Chapter 1

The Freshness of First Sessions

She was looking for what she calls "characteristic moments." "That's when people actually take control of their interview..."

ANNA DEVEARE SMITH, QUOTED BY BERNARD WEINRAUB, 1993

First meetings have a great potential if we know how to bring it out. Winnicott (1971b) certainly knew, from his work with children:

I was struck by the frequency with which the children had dreamed of me the night before attending... here I was, as I discovered to my amusement, fitting in with a preconceived notion... Either this sacred moment is used or it is wasted. (pp. 4-5)

Adults in trouble often resemble children, for they too want to give themselves away. (Of course, some adults, and children, dread trusting anyone and become more inaccessible the more they are troubled. We will discuss this in Chapter 2.) Yet we must know how to conduct ourselves to allow them this unburdening. Even if we are persuaded by Winnicott's picture of help, we will need to be careful about several technical points. In our own anxiety, we can get in the way. Often, these interviews get off on the wrong foot.

WHO IS LOOKING FOR SOMETHING

The Docile Body

Second-year residents in a clinic have to file the best report they can for the clinic chart from the first session. Thus, they are impelled to take control of the interview, which leaves the patient in the role of the one controlled by questions. The style is gentler than in a courtroom, but the patient ends up in the predicament of a witness against himself, that is, in Foucault's (1975) phrase, as a docile body, or
as a not so docile body barely able to contain himself. The residents get a half hour, and then it’s my turn.

I begin by summarizing what I have heard, but I reverse emphasis, from what the resident has found out, to what the patient, or the person who sent the patient, was looking for from us!

The Case of a Woman Looking for a Doctor to Give Her Lithium

A middle-aged mother of three had begun by telling the resident that she had lost her old doctor who had given her lithium, and now sought a new one as a replacement. The resident felt obliged to find out all she could about what had gone so far wrong that the patient needed this serious drug. She fired a volley of questions to pin down the disturbance, and instead pinned down the patient far behind the baseline, where the patient played very weakly, and began to twitch and look appealingly at me.

All I did was to reverse the field, by saying simply that she was looking for a doctor to give her lithium, which seemed to be very important to her. Oh yes, she said, it was terrible when she was twelve and depressed, and mother ignored her, even while her brother turning blue from asthma got rushed to emergency rooms right and left. Then at sixteen she became manic, which forced mother’s hand, yet the doctor attributed to adolescence the fact that she could not study at all with her racing thoughts.

I responded (now that the patient had taken over the interview) that she had been let down too many times. Oh yes, she said, and it is happening right now, because this very brother is living with her and terrorizing her in his drunkenness with plots to trap the skunks under the house with bear traps! She has nightmares of her children falling into them, but again her mother tells her she worries too much, and she is again woefully ignored. She tells me she is relieved by our talk, because I am on her side.

So the resident gets her evidence for the report in the clinic chart, but it is evidence driving straight at us on the strong wind of the patient’s passion for an ally, rather than evidence fleeing from us under covers.

Problem-Posing

This is precisely the difference between what you get when the patient is the active subject versus what you get when the patient is the passive object. I am not against questions per se, such as are necessary about disturbances that are dissociated and about symptoms that could be signs of physical illness. The order is the thing. A patient who has told her story can later bear some inquiry without losing her dignity. I follow David Malan’s (1979) example in this, which I remember vividly from my visits with him at the Tavistock Clinic. He brought out the subject in the first half of the interview, whereupon he wheeled like a naval officer and took two paces back to survey the damages objectively.
Yes, the great problem of the first meeting is to establish the subject in her own story. It is quite like the problem of Brazil’s Minister of Education in the liberal Goulart government, Paulo Freire (1970), who was called on to teach millions of illiterate peasants how to read and write Portuguese. When he sent teams of smart city people out to the country to instruct the peasants, nothing happened. When these smart city people reversed themselves by showing pictures to the peasants of the peasants' own world and asking them what words seemed fitting to them, the peasants could not stop talking, reading, and writing. The first approach is what Freire called the Director Culture, which reduced the peasants to a culture of silence. The second approach is what Freire called problem-posing, which brought out the full subjectivity of the peasants in their own generative language. We are in danger of being a Director Culture, and putting our patients in a culture of silence. This is why I pose pictures of what the patient is looking for.

The Patient Has Been Sent by Someone Else

Yet it is a mistake to assume the patient is looking for something, unless we make sure that someone else has not been looking for something by sending us the patient! The patient has been in such a muddle that she has driven some other helper crazy. So the helper is looking for somebody else to do something, and that is the only line to such an interview that will make any sense. The patient is only delivering a message, and will not come to life in Freire’s sense of generativity unless we bring out the presence of the message-sender that stands behind the play.

