing this to her attention, she smiled with relief, and said, "You're right. I just realized that I am afraid, as if I expected you to beat me." She then revealed incidents where her father beat her for doing "wrong things."

In focusing on feelings, it is essential to help patients to a realization that many of their emotions are not rooted in reality, but rather they are derived from misconceptions about life, about people, and about themselves. The patients' attention may be directed toward a variety of aspects, such as the relationship of feelings to disturbing symptoms, the environmental situations that stir up untoward emotions, the repetitive patterns of behavior that provoke destructive feelings, and the relationship with the therapist.

In the following fragment focusing in the session on the patient's feelings of tension and discomfort helps to bring the patient to an awareness of how disappointed he is in his progress and how resentful he is toward me. He realizes that his resentment conflicts with the pattern of constant need for approval and that his inability to express resentment fosters his symptoms.

Pt. I have a funny feeling of uneasiness that's been with me all day, all week, I mean.

Th. Any clues to this feeling?

Pt. No, just my feeling bad. Even yesterday I felt like throwing up.

Th. When did this uneasiness get most uncomfortable?

Pt. Just before coming here, *(pause)*

Th. Just before coming here?

Pt. I think I'm disappointed that I'm not better than I am. I've been coming here 2 months now. I feel I've accomplished nothing. I can't put it more bluntly.

Th. Well, you have a right to feel disappointed if you expected an immediate cure. Sometimes, rarely, this happens, but usually it takes a period of time before a person learns about patterns that stir up symptoms.

Pt. This whole week of complete tension made me think. But I could only think of my tension. I can't organize my thoughts. These thoughts are meaningless to me until I get so bad I have to force myself to think and try to solve my problem.

Th. Mm hmm *(pause)*

Pt. I feel insecure and inferior, and I need approval. Why do I need this approval? Because I have no security in myself. So I need somebody else's approval. So I don't act on my own motives. I try to be a smiling servant to everybody, to gain their good graces, to gain their approval. I lower myself to kiss everybody's behind to get their approval. Now why I haven't I got confidence in myself?

Th. That's a good question. If you need approval from the outside and have no confidence from within, there are reasons for it.

Pt. Why don't I have that self-security or self-approval?

Th. Well, what do *you* think?

Pt. I don't know, *(smiles)* But I do think you are helping me.

Th. But that isn't what you were just telling me.

Pt. Well … *(pause)*

Th. Could it be that you tell me this to get *my* approval—right now, I mean?

Pt. I know I told you I was disappointed in therapy. Maybe it doesn't make any difference what you think. I'm coming here and paying my hard-earned money and I have a right to say it.

Th. You have a right to say what you feel.

Pt. Maybe … wouldn't it be enough to cause tension for me to want to criticize you if I needed your approval, like I need everybody's approval? *[This sounds like insight.]*

Th. It might be.

Pt. So, if I get furious with you, that would be enough to make me feel that you wouldn't give me approval if I told you. And that could upset me like I was upset. But now that I've told you, I feel relieved and not upset any more.

FOCUSING ON ENVIRONMENTAL DISSATISFACTIONS

Environmental problems are suitable foci of attention; however, only rarely are reality circumstances entirely responsible for the patient's condition. Catastrophic life happenings occasionally do occur in the form of accidents, inclemencies of nature, disasters of war, death of close relatives and friends, and financial and prestige losses. Operative also are pressures of desperate economic circumstances, unemployment, inimical work conditions, unhappy choice of occupation, bad housing, disturbing neighborhood, abnormal cultural standards and pressures, and exposure to destructive family members and mate. The *reactions* of the patient to the environment, however, are usually more important than the environmental distortions themselves.

Most persons project their insecurities, fears, guilt feelings, and hostilities onto their environment. The presence of disturbing life circumstances that seem to justify these attitudes and emotions may satisfy needs and expectations; their absence may create a void in life and perhaps incite one toward involvement in some situational difficulty. Thus, individuals who are intensely hostile may manipulate their environment in such a way that they can conveniently vent their hostility on it. They may entangle themselves in relationships with aggressive or domineering people or get engulfed in situations in which they are exploited. These conditions will tend to justify to themselves their own outbursts of hostility and to support their protestations that they are being misused. They will bitterly protest their plight, little mindful of the fact that they have created the very conditions of which they are so indignant. Indeed, where there are inadequate circumstances to warrant the deep hostility that they feel, they will experience depression, tension, anxiety, and various psycho-physiologic reactions. Environmental manipulation and other supportive efforts directed at the milieu rather than at the individual may fail utterly in their effectiveness here, or they may precipitate neurotic symptoms more incapacitating than those for which therapy was originally sought. Even in severe environmental distortions the personality of the patient must be taken into account as an

important concern.

