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THE SILENT PATIENT: A CONSIDERATION OF THE USEFULNESS
OF GENDLIN'S RECOMMENDATIONS IN THE TREATMENT OF A
SILENT ADOLESCENT

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Submitted in partial fulfilment of the requirements for the degree
Master of Arts in Clinical Psychology in the Department of
Psychology, Rhodes University, Grahamstown.

Grahamstown

November 1989

ABSTRACT

This study comprises a dialogue between Gendlin's recommendations on the treatment of the silent patient and case-material taken from 39 sessions of psychodynamic psychotherapy with a 16 year old adolescent. The most characteristic feature of the therapy with this young person, was her pattern of silence and unresponsiveness. The aim of this study is to ascertain the usefulness of Gendlin's recommendations in the therapy of this category of patient.

The dialogue between the suggested recommendations and the case-material served to illustrate the point that Gendlin's recommendations are of great value in the treatment of the silent adolescent. The value of these recommendations lie in their ability to comment meaningfully on the process of therapy with the silent patient by providing not only skills and techniques, but also a conceptual framework within which to contextualize the therapy. The recommendations were also found to be sensitive to some of the key issues of relevance to adolescence as a developmental phase.

The case-study method was deemed an appropriate structure within which to conduct this examination.

ACKNOWLEDGEMENT

I acknowledge the support and assistance given to me
by my friend and supervisor, Geraldine Bailey.

To Jannike, for having trusted me. Your belief in me
facilitated my growth as a therapist and indeed, as a
person.

Aan My Ouers

Uiteindelik is ons klaar! Dankie vir baie jare se
liefde en ondersteuning.

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INTRODUCTION

INTRODUCTION

It is commonly accepted that psychotherapy with an adolescent presents the therapist with a unique set of challenges to be addressed. Josselyn shares her sentiments in this regard in the following quote;

Psychiatric treatment of the young adolescent is perhaps the most challenging, the most frustrating, the most baffling, the most anxiety-arousing, and the most narcissistically gratifying experience a psychiatrist can have (cited in Balser, 1957, p.13).

This case study was inspired by the psychotherapy of a sixteen year old female adolescent, Jannike Kent (pseudonym). Central to Jannike's presence in the therapeutic environment was her pattern of silence and unresponsiveness. In the first fifteen sessions, for instance, Jannike offered an average of approximately four or five short phrases per session. This type of in-therapy behaviour presented the therapist with a unique challenge, the challenge of facilitating 50 minutes of virtual silence in a therapeutic manner.

Eugene Gendlin, in a text entitled The Theory and Practice of Psychotherapy with Specific Disorders, proposes a set of recommendations to be implemented in the psychotherapy of the silent patient. It is the aim of this study to examine the usefulness of these recommendations with reference to the case presented.

Ref. ?

The focus in this study is a consideration of the practical problems facing the therapist in his attempt to therapeutically facilitate the long periods of silence in the therapy of an adolescent. The scope of this study is legitimate as it addresses two areas of importance in the psychotherapeutic arena, namely the tumultuous period of adolescence and the challenging arena of silence.

The hope is that the reader of this study will come away with an increased understanding of the practical problems faced by the therapist in an encounter with a silent patient, as well as having familiarised himself with the merits and demerits of Gendlin's recommendations.

METHODOLOGY

METHODOLOGY

Given the parameters and aims of this study, the Case Study Research Method was deemed an appropriate structure within which to situate this study. This section will serve as an introduction to the case study method with the goal of illustrating the appropriateness of this method for the task at hand.

Edwards (1989), in a paper entitled Case Study Research in the Clinical and Counselling Setting, provides an elaborate, thorough and well researched presentation on the case study as a legitimate research method. The present discussion will rely substantially on this paper as it provides a useful and systematic run down of the pertinent issues.

Historically, the sphere of research in the psychotherapeutic arena has been a subject fraught with much ideological conflict. A central component in this debate has been the prevalence of an ideological allegiance to the Natural Scientific Tradition in which the main focus of research is the use of quantitative methods.

Edwards submits that this allegiance to the dictates of the Natural Scientific method has been the result of various factors. He makes mention of the fact that in the field of Sociology, for instance, a decisive shift towards

quantitative methods occurred during the 1950's, linked to advances in computer technology and the resultant increased ability to manipulate quantitative data. A second factor mentioned by Edwards is the centrality of research publications in career advancement. The Natural Scientific Tradition provides a practical format in which large numbers of publications using quantitative methodology, can be generated. In his presentation, Edwards cites various statistics indicating that many such research papers are on overspecialised topics which are more often than not, of little practical relevance to most practitioners.

Edwards submits that this allegiance to the Natural Scientific Tradition, has yielded a picture in which research has developed into a "Scientist versus Practitioner" model. In this model, the practitioner is not conceived of as being pivotal in the process of research. Rather, research is viewed as being the legitimate domain of the researcher only. A split therefore exists between the practitioner and the scientist.

Various authors have experienced their dissatisfaction with this status quo. Barlow succinctly expresses his sentiments as follows;

Clinical research has little or no influence on clinical practice... Clinical psychologists are not influenced to any great degree by clinical research, let alone participating in the process (Barlow, 1981, pp147-148).

Kruger expresses similar sentiments when he asserts that;

In contrast to the highly intuitive insights of the founders of psychotherapy, psychotherapy research tends to involve persistent and excruciating attempts to objectify and quantify experiential and behavioural data in order to isolate variables which supposedly would make up what psychotherapy is (Kruger, 1986, p.199).

The sentiments expressed by the above authors, amongst others, are therefore clear; "the elaborate technology of formal experimental design and statistics has been of relatively little practical help to clinicians" (Edwards, 1983, p.3).

Research into psychotherapeutic issues need not however labour under the restraints imposed by the Natural Scientific Tradition. Edwards shares his thought in this regard by suggesting that;

An alternative approach is to adopt a practitioner-as-scientist model of psychotherapy within which the conduct of psychotherapy is recognised as a fundamental research enterprise, and the therapist as inevitably engaged in a scientific endeavour (1989, p.5).

This conception of psychotherapy finds support in Strupp's contention that;

There can be no doubt that most of what the field has learned about psychotherapy since Breuer treated his famous patient Anna O. a century ago, has come from astute and creative clinical observations (Strupp, cited in Edwards, 1989, p.3)

Edwards (1989) outlines the feasibility of the practitioner-as-scientist model at the hand of three points. Firstly, he submits that the psychotherapist has privileged access to quality research data. Within the context of the trusting relationship characteristic of psychotherapy, patients

verbalise thoughts and feelings and explore issues unlikely to be examined and considered in other contexts. Therapists, in their daily routine, are therefor exposed to information about their patients feelings and thoughts not easily accessed by research methods within the Natural Scientific Tradition, such as the use of questionnaires and one-off interviews. In order to facilitate such a deepening, therapists acquire basic therapeutic skills of listening, responding and questioning which are therefor essentially research skills.

The second aspect of the practioner-as-scientists model is that the professional context of psychotherapy is in fact a structured research setting. Edwards submits that this context, with it's attendant work of case conceptualisation, supervision, peer discussion, conferences and publications, is a fundamental method of advancing knowledge through the development and testing of theory.

Thirdly, Edwards submits that good psychotherapy is an exercise in applied science. Every case is treated as unique and requires the systematic and careful observation and conceptualisation which typifies scientific exploration of a new phenomenon. As theory proceeds, clinical decisions regarding specific interventions or management, are made using the same sorts of criteria that are used in research development. He therefor submits that;

No less than a field geologist or an ecologist, the therapist is an applied scientist who uses the

framework of existing knowledge about a particular area in order to systematically analyse and solve problems (1989, p.9).

Edwards submits that the principals of the case study method as documented in the recent literature by authors such as Bromley, Mitchell and Yin, provide a framework within which the scientist/practitioner split in clinical psychology can finally be overcome.

Firstly, it should be noted that in contrast to most experimental methods utilizing large samples, the case study method is idiographic as individual cases are examined in depth. Secondly, the process of case-study research should be born in mind. Case study research does not use statistical inference. Rather, validity is established by a logical process which has been termed "analytic generalisation" by Yin and "analytic induction" by Mitchell (Edwards, 1989).

Bromley equates this process to the building up of case-law in jurisprudence (Edwards, 1989). The examination of a few cases of a particular nature, yields a tentative body of theory containing essential concepts, distinctions and principles which are of value when dealing with such cases. As new cases are examined, some may not alter this established case law whereas others will require that it be refined, modified or extended. The initial insights gained from a single study, therefor gradually become systematised and refined as successive cases are considered in relation to one another. This process is continued until the constructs

seem sufficiently refined to require no further amendment. The above exposition therefor clearly illustrates the legitimacy of the case study as a rich and valuable method of research in the field of psychology. Bromley expresses his opinion as follows;

The intensive, largely retrospective study of individual cases can be as rigorous and informative as the extensive, prospective study of samples of people, whether in surveys or experiments. One *can* (present author's emphasis) generalise from individual cases and many important real-life human problems cannot be studied effectively, or at all, by experimental methods of enquiry (Bromley, 1986, p.286).

The present discussion also serves the function of validating the practitioner-as-scientist stance by acknowledging the value of contributions gained in the psychotherapeutic setting.

Case study research, viewed in its totality, is a complex process with many stages. The investigation of any individual case may serve one of many different purposes within the overall process of defining an area of study, articulating key processes and developing theory. Before attempting to situate the present study in terms of this process, it will be of value to consider a few types of case studies.

Edwards (1989) submits that the various types of case studies can be conceived of as points on a continuum ranging from studies which are largely descriptive, to those which are concerned with developing theory and finally, to those which emphasise the testing of specific aspects of already developed theory. He defines four types of studies on this exploratory/theory-development continuum;

Exploratory-Descriptive Case Studies

In essence, this type of case-study is exploratory and the goal is to provide a rich and accurate description of an individual case. It therefor serves the function of opening up an in-depth understanding of something as yet only superficially known. The focus is therefor not on developing new theory or on the testing of existing theory.

Descriptive-Dialogic Case Study

Here again the emphasis is on faithful description of a phenomenon, but the study is situated within the context of existing theory. Studies of this nature provide an informal test of the content of specific theories and test whether conceptualisations are adequately differentiated.

Theoretical-Heuristic Case Studies

Studies falling into this category are primarily concerned with rigorously developing and testing existing theory. Increased rigour is required and cases which are likely to be revealing should be selected.

Crucial or Test Case Studies

In this instance, the process of validating theoretical constructs is taken a step further in that a case is selected which provides a crucial test of a particular proposition. The challenge is to select a case which falsifies the proposition if it fails to support it. This type of study needs to occur within the context of well developed and operationalized theory.

The present study, as mentioned, comprises a dialogue between

a set of recommendations on the treatment of the silent patient and case material taken from a course of psychotherapy with an adolescent girl. In terms of a point on the exploratory/theory development continuum, this study falls in the descriptive-dialogic category. The bulk of this description will therefor comprise an attempt to ascertain the practical value of Gendlin's recommendations by dialoguing them with the case-material to be presented. The challenge will be to assume an objective stance and to render a faithful description of the case material so as to secure the validity of the results obtained.

