

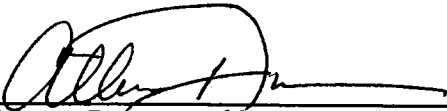
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I am submitting herewith a dissertation written by David R. Eskra entitled "The Absent Therapist's Presence: A Thematic Analysis of Patients' Experiences of their Therapist in Imagination." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

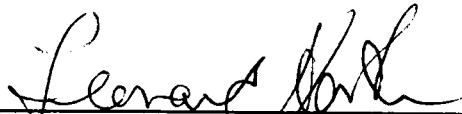


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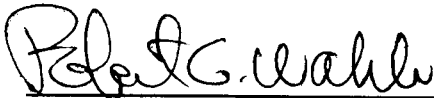
We have read this dissertation
and recommend its acceptance:



Alan Dunn, Ph.D.



Leonard Handler, Ph.D.



Robert Wahler, Ph.D.

Accepted for the Council:



Associate Vice Chancellor and
Dean of the Graduate School

THE ABSENT THERAPIST'S PRESENCE:
A THEMATIC ANALYSIS OF PATIENTS' EXPERIENCES
OF THEIR THERAPIST IN IMAGINATION

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

David R. Eskra

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DEDICATION

To Hana my wife who survived this ordeal
and who read every draft

and in gratitude to my parents for their
many means of support.

ACKNOWLEDGMENTS

I am grateful to the participants who were willing to share so openly these important experiences from their lives. I am grateful as well to my wife for her help in reading the drafts of this manuscript and for the countless other ways she in which she supported me in this process.

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Over the last five years I have come to appreciate the special quality of the Wednesday evening phenomenology research group. Thank you all for your support and insight.

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ABSTRACT

Patients' imaginal experiences of their therapist between sessions and after termination from therapy were explored from a phenomenological perspective. Twelve patients who had been in psychotherapy for a minimum of one year and who reported a predominantly positive experience were interviewed in-depth regarding such experiences. A thematic analysis of the transcribed interviews produced three interrelated themes: (1) not feeling alone, (2) being helped, and (3) having a model. Participants typically reported that such experiences arose spontaneously, though most also noted that they could call up an image of their therapist. The results are discussed in relation to notions of experiencing others, object constancy, internalization, imagination, and free will as well as in regards to recent psychotherapy research. In general participants reported that such experiences were an important part of the psychotherapy process although these experiences could not fully substitute for actual contact with the therapist.

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CHAPTER I

INTRODUCTION

This study is a phenomenological inquiry into patients' experiences of their therapist when the therapist is not physically present. Twelve in-depth, phenomenological interviews were conducted with participants who had been in psychotherapy for at least one year and who reported a predominantly positive experience. The goal of this study is to provide a thematic description of the experience of the physically absent therapist who is nevertheless present to the patient, and thus to gain a better understanding of the role such experiences play in the therapeutic process. The results, it is hoped, will aid our understanding of how therapy does or does not unfold between sessions and after termination.

Before moving on to a review of the literature, imagine for a moment a two year old child as he slides down from his mother's lap where he has clung tensely for several minutes, all the while avoiding the gaze of a stranger. After a few exploratory glances around the room, he ventures slowly across the floor. Several glances back to his mother confirm for him the rightness of his tentative steps towards the toys awaiting in the next room. He edges into the next room and is soon engrossed in playing with a toy soldier.

After a few minutes he looks up suddenly with a sense of distress and then rushes back to other room to see if mother is still there. She calmly reassures him and he is soon back at play.

This imaginary scene describes a prototypic moment in the process Margaret Mahler calls "Separation-Individuation" (Mahler, Pine, & Bergman, 1975) in which the toddler is learning to move out into the world and away from the safe and comforting orbit of his mother's physical presence; the child has taken steps in this regard, but still needs to confirm his mother's presence from time to time. What allows the child to leave his mother and enter the next room, according to Mahler, is that the child is developing an ability to stay connected with his mother despite her physical absence. The child is said to "internalize" an image of his mother along with his ongoing relationship to her. The mother, thus, is with the child even when away from her. This account of how the child retains a sense of connection and therefore a sense of safety as well, is for Mahler and her colleagues both a developmental milestone, and a model for all important relationships as the child grows into adulthood and old age.

Mahler's account of how and why this development takes place focuses on the first few years of life and on the child's all important relationship with his or her mother. But, as she acknowledges, staying connected to significant

others is something to be negotiated throughout life: friends move away, lovers are separated by work or war, a child goes off to school, a parent, a friend or one's spouse dies. Does the relationship also die in separation, or do some relationships remain vital to us despite separations? Mahler, like Freud before her, argues that we remain connected to others by internalizing them. Internalization has been linked by both Freud (1917) and Mahler (Mahler et al., 1975) to experiences of loss. The lost other is said to be taken in and experienced as part of the self.

The assumption made in the present study is that relationships are central to human existence and that separation and loss are painful and unavoidable. Although separations are routine in life, they take on a unique cast within the context of psychotherapy. In psychotherapeutic relationships separations must be dealt with each time a session comes to an end, for such relationships are necessarily circumscribed in the amount of time therapist and patient may spend together. Whether the separation is for a day, week or month, it is typically planned and comes on a regular schedule. While such separations are a minor inconvenience for most patients and a welcome interruption for others, certain patients, particularly those experiencing a difficult time, or those particularly attuned to the pain of loss and separation, can experience these separations as impassable chasms.

The experience of such chasms is believed to be common among patients diagnosed with a borderline personality disorder (e.g. Kernberg, 1967). Some theorists have argued that part of what is askew with such people is the ability to stay connected despite physical and temporal separation; borderlines are said to lack "object constancy" (e.g. Cohen & Sherwood, 1992); that is, they have never developed an ability to maintain a sense of connection in the absence of a physical presence and to use that feeling and knowledge to help them be more resilient in difficult situations.

For such individuals the therapist is believed to disappear when the patient is not in his or her presence. Emotional upset may also undermine a fragile sense of connection. When borderline patients are upset they often report feeling alone and disconnected. Implied in this formulation is that healthier patients are able to maintain a sense of the therapist's presence despite separations and are even able to make use of this sense of connection in times of difficulty. Such individuals might be able to remind themselves that they will see their therapist, or another important person, in a few days, or may recall how it felt to be with their therapist and thus feel comforted.

Since the earliest days of Freud's writings, for example about Anna O. (Breuer & Freud, 1895) and Dora (1905), psychoanalysis has taken note of the intense feelings which patients frequently develop towards their

analyst; these feelings signal the development of a "transference." The development of such feelings has been understood in a variety of ways in the 100 years since Anna O. fell in love with Breuer, but over the years a general consensus has developed within the psychotherapeutic literature about the importance of the therapist-patient relationship.

Within the psychoanalytic understanding of transference, the analyst is seen as becoming a primary figure in the patient's life, on par, more or less, with the patient's parents and spouse. At the same time, the patient is believed to begin experiencing the analyst much as he or she experienced important figures from earlier in life. These past figures have been internalized, which is to say, in part, that the patient has remained attached to this figures by taking them with him or her in the experience of self and others. In the course of treatment the analyst is also said to be internalized, much as the parents were internalized in childhood, so that a sense of connection is maintained despite separation; as a result of internalization, the patient's experience of him or herself is also altered.

Prior to Mahler's focus on the development of object constancy involving the mother, Freud's (1923) concept of superego was seen as the prototypic event for the internalization of others. Freud described the superego as

developing at the resolution of the Oedipal period, around the fifth year, when the child takes on the beliefs and values of the father. During this critical time the child comes to identify with the father and will even have the sense of being watched over internally, much as the father watches over the child externally. Later in life, the feelings that the child had regarding the father, who has been internalized, become reactivated in relation to other authority figures such as the analyst. The analyst, according to some theorists (e.g. Blatt & Behrends, 1987) then provides a figure who is also internalized thus minimizing the effects of the Oedipal figure.

Freud's theory of the superego emphasizes the development of moral values and the internal conflicts which result as these values cross paths with impulses arising in the id. Mahler on the other hand shifts the emphasis to interpersonal connections and to the need to remain attached to mother while separate from her. While the process of internalization remains similar in both models the functions which develop as a result of these internalizations differ. Mahler's shift in emphasis to the internalization of interpersonal connectedness, which simultaneously leads to an alteration in the sense of self, is reflected in current discussions of borderline pathology and in current discussions of how psychotherapy is mutative.

The result of Mahler's emphasis, as well as that of other object-relations theorists such as Klein (1932) and Fairbairn (1952), on the importance of internalizing others has lead to a view of the therapist as a potentially pivotal person in the life of a patient. This view, along with my own experiences of attempting to maintain relationships in spite of separations, has lead me to the question: What is the patient's experience of the therapist when physically separated from him or her? The review of the literature presented here concerning how we remember and think about others both in childhood and in therapy will present theories which have attempted to answer this question.

Object Constancy and Borderline Patients

Object constancy refers to a person's ability to evoke a positive image of another as a source of safety and comfort in times of distress. It also refers to the ability to maintain a sense of connection with someone even when separate from, angry at, or disappointed with him or her. This ability is believed to begin to appear in the toddler between the age of 18 and 24 months and to become relatively stable in the third year (Mahler, Pine, & Bergman, 1975).

During the difficult later half of the second year (the so called terrible two's) the child is described as developing a stable internal representation of his or her mother. In other words, the toddler forms an image of the mother's presence that can be evoked, along with an

affective connection to her. This internalization of mother's presence provides the toddler with a sense of security, efficacy, and connectedness, even in the mother's absence, which allows the toddler, in Mahler's account, to continue to grow psychologically by differentiating from mother. The achievement of object constancy, thus, is seen as preparing the way for further developments, such as attending school and entering into the oedipal period.

Mahler and her colleagues (1975) suggest that problems in the development of object constancy in the toddler might lead to adult psychopathology, most notably in the form of borderline disorders. Other clinicians have made use of her ideas in discussion of borderline patients (e.g. Adler & Buie, 1979; Cohen & Sherwood, 1991; Rinsley, 1982; Sherwood, 1989). For example, Cohen and Sherwood (1991) believe that a lack of constancy is central to the difficulties of borderline pathology. They define constancy: "Constancy can be seen as a kind of emotional home base from which children may venture forth to confront the larger world. Object constancy stabilizes this enlarged world through the illusion that a familiar presence sees, defines, and validates the child's striving and feelings (p. 13)." They go on to describe how a lack of object constancy affects borderline patients:

The borderline patient lacks object constancy.

Those interpersonal and psychological achievements

that are built on constancy are consequently missing, including the capacity for mature attachments, the ability to tolerate being alone, and a sense of sameness or continuity with self across time. In their place, borderline patients bring these convictions to treatment: Their important relationships are tenuous, and abandonment is inevitable; they cannot demand that their own needs be met in a relationship without losing the other person; anger and independent striving will destroy a relationship; aloneness equals loss of self. (p. 15)

Cohen and Sherwood argue that typically at least the first year of treatment with a borderline patient will need to be devoted to developing object constancy in the patient; this must occur before a more traditional, interpretive approach can be undertaken. They believe that the patient must come to count on the durability of the relationship, despite the patient's ambivalence and often stormy feelings regarding the therapist, before interpretations can be used by the patient. The relationship and an ability to depend upon the relationship become the focus of treatment.

Other theorists in the area of borderline patients also focus on problems related to object constancy. For example, Adler (1985) draws heavily from the work of both Kohut and

Mahler in his discussion of the borderline patient. He states:

The fundamental psychopathology of the borderline personality is in the nature of developmental failure: Adult borderline patients have not achieved solid evocative memory in the area of object relations and are prone to regress in this area to recognition memory or earlier stages when faced with certain stresses. The result is relative failure to develop internal resources for holding-soothing security adequate to meet the needs of adult life. (p. 22)

The notion of object constancy has proved to be a relatively popular one in psychoanalytic circles, although certainly not all major psychoanalytic writers concerned with infant development (e.g. Bowlby, 1969, 1980; Stern, 1985) emphasize the notion of object constancy. The attention paid to it by the likes of Adler, Buie, Rinsley, Cohen and Sherwood suggests its significance, however, particularly in the discussion of borderline patients. The notion of object constancy, especially as discussed by Mahler as the internalization of the presence of mother in order to negotiate the experience of being separate, offers a framework that has proven useful in understanding both the terrible twos and the ambivalence and fear of aloneness experienced by borderline patients. Something in this

theory strikes a chord among many clinicians; it makes sense, even if the process of internalization is obscure at times and even though recent infant research has challenged some of its conclusions.

History of the Object Constancy Concept

The term object constancy has been interpreted in a variety of ways by different authors. The term first appeared in the writings of Hartmann (1952). In this work, Hartmann followed upon Freud in describing the infant as existing in a state of primary narcissism in which the mother is related to only in as much as she satisfies the infant's needs. Once these needs are satisfied the mother loses her value to the infant, at least momentarily, and the relationship subsides. Before object constancy can develop, the ego must mature to the point where the drives of the infant can be neutralized. This allows for the for the "objectification" (1953, p. 187) of the mother as separate from the infant, i.e. as existing even when his drives are quiescent, which, in turn, allows for the libidinal cathexis of the mother as the source of need satisfying gratification.

Anna Freud (1960) elaborated a notion of libidinal development which is also determined, in part, by the neutralization of aggressive tendencies. In addition she brings in the idea of investing in an internalized image,

and this cathexis is maintained even in the absence of the mother.

Any assessment of the eventual pathological consequences of a separation trauma is inescapable, in our belief, from the assessment of the level of libido development at the time of its occurrence. Results vary according to the fact whether at the moment of separation the tie to the mother was still of a narcissistic nature, dominated by the search for instinctual satisfactions; or whether in the relationship to the mother the personal and affectionate elements had begun to predominate, transforming the attachment into object love; or whether the child had attained the level of so-called object constancy. In this last instance the image of a cathected person can be maintained internally for longer periods of time, irrespective of the real object's presence or absence in the external world, and much internal effort will be needed before the libido is withdrawn. (p. 61, quoted in Fraiberg, 1969, p. 13.)

Important developmental theorists concerned with the notion of object constancy, such as Hartmann, A. Freud, Spitz, Fraiberg, and Mahler, all agree that an affective tie to the mother which is not immediately dependent upon her as

a need satisfying presence is an essential aspect in the development of object constancy. Related to this notion is the idea that object constancy also implies an ability to remain lovingly connected to mother even when angry at or disappointed with her. In this regard Mahler and her colleagues (1975) will speak of the overcoming of splitting of the object, which Kernberg (e.g. 1967) describes as central to borderline pathology.

Finally, these authors all seem to concur with the belief that a representation of the mother is formed, an "internal image." Some authors, however, also write about the internalization of the functions provided by mother. Confusion over the term has arisen, despite these commonalities. This confusion can be traced, for the most part, to disagreements over the following: when the image of mother is formed, the degree of importance accorded the ability to evoke soothing objects, and the varying degrees of focus on the building of psychic structure.

Spitz (1965), for example, sees object constancy developing with the appearance of stranger anxiety at around eight months (Fraiberg, 1969). He notes that under the pressure of being faced with a novel situation, the infant can scan the face of a stranger, compare it with his representation of his mother and become anxious when he recognizes the stranger as not his mother.

Other authors have linked the development of object constancy to Piaget's notion of object permanence, which is seen in toddlers when they develop the ability to search for objects in spite of their absence and in spite of not finding it in the last place it was seen. Objects are said to have become "permanent" for the toddler because their existence for him is not dependent upon their presence to him. In the absence of any cue from his surround, he is said to be able to recall an image of the object (Fraiberg, 1969; Piaget, 1937).

Fraiberg (1969) places particular emphasis on the notion of object permanence in her explanation of object constancy. She states that the development of object permanence rests on the ability of the toddler to make use of "evocative memory" rather than simply relying upon "recognition memory." Recognition memory requires that the object be present in order to evoke a response, such as attachment behavior in an infant. A slightly more advanced state of recognition memory requires a cue from the environment to call an absent object to mind. Evocative memory, according to Piaget, is the ability to evoke the image in its absence, without specific reminders from the current environment. Stranger anxiety is an example of recognition memory as Fraiberg uses it; the stranger is recognized as not-mother and mother is clung to as a source of comfort and safety.

Toddlers between the ages of 8 and 13 months typically show an ability to search for objects hidden behind a screen. This ability increases to searching behind two screens when the object is seen being displaced. At around 18 months the child will begin to conduct a search for an object in which she seems to make deductions about where it might be. Not until the toddler is capable of conceptualizing mother in this manner, as an object that exists beyond her motoric interactions with mother and beyond always looking for her in one place, can object constancy be said to be obtained. Fraiberg suggests that the importance of mother to the child may lead to an earlier ability to evoke her image than with a toy, but not very much earlier.

Blatt and Shichman (1983) have made use of this distinction between recognition and evocative memory in their discussion of the developmental origins of severe adult disorders. They state that the failure to differentiate inside from outside, which they connect with the failure to develop adequate recognition memory and to form an attachment bond, is central to the difficulties of schizophrenic patients. Borderline patients, on the other hand, have developed recognition memory abilities, but have less stable evocative memory capabilities (for libidinally invested objects), particularly in times of stress.

Research supporting these distinctions between schizophrenic and borderline patients, however, is limited at best.

Despite various definitions of object constancy across the history of its use, more recent usage most closely approximates that of Mahler. Mahler draws upon previous theorists, notably Fraiberg, particularly in her 1975 book. But Mahler also emphasizes, at times at least, that the development of object constancy is not simply a cognitive ability, but, rather, is part of what she calls the developing internal "structure" of the toddler. Mahler's theory of child development, particularly her ideas concerning the development of object constancy, provide a framework for conceptualizing how other people are experienced as with us, despite being absent.

Mahler

Instead of relying primarily on reconstructed memories of adult analytic patients or on the unsystematic observations of parents and clinicians (e.g Freud, 1920; Klein, 1932), Mahler and her colleagues systematically observed infants and toddlers over a number of years. Although her account of infant development often blurs the line between theory and observation, her observations provide support for her theories. Many of her descriptions of infant and, especially, of toddler behavior accord nicely with more recent descriptions by other researchers,

especially with those of attachment theorists (e.g. see Bretherton, 1987, for a comparison).

Mahler's work focuses primarily on the first three years of life. Her primary metaphor for this period is the psychological "hatching" or "birth" of the infant as he or she moves through the process of "individuation" and "separation." This process, from the view of Mahler as researcher, is primarily concerned with real interactions between mother and infant. Although many theoretically driven hypotheses are made concerning fantasy and internalization processes, Mahler does not discuss the infant as primarily negotiating the vicissitudes of drives. Real interactions between mother and infant are seen as the building blocks of internal structures and of the child's sense of well being.

Mahler sees object constancy arising later than all previous theorists in this area, and suggests that it emerges in the third year. She does not reject the research of writers such as Piaget and Fraiberg; rather, she tends to subsume their observations and beliefs into her approach. For example, the transition from recognition to evocative memory and the need for an ability to perceive the object as permanent in Piaget's sense, are seen as necessary, but not sufficient capacities for developing object constancy. In one of her more recent publications she distinguishes with

unusual clarity her view of the development of object constancy from previous theorists:

In our view, however, "libidinal" object constancy only begins to be attained in the 3rd year of life (Mahler, 1963, 1965, 1966, 1968; Mahler et al., 1975; McDevitt, 1975). Although it is based on the child's libidinal attachment to the mother and on the cognitive achievement of person permanence and the symbolic function (Bell, 1970, Kaplan, 1972; Piaget & Inhelder, 1969), its eventual establishment depends on the gradual internalization of a constant, positively cathected image of the mother...The basic difference between these two points of view is that the former sees the libidinally cathected, inner image of the external world as existing in the infant's cognitive or representational world, whereas the latter sees it as becoming internalized as part of the structural organization of the psychic apparatus (Meissner, 1977; Rapaport, 1967). (McDevitt & Mahler, 1986, pp. 11-12)

For Mahler the interactions between mother and infant in the first three years of life, in combination with the infant's innate abilities and drives, lay down the foundation of the infant's lifelong personality and will

greatly affect later modes of interacting with others. Mahler, like Klein (1932) and Fairbairn (1952) before her, moved away from Freud's (1923) emphasis on the Oedipal period as the primary source of internal structure in both normal and pathological development to periods involving earlier, pre-oedipal, interactions with mother.

Mahler divides infant development into three phases: the "normal autistic" phase, the "normal symbiotic" phase, and the "separation/individuation" phase. This last phase is further divided into four subphases, "hatching," "practicing," "rapprochement," and "object constancy." The separation/individuation phase is the one most relevant to the present discussion.

In Mahler's stages the normal infant emerges from a state of isolation, the autistic phase, into a fused state with mother, known as the symbiotic phase. The growing child and even the adult will later long for and fear this symbiotic union with mother. The drama of individuation is played out against this early time of symbiosis with mother. What is described by Mahler's theory of development is the infant's moving away from this union. Because the slowly developing child does not immediately become functionally autonomous as he matures and because he becomes anxious in the experience of being separate from mother, he must somehow take mother with him as he moves away from her to minimize distress. The need for object constancy is almost

a logical necessity that follows from there being a symbiotic phase.

Sometime in the middle of the second year, usually between 15 and 18 months, the toddler enters the critical "rapprochement" subphase. This subphase is marked by a change in the infant's relationship to mother. Up to this age, the "practicing" toddler grows increasingly able to enjoy himself at a distance from mother, to be able not to worry about her whereabouts for brief periods of time, and even to accept mother substitutes, depending upon mood and physical state. The rapprochement toddler, on the other hand, becomes increasingly focused on mother.

Around 18 to 20 months the toddler's prevalent mood seems to become one of "general dissatisfaction" (p. 95) and temper tantrums become prominent around this time. The authors describe this as a clash between the toddler's desire to be separate and omnipotent, and his ongoing need of mother which he often does not want to acknowledge. "The period was thus characterized by the rapidly alternating desire to push mother away and to cling to her-a behavioral sequence that the word 'ambitendency' describes most accurately" (p. 95).

Mahler and her colleagues believe that mother's adjustment to this phase is crucial to healthy development. They state that the mother must accept the toddler's ambivalence, without withdrawing or attempting to encourage

a return to symbiotic dependence. Her soothing interactions with the toddler help to neutralize his aggressive impulses and to bring together split representations, thus allowing the toddler to carry with him or her an image of mother who is loved and who is loving.

Identification is seen as essential to the development of object constancy and the resolution of the rapprochement crisis, much as Freud (1923) saw it as essential to the resolution of the oedipal conflict. Mahler and colleagues note behaviors suggestive of identification during this period and suggest that identification is one of the primary means of dealing with the distress of recognizing one's separateness from mother. They describe how toddlers begin to display characteristics which mirror those of their parents:

By "intrapsychic" or "internal" we refer not only to the "goodness" of the maternal representations and the maternal introjects but, most importantly, to their assimilation into the self-representation and into psychic structure by the process of identification. (McDevitt & Mahler, 1986, p. 17)

Identification, as used by Mahler, seems to imply the taking over of functions formally provided by mother. Introjection, on the other hand, seems to imply that image or representation of mother developed by the child continues to feel like something foreign to the toddler. While both

processes are important in the development of object constancy, Mahler gives place of pride to identification, particularly in her most recent statement (McDevitt & Mahler, 1986).

By 21 months of age, the struggle which marked the rapprochement crisis generally diminishes. An easier, optimal distance from mother, in terms of both physical proximity and the psychological need for separateness, is generally worked out again. Mahler and her colleagues (1975) state that the development of language, the internalization of rules and demands, identification with the good mother, and the child's growing ability to express desires and fantasies in symbolic play are elements which allow this new equilibrium to be reached. The child begins to make use of "I" statements for the first time and begins to recognize and name familiar people in pictures.

The ability of children at this age to cope with separateness, as well as with actual separations, is dependent upon his or her history with mother as well as on the current state of relationship to her. Nonetheless, generally around this time the child begins to be less vulnerable to the possibility of losing mother and begins to be more sensitive to possible disapproval. The fear of loss of mother is gradually replaced by a fear of losing mother's love and this shift is interpreted as an internalization of the problem of separateness.