Getting a patient like this is like picking up a tangled ball of yarn (Gustafson, 1986; Selvini-Palazzoli, 1985). The more you pull on it, the worse it can become. Usually, several referring parties have already tried this, and given up in frustration. So it is not a good idea to dive into the yarn and tug on it with a hundred questions. A much better idea is to find the loose end. The loose end turns out to be in the mind of the person who sent the patient!

A Case of Whirliness

When the patient's chart comes in a wheelbarrow, you can look for the start of a very unsatisfying exercise. A seventy-year-old married mother of five was preceded by her voluminous records, which included three different cancers, cardiovascular disease including stroke and high blood pressure, depression, anxiety, headaches, dizziness, hot flashes, paresthesia, and so forth. She herself was as garrulous as her chart was long. Not only did she have an endless list of complaints, but she also had quite a list of enthusiasms. Obviously, the lady had a lot of energy, and was too much for anyone to manage.

The resident made a game effort to wrestle with all of this. She certainly wrote a lot of it down. After a half-hour, both she and the patient were very tense, for so
much was wrong. This problem saturation (White and Epston, 1990) is a very unpleasant state. But how was the mess to be sorted out in the quarter of an hour left to me? Certainly, there was a great deal of organic illness, and very likely there was a great deal of psychological overlay. For example, her complaint of “whirliness” in her ears was so idiosyncratic that I felt quite sure it would lead to her peculiar world. Still, I also felt I would be as lost as the resident and the patient if I grabbed hold of “whirliness” and ended up in a dust devil myself.

Instead, I backed away from all the details and asked the lady how she got to us? It seemed that she was sent by her oldest daughter, who had told her that the doctors were missing something. What had given the daughter that impression, I asked. Well, the old lady was especially worried about her husband. He had always been too trusting in the family business, and now that he was so dizzy with Ménière’s disease, he was leaving it in very bad hands. It made her so mad! She felt absolutely helpless!

At last, the patient, the resident, and I felt some relief, for the patient was getting some catharsis and calm. She went on to say that her daughter didn’t like to hear this distress about her own father, and her friends didn’t like to hear about it either, so there was really no one to tell. She had to listen to her husband, but no one wanted to listen to her!

What did her husband complain about most, I asked. “Whirliness,” she replied. I smiled to myself, for I saw that whirliness had been passed from the old man to his wife, quite as the ill fathers had passed on their physical complaints to their wives and daughters, who had felt stuck taking care of them in the 1890s in Vienna.

In other words, we had run into the phenomenon discussed by Breuer and Freud (1895/1966) in their Studies on Hysteria.

In hysterical patients, whirliness or some other physical complaint is acquired when the patient is in a helpless rage like this lady was. She has fastened on to the very complaint that gets her husband taken care of. This is what is called suggestibility. Now, she too will be taken care of. Similarly, the hysterical patients on Charcot’s ward got epileptic “seizures” when he introduced epileptic patients who were of dramatic interest to himself and his colleagues (Havens, personal communication).

As Sullivan (1956) showed, hysteria is a very simple operation. It begins when the patient imitates a malady she has witnessed. Hysteria only becomes complicated by the number of imitations attempted by the patient. Once the patient has got the talent, she can even invent illnesses without seeing them in others, simply by attending to the multifarious body sensations aroused by anxiety. In general, a single imitation of an illness, like the odor of burnt pudding in Lucy, the fainting spell in Katherina, or the sensory loss on the leg of Fraulein Elisabeth, indicates a more benign case that can be resolved in brief psychotherapy, while the large collection of imitations of illness, like in Frau Emmy and Anna O., indicates a more malignant case that will not be resolved in brief psychotherapy (Breuer and Freud, 1895/1966). Now, I could simply say to the patient that coping with her husband was too much, and she needed occasionally to talk with someone about it besides her daughter. She
psychic inflation
(viz. doing the
work of 2 in
a relationship)
acquires an ailment
forcing care

doormat
doormat

stifling
episodes of
helpless
rage

Figure 1.1. The horns of the devil in hysteria, a rampant dilemma.

agreed and left happily, but perhaps the greatest relief will be that of the daughter, the message-sender, because we took in her message.

WHAT IS THE GAP IN THE STORY

Sullivan's Hypothesis

So if the first problem of the interview is to establish what is being looked for, by the patient or his sender, the second problem is to reckon what it will take to reach the desired destination. Almost always, the patient is doing something to take himself off the track.

