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How Therapists Perceive, Think, Sense, and Process Their Experiences

The Compleat Therapist

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There was a time, long, long ago, when I was so anxious about doing psychotherapy, and so enamored of its complexity, that I was able to stay present with most of my clients practically al of the time. Sessions seemed over in a matter of a few brief moments. I was able to focus my concentration so totally on what clients were saying and doing that I, as a separate being, ceased to exist. I became so immersed in the activity of doing therapy, so intrigued by all its nuances, so fascinated by the experiences of my clients, that I could never have dreamed of leaving the room for more than a moment or two.

It is now many years later, and I notice quite a different phenomenon occurring: there is not a single client I see with whom I do not, at periodic intervals, tune out what they are saying and go off into my own mental world. Most of the time, these are fleeting moments — flash images that are provoked by something the client said or did. Yet with some clients who I find especially difficult to be with, I leave the room more often than I would like to admit. I am, of course, uncomfortable about these self-indulgent lapses that, while excusably human, are nonetheless unprofessional. I feel guilty that I am paid to listen to people, to give them my undivided attention, and sometimes I only pretend to fulfil my end of the contract. And I am curious about what this

behavior, these trips inside my mind, say about me. I wonder what other therapists do inside their heads when they are not at ending to the business at hand. Where do other therapists go when they leave the room?

The whole subject of what goes on inside therapists' minds is so interesting — not just when we are off into personal reveries, but more so when we are really humming along with a client, tracking speech patterns and nonverbal behavior, interpreting underlying meanings, sorting out and making sense of what we see, hear, feel and sense. And there is a distinctive way that therapists who are most effective in their craft are able to use their brains — a cognitive process that is both rational and intuitive, focused yet flexible. In short, professionals who are good at helping people resolve their difficulties are able to think in a multidimensional mode that transcends disciplinary boundaries. They stretch beyond conventional reasoning in ways that allow them to discover patterns, apply their skills and knowledge, and perceive things that are invisible to all but the enlightened.

Multidimensional and Multidisciplinary Thinking

So much of what constitutes good therapy involves understanding and explaining complex, abstract phenomena in more comprehensible terms. Most of our useful theoretical concepts were derived from ideas borrowed from allied disciplines; these ideas were then translated into instructive

metaphors for our own purposes.

Freud likened the psyche to the biological systems he was most familiar with. He relied on the literature of Shakespeare, the philosophy of Nietzsche, the science of neurology, and the investigative methods of anthropology to visualize the concept of the unconscious as a place to excavate layers of awareness.

So many other concepts — such as homeostasis, systems theory, even the now common idea of "feedback"—are the result of a cross-fertilization between the sciences, the arts, and our own discipline. Theoreticians and therapist trainers such as Rollo May (1986, p. 215) have proposed for many years that clinicians could best be trained by majoring in the humanities rather than in psychology as undergraduates, since "it is the humanities which give them the myths and symbols with which each age sees and interprets itself." The study of history, literature, the arts, and philosophy prepare the student for understanding the past and future.

The best clinicians are thus intimately familiar with fields other than our own. They are fluent not only in the languages of psychopathology and developmental psychology, but of biochemistry, and other social sciences, and the humanities. Within the discipline of philosophy alone, therapists must be familiar with each specialty. We delve into the realm of metaphysics by

attempting to formulate notions of universal reality, of how the world works. We are students of ontology in that we hope to discover for ourselves, and to facilitate in others, the basic structure and meaning of existence. Ethics, of course, plays an important role not only in guiding professional conduct, but in helping the client answer the questions, "What is right for me?" and "What ought I to do?" Logic is the basis for the scientific method and sound reasoning that are so much a part of clinical diagnosis and decision making. Finally, epistemology is that branch of philosophy concerned with the nature of knowledge. The pursuit of knowledge is of course central to almost every aspect of our enterprise.

Therapists think in multiple dimensions, constantly shifting from the concrete to the abstract and back again. One minute we are using a mathematically sound system of logic to reason through possible cause-effect relationship, and the next we are spinning a complex metaphorical tale to symbolize instructive concepts. From there we may drift to the principles of developmental stage theories, and then to a discussion of themes in a particular move or book. Finally, we move back into the realm of the sciences when we explore physical symptoms or medications.

Consider, for example, the case of a client manifesting symptoms of anxiety. Initially, we might conceptualize the problem in functional terms: How is the problem helpful to the client? What is the discomfort drawing

attention to that the client has been avoiding? What are the symptoms communicating? What do they represent or symbolize?

We next move from the functional in our thinking to the pragmatic. We start collecting specific information that might be useful. “When do you feel most anxious?” “What is it like for you?” “When did the symptoms first begin?” “How do you and others react?” “What have you tried so far to cope with the problem?”

From this point the therapist can shift in a dozen different directions, depending on particular specialties and interests. Perhaps a discussion will ensue based on the therapist’s devotion to cognitive/linguistic considerations: “What do you tell yourself about the problem?” “How do you talk to yourself when you first become aware that you are feeling anxious?”

An interest in history can play a part: “Who in your family has had a similar problem?” “Have you ever had a similar feeling before?” Perhaps there would be attention to biological factors: “What happens in your body when you feel anxious?” “What effects have various medications had on your symptoms?” Literature might be brought into the session, or at least metaphors, stories, and images that have been drawn from films, the theater, or books, to highlight a certain point: “Perhaps you recall from your college days in the sciences that the body reacts in protective ways even when it

misinterprets the perception of danger. The sympathetic nervous system is at work creating the sweating, rapid heartbeat, and adrenaline rush that scare you so much; it does so because it is overreacting to cues that it thinks are life-threatening and is therefore preparing you to run or fight.

The therapist has now shifted back and forth between disciplines and dimensions, constantly drawing on all of the wisdom at his or her disposal. Just how broad that base of knowledge is will determine the degree of creativity that is possible and the number of choices that are available in the selection of an intervention or course of action.

Searching for Patterns

The multidimensional and multidisciplinary perspective that is part of the effective therapist's style of thinking allows him or her to take in a vast assortment of information and process it in such a way that it can be organized, interpreted, and acted on. There is a scientific training component to the education of most therapists because of the belief that it teaches us to think more logically while reducing biases (Arkes, 1981; Turk and Salovey, 1986). This, in turn, is supposed to facilitate objectivity in clinical reasoning and to control excessive subjectivity that is often seen as an impediment to successful outcomes.

Most training programs favor models that teach clinicians to function

like behavioral engineers — learning to be familiar with structures, materials, and interaction effects. However, unlike the scientist who is concerned with verified truth and the discovery of new phenomena, the thinking processes of the effective clinician lean more toward the utility of gathering information: "A scientist uses the results of experiments as a steppingstone to refine the underlying theory and to formulate new questions. A clinician usually sees her task as completed when a therapeutic option has been effective" (Kanfer and Schefft, 1988, p. 13).

Therapists seek to apply scientific principles, combined with intuitive flashes, in the discovery of forms and patterns that emerge as part of the therapeutic process. We do this by drawing connections between things that were said or done earlier on the one hand and current events on the other, identifying thematic elements in the content of sessions and tracking the sequence of events. So much of the cognitive activity inside a clinician's mind consists of a series of judgments (Brehm and Smith, 1986; Gambril, 1990). Should I do this or that? Is this person psychotic or suicidal? What would be most helpful right now? How am I doing so far?