The fourth and last subphase of the separation-individuation phase is "the consolidation of individuality and the beginnings of object constancy" (p. 109). This subphase begins roughly in the third year. The attainment of a "definite, in certain respects lifelong, individuality" and the "attainment of a certain degree of object constancy" (Mahler, et al., p. 109) are the central tasks of this subphase.

Mahler states that there are two essential determinants for this process. The first of these is the development of confidence and trust in mother through the regular relief of need tension, beginning in the symbiotic stage. Through the course of development, the mother's satisfying qualities are slowly attributed to the "whole-object" and then transferred to the internal representation of mother. The second essential determinant is the development of the cognitive ability to objectify mother as a permanent object (in Piaget's sense) and to represent her symbolically to oneself.

Mahler also emphasizes that during this subphase the representation of the split object is unified into one representation which "fosters the fusion of the aggressive and libidinal drives and tempers the hatred for the object when aggression is intense" (p. 110). Unlike prior subphases, this phase is open-ended. Object constancy begins to take form here but also continues to develop and

change throughout life. Nonetheless, difficulties and achievements in the separation-individuation process will have significant impact on who the child comes to be.

Schafer

Psychoanalytic writers concerned with the notion of object constancy rely heavily on theories of internalization. Schafer (1968; 1976) provides an important critique of the language typically used in these analyses and of psychoanalysis more generally. The process of introjection, according to Schafer, can only be understood as the fantasized taking in of another. He prefers the synonym "incorporation," but is concerned that both terms spring from a spatial metaphor of mind. The use of such metaphors to describe the non-spatial activities of the mind, he argues, does more to confuse than to clarify discussions of "internalization." Nothing is taken in physically, nor are physical structures built. We fantasize or hallucinate about the presence of others; they are not "inside" of us as one thing is inside of another, even if the felt presence is powerful.

Schafer further notes that the phenomenology of introjects offered by patients often locates the presence behind the self, not in it. Such descriptions often suggest that the introjected object feels like a foreign presence, even though it is recognized as different from an external object directly perceived. Identification, on the other

hand, refers to seeing oneself as being like and acting like another. According to Schafer, identification often occurs, in psychoanalytic accounts, in relation to an object which has been introjected; that is, one models oneself on a fantasy of the important other. In Schafer's discussion identification and introjection are separate processes, but can be related in the manner described above.

Schafer also redefines structure as stability of function, resistance to change, or stability of motivation, so that the difference between a constant object and an introject, at least as a "structure," becomes simply one of the constancy or stability of how they function, motivate, and effect the experience of self. Schafer's critique, however, does not undermine the basic lines of Mahler's theory despite his concerns about the language of psychoanalysis and its emphasis on spatial metaphors.

Schafer does not dismiss, for instance, the importance of fantasies about others nor does he attack Mahler's emphasis on representations of self and others; rather he cautions against the reification of these representations. He also supports a notion of identification: "We are able to speak of identification as a change in the way one conceives of oneself and perhaps a corresponding change in the way one behaves publicly; as before the change would be modeled on personal and unconsciously elaborated versions of significant figures in real or imaginative life" (p. 161).

If taken seriously, Schafer's critique of the use of spatial metaphors would force a restatement of the process of individuation and separation, but would leave intact Mahler's basic ideas about moving away from a fantasized merger with mother to a more independent state bolstered by stable fantasies about mother's soothing presence.

Tolpin

Tolpin (1971) offers a detailed discussion of the process of internalization in the development of object constancy. She draws on the work of Winnicott, Kohut, and Mahler. Tolpin emphasizes the process of transmuting internalization, a concept developed by Kohut (1971), in which the functions provided by mother are slowly taken over, at least in part, by the child after experiences of minor frustration. These frustrations, when not so great as to overwhelm the child, force the child to fend for himself. Because they are relatively minor at any given time, the child is able to stretch his own capacities to provide the missing function for himself. She also describes the use of transitional objects in this process as a "transitional form of mental structure" (1971, p. 319).

As an example of this process, the mother of a neonate will soothe her infant to help him fall asleep. As the infant develops, on days when not overwrought, he comes to learn to use his blanket, or some other object, to replace mother's soothing presence. Eventually the blanket is no

longer needed as this function is internalized. The child transitions from requiring mother's presence, to substituting her presence with a blanket, to putting himself to sleep. Mother as a real or imagined presence does not appear to be required in the use of a transitional object, or at least this aspect of the process is not stressed by Tolpin, although the transitional object is seen as providing what mother once provided. Following upon Kohut, Tolpin states that these functions become depersonalized as they are internalized. Tolpin's account essentially details the process of internalization which Mahler emphasized, but with less emphasis on the development of an image of mother.

Stern

The work of Daniel Stern, particularly in The Interpersonal World of the Infant (1985), offers a clearly articulated alternative to Mahler's account of infancy and toddlerhood. Like Mahler, Stern is interested in the experience of the infant. In many ways, however, he is theoretically closer to Bowlby (1969; 1980) than to Mahler, although the three share common ground. Like Bowlby, Stern draws on cognitive psychology, although he does not highlight this connection.

In his description of the development of schemas, Stern uses a cognitive model but with the added provision that affective experience, not simply information, becomes part of the schemas. Like Bowlby, and unlike Mahler, Stern does

not attempt to stretch drive theory to accommodate his interpretations; instead, he tacitly assumes the centrality of interpersonal relations in the world of the infant. Although he does not explicitly posit an attachment drive he views the experience of the self as interpersonally mediated from the start.

Stern offers a very different version of the first two year of life than Mahler. Like Mahler, he organizes his model around the interactions of infant and mother and then makes inferences concerning the subjective experience of the infant. Rather than focusing on a process of separating and differentiating from a fused state with mother, however, Stern focuses on the activity required to obtain and sustain interpersonal experiences. Unlike Mahler, who describes the newborn as autistic and then symbiotically merged with mother, Stern describes the newborn as psychologically separate from mother. He also describes ways in which the neonate is physiologically and psychologically prepared to interact with others. Stern begins with studies which demonstrate many more capacities in the newborn than Mahler was aware of when she wrote her major works. From these data, he is led to conclude that infants never experience a time of "undifferentiation" with mother nor are they isolated by a stimulus barrier, as Freud argued.

For Stern, Mahler's autistic and symbiotic stages as well as Freud's state of primary narcissism are seen as

theoretically driven descriptions which do not fit observations of real infants. He states: "Union experiences are thus viewed as the successful result of actively organizing the experience of self-being-with-another rather than as a product of a passive failure of the ability to differentiate self from other (1985, p. 10)."

Stern describes four domains of the self as key developments as the child matures rather than stages or phases. He specifically uses the word domain, rather than stage, to highlight his belief that while these domains emerge at different points in the infant's development, they all continue as aspects of the self throughout life. One domain is not given up or subsumed into the next. As support for his demarcations concerning when these senses of self emerge, he states that nearly all infant researchers have noticed "epoch changes" (p. 8) around the same ages. These changes occur between the ages of two to three months, to a somewhat lesser extent between five and six months, between nine and twelve months, and between fifteen to eighteen months.

The second of these domains to develop, the "Sense of a Core Self," is the most germane to the present discussion. Stern argues that this domain begins to develop between two and six months. At this age memories of interactions with mother provide the infant an ongoing sense of being-with others. Stern calls memories of these interactions the

experience of an "evoked companion" (p.112) and Stern's discussion of the evoked companion is that part of his model which most closely connects with the notions of internalization and object constancy.

New research on the cognitive abilities of infants led Stern to propose cognitive representations at an age in the infant's life at which Mahler sees a symbiotic, undifferentiated, relationship with mother. Stern begins his discussion of the evoked companion by considering the importance in adult life of feeling "with" another, even when they are not physically present:

The sense of being with an other with whom we are interacting can be one of the most powerful experiences of social life. Moreover, the sense of being with someone who is not actually present can be equally forceful. Absent persons can be felt as potent and almost palpable presences or as silent abstractions, known only by trace evidence. In the mourning process, as Freud (1917) pointed out, the one who has died almost rematerializes as a presence in many different felt forms. Falling in love provides a different normal example. Lovers are preoccupied with one another. The loved other is often experienced as an almost continual presence, even an aura, that can change almost everything one does--heighten one's

perception of the world or reshape and refine one's very movements. (p. 100)

Stern applies the concept of the evoked companion to all stages of life, but describes its inception between the ages of 2 and 6 months. During these months the mother's interactions with the infant play an important role in regulating all aspects of the infant's life, from levels of arousal, to states of hunger and satiation, to feelings of being attached and secure. Stern argues that the actual experiences of the infant being with someone (mother) during these important regulating experiences, particularly when a high level of complementarity is achieved, is what others have described as merger experiences although he argues that no loss of boundaries occurs.

These important interactions, when consistently repeated over time, are accurately remembered by the infant in a specific way, which Stern describes as representations which have been generalized, or RIG's. For instance, a game of peek-a-boo will be remembered as a specific instance after being played once. But after a game of peek-a-boo has been played a number of times, each experience being similar to but also somewhat different from the others, a prototypic memory is developed. The episodes are generalized so that they are no longer specific memories, but are closer to an abstract representation. "It (a RIG) is a structure about the likely course of events based on average experiences.

Accordingly, it creates expectations of actions, of feelings, of sensations, and so on that can either be met or violated" (p. 97).

Stern distinguishes RIG's from cognitive appraisals by emphasizing that they also represent affective experiences of being with another. RIG's provide the cognitive base for the "evoked companion." Stern states that at some point the lived experience of the companion, i.e. the affective sense of another being present, is no longer necessary. Eventually behavior is altered based on cues that no longer require the lived experience to be evoked.

To support his concept of RIG's, Stern cites only one study (Strauss, 1979) in which 10 month old infants were shown schematic drawings of faces. At the end of the series, they showed a preference for a face which was an average of all the faces seen, but one which had not been shown. Stern argues that this supports his notion that the infants had "represented" an average prototype of the faces.

As with Mahler's constant object and Bowlby's "working models" (1980), RIG's help stabilize and regulate self-experience. RIG's are the "basic memory unit" (p. 98) according to Stern. They constitute the basis for the representation of self and others and many different RIG's which develop later coalesce to form a sense of a coherent self. He also argues against a view of the infant as distorting or splitting representations of self and other in

fantasy, at least before language has developed. Various RIG's may not have coalesced in infants, but this is different from splitting as an activity of the infant. The infant in Stern's model does not distort his experience or memory in a defensive manner, nor does he engage in fantasies of union with mother.

Stern, again in contrast to Mahler, does not emphasize an active evoking of the image of mother in the experience of the evoked companion. He states that it is possible for the evoked companion to be purposefully brought to life, but in general his discussion suggests a more automatic quality to the experience. The rattle which had been shaken by mother will call her to mind when the infant first learns to shake it for himself. She is part of the experience. Stern does not emphasize that the rattle is shaken to bring mother to mind; rather it just happens. Eventually mother's presence will no longer be evoked by the rattle if the infant continues to play with it on his own.

RIG's are described by Stern as open to modification through new input, which is constantly compared to the current model. He also suggests, without elaboration, that RIG's can come together to form larger units, such as Bowlby's working models. Like a working model, RIG's tend to be slow to change, and thus act as a relatively stable schema. Stern states that as the child develops, especially after the development of language, RIG's may become less

flexible through defensive processes which prevent the inclusion of new input into the RIG.

Because of the evoked companion experience, Stern argues that the infant in the first half year of life is rarely alone. "Once cued recall memory has begun to function, subjective experiences are largely social, regardless of whether we are alone or not...The infant engages with real partners some of the time and with evoked companions almost all of the time" (p. 118). Stern states that his description of the infant as constantly being in the presence of another leads to what others have called the development of a sense of basic trust (Erickson, 1950). He also suggests that Freud was not far off target when he discussed the "hallucinated breast." For Freud the breast is imagined when the infant is hungry. While the evoked companion is not drive related, the experience of the evoked companion appears to be closely linked to cues which evoke the memory of similar past experiences.

The emergence of "the sense of a verbal self" (p. 162) is the last domain to develop in Stern's model and also offers insight into the experience of absent others. This domain, which typically emerges in the middle of the second year, builds upon the achievements of the previous domains but also includes use of symbolic play and language. Such symbolic capacity dramatically alters the child's experience of himself and of his ability to interact with others.

Toddlers at this age come to be able to refer to themselves as objects external to their felt experience. They also can communicate about things and people no longer present. Stern notes that these developments mark the end of Piaget's sensorimotor stage and are best illustrated by Piaget's concept of "deferred imitation" (1954).

At about 18 months the child will see an action performed which the child has never before performed and later in the day will be observed performing that same action. Stern argues that to act in this manner, in addition to being able to represent accurately the action imitated over a period of time, the child must also have an ability to go back and forth between representation of a action and their performance of it. He must also have a representation of himself which allows him to be seen as similar to the model; a psychological relationship to the model must be recognized by the child. The most important new ability in this development is the child's ability to coordinate schemas about the world with interactions in the world. Thus, the capacity to make the self an object of reflection, the development of symbolic play, the acquisition of language, and the ability to coordinate cognitive schemas with ongoing experience are fundamental to the development of the verbal sense of self.

To support his notions about the toddler's growing ability to represent himself and others, Stern cites

research which indicates that not until about 18 months do children recognize themselves in a mirror. Before this age when they are surreptitiously marked with rouge they point to the color in the mirror but not to themselves. After 18 months or so they touch the rouge on their own face when they view it a mirror. This indicates, according to Stern, a new ability to objectify oneself. In other words, the toddler can now represent herself separately from her ongoing felt sense of self. Toddlers now also begin to use pronouns such as "I," "me," and "mine." Empathic acts also begin to occur for the first time. Stern argues that this developing ability to transcend immediate experience radically transforms the child.

From the point of psychodynamic theories, something momentous has happened here. For the first time, the infant can now entertain and maintain a formed wish of how reality ought to be, contrary to fact. Furthermore, this wish can rely on memories and can exist in mental representation buffeted in large part from the momentary press of psychophysiological needs. It can carry on an existence like a structure. (p. 167)

Such statements have a familiar ring to them. Mahler notes many of these same changes beginning about the same time, although she organizes them around the ongoing need to establish an optimal distance from mother. For Mahler,

developing a stable internalized image of mother plays a central role in the toddler's separation and individuation from mother and is the marker of this phase of development. In general Stern does not emphasize the development of stable representations of others in the same manner; such representations would seem to be a natural characteristic of the child's developing capacities, but do not themselves mark the development of new dimensions of self. Stern focuses more on how the child's developing abilities transform the self.

For example Stern argues that language also opens up new opportunities for relating to others and for experiencing the self differently. While not stated explicitly, Stern seems to imply that language acts "like a structure." In the form of a narrative which relies on memory, language protects wishes and representations from the immediate press of psychophysiological needs. Language also allows for a clarification of wishes and representations in the telling of stories. While representations and evoked companions continue to be present throughout life, the narratives developed about oneself and others determine to a large degree how these are organized and experienced.

The Therapeutic Relationship

For infant and child researchers mothers are commonly the important caregiver in discussions of the development of

object constancy or evoked companions; the therapist typically takes on a parallel role in discussions of patients who have difficulties in maintaining relationships when faced with separation or strong emotions. The focus in recent psychoanalytic writings on the therapist-patient relationship, and to a lesser extent on the ability of the patient to maintain a sense of that relationship between sessions or after termination, is part of a larger gestalt characterized by a growing consensus among psychotherapy researchers concerning the importance of the therapeutic relationship in therapy outcomes.

In recent decades psychoanalysis has increasingly focused on the therapeutic relationship as a central factor in therapeutic change (e.g. Greenberg & Mitchell, 1983). This has been particularly true of object relations theorists (e.g. Fairbairn, 1952; Guntrip, 1969) who have emphasized internalization as the key to therapeutic process. These theorists argue that in therapy patients' representations of self and other--and their representations of self in relation to others--are altered by internalizing experiences with their therapist. As noted above, theorists interested in borderline personality are particularly interested in these notions.

While much has been written about the importance of the therapeutic alliance and about the roles of transference and internalization in psychoanalytically oriented treatment,

research into what patients think and feel about their analysts has been less extensive. Psychotherapy research has produced a great number of outcome studies and, to a lesser extent, process oriented studies. Researchers have looked extensively at how positive feelings toward the therapist correlate with therapeutic outcome measures. Since how patient's feel about their therapist in session also appears to mirror how they think about their therapist when he or she is not present (Orlinsky & Geller, 1993), this literature is germane to the present topic.

Therapeutic Alliance Research

In a recent review of the history and research on the therapeutic alliance, Horvath and colleagues (1993) suggest a different version of Freud's admonishment to analysts about the importance of being "neutral." They begin by describing Freud's (1913) belief in the importance of maintaining a stance of "serious interest" and "sympathetic understanding" in relation to patients. Freud recommends this attitude to analysts so that a collaborative relationship with the patient might develop. This stance, Freud believed, would lead the patient to link the analyst with "images of people by whom he was accustomed to be treated with affection" (pp 139-140). They argue that in Freud's later writings (e.g. 1940) he amended his view of the therapeutic relationship to allow for the possibility of it being beneficially grounded in reality, so that parts of

the ego would become allied with the reality presented by the analyst. Such an alliance is believed to help the patient make use of the interpretations of the transference. Greenson (1967) later played a pivotal role in the psychoanalytic community in the United States in elaborating the importance of the real and the working relationship with the analyst.

Bibring (1937) offered a somewhat different view of the therapeutic situation when he described the analyst as offering a new object relationship to the patient. A wide range of analytic and non-analytic writers (e.g. Boss, 1962; Bowlby, 1980; Fairbairn, 1952; Guntrip 1969; Kohut, 1971; Loewald, 1960; Rogers, 1957; Sullivan, 1953, van den Berg, 1972) also came to accept and promote some version of therapy as offering a new relationship to the patient which is seen as directly beneficial to him or her.

In psychoanalytic terms the therapist and the patient's relationship to the therapist are typically described as being internalized. This process of internalization leads to the creation of new psychic structures, much as Mahler imagined the toddler internalizing the image of the mother. Interpretation continues to be valued by these authors although making the unconscious conscious is no longer seen as the sole therapeutic action of the therapy. In non-analytic therapies the relationship is understood in a number of ways; for example, it is seen as offering an

experience which restores the patient to the path of growth (Rogers, 1951), a chance to reconnect with the human community (van den Berg, 1972), or an opportunity to learn new interpersonal skills (Linehan, 1993).

Psychotherapy research has consistently pointed to the strength of measures of the therapeutic alliance in predicting outcomes. Strupp, Fox, and Lessler (1969), for example, note that in their research a positive attitude on the part of the patient towards the therapist was strongly associated with positive outcomes on a variety of measures. Based on their findings they describe the qualities of the "good therapist" as one who is "a keenly attentive, interested, benign, and concerned listener--a friend who is warm and natural, is not adverse to giving direct advise, who speaks one's language, makes sense and rarely arouses intense anger" (p. 117). This description of the "good therapist," drawn from the responses of patients in dynamically oriented treatments, suggests that patients who are helped by therapy generally like their therapists, feel that the therapist is warm and caring, and feel that they had a good relationship with their therapist.

Recent research has strongly supported the important role assigned to the therapeutic alliance by Strupp and his colleagues. Horvath, Gaston and Luborsky (1993) note in a review of psychotherapy studies that the strength of the therapeutic alliance, particularly as measured from the

patient's perspective, is consistently found to be significantly correlated with outcome measures. This has been true across all types of therapies, although they add that some results suggest that the effect is attenuated in highly structured therapies such as behavior modification.

Horvath et al. also note that research on the therapeutic alliance suggests that the patient's perspective on the strength of the alliance does not remain constant throughout therapy. Early measures of the alliance tend to be moderately stronger predictors of a successful outcome than measures taken in the middle of therapy. (No results of measures taken during the termination phase are mentioned.) These authors argue that fluctuations found in the patient's perception of the strength of the alliance suggests a "rupture/repair cycle in successful therapies" (p. 259).

Strupp et al. (1969) also attempt to examine the process by which therapy promotes healing or growth. They summarize their view of the "core" of the therapeutic process: "There is substantial evidence that the efficacy of psychotherapy is primarily a function of a central core of facilitative conditions. These are three: (a) experiential, (b) didactic, and (c) the role model which the therapist provides" (p. 135). The quality of the therapeutic relationship can be understood as the ground for these three facilitative conditions.

The Patient's Experience

Bernard and Drob (1989) conducted a study of patients' experiences after termination which suggests that the therapy experience continues after treatment ends. They interviewed 10 patients who had been treated in dynamically oriented therapy by 10 different therapists. These patients were interviewed between four months and six and a half years after termination. The length of treatments ranged from once a week for nine months to twice to three times a week for seven years. Methodologically, these authors used a semi-structured interview and presented their results in terms of a series of themes.

The first of the themes which resulted from their study was labeled "Internalization of Process." This theme describes how the therapeutic process is taken up by the patient once therapy ended. The authors note how the need for imagined contact with the therapist diminishes over time in successful outcomes. They state that several patients who ended therapy prematurely reported hearing their therapists tell them things or having imaginary conversations with them. They contrast this process with patients who terminated after mutual agreement with the therapist.

They quote one patient: "I don't have imaginary conversations with my therapist. I can visualize her, but I don't do so at particularly stressful times. I don't have

to think "What would she say?" I don't need tricks. Whatever is there is there" (p. 364). This patient's description of thinking of her therapist after termination suggests that while she can recall her, and might even choose to do so, she does not experience a need to imagine the therapist. Despite not actively calling up an image of the therapist, this patient was aware of dealing better with stressful situations because of therapy.

Bernard and Drob add that for all of the participants' interviewed the therapeutic work seemed to continue after termination. They state:

A number of them described how they think of their ex-therapists, and the values and perspectives they represent to them, when difficulties arise in their lives. This "internal evocation" of their previous therapist is a way these people have of using their treatment experience to deal with the ongoing challenges of living. (p. 366)

Bernard and Drob also report that patients tended not to recall specific insights gained in therapy, despite the dynamic orientation of the therapist. What patients spoke of instead was a more general change in perspective. The authors give the example of one patient discovering that he was "all right" (p 363). Specific insights seemed to be most important to those patients who were in therapy the shortest periods of time. Finally, these authors report

findings that further support the importance of the therapeutic alliance: Virtually every patient emphasized that their therapist's "human, caring qualities were significant for them long after therapy had come to an end" (p. 364).

Follow up studies to psychoanalysis provide similar findings. McLaughlin (1981), for instance, reviewed a number of such studies (Norman, Blacker, Oremland, & Barret, 1976; Oremland, Blacker, & Haskell, 1975; Pfeffer, 1959; 1961; 1963; Schlessinger & Robbins, 1974; 1975). These studies typically consisted of interviewing former analysands for an hour, four to five times over a period of weeks. Interviews typically were conducted by an analyst other the treating analyst in an unstructured format similar to an analytic session. Blatt and Behrends (1987) quote McLaughlin at length concerning how change occurs in psychoanalysis:

Improvement and change (in psychoanalysis) depend not truly upon obliteration of old structures and conflict, but upon their inactivation through internalization of higher psychic structures built up through the processes of transference in the analytic work. Experiences of the analytic relationship and memories of the attitudes and enactments of the analyst remain vivid memories and a vital part of the patient's inner life with effects that seem to be enduring. What was

'crucially different' in successful cases was that adaptation toward dynamic and object-related issues of the transference neurosis were altered for the better through the patient's internalization of aspects of the analyst's way of looking at things, now a self-analytic function and probably permanent psychic representation (pp. 652-653)." (p. 291 in Blatt and Behrends, 1987)

The findings of these studies, along with those of Bernard and Drob, indicate that memories of therapy and of the therapist remain important and "vivid" well after therapy ends. In partial contrast to the findings of Bernard and Drob, however, other research (Orlinsky & Geller, 1993) hints that successful treatments may result in patients thinking more often about their therapists after termination than in less successful instances. In this regard it is interesting to note that Bernard and Drob report that nearly all of the ex-patients they interviewed had some sort of post-therapy contact with their therapists, including those whose treatments were deemed most successful.

