

The Psychiatric Interview†

Harry Stack Sullivan

SINCE THE FIELD OF PSYCHIATRY has been defined as the study of interpersonal relations, and since it has been alleged that this is a perfectly valid area for the application of scientific method, we have come to the conclusion that the data of psychiatry arise only in participant observation. In other words, the psychiatrist cannot stand off to one side and apply his sense organs, however refined by apparatus, to noticing what someone else does, without becoming personally implicated in the operation. His principal instrument of observation is his self—his personality, *him* as a person. The processes and the changes in processes that make up data which can be subjected to scientific study occur not in the subject person nor in the observer, but in the situation which is created between the observer and his subject.

We say that the data of psychiatry arise in participant observation of social interaction, if we are inclined toward the social-psychological approach, or of interpersonal relations, if we are inclined toward the psychiatric approach, the two being, so far as I know, terms for precisely the same thing. There are no purely objective data in psychiatry, and there are no valid subjective data because the matter becomes scientifically usable only in the shape of a complex resultant—*inference*. The vicissitudes of *inference* is one of the major problems in the study of psychiatry and in the development of practical psychiatric interviews.

You will understand that I am not going to discuss anything like the theory of psychiatry or attempt to investigate the reasons why a good many of the things that I say seem to me to be of practical importance. In considering the subject of a serious conference with another person, I shall discuss only that which seems capable of being formulated about the steps most likely to lead to the desired end. These comments will apply whether that person is a patient in the sense of someone seeking help for what he calls his personal idiosyncracies, or peculiarities, or other people's strange

treatment of him; or a person looking for a job; or a representative of a corporation hoping to discover why some employee fails to make good. Interviews calculated to meet certain criteria, which I will shortly outline, are, so far as I know, indistinguishable in the techniques which could be used from those used by the psychiatrist in attempting to discover how he can serve the professional needs of his patient. I shall often fail here to distinguish between the terms *interrogee*, or *interviewee*, or *patient*, or *client*, but shall speak of the patient, and in some instances of the client, implying no restriction of the relevance of what I say to a medical, or a social-work, or a personnel-management field. All of these terms are, so far as I am concerned, synonymous, and I think you will see an excellent reason for that being the case before we have gone much further.

THE DEFINITION

As a point of reference for comments often somewhat rambling, it may be useful to attempt a definition of what I have in mind when I speak of the psychiatric interview. As I see it, such an interview is a situation of primarily *vocal* commu-

† *Editor's note:* This article has been prepared from recordings of Dr. Sullivan's lectures, which were turned over to the William Alanson White Psychiatric Foundation by Mr. James I. Sullivan at the time of Dr. Sullivan's death. This article represents the first lecture in a course given at the Washington School of Psychiatry. It has been edited by Dr. Otto A. Will, Jr.

nication in a *two-group*, more or less *voluntary integrated*, on a progressively unfolding *expert-client* basis for the purpose of elucidating *characteristic patterns of living* of the subject person, the patient or client, which patterns he experiences as particularly troublesome or especially valuable, and in the revealing of which he expects to derive *benefit*. Of course, any person has many contacts with other people which are calculated to obtain information—if only the directions for how to get where he wants to go; but these are not properly regarded as instances of the psychiatric, or serious, highly technical inquiry.

The Vocal Nature of the Communication

The beginning of my definition of the psychiatric interview states that such an interview is a situation of primarily vocal communication—not verbal communication alone. If it were a matter of assuming that everyone who came to a psychiatrist or another interviewer had to be pinned down, as one too often hears in psychiatry, or cross-examined to determine what was fact and what was fiction, and so on, psychiatric interviews which would make any sense of the other fellow would go on for hours and hours. With the consideration of the nonverbal but nonetheless primarily vocal aspects of verbal exchange, it is actually feasible to make some sort of a crude formulation of many people in from an hour and a half to, let us say, six hours of serious discourse. (I might add, not six consecutive hours, though I've even done that.) The point is that much attention may profitably be paid to the telltale aspects of intonation, rate of speech, difficulty in enunciation, and so on and so forth—factors which are conspicuous to any student of vocal communication. It is by alertness to the importance of these many things as signs or indicators of meaning, rather than by preoccupation only with the words spoken, that the psychiatric interview becomes practical in a reasonable section of one's lifetime.

The experience that gives me a peculiar, if not an important, slant on this

whole matter is that I was initially intensely interested in schizophrenic patients. At the moment the characteristic of schizophrenics relevant to our work is that they are very shy people, low in self-esteem, and subject to the suspicion that they are not particularly appreciated or respected by strangers. Like many another person of that kind, they are rather sensitive to scrutiny, to inspection, and perhaps in all too many cases are full of ancient traditional hokum from the culture about the eyes being the windows of the soul and things being seen in them that might not otherwise be revealed—which seems to be one of the most misguided ideas I've ever known. In brief, schizophrenics are embarrassed by being stared at.