The following excerpt brings out how a patient gains an awareness of patterns of aggression through the consideration of her immediate life situation.

Pt. My husband has been acting up constantly. Just doing mean things. I asked him if he would go out with me, and he said in a nasty way, "Don't intimidate me." Then he said, "Goodbye, you bitch." I had no desire to look at that bastard after that. Then I visited some old friends and stayed out until 1 a.m. When I got home, he was waiting up for me. He screamed at me, "What the hell do you think you are doing." The nagging continued. He said, "A fine household I have." I told him to go the devil. He shook his finger at me. I pushed his hand away and told him to just stop that. I was going to hit him before he hit me. This marriage of mine is what's causing all my trouble, *(pause*)

Th. You must have felt very upset.

Pt. I was. He is so insulting all the time. I called him a son of a bitch, and then told him to go to hell and went to bed. I woke up 4 a.m. crying, and went over to him and woke him up and warned him. I said, "Why should you sleep when I can't." I shook him and told him I'd break his head open if he repeated it.

Th. You didn't want to let him get away with anything?

Pt. You're darned tootin'. And I won't. I won't with anyone. Anybody starts anything, and I finish it.

Th. What usually happens after you finish it?

Pt. That's just it. Nobody seems to understand. I make enemies.

Th. It is possible that any aggression toward you sets a process into motion where you explode a little too much? *[a tentative interpretation]*

Pt. I have to do what I do to protect myself.

Th. Mm hmm. *(pause)*

Pt. Maybe I *do* go to extremes though. *(pause)*

Th. Perhaps to protect yourself, you feel you have to go to extremes, *[more interpretation]*

Pt. But I do see that it can give people the impression that I'm an attacking bitch. I think I do go to extremes. Maybe I shouldn't explode the way I do. Maybe I cause some of my own troubles.

Th. Is this something you'd consider a pattern?

Pt. I can see that it's been with me many years. I used to be a timid thing, but my marriage made a change. I seem to have gone to the opposite extreme.

FOCUSING ON CURRENT INTERPERSONAL RELATIONS

Identification of basic patterns in relationships may be achieved through an examination of the patients' dealings with other people. The characterologic strivings of the patients in relation to authority, to compeers, and to themselves are, in addition to environmental happenings, a dominant theme in the interviews. Such strivings may indicate why the patients' adjustment is being sabotaged. For example, they may anticipate criticism and attack from others. Accordingly, their life will be spent in fearful waiting, in detaching themselves from others, or in retaliatory counterattack. They may, in contemplating exploitation, assiduously avoid intimate contact with people and then act outraged at their isolation. They may feel forced to assume a submissive and ingratiating role and then burn inwardly at the indignation of needing to humiliate themselves in this way. They may be consumed by a power drive and want to domineer all persons with whom they have dealings. These aberrations will become evident as the patients talk about daily concerns and tribulations.

The relationship disturbances manifested by the patients will usually be vigorously defended by them, and they will attempt to justify such disturbance with rationalizations. They may even incite the individuals with whom they relate to provocations that precipitate the very reactions about which they complain. Repeated demonstrations are usually required before the patients recognize how they distort reality in line with their expectations.

It may be possible, therefore, by considering their immediate relationships with people, to

bring the patients to an awareness of how their patterns influence their adjustment and maladjustment. Sooner or later they may express dissatisfaction with their patterns, but they will recognize the compulsive hold that such patterns have on them. They may realize, too, that their patterns serve a spurious and temporary function of enhancing their security and of bolstering their self-esteem.

The following excerpt illustrates how a consideration of current interpersonal relations may bring a patient to cognizance of important inner strivings. In the session the patient exhibits tension, and he relates it to a recent meeting with a woman who had attracted him. He becomes aware of ambivalent attitudes toward certain women.

