The Psychological Interview in Medicine*

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I

The development of psychosomatic medicine and the general acceptance of its basic tenets, namely, the interdependency of psychological and somatic processes, has stimulated medical practitioners to an increased awareness of, and interest in psycho-dynamics. There is hardly a physician who does not know that psychological conditions of his patients have to be taken into consideration; they can be either entirely responsible for the patient's complaints, or they may adversely affect somatic ailments. But while progress in medicine has firmly established the importance of psychological factors, it has left the medical practitioner without much assistance in his efforts to understand the psychodynamics of his patients and to evaluate properly the psychological factors in any given case. One is justified in questioning the extent to which physicians in general "understand" their patients. The same problem arises is regard to teachers, who are supposed to understand their pupils in order to help them in their progress and adjustment. But do teachers by and large really understand children? And if they do, on what premise is their understanding based?

We find ourselves in the peculiar position wherein the need for psychological understanding has been well impressed upon the practitioners of various professions, yet at the same time little training has been available to them for a scientifically sound evaluation of psychological dynamics. Consequently, physicians, teachers, and others dealing professionally with people, have to rely on a pre-scientific, almost intuitive approach, based on ability to "sense" psychological factors, mostly through empathy.

We cannot blame any individual teacher or physician for his or her deficiency in this regard. It is in the scientific evolution of psychol-

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ogy that we find the reason for the inadequate knowledge of psychodynamics amongst professional workers.

Real progress in this field depended on the breakup of autocratic social organizations. In an autocracy it is neither necessary nor even advisable to "understand" the individual. Psychological considerations were only given to the masses which had to be subdued. It is characteristic for autocratic concepts to consider human behavior as being based on heredity (1), divine guidance, or predestination; this being so, there is nothing to understand, nor much to change; force alone can stimulate or suppress. All progress in psychological understanding has been made by investigators who were rebels and opposed certain cultural pressures of their time.

When psychology was recognized as a coming science, attempts were made to apply to the human being those approaches which had been found effective in natural and physical science. Experimental and statistical research provided valuable and new information about psychological mechanisms. But none of them could do justice to any one individual, explaining him in his uniqueness. Various theories were advanced in psychology, each one revealing other facets of the human mind and personality; but none provided an approach permitting insight into one specific person. One of the first theories, especially on the American scene, which attempted to analyze and to understand one individual, was Watson's "Behaviorism." It explained the individual in a *mechanistic-physiological* way, considering him as the result of innumerable stimulus-response patterns. While this theory offered some direction for corrective procedures, through exposing the individual to new stimuli in order to offset the past detrimental ones, it actually did not provide the professional worker with any tool to really understand the person, since no one had information about all the innumerable stimuli to which the individual had been previously exposed.

A revolutionary change in scientific methods of understanding individuals came from medicine, or more specifically, from its psychiatric branch. The physician has to apply whatever information science supplies. The psychiatrist uses "applied psychology." He cannot wait for statistical evidence, nor can he be satisfied with theoretical considerations of isolated mechanisms. He has to treat a patient and to find scientifically supported methods to do so. Consequently, it was a psychiatrist, Sigmund Freud, who revolutionized the science of psychology. He devised methods applicable to an individual case not only for

therapeutic purposes, but to gain insight into psychological dynamics. But Freud was the product of a mechanistic-deterministic era dominant in science throughout the last few centuries. He could only see *biologic-instinctual* processes which seem to dominate man, making him a pawn of hereditary and environmental influences. The rather involved and often far-fetched interpretations of the psychoanalytic school do not provide the medical practitioner with tools to understand individual patients. A psychiatric specialist is required to spend many hours to determine the psychodynamics of a person. The psychoanalytically oriented physician can only *assume* certain mechanisms which *may* operate in his patient. Actually, all he does is use an analytic label instead of the previous moralistic one. The old-fashioned physician may call a patient hysterical, selfish, irresponsible, stupid or whatever quality he may need to explain the patient's inability to function. The modern physician may speak about repressed hostility, anal or oral personality, guilt feelings, self-punishment, etc. It is questionable how much real understanding is accomplished by either giving such a verdict or treating a patient on the basis of it.

II

An accurate and rather quick understanding of an individual is available by what may be called the *socio-teleological* approach. It implies the recognition of the human being as a fundamentally social being, a *zoon politicon* (Aristotle). All his actions have social significance, all his functions have meaning within his social setting. The realization of the social nature of man is generally associated with another concept, namely, man's self-directiveness, his striving for goals which he sets for himself. In this perspective all actions are purposive, and their goals are of a social nature. In his goals all the past experiences and stimulations of a person come into play. Therefore, the teleological approach is holistic, and no holistic approach seems likely without the recognition of the social purposiveness of man's behavior. In his goals, which bring about his actions, feelings and thoughts, the individual reveals his total personality.

The socio-teleological approach is the most recent one in psychology, although Adler developed it about forty years ago. It leads away from the causalistic-mechanistic concepts of the past. It presupposes man's ability to decide for himself, to be a self-regulating agent. Such concepts are in line with the democratic atmosphere which surrounds

modern man. The power of any one force upon man becomes dubious and is even questioned in physical science. The causal principle assumes that a force can affect a passive object; however, it is established that no such passive objects exist, and that any organism "responds" to any force to which it is exposed. It is this response which determines the effect of the original force. This is true within the inanimate world, more so in the biological sphere, and most obvious in man. Man not merely reacts, he acts according to his own self-determination. This spells the end of an exclusively causalistic orientation.