As I wished to know as much as I could about schizophrenics (and with fortune, perhaps of other human events), I very early in my psychiatric research work abandoned the idea of watching people while they talked with me. Literally for years, seven and a half at least, I sat at an angle of ninety degrees from the people whom I interviewed, and usually gazed at something quite definitely in front of me—very clearly not at them. As the field of vision is so great that one can observe motor movement in a person over an extraordinarily wide range, I think I missed few of the starts, sudden changes of posture, and one thing and another, but certainly I could not see the fine movements of the face.¹

In order to become somewhat at ease about what was going on, I really did need to develop further an already considerable auditory acuity in order to hear the kind of things which, perhaps, most of you are inclined to deceive yourselves into thinking that you can only see. I do believe that the majority of clues to what

¹ A visual study to determine what there is about other people's faces that gives away falsehoods and so on immediately demonstrates the gross absurdity of thinking that their eyes provide us with any clues. Even in the lower part of the face, which is distinctly more expressive and closely related to the mental state of the person concerned, the tensions are not by any means so labile that they keep up with the changing mixture of truth, best appearances, untruth, and frank falsehood that make up a great deal of communication.

people actually mean reach us via the ears. Tonal variations in the voice—and by “tonal variations” I mean, very broadly and generically, changes in all the complex group of things that make up speech—are frequently wonderfully dependable clues to shifts in the communicative situation. For example, if somebody is attempting to tell you what the business of a journeyman electrician is, things may go on quite well until he is on the verge of saying something about the job which pertains to a field in which he has been guilty of gross disloyalty to his union, at which time his voice will sound altered. He may still give you the facts about what his journeyman electrician should be and do, but he will sound different in the telling.

In the psychiatric interview a great part of the experience which one slowly gains manifests itself in a show of mild interest in the point at which there is a tonal difference. Thus one would perhaps say, “Oh, yes, and the payment of exactly two-and-a-half percent of one’s income to this fund for the sick and wounded is almost never neglected by good union members, I gather”; to which the other might reply, again sounding quite different from the way he had earlier, “Exactly! It’s a very important part of membership.” And then, if you feel sure of the situation, you might say, “And one, of course, which you have never violated.” Whereupon the other person sounds very different indeed, perhaps quite indignant, and says, “Of course not!” If you are extremely sure of the way things go, you might even say, “Well, of course you understand I have no suspicion about you, but your voice sounded odd when you mentioned it, and I couldn’t help but wonder if it was preying on your mind.” At this he may sound still more different, and say, “Well, as a matter of fact, early in my journeymanhood I actually did pocket a little of the percentage, and it has been on my conscience ever since.” And the business moves along.

As I say, the psychiatric interview is primarily a matter of vocal communication. It would be a quite serious error to

presume that the communication is primarily verbal. The sound-accompaniments emphasize what is to be made of the verbal propositions stated. However, a great many of these propositions may be taken as matters of routine data, subject to the ordinary probabilities and to such further inquiries as will make clear what the person means.

I do not believe that I have had an interview with anybody, certainly in twenty-five years, in which the person to whom I was talking was not annoyed during the early part of the interview by my asking stupid questions. I am certain that I usually correctly read the patient’s mind. A patient tells me the obvious and I wonder what he means. But after the first half-hour or so, he begins to see that there is a reasonable uncertainty as to what he meant, and that obvious statements are often remarkably uncommunicative. They may be far worse than uncommunicative, as they permit the inexperienced interviewer to assume that he knows something. Only belatedly does he discover that this is not the case; that he has been galloping off on a little path of private fantasy which clearly could not be what the patient was talking about, because now the patient is talking about something so obviously irrelevant to it. Thus part of the skill in interview comes from a sort of quiet observation all along: “Does this sentence, this statement, have an unquestionable meaning? Could it be that there is *no* certainty as to what this person means?”

For example, during an interview one may learn that a person is married, and if one is feeling in some very quiet and, I trust, very mildly satirical mood, one can say, “And doubtless happily?” If the answer is “yes,” that “yes” can have anything in the way of implication from a dirge to a paean of supreme joy. It may indicate that the “yes” means “no,” and everything in between. The logical question, I suppose, after learning how happily the person is married, might be, “Was it your first love?” The answer may be “yes,” at which one says, “Is that so? That’s most unusual.” Now, nobody cares

whether it's most unusual or not. In fact, it is *fairly* unusual, but it isn't *most* unusual. The "most unusual" at least makes it an issue, with the result that the informant feels, "Well, by God, if it was my first love, it requires a little explanation; or it may even be something to be proud of." And at this point you may begin to hear a little about his history of interpersonal intimacy with the other sex. Frequently, for example, in cases of marriage to the first love, there is a very open question of love having ever entered the patient's life, and one discovers that the marriage was nothing very delightful.