Clients present themselves and their stories to us in a way that has some meaning, however disguised it might be. As we listen carefully, and watch the process unfold, we are constantly trying to do two things simultaneously: stay with the client in the present moment without judgment,

and make continuous evaluative decisions in our minds with regard to organizing and making sense of what we have heard.

Piaget offered us the concepts of assimilation and accommodation to describe cognitive functioning during information processing. That which cannot be assimilated into existing schematic structures must be accommodated by the creation of new categories of understanding. Someone who could overhear the inner workings of a therapist's mind would hear a lot of questions like the following: What is this similar to that I have seen before? How does this fit, based on what I already know about human beings in general and this person in particular? What is the big picture of which this is only a small part?

This distinctive style of process patterning is illustrated in the following case. A woman returns to treatment after a year's absence; earlier she worked on issues of marital adjustment for six sessions. *(What is she doing back again?)* She reports that she would like help with a particular problem that is disturbing to her. *(Why now?)* Although she has no difficulty driving her car anywhere in the city, there is one particular stretch of highway that causes her tremendous anxiety and discomfort. *(I wonder what that means?)*

As we get into things further, she brings up other issues — her job dissatisfaction and lack of direction in her life. *(What is the connection of these*

issues to her presenting complaint? What is the meaning of that special section of road?) I ask her to describe that part of the highway: "It has very high wall s, almost as if I am driving through a tunnel. There's no exit for several miles in any direction. It's also located real near where my parents live." *(Aha!)*

The client reports her family history as unremarkable: "Growing up was just like *Leave It to Beaver.* Both my parents are great. We've always had a good relationship." *(What is she not telling me?)*

We move along, and as our relationship progresses, she casually mentions that she can now drive on that stretch of road with minimal difficulty. However, now she reports she has trouble sitting in restaurants. *(There* is *a pattern here. But what is the connection?)* We explore issues related to her poor self-esteem and what it means to her to feel closed in by walls or trapped in a place she cannot escape from. She realizes the extent to which she seeks the approval of others for every decision she makes. *(What does she do to seek* my *approval?)*

Her latest issue is related to fears about a lump her doctor found in her breast. It is apparently benign, but the doctor wants to do a biopsy anyway. Should she get a second opinion? She seems unduly concerned about what is appropriate. She consults the opinions of everyone in her world and carefully relates each one of their reactions. *(Wait a minute! Something is missing. She*

has asked everyone what they think — everyone but her mother.)

I ask her.

Anger. Tremendous rage.

And, finally, out with it: her mother has never trusted her judgment. As a child, her mother protected her utterly and completely. She learned not to trust herself or her own opinions. Everything was done for her, and anything she tried to do herself was undermined. As an adult, she feels incapable of taking care of herself or making her own decisions — the source of her symptoms and poor self-esteem.

I present this case precisely because it is so familiar to most of us. It illustrates the process of how we think during the therapy process: listening, sorting, framing, adding, deleting, organizing, compiling, trying out different approaches. There were many hints during the therapy process that could have highlighted the patterns of this woman's issues. And it only takes a few key pieces for the puzzle to reveal itself.

Would a dozen other therapists working with this client have reached the same place? It is doubtful, because there are so many possible explanations that could account for her problems and so many different ways to think about them. Nevertheless, all therapists think in terms of themes,

patterns, and structures, even if we do not agree on what they should be call ed. If we are skilled at teaching the client about the therapy process, we do not even have to be the ones to discover the underlying structures; the client is fully capable of doing so herself or himself.

We attempt to teach clients to think in a special way, to look for recurrent themes, common denominators, significant factors, essences, and patterns. We ask clients to pay attention to the process that is unfolding in our relationship, to their feelings toward us, to their style of communication, to the way they interact with us. It is the mutual understanding of these structures, sequences, and patterns that forms the basis for much of the therapy (Rothenberg, 1988).

Rice and Greenberg (1984) describe the principles that underlie the therapist's discovery of process patterns. The object is to recognize recurrent phenomena — those episodes, that while not identical, occur with regularity in most therapy work. These include transference reactions, resistance, and moments of insight. The particular incidents that are studied in depth and the phenomena that are explored most fully are chosen on the basis of one's operating theory of change.

Clinicians give different weight to the importance of some client behaviors over others. There is a template overlay in the minds of most

therapists, guiding us as to what to look for, what is significant, and what usually unfolds. While this operating theory can be helpful in signaling us what to watch for, it can also be a hindrance.

Spence (1982), a dedicated psychoanalyst, finds his or any general theory to be confining in that established rules of practice limit our ability to see things as they really are. This is because we are so busy trying to find patterns that we expect to see: "To the extent that the analyst is guided by certain kinds of presuppositions, he will tend to understand the material in a more restricted fashion. He is handicapped in his task of constructive listening by the search for certain kinds of universals, and if some of these universals never appear, or appear in somewhat different forms, he is handicapped even further. He may, for example, miss the interpretive opportunities of the moment while waiting for some vague shape of the future" (Spence, 1982, p. 293).

How does one operate in unknown territory without any sort of map? How does the therapist work in the mysterious, ambiguous, confusing maze of human suffering without some idea of general guidelines regarding origins, causes, and antidotes for the problems?

In answer to this dilemma, Spence (1982) feels it is crucial for a therapist to be a "pattern finder," not a "pattern maker" who is inclined to

create reality from a biased interpretation of the facts. He explains that because the "truth" that clients describe as their experience is not really what occurred, and because the truth the therapist hears is not really what the client said, more and more degrees of distortion occur between narrative and historical truth. Those therapists who are able to use their theories as rough outlines rather than exact blueprints for what will emerge are able to exercise the degree of flexibility and openness that is needed to become a more accurate observer of reality.

Applying the Principles of Clinical Inference

What keeps us honest and accurate in our perceptions is the application of scientific principles to case analysis. This is the methodology that begins with the systematic study of all the background relevant to the presenting complaint, including what is known and has been tried before. Dependent variables that will be used to measure results are functionally defined. Predictions are made as to likely outcomes that may result from certain interventions. These hypotheses are tested by manipulating independent variables. Finally, results are evaluated and inferences are drawn as to what has been learned.

All in all, this is what therapists are introduced to in graduate school as The Scientific Method. It is presumed that such training teaches

practitioners/scientists how to reason logically and how to frame questions that can be addressed empirically. While such a model is quite helpful in writing theses, dissertations, and articles, there are certain limitations of the application in clinical practice. For one thing, we cannot ever isolate variables and manipulate them one at a time. Nor can we take the time to do a thorough review of literature and data related to the case. And further, it is so hard to remain objective, detached, and uninvolved with the "subject" when we have spent so many intimate hours together sharing ideas and feelings.

Effective therapists do, however, adapt the empirical method to their thinking on a regular basis. It is what allows us to sort out all the data flowing in, to formulate impressions of what we believe is happening, and then to double-check it and alter our diagnosis and treatment plan to better fit the specific needs of the client. We also apply principles of scientific reasoning in formulating and trying out new hypotheses, relying on logic to solve problems, and most of all, by investigating which methods have been found to be most helpful through systematic research rather than solely based on intuition or single authorities (Gambril, 1990).

