1-1-1994

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On the Development of Reflexive Thinking: A Practice Note

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Introduction

In this practice note, a case study is presented which focuses upon this practitioner's attempt to integrate theoretical insights of George Herbert Mead into a therapy session with an "agoraphobic" female. It is hoped that this presentation will provide some insight into the utility of theory in clinical practice.

Annie, a 35-year-old, white, never-married woman from a working-class background, presented as a self-labeled agoraphobic. In response to the question of why she wanted assistance, Annie replied that she wanted to be cured from agoraphobia, a condition that she knew she had ever since seeing a Phil Donahue show on this topic. During the initial consultation, Annie's various nervous ticks (e.g., pushing her glasses up her nose, twitching her eyes, and shaking her hands) accentuated the anxiety she was under.

Background

Annie had been previously seen in the family practice center at the medical center where the counseling took place. She had been referred to the family therapist in the Behavioral Medicine Department and subsequently referred to me due to my growing specialization in the treatment of stress and due to my

willingness to take cases that others did not want. The referral was initiated by Annie's physician on request. The physician felt that Annie's extreme anxiety surrounding the medical establishment would be problematic in the future if impending emergency treatment or elective treatment were performed.

Annie's only other experience with counseling was through the voluntary services provided by a lay hypnotherapist who was a friend of the family. Her immediate family was comprised of a still living father, mother, and older sister.

The following factors were identified by Annie as contributing to her present state of fear/anxiety about everyday living:

1. constant fighting between her parents during her childhood
2. seeing a neighborhood boy being hit by a car at age 6,
3. her father threatening her mother with a gun at age 8,
4. constant harassment about being a special needs student,
5. a sexual assault (i.e., rape) on her first date at age 18,
6. a constant non-supportive environment by her parents, especially her mother, during the above events.

Although not revealed in the initial interview but in a subsequent session, it should be noted Annie was sexually abused by her father from the age of seven years to the age of 12 years.

All of Annie's tensions and anxieties surfaced in two previous suicide attempts and frequent bouts with depression. Until Annie had seen the Donahue show, she has been living primarily in seclusion, too fearful to go outside her apartment. When she did venture out, she would frequently be overcome by anxiety attacks.

Intervention

As a symbolic interactionist imbued with the ideas of conflict theory, I generally focus on issues of the self and power relations. Annie appeared to have no power in any of her interpersonal relationships. With the idea of empowerment in mind, I asked Annie to design her own therapy. Since viewing the Donahue show, Annie had read a few lay, self-help books on agoraphobia. In some sense, she had more knowledge than I did on this particular ailment. Annie's first reaction was, "That's your job to cure me." I responded that my job, as I defined it, was to assist her in achieving her goals for personal growth. Annie responded back, "Well, then I'll go to a psychiatrist." I asserted that I would help her find a psychiatrist; however, if she decided to use my services, she could meet with me

the next week with a list of fears, a list of things that would help her get better, and a list of things that would tell her that she was getting better. Annie left miffed.

Needless to say, Annie returned and together we worked on her lists. On her list of things that frightened her, she had included things related to sickness/illness (e.g., emergency rooms, sirens, ambulances), to storms (e.g., tornadoes, thunder, lightening), to relationships (e.g., meeting people, talking with people), and to everyday occurrences (e.g, crossing the street). On her list of things to get better, she included walking around the hospital, possibly volunteering, learning more about the hospital and storms, and possibly joining a group. She felt that the main issue/criteria for improvement was her ability to participate in any of these things and not have an anxiety attack. For the purpose of these counseling sessions, we decided to focus on overcoming her medical fears and the fears of people since we could work on these objectives in the medical center setting.

Although Annie was placed in charge of the specifics of her program, I did not believe that her problem could be solved solely by addressing specific behaviors. If this were the case, we would be in counseling together, forever. Instead, a more generalized approach was needed.

According to Turner (1987) in his presentation of an interactionist model of motivation, the capacity for reflexive thought formulates the basis for the development of a substantive self-concept which subsequently determines behaviors by influencing the definition of the situation. Reflexive thinking is characterized by the ability to view oneself as an object (Mead 1934). This object, the self-concept, is comprised of both identity and self-esteem. Self-esteem is the evaluative component of the self whereas identify is the content of the self-concept (Gecas 1982). One's self-concept acts as a filter through which selective perception and recall occur. Hence, one's beliefs, encompassed by the phrase "the definition of the situation" are influenced by one's self-concept which subsequently influences behavior.

In Annie's case, I felt that part of her "fear" may have arisen from an inability to view herself in the context of her social situation. Hence, she would be unable to see herself as a participant; thus, she would be unable to make effective judgments concerning her behavior.