The Two-Group

To return to my definition of the interview, the next point is that this communication is in a two-group, and in that suggestion there certainly is a faint measure of irony. While it is practically impossible to explore most of the significant areas of personality with a third person present, it is also true that whereas only two people are actually in the room, the number of more-or-less imaginary people that get themselves involved in this two-group is sometimes really hair-raising. Yes, it's a two group, but two or three times in the course of an hour, to be conservative, whole new sets of these imaginary others are also present in the field. Of that, more later.

Voluntary Integration of the Participants

The next point I make concerns the patient's more or less voluntary entrance into this therapeutic situation on an expert-client basis. Psychiatrists are accustomed to dealing with people of all degrees of willingness, all the way from those who are extremely unwilling to see them, but are required to do so by process of law and so on, to those who are seriously interested in getting the benefits of modern psychiatry. To anyone who is distressed by that, I should say that these startling extremes probably accentuate the fact that most people go into any interview with quite mixed motivations; they wish that they could talk things over

frankly with somebody, but they also carry with them, practically from childhood, ingrained determinations which block free discussion; as a result these people generally hope that the psychiatrist will be either a great genius or a perfect ass.

Now, the other side of the picture: There are some more-or-less voluntary elements in the psychiatrist's attitude. He may vary from enthusiasm for what he is about to discover, to a bored indifference about the patient—and these attitudes unhappily may be determined very early in the interview, before there is adequate basis for the formation of any particularly strong opinion. The attitudes of the patient, of the interviewee, are data. Any striking emotion on the part of the psychiatrist, of the interviewer, is an unhappy artifact which amounts to a psychiatric problem. Any intense curiosity about the details of another person's life, particularly his sexual life or drinking habits, or something like that, is a very unfortunate ingredient in a psychiatric interview. And an actual, more-or-less disdainful, indifference to what the patient may have to offer amounts to quite serious evidence of morbidity on the part of an interviewer.

As I shall presently suggest, there is no fun in psychiatry. If you try to get fun out of it, you pay a considerable price for your unjustifiable optimism. If you don't feel equal to the headaches that it induces, you are in the wrong business. It is work—work the like of which I do not know. True, it ordinarily doesn't require vast physical exertion, but it does require a degree of alertness to a sometimes very rapidly shifting field of signs which are remarkably complex in themselves and in their relations. And the necessity for promptness of response to what happens proves in the course of a long day to be very tiring indeed. It is curious, but there are data that suggest that the more complicated the field to which one must attend, the more rapidly fatigue sets in. With a good many of the more serious problems of today—which are often demonstrated in very competent people

whose abilities one must if possible utilize—the nuances of what is reserved, and what is distorted, and what is unknown by the communicant, but very relevant to the work at hand, are not easy. So an enthusiasm about psychiatry is preposterous—it shows one just hasn't grown up; and an indifference is fatal.

The more dependable attitude of the psychiatrist in a psychiatric interview is probably the very serious realization that he is earning his living, and that he must work for it. One doesn't care so much whether the patient thinks that he is very eager to see the psychiatrist or the interviewer, or is bitterly opposed to it all. This does make some slight difference at the start, because one tries to accommodate, insofar as one readily can, to mood shifts, and so on, in the patient. In other words, I don't need to tell any of you that if a person comes to you quite angrily, it is not exactly cricket to beam on him and say, "Why, my dear fellow, you seem upset. Do tell me what's troubling you!" That is too reminiscent of the worst of past experience with maiden aunts, and so on. When people approach you angrily, you take them very seriously, and if you're like me, with the faint suggestion that you can be angry too, and that you would like to know what the shooting is about. And so it goes.

As I say, the attitude—be it willingness or unwillingness, hesitancy or reservation—of the client, patient, interviewee, or subject-person determines somewhat the attitude, and perhaps the pattern, of one's initial inquiries, but is not in itself to be taken very seriously. Many very resistant people prove to be remarkably communicative as soon as they discover that the interrogator makes some sense and that he is not simply distributing praise, blame, and so on.

