THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS

THERAPEUTIC PROCEDURES WITH SCHIZOPHRENIC PATIENTS

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Therapeutic Procedures with Schizophrenic Patients

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THE NATURE OF SCHIZOPHRENIA

What is the nature of that "illness"? First of all, "schizophrenia" is the catch-all category in hospitals, a label attached to anyone who is not clearly manic-depressive, alcoholic, epileptic or something else one can define. This means it includes about half the hospital's population and consists of just anyone. Some of these people are no different from anyone else, except that things recently happened to them which made life impossible and pushed them out of the world, so to speak. If someone can help them back into the world, they are not fundamentally different from other people.

Another group in that mixed population were perhaps pushed out of the world very early; they may never have been quite fully into the human interpersonal world. These people may be much more difficult to help. However, I use the same words about them. I think schizophrenics suffer from being disconnected from the world. Being in a hospital, particularly a state hospital, is a late, visible, physical dramatization of their being disconnected from the world—and this is the disease we try to treat in the hospital! At first, these people were abandoned and isolated as persons and often lived in situations which seemed externally all right. Other people could have existed interpersonally in such a situation, but this person could not. His

inward isolation explains why finally he could not last. Being isolated in a hospital in physical space is at least the second sense in which he has been abandoned. First he was abandoned many, many times in interpersonal space.

The point I want to make is that human beings are not machines who have loose wires in them or burnt-out tubes. There is not in us the kind of broken machinery that an ideal surgeon can reach and fix, or readjust, or take out the thing that is wrong or reconnect something inside this machine. We are interactive, experiential organisms. *When* I respond to what goes on in a person, *then* something goes on *in him.* Of course, something goes on in him also before I respond. He is in pain, anxious or dulled; he has lost his sense of himself; he does not have any feelings; everything is flat. When I respond (or let us say, when I succeed in responding, because I often try and fail for weeks and months), then something more is suddenly going on, he does feel something, there is a surprising sense of self and he feels "Gee, maybe I'm not lost." He does not say that. On the contrary, only then does he first say he feels lost. That is when he first says, "There is no place for me in the world." A person can *feel* and express anything only as he *is in an ongoing process.* Without *any* place or world he feels nothing, only weird and selfless. With me there is enough of a place and world so that he feels interactively ongoing. Then he feels lost. It is not the inside that is sick. The "illness" is not internal pieces we have to eradicate. The "illness" is not "in" the human being as if he

were a separated, boxed, packaged machine. We live as interactive processes.

How we five toward the world and others, how we sense ourselves in situations and referred to by others, that is us. If there is nobody there to refer to me personally and if I have not somehow learned in other relationships to respond to myself personally, or cannot now do so, then I am not there, and everything gets very flat, very strange and very weird. If you have ever spent five or six days by yourself without talking to anyone else, then you know something of the quality of feeling it is. But many people can five well toward nature or with their own responses to themselves. Others find only stoppage and weirdness when intolerable events and feelings have been ground into dullness and inner isolation has long been permanent.

What kind of an illness is that? We talk of *"resolving the symptoms* and not reaching *the basic illness."* This would be the case when there are no more hallucinations but the person is still miserable, cut off, alone. It is then said that "the basic personality trouble" has not changed. Thus, "schizophrenia" is not really the "crazy" symptoms as such. Then again, other people talk of just the opposite: "I know many schizophrenics who are out there in the streets, who are working, and they are all right, but they still have the same crazy experiences," says one well-known therapist. Here the personality difficulty seems ameliorated, but *that* is not what schizophrenia is either. Despite solutions in personality difficulty, these people still have "schizophrenic"

experiences. It is the symptom-mode which is "crazy." But, we say that the symptoms also are not quite what schizophrenia is. These symptoms can go on or off within minutes. When we cure the symptom we are not content. The overt psychotic manifestations do not really define schizophrenia.

A third factor is indicated in the evidence that schizophrenia is really a relationship. It is a sick way of being married or a sick family, it is an untenable way of being with another person. One is "isolated" from the world by reacting always within a given single intolerable relationship.

Within this relationship one's experiential feeling processes cannot be interactively ongoing—yet one is stuck within that relationship and not in the world. Not the bad relationship as such, but the stoppage of experiential process in it is the "illness."

The policy of many hospitals (in Wisconsin, for example) is to send patients back to the same relatives that signed the patient in. This policy sends him back exactly to the relationship in which he can be no more than his sickness. We are tending in two directions with that problem. One is to treat the whole family, which gives some recognition to this interactive nature of the illness. The other direction is to try and make a new life possible for the patient (protected workshops, halfway houses, new lodgings and work). But, the possibility of a new life for the patient should be held out to

him right at the beginning, when he is sitting there silent, has no hope and nothing to say. I can say to him "I think I can help you get out of the hospital, and if you want to, you can live in the city instead of going home. I suppose you don't believe that you could get out of here, but I do. First you work upstairs, and then we will help you find a job outside, and then

I'll help you find another job and a room in town, if you want one. I'll stick with you and get you out of here. I know you don't think that's possible now." If that is held out to patients when it still makes little sense, then the fundamental cut-offness can yield to a beginning interaction process into the world. We must *begin* by overcoming the break that has happened between the patient and the world, his sense that he is not in the world and cannot be. Inside himself he is not feelingly alive to think about this, or feel and express himself about it, hence we must begin by restoring the possibility for such feelings and thoughts.

My conception of the illness: *It is not so much what is there as what is not there.* The interactive experiential process is lacking, stuck, deadened in old hurt stoppages and in disconnection from the world. It cannot be ongoing, except in and toward someone and in the world. If a toaster is unplugged, would you take it apart to find out what is wrong inside of it?

The concrete reality of humans is the experiential process, and this is no

purely internal thing, but a feeling-toward others in situations. If it is not ongoing, then it cannot be made ongoing, except as we respond empathically to make interaction happen, as well as reconnect the person at least to a promised and imagined outside situation in which he might be able to live. Only if he can later actually try such situations long before he is objectively well enough to do so can he usually become well enough to do so. Later, we really must help him with job and room, be available for calls at night and meetings in odd places. It was through what some released patients taught me in this respect that I came to promise such things to other patients at the start.

Of course, we do not yet really understand what schizophrenia is. We cannot claim to know. In addition to symptoms, personality difficulty and experiential interactive stoppage, there may be physiologic conditions both etiologic and accumulated results of long isolation. If pharmalogic help is found, it may greatly speed the recovery. But, someone must respond. Only in being responded to does the patient then seem to *have* ongoing feelings and therefore the ability to "be aware" of them. It seems likely that the absence of this experiential interaction process is schizophrenia.

PSYCHOTHERAPEUTIC CONSIDERATIONS

Client-centered therapy was first defined in terms of the discovery that

a deep, self-propelled therapeutic process arises when the therapist "reflects feelings." In this type of therapist response, discovered by Rogers, the therapist freshly phrases his sense of the client's implied affective message or felt personal meaning. For a time this was hard to distinguish from mere repetition by the therapist of what the client *says.* Seeman moved further toward an experiential formulation by clarifying this question. The therapist does not repeat what the client says or clearly feels. Rather, he "reflects the *unformed* emotional experience" (my italics) of the client. The therapist aims at the client's directly felt, not yet formulated, experiential meanings.

On the therapist's side, the same experiential development meant that he would no longer hide his own person behind a screen. Rather than mechanically "reflecting," the therapist was becoming more "spontaneous," tending to voice his "immediate" feelings and responses to the client. Finally, Rogers redefined psychotherapy entirely in terms of therapist "attitudes" ("necessary and sufficient" for psychotherapy, regardless of the technique and orientation). Among these attitudes, the most important was genuineness or "congruence" of the therapist, eschewing any false front, screen, artificial maneuvers or techniques as such. The therapist was to be "himself," as he really is and reacts within this relationship.

Thus during this period client-centered therapy, like other orientations, moved toward emphasis on experiential concreteness in client, therapist and

their interaction.

Similar developments have been occurring in the other therapeutic orientations. In the last two decades the emphasis has shifted from the different verbal contents and techniques toward a common experiential focus.

Psychotherapy has become less technique oriented, less mechanical, less cognitive, less limited to the best adjusted and most verbal patients, and less divided along the old lines. Therapists of many orientations sense a common movement which transcends the divisions between "reflection of feeling" and "interpretation," between "analytic" ("exploratory") and "supportive," between emphasis on sex and emphasis on self-concepts, power strivings, will struggles, interpersonal feelings or other favorite *contents.* Very gentle and receptive therapists and very active and interventive therapists agree that when they are successful a similar experiential process transcends differences of words and techniques.