The extent and nature of an individual's identity is commonly assessed using Kuhn and McPartland's Twenty Statements Test (TST) (1954). The TST is an unstructured questionnaire in which respondents answer the question "Who am I?" with up to twenty statements.

In an attempt to assess the extent and nature of Annie's identity, a number of methods were employed. First, the TST was utilized during one session. Annie responded that she didn't know what I wanted her to do. Upon clarification, she

still did not know how to describe herself. Second, I then asked Annie to close her eyes, to picture herself, and to describe her image. She said she did not see anything and did not know how to describe herself. Finally, I asked her to draw a picture of herself. She responded by drawing a stick figure with curly hair.

The above testing procedure appeared to indicate that she had a very vague to nonexisting concept of her self. Although people may say that I really tested her verbal, writing, and artistic abilities, it is important to keep in mind that the basis of self formation, from a symbolic interactionist viewpoint, is language. However, I was not planning on giving her English lessons; instead, I was planning on developing her ability to see herself as an object.

The intervention developed into the following routine for approximately eight weeks. During the first half of the hour session, Annie and I would walk around the first floor of the hospital. I would allow her to direct the tours. We frequently ended up at the doors of the emergency room. She did not want to and would not enter this area. Upon coming across patients, and especially trauma victims, we would slow down so Annie could catch her breath. I noticed her immediate tendency was to stare directly at these patients as she entered her panic attack. We avoided all panic attacks by retreating from the area, by her learning to not focus on these victims, and by her learning to breathe deeply during these encounters. Slowly, the number of times she had to stop on these rounds were reduced. The emergency room, however, was still a barrier.

The second half of the intervention dealt with building her self-concept. We started with some basic methods. First, she would stare in mirrors and describe herself. Second, she would close her eyes and try to conjure up these images.

During these sessions, two minimal occurrences, but nontheless "break-throughs" were noted. In one instance, Annie came in with a tape of scary sounds. She was real proud she could listen to these sounds and not get scared. My immediate response, in a teasing manner, was to say "You, the person who is scared of everything, bought a tape of scary sounds?" Now, we've all had those crucial moments which are usually filled with dead silence, where we could kick ourselves for saying something not thought out. Well, this was one of mine. Realizing the intensely serious way Annie viewed herself and the world, this attempt at humor could have easily backfired. She finally burst out laughing, commenting, "That's funny, isn't it?" This was the first time she had laughed about herself or her actions during counseling.

In another instance, Annie and I were talking about a thunderstorm that had occurred that week. I asked her to imagine that she was floating by the ceiling and looking down. I then asked her to describe herself and her behaviors. She vividly recalled her activities, which included hiding under tables, and covering herself

with her mattress in her tub while waiting out the storm. As she was describing herself, she smiled and commented that she guessed she had gotten a little carried away.

After this eight-week session, I asked Annie to join the group therapy session I was leading, in part because she had gained some confidence about herself, and, in part, because I felt that the group could confirm, and disconfirm some of her beliefs about reality. Annie was able to manage her group member role quite well. During this time period, Annie "discovered"/remembered that she had been abused sexually by her father from age 7 to age 12. A referral was given to her for the rape crisis center which was currently treating adults molested as children.

The symbolic culmination of my work with Annie was a visit to the emergency room. At the end of approximately four weeks of group therapy, Annie felt that she would be able to go into the emergency room. I arranged with a nurse to give us a tour and we purposely chose mid-week afternoon to avoid potential chaos. The visit was successful, with two ambulances arriving with sirens blaring, dropping off patients, and leaving without Annie having a panic attack. In addition, she was not even visibly upset by the activities in the emergency room.

By this time period, both Annie and I had received some comments about her improvement from her physician, other therapists at the medical center, and her family. Although not a solid measure of improvement, these comments are at least an indicator of such.

Conclusion

The symbolic interactionist perspective has a great deal to offer the field of counseling clinical sociology. Reflexive thinking, as the basis for self-concept formation, and subsequent behaviors, provides an ideal entry point for intervention. For those individuals found lacking in social skills, training in the area of reflexive thinking should enhance the ability of these individuals to participate in more successful social relationships.

REFERENCES

Gecas, Viktor. 1982. "The Self-concept." Pp. 1–33 in Jonathan H. Turner and J. F. Short (eds.), *Annual Review of Sociology* 8. Palo Alto, CA: Annual Reviews.

Kuhn, Manford H. and Thomas McPartland. 1954. "An Empirical Investigation of Self-Attitudes." *American Sociological Review* 19:68–76.

Mead, George Herbert. 1934. *Mind, Self, and Society.* Chicago: The University of Chicago Press.

Turner, Jonathan H. 1987. "Toward A Sociological Theory of Motivation." *American Sociological Review* 52:15–27.