

INTERPRETATION OF PATIENT BEHAVIOR THROUGH GOALS, FEELINGS, AND CONTEXT¹

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Every response by the therapist requires some way of making sense of the patient's behavior. With a plethora of conceptual nets, the clinician typically has a bewildering bag of descriptive constructs but no effective working guidelines for making practical sense of what is going on with the patient. The thesis of this paper is that three working guidelines enable the therapist to interpret and make sense of patient behavior: (a) the goal-directed component of the patient's behavior, (b) the accompanying feelings, and (c) the situational context.

GOAL-DIRECTIONALITY

With the paradoxical exception of psychotherapy, it is axiomatic that psychological behavior is goal-directed. Psychotherapy stands almost by itself in jettisoning goal-directionality, and, instead, understanding patient behavior in terms of the interplay of pathological processes, disease-ridden dynamics, or psychoanalytic mental forces (17). Much of the appeal of motivational analysts such as Kanfer and Saslow (15), social learning theorists such as Rotter (28), and motivational interactionists such as Haley (13) and Szasz (30) lies in the simple elegance of rediscovering the Adlerian (1, 2, 3, 4) conception of behavior, including patient behavior, as goal-directed. They have helped remove the mystique of mental pathology from patient behavior.

In the analysis of patient behavior, the pertinent questions are: What is the patient doing? What could be the goals of this behavior? What behavior is accompanied with hidden inner feelings of pleasure and satisfaction? What kind of relationship is he constructing or maintaining? What is he avoiding, denying, pushing away? To obtain the answer to this last very important question Adler (4, p. 332) would ask the patient, "What would you do if you were completely well?"

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Four refinements assist the answering of these questions: focusing on (a) presently ongoing motivation, (b) behavior rather than denoted content, (c) goal-directionality of all behavior, (d) extraction of ultimate goals.

1. *Presently ongoing motivation* (8, 18, 20). As Adler (4, p. 89) asserts, this is more important than motivations not in operation at the moment, or deep-seated personality processes unrelated to the patient's current behavior (9). Although dependency may be among a patient's deep-seated personality processes, and passive-aggressive motivations may characterize other segments of his behavior, at the present ongoing moment his behavior may be most aptly described, for example, as directed toward the goal of avoiding a threatened rejection.

"Causal" explanations may be accurate but are unprofitable in telling us what is happening right now. It becomes irrelevant to describe a patient as psychopathic, of low ego strength, of dull normal intelligence, being brain damaged, being schizophrenic, being a delinquent (19). Instead, the focus should be on the goals which account for the behaviors to which these descriptions refer.

2. *Behavior rather than denoted content* (27), i.e., what the patient is doing rather than what he says. For example, when the patient's talk is of a depressed suicidal nature, his ongoing behavior may warrant the inference that his motive is to hurt and trouble others (3, 16), or to appeal for help in alleviating self-rejection (16). When another patient talks about a series of childhood events, his ongoing motivation may be carefully to organize the world into systematic compartments, or to open himself to the therapist, or to fend off compassion (24, p. 38). A patient may *talk* about his aggressive outbursts, replete with recounted examples of his impulsive temper, whereas his immediate goal may be to convince the therapist that he is not the scared, impotent person he suspects the therapist believes him to be. He may *describe* himself as being loving and compassionate toward his wife and children, although the more accurate ongoing motivation is to convey how unappreciated he really is. She may *refer* to a life of loneliness, but, rather than being lonely right now, she is inviting the therapist's compassion and nurturant understanding.

I term the misidentification of the denoted content with the immediately ongoing motivation the *content error*. The current apotheosis of behavior in contemporary learning-approaches to psychotherapy

runs the danger of incurring the content error. While the patient tells about his fear of open spaces, facial tic, compulsive handwashing, enuresis, or school phobia, and this is all the therapist is concerned with, the patient's ongoing motivations are missed.

