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A SMALL, STILL VOICE

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with Carol Tavris

FRED PORTER is on his way home from work. He is impatient at the traffic. His stomach hurts. There is a knot in it. Fred Porter reflects on his day at the office.

He realizes that he is more upset today than usual. Something nags at him but what it is eludes him. He tries to reconstruct some of the day's troubles but nothing clicks. He can feel the knot in his stomach.

Fred Porter decides to try some self-analysis. *You must stop getting so involved in your work, he tells himself. Don't let little things bother you so much.* The lecture doesn't help. He cannot pinpoint what is really bothering him but he is sure that it is only a minor aggravation. *Must have been losing that folder,* he speculates, *or maybe that damned argument with Jamison. I really must be above these little incidents. They don't matter.* The knot in his stomach disagrees.

So Fred Porter tries another routine, the relive-the-situation-and-make-it-come-out-better technique. He runs through what he ought to have said to Jamison that morning. He should have been friendlier. He should have been less critical. He should have said . . . but here the memory of what he really *did* say intervenes. The knot tightens.

In desperation, Fred resolves to change his ways. He will be calm from now on, play it cool, not get so frenzied over unimportant matters. He will be the Mature Man. The knot eases, but only for a moment. Its return reminds Fred that he has sworn at least 150 times to be calm—to no practical avail.

Fred stops for a drink. But when he leaves the bar the knot is only slightly eased, a little fuzzier, still there. Oof! Damn the job.

What Fred needs is a procedure for zeroing in on the problem that disturbs his emotional and physical well-being. Our research in psychotherapy has sought to isolate such a procedure and specify the steps involved.

We have tape-recorded several thousand psychotherapy sessions over the last few years. We asked: what are patients doing when therapy is successful? What are they *not* doing when sessions fail to help them? One finding has emerged consistently from a series of studies: there is indeed a characteristic of patients who improve that is not shared by those who fail. Successful patients are able to work with *felt meanings.* We must now explain what this means.

There are several ineffective routes to pinpointing a trouble. One can go over and over events: what specifically happened, what other persons did, what one wishes he had done, and so on. This process never really reaches what is wrong. Secondly, one can trot out various theories designed to *explain* the causes convincingly ("clearly I am hostile because of projected hostilities reflecting unresolved anger at my father"); still one usually remains unchanged, no matter how many intellectual explanations he is able to apply. Finally, one may concentrate on an *emotional tone,* such as depression. This, however, only makes one all the more depressed.

In contrast, a felt meaning is the *bodily felt sense* one has of one's trouble. It contains elements of the above approaches, but goes beyond them. That is, a felt meaning has to do with events, intellectual and verbal understanding, and emotions; but it is more than any of these. A felt meaning is not pure emotion; it is rather the experiencing of what the emotional tones are about. It does not have to do solely with specific events outside one's self; it deals rather with the way one is in those events. It may involve verbal descriptions, but the felt meaning is always more than one can articulate clearly. *Experiential focusing is a deliberate procedure for attending to the bodily felt sense of the problem.*

Let us return to Fred Porter and see how experiential focusing might work to relieve that knot in his stomach.

STEP 1: THE FEELING OF ALL THAT. Instead of lecturing to himself about his problems, Fred concentrates on the knot. This body symptom contains the answer to what is bothering him: it represents the whole aggravating situation, the feeling of *all that.* That pain in his gut encapsulates his anger at Jamison, his disappointments in work, his disgust with himself, his whole career, his doubts and defeats, his concerns and fears. If Fred thinks words, he can reach only one detail, the argument with Jamison. But if he keeps quiet and concentrates on that body pain, he can feel the whole of his problem.

STEP 2: LETTING THE MAIN THING COME UP AS A SPECIFIC FEELING. Fred feels *all that* for a few seconds and waits. What *is* the main thing that disturbs him? Soon a more specific feeling emerges. He cannot quite identify it. His attention now focuses here. What *is* this new felt meaning?

STEP 3: FOCUSING ON THE MAIN FEELING AND LETTING WORDS ARISE. He is able to describe the sensation: it is a sinking feeling. Fred realizes that he is scared. The word hits him again: *scared.* The knot eases just a little, a good sign that he is on the right track. He is surprised; what can he be scared of? *Scared that I can't handle it.* Without telling himself, he knows that by *it* he doesn't mean Jamison; he means that he cannot handle his life. He is doing something terribly wrong or stupid or dangerous: scary.