The socio-teleological approach was perhaps first defined and clearly established by Alfred Adler in his Individual Psychology. His perspectives were later adopted by other analysts who broke away from the orthodox school of Freud, beginning with Otto Rank, Karen Horney, the Washington School of Harry Stack-Sullivan, Erich Fromm, Frieda Fromm-Reichmann, Clara Thompson and the Chicago group of Franz Alexander and Thomas French. Each of them is in a different stage of breaking with the biological-instinctual past and discovering the socio-teleological future. Some, like French, still are blocked by their assumption that goals are mainly biological and concern the conflicts within the individual; but all are moving in the same direction.

This development is universal wherever the new aspects of man and life are perceived. In contrast to the early vitalists who left the door open for mystical concepts, the modern teleologically oriented scientists have no such inclinations and regard teleological mechanisms as part of natural forces. "The concept of teleological mechanisms, however it may be expressed in different terms, may be viewed as an attempt to escape from these older mechanistic formulations that now appear inadequate, and to provide new and more fruitful conceptions and more effective methodologies for studying self-regulating processes, self-orienting systems and organisms, and self-directing personalities. But these new concepts carry no psychic or vitalistic assumptions, nor do they imply that any mysterious supernatural powers or psychic forces or final causes are operating the system or guiding the organism-personality. The idea of purposive behavior is not a regressive movement to an earlier stage in the history of ideas, but forward movement toward a more effective conception of the problems we face today." (L. K. Frank (2)) The terms *feedback, servomechanisms, circular systems* and *circular processes* express the same basic mechanisms and substantiate in mathematical and scientific terms what Adler visualized half a century ago. At the same time he was considered "unscientific"

when he rejected a mechanistic explanation of human nature and recognized man's ability to set his own goals and to maintain them against outside pressure by establishing his own life style. Similar trends toward a new scientific orientation are reflected in the formulations of the "élan vital" by Bergson, the "cellula consciousness" by Pierre Jean, the "aritogenesis" by Osborn, the "nomogenesis" by Berg, Smuts' "holism," Rosa's "hologenesis," Driesch's "entelechy," du Nony's "telefinalism."

This rather theoretical discussion is necessary as a preparation and justification for the technique which Adler provided in examining the personality structure of a patient, a technique which permits a rather quick and reliable psychological analysis. Every physician should be familiar with such a technique which permits him a more objective psychological analysis of each patient, since psychological factors cannot only cause symptoms and disturbances, but aggravate pathological conditions. In many cases a differential diagnosis between psychogenic and somatic illness is hardly possible without a proper evaluation of the psychological condition of the patient.

Our technique of eliciting pertinent psychological information follows the well established pattern of Adler. Its slightly more systematic presentation became advisable for the teaching of medical students and the training of young psychiatrists. A questionnaire was evolved which facilitates the collection of all pertinent material within a short period of time. When Adler once declared that he, within an hour interview, could understand a patient, his problems and his whole personality, we, his students, stood in awe of his genius. Today we know that everybody can learn to do so, if not as efficiently. Every physician can learn, by using this technique, to understand the patient and his problems within a relatively short time.

III

In interviewing a patient for the first time, we let him talk about his condition, his symptoms, his discomforts and disfunctions. He gives us then—as we call it—the *"Subjective Condition."* We know then how he feels, what he experiences within himself, what he came for.

Then we examine the *"Objective Situation"* of the patient. We want to know the field in which he moves, the condition under which he lives, how he actually functions. Adler gave us the framework for such examination by pointing to the three life tasks which include all

human actions and endeavors, work, social relationships, and relationships to the opposite sex.

Both areas of inquiry require some skill. No experienced physician should find it difficult to obtain a correct picture of the *subjective* condition of the patient. All it takes is the ability to listen and to prod the patient to express himself. The clarification of the *objective* situation requires more specific skill. Some medical practitioners may not yet have acquired it, although a good physician generally can, so to say, read between the lines or "listen with a third ear." That is necessary in many cases. Particularly if the patient sees no reason why the doctor should ask such personal and intimate questions, he may be inclined to pass over pertinent data and answer the question about the three areas of functioning with, "Everything is fine." He likes his job, his family, gets along wonderfully with his wife, sex activity is "normal," he has many friends. This may be so, although it is questionable whether any one of our contemporaries can lead such a well-adjusted life. Such answer of a patient is even more dubious if the subjective complaints indicate some nervous tension. Then we can be quite sure that conflicts and dissatisfactions exist within the three areas of living. The difficulty is to induce the patient to talk freely. This requires skill, an attitude of sincere interest and understanding, tact, but also acumen in not missing certain clues which would lead to the exploration of a conflict situation. We have seen inexperienced students give a patient a clean bill of health in his field of action, when a slight scratching of the surface brought forth deep disturbances in human relationships and functions. It is our opinion that a correct evaluation of the present field of action is mandatory in any case of serious illness, of whatever kind it may be. This information is at least as essential as a careful anamnesis of past illneses.