Little quantitative research has been conducted on the extent and content of patients' representations of, or fantasies about, their therapists. Recently, however, Geller at Yale University and Orlinsky at the University of Chicago have separately developed instruments to explore

this area. While they have conducted a number of studies with their graduate students, nearly all of this research remains unpublished and somewhat difficult to obtain. They recently published two articles (Orlinsky & Geller, 1993; Orlinsky, Geller, Tarragona, & Farber, 1993) written jointly, however, in which they describe their instruments and summarize their initial findings. (Geller, Cooley, & Hartley, 1981, also published preliminary results of their findings.)

The "Therapist Representation Inventory" (TRI), developed by Geller and his colleagues (1981) consists of four parts. In the first part subjects are asked to write a five minute description of their former therapist. These descriptions are scored on a nine point scale based on Piaget's developmental model. The second part of the TRI is a 12 item "Therapist Embodiment Scale" (TES) which asks patients to rate the degree of contribution of different sensory modes, along with their vividness, frequency and duration of their experiences of their therapists outside of therapy. The third part is a 38 item questionnaire, the "Therapist Involvement Scale" (TIS), which focuses on the content of the wishes and fantasies patients have about their therapists. The final section is another questionnaire which rates the vividness, frequency, and content of dreams that patient's have about their therapists.

A description of the findings from the first section are not directly pertinent here. A factor analysis of the second part of the TRI, the Therapist Embodiment Scale, produced three factors tentatively named as follows: "visualization," "proximal embodiment," and "conceptual-conversational" (Orlinsky et al., 1993, p. 600). Visualization referred mainly to images of the therapist in his office. Proximal embodiment referred to "a blend of imagery derived from more immediate kinesthetic, proprioceptive, and tactile sense" (p. 600) of the absent therapist. The third factor, conversational-conceptual, was less robust than the other two and referred mainly to auditory and lexical representations of real or imagined conversations with the therapist.

The Therapist Involvement Scale of the TRI was also factor analyzed. It produced five factors: "Continuing the therapeutic dialogue;" "sexual and aggressive involvement" (the authors note in passing that these items were rarely endorsed); "the wish for reciprocity;" "the failure of benign internalization;" "the effort to create a stable representation of the therapist;" and "desiring contact" (p. 600). while these factors were not discussed, but simply listed, they provide a sense of the themes found using this instrument. Preliminary data from the final section, on dreams, suggests that while conscious representations of therapists tend to be primarily positive, particularly in

patients who report positive experiences in therapy, the dreams patients have of their therapists are more often negative. The authors suggest that during sleep representations of therapist may be more prone to being influenced by unconscious conflict.

The Intersession Experience Questionnaire (IEQ) developed by Orlinsky and Lundy (1986) is a 42 item questionnaire which is used primarily between sessions while the patient is still in therapy. A factor analysis of the IEQ converged in four factors. The strongest factor is called "recreating the therapeutic conversation" (p. 601) and seems similar to continuing the therapeutic dialogue of the TRI; it was reported to be particularly salient when the patient felt distressed. The second factor was labeled "evoking relief and remoralization" (p. 601) and was composed of items which ask how the patient felt when thinking about his or her therapist. This factor suggests that when patients who scored high on this factor recalled their therapists they experienced a "morale" boost. The third factor was labeled "evoked anxiety and frustration" (p. 601) and was composed of items involving negative feelings about therapy and the therapist. Patients who scored high on this factor did not find thinking about their therapist "uplifting." The fourth and weakest factor is called "preconscious or unconscious processing of therapeutic experience" (p. 601) and was defined by the

tendency to daydream, fantasize about, or remember a dream about the therapist.

The names given to the these sets of factors suggest the range of themes which characterize patients' thoughts, feelings, memories, and fantasies about their therapists. The authors do not discuss, however, how they arrived at the items chosen for these two scales although they do cite a range of theorists, most of whom come from an object relations or cognitive/developmental perspective, to introduce their research. How specific items were chosen is important since the themes that emerge from their factor analytic studies are limited by the range of items asked.

Orlinsky and Geller (1993; Orlinsky et al., 1993) state that the most striking result of their research to date is the sheer frequency of representations reported between sessions and even after termination. They note that over 90% of patients given IEQ's at an outpatient psychiatric clinic, where the average number of sessions was 13, reported thinking about their therapists between sessions. The greatest frequency of this activity is reported to occur right before and right after the session, although 25% of the patients reported that they thought "a lot" about their therapists at other times as well.

In another study, which looked at patients who had terminated three to 18 months earlier, about 25% of the subjects reported that they thought about therapy once or

twice a week, and about 60% reported they thought about therapy once or twice a month. The authors note that the frequency of patients' representations of their therapists tends to diminish over time, although patients who reported being in therapy longer, having positive feelings about their therapists, and experiencing more successful outcomes tended to show the greatest overall frequency and the least decline in frequency in recalling their therapist. The frequency of thinking about one's therapist after treatment generally correlated positively with the length and success of the treatment.

In another study reviewed by Orlinsky and Geller, Geller and Farber (in press) contrasted patients currently in treatment with patients who had terminated. The patients in treatment reported the "felt presence" (p. 602) of their therapist more frequently than those who had terminated although not more vividly. In both groups these experiences were reported to last between 30 and 60 seconds and to be "vivid."

Orlinsky and Geller report that auditory and visual imagery were the most common forms of representation among patients. They cite a study by Barchat (1989) which suggests that the types and vividness of representations of therapists by patients is affected by how the patients feel about their therapists. Barchat found that patients who reported more sadness about separation from their therapists

during a vacation break tended to experience more embodied forms of representations. He also found that patients who reported negative feelings about their therapists tended to visualize them less vividly than those who felt positive about them. This latter finding is confirmed by positive correlations between the Therapist Embodiment Scale and the Therapist Involvement Scale suggesting that patients who report being more involved in the treatment tend to have more vivid and complex representations of their therapists. In a like manner, Lehman (1991) reports that senior therapists tend to have representations of their patients that are sensorially richer than those of novice therapists.

Orlinsky and Geller (1993; Orlinsky et al., 1993) also review a study by Geller, Cooley, and Hartley (1981) which found that patients experienced their therapist most vividly and evoked them most often during times of stress. Just over half the participants still in therapy in that study and about 28% of the participants who had terminated reported using representations of their therapist in times of stress.

Orlinsky and Geller note several other times when patients tend to report thinking of their therapist. About 15% of the patients who had terminated made use of therapist representations to feel a sense of "relatedness." In addition patients reported thinking about their therapists when they wanted to be like the therapist or when they would

have wanted their therapist's approval. Orlinsky and Geller state that a high percentage of both current and former patients also report thinking about their therapist when problem solving (Wzontel, Farber, & Geller, 1992).

Orlinsky and Geller (1993) cite research by Orlinsky and Tarragona (1989) which indicates that experiences in sessions are highly correlated with the representations of the therapist experienced between sessions. In other words, patients who report experiencing positive feelings towards the therapist and who experience a strong therapeutic alliance tend to have positive representations of their therapists, as one might expect. It is interesting to note that patients' representations of their therapists in at least one study were more positive at five weeks than at five months. Representations also became less differentiated and less coherent in the middle phase of therapy. This finding appears to support, as both Orlinsky and Geller, and Blatt and Behrends among others have argued, that patterns of connection and rupture are characteristic of the therapeutic process.

Who the patient is also seems to affect the formation of therapist representations. Orlinsky et al. (1993), for instance, report a study by Honig (1989) which found a strong correlation between patients' description of their mothers and their representations of their therapist as measured by the TRI, suggesting that patients tend to

experience and represent their therapist in a manner reminiscent of how they experienced and represented their parents. Using the IEQ, Brenner (1992) is reported to have found that patients who rated themselves and were rated by their therapists as functioning poorly at the beginning of treatment tended to report more frequent use of representations of their therapists than did better functioning patients.

Finally, research in this area suggests that the type of representations patients form of their therapists are correlated with therapy outcomes. Tarragona (1989) is reported to have found (in Orlinsky et al., 1993) a correlation between improvement in treatment with representations characterized as "supportive-guiding" representations. Geller et al. (1981) also report that successful outcomes were found to be positively correlated, among both current and former patients, with scores on the factor "continuing the therapeutic dialogue." They also report that positive outcomes among former patients are positively correlated with missing the therapist. Sexual and aggressive fantasies about the therapist, on the other hand, have correlated with negative therapeutic outcomes (Farber & Geller, 1989), even though such fantasies are not reported frequently.

Beginnings of a Phenomenological Perspective

Phenomenologists, like radical behaviorist, have

typically criticized the representational emphasis of both psychoanalysis (Merleau-Ponty, 1962) and cognitive psychology (Aanstoos, 1983). The origin of this criticism arose with Husserl's dissatisfaction with a "copy" theory of perception. Husserl argued instead for a direct experience of the world that did require that a copy first be created or represented (Wertz, 1989). Husserl wanted to turn from an emphasis on representations to the world as it is lived.

In a similar manner, memory and imagination have been approached by phenomenologists from the first person perspective (e.g. Casey, 1976; Giorgi, 1989) in an attempt to elucidate it as part of the lived-world. In these studies attention is paid to how the world presents itself in memory and imagination. For this reason, hypothesized mechanisms of memory and imagination have proved less interesting to phenomenologists than how memory and imagination are experienced and how these modes of experience reveal us as meaningfully related to others and to the world.

Casey (1976), for example, is a philosopher whose study of imagination makes use of his own experiences as well as examples provided by novelists and philosophers. He emphasizes the autonomous nature of imagination and ultimately links imagination with human freedom (Ihde, 1986). For Casey imagination leads to new possibilities:

Pure possibility, finally, is the thetic expression of imaginative freedom of mind. Even if the purely possible is subject to certain formal and practical limits, these ultimate boundaries are not nearly so constrictive as those imposed upon whatever is empirically real. Pure possibility enables the mind's free movement to traverse a terrain considerably more vast than the region occupied by perceived and remembered things alone....Each journey into such a domain is potentially endless, since a given series of pure possibilities has no fixed terminus. Here freedom is the freedom of never having to come to a pre-established or peremptory end. (Quoted in Ihde, 1986, p. 150)

Jager (1987) takes up a similar perspective in his discussion of imagination. He begins by noting that in the West an image has typically been understood as a copy, an inferior copy, of the real world. Both Mahler's constant object and Stern's evoked companion seem to be sophisticated versions of this tradition. But Jager suggests an alternative manner of conceiving of an image.

Drawing on the work of Nietzsche, Heidegger, and Freud, Jager argues that the development of images and the use of imagination allows experience to be brought into view in a new way. In a similar manner, art, as mode of

representation, brings the world into view in a new manner, revealing its meaning, or at least potentially deepening our grasp of it. Imagination forms the heart of the artistic endeavor according to Jager. And art is essential in a world whose meaning is not always immediately apparently nor immediately absorbed. The need for images and imagination, like the need for art, he argues, lies in our difficulty in living in a world which can overwhelm our capacities to understand it. Imagination creates a "place" (p. 130) in which we come to terms with those aspects of experience which exceed our grasp.

In developing this argument, Jager refers to Freud's (1920) story of his grandson playing "fort" and "Da" as he calmly awaited his mother's return. In this game the child made a toy attached to a string go away and come back. Freud suggests that the game was a means of reestablishing the pleasure of having mother present when she went away and a symbolic means of gaining control over her coming and goings. Mahler might see this game as a transitional stage toward the development of object constancy. Although her interpretation might emphasize the child attempting to stay connected to mother, it would not differ in any essential way from Freud's interpretation.

Jager offers a somewhat different interpretation. He states that it is in the game "that mother's coming and going becomes for the first time differentiated and fully

experienced" (p. 129). In this account the game is not primarily a means of gaining symbolic mastery over his mother, nor of maintaining a sense of connection with her, but a means of grasping that mother goes away and returns. Within such an account, the toddler's image of her mother and the borderline patient's fantasies about his therapist take on an added dimension. The other is being reckoned with and the experience of absence contained and puzzled through. The world is offering something new with which one must be come to terms. Like Mahler and Freud who view internalizations primarily as a psychological response to loss, Jager notes that suffering often motivates an imaginative space in which to come to terms with the world.

The models of development provided by both Mahler and Stern provide a framework in which the representation of other people plays an important role in how they imagine us staying connected to other people when separated from them. But how these representations are experienced by toddlers is mostly left to imagination, theirs and the reader's. Orlinsky and Geller also develop a model of personality which emphasizes the representation of others. Although Orlinsky and Geller begin to describe what the imaginary experiences of the absent therapist are like for patients with the results of their factor analyses, a more detailed description of such experiences is called for.

The descriptive accounts of imagination offered by Casey and Jager, for example, suggest possibilities not obvious in the work of Orlinsky and Geller. In a like manner it is hoped that the in-depth interviews which have become the primary method of phenomenological research will offer a vehicle to gain greater sense of how the presence of the absent therapist is experienced and what meaning those experiences hold for patients.

CHAPTER II

METHOD

The methodology employed in the present study is phenomenological. It is a methodology that begins with a description of experience from the first person perspective and that aims to elucidate the everyday experience of the world (Giorgi, 1983; Kvale, 1983; Merleau-Ponty, 1962; Thompson, Locander, & Pollio, 1989; Valle, King, & Halling, 1989). The phenomenological approach employed in the present study makes use of insights gained from existential-phenomenological philosophy. As in philosophical phenomenology, the present study attempts to describe interactions with the world in terms of their experienced meaning and through reflection on those descriptions to gain a greater understanding of human existence.

Unlike its philosophical forbearer, however, phenomenological psychology emphasizes the use of empirical data over self-reflection; also, it is primarily psychological, focusing on understanding experience and behavior. It is not primarily concerned with ontology, as is philosophy, although the two concerns overlap at times.

In emphasizing the use of empirical data, phenomenological psychology more closely resembles a natural science approach to research than it does philosophy. Many

of the procedures and aims of the phenomenological method, however, are different from those of traditional experimental psychology. In traditional experimental psychology the model for good research has been a controlled experimental situation which attempts to measure the effect of variables on comparable groups (Leahey, 1991; Polkinghorne, 1989). The model in phenomenological psychology, on the other hand, has been to have participants describe a phenomenon as they have experienced it, with all the richness and complexity that characterizes human existence. Once such a description has been attained the next step is to look for similarities among the descriptions.

Unlike traditional research methodologies, phenomenological research does not emphasize breaking down the data into components to be measured and quantified for statistical analysis in order to establish a cause and effect relationships. Instead, the aim of the present approach is to engage the data, ultimately the people interviewed, in a manner that allows the experiences and behaviors to be understood in terms of their meaning, as lived by the participants, without first being transformed into numbers and statements of cause and effect relationships. In this manner, it is hoped that nature of the experience--its rhythms and contours and its overall gestalt-- will not be lost as it is measured and analyzed.

In a related manner, the language used to describe the phenomenon typically relies on the descriptions offered by the participants themselves rather than on the building up of a metatheoretical model.

Phenomenological methods do not begin with a hypothesis to be tested as do studies that are primarily oriented towards prediction and control of phenomenon. Rather, they begin in an attempt to gain fresh insight into a given phenomenon by immersing oneself in it, looking and feeling one's way through its rough edges, and waiting for a pattern to emerge. A utilitarian view is not abandoned, but must be set aside in taking up a phenomenological attitude toward the phenomenon of study. To that end, an attempt is made to understand a phenomenon without coercing it to prove or disprove one theory or another. Despite aiming at an understanding which does not focus on prediction and control, it is hoped that a greater understanding of a phenomenon will prove useful in related contexts.

While general statements are the aim of phenomenological research, metatheoretical systems, such as Freud's ego-id-superego model, are avoided since they tend to move us away from experience to concepts which are too easily reified in an unhelpful manner. Theories remain important as sparks to questions and as a means of organizing data and furthering understanding, but must be

set aside for a time in order to not determine the outcome of the study in advance.

Thus, the present methodology does not test hypotheses in any strict sense of the term, but attempts to remain close to human experience in language and content; as such, it is primarily descriptive. As with all research, however, the findings of the present study must be understood in the light of past knowledge and should not be construed as claiming to be free of all theoretical influences. As Gadamer (1975) argues, our past knowledge and our biases allow us to understand the world while at the same time also limiting that understanding. Everything that we know and believe shapes what we perceive. Despite this shaping, new knowledge and insight can appear at the horizon of our existing understanding, thus providing a new perspective, if we are open to it.

Reliability and Validity

Reliability and validity are concerns in the present methodology, as in traditional experimental psychology, but take on a different shape than in a natural science approach. In a phenomenological approach, reliability does not focus on others being able to exactly repeat a procedure with the same results within a certain error variance. The emergent quality of phenomenological interviews, which define the primary means of this research, preclude a definition of reliability as a simple repetition capable of

producing identical or highly similar results in a manner that can be quantified with a correlation coefficient. Each interview is different, even when all interviews are conducted by the same interviewer. Since no attempt is made to measure the meaning of an experience in the present methodology, a standard error of measurement is neither an applicable nor an appropriate conceptualization of reliability within the present frame work.

Reliability in the present context derives first from laying out a procedure and then following it rigorously, so that others can follow it well. In the present study this procedure involves in-depth, open-ended interviews followed by close readings of the interviews. The interpretations of the protocols are circumscribed by the requirement that one be able to point to passages in the transcribed interviews for support of a given interpretation. In the context of this process, the notion above all others which guides phenomenological research in regard to reliability is that another psychologically minded individual who understands the procedures followed and who examines the data in a similar manner will be able to comprehend the results, whether or not she or he agrees with them (Giorgi, 1975; Thompson, Locander, & Pollio, 1989). Reliability thus becomes an issue of supporting interpretations with reference to the data in a manner others can follow.

Within the context of the present research, issues of reliability are handled differently at different stages of the research process. Prior to any interviews with participants, a bracketing interview is conducted in which the primary researcher is interviewed regarding his or her own experiences related to the phenomenon in question. The goal of this interview is to help bring into view the researcher's experiences and beliefs--his or her biases--about the phenomenon.

During the stage of the research in which participants are interviewed, they are told that their description of their experience is the aim of the interview. This emphasis on the participant's experience is reinforced by the interviewer's constant checking of his or her unfolding understanding of the description with the participant. In this regard the participant comes to understand that he or she is the expert in regards to the described experience. An attitude of openness and discovery is cultivated by the researcher throughout the process--in presenting the project to the participants, in conducting the interviews, in encouraging the participant to be open to new insights, and, finally, in interpreting the transcripts.

Once interviewing has been completed, the process continues in the weekly meetings with a specifically trained research group and on an individual basis. At the meetings of the research group, participants' protocols are read and

discussed in minute detail. The group setting offers the advantage of different perspectives on the protocol and all discussions are guided by the rule that all interpretations must be closely supported by reference to specific sections of the protocol. Here again the process of more than one person being able to comprehend a given perspective, whether or not it is assented to, is primary. A similar procedure is repeated when analysis moves from individual protocols to themes spanning all of the interviews. During this part of the process, group members again offer multiple perspectives and demand an accounting of support for any given interpretation or organization of themes.

Finally, in reporting results of the study the procedures are described, much as they would be in natural science research, and examples of relevant data provided. Data are presented in such a manner that the reader, even if he or she disagrees with the name of a theme can see how that theme emerges from what the participants said.

The question of validity in phenomenological methods is similar in many ways to questions of validity in natural science approaches to psychological research (e.g. Chronbach and Meehl, 1955; Nunnally, 1978). Any interpretation of the results should be argued persuasively and the question of a reader agreeing or not agreeing with the interpretation moves to the fore. Here again, correlation coefficients, which can be all important in the development of a new

psychological test, are not relevant since no attempts at quantification are made in phenomenological approaches.

In the case of phenomenological research, the issue of validity can be posed as questions the researcher and the reader might attempt to answer: 1) Is the interpretation of the results argued convincingly based on the data presented? 2) Are the results related comprehensively to previous findings and theories in the given area? 3) Do the results and the given interpretations further or deepen an understanding of the phenomenon or offer new directions for treatment or research? Validity as understood in the present context, thus, is broadly understood in a similar manner to other areas of psychology, although it is not based on statistical correlations of one measurement with another.

Participants

The criteria for inclusion in the present study were as follows: 1) Being in or having been in psychotherapy for at least one year; 2) participating in a treatment that is not primarily behaviorally or psychopharmacologically oriented; and 3) reporting a predominantly positive experience in therapy. In the phenomenological method employed, the number of participants interviewed is guided by an attempt to represent adequately the range of experiences associated with the phenomenon being studied. Thus, rather than attempting to find a "representative sample" of a given

population, the researcher aims to interview enough participants so that the range of experiences defining the phenomenon in question are represented. While there is always the possibility that another interview will offer something completely new, after a certain number of interviews commonalities emerge and one develops a sense that something new is or is not being said about the phenomenon in question. The length of the interviews and the intensive nature of examining the protocols also set practical limits to the number of interviews to be conducted.

The initial plan was to recruit participants from closed files at the University of Tennessee Psychology Department's Clinic whose records suggested that the patient might fit the above stated criteria. All necessary permissions were obtained from the clinic and program directors and from the Human Subjects Committee; unfortunately, only one participant was obtained in this manner. Most of the former patients called were no longer at the same telephone number.

After obtaining the necessary approval of the Human Subjects Committee, notices describing the study were sent to several local churches and synagogues and placed on the bulletin board in the psychology department mail room; in addition a notice was placed in the Appalachian Psychoanalytic Society's newsletter. The criteria remained

the same, although participants were no longer limited to former patients of the Psychology Clinic. Participants were all initially contacted by telephone. At that time, selection criteria was described to them and they were asked if they met the criteria. All participants interviewed stated that they did meet these criteria and that they were willing to be interviewed.

Prior to each interview, the participant was given an information and consent form, a copy of which is to be found in the Appendix. Following this, the interview was then conducted and taped. Interviews ranged in length from about 40 minutes to 90 minutes, with most interviews lasting about an hour. A second consent form, also to be found in the Appendix, along with a highlighted copy of the participant's transcript, was later sent to each participant in order to obtain permission to use specific quotes. Two participants also were asked by telephone if they were willing to allow the use their entire transcript in the present document. They both consented and wrote a note to this effect on the second consent form. One of these transcripts is provided in its entirety in the Appendix as an example of the interviewing process and of the content found within a single protocol.

Demographics

Twelve interviews were conducted, although the sound quality of one of the interviews was poor enough to preclude

use of quotes from that interview. While demographic information was not explicitly solicited, the following descriptions of participants may be made: Six participants were women and six were men; all were Caucasian. At least 11 participants worked in some capacity; the majority either worked in a professional capacity or were students preparing for a career as a professional. Five participants were graduate students at various stages in their education in either clinical or counseling psychology programs. Two of the participants were psychologists and one was a social worker practicing in the community. One participant worked in an artistic area, but in connection with a technical field. Another participant worked in a secretarial position and another was employed as an accountant. The work of the final participant is unknown.

Participants appeared to range in age from mid-twenties to mid-fifties, with most participants in their late twenties to early forties. Six participants were married, two were divorced, one was widowed, and three were single. Five participants mentioned having children.

The length of time and the intensity of treatment varied. Two participants attended sessions every other week, but had done so for well over a year. Two participants reported analytic type treatments in which they had sessions three to four times a week and reclined on a couch. Two other participants went twice a week and one

also used a couch. Another participant attended sessions three times a week for a few months, then went more infrequently, and then went only when in crisis. The remaining participants attended weekly sessions

In regards to when treatment occurred, seven participants described past treatments, one of which had occurred over ten years ago. Eight participants spoke of current treatments and two spoke of both past and current treatments. In regards to lengths of treatment, the longest any of the participants reported being in treatment was for over seven years and the shortest was just over a year. Most of the remaining treatment lengths ranged from two to three years.