The scope of this study is deemed to be of value for the following reasons;

- It addresses an important therapeutic area, namely the management of the silent patient in the therapeutic setting.
- No other comprehensive set of recommendations concerned with the therapeutic management of the silent patient could be found in the literature. This elevates the importance of the present set by virtue of their exclusivity.
- Further, no commentary on the value of the present set of recommendations could be found in the literature and is therefor much needed.

This study will therefor constitute an initial test of the value of Gendlin's recommendations thereby leading to a process of refinement and differentiation. The data yielded by future studies of a similar nature, viewed in conjunction

with the results of this study, will secure the future refinement of these guidelines. This process of refinement will hopefully result in the occurrence of further studies emphasising the development and testing of theory in favour of a primarily descriptive-dialogic task.

It is hoped that such refinement will increase the potential resourcefulness of these recommendations thereby being of increased benefit to the practitioner.

PERTINENT LITERATURE

A. INTRODUCTION

B. ADOLESCENCE AS A DEVELOPMENTAL STAGE

C. SILENCE WITHIN THE CONTEXT OF PSYCHOTHERAPY WITH
THE ADOLESCENT

D. GENDLIN'S RECOMMENDATIONS

PERTINENT LITERATURE

A. INTRODUCTION

In harmony with the dictates of the case material to be presented, this section will comprise the presentation of pertinent literature of relevance to silence within the context of adolescence. An initial section will deal with the inherent problems of this developmental phase in general with a subsequent section referring specifically to silence. A final section will comprise an elaborate exposé of Gendlin's recommendations.

B. ADOLESCENCE AS A DEVELOPMENTAL STAGE

Josselyn (cited in Balser, 1957), referring to the developmental task associated with adolescence, submits that the primary picture in normal as well as disturbed adolescents, is that of an overtaxed ego. She conceives of this overtaxation as being closely linked to the adolescent's attempt to negotiate the various tasks characteristic of this developmental phase.

One of the most central tasks associated with this phase, is attempting to come to terms with physical changes (Stein and Kent Davis, 1982). The need for mastery over one's body in the face of increased strength and developing sexual and reproductive capacities, suggest a variety of potential

problems. For both the sexes, physical development can be a source of competition, envy, frustration, pride and deep inadequacy (Stein and Kent Davis, 1982). The fact that this process of physical change is continual, hampers adjustment to this new situation. Further points of great importance are the loosening and modification of ties to the parents and a distinct change in ways of relating to peers (Stein and Kent Davis, 1982). Feelings of ambivalence toward the opposite sex predominate and peer group opinion is a particularly powerful influence. The adolescent's urge to achieve independence finds expression in rebellious behaviour, specifically in reaction to the parents. Whilst many instances of rebellion would not be necessary in the face of evolving change, the adolescent feels an urgency for change and cannot always accept the slow pace that evolving modifications require. Josselyn (cited in Balser, 1957) suggests that this sense of urgency is rooted in the adolescent's fear of change. The adolescent is both eager to reach adulthood and terrified at the prospect of it. A further source of confusion in this regard is the need for independence in the face of continuing needs for security and closeness, which whilst being valued, are rejected as being childish (Stein and Kent Davis, 1982).

Josselyn (cited in Balser, 1957) suggests two further aspects which attribute to the adolescent's confusion. First of all, they are emotionally more reactive to stimuli that in the past were easily assigned to a casual place in daily

experience. This results in a pattern of emotional liability and sensitivity which is confusing to the adolescent. Secondly, because of the rapid bodily change, adolescents' identity becomes obscured and they experience their bodies as being unfamiliar structures. It is not only the internal body that is new; it responds differently both externally and internally. Josselyn further submits that the internal changes result in new sensations, which whether pleasant or unpleasant, stimulating or guilt-arousing, are still strange and, therefor may be anxiety provoking and confusing.

In addition to these aspects characteristic of adolescence itself, the individual is also exposed to the impact of the unresolved problems of childhood. Josselyn (cited in Balser, 1957) submits that every conflict of childhood has a resurgence in adolescence. Resolving these conflicts adds to the complexity of adolescence, some causing more disruption than other.

In terms of a summary statement, Josselyn conceives of the psychological task associated with adolescence, in the following manner;

The adolescent thus has to become familiar with who he is and what he is striving to express, and then to adapt the person he is to the reality of the world and the demands of a more mature conscience, the latter still in a state of maturational change (Josselyn cited in Balser, 1957, p.15).

Josselyn substantiates her submissions concerning the centrality of ego functioning to adolescence by emphasising that self-definition, self-integration and adaptation are all

functions of the ego. Because of the multiple pressures to which the adaptive potential of the ego is exposed as mentioned above, it is not surprising that, at times, the ego is overtaxed.

For a young person with a limited time perspective, the instability of this period can therefor be understandably unsettling and disruptive.

C. SILENCE WITHIN THE CONTEXT OF PSYCHOTHERAPY WITH THE ADOLESCENT

The issue of silence in the context of adolescent psychotherapy, has been addressed by various authors. I preface this review with a poignant quote taken from Miller, based on his extensive experience with adolescents;

This is the stage of development at which one silent boy said in psychotherapy; "It is not that I do not want to talk to you, nothing comes into my head and I cannot" (cited in Mills, 1985, p.67).

Meeks (1971) asserts that it is almost impossible for an adolescent to tolerate the tension involved in remaining silent while being confined in an office or under observation. He submits that silence is likely to accentuate the adolescent's anxiety, his fearful fantasies regarding the therapist and his difficulties in perceiving the sympathetic and benevolent attitude of the therapist. He believes that "Any discussion, no matter how apparently or actually trivial or unrelated to the purpose of the therapy, is preferable to an anxious silence" (p.61). If necessary therefor, he

believes that the therapist should carry the responsibility for facilitating the conversation, periodically inviting the youngster's participation. A more passive role can gradually be assumed as the adolescent begins to become responsive.

With reference to the older adolescent, Meeks (ibid.) submits that silence can often be managed within the therapeutic alliance by interpreting the patient's fear of his angry impulses. In the younger adolescent however, he suggests that it may be wiser for the therapist to facilitate the silence by talking or by suggesting some activity. This obviously means sacrificing some potential depth in the service of a tolerable relationship.

Silence does not however always present as a transference phenomenon. Meeks (ibid.) suggests that in some instances, silence constitutes a character defence of inhibitions and withdrawal. Such individuals may never have learned to view emotional communication in a positive way. In such instances, the therapist should be prepared to carry the major burden of responsibility for the dialogue whilst skilfully and tactfully educating the youngster in the value and techniques of conversation.

Sarnoff (1987) shares his observation that if no questions are proffered by the therapist, the adolescent will in many cases offer only silence. It is as if the individual's associations drift away from the self to dwell in worlds away from troubles. He suggests that unless there is current

anxiety to hold the problem in the individual's attention, interventions may be needed to keep the therapy on track. Often the patient did not bring himself for help for the dysfunction that only an adult can see as being inherently dangerous. The individual who did not seek help may not welcome it and may turn his anger or disdain on the "intruding" therapist. He may turn from the therapist to silence or may drift in a direction away from the desired tendency to go inwards toward the self. It should be born in mind that when the adolescent is alone or with his friends, troubles are talked about and treated as passing things. With the therapist, the child is reminded of the extended implications of a problem and silence tends to supervene.

Sarnoff (ibid.) claims to have improvised a strategy according to which such withholding can be overcome. This technique consists of active questioning which will not lead the content of the session away from the ideational content of the child. He calls this technique, "Interpreting on the Predicate."

He submits that whatever a relating adolescent says, contains a referent to himself and in most instances, contains new material in the predicate portion of the sentence. Therefore, with the silent adolescent, a synthetic form of free association compounded of the patient's own ideas, can be produced. As therapist, one needs only to remember the predicates and in times of excessive silence, make questions

out of them. He suggests that we ask questions about such things as what the patient did last weekend or will be doing next weekend. Further, one may enquire about films seen, events at school, favourite television shows, etc. The patient's answers provide new information and a starting point from which to fashion further questions.

Berman (cited in Balser, 1957) asserts that silence in the treatment may be indicative of a patient's reluctance to acknowledge that he has a problem, a situation which may be experienced as embarrassing and humiliating. Or, the adolescent may resort to silence in an attempt to control and master his impulses. To put them into words would be too frightening. A tension is therefor caused by the presence of two forces; the necessary repression and the demand to produce.

He urges us to keep in mind that the adolescent may well be frightened by the silence and requires help to get over his distrust, defiance and need to maintain a distance between himself and the therapist. It is the therapist who should encourage the adolescent to go first to material that can be safely discussed, and then gradually to the current problems.

Blos (cited in Esman, 1983) submits that the passivity of the therapist, often considered to be an obligatory hallmark of intensive therapy, can have a most detrimental influence on the therapeutic relationship with an adolescent. He asserts that we need to bear in mind that the adolescent tends to

experience his own feelings and thoughts as originating outside himself and that projection is often employed. The "screen therapist" has no place in the face of the adolescent's state of increased narcissism which has to be counteracted by outside stimuli. Blos (ibid.) believes that prolonged silences may mobilise projective mechanisms with the result that the patient's ego boundaries become blurred and anxiety drives the adolescent into acting out, withdrawal and negativism.

Blos therefor urges us to constantly be aware of the disorganising influence of silence in the therapy of adolescents. Therapists need to remain tuned to the adolescent's threshold of tolerance in this regard.

Toolman (1987) reminds us that adolescents find it difficult to sustain a free flow of associations and often find silence not only painful, but also paralysing. Finally, Copeland (1974) reminds us that the younger the patient (within the adolescent phase), the less likely he is to be verbal and the less tolerant he is of silence. Early active intrusion into silence is thus appropriate and needs to be managed by the therapist.

Given the backdrop provided by a statement of the developmental tasks associated with adolescence and a consideration of silence within this context, we can now turn to a presentation of Gendlin's recommendations.

Ref.

D. GENDLIN'S RECOMMENDATIONS

Gendlin (cited in Hammer, 1972) prefixes his discussion by introducing a conceptually innovative system of classification with reference to various types of patients. Prevalent in contemporary psychology is the notion that the various categories of psychopathology each pertain to a fairly homogeneous group of patients, each with its own particular set of characteristics. So we find that we treat neurotics differently to psychotics, differently to the personality disorders. On a more subtle level, we treat the narcissist differently to the borderline patient.

Gendlins contention is however that few of these terms from psychopathology actually *tell us what to do in therapy*. They are not informative with reference to therapeutic procedures. For example, if a patient has been diagnosed as being "Schizophrenic - undifferentiated tendencies", what does this tell me as a therapist 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.

Gendlin therefor introduces an improvised system of classification with categories not based on the divisions of psychopathology, but rather reflecting the specific in-therapy behaviour evidenced. We are therefor primarily concerned with categories of in-therapy behaviour, not categories of pathology.

Compare for instance the above-mentioned diagnostic label with the following category; "Patients who are quite verbal, but speak only about external and daily events." Such a category suggests certain kinds of therapist procedures which can be articulated and debated. Note, that as mentioned, such a category is not a category of psychopathology, as some psychotics, some neurotics and some normals will present a therapist with this problem. Nor is it a class of patients as the same individual who exhibits one type of in-therapy behaviour today, may present a different type in the future. It is therefore not appropriate to settle for one patient class with reference to a specific individual - as Gendlin puts it; "after all, we hope he will change!" (Gendlin in Hammer, 1972, p.345).

