© Journal of the Indian Academy of Applied Psychology
Jan 2016, Vol. 42, No. 1, 179-184

The self as a Part of Society: Person-Situation Interaction Contributing to Development of Belief System – a Case Study

Amanpreet Kaur
NIMHANS, Bangalore

Naveen Grover
IHBAS, Delhi

The present case study highlights the importance of person-situation interaction and the intake skills in psychotherapy. It is easy for a professional to get into the trap of joining client in blaming the 'obvious situation' for creating a mental health problem, despite being aware of the basic person-situation interaction formulation. Careful assessment is warranted to uncover person-situation interaction. Intake skills (for example, cost-benefit analysis, assessment of feasibility issues, ability to think of alternatives, etc.) play a role in developing successful psychotherapy contact and treatment planning. This paper follows a single case study approach, useful in highlighting issues in psychotherapy, through report of a therapy with a 29 year old woman seeking treatment for depression since five years following the death of her husband. Use of intake skills and interaction formulation has lead to better management and positive outcome for her in therapy..

Keywords: Psychotherapy, Intake Skills, Person-Situation Interaction

The person-situation controversy in personality research triggered by Mischel in 1969 settled itself to an interaction position proposed by Bower in 1973 (Kihlstorm, 2013). It states that behavior is best determined by the interaction of a person and situation variables (Funder, Guillaume, Kumagai, Kawamoto & Tatsuya, 2012). Despite being aware of the basic person-situation interaction formulation, it is quite easy for a professional to get into the trap of joining the client in blaming the 'situation' for triggering and maintaining mental health problems. Professionals may arrive at a unilateral 'situation' formulation based on blameworthy situations. This unilateral formulation could happen due to the processes of 'reducing valve' (Mischel, 1973) by reducing complex reality to a few simple generalities. Therefore, careful assessment is warranted in therapy to uncover person-situation interaction.

The intake session is crucial for further psychotherapeutic contact (Wolberg, 1988). Its role is to assess chief complaints and its severity, need for psychological inputs, service delivery method, referral questions and make plan for further contact. To achieve these goals, intake skills such as inferential skills, hypothesis building skills, cost-benefit analysis, assessment of feasibility issues, ability to think of alternatives, ability to take responsibility and courage are required to narrow down the problem for treatment planning.

In India, the availability of general mental health services is skewed to metro cities (Murthy, 2011) whereas availability of the manpower resources and specialized service of psychotherapy is restricted (Bhola, Kumaria, & Orlinsky, 2012). People have to travel from far-off places for utilizing mental health services. Nature of psychological services often requires a person to have frequent sessions, which could be difficult for persons coming from far-off places. Quite often, they are also not aware about the need and importance of psychological inputs to better their quality of life. It affects their willingness to come for psychological inputs. In these scenarios, either, professionals can fall in the trap of engaging in immediate need based follow ups of short-term goals or they can come out with solutions to overcome these feasibility issues for long term benefits. The role of intake skills becomes more crucial in such

circumstances. Intake requires skills to engage the client in a discussion on cost-benefit analysis and feasibility issues. It requires skills to bring out the need for psychological inputs and provide feasible alternatives for seeking help.

The case study mentioned here highlights that exploring role of the 'person' variable when the 'situation' variable overshadows the presented information can take psychotherapy into a meaningful direction. Simultaneously, it highlights the role of intake skills in preparing the client to overcome feasibility issues for therapy sessions. Preparing the client to come for therapy is important because availability of client is a necessary condition to conduct a therapy. The present paper follows a single case study approach, which has been found useful in highlighting psychotherapy issues (e.g., Grover, Kaloiya & Singh, 2008; Grover & Singh, 2005). Confidentiality issues were discussed before the start of the therapeutic contact. Informed consent was taken for therapy work and for academic/ publication purposes.

Identification Details[1] and Presenting Problems

A 29 year old Hindu widow, postgraduate, employed as a teacher from a rural domicile, lived with her aged father. She came to the psychiatric OPD of a well known hospital in Delhi with symptoms of depression of moderate degree from five years following the death of her husband. She had made three suicide attempts of low lethality and low intentionality. She had impairment in her socio-occupational functioning. She had lost interest in interacting with others and had difficulty in managing her anger and frustration at her workplace while dealing with kindergarten students. The client faced problems of fainting and the fear of fainting while travelling longer distances. Her sleep and appetite had decreased. These symptoms were continuous and deteriorating with time. Although, she continued attending to her father, her pet and work regularly. Along with medication, she was referred for psychological counseling. She came from a far off place and could not make frequent visits to the hospital. She would visit the hospital once a month and sometimes once in two months. She reported a recent increase in symptoms due to the pressure of remarriage on her.