Procedure

The initial idea for the study arose from the my reading in the area of the psychoanalytic notion of object constancy, particularly in relation to borderline pathology (e.g. Adler, 1985; Cohen & Sherwood, 1991) and from my experiences both as a patient and a therapist. Some of the authors concerned with object constancy articulated beliefs that an important part of the psychotherapy process was the imaginal use of the therapist who was not present. I wondered if patients shared the sense of this experience as important, and if they did, what was the meaning of such experiences to them.

As has become common practice in the phenomenology research group at the University of Tennessee, after discussing the topic with the lab I conducted a pilot interview to determine if participants would be able to talk about such experiences. A colleague from the lab volunteered to be interviewed. This interview was transcribed and the two of us discussed the contents. We were encouraged. This same colleague later interviewed me about my experience in this regard. This is also a common practice in the lab and is referred to as a "bracketing interview."

The goal of the bracketing interview is to highlight for the researcher his or her own experience of the phenomenon being studied so that when future interviews are conducted, the researcher does not blindly pursue expectations. This is not a naive belief that in such a process the biases of the researcher and thus his impact on the process are negated. Rather, in becoming more aware of personal bias, it is hoped that the researcher will be more sensitive to positions and possibilities different from his or her own. My colleague and I discussed the results of the bracketing interview.

Eleven additional interviews were then conducted. The pilot interview conducted with my colleague was also used in the analysis, thereby making a total of twelve interviews. Because of the sound difficulties with one of the tapes,

quotations from that interview could not used, but the interview did help to inform the reading of other protocols. In each interview after the study was explained, the information and consent form signed, and any questions answered, the following instruction was given to the participant: "What I would like you to do is to think about some times when you were aware of your therapist or your therapy, that did not rely on your therapist's physical presence, and describe those times in as much detail as possible. These times can be from between sessions or since therapy has ended, or even in session, and can be anything from recalling a session, to dreams, to anticipating a session, to imagined conversations, to fantasies. I want to leave the range of possible experiences as open as possible. Does that make sense to you?"

The wording of the question varied in minor ways from interview to interview since it was not read in an attempt to approximate everyday conversation. On two occasions the participant asked that the question be repeated. Following the statement of the question, and any necessary clarification, an open ended phenomenological interview was conducted. The primary aim of the interviewer in this context was to provide an atmosphere in which the participant felt free to explore in great depth and breadth the experience in question. In addition, the interviewer acted to clarify statements made by the participant, to

encourage elaborations of brief descriptions, to keep the participant focused on the topic -- though much leeway was allowed in this regard -- and to check the interviewer's emergent understanding of the participant's description of the experience with the participant.

All interviews were transcribed by the author and these transcribed protocols then became data for analysis. Over a period of nine months all of the protocols were closely read by the author. Three of the protocols also were read and discussed in great detail in the research group. The author then highlighted significant statements--i.e., those statements that seemed most pertinent to the research topic--in each of the 11 protocols. Over 220 statements were identified in this manner. A brief summary statement was then written for each of the protocols, and significant statements were later organized according to content to produce 10 categories.

These 10 categories were used to organize themes that seemed to tie the results together in a more comprehensive manner. These categories and an initial structure of three themes, along with the significant statements, were then presented to the research group. Two of the themes presented gained general support from the group whereas the third theme evoked disagreement and lengthy discussion. This theme had seemed the least cohesive of the three to the author going into that research meeting. After being unable

to resolve the difficulty with this theme in that meeting, several individual attempts were then made to reorganize the data, including experimenting with several variations of two, three or four themes. After a new structure of three themes was settled upon, it was presented in lab again. One of the themes which had been generally accepted in lab was broadened, another theme--the problematic one--was narrowed and restructured and the last theme remained much as it had been presented initially. The group was supportive of the new structure, with several members stating that it described in outline their own experience in therapy.

In addition to addressing the content of the three themes, much time and energy was devoted to deciding upon appropriate names for each of the themes. The naming of each theme is an important part of the process, much as naming a factor is in interpreting a factor analytic study. In the present research an attempt was made to use words actually spoken by participants in naming the themes. The name of the theme should also characterize the main thrust of that aspect of the experience and should be easily understood and related to by the reader.

CHAPTER III

RESULTS

Interviews with the present set of 12 participants revealed that they often were aware of their therapist outside of his or her physical presence, and nine claimed their therapist's presence as an important aspect of the therapy process. For three participants, however, the importance of experiencing their therapist's presence was less clear. One of these participants denied that it had much importance at all and the other two participants appeared ambivalent, sometimes suggesting that it was important and, at other times, sounding unsure. All participants were able to describe this phenomenon although not with equal ease.

As noted in the previous chapter, significant statements were taken from each of the protocols concerning the experience of the therapist's presence; these significant statements were initially organized into the following 10 categories:

- 1) Feeling connected
- 2) Caring for my therapist or wanting my therapist to care for me.
- 3) The type of relationship I have with my therapist
- 4) Therapist as role model
- 5) Comparison with my therapist
- 6) Imaginal conversations or contact with my therapist
- 7) What I learned in therapy

- 8) Recalling specific advice from the therapist
- 9) Comments on the process of experiencing my therapist
- 10) Feeling comforted by the therapist's felt presence

These categories provided a useful manner of organizing the data into a more manageable format than that of lengthy transcripts. The categories overlap significantly with each other and by combining related categories three distinct themes from across all of the protocols emerged. These themes seemed to provide the best description of the essential aspects of the experiences described by these participants. These three themes were labeled as follows: "Not Feeling Alone," "Being Helped," and "Having a Model."

The three themes are best thought of as a psychological gestalt with a particular structure (see Figure 1). Each theme emphasizes an aspect of the whole, but maintains a relationship to the whole which can be characterized in figure/ground terms; when one of the themes is figural, the other two tend to become a background for it. The themes, thus, represent an attempt at organizing the content and structure of the experience described in the interviews. As suggested above, the themes are interdependent; within a given protocol they often were intertwined with one another. Nonetheless, distinct aspects of the experience are expressed by each of the present themes; the most important aspects of the gestalt can be described in this manner as an aid to the reader in understanding the experience of the participants.

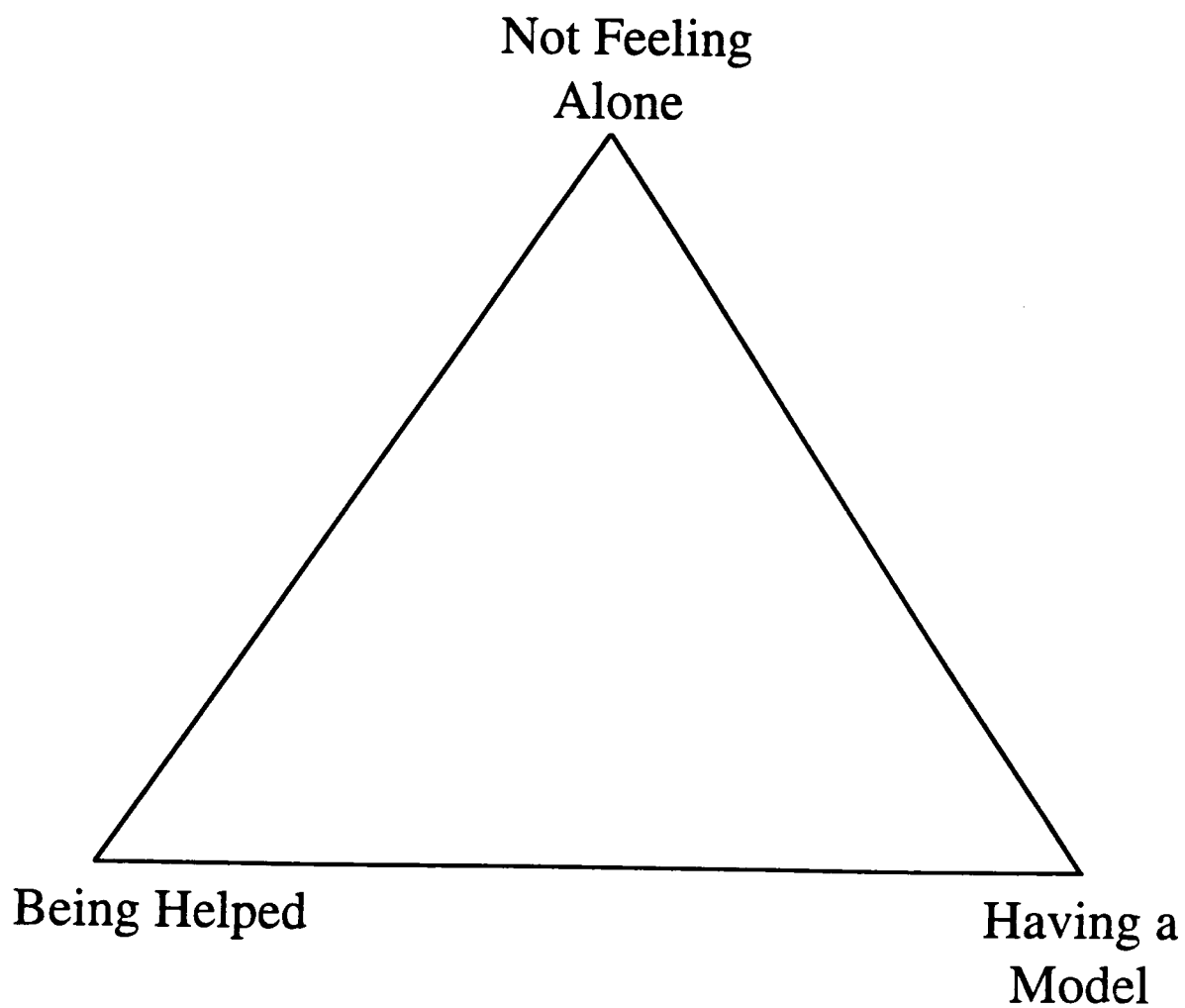


Figure 1.
The Structure of the Imagined Therapist Experience

Mode of Experience

Before moving onto a discussion of the individual themes and some of their interconnections I want to bring attention to the fact that the mode of experiencing the imagined therapist's presence is itself an aspect of the description of the experience. All participants described how they experienced their therapist. Given the wording of the interview question it is not surprising that a range of modalities are mentioned. No pattern across participants was evident and even within a given interview, however. Most participants noted a variety of ways of experiencing the therapist. For instance, most participants mentioned being able to call up a visual image of the therapist such as the one described in the following excerpt:

I -- just to see where her chair was, and the sort of the sunshine from the window behind her. It's just an image that I call to mind and I notice I do that with people I care about. It's sometimes not even to wonder what they're doing, not even to take it that far, it's just to call to mind their image. I don't even do it on purpose. It just happens as I go through my day. But to that extent, I can focus on it and sort of differentiate it out.

Nearly all participants also made reference to hearing their therapist's voice or recalling something that the therapist had said. For example: "I can hear her voice saying that phrase to me." Many participants also recalled a "felt presence," an almost palpable sense of the

therapist's presence. The following quote connects this felt sense to the affective quality of the experience:

There is this felt presence, not unlike the felt presence of being able to recall particular times of being with my wife and having... that memory, but also having enough of the feelings that go along with that, or more than just a kind of one dimensional piece, it's a multidimensional state, for lack of a better word, there is dimension to this presence and the intensity of that feeling ebbs and flows. And can... feel very faint or very strong....and quite possibly it is related to the intensity of my need.

Another participant focused on the bodily experience:

You know for me a more a basic level is just her physicality, her physical presence. (How so?) Well, when she took my hand. That was the only time that she has done that, but it felt like what was needed at the time. And I remember leaving and I could remember the feel of her hand and how warm it was.

Some participants spoke of dreams in which their therapist appeared. Some recalled fantasies, such as the woman who frequently anticipated running into her previous therapist. Some remembered their therapist by the way they--the participants--now sit, by how they greet somebody, or by how they deal better with their spouses. One participant characterized this as "remembering by doing."

Two participants stood out from the other nine in that they recalled relatively fewer experiences in which the therapist's presence was directly experienced. They focused primarily on what they had learned in therapy, in a largely cognitive manner. Even these two individuals made reference to experiences such as dreams, hearing the therapist's

voice, and to holding a pillow for comfort in a manner similar to how one was held on the therapist's couch. These participants also were notable because they did not express a strong sense of connection with their therapist, even though they felt helped by the therapy.

The quotes and examples presented above suggest the range of experiences reported by participants. For most participants, no single modality seemed predominant, although for all participants their therapist(s) was present to them in an important manner despite a physical absence. The apparent need to mention the way in which the therapist was experienced, however, seemed much less important to participants than what was experienced. Remembering how the hand of the therapist felt, for example, was important primarily because it was recalled as comforting and connecting, not because it presented itself in a kinesthetic rather than in a visual manner. The warmth of the therapist's hand conveyed the warmth of her presence and of her care.

Questions which focused on the modality of the experience, for instance pursuing the visual or auditory nature of it, frequently seemed, based on the participant's reaction, to be a distraction from more important issues. The therapy, the therapist, the issues of treatment, these were the topics that participants wanted to focus on despite

typically mentioning the manner in which the therapist was present.

In about half of the interviews, however, participants spoke of having a sense of the experience of the therapist's imagined presence shifting over time. The therapist's imagined presence, along with what the participant learned in the therapy, changed from feeling like something he or she was taking in from someone else to becoming more a part of who the person was. While describing such a shift in perspective, participants tended to be more interested the modality of the experience and how it came to feel more like a part of who they were than while speaking of other experiences of their therapist. Describing this change was typically difficult. A couple of examples:

I will say things to patients that he may have said to me or I least thought that he had said to me. Or things that I thought that he would say if he were in my, if he were seated where I am with a patient there, that -- it's a fascinating experience to spontaneously come up with something that feels a part of me, but also feels like it's been coauthored. And I just think that is a neat experience, like "Wow, it's kind of cool."

When she first said it, her voice would be very -- almost as if she were sitting next to me saying it. And then over the years... I don't know how to explain it, it's almost like it's gotten interwoven with my life so it doesn't feel like, quite so -- her voice is getting softer and softer... and more and more like my internal self. Part of my internal monologue or whatever, my dialogue. I don't know. It doesn't seem as loud and as outside....it just now feels like a part of me more and more. I can almost not differentiate it.

In both of these examples there is a blurring of what derives from the therapist and what derives from the participant; the therapist's voice is described as beginning to merge with their own.

Participants also stated they can purposely call up an image or a memory of their therapist, but mostly the therapist's presence seemed to arise with a sense of it being "spontaneous." Some times these experiences suggested an uncertainty about whether the therapist's presence was actively called up or was already there. For example:

I don't even know why it happens. I just know it's like those times when you're not focused on anything. When I have sort of a diffused awareness. I'm walking down a hall or sitting at my desk thinking about dusting a picture and I just notice that my mind brings up people that I care about and continue to care about.

In a few examples the therapist's presence felt intrusive:

And it was like I almost couldn't think about it, you know I almost couldn't think about it. You know I found myself really thinking about it and thinking "Oh shit." You know thinking about it this much and...those kind of things were -- it felt like forcing their way into my consciousness.

Some participants emphasized recalling their therapist in times of difficulty, but that was not the case for all of the experiences described. One participant noted: "What I find as I go through the days is that I will have memories of my therapist at all times of the day, whether I'm working, outside of work, dreams, and it's kind of a neat

experience." Several other participants also emphasized a continual sense of the therapist's presence:

It is so much a comfort, it feels like not being alone against something that... It feels like I always carry around with me now her comforting presence. And I can think of other instances of -
- my grandfather who died when I was very small. I always -- to be me is to feel as if I am still walking with him, so that's the closest I can come to... it feels like to be me now is to walk constantly with her.

Contrary to expectations, there did not appear to be a difference between participants currently in therapy verses those no longer in therapy, at least in terms of their ability to recall relevant experiences. Some participants who had been out of treatment for a number of years gave vivid descriptions that were richer in detail than descriptions offered by participants still in treatment. These differences may have been due to differences in participants rather than to the immediacy of the therapy; for these reasons, no conclusions can be drawn in this regard. It is interesting to note, however, that two of participants who were currently in therapy or who had just completed a treatment chose to focus experiences with a previous therapist. For these participants the therapist further removed in time may have been more present than the current therapist.

On the other hand, one participant, who was in analytic treatment three days a week for three years as an adolescent some ten years or so ago, was surprised at how few

experiences he could recall. This participant remembered having kept journals and having the sense that he had thought about his therapy frequently when it was in process, but felt he could recall little of that in the interview. Though he felt his memory failed him in recalling many specific examples of experiencing his absent therapist, he was able to recall a couple of very important dreams along with a few other memories. He also had a general sense of the therapy and of his feelings about his therapist.

Despite the relative length of time since this participant's treatment had ended, it is unclear if time was the primary factor in determining his ability to recall experiences of his therapist. In addition to not having been in therapy for some time, he also reported feeling isolated from his therapist even during the therapy. This sense of distance from his therapist was prominent throughout the interview and was reflected in his experiences of the therapist's imagined presence.

The Three Themes

Not Feeling Alone

The theme of "not feeling alone" describes a sense of being connected to or disconnected from the therapist. Closely related experiences grouped under this theme include a sense of being cared for (or not), a sense of caring for the therapist (or not), and a sense of the type of relationship shared with the therapist. In this theme, the

sense of the relationship, as opposed to what is gained from the relationship or how the therapist can be a model for the participant, is emphasized.

This theme appeared in all of the protocols in some manner, although in two protocols it was not focal in the way the other two themes were, with a concern for feeling connected to the therapist's presence lingering only in the background. Most participants, however, addressed this theme directly. Four participants actually used the phrase "not feeling alone," with one example already given above in the previous section. Another example already provided described the therapist as a "constant companion." Yet another put it this way:

It's a feeling of not being alone. One can be alone without feeling alone...Being alone with something, that's not feeling completely alone. Being alone with grief, but not feeling completely alone.

The therapist's presence, which conveyed the sense of not being alone, was typically accompanied by a sense of the therapist as being close, caring, and available:

So if I'm checking in, if I'm having a hard day or something and I check inside...myself to... see if she's there, but she always is, I mean it's -- I remember that -- the incidence of when I had my hardest thing to talk about and she said "Yes" she could listen.

Another participant wondered, as her treatment approached its end, how her therapist would feel about her: "You know does it end there, now I wonder how -- you know will she miss me, you know?" It seemed as important to the

participant that the therapist remember her outside of sessions as her remembering her therapist did. If the therapist forgot her, it would mean that the therapist did not care and that she--the patient--was just a patient. Thus, the quality of the therapist presence, as caring or not, was an important aspect of this theme.

In a related manner, a number of participants commented on a sense of caring for their therapist(s). A couple of participants went on to report fantasies of helping or comforting their therapist:

I guess I could even speculate that maybe somehow if R. had a wound, that it was fun at times to reverse roles and I could sort of be the mother and he would be the child, the recipient. I would nurture him and make him feel nurtured and loved.

Characterizations of the type of relationship that participants described having with their therapist also came up routinely in the interviews. Participants compared their relationship to their therapist with relationships to parents, children, lovers, friends, and other professionals. These analogies often revealed the way in which the therapist was present to the participant in terms of the feel of the connection. Several participants cast the relationship in terms of relating to parents:

That was just wonderful, and I thought about that and I still think about that because what it conveyed to me was the type of mother that she was, that she would notice and would be happy for and be proud of her son with these developments and that that's the kind of care that she could give me, that she's someone who pays attention,

she's someone who notices and realizes the significance of the things that I am doing.

Others cast the relationship in terms of being friends: "I used to say to myself, while I was seeing her, well I don't have any friends, so I'll just pay this woman to be my friend." Or lovers:

So I think it probably started, to be honest with you, when I really began to be attracted to him which happened pretty early on. After a couple months I think, he was really -- he had a lot of the qualities that I really admired in a partner.

Surprisingly, only two participants described sexual feelings towards their therapist(s). Another participant spoke adamantly about not having such feelings.

The sense of the relationship in sessions was typically mirrored by how the therapist was experienced when physically absent. A couple participants, as mentioned above, did not emphasize a sense of feeling connected to or cared for by their therapists. One stated, for instance, that he did not want his therapist to care about him and that he did not want to think about his therapist outside of session, at least in the sense of having a relationship with her, nor did he want her to think about him:

To me fantasies imply you want to... have some type of a relationship with your therapist. I can't conceive of that...just a relationship like... let's go have a drink together and just talk or something like that...no, no I don't want that at all....we had a problem in therapy one day when she said, you know, that she cared and that she was afraid for me. And I told her in no uncertain terms that I know she was stepping across the line that I wanted the objectivity, I did not want, I did not want any friendship

between us or anything...And I can't conceive of fantasizing a relationship, a friendship, a whatever, you know or anything, cause that's not, that's not what I want. I got more, I got more relationships than I can handle now. I don't need another one.

What this suggests is that the theme of "not feeling alone" can appear in a negative sense as well as a positive sense. Experiencing the therapist as distant or not wanting the therapist to think about the participant are ways in which the therapist was experienced more as an absence or as an intrusion rather than as a caring presence in the present study.

About half of the participants also commented on whether their therapist was available by telephone. An event involving the calling of the therapist was described and deemed very important in the therapy of several participants. Just knowing that the therapist could or could not be called was sometimes a part of the feeling of not being alone. One participant stated: "I'm always free to call her....I do in crisis (giggles). I don't just to make sure that she's there....I drive by her house sometimes." Having a sense of the therapist as available, especially in times of difficulty was extremely important for this participant. While she typically did feel her therapist's presence, it was a great comfort for her to know that she could call if she needed to.

To summarize, the theme "not feeling alone" describes that aspect of the experience of the imagined therapist's

presence which reveals a sense of connection, disconnection, or not wanting a connection to the therapist. An integral aspect of the presence is the experience of the therapist as there in a caring manner or as distant and unavailable. Many participants reported caring for their therapist as well. They also frequently characterized their sense of connection in terms of other important relationships and about half specifically mentioned whether or not the therapist was available by phone. For most participants this is a very positive experience; not feeling alone.

Being Helped

The theme "being helped" refers to experiences in which the therapist's presence was experienced primarily as helpful (or not). This experience can take a variety of forms, but divides rather easily into experiences of recalling being helped in some practical manner, such as having learned something in therapy, and of experiencing an emotional benefit from the therapist's presence, such as feeling comforted or enlivened. While such a division is not uncommon in discussions of what is mutative in therapy, experiences described by present participants suggest that the line between these two is not firm. For instance, making use of an insight gained from the therapist might also facilitate an emotional response--such as feeling comforted because the therapist understood. Here is one

example that describes being helped in both of these ways at once:

I do have an image of her face, which is very comforting, which I can call up, bring to mind. I'd say more than that though is remembering things that she said to me that meant so much. And one of the things that she said at one point when I was talking about my family and my parents and my sister... I was talking about how different I was than the rest of my family and how I've tried forever to figure out how I could be so different from them. And she said "You know, do you sometimes get the sense that you got the wrong parents and they got the wrong child?" and she kind of laughed a little bit and I laughed with her. And that was just so right on, and I carried that around with me and I said that to myself, and it was especially helpful.

In the above quote, the participant speaks of remembering something her therapist said and described that as helpful when she was dealing with her family. The flavor of the description, however, suggests that help was also gained from the experience of feeling understood. The fact that her therapist understood and helped the participant to understand an important aspect of the experience appears to have helped the participant feel connected to the therapist.

Nonetheless, a division between being helped through insight or advice, typically in a very practical manner, and through feeling different, such as by being comforted, seems a helpful organization of content related to this theme.

Some participants even offered this division themselves:

There's feeling her presence and that's wordless, and then there's things she says, advice or practical things that I carry somewhere else. So the part in here is just her presence, the reassuring, loving, accepting...nurturing

presence, yeah and that's apart from the things she says.

Practical Help

All participants described their therapist as helpful in some way and all seemed to have benefited in ways they recognized as resulting from therapy. In some of these experiences the therapist's presence was prominent. For example one participant stated:

At first, when I'd first have like a really raucous argument with my husband or something, I think I, I'd be constantly going like this between, "What did she say to do next?" (laughs) She was the mediator, I was not even really there. I was the mediator, like really between her and my husband.