Therapists who follow the hypothetico-deductive inference method of diagnostic reasoning tend to think about their cases as puzzles to be solved. Not unlike the way an internist might approach a complaint of abdominal pain, the therapist would formulate an initial conception of what he or she

believes is going on based on the limited data available. For example, the client reports feeling anxious and uneasy. He is not sleeping well and is feeling restless. He worries a lot. I then generate an initial problem formulation of "anxiety neurosis" and begin to test a set of hypotheses to confirm or reject this conception. Further exploration becomes focused not just on a complete picture of the client's world and functioning, but more specifically on the evidence of symptomatology related to this diagnosis.

Obviously, there are some problems with this kind of clinical reasoning since one's initial perceptions of what is going on can act as self-fulfilling prophecies that may cloud a more complex configuration of reality. For example, in the case described above, I learned that the onset of anxious feelings occurred right after a major life transition. The client recently moved to the area and just moved into a new house and began a new job. Because the data appear to fit the initial hypothesis, I may very well stop the exploration process, convinced that I have gotten to the bottom of things.

After six months of treatment this client made mild but erratic progress, eventually leaving therapy when he had convinced himself that he felt much better. And indeed he did understand himself better, even if those infuriating anxious feelings were still around. By this time, I was thoroughly convinced it would just take more time and patience, and so I neglected to look beyond the obvious. For example, when the client went on vacation for a week and felt

considerably better, I concluded: “You see, you get away from the stress of your job and look how much better you feel.”

Yet the client persisted in explaining that he liked his work and did not feel especially tense at his office. I called this “denial.” The client, at this juncture, decided to stop the sessions for a while, since he was not improving much more. I called this “resistance.”

Six months later the client called to schedule an appointment. Smugly, I replied, “Oh, I see you’re finally ready to deal with your unresolved issues.” The client showed up for the session calmer and more relaxed than he had ever appeared before. Before I could even begin, the client explained that he was not interested in resuming treatment but had made this appointment as a courtesy, in that he felt I might wish to know what had transpired. It seems that the furnace in his house started making strange noises, and so he called a repairperson who tested the equipment’s functioning and reported that there had been a leak. There was a dangerous level of carbon monoxide circulating through the heating system since he had been in the house. The maintenance person then asked him if he had been feeling strange since he moved in — any symptoms of restlessness, dizziness, anxiety, unease?

My persistence in holding onto an initial diagnosis kept me from remaining open to other possibilities, and most of all, from trusting my

client's intuition as to what might be going on. While this is a highly unusual case example, and one in which we could hardly expect any therapist to discover the physical cause of the symptoms, it nevertheless illustrates how the therapist's overconfidence, arrogance, and rigidity can get in the way of clearer thinking.

According to Elstein (1988), the therapist can, however, make good use of this clinical inference method of thinking described earlier, in spite of the dangers described. He believes that effective therapists have several things in common in their thinking.

1. They are able to draw on a base of knowledge and expertise that is compiled and organized in such a way that it can be easily retrieved.

2. They are highly flexible and adaptable in their thinking. They are able to apply a basic set of principles in unique ways to novel situations. They are quite willing to change course whenever the data do not fit (rational analysis) or something does not feel right (intuitive processes).

3. They have a sequence of procedural rules that are not easily articulated but that nevertheless guide thinking processes throughout interactions. Their clinical judgment consists of a series of logical and highly functional steps that are based on integrating previously successful and unsuccessful outcomes. Schön (1983) describes this effortless reflection-

in-action as what allows all effective practitioners to go beyond standard applications of technique with recognizable problems to the ability to handle cases they have never seen before. This highly intuitive form of applying existing concepts to novel situations is the correction for routine action.

4. They are able to apply generally recognized principles of practice more efficiently than those with less experience or talent. Their observations are not only more accurate, but they come to them more quickly.

With these qualities inherent in their style of reasoning and problem solving, effective therapists are able to draw a number of inferences based on the limited information available to them at the time. This is illustrated by the following representative situations in which a therapist might demonstrate sophisticated reasoning processes.

1. *A definable pattern from seemingly unrelated data.* "You have said previously that things were always easy for you growing up. You also mentioned how prone you are to erupting in temper tantrums. Further, I have noticed that with me, you become impatient when I don't immediately grasp what you mean. When you put all this together, it seems to point to a man who tries to impose the unrealistically high expectations you have for yourself onto others."

2. *A set of hypotheses regarding treatment strategies that are based on initial impressions.* "It is unlikely that medication would work

in a situation such as yours since your depression seems to come from a specifically induced episode — the loss of your job. I think that if you give us both a few weeks to help get you back on your feet, you will find your sleep and eating patterns leveling off. I also think that asking your family to join us might be helpful. Then we can all begin to examine some options you might have."

3. *Probabilities that certain things are likely based on factors in evidence.* "I take your suicidal fantasies *very* seriously, However, because you have children who would be helpless without you around, because you don't have a definite plan as to how you would kill yourself, I don't think hospitalization is indicated just yet. Let's keep a close watch to see if things change. And of course you can either call me or check yourself in if you feel that would be helpful."

4. *Predictions of what may occur based on past performance.* "Somehow, I sense that by agreeing so readily to my suggestion, you are not all that committed to following through with it. I have noticed that has been a pattern when you want to sabotage yourself."

5. *Generalizations about people in general from the study of a single case.* "Now that you mention how uninhibited you are when you are alone, acting out fantasies, and talking to yourself in funny voices, I suspect that most of us inhabit a secret world in private."

6. *Generalizations to an individual based on knowledge of people in*

general. "I can well appreciate the ambivalent feelings you have toward your wife as you go through this divorce, especially with all of the mixed messages you have been getting from her. It isn't all that unusual that you would feel such adoration and rage toward her at the same time. It is not even so rare that the two of you would end up in bed again before this separation process is completed."

7. *A universe of possible meanings ascribed to a single behavior or situation.* "This silence has been continuing for some time and you seem at a loss as to how to break out of it. I have been wondering to myself whether you are taking time to process what has happened so far, whether you are deciding where you want to take things next, whether you are confused about what we just discussed, whether you are waiting for me to rescue you, or whether you are testing me in some way to determine if I am worth trusting."

8. *The features of a case or narrative that are most significant and relevant.* "You have presented a lot of information during the past hour—that you are experiencing marital problems, that your job is in jeopardy, and that recently you started to lose sleep and become depressed right after your boss put you on probation. We will have plenty of time to explore those issues later. For right now, I am especially interested in the history of bipolar disorders in your family. And you also mentioned that several years ago you had an episode very similar to this one, although at the time there was nothing you could point to that provoked it. I think before we proceed further with our therapy it would be a good idea for

you to get a psychiatric consultation."

9. *Things that may have occurred in the past based on present levels of functioning.* "When I just pointed out to you something you were doing, you jumped all over me as if I were attacking you. It seems like you have been brutally criticized by someone close to you before."