It is against this backdrop that Gendlin introduces the notion of the silent patient. In a fairly informal presentation, he presents us with various categories of silent patients, each associated with specific therapeutic procedures. Those falling within the parameters of the case material, have been adapted and condensed by the present author into point form and are presented in a systematic manner. Some of the headings are not those of the original author, but have been provided by the present author. Furthermore, some procedures, differing only slightly, have been combined and presented under one heading. This processing has been done so as to present the information in a format which will facilitate the dialogue with the case

material. As many of these procedures were developed by Gendlin in his work with hospitalised patients, some of the examples reflect this origin. I have included such examples, even though the present case material does not pertain to a psychiatric setting, so as to remain faithful to the original material. Finally, before turning to a discussion of Gendlin's recommendations in detail, just to note that some of these recommendations do not only pertain to the silent patient, but are obviously basic therapeutic principles.

The recommendations which will now be discussed were all taken from Gendlin as cited in Hammer, 1972.

1. No Feedback Demand

As therapists, we often rely on a patient's response to let us know if our previous intervention was effective or ineffective. With the silent patient, such information is not forthcoming. Work with the silent patient therefor requires of us as therapists to continue working without the patient showing us that he hears us, that he agrees or denies or commits himself in any way. No feedback is therefor demanded.

2. The Sensible Person Assumption

Working with the silent patient requires of us as therapists to boldly assume that we are speaking to a sensible person there inside the patient. Often, in the face of the patient's total unresponsiveness, it is an assumption requiring much imagination. We need to assume that we are talking to a person in there, a fully human, almost

certainly suffering, person; Perhaps the person is unable or unwilling to send any sign - but there. Gendlin develops the metaphor of throwing something over a wall to someone. We cannot hear it land or tell if it is of any use to the person on the receiving end. Rather, it is thrown over the wall without expectation.

3. The Therapist is Self-Grounded

Work with this category of patient necessitates that the therapist makes it clear that he is speaking and acting on his own responsibility, because (s)he wants to say it or do it. Since the patient does not respond to what I as therapist say, it stands simply as what I wanted to say; Since he says nothing when I tell him the feelings I imagine he may be feeling, I make it clear that these are my imaginings. In this manner, we are not prematurely asking the patient to own various feelings and thoughts which (s)he is possibly not ready to own yet. In Gendlin's words, "I don't know how you feel about it. You haven't said. This just what I think of it" (ibid., p.347).

4. Ownership of Feelings is Specified

As therapist, when I intend to refer to the patient's feelings, I make that clear. When I speak about my own feelings, I make that equally clear. I clearly specify who is the owner of the feelings. This technique provides an invitation to the patient to own certain feelings when I nominate feelings which I believe he may actually be feeling.

On the other hand, when I refer to my own feelings, it leaves him uncommitted; It does not require that his feelings be prematurely clear to him or bearable enough to look at. "Patients are 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" (Gendlin *ibid.* p.347).

5. The Concrete Silence

In ordinary social intercourse, we feel compelled to fill time with words. This is based on the assumption that we usually think we are doing nothing (at least, nothing useful) if we just sit in silence next to someone. However, in the therapy of the silent patient in particular, the therapist talks about silently sitting together as something concrete. So for instance the therapist may name the silence saying, "It's all right to be quiet. We'll just sit together for a while." Or "We have approximately 10 minutes left until the end of the session. Lets just sit together quietly until the end of the session."

When we sit with someone, even if we have nothing valuable to say, that *is* something. Gendlin submits that he no longer needs constant evidence that he is being effective and helpful. He shares some of his personal experience when he describes how he has been in situations where his own pain could not be understood, and yet he received comfort just being with someone willing to *be* with him - someone who required nothing, could not grasp his torn-up feelings but

was human company, civilisation after wilderness. In his own words; "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" (ibid. p.348).

6. Manifesting Presence Periodically

Manifesting one's presence periodically can be of great therapeutic value to the patient. Gendlin suggests that the therapist lets himself be heard. He believes that the patient needs to hear the therapist often, to find himself in touch even while he cannot yet reach out or establish interaction. If the therapist is forgotten, the patient returns to isolated aloneness even while the therapist is with him.

What is said, usually demands no answer. If an answer is required and none is received, it should be indicated that this is all right. The therapist's periodic statements are often about himself, about what is going on inside himself, what he feels, imagines or wishes as he sits there. The patient may therefor say something once or twice or not at all; The therapist however says something every few minutes.

7. The Internal Frame of Reference Redefined

Gendlin recommends that as therapists we respond to the silent patient in such a way that what is said about the individual's feelings, can be checked and identified by him if he *chooses* to attend directly to what he is feeling. The therapist's response achieves its purpose if it refers directly and accurately to the patient's "felt meaning." The

Why?

response need not however be correct; it is just as helpful if it results in, "No it's really more like ...", as this allows for a process of negotiation. (Quite often, unfortunately, the silent patient will not attempt to dialogue what has been said with his own inner "felt meaning").

Rogers (ibid. p.367) calls this type of therapist response "taking the client's internal frame of reference." Such a response therefor says something which *could* be directly found and felt by the patient. It is therefor not an explanation, generalisation, external observation or a behaviour definition. Rather, it is a statement such that if the individual attended inwardly directly to the whole "feel" of what he was saying, feeling or doing just then, he would find there the feeling or meaning at which my response points. - Or, if the response is not quite right, he will find there whatever *is* there. The therapist should feel contented if his interventions can keep *pointing* at the present mesh of textured feelings being experienced by the patient.

One may well enquire as to the source of such therapist interventions. Gendlin submits that his actual trains of thought and feeling are the sources of his responses. He then describes a "process" according to which such an abundance of thought and feelings can be transformed into a verbal response. He correctly submits that a minute of silence is a

very long time! As therapist, one could never possibly say all that one thinks and feels - even if thoughts and feelings came in little "verbal units," ready to be spoken. Rather they come, he suggests, in "*felt masses*," only little of it in words. As the therapist sits there, he can convert *some* of what he is "feelingly thinking" into words. After some time, one or another of these thoughts seem fitting to tell the patient. These can now be mulled about, pondered upon, viewed from other sides and be shaped into a simple phrase. In the eventual expression, this simple phrasing is not necessarily adhered to. Rather, it ("it" being a feeling or a thought) is allowed to "run on in the therapists mind" and is allowed to come out of his or her mouth in a spontaneous tentative manner.

8. Using "Mistakes" Therapeutically

Some therapist responses came from a chain of thought familiar to most therapists - that is thinking about what (s)he (as therapist) has just said or done and how it could perhaps have been done differently. Especially with the silent and unresponsive patient, if the therapist has just said something and gets no response, (s)he can think of a thousand and one reasons why it might have been a stupid, wrong or threatening thing to say! These feelings are often experienced as a burden by therapists. Gendlin however suggest that such feelings, if used creatively, may well become a source of responses instead. In the following example, he describes such a process;

Suppose I had said, "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 realise 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. 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. 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" (*ibid.*, p.349).

As I, as therapist, respond to the patient in accordance with the "felt masses" (mentioned in the previous point) which come up for me after a possibly dubious intervention, he experiences me reacting to him, much as he would if he were verbal. He experiences my *intention* which is to focus on *his* feelings, *his* hurts as they were experienced by *him*, since this is the frame of reference of the things I say. His feelings may stir, become a little more alive and possibly more bearable than they were when he last could stand to look at them, *which he did alone*.

9. Making Contact in Non-Verbal Ways

Therapists and patients need not and do not only communicate verbally. Gendlin believes that isolated people need touch and many of our patients suffer precisely because they have

lost a degree of contact with their surroundings. He may for instance hold a hand firmly, or touch a shoulder, keeping his arms extended and stiff. He conceives of this as a way of saying "You, I am looking for you." Obviously the touching needs to be done in such a manner that it won't be confusing, sexual or frightening. (In his articulation of this point, Gendlin appears to be fully aware of the multitude of pitfalls which could result from misunderstandings in the realm of physical contact. In his defence he asserts that other modes of physical contact are common in for instance psychiatric settings - such as being pushed about by aides).

He believes that a firm grasp of a shoulder confuses few patients. So for instance, specifically with the silent patient, it is the only clear, fast and impactful way of saying, "I am here and I know you are here."

10. Accepting Rejection

Gendlin suggests that in our work with the silent patient, we be accepting of rejection. Rejection is a response; it has therapeutic significance and has potential for a follow-up intervention. He cites the following example from a psychiatric setting;

Suppose as I sit down, intending to keep a 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. 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* (present authors' emphasis). He is there but he knows I am here, waiting. He won't join me, but he knows I am here. *Much is happening* (present author's emphasis)(ibid. p.357).

The assumption is therefor that rejection is acceptable. It is not a bad thing for the client provided that the therapist can take it. In the above example for instance, how often has such a patient repeatedly rejected someone who nevertheless continued to want to know him? Almost certainly never!

11. Being Active

If little therapy is happening, often as a result of the silent patient's unreponsiveness, Gendlin believes that the broadest scope of action is desirable. When dealing with patients in a psychiatric setting, he will for instance get up and move around, sit down, go for a drink, perhaps tell the patient briefly how his day has been and so forth. The private practioner in a non-psychiatric setting obviously needs to engage in a different spectrum of activities.

12. Offering Health-Approaching Activity

Gendlin asserts that any patient activities approximating "what healthy people do," is probably desirable. The silent shy patient who seldom engages in light-hearted chit-chat may for instance well benefit from a few such moments in therapy. In general therefor, any move towards ordinary health is probably a good thing.

13. Utilising Redundant Activities Therapeutically

The silent patient often poses a unique challenge to the

therapist - the challenge of making contact with virtually no confirmation as to the meaningfulness or usefulness of a given intervention. With such patients, therapists often have to increase their "therapeutic repertoire" in an attempt to locate an area or an activity in which the patient indicates an increased responsiveness. The private practitioner may for instance engage the patient in a variety of predetermined exercises or games. A point is however reached at which these activities cease to serve as therapeutic vehicles. Gendlin suggest that the stopping of such an activity provides an opportunity for therapeutic work.

He discusses an example located in the psychiatric setting. In this particular case he increased his therapeutic repertoire with a schizophrenic patient to include the taking of walks and going to the canteen to buy soft drinks. This was done in an attempt to somehow "contact" the patient. At a certain point these activities became redundant; his concern was that the patient would not begin therapy at all but would rather conceive of the therapist as a benevolent caretaker whose purpose was to make his life slightly better by providing soft drinks and walks. To such a patient he might say "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" (ibid. p.360). Such statements stand as an invitation to deepen therapy from the level of sodas and walks to a more substantial and risking mode. The "soda and walk level" has

however been of value as it paved the way to a more substantial level of communication by providing an initial point of contact between the therapist and the patient.

14. Focusing on the Inward Side of a Feeling

Gendlin distinguishes between two sides to any feeling, an "inward side" and the "outer edge." He suggests that generally, we tend to express the *outer* edges of our feelings. We for instance say, "This and that which you did, hurt me." We do not say, "This and this weakness of *mine* made me be hurt when you did this and that." He submits that our task as therapists is to strive to find the inward edge of the feeling.