3. *Goal-directionality of all behavior*, verbal and nonverbal, "normal" and "pathological" (2, 13, 17, 19). The therapist must attend to the rich source of motivational cues provided by postures, body movements, gestures and expressions. The cues may refer to oneself (e.g., to praise, protect, show, or hide aspects of oneself) or to others (e.g., to elicit concern from them, dominate them, be sexually involved with them). Motivational analysis applies to the entire realm of behavior, from "normal" to "pathological," from bits of behavior to sweeping behavioral units, including what other viewpoints conceptualize as severe psychotic behavior or behavioral symptoms of brain damage. Behind the scrambled and bizarre incoherences of such persons is a mode of communication (13, 26) guided by motivations such as fending off understanding, blocking closeness, gaining superiority, or expressing resentment (19).

4. *Extraction of ultimate goals*. Every behavior is directed toward some ultimate goal the approaching of which is accompanied with positive, constructive feelings of pleasure, excitement, satisfaction, and happiness (19, 20, 21). The therapist may extract these goals by asking himself what is the hidden satisfaction, the pleasurable excitement, that the patient could possibly experience by carrying out this behavior? The patient who talks in a confusing, communication-blocking, incoherent way may be interpreted as directed toward the goal of preventing the therapist from reaching him, or of gaining a sense of superiority over the therapist, or of working the therapist into a state of frustration.

The therapist has three positions from which he can identify the motivational component of the patient's behavior: (a) as sensitive clinical observer of the patient's behavior directed toward the therapist and others; (b) as the patient's inner voice, if the therapist can free himself sufficiently to get inside the patient's motivational skin; and (c) as the direct object of the patient's motivations, in accord with the thesis that certain patient motivations will be reflected in their effects on the therapist (5; 14, p. 49; 25, p. 28; 29). How is the patient treating me? What are my reactions to him? How am I being affected? Although the therapist's feelings and reactions typically have

been considered as confounding intrusions, when properly understood they constitute a rich source of cues to the patient's immediate motivations. This is pointed out by Dreikurs particularly with regard to children's misbehavior. "What the teacher feels inclined to do . . . provides an indication of the child's intentions . . . It is [therefore] of great importance that the teacher learn to observe her own emotional response to the child's disturbing behavior" (7, p. 45).

FEELING

Feelings as clinical data have been substantially acknowledged by Adler, Jung, Sullivan, Fromm-Reichmann, Federn, and Rank, and, more recently, in the experiential approaches of Rogers, Whitaker, Malone, May, Maslow, and Gendlin. Whereas one component of patient behavior is its goal-directedness, these writers recognize the accompanying feelings as a second component. As working guidelines for the clinician, the following four characteristics of feelings may be understood:

1. Feelings refer to inwardly felt bodily events and sensations (10, 11, 12). These may be described in terms of their nature and bodily locus, for example, a dizziness in the head, a heaviness in the legs, throbbing in the genitals, tight aching band around the head, etc. Or, feelings may be described as internal behavioral states such as terror, helplessness, feeling calm and peaceful, feeling strange and unreal, alone and separated, frozen and tight, a sense of relief, etc.

2. Feelings may consist of inner respondings to ongoing behaviors, e.g. "I'm scared to death" (as the person is beginning to confess a secret sexual ritual); "This is marvelous" (as he finally is decisive about what he is going to do); "I shouldn't have said that" (as he sarcastically inquires whether the therapist has been listening); "I hate being like this" (as he is uninvolved); "All this is too much for me; I'm falling apart" (as he is about to express violence and rage).

3. It is important that the therapist note the immediately ongoing feelings (11, 21, 23, 31). Feelings are relatively open to identification and description. Even bizarrely behaving, or withdrawn, or scrambled and incoherent patients provide cues to their ongoing immediate feelings. They still can, with relative facility, locate and identify the feeling which is occurring in them right now. A little training and practice is all that is required.

4. The person can have only a single predominant feeling at the

current moment, pleasant or unpleasant. The clinician tracks the concatenation of predominant feelings.