The Expert-Client Relationship

The expert-client relationship, which I have mentioned, implies a good deal. As defined in this culture, the expert is one who derives his income and status, one or both, from the use of unusually exact or adequate information about his

particular field, in the service of others. This "use in the service of" is fixed in our industrial-commercial social order. The expert does not trade in the implements or impedimenta of his field; he is not a 'merchant,' a 'collector,' a 'connoisseur,' or a 'fancier,' for these use their skill primarily in their own interest.

The psychiatric expert is expected to have an unusual grasp on the field of interpersonal relations, and, since this problem-area is peculiarly the field of participant observation, the psychiatrist is expected to manifest extraordinary skill in the relationship with his subject-person or patient. Insofar as all those who come to him must be by definition relatively insecure, the psychiatrist is peculiarly estopped from seeking personal satisfactions or prestige at their expense. He seeks only the data needed to benefit the patient, and expects to be paid for this service.

There are exceptions, but by and large, if you traffic in the commodities about which you are supposed to be an expert, you are most often called, whether to your face or not, a fancier, or a connoisseur, or a sharper, or something of that kind. This is because people are at a peculiar disadvantage in dealing with the expert who has an extraordinary grasp on a field; and if he traffics in the commodities concerned, as well as in the skill, people are afraid and suspicious of him.

The cultural definition of the expert seems to indicate that he is a purveyor of exact information and skill, and has no connection with the commercial-industrial world other than to be paid for services of that kind. This is poignantly the case with the psychiatrist, who works in a field the complexity of which is so intimidating that a very few of them maintain for long the conceit that they are great experts at psychiatry. Be that as it may, the cultural definition of psychiatrists as *experts* having *expert* knowledge of interpersonal relations, personality problems, and so on, and having no traffic in the satisfactions which may come from interpersonal relations, and no pursuit of prestige or standing in the eyes of their

clients, or at the expense of their clients or their patients, is very, very striking. In accordance with this definition the psychiatrist is quite obviously uninterested in what the patient might have to offer, temporarily or permanently, as a companion, and quite resistant to any support by the patient for his prestige, importance, and so on.

It is only to the extent that the psychiatrist is very clearly aware of this taboo, as it were, on trafficking in the ordinary commodities of interpersonal relations, that many suspicious people discover that they can deal with him and actually communicate to him their problems with other people. Only when the psychiatrist is keenly aware of this particular aspect of the expert's role—that he deals primarily in information, in correct, unusually adequate information, and that he is estopped, by the attitude inculcated in everyone by the culture, from using his expert knowledge to get himself personal satisfaction, or to obviously enhance his prestige or reputation at the expense of the patient—only then can the expert-client relationship in this field be rapidly consolidated, and demonstrated with reasonable ease.

The Patient's Characteristic Patterns of Living

To return again to my definition of the psychiatric interview, I said that it is for the purpose of elucidating characteristic patterns of living. Personality very strikingly demonstrates in every instance, in every situation, the perduring effects of the past, and the effects of a particular past event are not only perhaps fortunate or unfortunate, but also extensively intertwined with the effects of a great many other past events. Thus there is no such thing as learning what *ails* a person's living, in the sense that you will come to know anything definite, without getting a pretty good idea of who it is that's doing the living, and with whom. In other words, in every case, whether you know it or not, to the extent that you correctly understand your patient's problems, you have already understood him in the major

characteristics of his dealing with people. Now, this relativity of difficulty in living to all the rest of the important characteristics of a personality is a thing which I must stress, because we are such capable creatures, we humans, that we do not always know anywhere near what we have experienced. Psychiatrists know a great deal about their patients that they don't know they know. For example, caught off guard by the offhand question of a friendly colleague—"Yes, but damn his difficulties in living! What sort of *person* is this patient of yours?"—the psychiatrist may rattle off a description that would do him honor if he only knew it.

And do you think that this is restricted to psychiatrists? What you know about the people whom you know at all well is truly amazing, only it may never have been very important for you to formulate it. It isn't worth anything to you, you might say. All that it's worth, of course, is that it makes for better understanding; but, as your interest lies in what the person does and not in understanding, you don't know how much you know.

In the psychiatric interview, quite an ideal situation, it is a very good idea to know as much as possible about the patient, and it is very much easier to do therapy if the patient has caught on to the fact that you are making a good deal of sense not only about what he thinks ails him, but also about the sort of person that his more admiring friends regard him to be, and so on. So I say, the purpose of the interview is to elucidate the characteristic patterns of living, some of which make trouble for the patient.