In many cases it may be advisable to examine the field of action as it was at the time of the onset of the present illness, at least if neurotic symptoms are present or suspected. However, one should not be satisfied with the patient's report of any *one* upsetting incident. For example, a young man traced the beginning of his phobias to an auto accident; nobody was hurt, and he merely got frightened. But since then he could not walk alone on the street or even be at home by himself; somebody had to be with him all of the time. It was only after insistent probing for about half an hour that the patient mentioned the death of his grandmother which had occurred around the same time. How did her death affect his life? She had raised him and had acted

as his mother. He felt completely lost and helpless since she had passed away. The "crisis situation" was not provided by the car accident, but by the new life without special service for which he was not prepared. One "trauma" by itself is never sufficient to produce symptoms; it is always the total life situation which has to be examined, first at the present time, then at the time of the onset of the disease.

After the subjective and the objective situations have been gleaned, the two sets of data have to be integrated. This is done through *"The Question."* This is the most important part of our dynamic approach. The patient is asked what would be different in his life if he were well. This question is generally received with some surprise; the patient does not know. He begins to think. In many instances he may not be able to give an answer at all. We may have to prod: "Let us imagine I gave you a pill and you would be completely well as soon as you left this office. What would be different in your life, what would you do differently than before?" Eventually, some statement is made. It is of utmost significance. It indicates whether the symptoms have psychological significance or not; and if so, what their significance it. Naturally, if a patient with a broken leg is asked *The Question,* he may point out what he would do without the handicap. It generally is easy to judge whether a present lag of function is in accord with the actual physical disability or exceeds it. In the latter case the disfunction has both, physical and psychological implications.

The answer to *The Question* indicates against whom or against what condition the symptom is directed. If he were well the patient might look for another job, do better on his present job, get along better with his wife, or perhaps he would get married; or she, the wife, might be able to divorce her husband or take on a job. All such answers are self-explanatory. They indicate *why* the patient is sick, if the illness is entirely neurotic, or what use the patient may make of an actual physical ailment. They reveal a psychological superstructure which has to be investigated regardless of any actual organic pathology.

The teleological premise of our technique becomes obvious now. *Every neurosis has a purpose.* Purposiveness is not a new concept in medicine. Around the turn of the century the neo-vitalists recognized the purposive nature of pathological conditions. The cell is fighting for its existence, engaged in a struggle for life, does not merely react to outside stimulations, but apposes them. Life has direction. Neo-vitalism opposes "the great mechanistic school around the middle of the past century" (Moriz Benedict (3)). Fever became recognized

not merely as a pathological process *caused* by certain noxes, but represented a healing process of the affected organism, and eventually became a method of treatment, being artificially induced.

One of the reasons for the difficulties in recognizing the purposive nature of neurotic symptoms is the still prevalent mechanistic-deterministic trend in psychiatry, originating in its organistic tradition and fortified by Freud's psychoanalysis. Freud was not always so adverse to teleological thinking. In his book *The Psychopathology of Everyday Life* (4) written while Adler was still closely associated with him, Freud comes very close to the recognition of the social significance of disfunctions which he called *"Fehlleistungen"* (slips). In one of his case histories (5) we find the following statement: "And he resolved his conflict which was in fact one between his love and the persisting influence of his father's wishes, by falling ill; or, to put it more correctly, by falling ill he avoided the task of resolving it in real life." Later on, Freud states: "The chief result of his illness was an obstinate incapacity for work which allowed him to postpone the completion of his education for years. *But the results of such an illness are never unintentional. What appears to be the consequence of the illness is in reality the cause or motive of falling ill."** Here we have in Freud's own words a clear formulation of the socio-teleological principle. However, his preoccupation with biological-instinctual mechanisms prevented Freud from maintaining this direction, later taken up by his straying followers who call themselves Neo-Freudians; Freud himself could only discern a "secondary gain" of neurotic disturbances, since the underlying conflicts appeared to him primarily as intra-personal frustrations and not as inter-personal friction as they appear to Adlerians.

It is the existence of a social benefit from symptoms or its absence which provides the most reliable if not the only basis for a differential diagnosis between organic and neurotic illness. This dynamic consideration is so essential that its neglect greatly impedes a physician's ability to determine the nature of his patient's illness. Without awareness of the possible social implication of a disease or a symptom, no reliable differential diagnosis can be made. The increasing frequency of psychogenic disturbances, superimposed on an organic pathology, or without any, confronts the physician constantly with the need to make a differential diagnosis betweeen functional and organic symp-

*Italics by the author.

tomatology. This is generally attempted on the basis of positive or negative organic findings. If a symptom or complaint of a patient cannot be explained by physical examination and laboratory tests, if these negative findings occur in the case of a patient who shows signs of nervous tension or other social and emotional maladjustment and instability, then the diagnosis of functional disturbance seems justified —to many medical practitioners. Such a far-reaching diagnosis, which generally implies abandoning further clinical investigation, cannot be made by default, merely by the absence of positive clinical findings. As long as the practitioner has no means to base his diagnosis on positive proof of psychogenic involvement, he will try to rely on the proof of general emotional unbalance concomitant with a lack of clinical evidence. The only way to attain a more reliable proof for or against the psychogenic nature of a symptom is through an analysis of the social implication of the disease complex. As long as physicians are not familiar with such a technique and are not even aware as yet of the significance of the social involvement, we as psychiatrists are time and again put in the unpleasant position of sending a patient back to the practitioner who referred him to us for psychotherapy, because we find no evidence that the patient's emotional condition is responsible for his complaints: further study revealed in each case the existence of organic pathology, not recognized before. Such cases prove convincingly that emotional upset and absence of organic findings are no justification for making a diagnosis of psychogenic, functional or neurotic disturbances.