10. *Things that may occur in the future based on present levels of functioning.* "I know you are having a good day and are thus trying to convince yourself that the worst part is over. And I don't mean to discourage you, but I think it's a safe assumption that setbacks are inevitable. The new strategies you are practicing at home are still a bit awkward for you so it is going to take a while before you get the results you want."

Each of these inferences allows the therapist to diagnose accurately what clients are experiencing. They even allow us to infer when inferring is not appropriate and it is time to go with something else. The complicated process of diagnostic thinking, for example, involves much more than applying the principles of hypothetico-deductive reasoning.

Forming Diagnostic Impressions

To do good therapy, the clinician must be skilled at figuring out what is going on with a client, what the difficulty is, what is contributing to the

problem, and what will probably be most helpful in alleviating it. This diagnostic impression is formed by some therapists within the first thirty to sixty seconds after meeting the client (Gauron and Dickinson, 1969), and most therapists create some kind of preliminary diagnosis within the first three minutes (Sandifer, Hordern, and Green, 1970).

We form such quick impressions as much to alleviate our own discomfort with ambiguity and uncertainty as for the client's good. Each client who walks in might be the one we cannot help. We may wonder whether we will know what to do. Will this be beyond our expertise? So there is immediate relief after settling on a working diagnosis. It is not usually the one we will stay with, but it helps us get a start with something familiar before we begin to explore the unknown.

This initial diagnostic formulation gives us a conceptual framework to begin systematic explorations and hypothesis testing. We start by noting, "This is a depression. There's no apparent severe personality disturbance. Appears to be functioning reasonably well. Has good relationships with others." We can then pin things down further: "Is the depression reactive or endogenous? Acute or chronic? Intermittent or continuous?"

It is not that there is anything especially wrong with forming an immediate impression of the client, but effective therapists will let this

impression go in the face of new and contradictory data: “The client did use the word ‘depression’ to describe the way he had been feeling, and indeed some of his symptoms like loss of sleep and appetite seem to be vegetative signs. But he’s been taking medication for high blood pressure. And he calls *everything* depressed that doesn’t meet his expectations. In fact, his self-obsession and narcissism are what seem to be his primary problems.”

Arnoult and Anderson (1988) describe the ways effective therapists are able to reduce biases in their thinking, such as faulty causal inferences or the persistence of erroneous beliefs. They are able to counteract their tendencies to form inaccurate decisions by generating multiple cause-effect relationships to keep thinking open and flexible (differential diagnosis). And they do not jump on the first idea and stay with it in the face of conflicting data. They demonstrate a healthy degree of doubt and uncertainty: “What am I missing? What don’t I know? What can’t I explain or account for?”

In a previous section we examined the process of pattern search in the context of how a therapist characteristically thinks and organizes the flow of data that stream in. The goal of this mental activity is to discover meaningful aspects of the way the client thinks, feels, or behaves as a clue to what the problem is and what needs to be changed. As is true with so many other applications in our field, there are tremendous variations in the particular way this pattern search takes place.

Beitman (1987) reviews some of the clusters/variables/themes that therapists tend to look for in their diagnostic observations. Psychoanalysts spend their time in sessions thinking about what defenses are operating in the client, what symbols are evident in dreams, or what transference reactions are being acted out. The cognitive therapist is searching for patterns of speech that indicate underlying dysfunctional behavior. The existentialist is processing patterns of core issues related to meaning, freedom, and responsibility. Even the educational consultant is assessing developmental patterns that have evolved over time.

There is, then, a matrix for observing the world that most therapists subscribe to. The details of this model — that is, whether attention is devoted to parent-adult-child transactions or linguistic patterns of communication — are relatively unimportant. But the *process* of diagnostic thinking is remarkably universal. Effective therapists tend to do the following things, though not necessarily in the same order: (1) allow data, observations, perceptions, and experiences to flow into the brain; (2) organize the information into temporary clusters that suggest hypotheses for exploration; (3) make inquiries to facilitate study in particular directions; (4) eliminate possibilities of what is *not* likely to be occurring; (5) match what is observed with existing schematas that have been experienced before; (6) make predictions as to what is likely to occur, if a given pattern seems to be in evidence; (7) note inconsistencies and exceptions that make this particular

situation unique; and (8) apply the pattern formulated to the guiding matrix.

Examples of this thinking process occur all the time in our drive to find meaning in behavior. A student schedules a conference to discuss one of her class papers. The matrix that suggests itself to me is one in which I expect a variation of: “This-grade-isn’t-fair-you-messed-up-and-you’d better-fix-it" I steel myself for the expected assault.

The student seems unusually contrite and timid. I alter the pattern a bit, but retain the matrix I favor in these situations: she is using guilt instead of aggression to get me to back down. All of this speculation, of course, has taken place before she has ever opened her mouth.

We begin. It is evident this meeting is not about her paper at all. Brilliant diagnostician that I am, I notice she does not even have *any* papers with her! In fact, she looks more like a client about to unload rather than a student. I notice she closed the door. She is twisting her hands in anguish.

It is time for a different matrix and a whole other set of possibilities; she wants me to listen and understand her. She wants a referral to a therapist. She wants advice. I notice it is my own anxiety about the unexpected situation that is leading me to rush ahead with solutions. I take a deep breath. And everything inside my head drifts into smoke. All this diagnostic stuff has interfered with my ability to simply observe and be with her. I suspend

thinking for a while and just watch, listen, probe a little.

During the course of speaking aloud what she has memorized to say to me, the student drops her pencil. I bend to pick it up and reach over to hand it to her, feeling attentive and caring. She cowers in her seat and starts sobbing. I reach a little closer with the pencil and she screams. Unbidden, one thought immediately jumps into place: sexual abuse. I am not sure why I think this just yet. But now I have my matrix again. I start looking for the data to support this possibility and suggest ways I might be helpful.

This process of diagnostic thinking follows certain integrative constructs employed by most clinicians (Millon, 1988). Most therapists believe, for example, that: diagnoses are labels of convenience that approximate (but do not actually reflect) patterns of behavior; there are no rigid boundaries between diagnostic entities, no pure forms of psychopathology; symptoms are best understood in the context of specific situations and personalities; the clinical attributes that make up a particular diagnosis have structural (self-image, temperament, and other semipermanent properties) and functional components (cognitive style, psychodynamics, and other expressive modes).

Diagnostic thinking involves both the structural, self-image aspects of the client's personality and functional, interpersonal behavior. In the case of a

histrionic, for instance, structural attributes would include being gregarious, charming, pleasure oriented, and busy, while functional attributes would include being flirtatious, manipulative, vain, dramatic, and demanding. The therapist is thus able to target treatment efforts toward the totality of the client's plight, including all dimensions of the problems — cognitive style, dysfunctional behaviors, interpersonal dynamics, self-image, characteristic moods, and psychodynamics. This merging of diverse elements into a unified method of information processing covers much more than the integration of structural and functional diagnostics. It also includes combining scientific, empirical methods — which rely on logic and objectivity— with heuristic and phenomenological approaches that access intuitive processes.

Thinking Heuristically

Rothenberg (1988, p. xii) sees the essence of effective therapy as a paradox in that the best clinicians are scientific, objective, rigorous, consistent, and logical, yet they are also highly imaginative: "They are scientific and rely on systematic data and theory, and they are aesthetic in their application of intensity, narrative, interpretation, and leaps of understanding."