At this point I have to contribute the notion that many people who consult psychiatrists regard themselves as the victims of disease, or hereditary defect, or God knows what in the way of some sort of evil, fateful entity that is tied to them or built into them. They don't think of their troubles, as they call them, as important, not especially distinguished, parts of their general performance of living in a civilized world with other people. Many problems are so thoroughly removed from any connection with other

people—when they are told to you—that the young psychiatrist would, I think, feel rather intimidated at suggesting to the patient that perhaps these things didn't happen with everybody, but only with some particular people; and I think that even the very experienced psychiatrist would scarcely wish to expose the patient to such unnecessary stress. But one can always ask *when* the trouble occurs—in what setting it is most likely to be seen. Remarkably often one of these patients who has an “organic,” “hereditary,” or what-not neurosis that has nothing to do with other people, can produce instances pertaining to five or six people—and for the life of him can't think of any others. It is only when he has come to this point that you say, “In other words, you don't have this difficulty so far as you know with your wife and her maiden sister, and so on and so forth?” The patient stops, and thinks, and quite honestly says, “No, I don't believe I ever do.” It is at that moment, you see, that he is on the verge of realizing that perhaps the other fellow *does* have something to do with the difficulty; and it is only after being led around to making that discovery from his own data that such a person is somewhere near realizing that it is the interpersonal context that calls out many troubles.

I am not attempting to say here that there is nothing that makes living difficult except other people and one's inadequate preparation for dealing with them. There are a vast number of things, such as blindness in one or both eyes, and harelip, and poor education, and so forth, which make difficulties in living. But the psychiatric interview is primarily designed to discover *obscure* difficulties in living, things which the patient does not clearly understand. In other words, the principal business of an interview is to discover what the patient does not understand: that which for cultural reasons—reasons of his particular education for life—he is foggy about, chronically misleads himself about, or misleads others about. The difficulties stand out the more clearly and the more meaningfully as one grasps

what sort of a person one has before him, and what that person does, and why.

To sum up, a patient's patterns of difficulty arise in his past experience and variously interpenetrate all aspects of his current interpersonal relationships. Without data reflecting many important aspects of the patient-client personality, the statement of symptoms and the observation of signs of difficulty are unintelligible.

The Patient's Expectation of Benefit

This brings me to the final portion of my definition—that the patient has at least some expectation of improvement or other personal gain from the interview. This statement may not impress you particularly; yet I would say that long interviews that have been very unpleasant to the victim have come to some ends useful to him and satisfactory to me only because the patient caught on to the fact that there was something in it for him. The *quid pro quo* which keeps people going in this necessarily disturbing business of trying to be foursquare and straightforward about one's most lamentable failures and one's most chagrining mistakes is that one is learning something that promises to be useful. Insofar as the patient's participation in the interview situation inspires in the patient a conviction that the psychiatrist is learning not only *how* the patient has trouble, but *who* the patient is and *with whom* he has trouble, the implied expectation of benefit is in process of realization.

I wish to put a good deal of emphasis on this, because there are interview situations in which there is no attention paid whatever to what the interrogatee—the victim, one might say—gets out of it. Instead, it is a wholly one-sided interrogation. Questions are asked and the answers are received by a person who pays no attention at all to the anxiety or the feeling of insecurity of the informant, and who gives no clue to the meaning of the information elicited. These one-sided interrogations are all right for certain very limited purposes. When I say they are all right, I might say that the more crudely one circumscribes what one

wants of a large number of people, the more inevitably one accepts a large percentage of error. If you want to know something about the people in the world that would be useful to somebody else in dealing with them, then you never use this one-sided interrogation. But if you want, for example, to accumulate in fifteen minutes some clues to whether or not this person will probably survive two years in the Army under any circumstances that are apt to transpire in two years in the Army, then you can use this type of interrogation. But the percentage of error in your judgment will be high—how high nobody has yet very adequately determined—and the reason for that is that even the people who use one-sided interrogation also interpret a good deal that goes on besides the answering itself.

You can, in a rather brief interview, reach certain limited objectives. For example, you can decide whether a person should be given a job as a telephone operator by discovering that he has no capacity for righting himself after a misunderstanding, that he is unnerved by somebody being unpleasant to him, and so on. But for anything like the purposes of psychiatric interview, in which one is actually attempting to assess a person's assets and liabilities in terms of his living—naturally, his future living, not his past—then some time is required, and a simple question-answer technique will not work.

As a therapist you must be sure that the patient is getting something out of you, that his expectation of improving himself (as he may put it), of getting a better job, or whatever may be adequate motivation for undergoing the interview, gets encouragement. As long as the therapist supports this personal objective of the patient, then the communicative situation improves, and one comes finally to have data on which one can make a formulation of some value to himself as an expert, or to the other person concerned.

