A Primer for Psychotherapists

Behavior During the Interview

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BEHAVIOR DURING THE INTERVIEW

Primarily, what the therapist wishes to take place in the interview is talking. Following our theory, you want the patient to translate his thoughts and feelings into speech which you can understand. In return, you hope to verbalize certain of your thoughts in a form which he can see as pertinent to his own. In spite of the aim to change the dynamic equilibrium of a patient's wish-defense systems entirely through the medium of speech, other modes of behavior arise both in the patient and the therapist. Before we consider what the participants in therapy say, let us discuss their actual behavior. I will make no attempt to examine in detail the motivations behind these actions, confining my remarks to ways in which they can be efficiently managed.

Behavior of the Patient

Besides what he says, the way the patient says it, with accompanying general aspect and gestures, may communicate valuable things to you. Though his entire behavior reveals lifelong character attitudes, much of what he does during the interview serves as a moment-to-moment defense against the immediate threats of the uncovering process.

For example, some hypertense patients pace up and down while talking. Hysterical characters may flamboyantly enact their thought contents as if giving a stage performance. Women patients may cross their legs seductively, while men may slouch, yawn, and hum in a transparent attempt at nonchalance. Should they impede the therapy, these defenses are handled like any others—at the right time and with an interpretation. Otherwise, they can be omitted from discussions in favor of more important topics.

More specific resistances in actions (what is defense for the patient is seen as resistance by the therapist) can be interpreted as they arise.

While lying on a couch, the patient, a painfully refined woman who has had many hours of psychotherapy, falls silent after saying, "I really have nothing more to tell you about myself." After a minute or so she points to an ash-tray before her and says, "I can't stand that damn bird." (The ash-tray consists of a clay figure of a long-beaked bird.) She then arises from the couch and moves the ash-tray out of her sight. The therapist remarks, "That bird must remind you of something, and you think that by

removing it from your sight you hope to rid yourself of an unpleasant thought." She agrees as to the defensive nature of her act and then confesses for the first time her great distaste for penises and anything that looks like one.

Besides moving objects in the room, the patient may treat those objects in a disclosing way, e.g., slamming the door or tearing up bits of paper into a mess for you to clean up. Too, the patient may rearrange or kick the furniture or even throw your possessions against the wall.

How permissive should one be? That the therapist is completely permissive is a polite myth. Your agreement with the patient is that he is free to say anything he pleases, not do anything he pleases. It is only a matter of common sense that the therapist, while interpreting such provocative transference behavior, as mentioned in the preceding paragraph, should tactfully forbid these actions. (A good parent must often be firm in defining limits.) Without a tone of shaming reproach, you can remind the patient of the basis of your working relationships—that he speak his thoughts rather than act them out—and frankly state that you expect him to stick to his responsibilities in this pact. Those patients having that degree of reasonable ego which fits them for psychotherapy will react favorably. With those you cannot influence in this direction, it is doubtful whether you have a workable psychotherapeutic situation.

Perhaps a more frequent problem arises when the patient, most commonly a woman, breaks down and cries. The therapist's position is simple enough—he waits until the patient is able to regain control and can go on talking about what upsets her. There is no need to say "there, there," to touch her, or to stop the interview. Since secondarily the patient, particularly if a man, may experience shame and embarrassment over his crying, you can give him a feeling that such a show of emotion is not at all disgraceful but in fact is entirely appropriate in the psychotherapeutic situation.

A man's father, loved and admired by the patient, is about to die. In speaking of the coming event, the patient suddenly breaks into tears and weeps freely. The therapist says nothing, waiting for the patient to partially pull himself together.

Pt. (*embarrassed and apologetic*): I'm sorry to carry on like this. It's such a stupid and childish thing.

Ther. (*kindly*): But why shouldn't you cry if something touches you? This is just the place for it.

Pt.: I guess it shows that underneath I'm a weakling.

Ther. (*delving, now that the acute burst of affect has subsided*): You mean a strong person never has deeply moving feelings?

In this manner the therapist can absolve some of the patient's shame, reinstitute the flow of material, and at the same time give the patient the feeling that he can speak of his innermost emotions without fear of humiliation.

Another behavioral problem involves the patient's request that you read something he has written about himself.

The material usually consists of an autobiography, stream- of-consciousness associations, or random reminiscences. The therapist easily recognizes the many possible defensive aspects of such behavior, e.g., to avoid talking freely, to impress the therapist with a willingness to "do something," to exhibit literary skills, to prepare the content of the interview ahead of time as insurance against surprises, etc. One approach is to have the patient read his writings aloud in the interview. Then you can deal with the content like any other of his communications and perhaps at some strategical point raise the question whether he is avoiding the free expression of his interview thoughts by the prepared writing maneuver.

Gifts (books, pictures, clothing, etc.) which the patient may bring to the therapist can also be considered as evidence of defensive purpose. The giving may have several meanings—to express love, hoping for love in return, to pacify a feared parent figure, to place the therapist in debt, etc. Whether one accepts or refuses the gift (cf. page 147), the important idea is that the therapist recognizes its transference-resistance motivation and introduces an examination of this behavior into the interview discussions. Therapists who frequently receive gifts from all sorts of patients can profitably explore in themselves the unconscious equation, gifts = love.

Behavior of the Therapist

According to the books, the therapist has only to sit, listen, and occasionally speak. Actually it is remarkable how close one can come to doing just and only that. However, a few activities are worth mention.

Sometimes a therapist may feel sleepy during an interview. To himself he owes a countertransference investigation and, if he dozes off, he owes an apology to the patient. The therapist can only hope that the defection will not provide too large a club for the patient's subsequent transference resistances. Other therapists have been known to pace up and down during the interview, exhorting and gesturing. It may be an impressive performance of magical inspiring, but it fails as dynamic psychotherapy.

An oft-discussed question is that of note-taking. Though taking notes during an interview may give the patient the feeling you are "doing something" and not "just sitting there," from the therapist's standpoint it has disadvantages. The main objection is that it perts attention from what the patient is saying and from your own associations to his remarks. One cannot possibly take down everything the patient says, and in trying to select the material one does not have the time or prophetic knowledge to judge which things are the more significant. Although recorded data often give the beginner a secure feeling that in case his memory slips he has an aid, this security is false and evanescent. Clinics usually require something in the chart. As the end of the hour, after the patient has left, one can jot down a few sentences which may satisfy this demand.

By the time one has become something of a psychotherapist, his medical diagnostic judgment has suffered a disuse atrophy of such a proportion that he is really no longer a reliable medical man. This plus other well-known theoretical and practical transference reasons determines the policy that the therapist should refrain from doing physical examinations on his patients. If an examination is required before therapy, a colleague can perform it. If, during the course of therapy the patient develops symptoms which, after careful consideration, the therapist feels might have an organic basis, he can have an internist examine the patient.

Should the therapist smoke during the interview? Why not? It will help drain the small amount of undischarged tension which is always present during an interview, and it contributes to the naturalness of his behavior.

Various problems concerning etiquette may arise, particularly with women patients. Though he acts as naturally as possible during the interview, a psychotherapist must at times bypass certain

chivalries, e.g., helping the patient on with her coat, picking up what she drops, and lighting her cigarettes. With men one usually shakes hands at the first meeting but not in subsequent ones. In addressing the patient by name, the prefix “Miss” or “Mrs.” should be used with women. “Mr.” with men is optional but it emphasizes the professional nature of the relationship and circumvents the patient’s calling you by your first name.

Let us now turn to the actual experiences of psychotherapy, piding them into a beginning period, a middle, and an end. Typical situations will be described using clinical examples from actual practice.