Heuristic thinking is the core of subjective perception — the unique, personal, individual way of processing experience through private filters.

When I am functioning heuristically I become aware of what is happening inside me in response to my client. I can feel tension or frustration or confusion, and by sharing my awareness, I can help the client to gain greater access to his or her own inner sensings.

Douglass and Moustakas (1985, p. 40) describe the heuristic method as "a search for discovery of meaning and essence in significant human experience." Derived from the Greek root *eureka* (as in the exclamation of insight and discovery), heuristics forms the basis for a subjective search for truth and understanding. It is similar to phenomenological thinking in that both view subjectivity as the basis for discovering truth, but different in that phenomenological truth seekers detach themselves from the investigation in order to perceive what is occurring more clearly, while heuristic practitioners immerse themselves completely in the journey. This is done to connect all aspects of experience through personal involvement and to enlarge the essence of an issue rather than seeking to reduce it. "Phenomenology ends with the essence of experience; heuristics retains the essence of the person in experience" (Douglass and Moustakas, 1985, p. 43).

The therapist (or researcher) employing this process helps the client conduct an exhaustive search of self through detailed descriptions of experience and provocative dialogue. While this method begins from a highly subjective, personal perspective, after data are generated, systematic and

structured paths are taken to organize, explore, and make sense of what has been discovered. It is passion that is personally driven that distinguishes heuristics from other methods of inquiry.

The process is not complex, but quite natural and self-evident. Hunches and intuition are substituted for hypotheses, neutrality replaced by conviction: “Heuristics is concerned with meanings, not measurements; with essence, not appearance; with quality not quantity; with experience, not behavior” (Douglass and Moustakas, 1985, p. 42).

Anytime a therapist or scientist abandons the rigors of empirico-deductive reasoning for the greater freedom of personal problem solving, he or she is likely to follow a path that includes an immersion in the problem or issue, an internal dialogue about the nuances of the theme, and a verification of internal perceptions by synthesizing them with others’ experience. It is a way of thinking that encompasses the total spectrum of experience — affective as well as cognitive processes, intuitive as well as analytic dimensions. It is spontaneous, free-flowing, moving in a rhythm, pace, and direction that, while self-directed, has a life and purpose of its own. When the clinician trusts this inner knowing and allows the internal wisdom — the tacit dimension of unconscious creativity — to lead and prod, he or she arrives at the truth in a most startling way.

The therapist who operates heuristically, either occasionally or routinely, begins with the recognition of an "itch." "Something is not quite right about this case. Something does not ring true. Something is out of balance. Things do not feel right. *I* do not feel right."

Immersion is the first step in which the therapist begins to explore the problem through an internal self-search that includes a gradually deepening and intensification of layers of awareness. "I feel uneasy about the way things are going. Yet the client appears satisfied. What in me feels unsettled? It's like I feel phoney, as if I'm pretending something. A flash of images raced by — of me playing a role in my sixth-grade play. I had a dance part and I was supposed to do a number with my partner, who was a girl I especially liked. I accidentally ripped my pants just before it was our turn to go on. I felt so embarrassed I tried to back out. But the teacher/director told me nobody would notice. That I should pretend everything was fine, and the audience would believe it as well.

"So why does that come back to me now? What in me has been touched by this client who appears so serene, and yet is seething inside? What am I missing that is right in front of me yet beyond what I can see?"

Polanyi (1967) called this gaining of access to hidden meaning a process of *indwelling*, in which we allow certain images, feelings, and ideas to incubate

within us. By immersing ourselves totally and completely in the issue, we are able to dwell on those dimensions that catch our attention and tug at our consciousness.

At no single clear point, the therapist moving through heuristic inquiry will eventually gravitate toward a general or specific direction. Understanding of the phenomena is elaborated by reaching out beyond the self to collect more data. Relying on the "tacit dimension" described by Polanyi (1967), the therapist senses that a particular line of exploration with the client may prove useful, without quite knowing why or how; to analyze the process would be to stop the flow of it. This *illumination* phase sparks an inner voice that is quietly urging: "I have been feeling uneasy about something as you were speaking, and I'm not exactly sure why. I just got this image, a feeling that what we're doing right now isn't quite consistent with what's going on inside of you. I can't exactly explain what you are doing or saying that doesn't appear congruent or authentic, but I just sense that part of you is pretending something you aren't really experiencing. What are you feeling right now as I'm saying this, and what images come to mind for you?"

The essence of tacit knowledge is to trust one's intuition without questioning or judging it. Yet once aware of a problem, the therapist must check it against the client's experience through self-disclosure, openness, dialogue, and, most of all, interaction.

A *synthesis* phase comes next. Information and understandings that have been processed internally and with the client must somehow be integrated. The new data are not classified, organized, or analyzed as in empirical deduction or even phenomenological reduction; instead, the essence of the experience is preserved. The therapist seeks to integrate the new learning for himself or herself, as well as facilitating a parallel process for the client. The thinking moves from fragments to a unified whole, from the specific to the general, from the individual to the universal, from appearances to essences, from raw data to meaningful themes, from a previous conception to a new reality: "What we both have experienced and now understand is that sometimes it is better to feel the raw pain, the shame and fear, and to work through the feelings to a place of self-acceptance than to deny the discomfort and pretend a self-assurance we don't feel."

The compleat therapist is able to think as an intuitive scientist who can reason both inductively and deductively, systematically uncovering mysteries, yet who has developed the tacit dimension, who trusts and uses inner forms of knowing. The clinician, thinking either heuristically or phenomenologically, is able to suspend all judgments in order to enter the client's world with perfect clarity.

This process of "epoche" was developed by the phenomenological philosopher Edmund Husserl as a way "of returning to the self to discover the

nature and meaning of things as they appear, and in their essence" (Moustakas, 1988, p. 2). In order to get at this purest form of knowledge, all supposition, preconceptions, theories, and other ideas that might interfere with pure listening must be suspended. The epoche process is one in which the therapist temporarily stops all thinking whatsoever, all intellectual problem solving, hypothesis testing, reasoning and analyzing, in order to open himself or herself up to the pure immediacy and spontaneity of relating to another person. It is a meditative state, a form of effortless concentration that allows us to see and hear and feel what is occurring within the client from a fresh and receptive perspective: "to focus on just what manifests itself in consciousness, to let things appear as such, let them linger and reveal themselves in their own time, nature, and meaning" (Moustakas, 1988, p. 111).

Thinking Metaphorically

The value of metaphorical thinking is self-evident to members of our profession. We must continually make shifts from one perspective to another, transcribing properties from one plane to another. We use metaphors to clarify, to describe complex ideas, to stimulate interest, to connect images with feelings, and to integrate the abstract with the concrete (Rothenberg, 1988). In a symposium on the uses of metaphor in therapy DiGiuseppe (1988) explains: "A metaphor is like a solar eclipse in that it hides an object, but

reveals its most salient characteristics when viewed through the right telescope. It enlightens while it obscures in order to appreciate better the subtle characteristics of a subject."