While most of experiences of this kind were positive, some were not. Sometimes the therapist was described as not helpful:

I guess I would get angry because she would respond the same way (in my fantasies as in session), you know, like, for example she'd say, what did she always used to say? I don't know, something to the effect "What do you feel about this?" You know, or, when I would say to her, you know, "What do you think of this?" And she'd say "Well, what do you think of this?" You know she'd throw things back at me so in my imagination when I was thinking about telling her this stuff, she would throw things back at me, not ever giving me straight answers.

Several other participants spoke of having imaginary conversations with their therapist in between sessions, albeit in a more positive light. For example:

There were times when I would carry on sessions in my head, uh, and it was almost -- it wasn't quite the same, but it was as close as I could get it to meeting more frequently... it was helpful. I

could, at least to some extent, create his, his presence in me. And while being soothing, it was also a way of my, at least at the time, of gaining additional insight, or of gaining a different awareness of what was going on with me at the time, uh, what might be good for me to do.... It was a way of processing feelings, and trying to stay in touch with my feelings and with the reality of that I really didn't want to stay in touch with to some extent.

These examples give a clear sense that therapy continues in some fashion between sessions. Other participants spoke of preparing for sessions or reflecting back on a just finished session in a similar manner. None of the participants described such experiences as the equivalent of being in the session. Rather these experiences are primarily important, it seemed, in as much as they extended a previous contact or prepared for the next.

All participants spoke of learning to make use of the therapist's advice or insight, applying skills learned in therapy, or doing for themselves what their therapist had done for them in session. Some examples:

I learned a lot from him I guess...I did, I mean if I have something that's really bothering me then I can calm myself down and think about it, working it out.

Another participant noted:

There were things that we talked about, certain themes that really became indelibly imprinted you know in my consciousness, after the long term therapy that I'd never forget... it's not so much that I think of him, but I do think of what I learned in the therapy about myself and that hasn't gone away. That's still there.

In these examples the therapist's presence is less figural. The focus for the participant is on the benefit gained and not on the relationship to the therapist. The fact that the benefit emerged from contact with the therapist is only implied.

In a similar manner, some participants spoke of recognizing their therapist's influence only after that fact. One participant called this a "remembering by doing," as mentioned previously. Another participant put it this way:

I don't think I consciously realized what I was doing, but I think I realized in the back of my mind what L. said. She says "I not telling you what to do J. I'm just planting a seed, just planting a seed." That's one of her phrases. And that one blossomed that day.

Such insight-oriented experiences gained a particular prominence in those interviews in which the participant did not emphasize the importance of a personal connection to the therapist.

Comfort

While learning new skills and making use of advice and insights were present in all protocols, nearly all also contained references--sometimes fleeting, many prominent--to feeling comforted, soothed, enlivened, or strengthened by the therapist's imagined presence. There also were references to feeling upset, guilty, or disappointed in relation to the absent therapist. This theme shares an immediacy of impact frequently described in regard to the

previous theme, "not feeling alone." The emotional experience of comfort is often experientially intertwined with feeling connected to, cared for, and accepted by the therapist, or, on the other hand, to feeling isolated from and criticized by the therapist. As noted above, however, this theme emphasizes the (normally) helpful or (occasionally) disruptive impact of the therapist presence.

Mostly participants reported positive, helpful experiences in this regard. A couple of examples:

It's like I didn't have to call him up and that he -- there was just always a sense of being more alive or more sparkling, or I don't know what word to use... more content. It was both an excitement and also a contentedness.

It is so much a comfort, it feels like not being alone against something that... It feels like I always carry around with me now her comforting presence.

One participant noted how her therapist's presence helped to diminish her own critical attitude toward herself, which she described as her superego:

I guess that would be more of the nurturing way, or role that he played. I remember once saying to him that I felt like he was a, sort of a wedge between myself and my superego and that helped me not be so tough on myself. So I think some of that happiness came about and that energy came about because he somehow -- my image of him could somehow prevent my own harsh superego from taking that away.

Another participant cast his therapist in the role of conscience. At times when he was out doing things he felt

he probably should not be doing, such as drinking while on medication, he would often think of his therapist:

He would always come back to me thinking about...if he knew this... I guess I would do it and then when I came to the realization that I was doing it or thought about it for a second, then it'd kind of bring me down or get me upset...just like your mother says you shouldn't be out drinking, you shouldn't be doing this, and then you go out and do it, it felt like he was looking over my shoulder, you know like waving his finger at me like I shouldn't be doing that.

This participant was one of those who reported relatively few experiences of his therapist overall and who also minimized its importance.

While most of the experiences were characterized as helpful, comforting or connecting, this was not always the case as the above quote suggests. Even many participants who emphasized the comforting, helpful aspects of the therapist's also reported events which felt disruptive. These disruptive experiences typically arose after a painful exchange between therapist and participant, although a few also arose in anticipation of criticism or rejection by the therapist. Unlike some of the private conversations mentioned above, in which the therapy seemed to continue between sessions in a helpful manner, imaginal contact typically did not resolve the very strong, negative feelings associated with the therapist's presence in these cases.

While the therapist's presence was frequently helpful in practical or comforting ways for the participants in dealing with other aspects of their lives, the therapist as

a disruptive presence typically would be not transformed in imaginal contact. One participant, for example, became upset when she saw her therapist in a dramatically new manner in one session after viewing what she thought was an empty wine glass in her office. She reported intrusive type thoughts about the therapist, wondering, for example, if her therapist were alcoholic, and her thinking about the therapist felt like it was little help. Only talking to her therapist helped her to settle down and to reconnect to the therapist.

Another participant recalled seeing her therapist in a sportscar with a man outside of the session. She said at that point that it was important for her to think of her therapist as "all mine," so this was very upsetting. She described how she dealt with upsetting issues related to her therapist:

I carry it until I can discuss it with her and say, I'd say this really upset me. This is really really upsetting to see you outside your office (laughs). And she'd understand, and we'd talk it over, so I didn't, I didn't carry them, I mean I carried them like in suspended states, it was like it happened, I would have an emotional reaction, but I wouldn't lay too many judgements on it and then I would just like hold on to it, I didn't really transform the event, I'd hold onto it until we we're going to have another session and then I could crack it open with her.

If participant and therapist never worked out the painful event, as some participants reported, it remained unresolved for a relatively long period of time. One participant, for example, described what to her was a very

hurtful exchange. She had never called her therapist at home, but when she received some very good news concerning a test she had taken for admission to graduate school, she called him to share her excitement. He was unable to be excited with her and was even critical. She cried as she recalled this event, even though over five years had passed since it occurred. She was unable to talk in any depth with him about it. Although she had thought about it frequently, the memory remained painful and very much alive. She was unable to transform it herself and it significantly altered her view of the therapist, despite still feeling very positive about him and about the benefit she had gained from the therapy.

Change Over Time

While the therapist's presence, at least when disruptive, appeared resistant to change without actual contact with the therapist or without some other exchange which is not imagined, many participants noted that how they made use of their therapist's presence did change over time and in different circumstances. Several participants stated, for example, that they began to do for themselves what they had experienced their therapist providing for them in sessions. Over time the therapist's presence became less prominent in many of these experiences. A couple of examples:

it doesn't seem like it's visual, and doesn't
really feel auditory either, it's just more like

she's in my head, it's like I've integrated things that we've talked about and worked on to the point that they're mine... but at the same time I associate them with her so it's like she's with me when I'm -- yeah when I'm doing it.

But I needed that therapy to get to learn to do that because now I think I can do it more on my own. I don't do it through an introject. I can just kind of go do something and enjoy it and -- without having an image.

As the help that the therapist's presence provides becomes integrated into who the participant is, the personnel nature tends to fade.

In summary, the theme of "being helped" covers a range of experiences of the therapist's presence, many of them practical: a piece of advice remembered, a conversation recalled or imagined, or a skill learned in therapy used. In these cases, the therapist is experienced as insightful and some times as present only in the background. The imagined therapist's presence itself can also be comforting, soothing, enlivening and strengthening, especially when the therapist is perceived as accepting and supportive. The imagined therapist's presence can also be experienced as unhelpful or disruptive. For the most part, negative experiences with the therapist were not transformed in imagination without working it through with the actual therapist. Over time as the help the therapist's presence comes to feel like part of who the participant is, the immediate personal and emotional presence of the therapist tends to become less salient.

Having a Model

In the previous theme the presence of the therapist was characterized in terms of the help it provided. The theme of "having a model" also suggests an element of being helped and of not being alone, much as the theme of "being helped" also often implies a feeling of not being alone. For the present theme, however, what is figural is a sense of comparison in which the therapist appears most commonly as a benchmark against which the patient compares him or herself.

Frequently, the comparison presents the therapist as a model to be emulated. For example one participant stated: "She was the guide. She's the teacher. She's the model of how to do it." This quote highlights a connection with the theme of "being helped" but also suggests a difference: who the therapist is and how she acts, in addition to her ability to be immediately helpful or comforting, is also brought to the fore in this quote. In this example, the therapist is helpful, in part, because of the example she sets.

The life arena in which the therapist became a model was different for different participants. Since a number of the participants were either already practicing therapists or therapists in training, it is not surprising that they would use their therapist as model for themselves when they were conducting therapy. A couple of examples:

When I am firm with a patient about a particular limit, there are times when I--his presence is

felt in me, cause of his... boundaries. I have-- it has been clear to me from day one where his boundaries (are)...I'm aware of, since being in treatment, sort of aware of my increased attentiveness to those frame issues...and also when I break those--or deviate from the frame, I become acutely aware of having gone against the benchmark...It's like the benchmark is set by him, and so he becomes kind of the measuring--or the benchmark against which, not all the time, I sometimes measure what I've done. That then sets up...some feeling state...of not having measured up to whatever the expectation is.

And:

Sometimes he's just like a regular person and I remember, "Oh, yeah, I can just be regular too with my patients." This helped me to relax a lot, seeing how relaxed he could be.

Another participant saw her therapist as a model of how to be female:

(I recalled) my not having a good female role model presence, my not having a good mother, so what's happened with her is she is my mom. I mean she plays all the spiritual roles, or the mental and emotional role of a nurturing female that I didn't have growing up.

Another participant stated that her relationship with her therapist and how he acted as a man provided her a standard against which she could compare her feelings about her husband in a faltering marriage. She later divorced and her therapist became a model for what she now looks for in potential partners. At one time she felt a strong sexual attraction to her therapist. Those sexual feelings have faded, at least to a degree, although he remains a model for her of a potentially good partner.

Another participant focused on how his therapist was part of an ethnic community in which the therapist was very involved, and by which the therapist was supported. The participant stated that his therapist modeled an interaction with the world that made it seem much more benign than the participant had previously experienced.

In a related manner, some participants spoke of their therapist as seeming so different from them that they could not be a model. One participant described how both she and her therapist had sons leaving for college about the same time. She stated that she could not help but compare what she imagined her therapist's experience was to her own.

It wasn't very pleasant, but I had pictured in my head for her it was really nice and they drove in a nice big car and they took him to college and had all the stuff in the back, you know the way it is suppose to be. But for me, I felt like my poor son just had to throw his stuff in the car and take off by himself and I wasn't really there for him, and I felt--maybe in a way I idealized her. I thought that, in that instance her situation was ideal where mine wasn't. I think that it alienated me because in a way, because I didn't, I felt like how could she understand me...That's why so many times I tried to get her to tell me, if she just told me something bad about her life, I would have felt maybe a little closer.

In this quote, the participant describes idealizing her therapist, but in a manner which highlights differences between them rather than serving to bolster the patient through connection with an idealized other or by offering a model which the participant could imitate. This participant often felt her therapist to be distant and described her as

not very helpful much of the time. Despite idealizing, at least at times, her therapist, the participant reported she often did not feel helped by her, which suggests that the themes are not necessarily related to each other by simple correspondence.

Another participant's experience, while different in many ways from the example just given, also suggests how interconnected the themes are, while indicating as well that they are not necessarily positively related. This participant described his therapist as brilliant and very helpful in regards to developing insight into himself. But he also tended to feel isolated and unsupported by his therapist. He recalled the following dream:

This dream, I recall, I was in some sort of a forest, sort of dark and isolated place, I recall this being a forest, but I'm not sure exactly... I came upon a building. There was a one story structure at the bottom, and the inside of the structure was furnished and well lit. And there was a group of young people, young adults in there, both men and women, who were socializing, and maybe making dinner together or something, and they might of lived together, cause I always shared apartments and stuff until here. And they were having a good time laughing and whatnot. They seemed very together, not particularly brilliant (Laughs) or anything, you know, just a happy group of young people. And at one edge of the structure.... it was kind of the foundation of a big 52 story building, I kind of put this together, actually he did, later. But he was 52 years old, and this big building was burned out at the bottom of the building. The lights were all out, it was kind of like a bombed out old building, and at the very top, there's was this light on at the very top, the very top the 52nd floor. And there he was. Actually, I don't recall if he was there or not, I may be construing him, but I think that's what the dream was about.

And there was somebody at the top and it's like this person was very -- was up there in this rarified environment, not much oxygen (Laughs) you know way up there in the sky, studying all alone. This person was brilliant, but very isolated...I felt like I could never reach that 52nd floor, and I felt kind of resentful that I was trying and that I was isolated from where I wanted to be. And my image of him was sort of as, somebody who was sort of beyond where I would ever reach. And who represented something that one hand I was very attracted to, but on the other hand I had, kind of misgivings about.

This dream suggests aspects of idealizing the therapist as did the last example, along with a sense of disconnection. In this example, however, the very aspect which is idealized, the therapist's brilliance, was seen as separating the therapist from others and even interfering with his being able to interact socially with others. The participant added that while he had not ever really thought about it before, his therapist, an analyst, had in fact become something of a model for him as a therapist.

This participant still compares himself to his therapist, mostly to make sure that he is not making the same mistakes he believes his therapist made. The participant's theory of treatment and his way of interacting with patients seems very different to him in comparison to the way in which his therapist conducted treatment. Unlike his therapist, this participant does not shy away from the aspects of therapy which resemble a "friendship," even though he recognizes the therapeutic relationship is different from a friendship. His sense of distance from his

therapist was seen by him as directly related to his own, more friendly, style. So, despite feeling helped by the brilliant therapist, this participant did not see the therapist as a good model, at least in some important ways. The contrast of this participant's experience with that of the previous example suggests that interactions among themes always take on a specific configuration for each participant.

The theme of "having a model" highlights those experiences which reveal the therapist's presence as a standard by which to compare oneself. Typically the therapist is seen as a role model of some sort--as a therapist, a lover, a mother, a father. The participant can feel helped by trying to act like the therapist or feel connected to the therapist by identifying with him or her. For the present theme, however, the figural aspect of the experience is how the therapist's presence allows the participant to measure how he or she is faring and to gain a sense of there being a model of how to do something. As in all of the themes, the therapist may be seen in a positive or negative light. Here the therapist's presence may evoke a desire to be similar to or different from the therapist: in both cases, however, the therapist appears as a benchmark against which to compare oneself.

In summary, three themes emerged from the thematic analysis of the experience of the imagined therapist's

presence: "not feeling alone," "being helped," and "having a model." Each of these themes may take on a positive or negative quality, although the great majority of experiences described were positive in all three themes. While a few participants tended strongly to emphasize one of the themes above the other two, aspects of all three themes were found in each protocol. And for most participants all three of themes became figural at different times in the interview. Further analysis also indicated that the three themes take on a different configuration for each participant, and that the themes were not related in a simple way.

CHAPTER IV

DISCUSSION

Results of the present study appear are similar to previous studies (e.g. Orlinsky & Geller, 1993; Bernard & Drob, 1989) which have reported that many patients frequently recall their therapist between sessions and/or after termination. While no attempt was made to measure the extent or the importance of these experiences in the present study, only three of the 12 participants indicated that imaginal contact with the therapist was not a significant aspect of their experience of therapy. Even these three participants then went on to describe experiences of their therapist's imagined presence that seemed significant; for example, one of these three participants noted that whenever he considered committing suicide, he recalled how his therapist had asked him, "Who will you let find your body?" He stated that this question kept him alive for over a year.

Rather than attempting to measure the frequency of such events, as Orlinsky and Geller did, the aim of the present study was to describe the content and process of a patient's imagined contact with his or her therapist. All participants in the present study were able to describe a number of these often fleeting experiences and their

descriptions lent themselves to being organized in a thematic manner.

The present study offers insight into the experience of therapy from the patient's perspective, particularly how the therapist is experienced between sessions and after termination. The experiences described by participants concerning imagining their therapist often resembled their experiences in sessions. In a like manner, the three themes "not feeling alone," "being helped," and "having a model" would seem to apply as much to the overall experience of therapy as to the experience of an imagined therapist's presence, though the experiences described in the present study present a particular perspective on the therapy as a whole. If the therapist was experienced as supportive in the session, the imagined presence tended to be supportive. If the therapist was experienced as distant in the session, the imagined presence tended to be described in a similar manner. The imagined contacts were thus part of the larger gestalt of therapy and typically were similar to the types of experiences that occurred in session.

The major exception to this parallel was described by a few participants who anticipated exchanges with their therapist which later turned out to be very much at odds with subsequent face to face contacts. Most of the experiences of this sort suggested a corrective experience in which the therapist acted kindly or was accepting when

the participant expected meanness or rejection. One participant, however, called her therapist anticipating a joyous response only to be severely disappointed.

The themes which emerged from the present study bear striking resemblance to Strupp's description (Strupp et. al., 1969) of the "core facilitative conditions" of good treatment. He labeled these conditions "experiential," "didactic," and "role model." "Role model" corresponds almost directly to the theme in the present study of "having a model." "Didactic" seems to relate to "being helped," though it seems a bit more narrow than the present theme. As used by Strupp, "didactic" appears to approximate the learning/insight aspect of "being helped."

"Experiential" seems to relate to the theme of "not feeling alone" as well as to the affective/comfort aspect of "being helped." A close link between the experience of affect and relating to others has been theorized by Modell (1968), among others, suggesting a point of contact between the affective aspect of "being helped" and the sense of "not feeling alone." Descriptions offered by the present participants often suggested such an intimate link between a sense of not feeling alone and a sense of being comforted. The therapist's imagined presence often was accompanied by an experiential quality, such as feeling comforted by that presence. This immediate affective experience seems related to what Strupp et. al. call "experiential."

The content of the themes from the present study also overlap with findings of Orlinsky and Geller. For instance, the Intersession Questionnaire developed by Orlinsky and Lundy (1986) produced four factors: "recreating the therapeutic conversation," "evoking relief and remoralization," "evoking anxiety and frustration," and "preconscious or unconscious processing of the therapeutic experience." Examples, from various protocols in the present study, of all four of these factors are evident, although the authors' limited descriptions make more explicit connections difficult.

Despite this difficulty, some connections seem likely. For example, their most robust factor, "recreating the therapeutic conversation" suggests the themes of "not feeling alone" and of "being helped," although it is impossible to know if their subjects were emphasizing a sense of being connected or a reflective type of experience concerning the issues being addressed in therapy. "Evoking relief and remoralization," the factor accounting for the second greatest portion of variance, seems to resemble the sense of comfort described by many participants in the present study which is similar to one aspect of the theme of "being helped." The factor "evoked anxiety and frustration" appears to be the more negative pole of the same theme; that is of a sense of not being helped or of being disrupted by the imagined presence. This factor may also reflect

elements of feeling disconnected or of disappointment with the model offered by the therapist. Orlinsky and Lundy's final factor seems more related to the modalities in which the physically absent therapist is experienced as present, e.g. dreaming or revery, than to the content of the experience.

While some overlap with their findings is evident, the extent of the overlap is hard to gauge. On the whole, their results seem to emphasize those aspects of the experience labelled here as "being helped." The themes of "not feeling alone" and especially the theme of "having a model" are less obvious in their findings. This does not seem surprising since the theme "being helped" is in some sense the most robust in the present findings as well. All of the present participants described a sense of feeling helped, even if they experienced their therapist as a poor model or if they did not emphasize the relational aspect of the experience. Having noted the robustness of the positive aspect of the theme "being helped," it is important to also point out that this theme was not the most prominent in all protocols.

Overlap with Everyday Life

In addition to attempting to describe an important aspect of the therapeutic process, the present study also touches on the larger issue of relating to others not physically present, an experience not unique to therapy. Participants in the present study frequently compared their

experiences of the therapist's presence with those of other important persons in their lives such as spouses, parents and friends.

As is common in modern day life, the telephone played a significant role in helping to maintain a sense of connection to their therapist for many of the participants, even though telephone contact with the therapist was a rare event. The telephone offered the possibility of closing the distance created in-between sessions and, thus, of supporting a sense of an ongoing connection whether or not it was used.

The issue of termination, particularly for those currently in treatment, took on a special importance in many interviews, much as it would if any significant relationship in the participant's life were lost or ending. For all participants their relationship with their therapist was important, even if they were dissatisfied with certain aspects of it. It is not surprising then that discussions of termination evoked metaphors of death for some individuals. Some participants spoke of termination as a break in the therapy or of hoping for the emergence of a new type of relationship with the therapist after termination, perhaps allowing them to avoid or minimize their sense of loss.

One participant, for example, imagined that recalling his therapist after termination would be akin to remembering

his deceased wife. Another participant spoke of having stopped seeing his therapist while having the sense that he would return to therapy at some point in the future. Before that future arrived, however, his therapist died. He described having a sense of support in his life falling away, as if "the floor underneath" him "had given way." This sense of loss occurred despite not being in treatment at the time nor having any immediate plans to return to treatment. Another participant still writes her therapist years after having terminated and despite having been through another treatment. She writes infrequently, but regularly, even though he never writes back. Writing allows her to maintain a sense of connection to him, to fill him in on her progress, and, in the process, to sort things out for herself.

On the other hand, one participant spoke of his therapist wanting him to continue in treatment after three years on the couch three days a week when the participant wanted to terminate. While the participant felt that the first year of treatment had been very beneficial, he had grown increasingly dissatisfied with the relationship he had with his therapist as well as with the role model the therapist provided. This participant felt that he finally had to end the therapy himself and he remains somewhat bitter, feeling that his therapist let the treatment go on too long, perhaps for financial, not therapeutic, reasons.

As with other important relationships--such as between parents and children, mentors and proteges, husbands and wives--transitions and terminations are difficult, often unpleasant times. Ending the therapy relationship can be difficult even when things have gone well; perhaps most especially when they have gone well.

One participant in particular spoke of hoping that a new type of relationship might evolve out the therapeutic relationship. She was facing termination in the immediate future because she was moving away, not because the therapy seemed complete. For her, the question of whether or not her therapist would remember her and continue to think about her was vital. While themes of "being helped" and "having a model" were clearly evident in her protocol, what stood out for her as she approached termination was the relational aspect of therapy. She wanted to stay connected to her therapist. She hoped her therapist would be open to a shift in the relationship and, above all, she hoped that she meant enough to her therapist to have the therapist continue to care about her when the treatment was over. If her therapist cared about her and thought about her, the connection could be maintained, suggesting that "not feeling alone" was often figural for her.

Given the contractual nature of the therapeutic relationship, it may be surprising that loss of the relationship did not evoke concerns centered around "being

helped." Though her focus on wanting her therapist to remember her is not necessarily representative of every patient, nor even of all participants in this study, what her experience suggests, and what seemed to be true for most participants, particularly those that seemed most satisfied with the therapy experience, is that a relationship which involved a sense of being connected and cared for, not simply helped, developed in treatment and was strongly reflected in the imagined therapist's presence.