The patient has a given feeling in relation to a given motivation. He is scared (feeling) in relation to reaching out for affection (motivation); he is excited in relation to open expression of independence; she is feeling a peaceful sense of relief in relation to sharing her deepest thoughts.

The clinician can identify the predominant ongoing feelings from the following sources: (a) Both the patient's verbal and nonverbal behavior provide cues. (b) The patient may himself describe his feelings as a participant-observer rather than a subject. (c) The ongoing feelings of the therapist, when he is in close alignment with the patient, indicate the patient's feelings (22).

SITUATIONAL CONTEXT

Outside of psychotherapy, a full psychological understanding of human behavior typically includes a description of the situation in which the behavior occurs. Any goal directionality involves specific others in defined relationships within particular settings. With regard to the interpretation of patient behavior, a goal to experience love may gear the female patient toward seeking an older, fatherly male therapist; or toward situations where an accepting male offers special favors and indications of extra concern. Pertinent questions include: What kind of situation is the patient seeking to establish? What kinds of roles is the patient assigning to specific others? With what kind of encompassing situation is the patient surrounding himself? What are the targets, objects or instruments of the patient's motivation? What is the nature of the situational context in which the patient is living at this current moment?

Two refinements guide the therapist's answer to these questions. (a) Situational context relates to the ongoing present (6), with the addition of components from the recent and distant past. The situation encompassing a female patient's motivation for complete sexual submission may include a powerfully sadistic male figure relating to the ongoing present (e.g. the husband's firm and tough boss), with components from the recent past (e.g. a near-rape experience while the patient was traveling in Europe), and the distant past (e.g. sexual play during childhood with her mother's second husband). The patient may be described as living in a present situational context with added components from recent and distant past situations.

(b) The patient lives in a situational context which bears some relationship to the immediate therapeutic situation. Thus, the female patient may relate to the therapist as a powerfully sadistic male figure, but her behavior is directed beyond the therapist to her older brother. In some instances the patient is living fully in the immediate therapeutic situation, with the critical situational context at some distance; in other instances the therapeutic situation and the critical situational context are intimately fused. There are times when the role of the therapeutic situation is negligible, and the patient is interacting directly within the critical situational context.

Less commonly, the therapeutic situation serves as the instrumental pathway toward an external goal. By being in treatment, the patient avoids a jail sentence; being in therapy serves to warn the spouse that the patient must be given more concern and attention; therapy is a means of maintaining or increasing compensation or welfare aid; or of forcing a family to reduce its pressures.

CLINICAL APPLICATION

The following examples illustrate how the therapist may apply the above three guidelines of goal, feelings, and context to the interpretation of patient behavior:

1. A young, heavy-set, swarthy high-school teacher who had recently been asked to resign his position, in the 6th session expostulated his social philosophy with regard to the "Establishment," United States foreign policy, and the ghetto communities.

Goal: The therapist inferred that the goal is to attack critically, and thus to convey and to experience a pleasurable intellectual superiority.

Context: The cues suggest the therapist as the target of the patient's intellectual attacks. The situation permits the patient to demonstrate and experience his intellectual capability and superiority over the therapist. Information about the patient's present, recent and past life suggests that the critical situational context includes a compound of authority figures (school administrators, supervisors, family, etc.) against whom the patient is warring and over whom the patient is seeking to gain intellectual superiority.

Feelings: Visible cues permit the inference of an inner sensation of bodily shaking, verging on fear and fright.

We conclude that the patient's overall present behavior is to be

interpreted as critically attacking and gaining intellectual superiority (goal-directionality), directed toward the therapist and critical authority figures (situational context), with internal shaking, fear and fright (feeling) in relation to this motivation.

2. A young woman began therapy because of a gradual depression which she dated from the death of her mother two years ago, exacerbating with her subsequent marriage a year ago. At the present moment she is giving the story of her life, almost reliving each episode, without interruption from the therapist. Each episode is remembered lovingly and described as if it were charmingly revisited.

Goal: She seemed to be giving the therapist her personal life story as if it were a specially treasured gift which the therapist was to receive. The motivation seemed to be that of giving something special (herself), something very prized and highly personal.