The roles of patient, therapist and relationship are coming to be viewed in terms of concrete experience. In the patient, psychotherapy no longer aims exclusively at one kind of content (Oedipal conflicts, self-concepts, etcetera). Although various orientations still favor one or another of these kinds of content ("vocabularies," I would call them), a basic experiential feeling

process is widely held to be what really constitutes psychotherapy. Without this feeling process there is mere intellectualization or rationalization. With this feeling process, patients change concretely, whatever vocabulary is employed. The therapist can aim his responses at the patient's concretely felt meanings: the preverbal, pre-conceptual experiencing. Of course, the therapist will conceive and phrase whatever he senses and will employ words and concepts that make sense to him. However, the object of the words and concepts will be the concrete, felt experience in the patient. The therapist's chief aim will not be to devise objectively correct sentences to describe the patient but rather to get the patient to attend directly to the concretely felt experience he has there in the immediate moment. In psychoanalytic terms, this is called the "preconscious," what one *can* feel and verbalize if attention is drawn to it. As the concretely felt "preconscious" is carried forward and responded to, more and more facets *become* preconscious—that is, they become directly felt and thereby capable of being verbalized. If the patient will attend to and work through what he directly and feelingly has there (to which the response points), then therapy will move and succeed, whatever the vocabulary of the response. With this emphasis on this concretely felt "working through" process, therapists have come to agree that how one points one's response matters more than the terms in which the response is phrased. Therefore, we commonly say today that a different therapist with a different conceptual vocabulary may do psychotherapy as well as those who

share our own vocabulary. What matters is whether he can engender the experiential concretely felt "working through" process in the patient.

Within the therapist too conceptual, professional machinery and technique have yielded to an emphasis on the therapist's real person in the interaction. Mere techniques are seen as self-defeating. By their very formality, inhumanness, mechanical or abstract character, they will fail to point at and carry forward the patient's unformed personal meanings. The therapist must use his actual personal responses and actual felt impression of what is happening. The therapist uses his own felt experiencing of the moment, much as he aims his responses at the patient's felt experiencing of the moment.

Finally, the interaction between patient and therapist is seen as an ongoing experiential process in which both persons change and are alive in new ways. Only a concretely felt new interaction can bring about newly emergent facets of feeling in the patient so that he is alive in new ways and actually *changes,* rather than merely finding out how he *is* and *has been.*

Characteristics of Schizophrenic Individuals in Regard to Psychotherapy

Work with the hospitalized schizophrenic patient greatly accelerated the experiential trend in client-centered therapy. This was partly because of the way we selected these individuals for therapy. We did not consider their

desire or suitability for therapy or the hospital staff's recommendations. Individuals selected on the basis of such considerations are those likely to succeed because of their desire for help, because of "suitable" (that is good) prognosis for therapy or because they have been able to attract staff interest. Instead we chose clients by strict research criteria (age, sex, social class, length of hospitalization) and so obtained much more typical (and much less hopeful) individuals. Here are a few of the characteristics we frequently found in our patients :

Silence

Over and over again we met hours of solid silence. This was not the kind of silence we value in psychotherapy when the individual deeply explores himself inwardly. Rather, it was a silence of emptiness, resistance, of not knowing what to do. Another type of "silence" was nonstop talk about trivial and external matters.

The Set for an Exploration Process Missing

Whether silent or talking, the patient would not share the therapist's "set" of searching for what is wrong, of exploring or helping with what is wrong. The patient had no such "exploration set." He might be totally silent or speak incessantly, but if he spoke, it would be about the bad hospital food, the troubles of his ward, his desire to go home or that nothing was wrong with

him. The therapist's attempts to reflect or interpret troublesome feelings would be rejected by the patient or would puzzle the patient. He would see no point in focusing on such feelings. The patient was not asking himself questions, was not embarked on an endeavor to explore himself or to understand or change himself. What seemed missing was not just a specific feeling. The patient did not see the *relevance* of a therapist's *sort* of concern, for exploration was missing.

No Self-propelled Process

Perhaps because of the lack of explorative set, perhaps for other reasons, the usual self-propelled therapeutic experiential process did not take place. (With more usual clients, such a process usually moves of its own accord after an initial period of therapy. At first, the therapist must pull the process along, must always refer anew to the experiential, felt aspect of what the client says; but soon more and more personal felt meanings emerge of their own accord, and both client and therapist are pulled along by "it," the concrete felt meaning which next emerges.) With these hospitalized patients, a therapy-like process might occur on a rare day, yet the next time it would be as though that had never happened. No continuous, self-propelled process developed.

Rejecting the Therapist

With great regularity both silent and verbal patients would reject therapy and the therapist. Such rejection was not part of the give-and-take of interview encounter as we are used to it. Rather, it was a total refusal to meet with the therapist. The message, often said explicitly, was—"Go away and leave me alone. I do talk to some people but not to you. Don't you have other patients you can go to see? I am not coming anymore. Don't come to see me." This might be the patient's consistent attitude over a number of months. Had it not been for research, we would not have continued with these patients and would not have learned how to continue without violating their personal rights.

The Challenge to the Therapist

These patient characteristics greatly accelerated the already developing experiential method. For example, a therapist accustomed to "reflecting" feelings is confronted by ten or twenty hours of absolute silence—what feelings shall he "reflect"? Or if the therapist usually "interprets," what will he do after he has variously "interpreted" the continuing silence? Whatever the therapist's techniques, he sees himself failing to reach the patient's feeling life. He does not know much about it specifically (it is probably deadened, or sore, highly chaotic, and unknowable even to the patient), yet he must somehow reach it, point at it, relate himself to it, ask about it, *respond to it even without specifically knowing what it is.* Thus, these patients force

therapists to point themselves at the directly felt, concrete, preverbal experiencing in the patient.

Let us say the therapist decides that exploratory techniques are not indicated and employs supportive therapy instead. The distinction may mean that the therapist ceases even to try to respond to implicit meanings. But then, silence. Nothing happens. Or let us say the patient speaks in a highly autistic way with personal meanings and events compressed into hardly interpretable masses. The supportive therapist just "lets him talk." Not only is this not supportive, it is positively harmful: The patient's rather desperate efforts to communicate continue to fail with a therapist who "lets him talk" or gives only broad suggestions. The therapist is forced to give up both abstract exploration and mere support. Instead, he must respond in such a way that the patient can bear it, can concretely feel and know what is meant, can attend better to his own immediately available feelings and can experience himself as perceived by and understandable to another person. There is no way to do that by simply using or simply avoiding interpretive insight. There must be explorative response, but of a different kind. The therapist must try to sense the patient's presently available felt referents and must show the patient that this is what the therapist values and responds to. With long-hospitalized schizophrenic individuals, experiential referents are often deadened, painful, chaotic and frightening masses of feelings and meanings. These are preverbal and felt, but only capable of being carried forward gently

in terms of (any) verbal vocabulary.

Thus, the characteristics of these patients lead therapists to transcend the old techniques. From whatever point the therapist starts, he moves toward responding to the patient's directly experience-able, felt referents, even when these have to be verbalized in very tentative and concrete words.

Similarly, these clients lead the therapist to employ his own concretely felt experiencing as a source of his response behavior. At first, the therapist may notice only that many difficult and unaccustomed feelings occur in him with these clients. But soon he comes to use these feelings to create interaction. In another place I described this development in these words:

The client is silent or talks of trivia. Attempts to verbalize his implicit communications make him angry, fearful or withdrawing; or, as we try to respond to a deeper level of feeling, we find that the client simply has not meant to look at himself more deeply—and misunderstands us. We have all sorts of impressions and images of what the client feels. Perhaps we only imagine these, or perhaps subverbally the patient does communicate. We wonder what to do with all this richness of events which occurs in our own moment-to-moment experiencing, as we sit quietly or converse superficially.

We feel much empathy but can show little. As we go along on a casual level or in silence, we wonder if we aren't allowing ourselves to be just as

helpless as this fearful person. We are in conflict, not knowing whether to push harder or to attempt being even safer. We blame ourselves for too much helpless waiting, then minutes later, for too much interruption, pressure and demand. We wonder whether the client is doing anything significant with us, whether we are failing him. We become impatient and angry at giving so much inward receptivity while so little of it seems communicated. We value deeply what little or trivial communication he gives us, and we do not want to push that away. Yet we feel dishonest when we seemingly assent to silence or to this trivial level of communication.6

We then become able to *use* these many feelings, images and impressions. They are our impressions of the patient and our incipient *moves toward the patient.* In suppressing them, we suppress our incipient interaction with the patient. Each minute we suppress five or ten such potential moves. Since the patient is unable to initiate a meaningful interaction, it is left to us to do so. Genuine starts for such interaction occur within us constantly. So we learn to use our own experiencing as therapists, but our feelings and images do not always come to us already shaped and verbalized in usable form. Therefore, we must focus on our own directly felt meanings and go through "a few steps of selfattention" to fashion a usable response to the patient.

Finally, we also learn from these patients that new, concrete interaction

can precede new feelings and new words. When the patient cannot yet verbalize or hear much verbalization, therapeutic movement depends on positive relationship events. The many difficulties which arise in relating to a hospitalized patient offer the therapist opportunities to relate to his patient as to a valuable and sensible person. For no matter how objectively wrong and obnoxious a patient's behavior may be, it can be met and opposed in a person-to-person encounter, and (while the behavior itself is stopped) the therapist can search for, find and respond to a positive thrust and integrity implicit in the patient's behavior.