The importance of the quality of the relationship with the therapist is not surprising given prior research on the importance of the therapeutic alliance in therapy outcome. Orlinsky and Geller (1993) report that length of treatment, frequency of recalling the "representation" of the therapist, and positive feelings about the therapist all correlated with positive therapy outcomes. Their findings, along with the large literature dealing with the therapeutic alliance, reinforce the findings of the present study: The quality of the relationship between the therapist and patient is an essential part of the patient's experience of therapy; it also suggests that wanting to maintain a sense of connection to the therapist, in contrast to making use of the therapist as a helpful ally, may lead patients to recall the therapist between sessions and even long after termination. Thus, while the therapy relationship is a certain kind of relationship, with its own peculiarities and

its emphasis on helping, it shares much with other important personal relationships. In the present study, while three participants focused primarily on how the treatment was helpful or not, all touched on the broader relationship with their therapist, which encompassed the more specific experience of being helped.

The Experience of Others

The themes of the present study also find support in, as well as offering validation of, a previous phenomenological study of the experience of others (Nowell, 1991; Pollio, Henley, & Thompson, in press). In that study participants were asked to describe their experience of other people. In response to this question, three themes emerged: "Relationship (proximity/connection/synchrony)," "Comparison (similarity/difference)," and "Benefit (utility/satisfaction/annoyance)." Viewed through the lens provided by this earlier study, the three themes in the present study can be considered as more narrowly defined instances of these broader themes; such a finding was neither anticipated nor predicted.

The theme of "not feeling alone" seems closely related to what Nowell and Pollio refer to as "Relationship." "Not feeling alone" relates to aspects of psychological and physical distance and proximity, feeling connected, feeling understood and feeling in synchrony someone else, as does the theme of "Relationship." The sense of being cared for,

which is also prominent in the theme of "not feeling alone," however, would more likely be located in their theme of "Benefit" (Nowell, personal communication). "Not feeling alone" differs from the theme of Relationship in that it emphasizes how the imagined therapist's presence makes a patient feel connected despite separation, rather than referring to the entire range of relational possibilities.

The present theme of "having a model" would seem to be a more specific casting of Nowell and Pollio's earlier theme of "Comparison." In "having a model" the therapist is experienced as a standard by which to compare oneself or as a model to emulate. While the focus in this theme is not on the act of comparison, but rather on the therapist as a model to compare oneself to or to imitate, the act of comparison is still present. For example, one participant spoke of his sense of his therapist as a benchmark against which to measure his own actions in every aspect of his life. The focus is a certain type of comparison, one in which the other typically appears as a model.

The present theme of "being helped" closely resembles Nowell and Pollio's theme of "Benefit," again appearing as a circumscribed instance of the more encompassing theme. In the present case, the sense of benefit gained tends to follow certain patterns. The therapist might be experienced as an ally in a difficult situation or might have given specific advice that is remembered. Benefit, like the more

general themes of Relationship and Comparison, thus, appears in the present structure within a certain range of experiences. It is colored by the therapeutic setting and by the imaginal quality of the experience.

Object Constancy

The present study was inspired in part by the notion of object constancy. Despite the inspiration offered by this theoretical notion, and its hypothesized lack thereof in borderlines, the present study did not directly examine the validity of this notion although it does address an experiential aspect of it. Only a small percentage of participants study could potentially be categorized as borderline, so this also is not a study of how borderlines experience their therapist when absent. In addition, no attempt was made to assess participants who might be said to have reached a stage of object constancy from those who had not.

Results of the present study do indicate, however, that maintaining a sense of connection to the therapist was important to many of the present set of participants, as the notion of object constancy suggests. Present results suggest that the development of an image, whether visual, auditory, or kinesthetic, often accompanies the experience of staying connected, of having a model, and of being helped. Some of the participants also described coming to experience their therapist as with them all the time or as a

comforting presence. Both of these experiences are implied in the notion of a constant object, in which constancy refers equally to the quality and availability of the so called internalized object.

Some participants focused on how their therapist's presence was helpful, especially in difficult times, which has been seen as a problem for borderlines, but others seemed to have difficulty in making use of the therapist's imagined presence at such times. For those participants who used their therapist in this manner, his or her presence was typically described as a comforting "felt presence." This description seems close to what Mahler imagines a toddler experiences as he or she develops an ability to make use of mother's image. In calling her to mind, the toddler is said to gain a sense of comfort and connectedness. While psychoanalytic focus on the development of psychic structure is not addressed in the present study, an experiential aspect of the notion of object constancy finds support in present results.

The psychoanalytic idea of internalization, which is also an essential aspect of object constancy, is directly addressed in this study but from a first-person perspective. In at least a superficial manner, the psychoanalytic idea of introjection, in which another, such as the analyst, is said to be taken into the patient's inner world but still experienced as separate from the patient's sense of self, is

broadly supported by findings of the present study. The therapist's presence in imagination was quite vivid for many participants. Despite being "interior" to the participant's imagination, the therapist's presence, in accord with Schafer's (1968) description of an introject, was experienced as not part of the self. Only one participant noted, however, a sense of the therapist as behind him, in contrast to Schafer's description. The notion of introjection is most closely linked in the present study to the theme of "not feeling alone," though it overlaps with aspects of the other two themes as well.

The theme of "having a model" also seems to resemble the psychoanalytic idea of identification. Schafer (1968) describes identification as feeling like and/or acting like another, and this process is thought to occur at a variety of developmental stages. As such, identification may range from the very primitive, such as in a psychotic process in which when the boundary between self and other are minimal and the patient might confuse aspects of him or herself to with the therapist, to more sophisticated versions in which the patient is said selectively to adopt aspects of the therapist, or of another important person, in order to gain a new skill or a more accepting attitude. While the theme of "having a model" does not emphasize differences between selective or gross identification, the protocols offer a variety of examples in which the therapist appears as a

model or a standard with whom the patient can compare him or herself.

In a similar manner, the participants' experiences of having their therapist with them outside of session offers some support to Stern's (1985) notion of the "evoked companion." A direct examination of his concept of "RIGS" is not directly possible in the present study, thus, the present study offers little in the way of evaluating the relative utility of Stern's concept in comparison to Mahler's.

Findings of the present study also support, at least in a broad sense, a process of internalization in which aspects of the therapist that are "internalized" are experienced as becoming more and more integrated with the participant's sense of him or herself. Tolpin described this process as a depersonalization, and Stern describes the evoked companions as fading over time as it is no longer needed. For example, in a manner reminiscent of a subject in Bernard and Drob's (1989) study, one participant in the present study spoke of how her therapist became part of her experience of herself. Part of the following quote was presented in the previous chapter:

I don't have to think about her, yeah...but I'm thinking now at first, when I'd first have like a really raucous argument with my husband or something, I think I'd be constantly going like

this between, "What did she say to do next?"

(laughs) She was the mediator, I was not even really there. I was the mediator, like really between her and my husband... Yeah, so early on she was much more of a presence, when I was first maybe trying out some of these skills, for saying here are my boundaries to my husband kind of thing. She was very much present in those conversations, and now...I feel grateful to her. I feel like I do and then I kind of say "Thank you" (laughs) to her so she's still there, but not in a visual or a sensate way, or not even in here (points to chest), I guess I'm -- somethings I probably have totally internalized so much so that I feel like I'm doing, like really taking on an ownership of new ways of interacting or being that I didn't know how to do -- didn't have a clue about two years ago.

Not all participants articulated this process of having the therapist's presence shift from being prominent in awareness to being more in the background. But in many descriptions where such a shift was not obvious, different parts of this continuum seemed to be described. One participant, for example, denied that the therapist was ever a prominent presence in imagination; but he stated that she was recalled after the fact, such as when he found himself

doing something she had suggested. He also went on to describe, times when he would actually hear the therapist's words, suggesting an immediacy which recalls the early stages of internalization as described by Tolpin.

Another participant offered an example in which the process internalization had not progressed far in terms of Tolpin's schema. He described his experiences of his therapist's presence primarily as a sort of conscience that would tell him not to do certain things, which he typically did anyway. In general, he claimed to have taken very little from therapy, although he acknowledged that therapy helped him stay alive when he was suicidal. This participant also reported having been reluctant to be in treatment most of the time and he often missed sessions. Nonetheless, he spoke of sitting on a couch at home holding a pillow to soothe himself in a manner reminiscent of what he did in the therapist's office, suggesting he was able to recreate some of the comfort he gained in therapy in concrete manner.

Noema and Noesis

Notions important to phenomenologists are also apparent in participants' descriptions, particularly the notion of how we typically experience objects in the world. In attempting to describe our relationship to the world, Husserl recast the traditional philosophical distinction between subject and object as a relationship between noema

and noesis (Ihde, 1986; Valle, King, & Halling 1989). Rather than seeing a chasm which separates the subject from the object, Husserl, and phenomenologists following him, describe an intentional relationship of the person and the world. Intentionality describes the individual as always related to, or in dialogue with, his or her world. Thus, there are always two poles to any human experience, that of the world (noema) and that of the mode of awareness (noesis). Neither ever occurs by itself since consciousness, by definition, is always conscious of something. Thus, we are essentially intentionally related to the world, not isolated from it.

Carrying this analysis further, Heidegger (1962), notes that in our everyday awareness we tend to be caught up in the things with which we are involved, such as when he describes a worker who loses sight of his hammer as a separate thing as it becomes part of his work. Only when his or her hammer breaks does it become merely a thing for the worker. In a similar manner, Merleau-Ponty (1962) speaks of being-at-the-world, suggesting that most of the time we are outside of ourselves, phenomenologically speaking, going about our business in the world and thus tend to be aware of the noematic pole of existence.

In the background, however, is the correlative noetic pole which can also become figural. The noetic pole is most likely to come into view when our everyday plans are impeded

in some way or when we choose to reflect upon how we are engaged with our endeavors. When the worker is ill or learning a new skill, for example, then he or she might be thrown back on himself or herself, perhaps with a sense of fatigue or frustration.

The present study speaks to this issue since the question posed to the participants already makes figural an aspect of the noetic correlate by stating several ways in which participants might be aware of their therapist. The present study also examined imaginal contact with the therapist--not contact based in immediate perception--thus bringing into view an experience more obviously rooted in the participants' activity than is perception. Despite this, participants in the present study tended to pass quickly over the noetic aspect of their experience, the mode of their perceiving the physically absent therapist, to focus more directly on the content of that experience.

Questions which focused on the way in which the therapist was experienced seemed uninteresting to participants and tended to generate little elaboration. In other words, much as in everyday perception, the noematic correlate was focal and the activity of the participant in creating the experience typically was less figural. Participants accepted their imagined therapist as the therapist, although this experience clearly was not confused with the therapist's physical presence.

Participants thus did not stop to wonder how they came to experience the therapist as present; rather, they were more aware of what the therapist was like, what he or she did for them, or how they were related in such experiences. While participants were actively able to call to mind their therapist, more often than not they spoke of experiences in which the therapist's presence seemed simply to be there, or in which it was not clear if the therapist was actively being conjured up or if the therapist appeared of his or her own accord.

A few participants noted with interest the in-between states in which it was unclear if they had called up their therapist or already found her there. After describing the ambiguous nature of the therapist's presence, one participant said: "Fascinating," suggesting that little more could be done with this observation than to note how curious it was.

Participants' descriptions in this regard are somewhat reminiscent of Sartre's Peeping Tom. As retold by van den Berg (1972), a man surreptitiously peers through a key hole from a hallway into an apartment. In his peering, he loses focal awareness of his body and of the distance and barrier that separate him from the object of his desire or curiosity. From a phenomenological perspective he enters the room. He returns to a focal awareness of himself as peering through a keyhole only when he is interrupted by

somebody in the hall. If it is a stranger, he feels embarrassed, if it is a co-conspirator, they will quickly reenter the room together.

Sartre's Peeping Tom suggests how we tend to be "at" the world, while typically losing sight of how we are involved in it. In a similar manner participants in the present study were primarily aware of their therapist's presence when they imagined the therapist. When that presence was not sufficient they might telephone the therapist or drive by his or her house. In such cases the distance to the therapist and their felt need of the therapist might then become figural, such as when the toddler's blanket fails to soothe the distressed child.

Winnicott (1971) describes a similar phenomenon in regard to the transitional object such as a toddler's all important blanket. He states that the transitional object occupies for the child an in-between state--that is, between internal and external. The transitional object occupies this intermediate area, in Winnicott's language, because the child is unsure if he or she created the object or found it already existing in the world; for this reason, the child goes back and forth in how he or she treats the object. The transitional object, thus, offers a special relationship to the child.

The transitional object helps the child negotiate the pain of mother's absence as well as other disruptive

situations. The child relies upon the softness of the blanket to soothe him or her much as the mother soothes the child when she is present, although the transitional object is also said to be experienced as part of the self.

Winnicott states that the child's mother herself can also appear in a similar manner. Mother's appearance and actions can appear to the child in this in-between state in which the child is not sure if she has created the mother or if she finds mother already there.

So too, the appearance of the therapist's presence can appear as helpful and comforting and to come without being called; it can also appear to be actively conjured or to be a mix of the two. Even when the therapist was described as being actively conjured, participants quickly shifted their focus to the content or function of that presence. As with everyday perception, in experiencing the physically absent therapist, participants were aware of being with the therapist in some way, not of thinking or imagining. In this regard, the experience of the imagined therapist's presence seems similar to that of the child with his or her transitional object. The child is likely to focus on how the blanket feels and how he feels about the blanket, not on whether or not he created it. At the same time, the transitional object becomes special to the child because it can be both created and found, thus allowing it to be there

when mother is not and thus allowing the child to make use of it in a manner not possible with mother.

The Freedom of Imagination

In his phenomenological study of imagining, Casey (1976) emphasizes how imagination is rooted in and reveals human freedom: "Mind is free--is indeed most free--in imagining" (p. 151, Quoted in Ihde, 1989). While not contradicting Casey's findings, results of the present study reveal another side to imagination. In contrast to Casey's open challenge to himself to imagine, such as his imagining himself freely swimming the ocean as a dolphin, and then to examine the content and the process of his imaginings, descriptions in the present study were initiated by a question which closely linked imagination to the physical world. In this regard, results of the present study reveal a process at the crossroads of imagination and memory, both because the participants were asked to recall experiences of the therapist's presence which had already occurred and because the experiences they recalled often contained an aspect of remembering a specific exchange with the therapist.

It was not always the case, however, that the experiences described drew heavily upon a memory of an exchange with the therapist, nor were participant descriptions limited in any manner to such events. Despite this, the overall sense of these participants' experience of

their therapist as an imagined presence was not one of freedom, but one of happening, much as the world appears to happen, without finding its source in us. This sense of happening was seen primarily in how it was much more common for participants to find themselves experiencing their therapist's presence, as opposed to actively conjuring it up. As noted, participants described numerous experiences in which the therapist's presence simply seemed to be there; these descriptions ranged from a "constant companion" to feeling intruded upon by images of the therapist. This sense of happening as opposed to active conjuring is also suggested by the fact that very few experiences were described in which either the patient or the therapist acted in the imagined scene contrary to how they typically acted in the real world. Participants did not describe actively manipulating the response of the imagined therapist.

In a couple of cases, however, participants did imagine exchanges with their therapist that were contrary to what they had experienced. These imagined exchanges went badly, such as the therapist acting in a rejecting or harsh manner, even though the participant noted that such an exchange had never actually occurred with the therapist. These descriptions did not suggest an act of freedom, however, in creating such scenes. On the contrary, such scenes seemed to force themselves on the participants, despite what they might have chosen at the time.

In a related manner, one participant described imagining seeing her therapist after termination. She imagined that her therapist would be glad to see her and that she would hug her therapist, something she had never done. This possibility felt good to her, and was something she could not conceive of actually doing with her therapist, and in that regard is reminiscent of Casey's study. When asked how these fantasies turned out, however, this participant stated that they seemed inevitably to be spoiled. The good feeling always went bad, much as the therapy had been disappointing for the participant because her therapist terminated before either thought treatment was over. This participant had always wanted more from her therapist than she felt she received. In her imagination, the therapist turn cold and would look down on the participant.

Participants' experiences of their imagined therapist's presence were typically similar to the ways in which they experienced their therapist in the world. In the everyday world, our sense of control over others is typically indirect at best. In descriptions provided by this set of participants, the sense of control over their imagined therapist was probably even less than in actual sessions, since the imagined therapist does not respond spontaneously as he or she might in the session itself. Without an actual response, the ability of the patient to influence the

therapist is limited, despite the apparent omnipotence that imagination might seem to offer. Winnicott (1971) makes a similar point in his discussion of the use of an object, an actual exchange with the object can be experienced as freeing in a manner unavailable in imagination.

Thus, despite having what initially might seem to be total control over the imagined therapist's presence, such experiences were not described as ones in which participants experienced a sense of acting freely. In this regard, both the psychoanalytic notion of an internalized object and Stern's notion of the evoked companion seem closer to the experience of the therapist's presence in imagination than does Casey's description of imagining himself as a dolphin.

The difference between imagining ourselves as dolphins and experiencing an imagined therapist is that participants had strong, meaningful connections with their therapists and the therapist's imagined presence was bound by those connections much as the real world therapist was. In this regard the freedom which Casey describes is reminiscent of Sartre's account of freedom which tends towards the absolute. In contrast, the freedom revealed in the present study is one that is tightly bound by a web of meaningful connections, composed of affective, cognitive, and historical strands.

This account of freedom more closely resembles Merleau-Ponty's (1962) account of freedom as acts which are always

circumscribed by constraints, even to the extreme of sometimes appearing wholly determined. What stands out in participants' descriptions of the therapist as an imagined presence is not that they have the freedom to create it the way they would like it but, rather, that it represents a continuity with the actual therapist. The imagined therapist's presence offers primarily continuity, not change, much as the constant object connects the child to his mother in a comforting, continuity-promoting manner.

One participant recalled, for example, how she "brought" her therapist with her in imagination when she met with her doctoral committee for the first time. This participant actively imagined her therapist, but she did so in a manner which connected her to support she had experienced with the therapist to aid her in a difficult situation. She did not imagine her therapist as something different from her experiences with the therapist.

Jager's account of imagination, while not at odds with Casey's, more closely captures some of the descriptions provided by present participants. Several participants described experiences Orlinsky and Geller (1993) might call "continuing the therapeutic dialogue" in which they had imaginary conversations with their therapists or more generally puzzled over some aspect of the therapy between sessions. One participant noted how often something that her therapist said would not strike her until after she left

the session. She would then often puzzle over it in an attempt to come to terms with it. She states:

I always tease him that he only gets paid for half the therapy he does, because lots of times I'll just--we'll talk about something in the session and a lot of times I'll just scoot right past something that, when I leave his office is the thing that stays on mind for the week. And so I just sort of have conversations with him about the thing and sort of...imagining him frees me to see different sides. It frees me up to imagine other possibilities, and it frees me up to go in and ask the real therapist; it frees me up to realize that I might not have heard him, that there are other possibilities and so I go consult him now, "Did I hear this right?" Instead of just taking it and running with it.

This participant did not always feel the need to bring these conversations up in sessions because often she could work them out with her imagined therapist's presence. With important, unfinished imaginary conversations, however, she would bring them to her therapist. The need to bring important issues back to the therapist was common to the protocols; many participants described thinking over something discussed in treatment, but important exchanges, especially those involving concerns about the therapist,

were typically not resolved in this (imaginary) way. In fact, no participant described such an occurrence. The therapist's presence was helpful in dealing with difficult situations, but not those which involved the therapist.

As one might expect, the imagined therapist's presence, powerful though it may be, is not always adequate. The real therapist offers the ability to surprise as well as the warmth of a living presence. As Jager suggests, to limit the notion of an imagined presence as merely a "poor copy" of the real thing is to lose sight of the creative potential possible with imagination. But as Winnicott also makes clear, a sense of reality, of limits and boundaries, as well as of strengths and capacities, is ultimately linked to real interactions with others, even if imagination can provide a creative manner of dealing with and understanding the real interactions.

Summary and Limitations

The present study indicates that the experience of the therapist in imagination both between sessions and after termination is an important aspect of the overall experience of therapy. The three themes, "not feeling alone," "being helped," and "having a model," describe the most prominent aspects of these experiences.

The present set of descriptions offers support to Jager's account of imagination which emphasizes its creative potential. Patients were able to use the therapist in

imagination in helpful and productive ways. Some participants were able to further their insight from imagining conversations with the therapist.

Psychoanalytic accounts of object constancy and internalization gain even more support from the present study. Object constancy emphasizes the importance of staying connected to important others by making them a part of oneself, and the present study confirms that the therapist is often experienced as present to patients, despite a physical separation.

The present study adds flesh to the psychoanalytic account, however, by describing in a thematic manner the content of the imagined therapist's presence as well as some of the process of how the therapist's presence is experienced. Participants' descriptions in this study indicate the importance of not feeling alone, of being helped, and of having a model as essential aspects of an imagined therapist's presence. The aspect of being helped was the theme which all participants reported in a positive manner, particularly in practical ways, but receives little notice in psychoanalytic accounts of internalization.

The process of the experience of the imagined therapist's presence is one typically characterized by having the therapist's presence appear with little or no active conjuring by the participant. The therapist's presence as providing help tends to fade over time. The

sense of feeling connected, on the other hand, may remain important for the patient indefinitely.

Generalizations based on the results of this study may be limited by the following factors. The number of participants is small in comparison to statistically oriented studies and, thus, cannot be considered representative of any particular population. No minorities were represented among the participants. In addition, participants were on average more highly educated and more knowledgeable about psychology and psychotherapy than most patient populations. All participants were currently employed, so the results might not capture the experience of more seriously disturbed patients, though at least one of the patients had been hospitalized for a psychological disturbance and at least two others reported suicidal ideation that extended for significant portions of their lives. All participants lived in the same city and all but one could loosely be described as middle class in terms of income and upbringing.

Participants did, however, meet the preplanned criteria. While no chronic schizophrenics or bipolar disorders were represented among the participants, a wide range of functioning was apparent in the interviews, from personality disorders to participants who would not currently meet the criteria for any diagnosis and who appeared to be well functioning in work and love. The range

of topics described in the interviews were also broad in terms of content. Despite this range, similarities across interviews were clearly evident and the aim of this study was to move from particular examples to general statements.

A possible shortcome of the study from within the phenomenological perspective is the wording of the question. A lengthy, somewhat complex question, which offered specific examples of the type of phenomena to be described, e.g. memories, dreams, fantasies, etc, was used in an attempt to prompt the participants to as wide a range of experiences as possible. The specifics may have been a distraction to some participants, at least in getting started and may have cued a cognitive set which may have influenced the direction of the interviews. A better question might have been: "Please describe in as much detail as possible any experience in which your therapist was present to you, even though he or she was not physically present." While still complex, it is less directive in terms of the types of experiences to be described and, thus, more in keeping with the spirit of a phenomenological approach.

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APPENDIX

PARTICIPANT CONSENT FORM

TITLE OF PROJECT: A Phenomenological Study of Patients' Use of
Their Therapists in Memory and Imagination

PRINCIPLE INVESTIGATORS:

David Eskra, M.A.
Student Counseling Ctr
University of Tennessee
Knoxville, TN 37996
974-2196; 539-1579

Howard Pollio, Ph.D.
301B Austin Peay Bldg
University of Tennessee
Knoxville, TN 37996
974-4361

The purpose of this study is to learn more about how patients/clients who have been in psychotherapy think about and remember their therapists during and after their therapy. Many patients, though not all, report thinking about their therapists in between sessions and after therapy is over. Some research suggests that this process may be important in the success of the therapy. Insight gained from this study about the role which imaginary contact with the therapist plays in the life of patients/clients hopefully will help therapists understand better how therapy works.

If you choose to participate in this study, you will be asked to describe your experiences of thinking about, remembering, and fantasizing about your therapist. The interview will likely take between 45 minutes and an hour. You are free to discuss only those experiences which you want to discuss; you need not speak of memories which you do not want to share. While we do not anticipate that the interview will cause significant discomfort, it is possible that participating in this study will lead you to recall painful memories associated with your therapy or with the issues which brought you into therapy. You are free to stop the interview at any time and are encouraged to do so if you feel that continuing will cause you distress. The interviewer, David Eskra, is a student therapist at the Student Counseling Center and he will be available to help if the need should arise, or to refer you to another therapist.