THE CONCEPTS OF PARTICIPANT OBSERVATION AND PARATAxic DISTORTION

I should like to stress that implicit in this last statement is the whole approach

to psychiatry as peculiarly the field of participant observation, which leads us back to the beginning of this discussion. The fact is that we cannot make any sense of the motor movements of another person except on the basis of meaningful behavior—that is, on the basis of what we have experienced, done ourselves, or seen done under circumstances in which its purpose, its motivation, or at least the intentions behind it were communicated to us. The meaning of the staggering panoply of human acts and so on is not to be deduced by sheer intellectual operations without any past background. As a matter of fact, almost all the things pertaining to communication form highly conventionalized patterns and are so fixed within the culture that if I mispronounce, as we put it, a word, some of you will wonder what in the world I am talking about. Things having to do with your past experience and with prescriptions of the culture and so on that were common in your home and in the other fellow's home; activities which are attached to you as the person concerned in their doing, and activities to which you respond as if you were the person primarily, directly, and simply concerned in them—all these are the data of psychiatry. And therefore, the psychiatrist has an inescapable, inextricable involvement in all that goes on in the interview; and to the extent that he is unconscious or unwitting of his participation in the interview, to that extent he does not know what is happening.

This is another argument in favor of the position that the psychiatrist has a hard job to do, and that it will be enough to do it without any pursuit of his pleasure or his prestige in so doing. He can legitimately expect only the satisfaction of feeling that he did what he was paid for—and that will be all, and probably more than he can do well. Never lose track of the fact that all the processes of the patient are more or less exactly addressed at you, and that all that you offer—your experience—is more or less accurately aimed at the patient, with a resulting wonderful interplay. For example, one realizes that statements are not things

that are rigidly fixed as to meaning by Webster's or the Oxford Dictionary, but that they are only approximations, sometimes remote approximations, of what is meant. But that is just the beginning of the complexities of the participant character of the psychiatric interview—for that matter, of all attempts at communication between people, of which the psychiatric interview is an especially characterized example.

That does not mean, as some of our experts in semantics might lead us to suppose, that before you start talking with your patient you are to give him a list of words that are not to be used. It simply means, as I said earlier, that you listen to all statements with a certain critical interest, asking, "Could that mean anything except what first occurs to me?" You question (at least to yourself) much of what you hear, not on the assumption that the patient is a liar, or doesn't know how to express himself, or anything like that, but always with the simple query in mind, "Now, could this mean something that would not immediately occur to me? Do I know what he means by that?" Every now and then this leads to one asking questions aloud, but it certainly does not imply the vocal questioning of every statement. So if the patient says, "The milkman dropped a can of milk last night and it woke me up," I am usually willing to presume that it is simply so.

On the other hand, a patient may say, "Well—and—he's my dearest friend! He hasn't a hostile impulse toward me!" I then assume that this is to explain in some curious fashion that this other person has done him an extreme disservice, such as running away with his wife—or some great service. I have yet to discover which, you see, and I say, "Is that so? It sounds amazing." Now when I say a thing sounds amazing, the patient feels badly on the spot; he feels that he must prove something, and he tells me more about how wonderful his friend's motivation is. Having heard still more, I am able to say, "Well, is it possible that you can think of nothing he ever did that was

at least unfortunate in its effect?" At this the poor fellow will at least remember the elopement of his wife. And thus we gradually come to discover why it is necessary for him to consider this other person to be such a perfect friend—quite often a very illuminating field to explore. God knows, it may be the nearest approach to a good friend this man has ever had, and he feels exceedingly the need of a friend. And so the work goes on.

The more conventional the statements are, of course, the more doubtful it is that you have any idea of what the person really means. For example, there are the people—I have dealt with too many of them—who have been trained to cultivate virtues with such horrible motivation behind the culture that they are truly almost incapable of thinking evil of anybody.

The psychiatrist, the interviewer, plays a very active role in introducing interrogations, not to show that he is smart, or that he is skeptical, but literally to make sure that he knows what he is being told. Few things do the patient more good in the way of getting toward his more or less clearly formulated desire to benefit from the investigation than this very care on the part of the interviewer to discover exactly what is meant. Almost every time one asks, "Well, do you mean so and so?" the patient is a little clearer on what he does mean. And what a relief it is to him to discover that his true meaning is anything but what he at first says, and that he is at long last uncovering some conventional self-deception that he has been pulling on himself for years.