The 'Obvious Situation'

According to her, the society was not ready to see her as a person rather it was seeing her with the lens of a 'widow' as revealed below:

"You can't live independently because you are a widow" – Soon after the death of her husband she was looked after by her family of origin for a few months as she was not in a state to take care of herself. She then shifted to her own house with her aged father. Her family members opposed this shift because they believed she cannot survive on her own since she is a widow.

"You should remarry because a widow's future is bleak" – People saw her as a bechari (poor girl). Family members and relatives worried for her future because they believed widows cannot live independently and they should remarry. Pressure on her for remarriage was increasing day-by-day. She did not want to remarry. She believed men marry widows as a result of pity and/or as an obligation to rejuvenate a widow's life.

"You are not expected to enjoy life" – Widows were not expected to enjoy their lives like others in the society and so she should stop enjoying. According to her, society believed she should stop laughing, wearing bright clothes, and look happy.

"You are a widow, so all your acts have poor intentions" – Even if she tried to help someone, her intentions and acts were misinterpreted and misunderstood just because she was a widow. In her neighbourhood and at her work place, independent widows were seen in a negative light.

"You are a widow so you are to be exploited" – She expressed that people do not love her and care for her. Also, she reported that her

1 Identification details have been modified

brother had set eyes on her property and her share of money. In addition, her in-laws were against her for asking the property of her late husband. According to her, any act of help to a man would bring about doubts regarding her moral character.

Development of Personality: The Person

Her pre-morbid personality revealed that she feared making mistakes. She would do what others expected from her. The client had a high need for affiliation since childhood. She was over cautious of the impression she made on others and what others might be thinking about her. She was sensitive towards others' reactions and comments and got hurt very easily. She was also critical towards each aspect of her personality. According to her, she could never say no to others. She suppressed her desire for higher studies and got married, as per her father's wish. She described herself as a very responsible, outgoing and sociable person. She used to get feedback from others that she was like a machine, very punctual, reached work on time every day. She tried to follow the norms 'perfectly' and adhered to various roles of a woman in the society. Based on the history, she came across as a person having a sense of increased responsibility (Hawton & Salkowskis, 2005), increased sensitivity towards criticism (Atlas, Fassett, & Peterson, 1994), increased need for approval (Horney, 1942), increased self-critical behaviour (Koster et al., 2011), and increased need to control and for perfectionism (Egan, Wade, & Shafran, 2011). Hypotheses about these personal characteristics were built and put to test and were proved during sessions for clinical formulation.

The personal history of the client indicated that these characteristics had its roots in her developmental period. She came from a small town and was the third child among her five siblings. Her mother died when she was in fifth standard. According to her, there was a qualitative change in her approach to life following the loss of her mother. She started fearing to make mistakes to avoid any fingers pointing at her about the fact that she does not have her mother that's why she does not know anything. She had to shoulder family responsibilities at a very early age. Being the eldest girl child and one younger brother having special needs, she had to provide for emotional and financial needs of the family. She took up multiple roles seriously and believed people will judge her for each and every thing she did and thus, she had to prove herself by doing things perfectly. She would put in extra efforts to keep things under control and not provide any opportunity to others for any criticism.

Therapy Session details

The intake session history revealed that she was having depressive symptoms and was unable to have a meaningful interaction with the clinical psychologist (CP) in the last five years. She would meet the available CP on the day of her visit for immediate need based solutions. She had become a chronic outpatient of the hospital since five years. When enquired about her long gaps in sessions, she expressed her inability to visit the hospital frequently.

In the intake session, she was explained about the need and importance of psychological inputs in her case. She was appraised of good prognostic indicators present in her case such as proven efficacy of psychotherapy in depression, the fact that formal psychological intervention was not tried, and her ability to maintain contact with hospital for a long period of time. She was also explained about the need to take sessions frequently from a single psychologist as visiting at irregular frequency lead her to seeking help from multiple psychologists, which did not help her much all this time.

Her inability to visit the hospital on a relatively regular basis was taken up for collaborative discussion to find a solution. Cost-benefit analysis concluded that probability of benefit was more than the cost to visit the hospital. Sessions also revealed that, in the past, there were minimal efforts made, if any, to engage her in regular therapy. She said she could explore the possibility of living with a distant relative for some

time. She said she could work out something at her workplace as well. The client lapped up to the suggestion given by the therapist to come down and stay in the city for 3-4 weeks whenever she is able to sort out the feasibility issues. She was assured that about 3-5 sessions per week could be held to maximize utilization of the time. She was prepared to take a leave of one month from work with prior appointments.