To find this inward edge of ourselves in our feeling, we need only ask ourselves the question "Why?" In the therapy of the silent patient we often find ourselves bored. This may result in our wanting to say "You bore me" or "You frustrate me." If however we find the "why" in ourselves which makes this so, we may find that "You bore me" is replaced by "I want to hear more personally from you" or "You are telling me what happened, but I also want to hear what it all meant to you." Gendlin, believes that what we find we need to express after having asked why, is often more personal, positive and safer to express.

He explains why feelings which first come up as anger, impatience or boredom have a positive side, in the following

manner. He starts with the assumption that nearly all our needs with our patients are positive ones; I need to be effective in helping him; I need to be successful in helping him arrive at his truth, I need to feel therapeutic. However, 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 astray. It therefor follows that when I ask "why" concerning my bad feelings, the emergent answer is a *positive* feeling; I am bored because I want to hear more personal, feeling-relevant things from him; I am angry because the time on which I count to be an effective therapist, is being wasted; I am critical of him because I wish something better for him. It is evident from the above how focusing on the inward side of a feeling can be a freeing experience for the therapist.

15. Openness to What Comes Next

This recommendation is based on the principle that a response is not in itself right or wrong. What is required is that we be sensitive to the *next* moment, that is, the patient's reaction to the response. If I can respond sensitively and accurately to *this* reaction, even if I have just said something possibly foolish or hurtful, a meaningful and positive interaction will emerge. Rather than having an over-punitive over-evaluative stance towards ourselves, Gendlin suggests that as therapists, we develop an open curiosity, a sensitivity and a readiness to meet whatever reaction we get. The over-evaluative stance, will inform me when what I have

said was "wrong" but this can be remedied if I *now* respond sensitively to what I have stirred up. *I now say whatever I now sense which makes what I said before "wrong."* That is, whatever it is which I now sense in him which makes what I said *wrong*, that is what I have to respond to at the next moment.

In the therapy of the silent patient, one often tends to be over-cautious as a result of the minimal feedback one receives. The above principle frees one to a certain degree in the realisation that as therapists we do not have to "get it right" every time. Almost anything is an opportunity for further investigation.

16. Being Sensitive to "Patient Overload" after (s)he has Volunteered a Response

In the therapy of in particular the silent patient, it may occur that a patient who says a few things after a long silence, is sorely oversensitive and cannot bear anything the therapist says in response. Gendlin suggests that if the patient winces with pain at whatever the therapist says, then we should be content to be silent. We may nod to indicate our understanding or possibly ask for a repetition. We can keep the responses we may have to ourselves, to be shared at a later stage when the patient is less vulnerable and more likely to own them. Even then, I make them mine, rather than loading them onto the patient. I should not imply, "what you said meant ..." or "means to me ..." Rather, I can say "I've been thinking - maybe you feel ..." In this way, I am

expressing it as my own. Some patients can stand anything that the therapist thinks, but cannot bear the same statement as an implication of what they have said. In Gendlin's words, "It is as if what they have said is all that can be stood and no more" (ibid. p.366).

The sixteen recommendations discussed thus far, have been taken from the first two categories of silent patients discussed by Gendlin namely "*Silent and Unresponsive*" and "*Silent but Responsive*." The remaining points have been taken from the category "*Verbal but Externalised*." Such patients never speak about their own feelings or personal meanings, only about others, external situations; events without their affect. The reason for the inclusion of recommendations from this category are two fold;

- Firstly, within the context of Gendlin's presentation, patients falling into this category can be conceived of as being silent, as they are not "giving of themselves."
- Secondly, the recommendations offered under this heading are of direct relevance in the treatment of the silent patient and can therefor justifiably be included.

17. Referring Interpretations Back to Any Aspect of the Patients Behaviour

The silent patient, perhaps more so then other patients, requires of us as therapists to be sensitive to any cues which may be indicative of the patients state of mind. Gendlin submits that whatever impressions, thoughts or

feelings we have of our patients, we received *from them* - from his behaviour or his speech. He suggests that the most useful way of sharing these impressions with the patient, is by referring back to whatever it was that created this impression in the first place. For example, I can say "The way you are *sitting* there - it looks sad to me, I don't really know - I'm wondering if maybe you feel that you'll never ever be happy again (present author's emphasis)." This strategy allows us to respond more specifically, rather than only giving the general conclusion.

18. Anything is "An Opener"

Gendlin suggests that if we look carefully, anything the patient says is an opener to a more personal communication. For instance, if the patient sees me smoking and says, "Smoking is bad for you" I can take it as an opener to relate, to talk about me, to discuss both my and his self-destructive behaviours, weaknesses and so forth. Attempts to develop such patient statements further do not always succeed, but with the silent patient, the need to explore all avenues of contact is paramount.

19. Retroactive Responding

This principle simply suggests that if I wish I had responded in some specific way a few minutes ago, or even the previous week, then I do so now. I might for instance say "You know, a while back, when you said such and such, well, I've given it some thought and I was wondering if" We do not

therefor have to wait for the patient to bring it up again.
The above nineteen recommendations or principles represent
the essence of Gendlins thoughts on the treatment of the
silent patient and will at a later stage be dialogued with
the case material presented.

CASE PRESENTATION: Jannike Kent

- A. BIOGRAPHICAL AND PSYCHIATRIC DETAILS
- B. A DYNAMIC UNDERSTANDING

CASE PRESENTATION: Jannike Kent

The case-material presented in this study is based on thirty-nine sessions of psychodynamic psychotherapy with a patient I have called Jannike Kent. The aim of this section is to introduce Jannike to the reader. The details provided reflect her life circumstances during the period of therapy. These will be presented under two headings, being "Biographical and Psychiatric Details" and "A Dynamic Understanding."

A. Biographical and Psychiatric Details.

During the period of therapy Jannike was sixteen years of age and resided with her mother only, in a town house located in a small Eastern Cape coastal town. She was a scholar and in the process of completing standard eight. Jannike had been referred by her family doctor as a result of his concerns about her eating habits.

The first session was spent with myself, Jannike and her mother present. During this session, Jannike came across as a shy and slightly sullen teenager. She was difficult to engage and responded to any questions directed at her in a reserved and blunted manner. She was overweight but well-groomed. Mrs. Kent was polite and appropriate and like her daughter, well-groomed. There was however an air of rigidity and inhibition about her and the session progressed in a sedate and

courteous manner.

Mrs. Kent reported that she was concerned about her daughter's weight, her shyness and her "not going out and getting on with her life." Jannike reported a similar scenario, indicating that she was hoping that therapy would help her to loose weight and to gain confidence. She had come to therapy of her own volition.

As the session progressed, it became clear that Jannike's shyness found expression in a general pattern of social withdrawal. She had a few superficial friendships at school but would never visit these friends after school or have them visit her. She spent much time in her room reading and seldom left the home other than to go to school. Enquiry revealed that this pattern of withdrawal typified Jannike's behaviour for approximately the last ten years. Her manner of relating in the session suggested a severe lack of confidence and social skills. At various point during the session Mrs. Kent deemed it appropriate to speak on behalf of her daughter. An enquiry about Jannike's academic progress revealed that she was not doing well and had only just managed to pass the previous year.

Enquiry as to Jannike's weight and eating patterns, revealed traits indicative of an eating disorder. She reported that she believed that the problem had started approximately five years prior to commencing therapy when she had gradually started putting on weight. She had found this increase in

weight distressing and had started the Weigh-less Diet. Two years later she had started purging herself by vomiting in an attempt to adhere to the prescriptions contained in the diet. For the following two years, these incidents of purging occurred approximately twice a week. A few months prior to commencing therapy, the purging had occurred once daily at which point her mother had found out. This resulted in decreased purging and upon entering therapy, Jannike reported that incidents of purging were now virtually non-existent. Details concerning her eating habits at that point in time, revealed that she was eating three small balanced meals a day. Enquiry revealed that she had never binged. Jannike was obviously distressed about her weight and she became visibly sad when I ask her about her feelings in this regard.

Upon enquiring, Mrs. Kent revealed two factors which she believed to be central to Jannike's present functioning. She reported that at age eight, she had sent Jannike to a private school because she had believed the tuition to be of a superior standard. Unfortunately, Jannike had not seen eye to eye with her teacher and this had caused her much distress. Mrs. Kent reported that it was at this point that she had noticed a deterioration in Jannike's eating habits. She started consuming vast amounts of food and this situation was exacerbated by her grandparents providing her with an abundance of sweets and cooldrink during regular visits. The second factor which Mrs. Kent believed to be of central importance, was Jannike's disrupted relationship with her

father. Jannike was not too willing to offer any thoughts as to the origins of her problems.

Enquiry as to Jannike's family history revealed that she was an only child who had grown up essentially with her single mother. Mrs. Kent, a nursing sister by profession, had divorced her husband when Jannike had been three years of age. Following this disruption, Jannike had stayed with her grandparents for a period of approximately two years. She recalls these years as having been happy and fun filled. During this period, contact with her mother had been minimal and she had experienced the subsequent return to her mother's home at the end of this stay, as being particularly painful and traumatic. This incident may well have been a pivotal factor in the history of her withdrawal.

In terms of contact with her father, the divorce had resulted in his leaving town and from that point onwards, Jannike had had very little contact with her father, the first contact she recalls occurring when she was ten years of age. In recent years, he would at times phone her on her birthday or during the christmas period. In terms of other family members, Jannike reported having a distant relationship with her maternal grandparents who reside in the same town. She recalls her mother having had two or three male friends, but claimed to have had little contact with them.

Details revealed during the session suggested a problematic

relationship between Jannike and her mother. Mrs. Kent reported that they had their "ups and downs." When I enquired as to the nature of the "ups," neither of them was able to volunteer any information. The "downs" were reported as having to do with each of them wanting their own way.

Having Mrs. Kent present provided an opportunity to enquire as to Jannike's early history. She reported that Jannike had been conceived out of wedlock which had resulted in a disastrous marriage between the two parents. Whilst Mrs. Kent had been physically healthy at the time of Jannike's full term and normal birth, the psychological milieu had been less than desirable. Mrs. Kent reported that Jannike had been a healthy and happy baby. However, as a young child, she had bitten her nails and at the age of six years, had needed a period of remedial teaching as her standard of reading had been significantly below average.

After this initial period of assessment, it was decided to offer Jannike psychotherapy on a regular basis.

B. A Dynamic Understanding

Seeing Jannike on a regular basis provided me with an opportunity to deepen and to expand my understanding of her and the issues which were of concern to her.

The most characteristic feature of Jannike's presence was her inclination to remain silent and unresponsive to any attempt to be engaged therapeutically or otherwise. During the early

stages of therapy, for instance, she at times said no more than four or five words during the course of a 50 minute session. With time it became clear that this pattern of withdrawal was associated with a life-style characterised by striking isolation and loneliness. She lived in a world in which people did not relate or reach out to one another.

This psychological milieu was the result of not only the literal absence of people around her with whom to engage, but also by the quality of the relationships that were available to her. It appeared that neither her grandparents nor her mother were able to offer this young person playfulness, love and warmth. This pattern of social and emotional deprivation was a characteristic feature of the major part of Jannikes life. There had always been only the grandparents and her mother as sources of interpersonal contact on the home front.