In this light, *The Question* gains utmost significance. A short discussion of a case may demonstrate the point. A patient with gastric disturbances consented finally to consult a psychiatrist, having rejected this suggestion for years, since he considered himself physically sick and felt insulted by the implication that he needed a psychiatrist. His condition cleared up completely as he began to realize its function. He was over-ambitious, tried to please and to make a good impression, and could not say "no" to anybody; his stomach "spoke up" instead of him. If he could not "stomach" a situation, he got sick. At that period of his life he had become increasingly doubtful about his ability to maintain his moral superiority, and consequently was sick most of the time. He not only understood in a short while what he was doing, but was able to change his basic assumptions, and develop a new perspective of life. He was an out-patient at a medical school clinic, and returned year after year as a token of gratitude to be demonstrated to the stu-

dents. One time, after several years of well being, he came and complained of a "relapse." He was sure that his pains which had re-occurred were again psychogenic, since they had first appeared on the train which brought him back to the city from a vacation. Consequently, he came directly to the psychiatric clinic. Upon closer scrutiny it became obvious that the pains were not "used" by him in any way; he functioned fully at home and on his job, and did not excuse himself from any participation or contribution. Therefore, the pains could not be psychogenic this time, although the patient felt the painful sensations as similar to those of years ago, except that the location was somewhat lower in the abdomen. He was sent back to medicine and to surgery; a small tumor in the testicles was found, and upon its removal the pains subsided. The patient was in no position to distinguish between the psychogenic and the organic pains—they both were identical. Only the exploration of patient's functioning and the use of the symptoms permitted a differential diagnosis.

IV

In most cases the medical practitioner will be satisfied if he can understand the patient in his present situation; such understanding will enable him to evaluate properly the function of the patient's disease. However, the incidence of psychogenic implications is so frequent that it is utterly impossible to refer every patient with functional disturbances to a psychiatrist. Unless the disturbance is severe, the patient will refuse to undertake an extensive and expensive psychiatric treatment, and the physician would lose the majority of his patients if he referred each patient with a functional disturbance to a psychiatrist. It seems necessary, therefore, that all medical practitioners, not only those in general practice, but also all specialists, have some knowledge of psychotherapeutic procedures for both diagnosis and therapy.

A considerable amount of psychotherapy takes place in every medical effort by doctors who are not psychiatrists and often may not be aware of the actual role they play in the treatment of their patients. Closer analysis would reveal the extent of psychological factors in supposedly strictly medical treatment; without psychological effectiveness no physician could maintain a practice. In most cases, the medical practitioner relies in his psychotherapeutic endeavors on general principles of conduct, good bedside manner, authoritative role of a father

figure, and similar empirically developed approaches. This will remain so until all medical practitioners are trained in the rudiments of psychotherapy. Then we will be able to distinguish major psychotherapy limited to trained specialists, from minor psychotherapy as used by the general practitioner and any other non-psychiatric medical specialist.

At this point we are concerned with an approach toward an understanding of the patient, as it can be used by any physician. So far we have described an approach to understand the patient in his *present* setting, in his field of action. In many cases it becomes advisable, then, to know more about the patient's personality structure which got him into his present predicament. After all, any crisis situation is created by the impact of a given life situation on a certain personality. What upsets one may not upset another. One patient gets sick when he loses his job and feels unable to get another one, another patient gets sick when he is suddenly confronted with the need to take on a job. Without some insight into the personality makeup of a patient it is difficult to comprehend the nature of his predicaments and difficulties.

Adler provided a definite and rather simple technique for a clear understanding of a person's basic personality pattern, which he called his "life style." This very pattern which characterizes each individual and all his movements through life is developed in early childhood. It is impossible to understand any adult without information about his first four to six years of life which are the formative years. In this period, every person develops concepts about himself and about life which are maintained throughout life, although the person remains completely unaware of the premises he has developed for himself and upon which he acts.

A clear formulation of a person's life style can be obtained through investigation of his *family constellation*, which is a sociogram of the group at home during his formative years. This investigation reveals his field of early experiencs, the circumstances under which he developed his personal perspectives and biases, his concepts and convictions about himself and others, his fundamental attitudes, and his own approaches to life, which are the basis for his character, his personality. After we know the setting, we can determine from his *early recollections* the conclusion he drew under those circumstances. From all the millions of experiences to which we are exposed in our early childhood, we remember only those which coincide with our outlook on life. All early recollections show, therefore, the same pattern; and where they differ, they supplement but never contradict each other.