Napier (1988), for example, describes the case of a couple who began arguing in the car on the way to a scheduled marital session. When they first entered the car, the wife discovered a piece of tar on the floor that she began to examine carefully. The husband disgustedly ordered her to throw it out the window. She steadfastly refused. An argument quickly escalated until they were both steaming by the time they entered Napier's office. Their starting point became an exploration of the significance of their heated interchange over a "black spot" that the wife had become attached to and did not want to relinquish.

Napier (1988, p. 4) says further: "This couple did not have a conscious plan to deal with this problem. The conflict emerged symbolically, and the 'dark spot' was unconsciously chosen to represent their difficulty with this issue. It was a mutually defined metaphor, or symbol, for the conflict, and it was not until we al deciphered the meaning of the metaphor that we could get to work on the emerging difficulty in their marriage."

The average clinical practice is replete with other illustrations of how metaphors can not only be used to represent patterns of dysfunctional

behavior, but also as dramatic forms of communication. Graham and I had been going around and around for some time, like dogs circling one another for an advantage, but neither one making any headway. This was the same client who I introduced in the Preface, the man who challenged me to explain how and why therapy works. For months we had been locked in a struggle that I did not know how we had gotten into, much less had any inkling of how to extricate myself from.

The conflict, in all its various manifestations, went something like this: Graham would demand that I provide more structure to our sessions, more guidance for the direction he should take in his life. I would explain, patiently and methodically, that my role was as a consultant, and that ultimately *he* would have to make his own decisions. The fact that he could not tolerate the ambiguity and freedom inherent in our encounter was a clue as to why he could not take charge of his life outside of therapy.

Forever concrete and regimented in his thinking, he would cry out in exasperation: “How can you just sit there watching me suffer and not *do* anything to help? You are the expert. You went to school for many years and have been doing this work for a long time. I know you could give me advice, or at least, more direct answers to my questions — but you continue to play those games of being so withholding. Why do I come to you if you won’t help me?”

I would then tell Graham all over again about how even if I did know what was best for him, and I agreed to tell him what to do, I would only be reinforcing the idea that he does not know what is best for himself, that he needs someone else to tell him what to do with his life. I further explained that he would only become more dependent on me the next time he was confused. While all of this sounded quite eloquent and convincing to me, he just refused to hear it. And so we went round and round.

The inspiration for our breakthrough literally came out of left field. For while I was talking I had been staring over his shoulder out the window of my office — which happens to overlook a Little League baseball field. The baseball metaphor began to take shape in my mind, since it brought together so many elements we had been discussing. The last piece of the puzzle was to personalize the metaphor in such a way that he could not block out the message. And since the whole focus of Graham 's life was his nine-year-old son, even that last piece fell into place.

"Graham, you keep asking me why I don't help you. And I have explained over and over that I *am* helping you just the way a coach is supposed to help — by teaching fundamentals. In your case, these basics consist of your learning to live with uncertainty and to make your own decisions.

"You see that baseball diamond out the window? Imagine that your son

approached you and asked you to teach him to hit to the opposite field — in his case right field. There you are, out there on the field, pitching to him. Each time he hits the ball s to left field, you refuse to retrieve them. Instead, you make him put the bat down and stroll all the way out there to get the balls *even though you are closer.* He complains each time: 'Dad, why can't *you* do it? It would save us time, and some of the balls are just a few feet away from you. This doesn't make sense.'

"But it does make perfect sense to you as his coach. For each time he walks out to left field to retrieve the balls that went awry, he has to think about what he did wrong and concentrate on what he has to do next time. Although it takes longer in the short run to complete your exercises, he will eventually learn to correct himself in order to avoid the consequences of paying for his mistakes."

The smile on Graham 's face told me immediately that he *did* understand. "So what you're saying as my coach is that the reason you don't offer easy answers is so that I will learn, even though it's frustrating and time consuming, to find my own answers?"

Yes, that's exactly what I had been telling him over and over for a long time. But until then, I couldn't get through. Whether it was really the power of the metaphor that made the difference, or some other variable that altered his

readiness to face this issue of self-responsibility, I will never know. But images such as this one are often associated with breakthroughs because they enable clients to recall vividly constructed examples that can be accessed on demand.

As clients describe their experiences, we are constantly making shifts inside our minds, asking ourselves: “What is this like?” “What is another way to describe the same thing?” “What’s an example of the point I would like to make?” “How can I translate this concept to one that will connect with the client’s experience?” Or, for those who operate less analytically, intuitive urgings will do their part to push to the forefront of awareness an instructive metaphor that fits with what is being discussed.

A client with panic disorder becomes immobilized by the first stirrings of any associated symptoms. As soon as she notices (and of course she is hypervigilant) the slightest sensation reminiscent of speeded-up heart rate or constricted breathing, she brings on herself a full-fledged “attack” by terrifying herself with thoughts that she is completely out of control. Her fear is further intensified by her frustration in making any kind of sense out of the symptoms. She refused any type of medication whenever it was offered, taking the more courageous stand of finding out what her body was trying to communicate to her. However, until such insights could be reached, she was teetering on the edge of stable functioning, fearful at any moment she could

be immobilized. She desperately searched for an explanation for what she was experiencing. It is, therefore, the therapist's task to help her think metaphorically about her symptoms in such a way that they will not be experienced as so disturbing to her. The following explanation is an example of an attempt to conceptualize the symptoms in a manner that is not so alarming.

"A long time ago whenever human beings faced danger, such as the prospect of being eaten by a saber-toothed tiger, the body equipped itself with a means for escape or defense. When the brain perceives imminent danger, the sympathetic nervous system kicks in gear to offer you better protection. The heart rate speeds up to pump more oxygen through the muscles you will be using to run or fight. Your breathing rate increases as well. The eyes dilate to improve vision. The digestive system closes down to divert energy to more useful places. Your mouth becomes dry, your stomach fluttery. Adrenaline pumps through your body providing extra bursts of power, but with the side effects of quivering limbs. Your body is responding to orders from your brain, which is overreacting to perceived stress. It is doing everything in its power to mobilize your resources to do battle.

"So whenever you start to feel these symptoms, remind yourself there really is not a saber-toothed tiger that is threatening you, and that your body is simply misinterpreting signals from your mind, orders that *you* can

change."

So much of our internal energy during sessions is taken up with either at ending to what the client is communicating or converting the descriptions that are presented to metaphors that we can do something with. Some of those that are most appropriate, we pass on to the client in the form of reframing their concerns or packaging them in ways that are helpful; many others we keep to ourselves. We have a private dialogue going on inside our heads, one that communicates in the language of metaphors, symbols, representations or what we see, feel, and sense. All of this takes place in order that we may tidy up all the information at our disposal, and thus concentrate on helping the client discover what it means.