As time progressed, a certain image of Jannike became increasingly pronounced in my mind's eye and I utilised this to develop a metaphor about her. The metaphor arrived and was that of viewing her psychic life as a fragile flame, susceptible to being extinguished by even the smallest draught or breeze. It was this metaphor that informed my therapeutic stance and allowed me to keep my empathy alive during trying times. I conceived of the task of therapy as being the stabilising and strengthening of this inner flame by providing her with containment, understanding and

interaction. Jannike was not accustomed to being listened to and my conviction was that providing her with time and space, would result in a differentiation and amplification of her inner life.

On one level, Jannike was aware of this "dead" side of her which needed to be superseded by vitality and effervescence as is born out by the following dream;

I dreamt I had to get into a coffin. I didn't mind. Then I was inside the coffin. Suddenly I started getting worried that I would suffocate - because I wasn't dead. The coffin didn't close.

The dream was reported in session 5. Within the context of her life circumstances, I understood this dream to be a message to the world that even though she appeared dead in some ways, she was in fact not dead at all. The fact that "the coffin didn't close" constituted a message of hope that she conceived of the possibility of regaining her strength and vitality.

Within the context of this study, it is therefore important to take note of the following aspects of Jannike's functioning;

- Jannike presented with a particular kind of silence; the silence of a person who was suffering as a result of an undifferentiated feeling world; an emotionally underdeveloped person.

- She was unskilled in the interpersonal sphere and was therefore prone to anxiety in such circumstances. She was not sure of her own boundaries and abilities in such a setting.

- Her life circumstances had been such that she was not accustomed to viewing the interpersonal setting as benevolent and resourceful. This had implications with reference to her ability to trust another.

Having introduced Jannike to the reader, we can now turn to a consideration of the dialogue which occurred in interfacing this material with Gendlin's recommendations in the therapeutic setting.

AN EVALUATION OF GENDLIN'S RECOMMENDATIONS

A. INTRODUCTION

B. A DIALOGUE BETWEEN GENDLIN'S RECOMMENDATIONS AND
THE CASE-MATERIAL

C. DISCUSSION

D. CONCLUSION

AN EVALUATION OF GENDLINS' RECOMMENDATIONS

A. INTRODUCTION

This section will comprise a dialogue between Gendlin's recommendations and case material taken from therapy sessions with the case presented. In this section, each recommendation will be presented within the context of relevant case-material so as to illustrate the applicability of each recommendation. The therapeutic benefit derived from the implementation of the recommendation under discussion, will be documented before proceeding to the next recommendation.

This presentation will be structured as follows;

- The initial discussion will deal with two of Gendlin's recommendations which I believe to be essential to the therapy of any category of patient, not just the silent patient. They are "base-line" prerequisites, of vital importance to any therapeutic encounter.
- Following this, the most central challenge experienced in the therapy with Jannike, namely that of finding an optimum position in terms of a rhythm of closeness and distance, will be discussed with reference to one of Gendlin's recommendations.
- The remainder of the recommendations are then discussed after having been divided into two categories. These two

categories will be introduced at the appropriate point in the text. 17.

- The remainder of this section will comprise a discussion. This discussion will consist of a general evaluation of Gendlin's recommendations, a consideration of these recommendations in terms of the literature presented and a discussion of recommendations and techniques not discussed by Gendlin but which were nonetheless found to be of value. The section will end with a few concluding remarks.

The reader may at various points like to return to the initial exposé of each recommendation. For this reason, page numbers have been included where relevant.

B. A DIALOGUE BETWEEN GENDLIN'S RECOMMENDATIONS AND THE CASE-MATERIAL

As has been mentioned earlier, some of Gendlin's recommendations are essentially relevant to the treatment of the silent patient, whereas others are more basic therapeutic principles. One of his recommendations in particular, I believe to be a prerequisite for any successful therapy, namely *The Sensible Person Assumption* (p.22). If, as therapists, we are not prepared to accept the assumption that our patients are real sensible people with the potential to flourish, then our task may well be doomed to failure.

Mentioned earlier was my conception or image of Jannike as a fragile flickering flame, vulnerable to even the slightest

breeze. Given that my conception of her was as a vulnerable person, my assumptions about her however were that she had the potential to become a rich and vital person. Extending the metaphor, I believed that she had the potential to become a powerful illuminating torch. The sensible person assumption is not however something that can be illustrated at the hand of an example. Rather, it was an attitude which I as therapist embodied with reference to Jannike. My belief is that her sensing my inherent respect for her, was a part of the therapy which both revitalised and contained her. It was as if my conception of her as a sensible person, created a space for her "to grow into."

wrong

A further recommendation which I believe to be a basic therapeutic principle, is Gendlin's assertion that the therapist should be *Accepting of Rejection* (p.29). Part of the patient's process may well result in a rejection of the therapist at one point or another. We are reminded of Winnicott's dictum that the therapist needs to fail his patient. In the therapy with Jannike, I was seldom called upon to be accepting of her rejection as she never rejected me in a substantial manner. At times, after my having for instance shared an insight with her, she might have said, "No, I don't feel like that" or "None of what you said really fits." Whilst in a sense these statements were a rejection of me, on the whole, they were construed by me as being essentially positive as they were indicative of a process of differentiation and a kindling of inner life and vitality. At

one stage, I grew a beard and it was obvious from Jannike's facial expression that she did not find the new look becoming - I chose not to address this "rejection."

In my therapy with Jannike, there was one particular challenge I faced which I believe to be possibly the most central feat to be accomplished by the therapist dealing with the silent patient. In a nutshell, the problem is that of finding an optimum stance or position at any given moment, in terms of a rhythm of closeness and distance. ✓

The optimum stance required of me by Jannike, was a fairly precarious stance which lay midway between being too close and too distant. At times I felt as if I was stuck in a dysfunctional static point between two feasible modes of being present to a patient. Neither vigorous exploration nor mere support were feasible ways of being with her. If I came too close to her, became too interactional and vigorous in my working, she clammed up instantly and became blunted and unresponsive. On the other hand, if I did not engage her sufficiently, she felt abandoned and became resentful, anxious and highly uncomfortable in the silences. The stance I therefor had to assume with her lay between these two points, namely the point at which she felt that she was neither abandoned, nor experienced demands being made of her. Maintaining this optimum position had certain implications in terms of therapist action and the process of change. The most important consequences of maintaining this middle position

was that Jannike gave me very little feedback with reference to her feelings, thoughts and even factual information. I was faced with the task of attempting to work therapeutically with a patient *who gave me virtually nothing to work with*. The challenge was to attempt to present something in the between which would resonate with something within Jannike. My task was to try to think, feel or sense what was happening for her and then to share this with her.

I have called the manner in which I did this, *Thinking Aloud*. This process or technique is very similar, if not identical to Gendlin's recommendation, *The Internal Frame of Reference Redefined* (p.25).

Let us now turn to a consideration of some case-material to illustrate what is meant by these two allied terms;

The context of this example was roughly the following; Jannike had come in at the beginning of the sessions stating that her father had come to visit the week before. I decided to pursue this in an attempt to explore her more deeply seated feelings about her father. The session proceeded as follows;

Therapist:

Would you like us to look more closely at some things around your father?

Jannike:

Yes

Therapist:

Any thoughts or feelings?

Any where in particular you want to start?

Jannike:

No

Therapist:

Is it okay if I structure things a bit?

Jannike:

Yes (I proceeded to enquire as to the nature of the contact that Jannike had with her father. For a few minutes this was fertile ground and then she indicated clearly that she didn't want to have anything to do with

him. At that point she withdrew and became unresponsive. After a few minutes of silence, the session proceeded as follows);

Therapist:

Seems to me that a part of you possibly feels a bit dead about him?

Jannike:

Yes

Therapist:

I'm wondering if it is an easy deadness or a heavy deadness - is it difficult for you to feel dead about him?

Jannike:

No, it's easy.

(Various attempts were made to facilitate her feelings without much success - she remained silent. The session then proceeded as follows);

Therapist:

I've been wondering - you mentioned previously that you were born out of wedlock - I'm wondering how you feel towards your parents about this - pause - And then they divorced soon after your birth. That left you and your mom on your own.

Silence - few minutes

Therapist:

And you're an only child - I was wondering - That might have left you rather lonely at times.

Silence

Therapist:

Perhaps there were times when you wanted to share things, but there wasn't anybody there - Must have been tough? - Pause - From a few things you've mentioned in the past, I'm wondering if in some ways you possibly had to grow up fast.

Silence

Therapist:

I suppose it's okay, it's okay to be tough - but maybe there are other parts of you that also want to come out.

Silence

Therapist:

At times I've felt that there may be a fragile sensitive Jannike who wants to be put to bed and to have her head stroked until she falls asleep - pause - But then there's also the playful Jannike who wants to have fun, to take chances and laugh.

Long silence



Therapist:

Jannike, in these last few minutes, I've just been thinking aloud about what your life may be like - I'm probably wrong in some ways, - but are some of the things I said right?

Jannike:

Strong nod of confirmation.

The above extract clearly illustrate Gendlin's recommendation. I responded, as recommended, to Jannike's feelings in such a way that what I spoke about, could be checked and identified against her own experience if she choose to do so. I speculated about feelings and thoughts which could possibly be directly found and felt by her. Jannike's strong nod of confirmation at the end of my contribution suggested to me that my responses had actually achieved their purpose as they had pointed to the mesh of textured feelings and thoughts being experienced by her.

Gendlin describes the process which fuels such contributions in terms of the transformation of felt masses in the therapist into tentative phrases offered to the patient. My experience with Jannike suggested a similar path. I conceive of this process whereby the therapist arrives at his contribution in terms of a three stage process;

- Firstly, my task is to be sensitively attuned to my patient in terms of her whole presence. This is done in an attempt to glean any information available which will inform me as to her presently available felt referents. In the above example I utilised various facets of Jannike's presence; I listened to the few words she said, I was sensitive to her facial and bodily expressions and was attuned to my own counter-

transference feelings.

- The second stage of this process consists of the construction of a more integrated and global felt sense of the patient and what the present issues may well be for her. This process of integration is based on a manipulation of the various fragments provided by the present "reading" of the patient against the backdrop of knowledge which I have already acquired with reference to the patient. In the example described above, Jannike's biographical details provided a framework within which to contextualise and conceptualise the fragments of information obtained in the session. I know for instance that Jannike is an only child, was conceived out of wedlock and stays with her emotionally reserved mother.

- The third stage comprises my conveying to the patient this felt sense that I have of her. This should be done in a tentative and gentle manner which encourages her to consider what I have offered and to feel free to accept or to reject it.

In the above example I had therefor empathically invited Jannike to face the wealth of feelings she may have towards her parents and paved the way to her facing and accepting her possible feelings of abandonment and loneliness. As illustrated, in the above example, she accepted my contribution.

In the case-material provided above, this three stage process of response formulation is therefor clearly illustrated. In

the initial stage a comprehensive "reading" of Jannike provided me with various fragments of information. In the second stage which temporarily cannot be distinguished from the first stage, these fragments of information were manipulated with the aim of arriving at a more global picture of Jannike. In the final stage, I thought aloud and presented her with some of my thoughts and feelings. It was by utilising this process that *I was able to continue the process of therapy beyond the point at which Jannike had withdrawn; without abandoning her or making demands of her.*

Movement in the therapy with Jannike largely depended on *my ability to disclose Jannike to herself.* Redefining the internal frame of reference as suggested by Gendlin, was a useful tool in this subtle challenge.