Let me illustrate this last by telling you of a young man who had been clearly sinking into a schizophrenic illness for several months and who was referred to me by a colleague in a neighboring state. Among the amazing things I extracted from this poor citizen was that, to his amazement and chagrin, he spent a good deal of his time in the kitchen with his mother making dirty cracks at her, saying either obscure, or actually bitter and critical things to her. He thought he must be crazy, because he was the only

child and his mother, so he said, was perfect. As a matter of fact, he had two perfect parents! They had done everything short of carrying him around on a pillow, and now he had broken down just because he was engaged in a couple of full-time courses at one of our best universities. In other words, he was a bright boy, and had very healthy ambitions which represented the realization of the very fine training that he had been given by these excellent parents. I undertook to discover what was so surprising to him about this business of his hostile remarks to his mother, and he made it quite clear that the surprising thing was that she had never done him any harm, and had actually enfolded him in every kind of good. To all this I thought, "Oh yeah? It doesn't sound so to me. It doesn't make sense. Maybe you have overlooked something."

By that time I was actually able to say something like this: "I have a vague feeling that some people might doubt the utility to you of the care with which your parents, and particularly your mother, saw to it that you didn't learn how to dance, or play games, or otherwise engage in the frivolous social life of people of your age." And I was delighted to see the schizophrenic young man give me a sharp look. Although he was seated where I didn't have to look directly at him, I could see that. And I said, "Or was that an unmitigated blessing?" There was a long pause, and he opined that when he was young he might have been sore about it.

I guessed that that wasn't the whole story—that he was still sore about it, and with very good reason—and then I inquired if he had felt any disadvantage in college from the lack of these social skills with which his colleagues whiled away their evenings, and so on. He recalled that he had often noticed his defects in that field, and that he regretted them. With this improvement in intelligence, we were able to glean more of what the mother had actually done, and said, and so on, to discourage his impulse to develop social techniques. At the end

of an hour and a half devoted more or less entirely to this subject, I was able to say, "Well, now, is it really so curious that you're being unpleasant to your mother?" And he thought that perhaps it wasn't.

A couple of days later the family telephoned to say that he was greatly benefited by his interview with me. As a matter of fact, he unquestionably was. But the benefit—and this is perhaps part of why I tell the story—arose from the discovery that a performance of his, which was deeply distressing to him because it seemed irrational and entirely unjust, became reasonably justified by a change in his awareness of his past and of his relationship with the victim of his behavior. Thus the feeling that he was crazy, that only a madman would be doing this, and so on, was erased—and, believe me, it is no help to anybody's peace of mind to feel that he is mad. His peace of mind was enhanced to the extent that it was no longer necessary for him to feel chagrin, contempt for himself, all sorts of dim religious impiety; but on the other hand he could feel, as I attempted to suggest in our initial interview, that there wasn't anything different in his behavior from practically anybody else's except the accents in the patterns of its manifestation. As he was able to comprehend that the repulsive and queer, strange, mystifying, chagrining, horrifying aspects of his experience reflected defects in his memory and understanding concerning their origins, the necessity to manifest the behavior appeared to diminish, which actually meant that competing processes were free to appear, and that the partitioning of his life was to some degree broken down. The outwardly meaningless, psychotic attacks on his mother did not give him the satisfaction that came from asking her more directly why in the devil she had never let him learn to play bridge. With the substitution of the possibility of a more direct approach, the psychotic material disappeared and he was better.

Whenever our attempt to discover what the patient is talking about leads him to be somewhat more clear on what he is

thinking about, attempting to communicate, to conceal, or what-not, his grasp on life is to some extent enhanced. And no one has grave difficulties in living if he has a very good grasp on what is happening to him.

Everything in that sentence depends on what I mean by "grave," and let me say that for this purpose I mean by "grave difficulties" those unquestionably requiring the intervention of an expert. It is my opinion that man is rather staggeringly endowed with adaptive capacities, and I am quite certain that when a person is clear on the situation in which he finds himself, he does one of three things: he decides it is too much for him and leaves it, he handles it satisfactorily, or he calls in adequate help to handle it. And that's all there is to it.

When people find themselves recurrently in obscure situations which they feel they should understand and actually don't, in which they feel that their prestige requires them to take adequate action (since they do not know what the situation is, of course, adequate action is a somewhat hypothetical entity), they are clearly in need of psychiatric assistance. That assistance is by way of the participant observation of the psychiatrist and the patient, in which the psychiatrist attempts to discover what is happening to the patient. A great many questions may be asked and answered in the psychiatric interview before the patient sees much of what the psychiatrist was exploring, but, in the process, the patient will have experienced many beginning clarifications of matters which will subsequently take on considerable personal significance.

As an example of such an obscure situation seeming to demand action of some sort, I refer to a patient whom I saw for a brief interview a number of years ago. She was a young lady of 43 or so who presented as her trouble in life the fact that at night her breasts were frightfully tampered with, and so on, by her sister who lived in Oklahoma. Now, such a statement is a reasonable sign of something being a little the matter with the mind. It

also developed that the pastor of one of the more important New York churches was the only help that she had ever been able to obtain in this cursed nuisance perpetrated by her sister. As I always appreciate any help that anybody can get, particularly from somebody besides me, I was pleased to learn this and wondered why she had sought me out.