Thus, just the difficult characteristics of these patients most highlight the role of experiential concreteness in patient, therapist and interaction.

THERAPEUTIC PROCEDURES

Different therapists' styles vary greatly. Each therapist finds different behavior to convey *himself* directly and spontaneously. My descriptions present the *scope* and the *kind* of therapeutic procedures we learned in working with these schizophrenic individuals.

I am going to describe in detail the processes that occurred in me as I worked with these patients, my attitudes, steps of thought and private procedures. I believe that in this way you can best evaluate what I do, take from it anything useful or be stimulated by it toward something different.

We must develop *a vocabulary—a science—about the therapist's personal procedures;* we cannot leave these private and unnamed. Without detailed vocabulary about what we do inwardly, we cannot talk to each other or train new therapists. We need a science of doing psychotherapy, and the first step is to develop a vocabulary that names some of the procedures we employ both within ourselves and externally. That is what this chapter attempts to do with a series of descriptions of situations and methods of handling them, which grew out of my work with schizophrenic patients.

Three Categories of Patient In-therapy Behavior

Not everything I describe here would be appropriate for every patient. Much of it has the following form: "If the patient at the moment does so and so, then I find it helpful to do so and so." Such formulae create categories, classifications of patient in-therapy behavior. These are different from the usual categories of psychopathology.

Few terms from psychopathology tell us what to do in psychotherapy. For example, if the patient is "schizophrenic—undifferentiated tendencies," what does that tell me about how to approach him? Little can be said about what to do which would be applicable to all who are given this label and not applicable to many patients with other labels. Compare this diagnostic label with the category: "If the patient is quite verbal, but speaks only about

externals and daily events . . This category requires certain kinds of therapist procedures and allows us to discuss what we do. Notice that this is not a category of psychopathology! Some schizophrenic individuals, some neurotics and some normals will present a therapist with this problem. Nor is it a class of patients. The same individual who presents one type of in-therapy behavior now may present a different sort later. Why settle on any one patient-class for an individual? After all, we hope he will change! I group my various descriptions under three categories of in-therapy behavior, not of patients:

I. The patient is totally *silent and unresponsive*, giving me no feedback at all, either verbal or gestural or postural. He sits or stands silently, unchanging and unmoved throughout.

II. The patient is *silent but responsive;* his face, gestures and rare words respond in continual, subverbal interaction.

III. The patient is *verbal but externalized;* he never speaks about feelings or personal meanings, only about others, situations, events without their affective aspects.

Interview Behavior I: Silent and Unresponsive

Throughout this section picture the patient sitting somewhat bent over, looking down at the floor between his feet, never stirring, never looking up or giving any sound or body indication that he hears. Imagine him in this position when we begin and throughout the interview. (This may be in my office, in the hallway or where he sits in the day room.) When I leave he is still sitting in the very same position. He has made no sound and has not moved.

NO FEEDBACK DEMAND. I used to depend on what the patient said to lead me to the next thing I would say or do. I needed the patient's response to let me know whether what I did was good or effective. I now think therapists should have *many* patients so that their sense of effectiveness does not depend on any one given patient at a given time. I can continue to work, speak and act without the patient's showing me that he hears me, that he agrees, denies or commits himself in any way.

THE "SENSIBLE PERSON" ASSUMPTION. I always assume that I am speaking to a sensible person, there inside the patient. This assumption has never failed of later confirmation, but in the face of *this* person's total unresponsiveness it is an assumption requiring imagination! I imagine I know I am talking to the person in there, somewhere—a fully human, almost certainly suffering, person—half lost and weird, perhaps—unable and unwilling to send up any sign—but there. I think of it as throwing something over a wall to someone. I cannot hear it land there, and I cannot tell if it is any good to him. I throw it over the wall without expecting to hear anything for some time.

My ways of being expressive as a therapist seem rather radical to me and have seemed so to some other therapists. I seem to be "out on a limb," not knowing if I imagine the patient or if he is really there. But much later the patient will say, "Why were you so silent? Why did you take so long? Why

didn't you say much more of that kind of thing? Seemed like you knew I couldn't talk, and still you often didn't do much."

From such statements I know that my assumption is not really very doubtful at all.

THE THERAPIST IS SELF-GROUNDED. I make clear that I speak and act on my own responsibility, because I want to say it or do it. Since the patient gives no response or commitment of wanting to meet with me, I tell him that I will continue to meet with him because I have decided to. Since he does not respond to what I say, it will stand simply as what I want to say. Since he says nothing when I tell him what feelings I imagine he feels, I make it clear that these are my imaginings. ("I don't know how *you* feel about it. You haven't said. This is just what *I* think of it")

OWNERSHIP OF FEELINGS IS SPECIFIED. When I intend to refer to *his* feelings, I make that clear. When I speak about *my* feelings, I make that equally clear. I specify who is the owner of the feeling.

This distinction lets the patient know that I point at whatever *he actually* feels. On the other hand, when it is something *I* feel or want to say and do, I make that clear. It leaves him uncommitted. It does not require that his feelings be already clear to him or bearable enough to look at. The patient is rarely disturbed by whatever I am, think, feel or want to do if I can keep it

clear that this is me and leave him uncommitted.

THE CONCRETE SILENCE. I talk about silent sitting together as something concrete. In ordinary social intercourse we must fill time with words. In a living room with others, even thirty seconds without talk brings strong discomfort. We *must* say something.

We usually think we are doing nothing (at least, nothing useful) if we just sit in silence next to someone. Sitting down next to a silent patient, one feels one's own implicit demand: "Say something!" Especially if the therapist has spoken, the eventuating silence builds a tension. The patient knows he should say something, but he won't. The time is a bad time, much like the rest of hospital time, wherein the patient refuses and resists while staff loudly or silently demand and criticize. Therefore, there is relief for the patient (I believe) when I say, as I usually do, "It's all right to be quiet. I'll just sit with you a while."

Perhaps after some time, I may say, "Now I'll sit with you a little longer, then I'll go. I'll be back on Tuesday."

When I sit with someone, I know that *is something,* even if I have nothing valuable to say. I no longer need constant evidence that I am being effective and helpful. I can just sit and give my company. I have been in situations where my pain could not be understood, and I have taken comfort

just being with someone willing to *be* with me, someone who required nothing, could not grasp my torn-up feelings but was human company—like a place to go when you are down and out, a human presence, civilization after wilderness. It is a lot when I just sit with someone. But I believe it helps to *say* that I mean to sit in silence. It helps to make it something.

MANIFESTING PRESENCE PERIODICALLY. I speak every few minutes when I sit in such a silence. I let myself be heard from. I feel the patient needs to hear me often, to find himself in touch with me even while he cannot yet reach out for me or establish interaction. I do not want to be forgotten, so that he returns to isolated aloneness even while I am with him. What I say usually demands no answer. If I do demand an answer (and get none), I indicate it is all right. ("I wish you'd tell me, but it's all right for you not to.") My statements, every few minutes, are often about myself, about what is going on in me, what I think, feel, imagine, wish or do inside myself as I sit there.

Usually in therapy with neurotics, the transcripts of the tape-recorded interview show what therapist and client say alternately: T. C. T. C., etcetera. The sort of transcripts which come from the above, when it is tape-recorded, run—T. T. T. T. T. T. T. T. T. T.—throughout a whole interview! The patient may say something once, or twice, or not at all. The therapist says something every few minutes.

ACTUAL RESPONSE PROCESSES. My actual trains of thought and feeling are the source of my responses. I think many things of all kinds in these minutes of silence. A minute of silence is a very long time! I could never possibly say all I think and feel—even if thoughts and feelings came in little verbal units, ready to be spoken. Actually they come in felt masses, only little of it in words. I put *some of* what I feelingly think into words for myself, as I sit there. After a time, one or another of these thoughts seems fitting to tell the patient. Perhaps I still mull about it, ponder it, see other sides of it, find a simpler way of phrasing something. But I do not stick at this or that phrasing. I let it run on in my mind. When I decide to say it (whatever "it" is, "this" thought or feeling), I won't have all the words prearranged for it. It will come out of my mouth spontaneously.

I will now describe several sources for such responses.

WHAT THE THERAPIST MIGHT EXPRESS. Some of my responses come from a chain of thought that is well known to every therapist, though few use it as a source of responses. This is my thinking about what I just said or did and why I should perhaps have done otherwise.

Especially with silent and unresponsive patients, if the therapist says something and gets no response he can think of ten reasons why it might have been a stupid, wrong or threatening thing to say. These feelings used to

burden us as therapists, but they have become a source of responses instead. In the following I will describe my intervening thoughts to show how such a sequence of thoughts leads me to something further which I can tell the patient.

Suppose I had said (as I just described), "I'll just sit with you a while. It's all right to keep quiet."