Three of Gendlin's recommendations have thus far been discussed. In an attempt to systematise the rest of the discussion, the remainder of the recommendations have been divided into two categories. Recommendations falling into the first category will comment directly on the process of therapy with the silent patient. The second category will include those recommendations which require an active stance from the therapist in the challenge of overcoming the prolonged periods of silence characteristic of therapy with the silent patient. Suffice to say at this point that a few of the recommendations do not fit snugly into either of these categories. In the service of structure, this division has

however been implemented.

The discussion will commence with a consideration of those recommendations falling into the first category. The first two recommendations will be discussed with reference to the case-material already presented.

In the dialogue between the therapist and the patient thus far recorded (p.50) it is clear that *Ownership of Feelings is Specified* (p.23). In my "thinking aloud" I constantly indicated the ownership of the feelings I shared. This ownership was specified in the manner and terms in which I addressed Jannike. Many of my contributions were prefaced with the words "Seems to me that ..." or "I'm wondering if" When I intended to refer to her feelings, I did so by specifying that *I* felt that *she* may be feeling x,y and z. For instance, "I'm wondering - pause - is it difficult for *you* to feel dead about him?" or "*I'm* wondering how *you* feel toward your parents" As Gendlin has mentioned, patients are rarely disturbed by what the therapist thinks if it is conveyed in such a manner that ownership is clearly located with the therapist.

Specifying the ownership of feelings in my therapy with Jannike allowed her to differentiate clearly between me and my feelings as opposed to her and her feelings. It facilitated her conception of therapy as being an encounter with another. Providing these two poles in the therapeutic relationship allowed her to process and integrate the

material presented from my side at a pace which suited her.

An allied point is Gendlin's recommendation that *The Therapist is Self-Grounded* (p.23). Referring back to the second half of the case-material presented (p.51), I made it clear that the assumption made about her life, originated in me as a separate person from her. I postulated the possible existence of two further aspects of Jannike seeking expression (... "there may be a fragile sensitive Jannike... " and "the playful Jannike who wants to have fun ..."). The benefits derived by Jannike from this manner of interacting are much the same as those discussed in the point above, namely that it facilitated an encounter between two separate entities. It allowed her to experience me as a whole and real person, not just a set of techniques being executed with her as the point of focus.

I also expressed my self-groundedness in other ways. At various points in our time together, Jannike and I discussed debatable topics such as morality and religion. During these discussions I disclosed some of my own feelings in a tentative manner so as to allow her "to come up against somebody." This sparking off of ideas between us facilitated her process of arriving at her own personal convictions with reference to these matters.

Therapy with Jannike was characterised by long periods of silence. Gendlin's recommendation is that we treat such silences as something concrete (*The Concrete Silence*, p.24).

In my relationship with Jannike the key to concretising silence lay in the naming and addressing of it. In our time together, this was done during virtually every session, if not two or three times in the same session.

During our first session together, the issue of silence was addressed directly. I indicated to Jannike that we were bound to have plenty of silences during the course of therapy and that they may well be awkward. I further indicated that the awkwardness was not however in itself problematic and that we could talk about it. I offered silence as being a legitimate way of being together, as yet another way in which we could communicate. This initial brief was repeated at regular intervals during the early phase of therapy. During the course of therapy, silences were often named and negotiated as they occurred. At one stage we discussed the various faces of the silences we had encountered. Together we identified the "uncomfortable silence," the "peaceful silence" and the "dead silence."

In session 18 I traced the history of the silences we had experienced in the time that we had spent together. This occurred during a session in which Jannike had been far more responsive and playful than usual. At a certain point, after having worked fairly vigorously with issues pertaining to her family life, we both lapsed into a peaceful and relaxed silence. It was at this point that I shared with her my conception of the changing face of our silence together;

Therapist:

I was just wondering - we've spent the last few minutes in silence - how has it been for you?

(Jannike did not respond verbally but I took her smile and a nod as indicating that the silence had not been uncomfortable to her).

Therapist:

You know, we've spent nearly twenty sessions together. Do you remember in the beginning our being together in silence was nearly always difficult - it seems to have changed with time - it's as if we are at times more able to relax in one another's company. - pause - Does that feel right to you?

(Jannike nodded her acknowledgement - which I know from my experience with her she wouldn't have done had she not agreed with my statement).

Addressing the silence as something concrete and real as illustrated by the case-material above, inevitably resulted in an easing off of the tension with reference to the silence between us. This easing off of the tension between us, allowed Jannike to spend time thinking and feeling in silent retreat, *yet contained*.

As has been mentioned previously, I was constantly sensitive to Jannike's degree of discomfort during prolonged silences. A useful technique recommended by Gendlin to soften the blow of such silences, is *Manifesting Presence Periodically* (p.25). At times I would think aloud and share any thoughts I had about what may be happening for her. For instance, I might say "You seem a bit sad" or "It's all gone dead inside, has it?" At other times I shared with her what was going on inside me. For instance "You asked me earlier what it was like having a brother and a sister - I'm sitting here and wondering what it is like not having brothers and sisters, like you." Such manifestations of presence provided

containment and support during periods of silence in which it was clear to me that she was suffering as a result of what was happening inside her. My reaching out therefor provided islands of contact in an ocean of often painful silence.

Jannike's unresponsiveness and silence at times resulted in feelings of anger, frustration and boredom within me. During these moments, *Focusing on the Inward Side of a Feeling* (p.32) became a valuable aid to me.

During the later phase of therapy, after having had an exceptionally fertile sessions with Jannike, my feelings of well-being and competency inspired me to spend some time reading my notes on previous sessions so as to further improve my grasp of Jannike's case. I started the next session full of enthusiasm and hope - only to be met by a totally silent and unresponsive patient. At this point, I recall feeling frustration and anger which as the session progressed, turned to despair - How was I to help this girl!

After a period of silence, a degree of clarity returned to me. The following dialogue, taken from session 29, followed;

Therapist:

Jannike, sitting in silence like this has allowed me to dwell on my own thoughts and feelings. What I've come up with, is that I feel bankrupt. As I mentioned to you in the previous session, we have approximately 11 sessions left. My wish is that in the time left, we can together create something valuable for you to take away with you. But I'm not sure how best to do this. I feel that I reach out to you, but that for some or other reason, you aren't able to be here.

Silence

Therapist:

As I have suggested in some of the previous sessions, I want you to take a deep breath and to see if you can find something which lies behind the deadness.

Silence

Jannike:

I feel sad.

Therapist:

Okay - Is it okay if I become a bit like a policeman and dig a bit?

Jannike:

A timid nod of permission.

Therapist:

When we are sad, it means that we feel we may be losing something - what is it you feel you are losing?

Jannike:

We will be ending in 11 sessions.

(At that point, she became tearful - the saddest I had ever seen her).

Therapist:

Yes, I too will be sad when we stop - pause - and this isn't the first time that you have lost someone.

(As the session was nearly over, I supported her in silence for a few minutes and then ended the session as follows);

Therapist:

Jannike, you've been brave. We decided that we would look behind the deadness - and you did. - Pause - I feel much closer to you now, after your having shared your feelings.

(The session ended soon after this with a few supportive concluding remarks).

At the point at which I regained some clarity mentioned earlier, I had changed my focus from the "outer edge" to the "inward side" of my feelings. By focusing on the inward side, I was able to regain my empathy and energy and managed to reconceptualise the feelings around my bankruptcy in terms of my desire to give Jannike something of therapeutic value in the remaining 11 sessions. As is clearly illustrated by the case-material, this change from the "outer" to the "inner" resulted in a substantial deepening of rapport and paved the way to addressing and exploring the issue of termination with

Jannike.

In session 26, after a period of prolonged silence, Jannike said "I don't like the silence, I wish you would say something." In previous sessions, after such a request, I would have facilitated the silence. This would have been done either by addressing the silence directly, or by introducing a topic for discussion. However, in this session, I felt inclined to let the silence continue for a while. It was as if the quality of the silence, or her presence to it, had shifted. I therefor prolonged the silence, being unclear as to the consequences of this decision.

At this point, I employed one of Gendlin's recommendations; My stance was one of an *Openness to What Comes Next* (p.33). In the moments that followed, Jannike remained pensive but silent. During this period I gave her my full non-verbal attention in an attempt "to carry her through the silence." I remained open to any communication from her - perhaps a sign that she was "drowning," or a "sign of life" that could be encouraged and followed up. Fortunately, my risking paid off as after a brief period of silence she volunteered an area for discussion.

The area she nominated was a central therapeutic issue, namely her weight. In the discussion that followed, she accepted more responsibility for the continued flow of the session. This change may well have been the result of my having provided her with a challenge and having been

supportive and *open* to her in the moments that followed.

With Jannike, being as vulnerable as she was, respecting the sequence of her unfolding was important throughout. This resonates with Gendlin's recommendation, "*Being Sensitive to Patient Overload after (s)he has Volunteered a Response* (p.34). The way in which we were together in session 12 illustrated this recommendation.

In this session, various aspects of Jannike's interpersonal relatedness were explored. The picture which emerged was one of severe isolation (no father in the home; an emotionally reserved mother; being an only child; no aunts, uncles or cousins; no good friends at school, etc.). It seemed that the only unconditional and spontaneous love she received came from her neighbours pets, two playful dogs. As this picture of isolation and detachedness developed, the theme of loneliness became increasingly pronounced in my thoughts. I shared this with Jannike in the following way;

Therapist:

As we sit here, I'm aware of all kinds of feelings inside me - it reminds me of times when I have felt alone; separate from others. Do you know this feeling?

Jannike:

Sometimes I feel a bit lonely.

(This was said in such a brittle, robot-like manner that I was momentarily taken aback).

What this tone conveyed to me was something like "Yes, I am lonely, but I can't look at it any closer and I *don't* want to talk about it now." I did not explore the statement any further for fear of overloading her. Rather, we both silently acknowledged her loneliness. It was as if we had come to an

agreement; The loneliness was very important, but we would deal with it later.

In session 30, the theme of loneliness was worked with vigorously and rewardingly. She was now able to work with it without the fear of being totally overwhelmed by it.

Perhaps one of the most central pointers in the process of therapy with the silent patient is what Gendlin refers to as *No Feedback Demand* (p.22). In my work with Jannike, I received very few cues according to which I could structure and pace the therapy. This required of me to "read" her in as comprehensive a manner as possible, as the verbal cues alone were not sufficient to sustain therapy. Making demands of her would have been inappropriate as her pattern of silence and unresponsiveness was obviously part of her pathology.

The challenge of attempting to facilitate the silences without demanding any feedback, required a particular stance from me. I was aware of having to *trust* myself more as a therapist. I had to be increasingly willing to *risk* myself, to offer interventions which I could only substantiate *intuitively*. The absence of overt feedback increased the importance of working with her *dreams*. As therapy progressed, I found myself becoming increasingly *attuned to the subtleties of her bodyliness*; her eye contact, hand movements, the general tone of her body, head movements, facial expressions, etc. A degree of *tolerance* not often required with the more responsive patient was required of

me; At times I had to work at keeping my empathy alive. a) ✓

This stance of tolerance towards Jannike's unresponsiveness was therapeutically beneficial in that it facilitated the process of inner differentiation without being demanding and insisting on a commitment from her - something she was unable to give.