Something is wrong. The phrase has a distinct bodily effect—the pain lessens. Something is wrong about what he is trying to do at work. Fred feels that he has made a momentous discovery; it seems obvious and superficial, since he knows little more than before, but the easing of the knot in his stomach indicates that the discovery *is* important. He pursues it. What is this feeling that *something is wrong?*

STEP 4: GOING FROM THE WORDS BACK TO THE FEELING, AND THEN AGAIN TO THE WORDS. Fred tries to phrase it more exactly, going back and forth between word and feeling, waiting for the two to

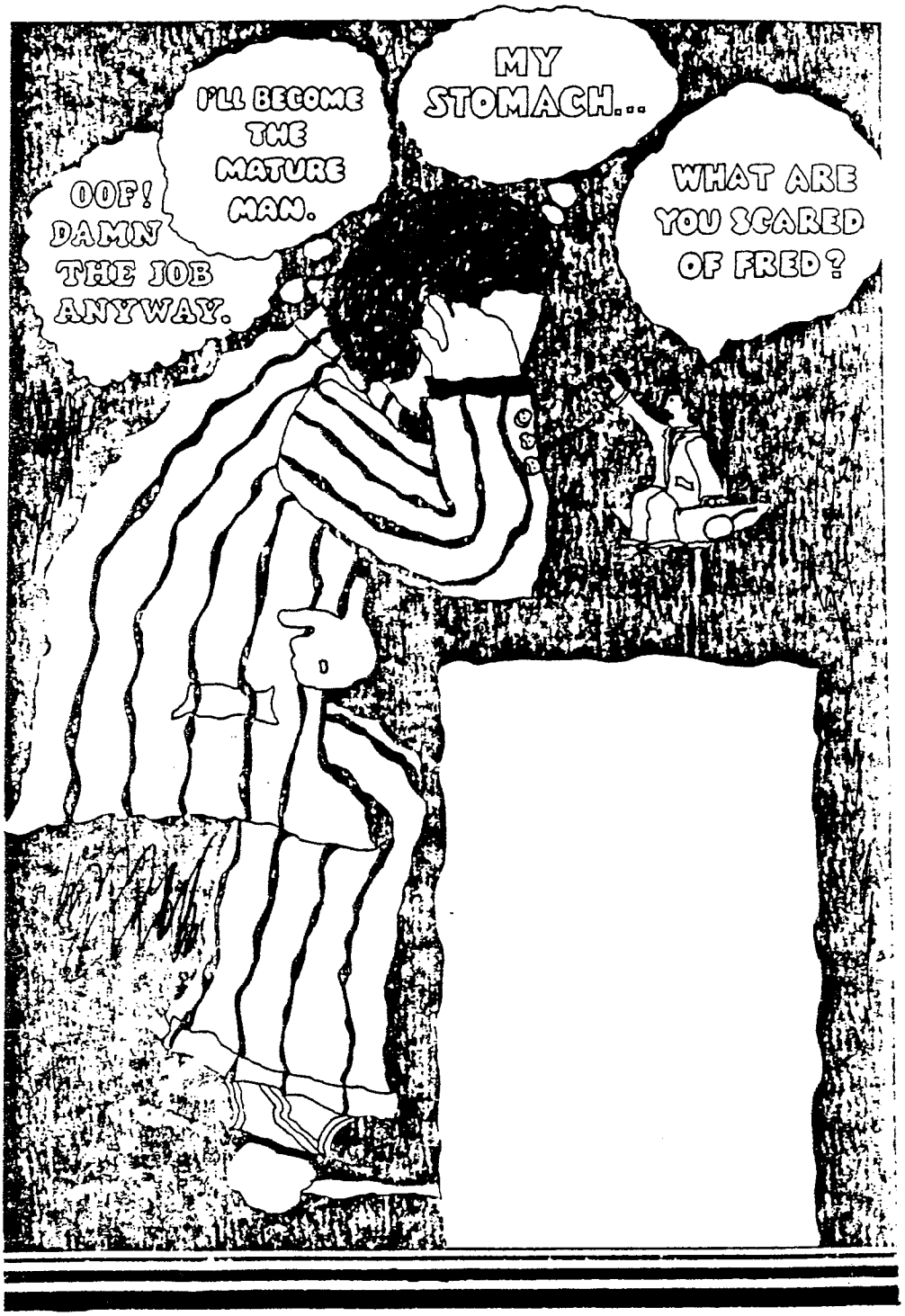
mesh. What other words fit his feeling? Wrong? Stupid? Improper? Inappropriate? There it is! That is what is wrong with his plans; they feel *inappropriate*. He senses that the word touches the feeling in his stomach, while the other phrases did not. He says *inappropriate* again, and follows how it makes him feel. The word sharpens the feeling, focuses it. He feels released. Now he knows.