Now I might find myself thinking: Silence is very well for me but he needs help. What if my saying that silence is "all right" means to him that I don't care to help, don't even know something is wrong, that I don't realize the silence is really terrible, awful, horrible, and not a bit "all right." Maybe he wishes he *could* say something, but he can't. Now I have quite a lot I want to tell him. There's no hurry. It is only a few seconds later. I mull it a while. Somehow I am going to tell him that I know he is suffering and that I want to help, although I do not need speech from him right away. I know from his sitting there like that, head down, looking at his feet, that he is suffering, discouraged, hopeless, something like that. But I do not *know* about him, and I do not want him to think I know all about him, have read his record, or am connected with one of the people in his life. I will have to tell him also that I do not really know anything about him. Now I feel I know what I want to tell him, something like: I think he is suffering; I don't really know that; I'd like to help; I need nothing special right now. After a while of mulling, I might simply

say, “Most people in here are really suffering pretty badly. I’d like to help you. Sometime maybe I can.”

But he does not know I mean help via his talking to me. Perhaps he thinks I could “help” him “sometime”; I’m not doing it now because I don’t feel like doing it yet. I’ll have to tell him I want to hear from him what is wrong, what to help with. After a while, I might say, “Sometime I hope you’ll tell me something about how you came to be in this hospital.” Then I wonder what if he thinks I want an explanation or a defense? After all, I want to hear about his feelings, not the events as such, objectively. I might say, after a while, “I bet you went through a really tough time. I don’t know anything about you, that’s just my guess.” Then I might think perhaps he’ll take that as curiosity, my trying to find out about him, wanting to hear dirty stories or embarrassing facts. So I might say after a while, “Whatever hurts inside you and makes you feel bad, that’s what I would care to hear about, whatever has you so silent and sad.”

Then I might think what if he isn’t sad at all, just lost or sullen, or what not? So I might say after a while, “To me you seem sad, sitting there so silently with your head down. Of course, I don’t know how you really feel.”

Words like “sad” or “angry” or “rough time” turn an individual’s thoughts to his own feelings rather than to other people’s views of him and

condemnations of him. Many patients expect to talk in the frame of reference of what they should have done or not done, or what they have been condemned for or are innocent of. “To me you seem sad” indicates my wish to talk and think about him, his feelings, not about outward events, condemnations and excuses. Inside himself he might find for a moment what he *does* feel, not sad but , and this will help. For an instant, he might feel like stirring and answering me, to correct me: “Not sad, just flat, empty, hopeless” or perhaps, “I wish I did feel sad, it would be something.” My patient here says nothing, does not stir, but I feel it helps to talk to him about his feelings and to indicate that I am thinking about his feelings, even if I have to call them by misnomers. I make it plain: “I realize I don’t know what your feelings really are.”

Perhaps he does not know himself. I might tell him that too after a while: “Often people’s feelings are all mixed up, they don’t know just what they feel, except maybe just bad. It might be that way with you, or anyway that’s what I was just thinking.” It lets him know I was thinking about him, about how he feels.

But now I think further: Maybe he knows exactly what he feels, just can’t *say* anything. What if he is quite ready to say it, except that it’s the sort of thing you *never* say to anyone? Perhaps he doesn’t know that the kind of thing he *would* say is appropriate to say to me. I wish he would say it! I want him to

know that. I want him to know I am a therapist, a feeling doctor. I want him to know what I am doing here and that the sort of thing he feels is the right kind of thing to say to me. How can he know that? I have to tell him.

Then I might say, "I'm the kind of doctor that understands about people's feelings. Of course, I don't know yours, but I know a lot about this kind of trouble. That's the kind of doctor I am. Sometime I hope you'll tell me what you feel that bothers you. I might help with it."

Then perhaps I think: What if he is ready to talk *now,* why do I keep saying *sometime?* So I might say after a while: "Anything at all, whatever it is, that you would care to tell me, I'd care to hear it." Then, as the silence continues, I might think what if he wants to and can't? Then I might say: "If it's too hard to talk now, that's O.K." Then I might think that I'm just encouraging his flabby, heavy, discouraged tendency to do nothing and so I'll say, after a while, "I sure wish I'd hear more from you."

From these descriptions you can see the thought sequence which leads me to responses. It is that familiar sequence in which the therapist has his doubts about whether what he just said was fitting and wonders if it was perhaps stupid, hurtful, wrong or misunderstood. We all have these thoughts, and they include the reasons *why* we doubt the worth of what we have just said. These need not be left as uncomfortable feelings. With silent and

unresponsive patient behavior, we can use such sequences as a source of responses.

The "Imagined Patient" Sequence. Another sequence of thoughts which gives rise to responses concerns the patient. Later in therapy (perhaps the patient is still silent and totally unresponsive), I am active in many more ways. Among other things, I say more about him. So far I have used examples only from the first few meetings with patients who are silent and unresponsive. Here are some examples of what I might say a week or two later: "My God, you're sitting in the same place I left you last Friday! It seems awful that you would just sit and sit like that!" or "I don't know, of course, but it seems to me you look *so* sad. I wonder if you're just feeling like you're hopeless, like it's no use."

Saying such things gives rise in me to a whole sequence of thoughts about someone who feels hopeless and no use. Of course I do not know if he feels that way (and I will tell him that, too), but *the kind of interaction* we have as I talk is helpful, even if the *content* of my words may not fit him. I might say after a while: "Sometimes a person can feel so no-use and no-good, he just tries to give up on himself."

I might ponder that a while and then say, "But, you know, it doesn't really work to give up on yourself. Maybe you try and try to give up, but it

only hurts."

Then, after a while, "Maybe it's hard to even think of picking things up again. Sometimes a person feels that to try again is like telling people it's all right that they hurt you."

After I ponder that, I might say, "If they did hurt you, that's *never* all right."

That will lead me after a while to another thing, perhaps: "Sometimes the ones that hurt you are just the people you most wish loved you. That's the hardest to take, I think."

Some of these sequences will fit anyone, but just as often the sequence will not fit the patient. These are responses to a person I imagine—a sad person, silent, broken, given up, hurt by those he cared about, in a state hospital, not cared for enough or not understood. As I respond to such a person, all the while phrasing clearly that I do not know how the patient really feels, he experiences me reacting to him, much as he would if he were verbal. He experiences (he need not understand) my intention, which is to focus on his feelings, his hurts as they were to him, since that is the frame of reference of the things I say. His feelings may stir, become a little more alive and perhaps a shade less unbearable and disorganizing than they were when he last could stand to look at them, which he did alone.

Then perhaps I shift. It strikes me that being hurt by those you care for and therefore not wanting to try again is too specific, probably wrong. Perhaps he is just out cold, too confused to feel anything, hearing my words as mere distant music or noise from someone too frightened to hear. I begin to respond to his possibly global confusion. I might say, "Maybe what happened to you and what you feel is all one big mess that just hurts. Maybe you don't know *what* it all is." So I begin another sequence, perhaps without specifically thinking of it as another sequence. It occurs to me that this global confusion might be full of crazy stuff too. I say, "When a person gets *too* hurt, sometimes a lot of strange stuff goes on in him. I don't know about you but I know about *that kind* of thing."

Even a Few Minutes Help. Unless we *arrange* fifty-minute hours with a patient, he does not expect that. In a hospital, I leave myself free. I come when I can. Only if I really know that I certainly will be there on Tuesdays, do I tell the patient that. Often I do not say how long I am coming to stay. I do not leave abruptly. When I want to leave, I usually say I will go, and then I stay a little longer.

But this may be after ten minutes. Especially if I am tense or the patient has been very violently rejecting of me (sometimes patients are totally silent *except* to say quite verbally, "Go away, don't come anymore, can't you understand that?"), I might impose myself on him only briefly, both for his

sake and for mine. I might say, “I know you said you don’t want me to come anymore. I won’t stay long.” Then I might stay only a few minutes.

Other more verbal patients may stop me in the hallway. I speak with them intensely for a few minutes. They may know that I cannot stay long. They accept my moving on quite soon, but I listen intently and respond to what is going on deeply within me in the time I do spend. In this way I can carry a somewhat larger number of relationships than I otherwise could.

It is a mistake to think we should not respond therapeutically to patients if we cannot commit ourselves to them totally for many whole hours. This view comes from concern not for patients but for therapists and clinical agencies and out of tradition. It is true that if you help someone open up his feelings he may then be more trouble than if he had not been responded to. (But he may also be less trouble as a result.) We are protecting *ourselves,* not the patient, when we say, “If you can’t commit hours and months, don’t respond at all.” For the patient, a few minutes can be of crucial help. The experience of making sense to another person and living less autistically, even for a few minutes, may provide something the patient can keep and work with for weeks. I mention this here because one of the ways in which a few minutes can help involves the following principle that is important in working with the silent and unresponsive patient.