Operating Intuitively

All of the intangible components of what makes an effective therapist — the hunches and feelings and senses about what is happening—can be lumped together as intuition. Whereas rational thought is that part of us that diagnoses, analyzes, examines, investigates, and dissects, intuitive thought observes, listens, feels, takes in without evaluation, and then simply *reacts.*

About intuition Anne Morrow Lindbergh (1955, p. 17) said: "One never knows what chance treasures these easy, unconscious rollers may toss up, on the smooth white sand of the conscious mind. . . . But it must not be sought for

or — heaven forbid! — dug for. No, no dredging of the seabottom here. That would defeat one's purpose. The sea does not reward those who are too anxious, too greedy, or too impatient. To dig for treasures shows not only impatience and greed, but lack of faith. Patience, patience, patience is what the sea teaches. Patience and faith. One should lie empty, open, choiceless as a beach — waiting for a gift from the sea."

These intuitive gifts, however, are only available for those who have sufficiently mastered their fields. It is only the expert who can take a dozen separate steps of the beginner, and in a single leap, find the essence of a problem. Benderly (1989, p. 36) for example, describes the process of intuition in the case of a physician's thinking processes: "An experienced doctor takes one look at a spot y, feverish child and instantly diagnoses measles. A young intern looks at the same patient but takes far longer to arrive at the same diagnosis, methodologically eliminating chicken pox, Germ an measles, and scarlet fever. The experienced doctor's analysis is fast and accurate; she constructs the investigation around a comprehensive view of possibilities, unlike her junior colleague who must move through a series of small ad hoc decisions."

Intuition, then, is a form of organized experience that allows effective therapists to access knowledge and find meaningful patterns. It is relied on, not as a substitute for rational thought processes, but as the springboard that

initiates them, or as the guide that validates whether we are headed in the right direction. Goldberg (1983, p. 34) could have been talking directly to therapists in his book on intuition when he said: "When we attempt to be logical in complex situations, when we are forced to deal with incomplete information, unfamiliar subject matter, or ambiguous premises, we are dependent on intuition to tell us whether we are on the right track."

Common to those with heightened sensitivity, intuition represents all the predictions and interventions we make without being able to explain fully just how we know. That is not to say that we do not make something up that sounds reasonable if we are challenged to account for our behavior. But when we are *really* honest with ourselves, we *know* that it was not just a "lucky guess," nor was it a deliberately and carefully thought- out plan. In fact, we do not really know what it was. One minute we were just buzzing along in a session, doing what we usually do, and then, before we quite knew what was happening, some strange idea just popped into our head. One therapist relates this example of an intuitive experience:

> I was sitting with my office partner at the end of a typically full, volatile day. We were reviewing our cases with one another when, out of the blue and seemingly apropos of nothing, I said to her as she was describing one of her clients: "You need to check the boy out carefully. Watch him for any marks or bruises. I sense that he may somehow be hurt." She asked if I was concerned with abuse, and I replied that I was more worried that he would harm himself. I have no idea why I said that or what I was basing these feelings on. I had never met the boy before, and I had only heard the briefest of descriptions of his issues. Nothing my partner related to me

> indicated the slightest impression he was at risk, and when she pressed me for an explanation, I could give her none.
>
> The next morning as I walked into the office I was met by my partner, who appeared quite shaken. She informed me that the boy I was concerned about had showed up for his session with his wrist bandaged. He reported that he had "accidentally" fallen on a broken piece of glass (in an unlikely way) and nearly severed the artery.

So what was this all about? Coincidence? Had this therapist picked up the apprehensions in her partner that she was unaware of as she described the case? Was this "intuition" a case of preconscious hypersensitivity to certain cues?

While hardly in as dramatic a way, most therapists put their intuitions and hunches to work on a daily basis. "When you arrive at a conclusion through rational thought you can usually trace the mental process backward and identify the antecedent steps. Intuition is inexplicable" (Goldberg, 1983, p. 33). Or at least the process is so complex, elusive, and abstract that our present levels of sophistication and knowledge make analysis difficult — and perhaps even undesirable since once we begin to analyze or explain intuition we begin to lose its power.

Hayward (1984) speaks of the imbalance in the thinking of most scientists and professionals when they strongly favor logic over intuition. This leads to fragmentation, quantification, abstraction — separateness from

the essence of what is experienced.

Intuition, if taken too far, also creates its own problems — mostly a lack of clarity and precision. But it also adds another dimension of power to our thinking. Intuition involves an interconnection among all the nonconceptual elements that are beyond our awareness and consciousness. It thus gives us access to not only things we already know, but to a whole universe of possibilities that are currently beyond our grasp.

Reason and intuition are complementary in the effective therapist's mind. They feed off one another. They validate the truth of what the other infers. One encourages and supports the expansiveness of the narrow belief of the other. And when applied together, they provide the high degree of flexibility that is so important to therapeutic work.

Functioning Flexibly

While over a half century of empirical research has not been able to demonstrate the superiority of one therapeutic approach over another, it has been very clearly determined that certain kinds of interventions and clinical styles are likely to be more effective with particular clients. Change is multidimensional (Lambert, Shapiro, and Bergin, 1986).

It has been fairly well documented in the literature that certain phobic

reactions are especially responsive to behavior therapy, that sexual dysfunctions are best treated with a combination of sensate focus exercises and insight therapy, that bipolar symptoms and endogenous depressions are most amenable to psychopharmacological treatment, that relationship-oriented insight therapy is best for those with unresolved internal struggles. Even on a more pragmatic level, most clinicians notice that some clients tend to do better than others with particular kinds of interventions. Even if we remain "true to our school," there are still many possible treatment methods.

Craig (1986), who identifies himself quite strongly as an existential therapist, was nevertheless taken aback when asked to cite the single key variable in his work with clients. For although he embraces a set of assumptions about what constitutes good therapy, he does not apply them in the same way more than once. Some clients seem to need more overt support than others. Some respond better to more or less active involvement on the part of the therapist, or more or less structure.

Garfield (1980, p. 187) feels that flexibility is the cornerstone of a therapist's effectiveness: "This should not be interpreted to mean that the therapist simply flies by the seat of his free associations or intuitions. The therapist should have some hypotheses to guide him and some tentative plan for therapy. However, as already emphasized, he has to be ready to test his hypotheses as time goes on and be willing to modify them in the light of new

observations and information." Although Garfield sees some problem with a process as "unscientific" as intuition, it is very often a hunch, a feeling, or an image that leads us to give up a particular course of action and try something else.

In short, the therapist's flexibility allows for the ideal match between what a particular client needs at a given moment of time — whether it is confrontation or reassurance, structure or permissiveness — and what the clinician is able to deliver. Alexander and French (1946) concluded long ago that the single most important variable in helping treatment to proceed in an efficient and effective manner is the clinician's own flexibility.

Among other things, this flexibility requires an egalitarian outlook. Therapists need to be flexible in the sense of being accepting, open, and nonjudgmental. Flexibility also operates in therapists' choice of interventions.

Behavior therapists would define this in terms of specific techniques that are at their disposal. They would thus attempt to familiarize themselves with as many intervention strategies as possible, employing one method with migraine headaches, another with enuresis, still another with school phobia or insomnia. On the other hand, insight-oriented practitioners — who eschew technique-oriented styles — practice their craft with a high degree of adaptability to a given issue, client, or circumstance. This flexibility promotes

greater effectiveness because of the therapist's ability to change just as the client changes. Any marriage will conclude unsatisfactorily when only one partner changes and the other remains the same. So while the therapist does show a certain stability or even predictability in his or her behavior, there is also much room for maneuvering. This allows the therapist to be active or passive, lighthearted or sober, wit y or sincere, loving or stern, or warm or disconnected, depending on just what is called for. The essence of therapeutic effectiveness is to know or sense what might work and to be flexible enough to change directions in mid-course to more effectively address what is going on.