It is unfortunate that such a simple and—as experience has shown—most reliable approach to an understanding of the basic personality of a person should be so little known today, exactly forty years since Adler described this procedure (1913) (6). This can be explained by the overshadowing influence of Freud, who considered early recollections as cover-up recollections for the really significant but repressed, and, therefore unconscious experiences (7). Only now that Freud's premises are critically re-examined, do psychiatrists and psychologists take notice of early recollections.

V

The examination of the family constellation and of the early recollections is a simple procedure, but nevertheless requires some skill and training. For the benefit of students and trainees, we have developed a questionnaire which assists the examiner in obtaining all pertinent information. Questionnaires are somehow traditional in Adlerian literature; but most of them have dealt with children (8). Wexberg devised one for the treatment of functional neurosis (9). Ours is concerned with information given by adults about their own childhood. It is presented herewith.

Guide for Initial Interviews Establishing the Life Style

I. Family Constellation

List all siblings in descending order, including the patient in his position. Give patient's age and add after each sibling the years of age difference with patient, with plus and minus sign. Include siblings now dead.

A. Description of Siblings

1. Who is most different from you? In what respect? (Ask patient to elaborate)
2. Who is most like you? In what respect?
3. What kind of kid were you?
4. Describe the other siblings.

B. Ratings

List highest and lowest sibling for each attribute, and, if patient is at neither extreme, give his position as to similarity to either.

1. Intelligence
2. Hardest worker
3. Best grades in school
4. Helping around the house
5. Conforming
6. Rebellious

7. Trying to please
8. Critical of others
9. Considerateness
10. Selfishness
11. Having own way
12. Sensitive—easily hurt
13. Temper tantrums
14. Sense of humor
15. Idealistic
16. Materialistic
17. High standards (of achievement, behavior, morals, etc.)
18. Who was the most athletic? Strongest? Tallest? Prettiest? Most masculine, feminine?
19. Who had the most friends? What kind of relationship—leader, exclusive, gregarious?
20. Who was the most spoiled, by whom, how and for what?
21. Who was most punished, by whom, how and for what?

C. Siblings Interrelationship

1. Who took care of whom?
2. Who played with whom?
3. Who got along best with whom?
4. Which two fought and argued the most?
5. Who was father's favorite?
6. Who was mother's favorite?

D. Description of Parents

1. How old is father? Mother?
2. What kind of person is father?
3. What kind of person is mother?
4. Which of the children is most like father? In what way?
5. Which of the children is most like mother? In what way?
6. What kind of relationship existed between father and mother?
   a. Who was dominant, made decisions, etc.?
   b. Did they agree or disagree on methods of raising children?
   c. Did they quarrel openly? About what? How did these quarrels end?
   d. How did you feel about these quarrels? Whose side did you take?
7. Who was more ambitious for the children? In which way?
8. Did any other person (grandparent, uncle, aunt, roomer, etc.) live with the family? Describe them and your relationship to them.

II. Early Recollections

How far back can you remember? (Obtain recollections of *specific incidents*, with as many details as possible, including the patient's reaction at the time. Make sure that this is a recollection and not a report. Childhood dreams *are* early recollections.)

III. The summary of the family constellation and of the early recollections permits the derivation of the basic mistaken assumptions on which the life style is based.

This questionnaire requires some discussion in order to clarify the meaning and significance of the questions asked.

I. Family Constellation

Writing down the names of the siblings in their age difference from the patient often provides an immediate impression of the grouping within the family. First of all, it shows the patient in the characteristic position of a first, second, middle, or youngset child, as an only boy amongst girls, or the opposite. The closeness in age separates one group of children from the others, and thereby often establishes clear indication of the sub-groups. Such sub-groups with their own inner tensions and conflicts are not only provided by the age distance, but by other factors affecting the family; change in domicile (American or foreign born) and changes in economic status distinguish one group of siblings from the others. Siblings who died very young may have had considerable influence on the patient's life; they may be responsible for parental anxiety about patient's health and survival, or they may represent an unbeatable rival, since nobody can compete successfully with a dead brother or sister. Sometimes a patient may have felt accused or responsible for a sibling's death, so that his whole childhood life was affected.

A. Description of Siblings

The first question as to who is most different from the patient is of utmost importance. Difference in character, temperament and interest always indicate competition. Competition may coincide with rivalry, but is not identical with it. Open rivalry may be absent in a strong competitive relationship which is revealed by the differences of personality (9). The most different sibling, therefore, can be recognized as the strongest competitor. In most cases it is the next older or next younger brother or sister. (The first and second child are usually most different, indicating strongest lines of competition.)

Most patients have no difficulty in naming the most different sibling accurately, except a patient who is over-concerned with being right and afraid of giving the wrong answer, or one whose desire for moral superiority prevents him from saying anything "bad" about a sibling.

In asking the patient to elaborate spontaneously on his dissimilarities with his main competitor, he describes each one's *movements* in their competitive effort to find a place in the group. *Character traits are expressions of movements.* Where one sibling succeeds, his competitor will give up every effort; where the other fails, he will move in. As a result, each becomes different from the other.

Conversely, the siblings who are most alike are the allies. The answer to question 2 indicates these alliances. The description of the patient himself as he was as a child provides information of the approaches and movements which he developed. The same holds true for his descriptions of the other siblings (not as they are today, but as they were as children).