At this I learned that there were other difficulties. She was coming to suspect that a woman who worked in her office had been employed by her sister to spy on her (this nice psychotic lady, like many others, was earning a living) and I said, "Aha! Now we are getting somewhere! Tell me all about that." Whereupon she bridled, realizing that it was risky to admit psychotic content to a psychiatrist. It developed that she had been controlling increasing rage against this other woman in her office for weeks, and that she had been consulting her pastor with increasing frequency about the problem. I didn't ask what he did. But I did happen to look at the clock at that point and discovered that I had been keeping another patient waiting twenty minutes. So I said to the young lady, "Well, look here. I don't believe it would be practicable for me to attempt to substitute for the friendly adviser who is considerable comfort and support to you, but I do want to say one thing, which I have to say as a psychiatrist and a member of society. If you feel impelled to do something physical to square yourself with this persecutor in your office, then, Madam, before you do it, go to the psychopathic pavilion at Bellevue and apply for voluntary admission for two or three days. In the end that will be much better." And she said, "Oh, you're like all the other psychiatrists!" With which the interview was over. I am quite certain that she derived considerable benefit from the finish of that interview.

Now let us notice a feature of all interpersonal relations which is especially striking in the intimate type of inquiry which the psychiatric interview can be, and which is, in fact, strangely illustrated

in the case of my psychotic friend just noted. This is the parataxic, as I call it, concomitant in life. By this I mean not only are there quite tangible people involved (in this case the patient's sister living in Oklahoma and a fellow employee in her particular office), but also somewhat fantastic constructs of those people, such as the sister tinkering with the patient's breasts in her Manhattan room at night, and this employee acting as an emissary or agent of her sister. These psychotic elaborations of imaginary people and imaginary personal performances are spectacular and seem very strange. But the fact is that in a great many relationships of the most commonplace kind, with neighbors, enemies, acquaintances, and even such statistically determined people as the collector and the mailman, variants of such distortions often exist. The characteristics of a person that would be agreed to by a large number of competent observers may not appear to you to be the characteristics of the person toward whom you are making adjustive or maladjustive movements. The *real* characteristics of the other fellow at that time may be of negligible importance to the interpersonal situation, and this we call *parataxic distortion*.

Parataxic distortion as a term may sound quite unusual; actually the phenomena it describes are anything but unusual. The great complexity of the psychiatric interview is induced by the interviewee's substituting for the psychiatrist a person or persons strikingly different in most significant respects from the psychiatrist. The interviewee addresses his behavior toward this fictitious person who is temporarily in ascendancy over the reality of the psychiatrist, and he interprets the psychiatrist's remarks and behavior on the basis of this same fictitious person. There are often clues to the occurrence of these phenomena. They are the basis for the really astonishing misunderstandings and misconceptions which characterize all human relations. Certain special precautions must be taken against them in the psychiatric interview when it is well under way. Parataxic dis-

tortion is also one way that the personality displays before another some of its gravest problems. In other words, parataxic distortion may actually be an obscure attempt to communicate something that really needs to be grasped by the therapist, and perhaps finally to be grasped by the patient. Needless to say, if such distortions go unnoted, if they are not expected, if the possibility of their existence is ignored, some of the most important things about the psychiatric interview may go by default.

In passing, let me list certain "anti-psychiatric" elements in the culture which constitute blocks to the advancement of learning about one's way of behaving with others, and tend to close the door to any investigation of behavior, current or past.³ These elements are familiar of our daily living, rationalities whereby we encourage persistent lack of awareness of what we are about, and they continue to be honored by time and deserving of that peculiar respect tendered to misconception entombed as truth. Without further comment on my part, these "antipsychiatric" elements are:

- (1) it is possible to "know thyself" as a unique individual;
- (2) one is the possessor of a fixed something or other known as "human nature";
- (3) one "knows what one likes," what is "good," what is in one's interest, what is "considerate and decent";
- (4) one respects and is governed by "logic," or "exact information," or "good natural instinct," or "intuition";
- (5) one is capable of exercising choice—on some actually transcendental basis—or (among the more sophisticated) one recognizes and corrects the deficiencies of one's early experiencing by "sublimating";
- (6) one "ought not" to need help and is a fool to seek or expect it, often

³ *Editor's note:* The remaining section of this paper was not included by Sullivan as part of his lecture, but appears in his notebook on this subject.