THE TECHNIQUE OF PSYCHOTHERAPY

THE INITIAL INTERVIEW
EVALUATING THE PROBLEM

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A tentative assay of the existing situation is helpful to the therapist in outlining a temporary treatment plan and in roughly prognosticating the extent of future change. This assay will need constant revision, in some instances radical alteration, due to the emergence of data during the course of therapy not available at the first interview. Nevertheless, it may provide a sort of guide for the initiation of treatment, without which the therapist may flounder about, adding to the patient's helplessness and confusion.

The formulation of the existing dynamics will vary with the therapist's perceptiveness, skill, training, and experience as well as theoretic bias. The same patient, thus, may be seen from different points of view. Each viewpoint will stress familiar aspects of data presented by the patient that substantiate a specific theoretical emphasis favored by the therapist.

For instance, let us imagine that a therapist who does supportive therapy is consulted by a male patient who complains of tension, anxiety, headaches, and gastrointestinal distress brought on by an address that he must make to members of his industry at a forthcoming convention. Discerning that the patient habitually gets upset whenever he is called on to make a speech, the therapist may formulate the problem as "stage fright" and correctly estimate that the symptoms will disappear after the patient has fulfilled the assignment. The therapist may then assert that there is nothing physically wrong with the patient and enjoin him to "ride his symptoms" since his reactions are "natural." A therapist who is a physician may prescribe tranquilizers, sedatives, or other medicaments to "tide the patient over" the crisis period; a non-physician may refer the patient to his family physician for such medications.

Another therapist, seeing the same person, would possibly formulate the problem as one in which the patient has lost faith in himself and offer him solace through personal reassurance. A third therapist, psychologically trained, might conclude after testing the person's intellectual caliber, vocational interests, and aptitudes that the problem is essentially that of an individual pursuing an occupation in which he is not really interested, that public speaking is one of his weak points that he might best avoid, and that he is ideally suited for another occupation that will remove him from his present source of stress. A fourth

therapist, with experience in social work, may regard the problem as that of a person who is constantly being called on to perform tasks that frighten him because he has never developed confidence in his ability as a speaker. The patient may then be advised regarding community resources for training in public speaking, and he may be guided toward entering into groups where he can exercise his skill. A fifth therapist, with a pedagogic bias, may approach the problem somewhat differently, considering that what has been lacking is adequate organization and preparation of his forthcoming talk. The patient may be shown how to outline his subject for presentation, how to arrange the material, and perhaps how to employ certain tricks to avoid fear, such as are practiced by public performers. A therapist trained in behavioral therapy may attempt assertive training and in-vivo desensitization by encouraging the seeking out of opportunities for public speaking.

If the therapist has been trained to do more intensive psychotherapy, say reeducative therapy, the problem may be formulated in a more incisive way. For example, strong perfectionistic traits may be detected that drive the patient toward exorbitant expectations of himself. He may believe that each projected talk constitutes a challenge that must be overcome by an extraordinary performance. The patient may feel unable to live up to merciless expectations that he imagines are demanded of him. Or the therapist may find evidence that the patient automatically anticipates criticism or hostility from people, his panic being a reaction to the ill will others bear toward him. Fear of failure or of living up to expectations may, in the opinion of the therapist, produce such strivings as detachment, dominance, competitiveness, aggression, compulsive ambition, grandiosity, and masochism. Many contradictions would, of course, be residual in the simultaneous operation of several of these traits, and the outcome may be conflict, with the result of inhibition of function such as is being experienced by the patient. A formulation in these terms will be helpful in planning reeducative therapy during which the patient is brought to an awareness of how these traits disorganize him in his relations with people and in the achievement of essential goals. The therapeutic effort will then be directed along lines calculated to bring disturbing traits under control and to replace them with more adaptive ones.

If trained in reconstructive therapy, the therapist will undoubtedly organize a tentative formulation of dynamics in terms of this training orientation. The patient's stage fright may be regarded as a manifestation of deep feelings of self-devaluation, of self-contempt, of inferiority, or of residual dependence. Symptoms may be looked upon as an outcome of fears of mutilation that are residual from

an unresolved Oedipal conflict that shadows the patient, threatening him particularly when he competes or exposes himself to the judgment of an audience. His striving to avoid talks and presentations may also be regarded as a cover for exhibitionistic tendencies, a yielding to which may bring fantasied havoc upon him. He may then seek refuge in a passive retiring manner, shrinking from public appearances. Yet this defense is inadequate since it convinces the patient that he is inept and mutilated. The therapeutic task here would be to bring derivatives of these unconscious tendencies to the patient's awareness until he recognized the raw conflicts that incited his fear. Once he knew his real enemies, he could cope with them in a manner more appropriate than his prevailing ineffectual infantile methods of defense.

No matter how skilled and well trained the therapist may be, it is not always possible at the beginning of therapy to obtain an understanding or even a perspective of the dynamics of the patient's problem from his verbalized complaints, his past history, and his reported present relationships. This is because many of his patterns are not identifiable to the patient, although he may act them out constantly. For instance, a man struggling with an urge toward homosexuality may have only a minimal idea of the degree that he fears and despises women, toward whom he professes a congenial tolerance and understanding. Another example: A woman, the only child of a couple who expected a male infant and did not hesitate to impress the little girl with their disappointment, as an adolescent and adult became fiercely competitive with males. She did not realize the true depth of her fury at having been born a female nor the extent of her refusal to give up the hope of eventually becoming male. Sometimes it is possible at the start to get glimpses of repudiated trends. Yet the exact operation of repressed aspects of personality may escape definition and even detection until the therapeutic process has well begun and as repressions start lifting while the patient is helped to face himself or herself in an honest and resolute way.

Most patients, thus, are incapable, during the initial interview, of verbalizing sufficiently to give the initial interviewer an idea about the operative conflicts and the important mechanisms of defense. As a rule, many sessions of therapy will be required before the dynamics begin to unfold.

Patients who are able to talk freely about themselves and their feelings, however, are often capable of revealing sufficient clues about their deeper problems to enable an astute interviewer to make some

hypothetical assumptions about the dynamics. Much will depend on the perceptivity and experience of the interviewer and upon the ability to pick up nuances from the verbal and nonverbal behavior of the patient.

Generally, little information about dynamics will be obtained from the statistical data, the elaboration of the chief complaint, the history and development of the complaint, and other associated symptoms. If the patient, however, reveals one or two dreams that are significantly imprinted on the patient's mind, discourses on feelings about and relationships with parents and siblings, it may be possible for the interviewer to make important connections between underlying mental processes and the surface symptomatology.

Projective psychological tests are sometimes valuable in formulating the tentative dynamics, especially for patients who are not able to verbalize freely and who do not remember their dreams. From the unstructured ink blots of the Rorschach it may be discerned how the patient handles anxiety, reacts to emotionally stimulating situations, and organizes a defensive facade. Revealed also are the intellectual operations of the individual, inner psychologic mechanisms, and the quality of fantasy life. From the structured pictures of the Thematic Apperception Test there are elicited associations that are most revealing of basic characterologic attitudes and patterns as well as the interplay of emotion and personal interaction. The Man-Woman Drawing Test reveals reflections of the patient's body image, the emotional significance of various bodily parts and organs, and basic conception of "male" and "female." The Szondi Test is said to bring out the dimensions of the patient's basic needs and drives. Dynamics revealed by projective psychologic tests must always be validated by clinical corroboration.