Context: She assigned to the therapist the role of a listener, receiver, to whom a special and prized gift is to be awarded. This was the role of the deceased mother, and the patient's striving to give herself as a specially prized gift is occurring within a context which includes mother, husband, and therapist in the role of wholly accepting receivers.

Feelings: These included warmth, softness, a sense of peace and inner tranquility.

The patient's immediate behavior may be described as strivings toward a highly personal giving of herself (goal-directionality) to the therapist, husband and mother as specially valued figures in an intimately receiving, accepting situation (situational context), with feelings of warmth, softness, peace and tranquility.

3. A man in his late forties initially focused on his teen-aged daughter's escapades and his angry feelings about her and her acquaintances. The focus then shifted to his sexual arousal by the activities of his daughter and her female friends, including growing tendencies toward adulterous behavior. In the present session the patient finally spoke of his wife, describing her as the essence of almost childlike goodness and sweetness, lovingly protected by her husband. He sobbed continually and inquired whether the therapist considered him a bad, evil person.

Goal: The patient had been struggling to deny his sexual thoughts and tendencies throughout his adult life. Recently he has been increasingly confronted by his sexuality through his daughter's activi-

ties. During the present session he sought loving acceptance and forgiveness for his exposed, secretly thrilling sexuality.

Context: The therapist is to serve as the accepting and forgiving judge to whom the patient confesses his evil inclinations.

Feelings: Sobbing openness, a letting down of barriers, a sense of raw exposure, good feeling of "this is what I am like."

The patient's present behavior may be described as a seeking of forgiveness and acceptance of his own thrilling wicked sexuality (goal-directionality), before a lovingly understanding, empathic judge to whom he confesses his sexual sins (situational context), with accompanying feelings of raw, open relief (feeling) with regard to this motivation.

4. A twenty-two year old girl living at home with her parents, was completely dominated by the family. Depression and suicidal thoughts followed the parents' thorough squashing of her abortive overtures to leave the family. During the present session, after her depression was reduced, she cited her parents' oppressive demands and pressures. Then she lapsed into a silent period of ten minutes. Cues arising from both the patient and the therapist suggested that the silence was her way of standing up, declaring her goal of independence, stoutly resisting. The message was that, for the first time in her life, she was going to do what she wanted; to become a person in her own right.

Context: The patient seemed to go beyond the immediate therapeutic situation, and appeared to be living in a protest scene with her parents, a situation which had begun to occur first with her overtures to leave the family and again through the onset of the depression and the suicidal thoughts.

Feelings: She seemed comfortable, almost pleasantly excited and satisfied during the silence. Following the silence, she confirmed this impression with further reportings of a lightness and tingling throughout the chest and head, and rising bodily sensations of aliveness.

In sum, the patient's behavior during the silent period seemed to indicate a protesting, a declaring of independence, a becoming a person in her own right (goal-directionality), directed toward her parents, especially in a scene in which they are domineering figures (situational context), with accompanying feelings of internal excitement, pleasurable tingling and aliveness (feelings) in relation to the motivation.

SUMMARY

In order to understand and respond to a patient, the clinician requires guidelines to interpret and make sense out of the complex of cues comprising the patient's behavior. Three conjoint guidelines are proposed:

1. The patient's behavior is interpreted in terms of the goals toward which it is directed. These are identified by focusing upon what the patient is immediately striving to achieve, the underlying motivation guiding his behavior, the nature of the relationship he is establishing, and the source of the internal, hidden, secret feelings of pleasure and satisfaction.

2. The patient's behavior is interpreted in terms of the immediately ongoing, predominant feelings. Inwardly felt bodily events and sensations occur in relation to the goal.

3. The patient's behavior is interpreted as occurring within a defined situational context, including relationships to others within particular settings. The total context includes components from the recent and distant past, as well as the situation occurring in the ongoing present.

Four cases are briefly described, illustrating the use of these three guidelines.

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