The interview will be audiotaped with a cassette recorder. The tape, along with your signed consent form, will be locked in a file cabinet in a locked office in Austin Peay, to which only the directors of this project will have access. The tapes will be transcribed either by the principle investigator or by a professional transcriber, who will not have access to your name, and who will agree not to speak of what she hears to others. The transcribed interview will then be edited to remove any identifying information. The transcript will then be used as the basis for a thematic analysis. The tape will be erased after the transcript is made.

THIS STUDY IS COMPLETELY VOLUNTARY, AND YOU WILL NOT BE PENALIZED IN ANY MANNER FOR REFUSING TO PARTICIPATE OR FOR WITHDRAWING AT ANY TIME. Only participate if you want to.

If you have any questions please ask them. If any questions or concerns about the interview should arise after you have left the interview, please call David Eskra at the number listed above. Also, you may be contacted after the thematic analysis is completed if we wish to use a quote from your interview. We will call you at that time and arrange for you to receive a copy of your transcript with the quote we want to use highlighted. You will be asked then to sign another consent form to

give us permission to quote you, anonymously. The results of the study will also be made available to all the participants who are interested in seeing them. Thank you for your participation.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE AND UNDERSTAND MY INVOLVEMENT IN THIS PROJECT. I WILLINGLY AGREE TO PARTICIPATE IN THE MANNER OUTLINED ABOVE. I ALSO UNDERSTAND THAT I MAY END MY PARTICIPATION AT ANY TIME.

Name of Participant

Signature of Participant

Date

PARTICIPANT CONSENT FORM II

TITLE OF PROJECT: A Phenomenological Study of Patients' Use of
Their Therapists in Memory and Imagination

PRINCIPLE INVESTIGATORS:

David Eskra, M.A.
Student Counseling Ctr
University of Tennessee
Knoxville, TN 37996
974-2196

Howard Pollio, Ph.D.
301B Austin Peay Bldg
University of Tennessee
Knoxville, TN 37996
974-4361

We wish to use a quote from your interview concerning your imaginary contacts with your former therapist. You have been given a copy of the transcript of your interview. The lines which are highlighted are those which we hope to quote. Please read them and if you agree to allow us to use your statement, please sign below. Please report any discrepancies you might note between your recall of what you said and what you read in the transcript. All quotes will be anonymous and a copy of any paper derived from the dissertation based on this research will be sent to you if you so desire. The dissertation will be available under David Eskra's name at the UT library.

I HEREBY GRANT PERMISSION TO INVESTIGATORS NAMED ABOVE TO QUOTE, WITHOUT THE USE OF MY NAME, THOSE SECTIONS OF MY TRANSCRIBED INTERVIEW WHICH HAVE BEEN SHOWN TO ME AND ONLY THOSE SECTIONS, FOR USE IN PAPERS, DISSERTATIONS, AND BOOKS.

Name

Signature

Date

INTERVIEW
Female

I: What I normally do is just repeat the question that you just read and that I just said to you, is just to think of some times when you were aware of your therapist, either between sessions or since therapy and it can be any of that kind of range of experiences listed there, remembering, imagining, fantasizing, dreaming, anticipating sessions, any -- that whole kind of broad range of your awareness of the therapist outside of his or her physical presence.

P: Okay, cause I mean -- it's been different for different, with different therapists I guess, depending upon whether they have been male or female, I've had different reactions to different kinds of things, so would you like me to

I: That would be a great place to start. If you want to start there, that sounds interesting.

P: Um...I'm sure, I'm sure that the reason the person is in therapy is going also determine how the therapist role shows up. In my case, so in my case, can I talk a little about where I came from?

I: Please.

P: I uh, I'd gone to therapy, and started to because my world was very narrow as an adult, and it was quickly getting narrower and somebody suggested to me that I could use a friend to talk to (Chuckles) and just to think of therapy as rent-a-friend and so I didn't have a context for it, so it was okay. My therapists have always been my friends I guess, the good ones. And the very first one I had was a woman and uh, I was only there six months and then I moved. I won't say too much about her since it was not a year, um.

I: If you have something to say about her, that's fine.

P: Okay. Well, I was there six months and after three months, the uh, the thing we uncovered, or the thing that I started to talk about that I hadn't talked about was what happened in my family as a child, when my brothers sexually abused me. And that was not something that I didn't know, I always knew, but I just never gave it any significance so when it came up with her, then suddenly it felt significant and I remember being -- going to see her in her little office which was a half a mile walk from my house and enjoying the walk all the way down there and stuff and I only saw her in that room and that's where I placed her, so when ever I thought about her it was in the context of that room. And it turned out she lived in the neighborhood and one morning when I was going to work I saw her running by (humorously) in her jogging shorts and she waved at me and said "Hi." And it was really shocking to see her in person outside of that context where she resided in my mind and um, I wasn't ready then to really think about her as a person, you know, with her own life (Hm huh). She was there for me totally. I'm saying that because that's a theme throughout all my experience is something I have talked to D. about, is uh, and the bad therapists I've had when I have been, I mean bad experiences I've had with therapists, when I've been with them it's been unhelpful when they, when they are so real that they.... they're there with needs to be met too and it's very obvious, so if I'll say I'm having this kind of certain problem or this kind of experience, then -- like this woman who jumped in and said (Imitating her) "You know that's happened to me too, let me tell you" and so she would end up telling me her story and almost a role reversal kind of

thing and that just threw me for a loop because I was there for her to be a certain way with me, I guess that's an understanding about therapy is that the therapist is there to kind of uh, be -- I don't know, embody all the spiritual attributes of a, another person, but they can't actually be another person. So that when I saw that first therapist running by in her jogging shorts, you know I mean intellectually I knew she was a real person and had a life and stuff, but it was shocking to see, to see her recognize me outside of that -- and I see my present therapist quite often (quick laugh), run into her, yesterday I saw her at the place I was having lunch and it's strange. I remember the first time it happened, I saw her and... and I've never actually physically touched in therapy, but when I saw her at this lunch place I had to touch her elbow and I -- just like I would, I would do that normally to a friend; but it was to reassure me that she was solid, that she wasn't just a figment of my imagination because, I guess without physical contact I doubt, I doubt my existence. I mean that has to do with sexual abuse too, you know without someone handling me, I'm not sure that I live, I exist, is what that comes back to, so that's kind of interesting (giggles) thing, but for me to actually reach out and touch, outside of the context of therapy, um, was interesting, but, and then in between there I had a male therapist who was very astute about sexual abuse issues. And I saw him over the course of a year, but in bursts, so it was 12 week bursts, then I'd be off, he was with the employee assistance program. (Sighs) And I wanted him to be my friend, really, really much. I mean I wanted to have lunch with him. I mean he understood me so well, but outside of the context of therapy I thought that I needed to stay in contact with him. He was my lifeline. I guess every therapist has been my lifeline. I guess everytime I've gone in it has been in a somewhat desperate frame of mind (Hm huh). Now I've been with my present therapist about three years almost, which is long enough -- I've never been in therapy with any one person for three years. I've moved or it's ended because it was a short term thing or it wasn't a good situation or I just thought I couldn't afford it, all sorts of reasons. But with her it's uh, we've burrowed underneath the incest issues to look at what allowed that to happen in my family and uh, that has to do with (clears throat)...my not having a good female role model presence, my not having a good mother. So what's happened with her is she is my mom, I mean she plays all the spiritual roles, or the mental and emotional role of a nurturing female that I didn't have growing up (Hm huh), and uh, without the hugs and kisses. She's very -- she plays that role without it, you know, being physical, and for me to trust that I guess has taken a long time cause because, I didn't trust words and feelings, I only trusted if someone was touching me, so, the history part of the incest stuff, um...so uh, she shows up in my dreams, sometimes she's herself, but more often I'll come and talk to her about a puzzling dream, and she'll say "Do you think that bear was me? or do you think" you know, and it usually fits, that she is, there, um

I: What's that like for you to have her show up in your dreams?

P: Well, it's very comforting actually (laughs).

I: In what way?

P: Well, she's somebody I can trust and she always shows up in a role that's...trustworthy, so I mean that's a great comfort to have somebody I can trust, and I'd say that took the whole first year, was just seeing if I could trust her. And actually she, she did not show up several times or she forgot my appointment or her car broke down, and she says that she could sense how much abandonment was an issue with me and she figures that she was -- some part of her was playing out that stuff, and could be-- things that usually wouldn't happen with other clients

(laughs). So we talked about that a little after she was probably subconsciously how, how big an issue that was and that I was wanting her to be this so much, maybe wanting her to not show to prove that I was unlovable or whatever. In this the first year, when it was very important that she be there quite often she wasn't, and that was very scary and very weird and it still is, now days, if she's sick or something it's still a little weird. But now I trust her, I know that she's not doing it to try and get away from me or because I'm too needy, I mean that's the thing about being too needy and then the person goes away cause my needs are so great they would swallow up any other human being, you know. My mother wasn't there when I was -- before I could think even, um, I just thought everything was my fault, thought without thinking that if she's not there, than I'm flawed (Hm huh) or something.

I: Do you remember in that first year or since then if she didn't show up or -- what was that like, what would you think about her? Would you have fantasies about why she wasn't there or how did that get played out for you before you got to work it out with her?....Do you understand.

P: Yeah, I think I just went into grief. I didn't really logically try and figure it out: Is she leaving me on purpose? and all that kind of stuff, but just the lack of her, expecting her to be there and her not being there threw me into... a pain that couldn't be placed on anything, because I didn't really want to blame her, it didn't make quite sense to blame her. I don't know if I quite blamed myself, but I remember being catatonic (Laughs), I mean not functioning very well the rest of the day, but it always did get explained very quickly, which was another very wonderful thing, so she would be on the phone to me right away, like the few times she did forget, she would call right away and apologize profusely and then the next time I saw her she would make sure she apologized profusely and uh, so there wasn't a lot of time that I was left to wonder what was going on, but when it did happen... I still had flung out my lifeline to her and I knew she caught. So it was like the lifeline was just underwater, I couldn't see it, so I trusted still that she was going to be there, even before I knew her very well, because the act of going into therapy is a lot better than me projecting on people who can't meet my needs or me wishing that my mother would be there, or in my case I have a history of using sex with men to get needs met, so I would always be projecting onto -- I'd always be in love with, terribly with one man or another, there would never be a time in my life when I hadn't thrown my lifeline out to connect with somebody to try and know who I was and have myself validated. I knew it was appropriate to do it with her I guess, is what I'm saying so it never felt as terrible as when I would do it with a man who would let me down or not call me back, not want to have a romance with me or something.

I: Do you see her once a week, do you mind if I ask?

P: Yeah, once a week.

I: How does that lifeline stay connected in between sessions for you? Or does it?

P: Hm huh. I'm always free to call her.

I: And do you?

P: I do in crisis (giggles). I don't just to make sure that she's there.

I: Is that something you wonder about sometimes, if she's really there? Like

P: Yeah, I drive by her house sometimes (laughs). We went from -- this year we went from, I guess the first year and half or so or two years she had an office in an office building and then she moved her office to her home, so it's a room in her home, and uh, I didn't like that at all at first, cause it showed me how human she was, again I just wanted her to be there for me, to listen totally and not -- like if she had her migraine headache, she'd have a migraine every once in awhile, but she'd have to cancel appointments, so uh, it was just a reminder that she had her vulnerabilities too. And I, I feel selfish saying this but I just wanted her to be totally there, for me (laughs), and at first it was hard to even imagine her seeing other clients, I mean I just had to not even think about that, that she could be there for other people too. And now I'm comfortable with that, that's okay. And um,... but I didn't answer your question, what was your question.

I: I was asking how does that lifeline stay connected in between sessions.

P: Well, she lives -- she's part of me. (How do you) I've internalized her in the way that, I mean I've internalized my mother too, and I think maybe slowly she's replacing my mother? Um, cause I know she's there if I need her, I know she's even human and even that is okay (laughs), but um, she's always there, I know she's always there, I know that she's at the end of this phone number, she has voice mail, so there's never a chance of not even connecting. I can always say something and I know that she'll always get it.

I: So you have a sense of her always being available if you need her.

P: Hm huh, there's never been a time actually -- I mean she goes to conferences and she's out, but she always says she's always checking her messages, so I know that she's always there (inaudible).

I: Do you ever have a sense of her presence even when you're not actually talking to her?

P: Sure. That's what I mean by, that I've internalized her, is that she

I: Could you talk about that, how you are aware of that, what that's like?

P: Hm, okay....I can only compare it to how I internalize my mother, because I've always felt like my mother was always there, but she was always a little uh, wolfdevil on my left shoulder (laughs), she was about this big (indicates about 6'') she's always, my mother was always present in a -- a consistently critical presence, always nagging or saying that you are doing that wrong or that kind of thing, I don't know... I think my therapist is on my other shoulder and she's not outside of me; she's more inside of me, and I guess... she's uh, she's somewhere around my chest area. And it's not her whole body, it's mostly her...face and her...just a picture of her from here to here (gestures from waist to top of head), or I have a picture of her as she sits you know about that distance away from me and (inaudible) she's sitting in that -- I guess all the times that I've come with really hard things to talk about, and I've had to ask her, "Are you sure you can take this? You know something, something that I've never told anybody or I can't -- you know, this thing that I have to talk about I've never talked about before and it's so awful or it's so laden with grief that, I worry about telling you," so I check with her first to see, "Can you handle this, what I'm about to tell you." And she always says "Yes," very assuredly, she never hesitates, she always says yes. And that's

the part that I internalize, so if I'm checking in, if I'm having a hard day or something and I check inside...myself to... see if she's there, but she always is, I mean it's -- I remember that -- the incidences of when I had my hardest thing to talk about and she (softly) said "Yes" she could listen.

I: If you're having a hard day now, you recall how she has withstood the test before (hm huh), so if you are having a hard day you can recall how she doesn't hesitate, and she's there and you can physically feel her presence and the image you get is of her face, but it is kind of connected with your chest, your heart area. Is that right? (Yeah...) Can you think of a specific time when you went through that process? When you might have been having a bad day and thinking about her what that was like, and describe that.

P: Hm huh.... I guess when I'm having a bad day and I think about her it's just to check in and to know she's there and if it's a bad day I'll want to call her so then it's more a decision point of do I call her or not. (Okay) And often times when I've called her I feel so wimpy calling, but she said it's not wimpy to call me, um...

I: You can feel her presence, but sometimes it's not enough, sometimes you really need to talk to her.

P: Right, right, yeah. (Inaudible) On a bad it's not enough to know to know that's she's replacing this other figure of my life. I feel if (inaudible) and sometimes it will just be... uh, I know she's there and I won't really go inside and touch base with her as she here so much and I'll just count the days until my next session and ask myself "Can I go without calling her?" Or just say okay, two more days, I know I can put off this for three days, or I know I can endure. I can live my life, you know for a few days. And I think of her advice too. I guess there have been enough times when I have called her...when I unload everything and I say "How do I live? What do I do?" Or she has counseled me on the phone when I've gotten through with describing something and I'm in a state of having reverted or what do you call it? Gone primal again? (Laughs) When I'm very very young. And the thing to do is always to just do what's in front of you, is what she tells me. "What do you have to do now?" It's what's in front of you, it's very Zen I guess. Be involved in whatever your daily activity is, washing the dishes or being with your kids, or whatever. So I remember her in -- I remember that kind of thing too about her, that which is just -- and that's not part of remembering her and seeing her and feeling her. That's just like advice. That's just like a skill thing that I'm slowly incorporating, that she's taught me.

I: Do you remember her specific words at those times or do you just have a sense of "Oh in the past she said this, I can focus and do this." Or what is that experience like when you recall that she's given you advice that's been helpful?

P: Hm... No I can't think of whether it's the words or a picture of her and words (laughs)...

I: So you will get a picture of her saying the words? I'm not sure I follow you?

P: No, no I can't differentiate, at this point I can't think of how it comes to me to do that.

I: Okay, but you recall times when you've called her and she's been helpful before is that part right?

P: Yes, definitely.

I: Okay, and it sounds like she kind of provides two different kinds of things there. Part of it is just a sense of feeling her presence or actually hearing her words that is somewhat different than the advice that she actually gives. (Right, Hm huh) Is that right?

P: Right, well what you said, there's feeling her presence and that's wordless, and that's wordless, (Uh huh) and then there's things she says, advice or practical things that I carry somewhere else. So the part in here is just her presence, the reassuring, loving, accepting...um, nurturing presence, yeah and that apart from the things she says. (Okay, okay)... I can tell you a few dreams that have been great with her. (Sure) I was seeing her, but I was going through my cycle of being attracted to other men and being really torn up about it, knowing that I shouldn't do it and I know, knowing that uh, just projecting on them and it's not really about the real issue, but that's all I can do and I've been doing that ever since I was a child, so -- it's a big long heavy pattern -- and uh, so I was going through one of those, quite early when I was first seeing her and she was telling me things like, well, friendships can feel rich without crossing that sexual boundary, and I just.... she said that they can be even richer that way, and that was just incredible information that she was telling me. So I was going like "Really!" (laughs) And uh, it came up often enough that she would keep saying this in different ways, and uh, and then I had a dream about being uh, out on a barren plain with uh, from Star Trek, the guy uh, Captain Picard standing on the barren plain (laughs) and uh, you know it was an interesting dream and I was telling her about it. He was saying how great things, how great the future could be and all I saw all around him was the barren plain and as we talked about it she said "Well, Captain Picard was probably me." And we talked about and I realized, "Yeah," cause it was like she's my leader, she's my captain, (Hm huh) she's telling me about brave new worlds, but I'm still stuck in this place where I'm hearing her words and I'd like to believe her but all I see is the barren plain, you know (laughs). And I've dreamed of her -- she is a woman, so her she was a man, but I identify with men. I've had bad experiences with women, I'm always rooting for boys. Boys are who nurtured me when I grew up. Boys, men are the only people who, who seem to have come through with me, for me, even though it was a double edged sword because it was also the taboo thing, so just learning to trust her and know she's female is another thing, I can remember having another dream where she was naked and I was naked and we were comparing our bodies and uh, her, let me see, the part of my body between, I guess from the belly button up and lower, it's like from the belly button down is -- my associations are where your primal urges and more earthly centered self, and from here up is the more spiritual and um, lofty ideals and things like that, and in her body -- I was looking at her body and my body in profile and when I came to my belly button then my...my pot belly stuck out and then I looked at hers and she had a smoother transition. She still had a little pot belly which told me that she was human, (laughs) that she wasn't one of these model types, you know, which was nice, and reassuring, but hers, I just remember saying to myself in the dream, you know her transition is smoother. And then as I talked to her about that dream, I realized how I think of dividing up the body and that for me it's a rough, it's a rough transformation to come from my experience which is totally physical into trusting and uh, believing that the two can even intermix and talk to each other and uh, and for her you know the transition is very smooth. It's like she was able to take me there and show me -- plus in a female way. You know you can't get any more female than looking at female bodies.

I: So in some ways she's kind of a model for you?

P: Definitely, yeah, yeah.

I: Something to compare yourself with and to see (Yeah) how she does some things better.

P: Hm huh....So those are the two dreams (inaudible)....

I: You mentioned earlier that um, it's very different for you seeing the one man verses seeing the two women that you've mentioned (Hm huh), do you want to elaborate on that any more (Sure) or what it was like to think about him between sessions or since that therapy is over.

P: Yeah, well, I uh,.... I guess since my pattern is to look for a male person to understand me, to understand my inner world and show it back to me, just confirm and be reassuring, since he was my therapist... he was going to do that. (Laughs) And he met all my fantasies of what men were supposed to do, but which usually didn't work out. Cause my pattern with men in romances was to meet 'em...and to fantasize about them until the point where it became clear that they were not meeting my fantasy, or they didn't clearly understand me or, and then I would subtly withdraw and start looking for someone else, so I saw him and he would say very, almost rude things, cause he knew, he knew very, very much what sexual abuse was about and he knew my very affliction cause he had suffered it himself. So it was like this was his specialty, only he did the same thing with women and he told me that up front. And I remember him saying something, oh I'd tell him my dreams and uh, or something, I forget the context of this exactly....but it was just so rude when he said it that it just got me where I lived (laugh) and at that point probably I started to really project on him more than ever or really cling, or cling to him, and that was, was -- I mean I remember what he said, I don't remember what I said, but what he said was "You really worship the penis, don't you?" (Laughs) And at the time I just....said "Well, that's one way to put it." (Laughs) It's like yes, you have an affection for male traits, don't you. That was like well, he knew enough about my history with brothers and stuff and.... So I uh, I dreamed of him liked I dreamed of being in a phone booth with him, in very close quarters and he was touching me, stroking me, and I was telling him all of my problems, and I was having a great time and I would start floating on the ceiling of it and saying "Look, look C. here I am" and stuff like that, and to me that was a very exhilarating and positive dream and I'd bring it into him and he'd, he'd come and right away zero in on some background figure (laughs) that was in the dream who was showing that all was really not well (Hm) and oh, I hated him for doing that, but I

I: For ruining that good dream? (Uh huh, laughs) It felt so good.

P: Yeah, and it was 12 weeks and he knew it was 12 weeks and he was there to stir me up, he was there to get me back into therapy, I'm sure. I mean he said he was going to be brutal (laughs) and he was. Um,...

I: So he really challenged you (Hm huh). Did that affect -- did you ever develop a sense of his presence the way you have with your current therapist? Or was there a sense of carrying him with you in between sessions?

P: Uh, yeah I carried him, but it was more uh, it was in the way that I carried males around who I'd be afflicted with, with whatever romance I was in, I would think of that person and I would think in terms of them,

but it was more of a comparison kind of thing. Cause I'd think "Oh, if I wore my hair this way, or if I got this dress, what would so and so think." And I wouldn't even be in touch with myself about what I think, it would just always be judging myself, and gauging myself by this imaginary outer male figure.

I: Looking at yourself through his eyes. (Yeah, that's it.) How would he respond.

P: That's it exactly. So, as my therapist I was doing that, and early on I was feeling very free in telling him that because I thought, you know I'm doing the same thing with you that I do with romances, but you're here to help me, and I'm not, I'm not here to fall in love with you or to do this stuff with you. So I start going through you, your eyes -- that seemed like a positive thing...but then it did turn into a romantic kind of thing

I: Your feelings?

P: My feelings toward him. And I told him that and he really surprised me by saying, "Well why shouldn't you feel that way? We're about the same age, da, da, da" and he gave me all these reasons, which were the very reasons that I always...shamed myself over, huh, so he was totally reassuring that it was perfectly normal...behavior to fall in love with your therapist and then he told me how he fell in love with his female therapist and stuff, and I said so what was it like when it was over, how did you know when it was over? So he was telling me stuff...so he'd be very human, now that I think about it, I mean he did share his experiences, but it was never from a needy point of view. It was always showing me similar examples that were instructive. I'm thinking of the bad therapist I had who would tell me things about her own life, but I could sense that it had nothing to do with me, you know (Hm huh) that she had some need to feel close to people, or close to me, it was really different in that case, but -- so the way I carried him around was, we were both downtown and I'd be out at lunch and I'd look for him, you know and hope that I'd bump into him or if I knew that I was looking especially good that day, you know I'd really hope to see him and uh, my...my sense is, or my ability to zero in on men who are interested in me, I mean just subtle, subtle things which were key to my survival when I was quite young, I would apply to him and I would for that too when we had therapy sessions, it was like were his eyes looking at me, looking up and down me, or was he going to compliment me on my hair or how I looked that day or stuff like that. And he never.... he never did that and uh, in therapy, and what I was telling D. about therapists is the interesting thing is that they have to be, well it's what I started out saying is that they have to be totally human and yet not...not totally, not specifically human themselves, (Laughs) it's the kind of thing it is. They have to embody all those traits so that the person you were working with can reclaim themselves (Hm huh), but you can't be so specifically yourself that you... that you intrude upon that's person's process. So it's a really

I: The way that one woman (Yeah), her needs intruded.