Gendlin, in his recommendation entitled *Retroactive Responding* (p.36), suggests that as therapists we should feel free to return to the discussion of an issue which was raised, but perhaps not resolved in a previous session. In sessions 26 and 27 such an incident occurred.

Session 26 had been a particularly dead session in which I had worked particularly hard at facilitating the silence - without much success. Towards the end of the session I felt a bit angry and fairly desperate. As I drew the session to a close, announcing that time was up, the following dialogue occurred;

Jannike:

For how long are these sessions going to continue?

Therapist:

We decide that together, perhaps you can give it some thought and we can discuss it next time.

Jannike:

I didn't say I wanted to stop, I was just wondering for how long we are carrying on.

Perhaps because of my state of mind, I did not immediately recognise this as the emergence of a termination issue. As she left through the door, this thought however dawned on me - but it was too late. I was therefor left with something I

wanted to say to Jannike without having her there to hear me out.

In session 27, I responded as follows;

Therapist:

I've been thinking about last week's session. Do you recall, it was a difficult session. - Pause - Towards the end of the session you asked for how long we would still be meeting. well, I counted the number of sessions - we have 12 sessions left.

Silence

Therapist:

I've been wondering if last week's difficult session had anything to do with us ending. You know what it's like; Sometimes when we know a friend is going to be leaving town, it's as if the friendship starts becoming a bit sticky?

Having carried over a theme from the previous session via this retroactive response, allowed us to address the issue of termination in this session. She chose not to engage me in this regard but the hope was that this initial work paved the way to dealing with termination issues in later sessions.

As mentioned earlier, this discussion has been divided into two fairly flexible categories. The recommendations discussed thus far, have commented essentially on the *process* of therapy with the silent patient. The remainder of Gendlin's recommendations to be discussed will be those requiring an active stance from the therapist in his attempts to facilitate the periods of sustained silence.

Silent patients, because of their lack of responsiveness, are invitations to therapists to develop and to improvise new ways of being active so as to therapeutically facilitate the

time spent together. Gendlin submits similar sentiments under the heading *Being Active* (p.30).

In the therapy with Jannike, I employed various techniques which required an active stance of me. At the beginning of each session, I often did what I have called "mopping up." ✓ This consisted of a set of routine questions I asked with reference to various facets of her life. I would for instance enquire about her dreams, any snippets of information about her week at school/home and about how she was feeling at the present moment. This principle of actively enquiring was extended into the session by my actively nominating various previously determined nodal points for discussion. For instance, "How are things going with you and mom?" or "Have you had any further thoughts about your dad?" This technique of actively questioning was done in an attempt to find Jannike's energy which, once located, could then be pursued.

At other times, I would introduce a fairly safe topic for discussion which I would then treat as a projective technique. In the therapy with Jannike we for instance discussed the type of car she would like to drive (a red MG) and how she would like to decorate her home one day. The information I gleaned from such an exercise was fed back to her in the hope of increasing her self-knowledge (e.g. "that's an unusual car - perhaps you yourself are unusual in some ways?").

Another activity I introduced was recommending a specific book for her to read. At one stage I recommended Paul Gallicos' Love of Seven Dolls as I believed that the abundance of readily accessible feeling-life would hopefully invite her to contact some of the blunted feelings inside her. This exercise proved to provide a bond between Jannike and I via this shared activity.

Central to my being active was developing Jannike's imaginative and creative abilities. In one session I asked her what she would do if I gave her a magic wand. She indicated that she would like to be on horseback in the veld. This informed me as to the desire of her psyché to be mobile and not tethered by various restraints. In a further session, I asked her if she was happy with her name. What followed was her nominating a new name and us together exploring what the "new Jannike" would be like. My belief is that these activities facilitated a sense of future in Jannike which was sadly lacking in the initial stages of therapy.

From the above it is evident that my active stance as therapist illicited a wealth of information and enhanced the process of therapy.

Offering Health-Approaching Activity (p.30), a further recommendation posited by Gendlin, is aptly illustrated by the following case-material. As therapy progressed, there were moments during which a milieu of friendship existed

between Jannike and I. Often, she would take the initiative by asking questions such as "Have you been overseas before?" or "What kinds of books do you like reading?"

Whilst being aware of the many dangers of becoming too familiar with the patient, I decided not to "kill off" or to interpret these statements. The reason for this was that given her isolation, I was of the opinion that Jannike stood to benefit greatly from exercising some skills required in initiating and sustaining a friendship. Simply attempting to manage a friendship was a challenge to her. In addition to this, I respected her attempts to save us from the awkward silences. Allowing her these overtones of friendship created a space for her within which to exercise and to develop her skills of assertiveness.

Many of the activities Jannike and I engaged in were not in essence therapeutic. As has been mentioned, time was spent on talking about such things as fashion, music, books, aerobics classes, etc. The challenge I was constantly faced with, was the task of deepening such talks into something more personal. A discussion we had in session 18 is a choice example of Gendlin's recommendation that *Anything is "An Opener"* (p.36).

In this session, I enquired of Jannike if she had read any books recently. She mentioned that she had just finished The World According to Garp. In response to my asking if she had

enjoyed it, her response was that she had found it full of infidelity. Together we explored this theme of infidelity which deepened to the extent that we ended up dealing with her anger at having been conceived out of wedlock. Discussing a fairly neutral activity such as a book she had read, had therefor provided an opening to a more personal communication.

Gendlin submits that *Referring Interpretations Back to Any Aspect of the Patient Behaviour* (p.35) is a useful tool to be used in the area under discussion. In session 10 an incident occurred which provided me with such an opportunity.

In this session, Jannike came across in an emotionally blunted, but not entirely unresponsive manner. After a fairly long silence, the following dialogue occurred;

Jannike:

What are you thinking?

Therapist:

(I paused for a moment to gather my thoughts and then decided to be truthful);

I am trying to find an image in my mind which comes up for me when I think of you not talking.

Jannike:

Responded by shooting a glance at her watch, presumably to see how much time there was left.

Therapist:

Jannike, I noticed that as I spoke, you looked at your watch - pause - Perhaps you feel a bit uncomfortable at the idea of me getting to know you too well?

Jannike:

Gave me a smile of acknowledgement.

Having referred an interpretation back to a specific aspect of her behaviour had therefor provided a moment of honesty between us which resulted in a deepening of rapport.

In his recommendation *Using Mistakes Therapeutically* (p.27), Gendlin submits that "mistakes" by the therapist may well serve as the source of a therapeutic response. In session 16, an incident occurred which provided me with an opportunity to turn a "mistake" into a meaningful interpretation.

In this session, Jannike came across in a playful manner but did not take up any attempts by me to deepen the session. We ended up discussing a variety of issues as is often the case when I "scan" in an attempt to locate an area within which to work. The following dialogue occurred towards the middle of the session;

Therapist:

Have you seen anything good on television recently?

Jannike:

No

Therapist:

Did you not see the crowning of Miss South Africa?

(As fashion and beauty is an area often discussed, I thought this to be a safe area.)

Jannike:

No - (Said in a curt cutting manner - assumed her withdrawn and blunted posture).

Silence

Therapist:

I sometimes get the feeling that you feel uncomfortable when I become too inquisitive - but then, on the other hand, I'm wondering if you feel a bit left out when we don't talk about you at all?

In this dialogue, I had construed the curtness of her reply as saying "I don't want the focus on me fully, but don't introduce other characters (women) who could take my place either!" I therefor chose to make the interpretation relating to the rhythm of distance and closeness.

My "mistake" had therefor provided me with an opportunity to work with an issue of central importance. The session proceeded in a less fragmented manner from this point onwards.

Events occurring in sessions 14, 15, 16 provided me with a unique opportunity of *Making Contact in a Non-Verbal Way* (p.28).

In session 14, a substantial amount of time was spent dealing with Jannike's relationship with her father. At one point, she said in a rather brittle voice, "He doesn't care about me." As she said this, a shiver ran through her body and I was aware of goose-flesh on her legs. I reached over to another chair and took my jacket which I then offered to her to put over her legs, while saying, "This thing with your dad really chills you doesn't it."

In session 15 and 16, similar scenarios unfolded. As session 15 proceeded, I became aware that Jannike was becoming colder and colder. At one stage I left my chair and switched the heater on beside her. (This warmed the session in more ways than one). In session 16, she was so cold that even though she was warmly dressed, she sat shivering in her chair. I suggested to her that we put her chair in the sun and then promptly did so.

I had therefor "read" her being cold as her asking me for warmth in a very concrete manner and had obliged. It was as

if a non-verbal support structure, running parallel to the main therapy, had developed in the ritual of my providing her with warmth. ✓

Utilising Redundant Activities Therapeutically (p.30) is yet another recommendation posited by Gendlin as being a potential opener to a more personal communication. During the first few sessions of therapy with Jannike, I employed various games and activities to tide us over the initial period of discomfort. Such activities included the making of a collage and the playing of a "squiggle game." During this initial phase, these activities were therapeutically functional, but with time such activities ceased to serve a therapeutic function.

At the end of session 2, my feelings were that this point of dysfunction had been reached. I started session 3 as follows,

Jannike, I know it's difficult for you to talk about the things that are upsetting you. However, at the end of the last session, I was left with the thought that perhaps you were feeling a bit frustrated because we weren't talking about these things that are so important to you.

She nodded her acceptance of the point I was making. Utilising this redundant activity therapeutically had therefor served as a catalyst which moved the therapy from the "getting to know you" phase to a more therapeutically vigorous phase.

Having presented each of Gendlin's recommendations within the context of the pertinent case material, we can now pause to

reflect on this dialogue.

C. DISCUSSION

As has been stated, the intention of this dissertation is to examine the usefulness of Gendlin's recommendations in the treatment of the silent patient. In reviewing the material submitted thus far, one cannot but be struck by the graceful interface between Gendlin's recommendations and the case material presented.

It was with great ease that I was able to illustrate the recommendations at the hand of material taken from my work with Jannike. In terms of an itinerary of practical interventions, skills and guidelines to be used in the therapy of the silent patient, these recommendations are therefor undoubtedly of great value. Viewed in their totality, these recommendations are indicative of an inherent respect for the patient and his concerns and a gentle, containing and yet efficient stance is encouraged from the therapist. An approach is invited in which listening skills, in the broadest sense of this concept, are emphasised, rather than a generalised fuelling of our interventions from book-knowledge.

Within the parameters of these recommendations, the therapeutic relationship is conceived of as an unique encounter between two people. The concerns of the patient as an individual, rather than as a member of a category of

patients, is emphasised. Both the sequence and the pace of the patients unfolding are respected.

With reference to this particular case, not all the recommendations were of equal importance. *The Internal Frame of Reference Redefined* and *The Concrete Silence* were probably the most central. It is likely that the relative importance of each of Gendlin's recommendations will differ from case to case, depending on the particular set of variables involved.