The Continuing Interaction. The patient can live in interaction with me even when I am not there. Let us say I have spent a few minutes—fifty, twenty or five—with my silent and unresponsive patient. Now I leave. He is more alive and upset, perhaps more of a "self" inside than before. He hates me (for example) because I make him hope and he cannot stand the pain that comes the moment he hopes. So he fights it down. He is again totally still, empty inside. He goes to lunch, waits in line, silently, thinking to himself, "Maybe, next time he comes, I'll hit him." He visualizes all that, sees and feels it, decides not to hit me. "Maybe I'll tell him I'm going to hit him." He experiences all this, imagines it, decides he won't say anything to me, ever. He eats lunch. He thinks maybe he will tell me he isn't any of the things I say; he is just angry at what "they" did to him (perhaps to himself he calls them "the jury" or "the machine" or what not); he decides not to tell me because it will sound crazy. He decides never to say anything. He finds himself "talking to me," saying this and that to me, justifying himself, explaining, wishing, demanding, carrying on; catches himself, decides to say nothing to me, ever. He returns to the day room and sits in his corner, as usual, looking at the floor. That reminds him of my having sat next to him. He kicks the chair hard, away from him. His heart pounds, he is live anger. The attendants come over. He subsides, thinks of nothing or tries to think of nothing. Visitors are announced on the loudspeaker for another patient. His tears seem to want to come. He chokes them down, finds himself mentally telling me how busy his own folks are, why

they can't come to visit him. He imagines that he finds himself crying with me, gets furious, decides to tell me nothing, ever, thinks perhaps he will tell me that nobody has any use for him. It is only one hour since I left.

Naturally enough, when I come the next Tuesday he is totally silent again, as if nothing had intervened. But a lot has happened, some of it in the context of talking to me, feeling with and at me.

For this reason, the *kind* of interaction I have with a patient seems to me much more important than exactly what I talk about. Even if he says nothing and even if everything I say is foolishness and fits him not at all, I believe that this kind of interaction and pointing at feelings gives him a context to live in, imagine in and relate in during the many, many hours when I am not there, as well as when I am.

Making Contact. Apart from these examples of what I might *say,* there are also things I *do* to make contact with my patient. I might get down on the floor in front of him and look up into his face for a moment. I might explain it as: "Sometimes I get to wishing you'd look up at me." I would not do it for long, but if our eyes met once, I would be glad, and say so.

I might put my hand on his shoulder, or I might grasp his hand. I might do this in some context or in my effort to reach him somehow. (Perhaps I first said, "I sure want to hear *something* from you.)

Isolated people need physical touch, especially children, whom one can pick up and hug. I think children are not different for being my patients from any other children. We deprive them of what we would easily give normal children (and these need more) when we refuse to hug them because they are patients.

Similarly, with an adult, physical touch is often the only way to make contact. I make my touching a mode that won't be confusing, sexual-like, or frightening. It is a message, a contact, a firm holding of hand. Or I hold shoulders, keeping my arms extended and stiff. It is a way of saying, "You. I am looking for you." It is important, then and later, that the patient is not threatened by, or forced to speculate about, the possibility of a sexual pass or overture. These are frequent in hospitals and even more prevalent in patients' minds. However, other forms of physical contact, like being pushed about by aides, are just as prevalent. A firm grasp of a shoulder confuses few patients. In many contexts it is the only clear, fast and impactful way of saying, "I am here, and I know you are here."

Interview Behavior II: Silent But Responsive

In this section please picture a patient who says very little. He may offer barely understandable, highly compressed, summary statements like "Must be somebody has a use for a person" or "I'd like to take them and shake

them." For the most part, he is silent. However, he is highly responsive. He looks at the therapist at times, can look quickly away or down, and back again. He may stand, sit, walk away quickly, come back. He may jump backward three paces if what I say disturbs him. He may get angry and seem to walk at me as if to walk through me. His face tells every moment that something new is happening, though the therapist may have only a vague sense of what it is.

The "silent but responsive" patient today may be the same individual who was silent and totally unresponsive at first. Or the patient may be "silent but responsive" from the start. When he is quite silent for long periods, much of what I said in category I will apply. "Silent But Responsive" is a category of in-therapy behavior, not a category of patient. I will again present procedures applicable at the beginning and then mention procedures appropriate later in therapy.

ACCEPTING REJECTION. It is all right with me—though I surely do not like it—when the patient rejects me. Suppose as I sit down, intending to keep the patient a few minutes of silent company, he gets up and sits down elsewhere. As I join him, he angrily moves away again. I call that "responsive," compared to no reaction at all. Now it is not the case that I have nothing to work with except what I bring. The patient is doing and expressing a lot. He gives me a lot to work with if I can tolerate it.

If he continues to leave wherever I go, then I stay where I am, and let him stay there. This is an interaction. He is there but he knows I am here, waiting. He won't join me, but he knows I am here. Much is happening. The whole day room may be tense with it. Or this may occur in an office: he walks out into the hall. Now he is out there and knows I am here. Or I may go out and stand next to him. If he leaves again, I may walk within sight of him and then stop and stay there. The ongoing interaction is a tensed rubber band between us.

My assumption is that I can be rejected. It is not a bad thing for him, if I can take it. How often has he repeatedly rejected someone who nevertheless continued to want to know him? Almost certainly never.

A few minutes of this can be very important. After a while I can go. Before I go I want *some* contact with him. I might say loudly, "I'll see you Friday," and go. Or if he stays within closer hearing distance long enough, I might say, "I know you don't want me to, but I think I can help and I'll be back."

If he will stay where we can talk, I might say, "Why be so scared?" or "I wish you'd stay put for a minute." or (if I see it on his face) "I guess you're mad at me for not leaving you alone," to which his face might say, "Damn right!" and I might then join in a harder-sounding way of talking: "Yeah, but

what good is it if I leave you alone, you'd just stay in here. You've been here—how long? Whatever it is, it's probably long enough. What good am I to you if I leave you alone? That doesn't help anybody." Or his face might say, "You're strange; I don't get you at all; what are you doing?" to which I would say, perhaps, hard and briefly: "I'm a doctor and I sometimes can help people in here. Quit running away from me—I'm not gonna do anything to you." Or I'll just say, "It's all right. I'll be back Friday." Only a few minutes do I impose myself this way, but before I go I want a moment to indicate I have not been overly hurt. Perhaps I just wave good-bye from a distance and go.

Often the patient will refuse to come to a therapy office, yet he will be quite willing to meet the therapist in the day room or hallway. He knows he is free to walk away. Therefore, when he continues to stand next to me, I know I am not imposing upon his freedom if I stay. We stand in the hall. He says nothing. I say the same type of things I already have outlined, but his face and posture respond. Then I respond to that. "I don't know for sure, but maybe you feel . . ." whatever I get from his gesture or motions. I end many such responses with, "But, of course, I don't really know what you feel, that's just what I imagine" or "That's just what *I* was thinking maybe you felt, then, when you jumped away from me."

Many instances of rejecting the therapist require such an interim period of uncommitted hall meetings, in which the patient is free to walk away, but

does not.

I must now mention a series of procedures that involve my actions, before I can deal more fully with this largely subverbal therapeutic interaction.

BEING ACTIVE. If little therapy is happening, the broadest scope of action is desirable. I find it helps me to shift, move, get up, sit down, go for a drink, tell about how my day has been (briefly), smoke, offer cigarettes (as I would do with anyone who is with me when I take out a cigarette), offer to buy him a soda (as I would with anyone when I buy myself a soda), and generally widen what I might do to include whatever occurs to me.

OFFERING HEALTH-APPROACHING ACTIVITY. Any patient activities closer to what healthy people do is probably a good thing. If the patient just sits, then looking up is probably a good thing. If he is always in the hospital, then going out on the grounds and to the canteen is probably toward health. If he will come to the nearby store with me (off the grounds) that is probably toward health. One can see the patient getting his land legs back. “Gee,” he thinks, “I still know how to go to a store! I can still get around.” Perhaps at first he is frightened, goes up to the counter, stands, lets others go ahead, backs off again, no cigarettes bought.

Perhaps we walk into the store together and immediately he wants to

leave ("It's too crowded."). But whatever move he can make toward ordinary health is probably a good thing.

Long before he is willing, I invite him to come outside on the grounds with me to the canteen. He does not even answer perhaps, but then I say that I think he might later want to, and *Vd* like that. *I* thought he might, some time. This process moves from the candy or soda machines, downstairs to the canteen, to the store outside the hospital, to going downtown to a drug store, bar or store.

HELPING THE PATIENT RECONNECT. Long before he is really ready, the patient needs to be invited and helped to reconnect himself to the outside world. We professionals have cut up the field so that one profession, "psychotherapy," is supposed to move the patient from the sick stage (occurring in the office) to the nearly well stage. At that point another profession (social work) is supposed to help the patient with the world he returns to. Still another profession (vocational rehabilitation) works with his possible job, and so on. These other professions often refuse to help until the patient is "well enough," but the patient is not cut up into such slices. He is all one piece and often falls into the gaps between our professions. I have (rather painfully) learned that if I want my patient to move toward getting well, I have to be willing to do these things *before* he is "well enough." I will say, "Later on we will help you find a job in the city; you might want that then." I

say this at a time when the patient cannot even talk. I also say, "I know you can't do that now, but you might be able to, later." Getting reconnected to the world (and perhaps in a situation different from that in which he became sick) is an essential part of the process of getting well. It must not be left "until the patient is ready," or he won't become so.