B. Ratings

So far, we have let the patient provide us spontaneously with information, the significance of which is naturally unknown to him. We have to rely on what he can tell us, since in most cases we have no other access. Now we are proceeding by presenting the patient with a set of qualities, asking him to tell us which one of his brothers and sisters rated the highest or lowest in each of these qualities. In this way we obtain again the lines of movement for each child, and can draw the diagram about the lines of competition and alliance, for the purpose of discerning the patent's own movements in his interaction with all the others.

The various qualities have been chosen because of their significance as to the success and failure, high and low status of each sibling. Most of these qualities are self-evident in this regard. The last three questions (19, 20, 21) permit a description of interactions with peers and parents. Particularly 21 is significant. Some siblings are punished for mischief, others because their non-conformity is based on their own righteousness which does not permit them to yield to the "unfairness" of the authority.

C. Sibling Interrelationships

Here lines of rivalry or responsibility, of function within the family group become visible. Question 2 generally indicates the "natural" grouping of the siblings. It must be kept in mind that the question of competitiveness does not necessarily come into play in question 3 and 4, which deal with getting along or fighting. Sometimes the main

competitors reach a working agreement by which they get along famously, the successful one protecting his defeated and, therefore, "weak" competitor. Favoritism by parents leads to the exploration of the powers behind the scenes, of father and mother.

D. Description of Parents

We need to know what kind of a person each parent was. We correlate the information about each with questions 4 and 5, pointing to the likeness with certain siblings, who followed parental "guiding lines." This in turn provides us with a verification of the information which we received previously about each sibling. Question 6 is of eminent significance. The relationship between the parents sets the pattern of all inter-personal relationships within the family, be it between parents and children or between individual siblings.

Other people living with the family have to be included in their role within the family setting. Some of them may play a more important role for patient's development than the parents. Excluding them may give a wrong picture of the interactions which explain the patient's movement on the scene.

II. Early Recollections

The beginner is likely to get incomplete or inaccurate information about early recollections. We must distinguish, first, between a recollection and a report. Reports may sometimes have significance in reflecting the patient's evaluation of himself as a child and of life as he sees it. But reports are *not* reliable—recollections are. They represent a *description* of actual incidents which the patient remembers. It is not important whether the incidents did occur in this way; but it is all important that the patient thinks it did happen. Members of the same family may remember the same incident; but what they remember of it generally differs greatly, in accordance with their basic outlook on life. The details which the patient remembers are of utmost importance. Without them, the recollection may be utterly insignificant, or its significance may be completely distorted. For example: A patient remembers a big flood at the age of three; men were working to repair some damage. Without details this meant little. It took prodding to get the details of the recollection: Patient, held by mother, was looking out of a third floor window, watching the big men working below. This is revealing. The little child who needs protection and, compensating

for his being small in a dangerous world of strong men, looks down on the strong who do the "dirty" work. (This was his basic personality pattern.)

Childhood dreams are memories. It does not make much difference whether the recollection contains an actual event or a dream. It would not be remembered unless it fitted into the general outlook on life.

One must keep in mind that the incidents which are remembered are not important because they *happened*, but only because they are remembered. Every person has experienced falling down and hurting his knees. But only those will remember such incidents who still think that they cannot take care of themselves and are in danger of falling down and hurting themselves.

III. Conclusions

The summary of the life style which can be gleaned from the information about the family constellation and about early recollections constitutes the most difficult part of the whole procedure. It requires skill and experience. The ability to recognize all aspects and implications of the information obtained distinguishes the expert from the beginner. However, it can be stated definitely that everybody using this technique will know more about a person than is possible without having this information or without knowing the significance of it. The expert may be able to know more, but this should not discourage the beginner from growing by his own experiences and observations. If he has a chance to study with a well-trained Adlerian, he can expect to progress faster. But we have seen people who were able to train themselves, once they became familiar with the method, and progressed through their study of the literature, and by experience.

VI

Let us finally present a case to demonstrate this technique.

Harry W., thirty-five years old, complains of extreme nervousness ever since his father and uncle died of a heart attack a month apart, half a year ago. He became afraid of suffering a heart attack, becomes upset when he thinks of them, developed a nervous stomach, lost thirty pounds the last half year. Previously he had suffered with what he called "tension headaches." Since the two deaths, the headaches had disappeared. He is irritable, has a temper which he tries to control, has "bad habits," cracking his knuckles and swinging his foot. He worries

about business unless other troubles come up. He dislikes being left alone, and has short depressions without apparent reasons. Always he has been a hypochondriac, always afraid something may happen to him, afraid of dying, constantly running to the doctor.

This is the subjective situation for which he seeks help. His objective situation seems outwardly well under control. He has been married for nine years, has three children, gets along well with his wife. There is no boss, just a give and take. However, he gives in if she gets aggravated. Arguments? Not more than "normal." When? If he does not do what she wants. Sex is "normal." The frequency depends upon how *she* feels, generally two times a month. He would like to have it more often, but she refuses if she is tired. She responds fully. He considers himself "very happily married" but goes regularly to prostitutes.

He has "loads of friends," is very gregarious. He likes people around and likes to go out.

He is a partner in a family business which his grandfather established. He is his own boss, the head of a separate department. He and his younger brother run the whole business since father's death. The brother knows more about it and Harry gives in to brother to avoid clashes.