This self-defeating something will be left neatly out of his narrative (not consciously). The patient is himself unaware of his own part in derailing himself. This is what Sullivan (1956) called selective inattention:

And the selective inattention is so suave that we are not warned that we have not heard the most important thing in the story—that it has just been dropped out . . . so that we just do not notice the gap where it belongs. (p. 52)

Selective inattention is the classic means by which we do not profit from experience. (p. 50)

Sullivan rightly notes that selective inattention is of "profound theoretical signifi-
cance" (p. 48), because it is the very turn in the road where the trip continues or gets derailed. It goes unnoticed. It will not be mentioned. What could be more important to psychotherapy? Nevertheless, the concept itself soon slipped out of sight after Sullivan put his finger on it. Why? Sullivan's answer is that it is more important to feel secure than to know what's going on. Thus, the concept was lost. Feeling secure helps an individual to keep his standing in groups, even if he does not know what he is doing.

Therefore, my second problem is to listen for the gap in the story. I will look for the patient to veer away from it, whenever we get close.

A Case of Intimidation

An extreme example will make the point clear. A wiry middle-aged man came in warily, in combat fatigues, wearing something like an Australian bush hat. He declined the chair next to the resident, waved him off, and lowered himself carefully into another chair just inside the door. Asked about why he came in, he began to pontificate about the value of self-help organizations for schizophrenics like himself. Occasionally, he threw in a sneer at doctors and their rotten drugs. Obviously, he was in charge, and had no intention of giving up his command.

The resident was tactful, and the patient settled in. We learned little more, because the resident was pinned down by his own politeness. He was half right, for without this concession, the patient would break off in a second. The problem was that the resident did not know how to keep one foot still while letting the other foot circle toward the disturbance like a compass. Instead, he got in occasional queries that the patient dismissed readily. Finally, as time ran out, the resident became a little desperate and jumped on the subject of the patient's mother, which had rattled the patient when run by him earlier. The patient exploded into curses and fled the room.

Thus, you often dare not go straight for the gap in the story. If you do, the results are apt to be exciting but unworkable. You have to back away from the gap and move toward it gradually, with a logic the patient can follow. For example, this patient could have been offered a smooth transition (Gustafson, 1986; Sullivan, 1956) as follows: "Obviously, you have gained a great deal from self-help organizations. Let's go back to when it was working best." The implication is clear. There has been a falling off, which we will have to reckon with if we are to be of any help. We will first establish the patient's success. This relieves the patient of his dread that we wish to unsaddle him: not at all. It has already happened, and we only want to help him get back on top where he is comfortable.

In other words, the doctor has a dilemma. If he lets the patient stay on top in grandiose control, the doctor will not get near the disturbance. If he takes the patient off his high horse, he will have a patient who is helpless on foot and explodes out of the room like this man did. The most probable way through the horns of this dilemma is to establish the patient's success more firmly by history, and then note that it is something in the world that unsaddled him. Thus, I will say: "You were
doing so well in your organization for self-help, until something went wrong. Otherwise, you would not have landed in the hospital. This will be a lot easier for the patient to take, for the world did it to him, not the doctor. Still, highly manic patients will not allow you to do even this, for they have to be charging around continuously to overlook their helplessness.

**Sullivan's Romance**

Now while it is true that a skillful interviewer can discern the gap in the story and move into it with tact, it is by no means true that the patient will be able to work with this decisive turn in the road. Sullivan (1956) made the job sound workable, when often it is not at all:

Thus we try to proceed along the general lines of getting some notion of what stands in the way of successful living for the person, quite certain that if we can clear away the obstacles, everything else will take care of itself. . . . The patients took care of that, once I had done the necessary brush-clearing. (pp. 238–239)

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**Figure 1.2.** The doctor's dilemma with the manic patient.
Uncovering is just not that potent. It may alarm the patient so much that he clings like a drowning man to the status quo. You may point to the necessary crossing, but he may not be ready to take the plunge. He may never be ready. Notice that I have shifted from a landscape of action, which promises footing, to a seascape, which arouses terror.

A Case of Napoleon

This man was a manager whose hero was Napoleon, in the very precise sense of the autocrat and general of the Revolution. He was there to set the country right. Unfortunately, his actual job was less that of a general, and more that of a chief steward. Therefore, he was continually thwarted and, thus, vexed. He wished to be in one of the hundred best companies, where his rightness would be recognized. Since he was placed, instead, in the wrong universe, he was depressed.

I posed the gap in his story. If he was going so wrong trying to be on top of everything, what happened when he detached? Well, he could not do that. He would end up not caring at all! I responded that he seemed all or nothing. All was ruining him, and nothing was an empty sea. As we ended the hour, I purposefully did not conclude. Rather, I proposed to write him a letter summarizing the situation.

I proposed in my letter that he might be like one of Jung's patients who were captains of industry in Zurich (note, captains and not generals). Some of them could find a new self in the shadow of their dreams and begin anew in middle age, and some could not. Like any other medical consultant, I proposed more tests, and in his case, a test of his ability to bring dreams.