Pt. I just don't know what it is that upsets me, and I've been having lots of trouble.

Th. Let's talk about it, and maybe we'll learn something about it.

Pt. I don't know what it is. My wife is having trouble with the kids. She thinks I'm not sympathetic. It's like I fear she'll attack or criticize me.

Th. Mm hmm.

Pt. And I met this woman and I found myself thinking about going with her. *(pause)* Having an affair, I mean.

Th. Mm hmm.

Pt. But I don't want to go out with her. *(pause)*

Th. Why?

Pt. I don't know. She's very attractive, but still … *(pause)*

Th. Anything to do with your wife and how she would feel?

Pt. Oh, no. It's more to do with her—the woman. I feel like irritating and teasing her.

Th. What does she mean to you?

Pt. I have a picture of her as a big wheel in the community. I think she is a person who likes to control things with men. I feel she doesn't want to be at home, wants to be a big wheel in the community.

Th. I see. *(pause*)

Pt. I'm a sucker for this kind of woman. Before I know it I'm up to my neck in trouble. I go for them, and then I can't get away. I feel like digging at this woman. Not that I'm mad at her personally, but she does something to me.

Th. The fact that you feel she's a big wheel in the community seems to have something to do with it. *[making a connection for the patient]*

Pt. I hate women who try to wear the pants. My first wife was like that. My mother was like that. Never home, always telling you what to do.

Th. But this type of woman seems to attract you.

Pt. Yes, that's the peculiar thing. I smell them out. At any party I make a beeline for certain women, and by gosh, there I am.

Th. What do you think this means?

Pt. Well, there's only one conclusion. I must be crazy about them and hate them too. I must want to suffer to get involved with them, but that's what I keep doing. *[This is the first inkling of awareness the patient had of this problem.]*

Th. It sounds like a vicious circle.

Pt. But I'm not going to call this woman I met (*laughs*) although I must admit the temptation is great.

Th. Well, that will at least give us an opportunity to investigate this attitude you have toward certain kinds of women.

FOCUSING ON PAST HISTORY

In supportive and reeducative therapy the past is relegated to a secondary position compared to events in the here and now. Yet inimical influences in early childhood, sometimes

produced by improper handling by parents, sometimes by unfortunate experiences in relationship with other persons, can be catastrophic. Children whose experiences during early life are harmonious usually are able to evolve a system of security that permits them to regard the world as a bountiful place and to develop self-esteem that encourages assertiveness and self-confidence. They will be convinced of their capacities to love and to be loved. They will most probably possess character strivings that enable them to relate constructively to other persons and to express, through culturally condoned outlets, important needs. On the other hand, for those children who have been rejected, overprotected, or unduly intimidated, the world will constitute a place of menace. They will be devastated by fears and tensions. Their self-esteem will be warped to a point where they are overwhelmed by feelings of helplessness, by lack of assertiveness, and by loss of self-confidence. Relationships with people will be disturbed with the harboring of destructive attitudes toward others. Finally, inner strivings and demands will suffer repression in greater or lesser degree.

It usually will be discerned during interviewing that the patient projects onto others attitudes and impulses derived from relationships with important past personages. Thus, the individual may regard and treat certain people as rejecting mothers, punitive fathers, and jealous or hostile siblings, irrespective of the reality elements in the existing relationships. If early experiences with mother had conditioned the patient to expect that women are overprotecting, there is apt to be an automatic transfer of this attitude toward all women, or specifically toward those persons who symbolize in the patient's mind a mother image. As defensive gestures, one may observe in the relationships of the individual toward others such attitudes as detachment, resentment, aggression, submissiveness, and masochism that have no affinity with the reality situation. Where the patient has been unfavorably conditioned by strong sibling rivalry in childhood, the response to people might be as if they were facsimiles of destructive brothers and sisters. The individual's social and work relationships will possess a pervasive competitive tinge that expresses itself in fears of being vanquished or in triumphing over others.

Other aspects of the past history are also important in understanding the life circumstances under which adjustment is most adept and maladjustment most apparent. Repetitive patterns will clearly be evident as one focuses on different epochs in the patient's past.