One of our very good therapists saw his patient for more than two years once or twice weekly. She was often silent and very quiet. Finally he became impatient and urged her to think about getting out of the hospital, perhaps with the aid of vocational rehabilitation set up by the therapist. She responded by saying, "I've been wondering if you'd ever want to *help* me." It seems she had much appreciated this nice man's coming to see her and had silently hoped that sometime he might wish to help her. To her that meant help with her whole situation, not just some truncated separate part (her feelings or "illness").

"Schizophrenia" is being disconnected from the world, rather than in interaction with it. One cannot get well from it first and then become reconnected and interact in the world.

I must invite the patient long before he is ready. After a time, we go to the soft drink machine, the canteen, the store, the city, a job. (Of course, I have time for this only with some. I try to arrange for someone else who will do

this with other patients.)

OPPORTUNITIES FOR INTERACTION. When activities no longer serve as therapeutic vehicles, they can be stopped. Such stopping gives opportunities for therapeutic work. Patients get used to having soft drinks and taking walks, and therein lie two pitfalls: (a) that I shall have trouble bringing to an end for the patient a particularly desirable pattern—a convenient way of getting soft drinks, cigarettes, time out of the hospital—when it ceases to be producing therapeutic movement. Making this break used to be difficult for me, but now I use my feelings of this difficulty just as I use my other feelings. For example, "I don't want to buy you soda anymore—it makes me think now that I'm just keeping things the same, when really you could go out and work and buy your own sodas. So it doesn't seem right anymore. But I worry that I'm letting you down now, when I say this. After all, I was the one who first invited you to accept sodas. In those days you didn't want to take anything from anyone. I kind of forced it on you and I know that." (b) that the patient will not begin therapy at all but will take me for a Gray Lady whose purpose is to make his life slightly better with the soft drinks and canteen. To these patients I say often, "You know, what I am here for is to help you with what keeps you in the hospital," or "And now it's time you tell me something of how you feel, if you can and want to." "Whatever hurts you and has you stuck, so you aren't getting out of here, that's what I'm supposed to help you with. I know you might not think you can get out of here, or maybe you don't want to, or you

aren't sure what you want, but I guess you know, *I* want you out of here. I am looking forward to meeting you in town, in my office. I really can't stand for you to be in here."

Aside from constituting the movement toward health, candy and soda machines and stores provide vehicles for ongoing interaction. You will see that many of my examples in the next section concern my interaction with a patient in front of the candy machine, in the drugstore or in going from the day room to the machine downstairs. For these reasons, I have mentioned these things here.

Occupational therapy was once intended to be this type of vehicle—supplying events so that therapists could respond to patients. In many hospitals it has degenerated into making belts and wallets, usually in silence. (The patient usually does not need a wallet, let alone three!) It has been largely forgotten that such activities were intended to be situational occasions to help interaction occur so that therapeutic responding might thereby be possible.

But one *need* not do all this. Even with the patient I see occasionally for a few minutes in the hall, *there is a situation:* where we should stand, how he feels about others listening, my hurrying away so soon. His and my feelings in any *situation* are a vehicle for therapeutic responding, especially if the patient

is only subverbally responsive.

DOUBLING BACK. Some of my feelings about him in the situation are a good source of responses, if I tell them in a personal, detailed way. The patient we are speaking about may be silent or not, but he is responsive. Every moment something is happening with him, and he shows some of it. Perhaps I cannot be sure just what he feels, but I see he feels *something.* (Note: we are almost always wrong in guessing just what someone feels, but never in seeing visibly that he feels *some* reaction. One can talk to, refer to and accept that reaction, whatever it is, without ever knowing *what* it is!)

One whole set of feelings I have for others in situations comes to me at first simply as discomfort. As I look to see why I am uncomfortable I find content relevant to the person I am with, to what we just did or said. Often it is quite personal. I was stupid, rude, hurrying, embarrassed, avoidant, on the spot; I wish I didn't have to go since he wants me to stay. I wish I hadn't hurried him out of the store in front of all those people; I feel bad that I don't know what to say; I am embarrassed that the nurses see us looking silent and stupid; I wish I had a chair to sit down on.

As we get outside the store (after I have had to insist that we leave), I might say, "Now I'm sad that I embarrassed you in there. I am always worrying about being late and I get rattled. But I wish I hadn't rushed you in

front of all those people—that bad feeling is just what I wish you didn't have to put up with."

Or, as we arrive downstairs at the candy machine, where we are alone, I might tell him, "I am never as comfortable upstairs where everybody listens to us" or "I didn't feel like saying this to you upstairs, I just didn't feel at ease with all the aides watching us."

Or "just then, when you made that face, I didn't say anything about it because I didn't know what to say, but now I wonder, are you mad at me?" or "I don't mind us standing here, but I am getting tired standing. I wish we could go to the lounge, downstairs, where I could sit down." So, a week later, he might lead me to the lounge; it is clear to both of us that this is not what *he* wants, we are doing that for *me* because I get tired standing. "I am very glad you want to do that for me. Thanks!"

Or "I guess you're mad at me because I'm leaving. I don't feel good about it either. It just never feels right to me to go away and leave you in here. I have to go, or else I'll be late for everything I have to do all day today, and I'll feel lousy about that." Silence. "In a way, I'm glad you don't want me to go. I wouldn't like it at all if you didn't care one way or the other."

These examples have in common that I express feelings of mine which are at first troublesome or difficult, the sort I would at first tend to ignore in

myself. It requires a kind of *doubling back.* When I first notice it, I have *already* ignored, avoided or belied my feelings—only now do I notice what it was or is. I must double back to express it. At first, this seems a sheer impossibility! How can I express this all-tied-up, troublesome, puzzling feeling? Never! But a moment later I see that it is only another perfectly human way to feel and in fact includes much concern for the patient and empathic sensitivity to him. It is him I feel unhappy about—or what I just did to him.

A very warm and open kind of interaction is created in telling my feelings this way. I am not greatly superior, wiser or better than the other people in the patient's life. I have as many weaknesses, needs and stupidities. But the other people in his life rarely extend him this type of response.

THE INWARD SIDE OF A FEELING. What I term the "inward side" of a feeling is the safest aspect to express. We tend to express the *outer* edges of our feelings. That leaves *us* protected and makes the other person unsafe. We say, "This and this (which *you* did) hurt me." We do not say, "This and this weakness of mine *made me he* hurt when you did this and this."

To find this inward edge of me in my feelings, I need only ask myself, "Why?" When I find myself bored, angry, tense, hurt, at a loss, or worried, I ask myself, "Why?" Then, instead of "You bore me" or "This makes me mad," I

find the "why" *in me* which makes it so. That is always more personal and positive and much safer to express. Instead of "You bore me," I find "I want to hear more personally from you" or "You tell me what happened, but I want to hear also what it all meant to you." Instead of saying, "When you move so slowly and go back three times, it makes me mad," I say, "I get to thinking that all our time will be gone and I'll have to go without having done a thing for you, and that will bother me all day."

It is surprising how positive are the feelings in us which first come up as anger, impatience, boredom or criticism. However, it is natural, since our needs with the patient are nearly all positive ones for him. I need to be effective in helping him. I need to be successful in helping him arrive at his truth and a way to live. I need to feel therapeutic. When my feelings are for the moment constricted, tense, bad, sad or critical, it is because in terms of some of these very positive needs I have with him, we have gone off the track. No wonder then that when I ask "why" concerning my bad feelings, the emergent answer is positive feelings. I am bored because I want to hear more personal, feeling-relevant things from him. I am angry because our time is being wasted—the time on which I count to be an effective therapist. I am critical of him because I wish something better for him.

But often there is also a peculiarity of mine involved, and this must be expressed. Do such expressions make the patient feel that the therapist is

weak, in need of help or unreliable? I make sure the patient knows I can perfectly well stand what I feel. I will not say much about my unresolved personal problems or situations. I might say, "Today I feel rattled about something that happened to me. It isn't too bad, but it means I might have trouble with the people I work with downtown." Again, here my way of saying it conveys that I know what it is and I can stand it.

OPENNESS TO WHAT COMES NEXT. A response is not in itself right or wrong. One must be sensitive to the *next* moment, the patient's reaction to the response. If I can respond sensitively and well to his reaction at the *next* moment, even if I just said something foolish, hurtful or wrong, a meaningful and positive interaction will emerge.