He brought a number, and then desisted. He stuck to his guns at work, buttressed by the resident giving him antidepressant and antianxiety agents. Thus, he kept his favored footing, and declined a passage at sea. (In a letter from the patient responding to this account, he gives a slightly different picture. In his dreams, he is more of a Western cowboy than a Napoleon and in danger of going off by himself into the sunset like in the movies. This alarms him, and drives him back toward his familiar stewardship of the company. So, he tends to be overresponsible in his persona, or throwing off all responsibility in his shadow. A middle ground or third position is a very slow development in such cases (see Gustafson, 1995, especially Chapter 11 on Jekyll/Hyde).

WHAT COMPANY IS NEEDED

Winnicott's Dream Dive

It is not necessary to pose the sea passage in shadow in the form of dreams. There are other tests of readiness or nerve. For example, patients who are being trampled can be told that they are probably not up to facing certain difficult people, or certain feelings like anger, or certain assignments to show their skill.
But like Winnicott, I like to propose a dive into a dream, once the drift of the present course is charted. Dream analysis has several advantages. One is that it drops us into the feelings that must be borne to get across the sea. A second is that it provides a precise and individual map of the terrors of the sea in the particular patient. His unconscious has already X-rayed the gap. We are testing the readiness of the patient to face his own X-ray. A third is that we will discover if there is satisfaction for the patient in the descent, which will buoy him through further arduous passages.

A Case of a Black Hole

A forty-year-old divorced mother of two came for a first appointment after her sixteen-year-old daughter elected to leave her to go live with the father. Her distress was evident. The resident linked the patient's distress to the patient's own childhood. She felt burdened as a teenager by her own mother's confiding distress, and wanted to go to her father for refuge. Her father hadn't wanted her. Thus, she had gotten sexually active with a boy, to find comfort that she could not get from her father. Now her daughter wanted to get away from her, and go to the father, where the daughter could get away with being sexually active because she would not be so closely watched.

Thus, the resident had done a very nice job of linking the pain of the present to the pain of the past. In my turn, I just stayed with the pain, because the patient could bear it without the grave complications of suicidality and psychosis and because the resident had room to take the patient. How had she lost custody of this daughter, I asked.

Her husband had been abusive and mean to her. She had felt helpless, but then began to feel like taking it out on her girls. She confessed this to the Family Court, whereupon the court decided that both parents were injurious to the girls, and awarded joint custody. This was altogether too much for her to take, for opening her mouth had gotten her kicked in the teeth. She felt altogether swindled, since her husband had been literally brutal, while she had only felt like it and asked for help not to become that way. She felt like screaming in the court, "Those children are my life," but instead collapsed in shock.

Like many who have become victims, she had been too open and too trusting. She had mistaken Family Court as help, rather than as a contest for possession of her girls. By staying with her pain, we had gotten a most vivid picture of her posture of trust that allowed her participation in her own tragedy.

I asked her for a recent dream. She gave me a long and powerful, or epic, dream that culminated in a scene in her childhood bathroom: There was a white picket fence around a black hole in the floor, with a little four-legged black chair over the hole. The white picket fence took her to her American dream of a family, while the black chair and hole seemed to draw her from potty training into it as if it were an immense gravitational field. She became extremely anxious, and tried to wake up,
and imagined her boyfriend was standing by her bed. This last image was a hypnagogic illusion, but terribly important because it showed her how her need threw her into the arms of someone she hardly knew.

The reader may ask what has been gained from the individual map of the dream that we did not already know from our map of her stance of excessive trust. First, we get a vivid picture of her American dream: she loves white picket fences so much, so to speak, that she is not apt to look closely at who is living inside them. Second, we get a vivid picture of her terror, which reaches back into the early childhood of potty training: if the light is still dim so far back, there is still ample suggestion she had reason to fear her parents early in her life. Third, we see that her terror literally drives her into her excess of trust: she leaps out of what is most dire into the arms of what is most idealized.

Her helpers now knew about more than her excessive trust. They also knew something of its motives, namely, that she is like a poor, overrun country trying to defend itself from one enemy by opening its doors to another enemy because it so desperately requires protection. This idealization of the second enemy, while understandable, is exceedingly dangerous to her. This will become a crucial subject of subsequent discussions.

I think the dream was also directly relieving to the patient, for it provided a vehicle in which we could travel with her from what is most beautiful to her, to what is most terrifying, to the jump to illusive safety. The dream itself had been bewildering, but the retelling to us slowed it down, gave her company—that is, pause and comfort, and allowed her to take it in as a set of signposts to heed. Patients are often like frantic travelers until a guide can settle them down so that they can use the maps they carry unwittingly inside themselves.