A Primer for Psychotherapists

Time and Space Conditions for the Interview

Kenneth Mark Colby M.D.

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TIME AND SPACE CONDITIONS FOR THE INTERVIEW

The work of the therapeutic interview takes place under certain time-space conditions. To belabor such a peripheral though obvious fact may appear trivial. Yet these considerations, self-evident to the experienced therapist, present a batch of unwelcome problems to the beginner.

Time Considerations

Most patients, being eager to come, arrive for their interviews early or on time. Some are consistently a few minutes late—a phenomenon of interest to the therapist but one which can usually be ignored in the interview discussions. If a patient frequently fails to show up or comes so late as to make the brief interview of little therapeutic worth, one then knows that a major resistance is operating which must be openly dealt with by the therapist without waiting for the patient to bring it up. The following clinical examples are illustrative:

For the two previous interviews a woman had been thirty-five minutes late, leaving only fifteen minutes for therapy. On the day of this interview she was again thirty minutes late, stating that she had neglected to keep track of the time.

Ther. (*friendly*): You've been late the last few times. What do you think this might mean?

Pt.: Last time I just forgot, and the other time I had bus trouble.

Ther.: Well, we would have to consider the possibility that coming late is an expression of your feelings about the treatment. Maybe you have doubts or reservations about coming.

Pt.: You mean that maybe I don't want to come?

Ther. (*in a manner of being open to suggestions*): Could be. Or maybe other things. What do you think?

By making the appointment-breaking or tardiness a subject of discussion, the therapist opens the area of the patient's attitudes toward therapy itself and begins to handle the resistances more directly. In passing it should be added that if a therapist fails appointments or is unpunctual, the patient may justifiably accuse him of having counter or collateral resistances.

At the other end of the interview you may find the patient trying to shorten or lengthen his session.

Pt. (*obviously feeling increased tension*): Well, I guess that's enough for today, don't you think, doctor?

Ther. (*gentle but firm*): No, our appointments run about forty- five minutes, and we still have time left. But you seem anxious to leave. Is there something on your mind that makes you uneasy?

However, with some patients (cf. page 146) it may be more expedient to allow them this defense of avoidance for some time rather than subject them to a temporary increase in anxiety.

Patients may attempt to prolong the interview by asking questions at the end requiring a lengthy discussion or trying to engage the therapist in a social conversation after he has stated that the time is up. To questions at this time one answers, "Let's discuss that next time" or "Let's talk about it some more next time before you try to make up your mind." Attempts to launch a social conversation, which may represent the isolation of therapy from real life or a striving for gratification in the transference, are parried by the therapist by not "playing the game" (Fenichel). You may simply remain silent or say, "See you next week," or, better yet, if you can, connect the material in the patient's social conversation with what was discussed during the hour.

A young woman spent the hour telling of her admiration for her father's taste. He used only the best in clothes, autos, whisky, etc. She scorned men who did not share these values. They were "slobs" with no appreciation of the finer things. At the end of the interview, while walking toward the door, she remarked, "Those are nice shoes you have. Where did you get them?" The therapist answered with a smile, "You are wondering if I come up to your father's standard or whether I'm a slob, too."

The length of the interview varies, but it should be at least forty-five or fifty minutes. Patients receiving mainly counseling or supportive guidance require less. The therapist designates termination of the interview by "Our time is up for now" or "We must end now" or "Let's stop there for today," accompanied by getting up from his chair. For his own sake, the therapist should have a few minutes' rest before the next patient arrives. Also it is wise to have an hour or two during the working day in which you can read a little, write letters, or perhaps at leisure think about countertransferences.

The period spent with the patient should be uninterrupted. This ideal is frequently violated, especially by the insistent summons of the telephone. A therapist can excuse himself, answer the call, make it as brief as possible, arrange to phone back at another time if he foresees a prolonged

conversation, and apologize to the patient if the call is unavoidably long. If interruptions are handled with tact and the patient sees that you sincerely attempt to moderate them, he usually has no difficulty in understanding and accepting such reality demands.

Space Arrangements

You and the patient should work alone. At times one may see a man and wife or a parent and child in a single interview, but otherwise psychotherapy involves two people only.

The room you use is unfortunately more often determined by the financial or prestige status of the clinic than by its suitability for an interview. It is easy to take a good room for granted. A bad one introduces complications and irritants which need not be there at all. In a therapist's dreams there is a spacious, even-temperatured, quiet, well-ventilated room with friendly yielding furniture, some books, and perhaps a few pictures. In harsh reality such a set-up is enjoyed only by monetarily unembarrassed private practitioners.

Even though you may be relegated to the end of the mop closet nearest the elevator shaft, do the best you can with the help of the following thumb-and-finger rules. First, have a comfortable chair for yourself. Six or eight hours a day on one of the galley seats some clinics provide may sap your good humor. A desk need not be something to shelter one's self behind. Having the patient in a low chair and towering over him while light glares in his eyes from behind you is moviesque "corn." Also skulls, charts of the autonomic nervous system, brain models, and other medical trappings are needless props. There is no reason to feel that the room should be a bare cell "so the patient can't learn of your personal tastes and thus blur the transference." Such misguided refinements dehumanize the therapist, who after all is first a human being.

If it is at all possible, use a couch. Freud said it simply and honestly—it is unbearable to be stared at for eight hours a day. To be under constant scrutiny means that some of your energy, which should be entirely devoted to the patient's communications, is shunted into efforts to guard your facial and bodily expressions. Using a couch does not automatically mean psychoanalysis nor does it necessarily demand free association. With the patient lying down one can converse and discuss with him just as in vis-&-vis

therapy. Most schizophrenics admittedly should not be placed on a couch (see Chapter 9).

Some beginners feel awkward about asking the patient to lie down. Your request understandably should not be made in the first interview. But after two or three sessions one might say, "Now today won't you lie down on this couch? It will help you to relax, and we have found that this is a convenient way to work." Most patients take to the idea easily. If the patient balks at your suggestion you might briefly discuss his objections. However, if he shows a great deal of anxiety about the prospect of lying down, allow him to remain upright and move on to another topic. Perhaps later you will discover what he is afraid of in another context.

At the beginning of the third interview the therapist wished to shift a woman with a street phobia from sitting up to lying down.

> **Ther.** (*matter-of-factly*): Let's start today with you lying down over here on the couch.
>
> **Pt.** (*startled*): Any special reason?
>
> **Ther.** (*cautiously*): No, just that a couch sometimes has advantages in this sort of work.
>
> **Pt.** (*openly upset*): Well, I'd really rather not lie down if you don't mind.
>
> **Ther.** (*with a smile*): Don't mind at all. Now, last time you were telling me about your troubles at home. What's going on there these days?

The therapist intended to relieve the patient's sudden discomfort by shifting her attention and thus making psychological distance from an anxiety-laden area.

In no way make an issue out of the couch and don't give the patient a feeling that you are commanding him to lie down with an implied "or else I won't like it" threat. Like most of one's behavior in therapy, if this procedure is done quietly, smoothly, and matter-of-factly, few difficulties arise.

Having described the participants in the psychotherapeutic process and their temporal-spatial positions, let us now set them in motion and consider what goes on in their meetings.