1-2 Profile

PROFILE CHARACTERISTICS

Marks notes that clinical studies indicate that introvert tendencies tend to be fairly stable over long periods of time. People who were shy and socially uncomfortable as children often remain so as adults. Some elements may have been determined genetically, but this type of profile also reflects a childhood characterized by an absence of outward human warmth and physical contact.

The socially extroverted adolescent who has trouble studying because of frequent socializing and social drifting, often become the adult who is constantly trying to be in the middle of social events. This possibly suggests a person whose increased need for social stimulation may be driven by a significant degree of insecurity rather than a need for more intense social experiences.

Therapy for these patients should concentrate on helping them find ways to accept and enjoy their shyness rather than trying to change through desensitization and possibly expose themselves to what they may feel as degrading experiences.

For those patients who are more socially mobile, therapeutic interventions should concentrate on helping them accept, reinforce and enhance their self-confidence and structure their socializing so that it doesn't interfere with their responsibilities.

Patients with this profile often experience fear of irretrievable loss of some highly valued physical or emotional object. They tend to respond to this loss by blocking of further needing or "wanting." They are blocked in the "despair" phase of the mourning process and are afraid to cry and feel angry. They will need to express anger and "rage at fate" in order to finish the grieving process. Frequently these patients will discuss past losses and present feelings of hopelessness about ever being happy, and they ignore any positive feelings or events that happen to them in the present.

Attempts to reassure these patients about their health and focus them on their psychological problems only increases their fear that they will be overwhelmed by pain with nobody to turn to. A more effective approach would be through desensitization by the patient re-telling the frightening earlier experiences relating to pain and fear of death and thereby diffusing the emotional charge that led the client to overprotect against bodily harm and loss of bodily function.
(Marks, P.A., 1987)