Outwardly the situation seems to be without conflict; at least, this is what the patient thinks. It does not take too much psychological sensitivity to feel the underlying tension, how he gives in to his wife, to his brother, how he feels deprived of sexual gratification and seeks it otherwise, how much of an inner anger and rebellion he has, which he tries to "control" or better, to conceal. This is clearly expressed in his answers to *The Question*. If he were well, that is, if he were not irritable and nervous, did not suffer with headaches and live in fear of heart attacks, he would take more interest in his children, not be interested in prostitutes, make more effort in his business.

It is obvious that the patient feels unable to solve his actual life problems and hides them behind a smoke screen of various physical and emotional complaints. A physician trying to treat his symptoms with medication would obviously help him as little as another who would tell him that he is physically well and everything is simply imagination. What is wrong with Harry is neither his body nor his "mind." It is his total personality in his specific setting which is his problem. One can neither cope with this by curing his body nor calming his mind. One must help him to understand the impact of his personality and the situation in which he finds himself. In other words,

anyone trying to help him would first have to understand him; then he could help the patient to understand himself, and eventually to change his outlook, his attitudes, his movement toward life and others. At this stage we had no idea about his life style, although he gave the impression of being a pessimist, of expecting not to succeed and, therefore, giving in and rebelling at the same time, of feeling weak and sorry for himself, of fighting against the dangers of life, never sure of anything. The two deaths apparently justified and intensified his distrust of life. We can assume that the death of his father may have put him in the difficult position of coping with his brother on his own, without the "control" of father over both. But why has he no confidence in himself, or in life, for this matter? The answer can be found only in establishing his life-style.

The Family Constellation

The sequence of the children is as follows:

Louise +6, Robert +5, Patient (35), James —1½, Blanche —6. The age distribution indicates immediately the grouping of the children; there are the two oldest, the two middle (patient and James), and the baby. We can readily expect the answer to the first question as to who is most different. Naturally, it is James, the brother closest in age to him, who establishes himself by this difference as his most important competitor. Interestingly enough, when patient is asked to elaborate on the difference, he gives at first a very superficial description. He considers himself more flashy, having fewer inhibitions than James, while the latter is satisfied with what he has. We will see later in that this is true in a sense, but in a different way than patient realizes. Who is like him; The baby, Blanche. Both are gregarious, like to have money, like to go out and have a good time. One already guesses what they have in common; they want to "get" things. Maybe both are convinced of their lack of strength.

According to our outline we let patient describe his siblings and himself. He has something good to say about everyone. How does he describe them?

Louise is vivacious, energetic, very capable. She raised the younger children and took on responsibility at an early age. She is down to earth and everyone likes her.

We can expect Robert, the second child, to be just the opposite. He did not apply himself to school. Father was down on him because

he did not live up to his expectations. Robert is very generous, has a lot of humor. He will "give you his shirt," provided he likes you. We can see here a boy who is defeated and discouraged, but makes the best of it.

Now comes Harry, the patient. By his own description one can see immediately how he fits himself into the family pattern. Is he successful like Louise or a "failure" like Robert? Here is the answer. He, too, is generous and gregarious; he, too, "disappointed" father because he did not live up to his expectations. He has never considered himself much of a man. But in contrast to Robert he does not have such a good humor, has rather a temper. In other words, he does not take his defeat as philosophically as Robert, but rebels—and makes demands. He was sick as a child and nearly died, which probably induced some spoiling and overprotection.

Now comes James, his main competitor. We can already imagine what type of a person he is; down to earth, very conscientious, hard worker, does not show his feelings outwardly, in other words, does not indulge himself, but keeps on doing things.

Blanche, the baby, is the only other girl in the family, and as such like her older sister Louise. However, she is not as capable nor as intelligent as the older sister. It was stated that she likes to have a good time, to get things, in the same way as does Harry, the patient.

Here we have a pretty good picture of the lines of competition and alliance, of success and failure. As we analyze the various qualities and attributes of each sibling, the lines become more pronounced. In regard to intelligence, James is highest, the patient lowest. The same holds true for grades in school. In temper, Harry is highest and James lowest. James is father's favorite, and Harry mother's. James *is* most like father, and Harry most like mother, in actions and thinking. Harry considers himself lowest in many other regards where James is not necessarily the highest. He has the least number of friends, considers himself least handsome, but he and Robert try most to please others. Robert does not stick out anywhere. He is generally in the middle of the ratings, except that he was the one most punished. (Which contradicts patient's statements of Robert's philosophical accepting his defeat; he did not rebel openly with a temper, but more passively by being stubborn and "ornery.")

The parents are naturally responsible for the efforts of each child to find his place in the family in his own way. They encourage and discourage each child in his efforts and set the pattern for the whole

family. In this family father established a very well defined masculine pattern. He was down to earth, always tried to do the right thing, was very ambitious, very well liked. He wanted the boys to go to college, but only James did.

Mother, on the other hand, took the patient's part. She got along best with him and Blanche, the baby. Patient in turn felt warmer and closer to mother who was very generous to him, her favorite, and tended to spoil him. She, too, was hard working; her family came before herself. In a certain sense she was the boss in the family because father was very much in love with her. Actually, her authority existed only through the strength of father who gave her the outward status of the master of the family. They got along very well under this arrangement.