He knows that he is making a fool of himself with his reorganization plans. The job is hopeless, it's a dead end. Nothing will happen, nothing big, anyway. His work at the office is nothing compared to what he would like to do, the man he would like to be. The feeling of *inappropriateness* is now overwhelming. As he experiences it the word *unrealistic* arises. It fits as the feel of it lets him know. His plans are *unrealistic:* at best he will earn a few thank yous. Nothing is wrong with the plans themselves, Fred now knows, but they will not lead to that meaningful life he had counted on. The reorganization plans cannot realistically change that. The poor job must not carry the burden of what might have been.

So the reorganization plans won't help. What will? Another job? The stinging sensation of fear returns. The source of the *scared* feeling is isolated. Fred is too scared to quit his job and look for another; he might fail.

This realization is discouraging but at least it brings relief. Fred senses his overinvolvement with his plans evaporating. The truth is that he has not made of himself or his life what he wanted. But experiencing the truth as it emerged has made him free. The plans don't *have to* work. He doesn't have to get them adopted. He doesn't have to argue so hard for them. The knot in his stomach has dissolved. Fred Porter is relaxed and at ease for the first time in months.

This procedure has taken our man only 10 minutes. The vital silent periods —waiting for a specific feeling to emerge, waiting for the right words to describe that feeling—last only 30 seconds or so. But look at your watch and you will see how long 30 seconds of absolute silence can seem. Hardly ever do we give ourselves that much time between thoughts. Direct focusing on the way it all feels can accomplish what years of replaying events, vowing to reform, and analyzing motives cannot. As one patient said, "The tough thing is the waiting, but the surprising thing is that words do come from the feeling. It's like some kind of knowledge was in there, able to tell me what the trouble really was."



The method I call experiential focusing is both new and ancient. It has been called by many other names but the specific instructions for the procedure are usually omitted. Meditation, for example, is one form of experiential focusing but generally one is told to focus on nothing, to "clear one's mind." This sounds like trying to ignore your worries. By that route meditators tend to become sleepy or tense and frustrated. Genuinely clearing oneself by focusing involves something like what we have described, but it is different from working on a problem. Instead of pursuing one problem through many steps, one seeks to run through all present problems, giving each only one step. The object is to let them all go, to release oneself from them all for the moment. One asks: "What is *now* keeping me tense?" Then whatever comes, let it speak its own truth in one genuine focusing step, with the bodily felt release which is the hallmark of such a step. When that has occurred let it go. Ask,

"What else is now keeping me tense?" Large or small, deal with it honestly in the same way. If it is something you fear to forget, write it down, so that for the moment nothing in your viscera need stay tense to hang on to it. By that road, a deep condition of peace and aliveness is reached in a few minutes.

In my theoretical work I have always believed that the different methods of psychotherapy, when successful, involve the same bodily process. It doesn't matter whether the therapist is a physician, a psychologist or a minister. It doesn't matter whether his fee is large or small or whether he belongs to the psychoanalytic, existential or any other school. Nor does it matter whether the patient is asked to talk about sex, life meanings, personal relations, daydreams, night dreams, or self-concepts. *The same bodily and emotional process is involved in all of these therapies* when they work. The experiencing of bodily felt shifts in felt meanings is involved, regardless of the vocabulary the therapist chooses.

For instance, the patient can tell his psychoanalyst that "when I talk to my boss I feel castrated." He can tell a Jungian that "going to the boss made me dream of a magic lake I couldn't swim in." He may tell a Sullivanian that "I have sexual troubles because I can't relate on equal terms with anyone." He may say to an existentialist that "I can't take hold of life and have the nerve to choose authentically on my own." The *words* here are irrelevant. What matters is how the words are used to express the same release in the felt meanings of the same bodily sensed problem. The effective therapist, regardless of school, is able to help the patient to moments of experiential focusing.