In therapy sessions, assessment revealed that formulation in her mind was clear: society's attitude and behaviour towards widows was leading to problems for her. Further, she reported that her belief, directly or indirectly, got reinforced by her interaction with mental health professionals in last five years. Assessment in these sessions also brought out information about the development of her personality, which was not available earlier. Hypotheses were proposed regarding her personal characteristics and their possible impact on perception of the environment. It was discussed that personal characteristics are not pathological on their own. However, when they come in contact with a situation, they may predispose the person to perceive the frequency, intensity and duration of different stimuli in an exaggerated fashion. They have the capacity to colour the perception negatively, following the principle of self-fulfilling prophecy (Carson, 1982). The person, situation and behaviour variables also get into triangular interaction following the principle of reciprocal determinism (Bandura, 1978). It was, however, noted that the role of the society was a contributing factor to her problems, which cannot be undermined.

In therapy sessions, it was discussed with her that society is not just the outside world rather it is integrated into the personality. Lewin (1951) asserted that the social situation includes the person himself or herself: the person is a part of the social stimulus field to which he or she responds. In this client's case, based on the developmental history, her core beliefs were very much in line with society's attitude and behaviours. Thus, she was also a part of the society in being critical of herself as a 'widow not following norms.' Further, she had been a person who always tried to follow norms of the society in playing "perfect roles" so that no one pointed a finger at her character. However, history reveals that she was unable to live up to these internalized views of the society about widows currently. This inability has a potential to bring significant distress to her (going by the developmental patterns established in her life).

During sessions, based on the 'obvious situation' and the development of personality information, hypothesis of person-situation interaction in her case was forwarded tentatively to see her reaction. The discussion included how believing in unilateral situation formulation did not help her over these years and how person-situation interaction position could be viable for management. She was able to understand these hypotheses and reacted positively.

However, she had to return within 10 days of arrival contrary to the plan of staying one month as she had to resume work earlier than expected. Five sessions of 60-90 minutes were complete in 10 days. Decrease in symptoms was reported when she came after two weeks. The next two sessions were taken on once a month basis. In these two sessions, process of recognizing personal characteristics and its impact was discussed with homework assignments.

Discussion

Trap of unilateral situation formulation: The negative perception of society towards widows and the difficulties they face have been highlighted by many researchers (e.g., Chakravarti & Gill, 2001; Trivedi, Sareen & Dhyani, 2009). It is a harsh reality that widows have to face in their day-to-day life despite various socio-cultural changes occurring in the society (UN Division for the Advancement of Women, 2000). The present case history highlighted that clients and professionals as well can fall in the trap of unilateral situation formulation. For the client, it was difficult to formulate her personal characteristics contributing to problems because a) there was a lack of awareness of these characteristics since

they were of long standing nature b) the same characteristics had brought her reinforcements in the past (avoidance from negative feedback and availability of positive feedback) and c) of fundamental attribution error. Professionals could have fallen in this trap due to the lack of skill to assess. Their thought and action were not in synchronization i.e., they were not aware that although they believed in a minimum basic rule of person-situation interaction but, in action they were going with unilateral formulation. Lack of intake skills also could have contributed to the trap because assessment of personality requires at least 2-4 sessions, which would not have been possible without the application of these skills.

Role of Intake skills: In the present intake session, the focus was not on information collection, rather, it was on developing a working alliance (Whiston, 2009), collaboration, goal consensus, and engagement with the patient (Tryon, 1989) to bring her in therapy for relatively regular contact. Intake skills such as recognition of suitable candidates for therapy, handling of feasibility issues, ability to take responsibility (e.g. commitment for 3-5 sessions per week), communication of the belief that therapy is effective, and cost benefit analysis for better awareness could bring the person for regular therapy. This led to the availability of crucial information, which helped in better clinical formulation.

Person-situation interaction: In the present case, the previous situation formulation leads the patient to keep blaming the situation (which is not under her control) for her condition. It has been known that unidirectional causal formulations have poor value for management (e.g., Grover & Dang, 2013) and that an effective formulation lends itself to opportunity for feasible management (Butler, 1998; Madan & Grover, 2011). Keeping this in mind, the current formulation from person-situation interaction perspective helped her to recognize those contributors to her problems, which were under her control, leading to a better outcome.

Conclusion

Clients as well as professionals can get trapped in unilateral 'situation' formulation despite awareness of basic person situation interaction. This unilateral formulation can lead to chronic use of health services by clients. It is difficult for clients to decide on their own to come frequently for psychotherapy. Intake skills are crucial in such circumstances to help the person come for therapy and achieve better outcome.

References

Atlas, G. D., Fassett, B., & Peterson, C. (1994). Sensitivity to criticism and depressive symptoms. *Journal of Social Behavior and Personality, 9,* 301–316.