If we could enter the mind of any therapist while conducting a session, it is likely we would witness an inner dialogue that goes something like this:

Okay. Where were we? Oh, yeah. She was talking about . . . Oh oh. Her face is clouding up. Something is going on. Wonder what it is . . .

"I notice that your face changed as you were talking, as if you were saying one thing but thinking quite another."

Not bad. Short. Sweet. Accurate. But she's not buying it. Why is she shaking her head? Could I have misread her? I doubt it.

"You shake your head, yet you don't look very convincing . . . ?

Oops. I 'm not listening to her. Even if she is denying something, that is her right. I 'm pushing her too hard. Time to back off.

"When I interrupted you earlier, you were talking about . . . "

Just stay with her. She's not ready yet to face what she is avoiding. But she looks bored. As if she's reading her lines, taking up time to get through the session. But if I confront her with that, she'll just deny it. I 'l wait awhile and see what happens.

"So you are feeling like . . . "

Enough is enough! This isn't working. Even if she's okay with this, I *can't go on any longer with this game. I need to tell her that.*

"Excuse me. Much of the time you have been talking, I have been aware of what has been going on inside of me. It feels very much like we are both . . . "

Ah, I see. I got her attention. She looks intrigued by what I said. But she essentially ignored the message I presented and focused instead on the part she is comfortable with. Maybe I should . . .

What is clear in this inner dialogue is the therapist's willingness to monitor what is happening for the client as well as personally. In doing this,

the therapist is able to assess what is working and what is not and to change directions as often as necessary, until the client seems to have been helped by the intervention.

Practicing Creatively

Eminent writers and artists usually have a unique, identifiable style. The same could be said for effective clinicians. After all, there are limits on how far apprentices or disciples can go if they follow their mentors slavishly and cling to orthodoxy.

There is something to be said for technical competence — that is, the ability to apply the tools of one's trade successfully. However, being a truly gifted writer, artist, or therapist involves going far beyond what has been derived from others' work; it means having been able to integrate what has been done before into a personal and original vision, one that is ideally suited for that professional's unique assets and capabilities. As Yalom (1989, p. 36) explains, "If they are helpful to patients at all, ideological schools with their complex metaphysical edifices succeed because they assuage the *therapist's,* not the patient's, anxiety (and thus permit the therapist to face the anxiety of the therapeutic process). The more the therapist is able to tolerate the anxiety of not knowing, the less need is there for the therapist to em brace orthodoxy. The creative members of an orthodoxy, *any* orthodoxy, ultimately outgrow

their disciplines."

I have been emphasizing what effective therapists have in common, but it is just as important to applaud their differences. The fact is that most of the world's best-known professionals, in our field or any other, are creative characters. They found a way to be most thoroughly themselves and invented a system or approach that encouraged them to be themselves. Just as clients get into trouble when they try to be somebody they are not, so too do therapists limit their powers when they attempt to be exactly like the mentors they most admire.

Compleat therapists have found their own voice. They are creative because they are not limited by what they have seen before. Each interaction with a client becomes a unique opportunity for creating a learning experience that has been individually and spontaneously designed, one that permits maximum flexibility and creativity in thinking and action.

Rogers (1986, pp. 48-49) captures the disadvantages of dogmatism as follows: "I believe that there is only one statement which can accurately apply to all theories — from the phlogiston theory to the theory of relativity, from the theory I will present to the one I hope will replace it in a decade — and that is that at the time of its formulation every theory contains an unknown (and perhaps at that point an unknowable) amount of error and mistaken

inference. . . . To me this attitude is very important, for I am distressed at the manner in which small-caliber minds immediately accept a theory — almost any theory — as a dogma of truth. If theory could be seen for what it is — a fallible, changing attempt to construct a network of gossamer threads which will contain the solid facts — then a theory would serve as it should, as a stimulus to further creative thinking." These words apply as much to our own field as to any other.

Listening to Internal Voices

Minuchin (1986) traces the development of his own thinking in the voices of others that he hears constantly reverberating in his head. He believes (1986, p. 12) that his awareness of where the voices are leading him is what makes him most effective: "Clearly the voices I hear do not mean that everything is the same or that eclecticism is beautiful. The demands of a situation, and one's own possibilities and limitations, still operate selectively. Perhaps this is like the harmonic context of a melody. Within that context, a theme appears, is taken up by other voices, and can reappear in counterpoint or in inversion. Within the possibilities open to us, the best in us always learns from the best of others."

We are all like Minuchin in that we are the sum total of al the voices we have heard — the mentors and models and teachers who have demonstrated

things we like. Our thinking often involves sorting out all of these voices, selecting those that speak to us most helpfully at a particular moment and then translating their words into a voice of our own.

A client remains stubbornly silent in response to what I believe was an especially insightful interpretation on my part. We stare at one another, waiting each other out, our minds whirring with activity. I hear a dissonant chorus of voices whispering to me and telling me what to do. In a matter of seconds, I try to identify all the different ways I have seen this situation handled by others.

My fourth-grade teacher would glower in a way that could melt lead, much less the puny resistance of a nine-year-old. I try a stern look, then hear echoes of *Not that!* and quickly mute my expression to one of patient indulgence.

The whispers now become louder: *Wait him out. It's* his *responsibility to keep things going.* A moment of relief.

Then: *No, it's not. It's* your *job to keep things moving along. Isn't that what you're paid for?*

Yes! I must do something. But what?

Certainly there is no shortage of suggestions from the voices inside my head.

Interpret the silence as resistance.

Reframe the silence as a different form of nonverbal communication.

Stay with the silence. Respect what the client is saying.

Use humor to exaggerate the behavior.

Confront the client's game playing.

Stay calm. He just needs time to process what was said.

It is the last voice that speaks the loudest at this moment, so I pay attention to it. I even remember whose voice it is and where he was when he said it to me. It is my voice now. Because it fits with what I sense is happening. If the silence goes on more than a few minutes longer, I will think this through again and make a new decision about another voice to listen to, another voice that is part of my own.

As this example suggests, effective therapists give themselves many choices in the way they respond to clients. This makes it necessary to have an internal filing system that allows us to find what we are looking for. We could

have the fastest computer in existence, one with virtually unlimited storage space and memory and with a collection of all the software we could find, but unless all this information is organized in such a way that it can be easily retrieved, it is useless.

Effective therapists not only know a lot and can do things well , but they have an organized system of information storage and retrieval that is highly efficient. They have the capacity to constantly upgrade their data, to refine their assumptions, and to restructure the way they view things based on new information and experiences. Thus the style of thinking adopted by almost al fine clinicians is remarkably similar. The best therapists have great capacity for empirical and logical analysis, yet they are also quite intuitive. They are flexible, multidimensional, and able to find patterns that most others cannot see. They are able to integrate the voices of their former teachers, and from this union of all that they know and sense and feel and understand, they are able to communicate clearly, sensitively, and perceptively.

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