Behavior therapy's process of desensitization is also quite similar. In that method patients are asked to visualize scenes relevant to a problem. While they are not instructed to focus experientially as in our steps here, Bernard Weitzman found that when desensitization works, patients report afterward that they went through steps quite similar to these.

Experiential focusing gets at one basic ingredient of all personality growth. Whatever the method, this bodily process of resolving felt meanings is involved. The other basic universal ingredient (we have not discussed it in this article) is *interaction*. A human being is an interactional process: how he is in himself depends to an amazing degree on how he is toward the people he is close to and how they are toward him, how they let him be toward them, how he lets them be toward him, how they enable him to let them be toward him and how he enables them to let him be toward them. Where it starts we don't know but we do know that psychotherapy involves changing the interaction a person is used to.

Around experiential focusing and freer, more honest, interaction, the varying methods of psychotherapy and the varying vocabularies can unite.

Experiential focusing may seem a very private process, but we have been able to measure it in a number of ways.

I devised an "Experiencing Scale." With the permission of the patients, randomly chosen parts of each taped clinical interview are recorded and coded. The segments are shuffled and given to two raters. Working independently the raters listen to each segment and assign it a number based on the scale.

The scale has ratings from one to seven, each number representing a specific behavior shown during the interview. Thus, one means that the patient talked only about events or other people or that he was quite detached; three indicates that the patient talked about experiences and persons that were meaningful to him, but he was incapable of focusing on felt meanings directly. He might have told a long story and cried without attending to the feeling of why. A rating of five means that the patient could speak directly from felt meanings, letting words come *from* the feeling. Instead of pursuing only words and thoughts, he spoke from his felt sense of what he had been saying. The highest rating, seven, is given to patients who are able to move in "experiential shifts." That is, a new awareness leads to others; one release of one tense felt meaning changes "the whole scene," so that soon again renewed focusing enables another felt step. All four steps in the focusing process are evident.

When the raters show significant agreement, the scores for all the segments in each case are averaged to give a score: the individual's "level of experiencing" during the therapy interviews. We can then ask whether high-scoring patients eventually have more successful outcomes in therapy than low-scoring patients. And they do.

Measuring outcomes of therapy of course is a difficult project and in recent years there have been numerous attempts to devise accurate tests. We used several ways of evaluating outcomes: patient reports, therapist reports and psychometric tests given before and after therapy. Using any one of these methods to define successful cases, patients who improved greatly in therapy were those who showed a significantly higher level of experiencing in their interviews.

Other kinds of research support this description of experiential focusing as a bodily process. The galvanic skin response, (a measure used in lie detecting), heart rate and skin temperature, show tension patterns when people first think of a troublesome personal problem or when first they think about the day's events. However, when they follow the focusing instructions on that personal problem, the tension measures show evenly increasing relaxation.

More recently, we have applied Eckhard H. Hess's work with eye movements. In 1967 Niles Bernick and Mark Oberlander found that there is far more constriction of the pupil during focusing —indicating relaxation—than under other conditions.

A fascinating study to support the body-process theory was done by J. E. Gorney, M. A. Lieberman and S. S. Tobin in 1967. These researchers conducted a long-term study of residents of old-age homes, using more than 100 different measures. The Experiencing Scale (applied to the answers given to five questions) was the only one that distinguished between 40 patients in their 70s who later died in the year-and-a-half period from 40 others of equal age who did not. High scorers on the scale were far more likely to survive. There appears to be a period of life review in the 70s when a person works through what his life has meant. The ability to apply experiential focusing seems crucial for surviving.

This study illustrates poignantly that psychological events are body events. The theory of experiential focusing may prove to be an interesting bridge between psychology and biology. So far such bridges are few and are needed for two such interdependent fields.

We are presently engaged in experiments to see whether experiential focusing can be taught. Since research indicates that therapy will fail if treatment is nonexperiential, can failure-predicted patients learn this focusing procedure? If our teaching turns out to be effective, then possibilities open up for teaching experiential procedures to everyone as a problem-solving skill. This would be a preventive step in mental health, since people could solve more of their own problems and help others to do so.