Bandura, A. (1978). *The Self System in Reciprocal Determinism.* American Psychologist, 33, 344-358.

Bhola, P., Kumaria, S., & Orlinsky, D. E. (2012). Looking within: self-perceived professional strengths and limitations of psychotherapists in India. *Asia Pacific Journal of Counselling and Psychotherapy, 3,* 161-174. doi: 10.1080/21507686.2012.703957

Butler, G. (1998). Clinical formulation. In A. S. Bellack & M. Hersen (Eds.), *Comprehensive Textbook of Clinical Psychology, Vol. 6* (1st ed.). Elsiever Science Ltd: Great Britain.

Carson, R. C. (1982). Self-fulfilling prophecy, maladaptive behavior, and psychotherapy. In J. C. Anchin & D. J. Kiesler (Eds.), *Handbook of Interpersonal Therapy* (pp.64-77), Elmsford, NY: Pergamon.

Chakravarti, U., & Gill, P. (2001). *Shadow Lives: Writings on Widowhood.* New Delhi: Kali for Women.

Egan, S. J., Wade, T. D., & Shafran, R. (2011). Perfectionism as a transdiagnostic process: A clinical review. *Clinical Psychology Review, 31,* 203-212.

Funder, D. C., Guillaume, E., Kumagai, S., Kawamoto, S., & Tatsuya, S. (2012). The Person-situation Debate and the Assessment of Situations. *Japanese Journal of Personality, 21,* 1-11.

Grover, N., & Dang, P. (2013). Empty Nest Syndrome vs. Empty Nest Trigger: Psychotherapy Formulation Based on Systemic Approach - A Descriptive Case Study. *Psychological Studies, 58,* 285-288.

Grover, N., Kaloiya, G.S., & Singh, T.B. (2008). Process of psychotherapy with an adult survivor of childhood sexual abuse. *Psychological Studies, 53,* 207-212.

Grover, N., & Singh, T. B. (2005). Brief psychotherapy with adult survivor of childhood sexual abuse.

Indian Journal of Clinical Psychology, 32, 137-140.

Hawton, K., & Salkowskis, C. (2005). *Cognitive Behavior Therapy.* Tehran: Arjmand.

Horney, K. (1942). Self-analysis. Routledge, 51-56.

Kihlstrom, J. F. (2013).The Person-Situation Interaction. In D. E. Carlston (Ed) *The Oxford Handbook of Social Cognition. Oxford Library of Psychology:* OUP USA.

Koster, E. H., De Lissnyder, E., Derakshan, N., & De Raedt, R. (2011). Understanding depressive rumination from a cognitive science perspective: The impaired disengagement hypothesis. *Clinical Psychology Review, 31*, 138-145.

Lewin, K. (1951). *Field theory in social science: selected theoretical papers* (Edited by Dorwin Cartwright). Harper & Row.

Madan, N. & Grover, N. (2011). Therapy process: a reflective account from therapist's perspective. *Psychological Studies, 56,* 393–397.

Mischel, W. (1973). Toward a cognitive social learning reconceptualization of personality. *Psychological Review, 80,* 252-283.

Murthy, R. S. (2011). Mental health initiatives in India (1947–2010). *National Medical Journal of India, 24,* 98–107.

Trivedi, J.K., Sareen, H., & Dhyani, M. (2009), Psychological Aspects of Widowhood and Divorce. In: *Some Issues in Women's Studies, and Other Essays* (A.R. Singh and S.A. Singh eds.), *MSM, 7,* 37-49.

Tryon, G. S. (1989). Study of variables related to client engagement using practicum trainees and experienced clinicians. *Psychotherapy, 26,* 54-61.

UN Division for the Advancement of Women. *Women 2000. Widowhood: invisible women secluded or excluded. 2001.* [Accessed 28 March, 2014]. Retrieved from: http://www.un.org/womenwatch/daw/public/wom_Dec%2001%20single%20pg.pdf .

Whiston, S. C. (2009). *Principles and applications of assessment in counseling.* (3rd ed.). Belmont, CA: Brooks/Cole, Cengage Learning.

Wolberg, L. R. (1988) *The Technique of Psychotherapy Parts 1 & 2.* New York; Grune & Stratton.

Manuscript received 25th May 2015
Final revision received on 7th September 2015
Accepted on 8th September 2015.

Amanpreet Kaur, Ph.D Scholar, Department of Clinical Psychology National Institute of Mental Health And Neuro Sciences (NIMHANS) Bangalore 29. Email: preeti89aman@yahoo.co.in

Naveen Grover, Asst. Professor, Department of Clinical Psychology Institute of Human Behaviour & Allied Sciences (IHBAS) Dilshad Garden, Delhi 95. Email: grovernav@gmail.com.