We see here a very definite alliance of the "masculine" people, consisting of father, James, and —peculiarly—Louise. (By the way, this possibility of girls following the masculine pattern of father and boys the feminine pattern of mother is only found in a democracy where women have gained similar status to men. In this regard the situation in the United States is quite different from that in many other countries, where a girl is supposed to play the woman's role—and generally does so.) On the other hand, the feminine pattern was established by the close relationship of mother, Blanche—and patient. Between the two triangles Robert was completely left out and had to shift for himself. This is the picture of the family constellation.

Early Recollections

Harry remembers an incident from age six. Dad came home with a new car. He and James got dressed; he put on black sox. All were anxious to see the car.

Here we can see what is important to Harry. He is a flashy dresser and feels that clothes makes a man. Or a car. Those are the only things that count, things which one can "get."

At the age of five he remembers falling down brick stairs and breaking his nose. This is actually not a recollection but a report. Still it shows what happens to him when he has to rely on his own resources.

This comes out more clearly in another recollection. He was very young, doesn't remember the exact age, when he visited an aunt's

house in a poor neighborhood. Someone sent him for cigarettes. It was a very dark street; he was scared. On the way back some man followed him. He ran home and could not run fast enough. That is how he looks at life and at himself in it. A little frightened boy, in a world full of danger.

At the same age a boy told him that he had found a dime in the grass. Harry asked where, and the boy showed him. He got down on his hands and knees, and he, too, found a dime. He told it to the boy who did not believe him and called him a liar. Here we can see how even "getting" something will not give him status in this world. Nobody believes that he is worth while and can do things. At least, that is what *he* thinks.

At the age of six Robert, his older brother, was making a ring out of beads. Harry begged for a ring, too, but Robert did not have enough beads. However, he wis willing to make Harry one if he would get the beads. So Harry went out to ask another boy for beads. He ran across the street and was almost hit by a car. The boy "bawled the hell out of him," and did not give him the beads. We have to keep in mind that this incident as such had no significance for Harry's development. The importance of this incident does not lie in the fact that it happened, but that Harry, now an adult, still remembers it. This is what he thinks of himself in life: trying so hard to get something, endangering himself while doing so—and not getting anything in the end.

Summary

Patient is the third of five, the middle of three boys, and actually the first of two. He is overrun by his younger brother who overran both older brothers. His older brother was completely left out between the two alliances of father, James and Louise, and mother, himself and Blanche. This brother, in addition, was pushed down by a wonderful and capable older sister and an ambitious father to whose expectations he could not live up. Patient, too, felt unable to live up to father's expectations which were only met by his younger brother; but he, the patient, overran his older brother through his charm and ability to get things, encouraged by his being the favorite of his mother. Despite this favorable position he, like his older brother, considered himself as a failure because masculinity as represented by father and younger brother seemed to be of utmost importance. He could not find his place in a masculine world, only with women. Stimulated by mother's

protectiveness, he was more interested in getting (approval, money, sympathy) than in doing.

The early recollections show the conclusions he drew from the situation as he perceived it. Life is dangerous, and I get hurt, and there is no recognition for me, particularly in a masculine world. (All recollections are about men, who threatened, rejected or thwarted him.) Only by getting and by chance can I get somewhere, and even that will not be recognized by others, especially by men.

These conclusions permit the formulation of the *Basic Mistakes* which patient made in his childhood and maintained throughout life. We can point out the mistakes in his assumptions, somewhat as follows:

1. Neither life, nor the world of men is as dangerous as he thinks;
2. He has a place in the masculine world, but does not know it;
3. He does not recognize his own strength; therefore,
4. He does not need to "get" or to rely on chance; he can depend on himself and his own strength;
5. He neither trusts life around him nor within him.

Now we can see that our first impression was accurate. At that time we did not know why he was pessimistic, why he did not trust life, messed things up, and felt sorry for himself, why he could not fully cooperate on any level of life, and why he was so impressed with death. It was his doubt in his own masculinity, in his own strength, in his determination to "get" without doing. After six interviews his ability to "understand" himself led to some reorientation. His symptoms disappeared completely, not only his fears and nervousness, but also his headaches. He became more courageous, stopped being afraid of walking at night, catches himself when something looks dangerous to him, and realizes it is not. He began to see how he always magnified or provoked dangers. He found that he even used better judgment in business. He realized his unwillingness to "give" at home, being more interested in going to a ball game than playing with the children, and is considering a change in this attitude also. He is by no means "well" or "adjusted" yet, but very much on the way.

Conclusions

The socio-teleological approach as developed by Alfred Adler permits an immediate examination of a patient's movement in life, both on the present scene and throughout his lifetime, beginning in his

formative years. All actions and reactions can be understood by the direction of the movements. The total personality has mind and body at its disposal to be used in accordance with the intentions and the resultant movements. Only in the light of these movements can the significance of symptoms be determined.

A technique as we described here, if acquired, would enable every physician to "understand" his patient, and perceive his goals. Such understanding should be part of every examination, but is particularly necessary for the "minor psychotherapy" which every physician should be able to carry out.

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