Through proper interviewing the patient may be brought to an awareness of trends and mechanisms of defense as they have manifested themselves in the past. The tracing of interpersonal patterns to their origins in childhood, their disclosure as archaic and destructive to reality functioning, will also enhance a challenging of early attitudes and a new conception of the self.

A patient with a personality problem of detachment, which had interfered with her capacity to establish a relationship with men, came to therapy because of a feeling that she would never get married because of her attitudes. Focusing on her past life brought out certain trends that were operating in the present.

Pt. I feel that I have the capacity to feel, but I feel impersonal about everything. I've had this feeling as far back as I can think. With my father I was given the basic necessities of life—food, clothing—but aside from that there was nothing.

Th. Nothing?

Pt. One never dreamed of going close to him for anything. I remember when I was little I would run to him, but he would keep pushing me away. I felt it was wrong to need him. I felt awful when I was little, but then I felt all right. At school I had some friends, but I never felt close to them.

Th. Did you ever feel warm and close to any person in your past?

Pt. Yes, I had a music teacher. I felt he knew me and understood me. I felt that he was like God. But I hated him too. He seduced me. I couldn't resist him. I felt awful about the thing.

Th. Mm hmm.

Pt. I remember once my father came home with a box of candy. He handed it to me, and I was so happy I cried. Father asked me why I was crying and I didn't know.

Th. Do you know why now?

Pt. I believe that meant to me he preferred me. But he didn't. He said, "That's for your mother, bring it to her." I cried and cried and never got over it. I felt it was better not to expect anything.

Th. Not to expect *anything?*

Pt. From people I mean.

Th. Could that account for one of the reasons why you can't feel anything now? *[interpretation]*

Pt. You mean a feeling I might be disappointed. *(cries)* I do expect that all the time.

OBSERVATIONS OF SLIPS OF SPEECH

While slips of speech do not happen frequently, focusing on them when they do occur may reveal significant patterns. A young woman, in a defiant relationship with her father, showed a poor response to therapy during the first few months. During one session she exhibited a slip of speech that revealed rebellious attitudes toward any type of control.

Pt. I just don't know what I'm getting out of life right now.

Th. What are you getting out of coming *here* right now?

Pt. I come here to get well—that's my *blame, [slip of speech]*

Th. That's your *blame?*

Pt. Did I say that? I mean that's my *aim.*

Th. You said "blame." I wonder if you blame yourself.

Pt. (blushes) Maybe I'm ashamed of myself.

Th. Ashamed of coming here?

Pt. I just think I don't want to get well to annoy you.

Th. To annoy me?

Pt. You know that I'm capable of doing anything, and I slop around so.

Th. Maybe you are slopping around for my benefit, *(smiles)*

Pt. (blushes) I don't want you to get too controlling. I feel if you would only leave me alone.

Th. You feel I control you?

Pt. Yes, I do.

Th. How?

Pt. Not so much control as I need to do things for myself. I don't want you to interfere.

Th. Am I interfering?

Pt. This is what's funny. You don't, but I think I do feel you do. I don't like anybody controlling me.

Th. But why do you come here then if I do these terrible things to you?

Pt. I look on you as my bridge to health. I don't want to be this way. I don't like to slop around. I can see this is something I do all the time. Even good things I throw away because the goodness spells danger in my standing alone.

Th. So that your "blame" in coming here is in not wanting to do what part of you wants, which is health? *[interpreting the slip of speech]*

Pt. I'm being a horror by fighting everybody. I know. Why do I act so rebellious?

Th. That's a good question. Let's start investigating that.

USE OF INTUITION

Sometimes therapists have to depend on hunches and intuition in perceiving what is going on in the patient. By self-observation therapists may recognize certain emotions in themselves that are evoked by what the patient is saying or not saying (countertransference). They may use

this intuitive feeling in various ways, as by questioning, reflecting feeling, focusing, and interpreting. A sensitive therapist with a great deal of experience may be able to perceive nuances through this use of intuition that escape the usual observational methods. *Intuition* is probably a misnomer, for the skill alluded to does not just automatically happen; it is acquired by a sensitive and astute therapist with good clinical judgment who has had extensive clinical experience. A seasoned therapist is best capable of utilizing countertransferential feelings constructively. These are especially important indicators of what is going on unconsciously in the patient, being manifestations of projections from the patient that are subtly being communicated to the therapist.