I used to ponder whether I was about to say a right or wrong thing. Then, if it was wrong (as I could tell from the patient's reaction), I would not know what to do. Now, I spend moments letting my feelings clarify themselves, but once they feel clear, I no longer wonder so much whether it is right or wrong to express them. Rather, I have open curiosity, sensitivity and a readiness to meet whatever reaction I will get. This may tell me what I said was "wrong," but all will be well if *now* I respond sensitively to what I have stirred. I now say whatever I now sense which *makes* what I said before "wrong." (It is not my admission that I was wrong which matters here. I rarely make a point of having been wrong. That matters only to me. I am the only

one who cares how often I am right or wrong. But whatever it is in him which I now sense and which *makes* what I said wrong, I now see it in his further reaction—*that* is what I have to respond to at the next moment.)

ALMOST ANYTHING IS AN OPPORTUNITY FOR FURTHER INTERACTION. Under these circumstances a very intense and eventful interaction occurs. Perhaps on the side of the patient it is nonverbal but visible and active. On the therapist's side, it involves both the concrete moves and facial expressions he cannot help and the verbalizing of his thought processes. Many therapists have remarked about the schizophrenic patient's "exquisite sensitivity." There is a great deal of subverbal patient response. The therapist must respond further to make *further* interaction proceed with warmth and openness.

Therefore, when I have taken a patient out to some stores and then want to discontinue it, I may actually welcome the difficulty. It is an occasion for a close interaction. I will have to tell him that I feel bad about letting him down on a promise, perhaps say that I well remember it was I who first invited him. Perhaps he feels let down, betrayed, angry, disappointed, or what? Whatever it is, we won't hide from each other. I will also tell him I feel it is not a new breakthrough thing anymore. I want to see him well soon and able to go places alone. I don't feel useful anymore doing this and I don't feel good if I think I am not useful. (Or whatever I do feel, in some form I can tell

him.)

In these last sections, I have emphasized bad, troublesome or difficult therapist feelings, because they offer rich sources of personal, positive responding. Of course, I also have many "good" feelings. For these, too, I need a few moments to find a form in which to say them. It is most noteworthy, however, that just in those instances in which we feel stuck or sense that we have just fallen down or are strongly puzzled over what to do next, we have incipient therapeutic responses, if we allow what we sense to become clarified in ourselves. After all, the patient is someone who has difficulties in relating. The patient can move beyond these only if the therapist moves beyond them as he feels them in terms of himself.

IF THE PATIENT CANNOT BEAR ANY RESPONSE WHILE HE TALKS. Sometimes a patient who says a few things after a long silence is sorely oversensitive and cannot bear anything I say in response. If he winces in pain at whatever I say, I am content to be silent.

I just nod when I understand, or I ask for a repetition. I keep my responses and make them *later,* when he is no longer trying to say something to me. At that time, I make them *mine,* rather than loading them on him. I need not imply, "What *you* said meant . . or "means to me. . . Rather, I probably say, "I've been thinking—maybe you feel . . ." (as I would put it if it were all my

own). Some patients can stand anything *I* think but cannot bear the same statements as implications of what *they* have said. It is as if what they said is all that can be stood and *no more.*

COMPRESSED, HARD-TO-UNDERSTAND PATIENT SPEECH CAN BE RESPONDED TO BIT BY BIT. When an isolated, autistic person at last tries to speak with someone, twenty significant allusions may trip over each other in one sentence. I will say, "Just a minute. I want to understand. I understood when you said so-and-so, and I know, I think, that this made you feel such-and-such. Is that right? (Yes.) And then you said . . . and I didn't know what you meant by that. I got you up to there. Tell me again from there. Did I hear it right?" The patient may have said ten or twenty things before I stopped him, and I grasped only the first little thing. But the patient is soon glad to repeat and expand, as he senses that the therapist really wants to grasp each thing, and from then on I really do grasp each thing one by one.

I never let such a patient mumble on. The therapist's bit-by-bit solid grasp and response is like a pier in the patient's sea of autism and self-loss. As each bit is tied to another person who grasps it, the vast, lost, swampy weirdness goes out of things. It is not a matter of this or that content as much as the autistic, isolated manner of feeling and living. If I let him talk, I can then make only a general response which does not affect the patient's lonely autism. The therapist's bit-by-bit grasping and response is needed.

Interview Behavior III: Verbal But Externalized

The third type of interview behavior characteristic of many hospitalized individuals is free and reality-oriented verbalization, none of it "therapeutically relevant" in the usual sense. It is all about external events, about what others did or do, what happened during the week, and so forth. This third category of interview behavior is common not only in hospitals but also in ordinary outpatient psychotherapy. Nearly every therapist has worked for a long period with an individual who spoke almost never about his feelings and affective meanings but almost always about situations and events. Coming to psychotherapy meetings can mean very much to these people. It can be like a life raft for them. One knows something of importance is happening. But it is not psychotherapy, as the repetitions over the years eventually show. Without rejecting or destroying the desperately needed support which such a relationship does give, how can we bring into it the missing therapeutic process?

This "verbal but externalized" group included a number of our hospitalized patients as well as most of our *normal* subjects. Thus one should not assume too quickly that externalized talking indicates abject fear, "schizophrenic flattened affect" or unusually great repression. Perhaps externalized talking also indicates that the individual does not feel it to be appropriate to express his feelings. Whether the individual is labeled normal,

neurotic or schizophrenic, verbal but externalized interview behavior presents the same problem and demands some of the same kinds of response from the therapist.

THE INTERNAL FRAME OF REFERENCE REDEFINED. I respond in such a way that what I say about the individual's feelings *can be checked by him if he will directly refer to what he feels.* Quite often, unfortunately, he will not try to check what I say, will not try to pay inward attention to his felt meaning. But my responses are intended and phrased so that he *could* directly find and feel what I say. My response achieves its purpose if he refers directly to his felt meaning. My responses need not be correct; it is just as helpful if it results in "—No, it's really more like. . . ."

Rogers called this type of therapist response "taking the client's internal frame of reference." As I define it, such a response says something which could be directly found and felt by the client. It is not an explanation, generalization, external observation or behavior definition. What is it then? It is a statement such that if the individual will attend inwardly directly to his whole "feel" of what he is saying or doing just then, he will find there the feeling or meaning at which my response points. Or if I am not quite right, he will find there whatever is there.

This type of response moves from the sharply defined units of speech

(in what he *says)* to the as yet undefined (but directly felt) mass of personal meanings and feelings he has as he speaks.

For example, the client is angry (says or shows it) or, more exactly, he *might he* angry (so often my first impression is wrong). But in addition to a well-defined unit (like "anger") there is always a whole mesh of feelings and meanings. He is angry *at* me *for* doing such and such *because* it seemed to prove I did not care for him in a certain important way, and this upsets him *because* he had invested himself and now feels let down, which makes him feel desperate and makes him vow not to get "conned" again as he has so often before, when he ... . This chain is just an example of the texture always implicit in felt meanings. Therapeutic movement in depth consists of such further steps into a felt meaning. I want to respond to the felt meaning so that he will attend to it and move such steps. I can do that by pointing my words at "this whole way you feel" without knowing much about it. (Any bit I do sense helps me phrase a more specific pointer.) I *point* there and invite the client to look there. I would like to know what he really *does* find as he looks there. I am gladly corrected if he finds something different or if other words seem to him to fit better.

For example, I say, "I guess you're scared." He checks against his feeling of it and says, "No, I'm not scared at all, I'm determined." I accept that. The word "determined" better names what he has there. Whatever he names it, I

want to hear more from it. He continues, " determined not to let them get me, not this time, by God!" Now I am hearing more from it. Again I respond, "They've always got you before, but you've made up your mind, you won't give in now." "Right, and another thing is . . ." (I prize this "and another thing is"; another thing usually will come up when we move into felt meaning). "And another thing is . . . the way they get me is ... I start to say, 'No, I won't go along with it' but then I get mad and I don't get mad like I should, but instead I go to pieces, I get all nutty, I carry on, and then they've got me."

Notice that if I am a stickler I can insist that of course this patient *is* scared. I was right in the first place. But we would not get into felt specifics if I stick at general words. It does not make much useful sense to say he *is* or he *is not* scared. What he has there is always a texture of much more specific felt facets. He *is* (if you insist) scared *of* that which he is "determined" to avoid. I am content with any words and any corrections of what I say, so long as we can keep *pointing* at his present mesh of felt meaning and taking concrete steps in it.

AN IMAGINED FELT REFERENT. Even when I know perfectly well that the client is not working on anything, I ask myself what *might* he be working on if he *had* said this given thing as part of a therapeutic exploration? That leads me to sense or imagine an aspect of it which he might feel and which can set a therapeutic process into motion.

CREATING AN "IT." Even when the patient does not indicate that he has any tissue felt meaning there at all, I create it. I imagine it: a felt sense of "all that" he has there, feels and *could* pay attention to if only he would! I have no sharp idea what it might be like, but I can respond deeply, even with my vague sense of it. For instance, he says, "She'll take me for every cent I've got" (meaning his wife, who is getting a divorce). I know he is not "working on" anything therapeutically now. Yet, if he were, he might what?—look at his whole texture of felt meanings concerning his marriage, his being imposed upon, his helpless feelings, his passivity, his important anger, his sense that some of his perceptions are after all realistic and trustworthy. He is not intending to look at, or work on, any of these themes, but I can invite him to just by responding, "And what's awful is, here you are, helpless to do a thing about it." Perhaps his next remark enables me again to point at a felt referent. I nearly always point at felt referents. If one in a hundred opens out, that is an adequate percentage for movement.