In reviewing the contributions of the authors mentioned earlier under the heading "Silence Within the Context of Psychotherapy with the Adolescent," two central pointers emerge. Firstly, in the therapy of the adolescent, silence is more often than not counter-therapeutic as it induces a variety of negative states in the patient. Secondly, it is emphasised that it is the responsibility of the therapist to actively facilitate the silences which occur during the course of therapy.

Gendlin's recommendations are in harmony with these dictates as the inherent assumptions and convictions implied in the formulation of such a set of recommendations, is that at some point in therapy silence becomes dysfunctional and needs to be directly addressed and facilitated by the therapist. The case material presented constitutes one example after the other of silences being addressed in an attempt to avoid the development of negative states which could occur as a result of prolonged silences.

As recommended by these authors, both Gendlin's recommendations and the case material presented, reflect an active stance by the therapist as he continuously remains sensitive to the patient's level of responsiveness. The patient should neither be rescued from the silences prematurely, nor be left to be overwhelmed by them.

Even though Gendlin's recommendations were not specifically written with the adolescent in mind, they reflect a sensitivity to some of the key issues of relevance to silence within the context of this developmental phase.

The findings of this study suggest that each individual case will probably lend itself to the development of a further set of recommendations reflecting the character of that specific encounter. In my work with Jannike, certain techniques and skills, not mentioned by Gendlin, did develop. These reflect the unique ingredients of our particular relationship and will now be discussed.

As has been mentioned repeatedly, in my work with Jannike I constantly needed to monitor her presence with reference to a rhythm of closeness and distance. With time it became evident that essentially two levels of contact tended to predominate. I distinguished between a surface level and a deep level. I therefor found merit in *Providing Two Levels of Therapy*.

At times I would find that our sharing was a playful and light exercise. Even though I had to take the initiative,

Jannike was at times able to share limited snippets of information about a film she had seen, a book she had read, the latest events at school, etc. At other times, our relationship was characterised by fairly vigorous attempts by me to arrive at feeling states, to make links and to facilitate insight. As therapy proceeded, these two levels became increasingly pronounced.

Being sensitive to the rhythm between these two levels of contact, resulted in a collaborative and playful relationship between us which enhanced the process of therapy.

Given Jannike's difficulty in engaging me fully and responsively, I attempted in various ways to reach out and to structure therapy in such a way as to make this easier for her.

At times I would *Contract with Her to do a Specific Piece of Work*. In session 11 for instance, I contracted with her to spend 10 minutes focusing on issues around her father. In this instance she utilised the time well and we worked productively for the full period nominated. On other occasions, we made different contracts. In session 13, we contracted to come up with three feelings or thoughts about her mother before we moved on. These periods of vigorous work were "rewarded" by periods of light playfulness.

Having asked permission to intervene in a specific way (via the contract) facilitated a collaborative and playful

relationship.

There were moments when it was clear to me that Jannike was being unresponsive not because she was shy, defended or rebellious, but because she really didn't know what was happening inside.

At such times, I would attempt to facilitate the process of differentiation by what I have called *The "Multiple Choice" Format of Facilitation*. I will illustrate this point at the hand of an example. Session 12 was spent dealing with issues around her father;

Therapist:

Jannike, what do you feel other girls benefit by having a dad around?

Jannike:

Just to have somebody there.

Therapist:

What does having somebody there mean to you?

Does it mean

- having somebody loving around;
- or somebody exciting and playful;
- possibly somebody that can give advice or perhaps something else?

Jannike:

All three.

Therapist:

And if somebody offered you a third of a dad as I divided them, which would you take?

Jannike:

The loving one.

The example illustrate how Jannike moved from a hazy unclear response to a more specific response. The "Multiple Choice" format of facilitation had therefor promoted the process of differentiation.

A further way in which I facilitated Jannike's responding was by "*Asking Her for Assistance*." In session 18, for instance,

I shared with her that at times I found it difficult to know whether she wanted me to carry on talking, or to be silent.

Having stated this, I then asked her to give me feedback in this regard, thereby making the management of the session a shared responsibility in this respect.

In terms of this request, she was seldom able to respond overtly to me. My hope was however that even if she didn't share her thoughts in this regard with me, she nonetheless asked herself this question at times. Even this inner dialogue would have helped her to clarify her boundary issues.

Self-Disclosure by the Therapist may at times be useful in the therapy of the silent patient. In session 18, I shared some of my own experience with Jannike.

At this point in therapy, it was apparent that we were both dog lovers. I chose to share the following incident with her; On my walk home from work that day, I had reached out to pat a dog I regularly greeted on this route. However, as I put my hand through the gate, the dog suddenly became vicious and bit my hand. I felt very indignant that my attempt at "friendship" had been met in this manner. At this point, Jannike went silent and it appeared to me that she was thinking deeply. I responded by saying "I wonder if there have been times when you have reached out and have been bitten - or have been disillusioned by friendships?"

My self-disclosure had therefor provided the groundwork for Jannike to contact feelings of betrayal and disillusionment.

For the bulk of the time we spent together, Jannike would respond to any and every enquiry I made of her with "I don't know" as the inevitable reply. I attempted to overcome this habitual response by "*Having Two Therapists in the Room;*"

Therapist 1 (Me, my usual therapeutic tone):

Jannike, you mentioned that your dad had phoned your mom yesterday - I'm wondering how you felt inside?

Therapist 2 (Me, in a playful, urgent, barely audible tone):

You're are not allowed to say 'I don't know'!

At this point, we both started laughing, this laughter being an acknowledgement between us of what was happening. We returned to the task at hand with deepened rapport and increased energy.

By using this technique, I managed to keep her attention focused on the issue at hand in a playful non-threatening manner. (It wasn't long before she had developed the habit of either "knowing" or saying "I *really* don't know").

The *Didactic Function* of therapy is often an important aspects of one's work with an adolescent. At times I found that I was able to detoxify a situation by imparting knowledge with reference to the area concerned.

In the initial period of therapy, I informed Jannike as to the structure of therapy. I mentioned that it may be awkward in the beginning and that it would take time for us to get to know one another and to learn to share in a feeling language.

I also indicated that at times it may be painful. We spoke at length about the nature of our psychological life.

In session 11, Jannike was particularly overwhelmed and I shared with her the thought that adolescence is a period of turmoil, a period of transition and change. In a later session we addressed such issues as religion and career guidance, issues of central importance to the adolescent.

I was left with the feeling that this didactic function often resulted in decreased anxiety, possibly by virtue of providing structure and containment. It also served the function of allowing her to work with developmentally appropriate issues.

Presented above are the additional skills and techniques I employed in my therapy with Jannike which are not mentioned by Gendlin. The strategies reflect the difficulties I came across specifically with reference to her silence and unresponsiveness and may well be of relevance in the treatment of other silent patients. (Indeed, most of them have a degree of relevance in the therapy of patients who are not silent and unresponsive).

The work with Jannike therefor provided a unique patch of fertile ground for the development of new skills, techniques and attitudes. This perception pays homage to the spirit of Gendlin's work in the sense that it is consistent with his emphasis on the individual as an individual - as a unique

being.

D. CONCLUSION

Given the content of this discussion, it is clear that Gendlin's recommendations provided a relevant and versatile set of guidelines comprising skills, techniques and attitudes of value within the parameters of the case presented.

Whilst the therapeutic benefits gained by the implementation of each recommendation have been discussed individually at the point of dialogue with the case-material, it may well be of value to pause briefly to reflect on these benefits.

The first two recommendations discussed ("The Sensible Person Assumption" and "Accepting Rejection") served as a reminder of some of the basic tenets which make up the therapeutic environment. These two recommendations re-emphasise the importance of viewing the other as a "Thou" (Buber) and reiterated the fact that the therapeutic environment should be structured so as to serve the patient, not the therapist. Having provided this sound basis of positive regard for Jannike, allowed for the unfolding of further elements in the therapeutic process.

The third recommendation discussed ("The Internal Frame of Reference Redefined") aided me in the constant challenge of maintaining the optimum stance with reference to a rhythm of closeness and distance. This was achieved essentially by

providing me with a technique via which I could contribute or share feelings and insights without being too demanding, or abandoning her. As the relative success of each session depended to a large degree on my ability to achieve this middle ground, the value of this recommendation cannot be over-emphasised.

In terms of those recommendations dealing with the process of therapy, it is clear that the implementation of these recommendations allowed for an optimal unfolding of the therapeutic process. The following advantages, amongst other, were gained;

- I was able to be both sensitive to and to respect the sequence of Jannike's unfolding;
- An optimal therapeutic environment was maintained as a result of an openness to the changes which occurred and marked the various transitions, characteristic of the therapeutic process;
- Jannike's conception of me as a "real" person, separate from her, was facilitated. This allowed for therapy to be viewed as an encounter between two persons and served as an encouragement to her to develop as an individual in her own right;
- A containing, supportive, playful and yet challenging relationship prevailed;
- I was able to maintain and regain my empathy, compassion and energy during trying times;
- A progressive process of increasing rapport was

facilitated;

- I was able to utilise the time spent together efficiently with reference to therapeutic goals.

In terms of those recommendations requiring an active stance from the therapist, essentially three areas of benefit appear to have evolved (two of these have already been mentioned above). Firstly, the active stance yielded a wealth of information of direct relevance to the therapeutic process. This information was obtained without undue discomfort to the client. Secondly, this stance resulted in an efficient therapeutic ethos as by far the major portion of time was utilised therapeutically and productively. Finally, this stance served as a rapport builder, one of the corner-stones of successful therapy.

Reviewing this dialogue between the case-material and Gendlin's recommendations, affirmed my conviction that the process of therapy is a complex, multi-faceted rhythm. It does not comprise the application of various isolated and unrelated "tricks" or techniques. Rather, the principles and skills applied determine and reflect one another. They are contained and subsumed by one another.

In conclusion, it would appear to be accurate to say that while Gendlin's recommendations are undoubtedly of great value, they are not conclusive.

CONCLUSION

CONCLUSION

Reviewing the road that Jannike and I had walked together, allowed me to stand back and to reflect on the qualitative changes that had taken place with reference to her silence.

In the initial stages of therapy, the silence had had connotations of brittleness. I had felt that if I were to have made even the smallest request of her, that she would have shattered. However, as our work progressed, I had found myself becoming more demanding of her. It was as if the quality of the silence had changed. Towards the end, I had felt free to ask her to explore "behind" the silence and on various occasions had encouraged her to remain at this impasse for some period of time.

The silence had therefor changed from something which had possessed us, to something which whilst remaining a stumbling block, could be named, addressed and worked with therapeutically. This positive change in the quality of the silence, I believe was largely attributable to the application of Gendlin's recommendations as has been clearly illustrated by this study. These recommendations therefor constitute a valuable set of guidelines to be employed by the practitioner dealing with a silent patient. ✓

In our time together, Jannike and I learned to talk. The task

which lies ahead of her is to use her newfound courage, confidence and skills to make the transition into the world outside.

Her journey continues.

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The concept: Case Study Research Method with the emphasis on a descriptive-dialogic case study where the study is situated within the context of existing theory is useful, enlightening and enriching. It makes a real and worthwhile contribution to the practitioner-scientist.

In this case

✱✱ Thinking about p55, wrapping up p.66

criticism: References - serious oversight

p. 48

p.56 Benefits to the patient derived

p.64. It is an agonizing therapy.