REFERRING INTERPRETATIONS BACK TO PATIENT'S SPEECH OR ACT. Whatever general (diagnostic or other) conclusion or impression I have of him, I received it *from him*—from his behavior and speech. I can give it to him best if I remind myself how he gave me this impression. Then I can respond to that more specific feeling, statement or behavior rather than giving him only the general conclusion. For example, I can say, "When you said . . . it got me to thinking . . ." Another example: "The way you stand there so sadly—it looks

sad to me, I don't really know—it makes me wonder whether maybe you think they won't visit you, even though you say they will . . ."

ANYTHING IS "AN OPENER." I can choose to look at anything said as only an opener to a more personal communication. If the patient sees me smoking and says, "Smoking is bad for you," I take it as an opener to relate, to talk about me, touch me, discuss both his and my self-destructive behaviors, weaknesses and so forth. Similarly, if the patient says, "Can you get me a weekend pass?" (I know I can't), this can become an opener to a conversation about me, him, wishing to get out of the hospital, home, the people he would see if he went home, whether they really want to see him or not, etcetera. Of course, nine times out of ten my attempts at such a conversation fail, but the tenth time I succeed in developing it.

RETROACTIVE RESPONDING. If I wish I had responded some way a few minutes ago or last week, I do so now. (I used to think I had to wait until the client brought it up again.) I might say, "You know, a while back, when you said such and such, well, now I think about that, and I think . . ." or "Last week, when I drove home, I thought that maybe you . . ."

UNTWISTING. I will not remain what I call "twisted." If the patient has somehow gotten me to seem in a way I do not feel, then I no longer feel "straight." I feel "twisted." Perhaps I am responding socially, smiling, while

actually I know we are avoiding something. Or perhaps I have promised something I do not wish. I feel "twisted" out of my own shape, and I will not stay that way. It may take me a few minutes to work my way out, but I won't silently let it pass. Soon I will say, "I think now that I don't want to do this thing, which I promised a while ago. I don't feel good about disappointing you, and maybe, if you're mad, you're right—but I won't do it." or "Well, a while ago that business about so and so seemed real fine, and we both said it was great, but now I wonder, maybe are you making it sound better than it is?" Such instances are opportunities for more direct relating between us.

NO UNMENTIONABLES. Anything that seems unmentionable is really an opportunity for more direct relating. If the client implies (or I sense) some very painful, threatening thing, I respond to it. I believe the client *already* has and lives such a thing, if it is there (if, as he checks inside himself, he finds it there), and I cannot protect him from that. I have the choice only whether to leave him alone with it or keep him interactive company with it. I won't wait until the client brings it up himself. He is probably doing just that, right now, as best he is able.

Often the patient refers to something which is unmentionable because it "dare not be," cannot be tolerated; for example, "that they don't care for me"; "that I am crazy"; "that the therapist doesn't care for me"; "that I am ugly" and so forth. It helps if I speak these out loud. The patient is still here. He has not

been shattered. I phrase it with a "maybe" so we can back out if need be. I say almost lightly, "Maybe you're awful scared you really *are* crazy." or "Maybe I don't care for you at all" or "Maybe you're too ugly for anybody to like." The result is usually relief. I respect the patient, not the trap he is caught in.

TWO-SIDED COMPOUND. The reasons against expressing something must also be included. Whatever in my feelings holds me back from expressing something, that too I can express, and in fact, I *can* express the two-sided compound, whereas I did not feel I could express just the one feeling.

For example, to say just, "I think maybe you're very scared that you really are crazy," might scare him all the more because he might feel that *I* think he is. Actually, he often makes very good sense about many things and if I express that too, "Actually, you make very good sense about a lot of things," the first sentence becomes a safe one. This therapist expression becomes possible for me as I decide to voice also that which at first stopped me from expressing my feeling. Another example: "I don't like it when you do that, and I don't want you to do it anymore. *But I think you do it to . . .* and I like *that."*

POSITIVE RECOGNITION. That last example illustrates a special case, the case where I need to set a limit or call a halt to some behavior. I can do this more easily (and I think more therapeutically) when I find and voice the

patient's positive thrust in so acting. For example, I might not let a patient touch me or grab me. I will stop the patient, but in the same words and gesture I will try to respond positively to the positive desire for closeness or physical relations. I will make personal touch with my hand as I hold the patient away from me, contact the patient's eyes and declare that I think the physical reaching out is positive and I welcome it, even though I cannot allow it. (I know at such times that I may be partly creating this positive aspect. Perhaps this reaching is more hostile right now than warm. But there is warmth and health in anyone's sexual or physical need, and I can recognize that as such.) The total effect of such stopping is therapeutic and positive, a moment of contact, because I have expressed not only the limit but I have also met the positive thrust.

We often find it difficult to set limits because we fear to hurt. I do not say, "I'm afraid to hurt your feelings," but rather I say what these feelings are in him (which one might fear to hurt). I can recognize these in him, and usually they are positive.

THERAPIST-SUPPLIED AFFECTIVE MEANING. The patient talks, perhaps gets much value from having a friendly caring listener, but nothing of therapeutic relevance is said. There is only talk about hospital food, the events of the week, the behavior of others, a little anger or sadness, no exploration.

I become the one who expresses the feelings and felt meanings. I say, "What a spot to be in!" or "Gee, and they don't even *care* what *you* think about it," or "I guess that leaves you feeling helpless, does it?" or "Boy, that would make *me* mad," or "It must be sad that he doesn't care more for you than *that,"* or "I don't know, of course, but I wonder, do you wish you *could* get mad, but maybe you don't dare?" or "I guess you could cry about that, if let yourself cry."

Sometimes I must retell the events in such a way that the probable felt meaning emerges. For example, "So your mother and your husband decide even which laundry you should send your stuff to. I guess they decide everything. Not much of a home of your own? Must be a helpless feeling?" (Patient says nothing.) "Maybe kind of *insulting* to you?"

Sometimes I say such things on my own responsibility: "I wish they'd care for you more than they seem to."

At first the patient's only reaction may be a brief blank look, after which he resumes his narrative, grateful that I let him (that I do not stop us and insist on the feelings to which I pointed). I am always willing to let him ignore what I say and go on; that helps him to stand my expressing such feelings.

THERAPIST TRUTHFULNESS. I try not to do anything phony, artificial, untrue, distracting or unreal, ever. Of course I do many phony things before I

even notice them, but that gives me a chance to double back and express the truth. We must help patients five with, in and through what *does* confront them, the world they *already do* live in. The patient can successfully five only with what *is* there. There is no way to live with what is not, with falsehoods, with artificial roles played by psychologists. One cannot learn to live with the untrue, no matter how good its untruth might be. Really, the untrue is not there in a fullness that can be lived *with.* On the other hand, saying what is true helps because it is *already* there and one can learn to live with it better and differently.

For the therapist to be committed to the truth has another advantage: truth has its own check within the patient's (or the therapist's) felt mesh of experiencing. To seek truth we need not be bright, or guess rightly, or choose wisely.

THE CLIENT-CENTERED RESPONSE. Whenever there is anything to respond *to,* when the patient says, does, conveys or acts out anything, then the best response is still the client-centered response. In such a response I attempt as plainly and purely as possible to voice my impression of what the patient means and feels at this moment. Nothing else is as helpful and powerful as that sort of response. It lets the patient know that he has been understood; it focuses his attention on his felt referents so that he can check what is said and carry it further; it shows him that I consider his felt meanings

the ultimate deciding basis for what is true and what is not; it generates the therapeutic process of experiential movement; it tends to lead him to pay attention directly to his felt meanings without distorting them by what he or I may think; it lifts erstwhile private, hardly bearable aspects into the non-autistic interpersonal world; it lets the patient experience not only what he already knows he feels, but also what he almost but not quite feels (so that he feels it clearly, after it is spoken of); it keeps my own person and feelings clearly separate from his person and feelings so that there is room for both to be clear and undistorted; and it is the only way I know in which feelings that are too chaotic, weird and painful to bear can come to be lived with and borne. Such an interaction process provides solidity, clear intention, simplicity, respect and openness. Any feelings that are concretely lived in that manner become not only known, but also take on that manner. Therefore, their implicit sense and positive life thrust can emerge and the individual can come alive in a way that lessens the desperation and alters the very quality of these feelings.

Thus the various procedures I have described in this chapter are primarily used when the patient does *not* interact with me, is *not* (over a long period) saying, expressing or acting-out anything meaningful. When, through any of these channels, he *is* communicating meaningfully, then my response is the one long associated with client-centered therapy—the effort accurately to sense the client's felt meaning at that moment and to communicate to him my

understanding of that meaning as clearly as possible.

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