P: Yeah... so I carried him around, C. now the last time, I remember the last session we had I was totally...wrecked, I remember crying. I don't remember what it was about especially except that I was saying "Why are you doing this to me?" And I knew it wasn't him, I knew that some grief had come up and it was trying to get processed and... I know what it was, I had asked him for a hug. And he said "I don't do hugs." And he said "It's nothing personal, nothing about you at all, but I personally just -- I'm one of these people who doesn't like physical

contact." And I didn't, didn't believe him in the first place, but I knew that that's probably more appropriate cause of the, the relationship, the therapy client relationship, so.... but I'd gotten to the point where, I don't what had happened in my own development, but I needed, thought that I needed you know to have physical contact with him of some sort, or reassurance -- it wasn't enough that he was being therapist. And maybe he was starting to withdraw cause it was the last session or something and I could sense that, but I remember crying... and him... saying "It's not me. Who are you really talking to S?" Which was hard, and in between weeks when I wasn't seeing him I'd usually be quite stirred up. One time I did call...and he did call back, but he -- it's not like it is now, he was, I could tell he was busy or distant or "We'll talk about it when you come in" kind of thing and at one point I called him on the weekend, talked to the answering machine, then I think our appointment was Monday and I said I called you and he said "Yeah and it was the weekend." Meaning he doesn't, he has his weekends, and he's not there in total service. Where -- I think I can call my present therapist in the middle of the night, and you know (laughs), I'd know that she got the message or she'd be...she'd be there in ways that he wasn't, or he was just -- in that way he was too human. He had his limits and his boundaries (Hm huh) um, and I sure that my present therapist has her limits and boundaries too and I trust that she takes care of herself. And that's an important thing, I have to know that she's able to do her job. So if I saw her groveling or you know calling me back in two minutes everytime, but I called her -- I think I wouldn't feel comfortable with that either, so there's just enough of my sense that she's doing right by herself in her role as therapist, and at the same time it's enough to, for me to feel like you know, that I'm getting fed, and I used to do a test on other people all the time to see how much I could get them to be there, so I, I'd often, would test people by you know calling them in the middle of the night and seeing if they'd call back and if they weren't then I'd just say "Oh, fuck them I've got to go find someone else now." Or if they did, then that was too scary. If someone actually was as intense about me as I was about them, right away I would do a flip and say well, they're sick, (laughs) anybody who would love me would be sick, so it would never actually do the thing that I was trying to get someone to do which was to prove to me that I was lovable, so it was -- they call double indemnity (laughs), you know catch-22 or whatever.

I: But your current therapist has managed that pretty well.

P: Yeah, I guess over time, I just think trust is so much of it, over time -- that I can trust her....cause I -- this came up with my husband recently, when, when uh, it came up, an issue about trust, and I don't trust him, in the way that I trust her (Hm huh), and I told him that and he said he was jealous, (laughs) but he understood, um, so whether she is really trust worthy or not, I don't know, but it's this process that I have to go through, I think that's part of my healing, being able to trust someone so much that I internalize them, and eventually, I guess what'll happen is that she'll become just a normal person again. We're at the point that I'm so full of self-trust through being able to trust her, that it won't matter to me if she...it won't matter to me if she doesn't call back, or it won't matter to me if uh, she has migraines for five weeks or something -- not that it wouldn't matter, I'd be concerned about her as another human being, but that lifeline thing wouldn't be at issue, you know. I mean that's kind of how I picture, as I've watched myself evolve with her, that's kind of how I'm extrapolating that things might go, I think that that's what might happen.

I: That what you now get from her, you'll one day be able to provide for yourself.

P: Yeah, cause of a lot of it I can already -- I mean I sense a big difference from what I was like three years ago as far as being able to provide for myself. Just recently I've had the sense that my soul is no longer hovering out here but is inside of me, and that's the same kind of.... I don't if it happens -- I'm trying to now think, okay did that happen about the time that I pictured her inside of me (laughs), you know, but I think I internalized her quite early probably, and only recently have I started to feel like my soul and my body are together (Hm).....

I: She actually preceded you in

P: Yes, yeah, she was the guide. She's the teacher.... She's the model of how to do it. And I see enough of her life, being at her house (laughs), I see enough of how she conducts her affairs and lives her life to know that she is a person whose soul resides in her body, and she knows how to take care of herself and how to set boundaries, and things that I struggle so much with... and yet there are things about her -- I mean it just so happens that we share a lot of the same tastes in furniture and art and stuff like that so it's been easy to internalize her, but like, you know, I don't like some of the clothes she wears, and that's okay (laughs).

I: You compared her to your mother at one point, in terms of balancing your mother, could you say anything more about that and how that happens, how you experience that, the difference?

P: Well, just for the longest time, I guess they were -- the two of them existed, but my mother, the mother presence always had the upper hand, or always was the one in crisis that I would listen to, so I may have had my therapist and I may have had my mother, but she was never, she could never really compete with this one over here, but the more we talked about these issues and how the whole betrayal thing has worked with my mother, you know just very concretely looking through experiences and what that meant to me in relation to my mom, the more we've explored those things, the more it makes sense to me and it's not just a mysterious thing of how my mother controls me, so... so there's been, as I've understood, and this is just intellectual understanding of how, how I incorporated a lot of negative beliefs because of how my mother modeled them, she being the only other female in my life, how I took this in. I mean I didn't even understand that, that I would take stuff in, just because she was another female, you know (laughs).....That, she's just, and, but -- my mother lives near-by so I see her fairly often, so there'd be enough raw encounters then I could discuss with my therapist about what was going on...so that my mother is not the big beast. And I said that she's only this big, but she's a big beast (laughs)....She's....she's a, my mother is more human and less metaphysical. Less a metaphysical threatening presence and more just a human being that I can deal with, and at the same time I guess my therapist has been growing, as she's been shrinking and she's probably more metaphysical, she's probably more of a presence... So there's kind of a -- I guess when I first was seeing her, they were separate and then somehow at some point they fused, because at the point probably when I realized that these have to do with female role model issues about my very sense of self, and so my mother was really the big balloon, two big balloons next to one another, like two breasts (laughs) you know, and so now she's um, my mother is the shrunken one and my therapist is the bigger one, so they're tied to each other, they're very much

I: Your therapist has transformed her in some way.

P: Yeah, yeah, you could say that. I mean I'm part of it too. I feel like I (I didn't mean) but yeah, and I don't know if any of that could happen with uh,... if my therapist were male, cause actually C. had that, you know, "It might be good for you to see a woman, for the very reasons you don't want to." Cause I said "Ah, I'm through with women." (Laughs) I don't relate to women...

I: So there's another difference between the men and the women...she can be more of a role model for you in terms of what it's like to be a woman.

P: Yeah....(long pause)

I: I was wondering too -- unless you were going to go somewhere --I was wondering, about where you started, about your therapist and seeing her running and the current therapist and seeing her at lunch, was that something -- it sounds like that was kind of jarring or disruptive for you (Hm huh) -- was something then -- would you think about that, or would you put that aside or is that also something that you ended up carrying with you?

P: I carry it until I can discuss it with her and say, I'd say this really upset me. This is really really upsetting to see you outside your office (laughs). And she'd understand, and we'd talk it over, so I didn't, I didn't carry them, I mean I carried them like in suspended states, it was like it happened, I would have an emotional reaction, but I wouldn't lay too many judgements on it and then I would just like hold on to it, I didn't really transform the event, I'd hold onto it until we were going to have another session and then I could crack it open with her. So that's different from how it was um, not being in therapy, but maybe remembering another therapist, cause I went for a very long -- I went for eight years without, from the first therapist I had until I had another it was eight years (Uh huh) and so I carried a lot of her around, but she didn't last very long (laughs). I mean it didn't, I didn't get to any practical advice really, with the first therapist, I internalized her and she was a positive female, and she was someone who listened to me and understood and once, I even saw a tear in her eye, which -- even as I saw it, I didn't believe it. My mind would say "This couldn't be happening."

I: That she could care (Hm huh) enough (Hm huh)

P: So I remembered that enough...um, but then my whole life changed, I got married, I got pregnant in those eight years and we went into couples therapy a few times during that time and...so I still think of her oh so fondly, (Hm) I think during eight years a lot, a lot of other stuff that was very big was happening and change...

I: When do you think of her now (inaudible)?

P: Oh, I still do think very fondly, I have a picture (the participant noted this was a "mental" picture when she read the transcript) and I hope she's, you know I wonder if she's still doing her work and I wonder if she's still -- and actually I just thought of her...yesterday because I knew that a mutual friend was seeing her too who was anorexic and that was something I had as an issue when I was a teenager...and I was wondering how G. had dealt with that woman, I thought "God, what an impossible position to be in." I was empathizing with my therapist, I was thinking about her because my daughter who's in fourth grade had a little friend who's starting to be on a diet -- fourth grade, being on a diet, and I was thinking "How did, how has G. dealt with this woman?" Cause you don't actually get to the life threatening, you probably don't

get to the anorexic issue until such a long time, to actually get her to start eating (laughs) to help herself um,...cause I think of my therapy now and how long -- it's taken a very long time for me to understand my behavior about obsessing over men, to the point now where I feel like I'm making conscious choices about what I do when I feel attracted to somebody...(inaudible--laughs) So that reminded me of -- I felt sympathy toward her. Actually, I think that would be a hard job. If you care about somebody, if you're being a counselor because you care about 'em, care about people and you know it' going to take a long time to get them...to stay there and keep looking at these hard things and actually get to the point where, where if they're bulimic or whatever -- my sister's bulimic -- all these eating disorders are (inaudible)

I: That sounds like that therapist really has become more human for you if you could wonder about what it's like for her

P: Hm huh, well maybe I'm thinking about that too cause I knew I was going to see, cause I've often thought about my present therapist about what -- and I was going to ask her even, after I saw you, I mean I was going to see her -- at our next session, what makes, why are you doing this? Why did you choose this profession?

I: Why are you going to ask her that?

P: More as a human than anything else (laughs), I guess I'm just curious....cause when I see her out having lunch, like I did yesterday, I think you know she could work as a teller in a bank. She could be a bank teller, but instead she's, she does this really hard work. I think it would be really hard work to be a therapist....I think it would be really hard work if I think that she wouldn't get anything out of it, if all she would do is hear people's painful stories, and uh, and have to hold herself at enough distance that she's not harmed, cause that's got to be part of what therapists do, and.... I had talked to her about some of these things, about what, what it's like for her to work with me. "Are there any others, do you work with any other with any other incest victims who do this, who do these particulars of my life? (laughs) And she said "Yeah, a lot of people actually, might be -- work issues out similarly to the way you are who've had a similar history to you." And one dream I had actually with her, we were, I forget what it was, but I ended up talking about it to her and saying "Tell me, when you're with me is it like improvising? Is it like ad libbing, because if you haven't had a specific person like me before, you don't have a rule book" -- you know I never see her with her rule book about what to do (laughs). When S. says this then, you know, what kind of thing does she say back. And she said "No, it is a lot like ad libbing," and it is transformative to her too, that she -- it's not, it's not something that's uh, one way. Although when I first go, went there it needs to be one way. I mean I can't even begin to think about her as a person. How this is affecting her, I just need her so much and it feels selfish and that's the way it is. I need her so much to be there, to be almost inhuman in her constancy, in her...well in her constancy more than anything (laughs) else I guess.

I: But now that's changing.

P: Now that's changing, yeah, I can accept her vulnerability....

I: It sounds like seeing her at lunch was less disruptive than for instance seeing you first therapist (Yes) jogging.

P: Yeah, hm huh, and quite early I'd seen this therapist at lunch and that's when I had touched her elbow that first time. That was in the first year I was seeing her, so seeing her again, I didn't want to

linger, I didn't want to stop at her table and say "Hey, how are you doing?" (Laughs) But she saw me and smiled and I saw her and smiled. And she said "Hi." As it happened I had forgotten my umbrella, so I left and thought "woo" (inaudible) I had to go back (laughs) and get my umbrella, and so I didn't even look at her. I went about my business, straight in and out. I remember another time I saw her outside of the office, which was maybe in the second year and I saw her with a man in a car driving, in a sports car. I thought it was her, but I wasn't sure it was her, and to see her with a man really threw me for a loop. She's mine, you know (laughs). I picture her as mine. And I realize on the one hand, you know I know she's got a life, she's married -- and I didn't even know these things about her. Actually I had to ask her at that point, you know "Are you a lesbian?" You know I need for you to be probably a lesbian, cause I can't, I don't think I can handle you having a man relationship, cause that would mean too much, or if I thought about it would mean too much. It was too much information or something, but I asked her and she said she did have a partner and was a male (laughs) and uh, she didn't know if that was him with her in the car, but I was just floored again when I saw her outside the office and in a car with a man.

I: And was that like when you saw that first jogging, you had to just (Yeah) kind of suspend that, hold onto, but couldn't really do anything with it until you talked to her about it.

P: Yeah, and I just cried and cried when it happened, when I saw cause of what it meant, what it could mean. It'd mean that I'd lose her. It meant that she really wasn't there for me because my context was so small. (Hm huh) So now my context is bigger so I can see that she can be there for me and have relationships and have migraine headaches and she's still there for me, that part doesn't change.

I: But that was the threatening part, is that you couldn't be connected (Hm huh) to her in the same way if she wasn't there (Right) just for you.

P: Right, the very primal, early understanding of how I connected to people meant that it had to be exclusive, that's what I entered into therapy believing, a total, absolute, and exclusive, you know, in a way that probably a baby and a mama connect, cause that's where I was coming from. This stuff wasn't there for me from day one, so and that's what I'm understanding too is how much, how intense some of this stuff is and why it's so intense and why it doesn't have words, and that's because it's before there were words. But it's starting to make sense....Well I think she's marvelous (a la Billy Crystal--laughs) I don't know how she can know all this stuff that -- you know when I say this feels really primal, she'll nod her head and say "Probably is." I wouldn't like to learn the kind of things she knows by reading books and going to psychology school, and I don't think she could be good at it if that's all she did, so -- and I've asked her this too, "Have you lived through some of these things, is that why you are able to do it?" And she said "Yes." (laughs) And I believe it, so if I know, that's another comforting thing...cause my whole family scenario was so much -- head and heart were so far, they were miles apart from each other, so you would only know things by reading it in a book or by getting an "A" on it in a class, but any knowledge that came from experience or emotion was negated or just not counted at all. The two never met, so if I ever were counseled by someone who was a by the book person, or I ever sensed that they were too intellectual, I probably wouldn't trust them at all (laughs). And she -- some therapists I have had have said (in a formal, faux academic tone) "Well, yes I can see that this a thing that comes from a Jungian nuh nuh nuh." And I've asked her what her background is,

but she's never used that, she never said you know "When I studied this in graduate school" (laughs) or uh, "This recent book I've read has given me insight into your problem." (laughs) She always -- she just stays... she's just for me a model of perfect integration between head and heart, and maybe I see it that way cause that's what I want to be (Hm huh), that integration of head and heart. Maybe she's not that way at all (laughs), but that's what I need her to be, and that's the fascinating thing about therapists is that they I think they are what you need them to be as you're going through all your phases, somehow they know just to -- I don't know I think it's a very intuitive science. I think it must be (laughs).

I: She's been just what you've needed her to be.

P: Hm huh. Yeah, as far as fantasizing, sometimes, like in the shower once, sometimes I stopped dead because I thought "What would I do if she died? What if she got into a car wreck," you know, "What would happen next?" You know, I told her about that too. I tell her everything that I can think of to tell her (laughs), cause that's a part of my, my cure, talking about the many things that I'm so ashamed and embarrassed about, but... I still don't want to think about that even now, if she should die (laughs), but you know she's human and she drives in cars like everybody else so, God, it's almost like I want her stay in her house and never go out and just be there for me. (Hm huh) So I think thoughts like that during the week too, it's like "I hope she doesn't go out much this week." (laughs) you know.

I: Cause it scares you?

P: Yeah, yeah, I couldn't -- you know the lifeline is there, it's like I can remember -- there's this episode of Star Trek where, where Picard is getting, he's living a whole life in 25 minutes, but he lives 25 years, did you see that episode?

I: I did see that episode.

P: Yeah, that's what it's like and I'm in the middle -- what if I'm in the middle of... of that, you know they tried to cut him off and he started to go into cardiac arrest (Right), and so that's what I imagine it would be like, you know if she were to die or not be able to be a therapist.

I: Before you're finished?

P: Right, before I'm finished. And I don't know when I'll be finished and I definitely sense progress, you know, I definitely feel better than I've ever felt in my whole life, so...

I: Is there a sense that you would lose what you have gained so far if she were -- if something were to happen to her?

P: There is that possibility because with the first therapist even after six months, a lot had happened and then I felt like the next eight years I just totally backslid, and that's probably not true, I mean there were so many changes in my life that it -- I'm sure it was new stuff happening, so I don't think I undid all the stuff that I learned, but there were just so many new circumstances and since I've only done therapy in short bursts, I think "Okay this will fix me and I will be okay now," and I never have been. I always get worse again, and then I get into a crisis and I never want to admit that I need to see somebody again (Hm huh), so this is the first time that I've really stuck with it, for three years...I'm not about to give it up, (Laughs) until I see

it through, what ever that means. I'm not sure what that means, so yeah there is a fear that I could.... I could lose a lot of what I learned, I don't think all of it. I think so much of it -- I mean there is so much of her that exists here as a presence and if she dies that part wouldn't go away, so I'd have that... and I have learned a whole lot of skills, about just how to deal with having...boundaries and having constructive arguments with my husband and those kind of things I've practiced and I don't even call her up anymore to do that (Hm huh), it's like I just know how to do that now, unless I'm really tired and stressed out and all sorts of other elements are happening, then I won't feel so sure of myself and so safe, but that's just if the stress factor is up and so, in a normal good day I think a lot of skills that I've incorporated that she's taught me.

I: You don't have to think about her

P: And I don't have to think about her, yeah...but I'm thinking now at first, when I'd first have like a really raucous argument with my husband or something, I think I, I'd be constantly going like this between, "What did she say to do next?" (laughs) She was the mediator, I was not even really there. I was the mediator, like really between her and my husband (tape ends) Yeah, so early on she was much more of a presence, when I was first maybe trying out some of these skills, for saying here are my boundaries to my husband kind of thing (Hm huh). She was very much present in those conversations, and now...I feel grateful to her. I feel like I do it and then I kind of say "Thank you" (laughs) to her so she's still there, but not in a visual or a sensate way, or not even in here (points to chest), I guess I'm -- somethings I probably have totally internalized so much so that I feel like I'm doing, like really taking on an ownership of new ways of interacting or being that I didn't know how to do -- didn't have a clue about two years ago....

I: Are there any other times that come to mind that you want to talk about?

P: Oh, I did have to tell her....that I loved her. And that was really, really hard. And she said that that was okay....

I: And was that something that you worked over a lot before you actually

P: Yeah, yeah, a whole lot....and part of me just felt like "Oh God, I've read about this transference thing." (laughs) You know, part of me was uh -- I don't know much about therapy, but I understand that it's a normal phase that you fall in love with your therapist and that um, at some point you are going to get angry with them, things like that...but at that same time it felt authentic enough inside me...that it was okay. I mean I've had to put aside that sort of stuff, and I was able to put it aside to just say, "Well, yeah this is what I'm really experiencing right now" and uh, if I don't talk about it, it will feel like I'm carrying some rocks in my throat for the next week, so do I want to do that?...I don't. Sometimes it works funny in ways like, I'll get in there and forget that I was going to talk about something important like that and then five minutes before it's time to go I'll remember (laughs) and say "Oh yeah! I remember what I was going to talk about today." (laughs) It's funny how that works. And even on those times when that's happened, she's given me the extra time, which means a lot to me too. And I don't want -- as I said I use that as a test with people sometimes, to see if they'll go the extra mile for me...and uh, if like she cut off before 50 minutes, well I'd be judging her then too. But there have been enough times that she's gone over the 50 minutes when it's been clear like we just talked about something and I'm still in

tears or something, she'll make sure I'm okay before we go, or if an issue comes up at the last minute, she has her schedule probably so that she could do stuff like that. It's never happened that she said "I absolutely have got to end right now." (giggles)...But yeah, that feeling that I had about loving her was that same kind of... cloying, unacceptable love feeling that I've had whenever I get uh, -- I mean I was doing the same thing to her as a female that I would do with these men all through my life, that I would be throwing my lifeline out to, and um, so it was kind of weird when I, I (inaudible) wondering about, I wonder if we'll record that (laughs), wondering if I was -- well I didn't think I was bi-sexual, but I thought "Well, I could be. This is all about exploration," so um, I didn't know how I loved her, or anything, you know if I wanted to make love to her or if I just loved her like a child loves a mother. I just didn't know, but it was just a very strong feeling that I had to say, that I'm being affected here in a very strong way and I can't not talk about it cause it's something very important.

I: And she could accept that.

P: Hm huh. And she didn't do it with a big smile like if (inaudible) (laughs) I was watching her so carefully to see how she'd react... and it was okay, but she took me serious -- I'm sorry.

I: I was just going to say that it seems her response was (inaudible)

P: Hm huh....And more recently, I don't know if it's my perceptions or how she's being with me, but more recently she'll show humor, her own humor...like she's explaining something to me about, something that my husband's going through, and she explained in terms of saying uh, "Well it's kind of like how little boys go out to play and then they come in to mommy and they say 'Hi mommy' and then run out again and play and that might be how he's doing things with me, but don't tell him I said that." (laughs) And kind of winked or smiled or something, and so, she seems more at ease and maybe she knows that she can be more herself with me in that way, that maybe she knew early on that she couldn't be that way. I don't know if it's her perception of how her role needs to change with me (Hm huh) or what. But I like that, it's just another element of her -- of me seeing her being what I call human and me being able to live with it....so she just gets broader and broader, but I've still got the lifeline intact. There's no worry on my part at all...aside from her dying I guess (laughs) there's no worry that it's corruptible at this point. I mean nothing could go back, nothing could take away...but (inaudible) (Hm huh) Yeah and with all of the romance things when I did this, there was always such -- I mean I don't even trust my husband because of that, because he's a male, because of my experience, I still, I still feel like he could leave tomorrow and I would not be not be surprised in one sense, even though we have a wonderful relationship, I can't -- maybe that's the next thing after trusting a woman is to go start trusting men, I don't know. This is self protection for me, I can't put all my trust in any one person, cause that's not what persons are there for, but the therapist is not a person. (laughs) Is and isn't. She's there for me to develop trust and she must know that, so...

I: (inaudible)

P: Hm huh. And so also more and more with me it's also okay that she show human foibles, and that does not alter my view of her as trustworthy. That's the new thing I guess is my definition of a trustworthy person. It used to be very different from what it is now, so now I can accept all sorts of -- a range of emotion and activity and

still say that's a trustworthy person and that's more real I think. Cause to expect that a person is going to be totally constant, totally there, never let you down, be totally dedicated to meeting your needs is not realistic because that's not what -- that's not how a real relationship works, but that was my definition of a relationship, cause that's the kind that I needed so desperately, so that's why none of these romances would ever last, cause they never took into account the other person's humanness or vulnerabilities or that they might need things from me that I couldn't provide to them, cause I didn't see myself as providing anything to anyone, so now... so what I've learned through her about being um, having foibles and still being trustworthy, I do apply to other people in my life more. I don't get disappointed as badly in my other relationships, because of the model of her, so... and I guess -- I write a lot in my journal, so I think about those things and I'll write them down, so if you're saying did I think about that during the week (laughs), if I realize that I just -- someone whose just broken my heart, some relationship, you know this person has just -- I've just been disappointed in something they did and I realize "Oh, I was expecting them to be superhuman." And I realize that I still have a relationship with that person. It's kind of bittersweet, kind of poignant, and uh, to say that they are vulnerable and yet trustworthy, uh, and it's that she showed me that.

I: She's been the model for

P: that too...And that's so much more comfortable with those people...so now I'm on this humane campaign, or human campaign in everything I do, I just want to make sure it's as human as can be. My work is doing design and communicating information, that's kind of technical, and I'm just on a campaign to make it readable and understandable, you know, take the jargon you know, this has got to be -- we shame people so much when we are using words they don't know or using the King's English when you could use vernacular, you know and uh, so it's affected me professionally too (Hm)...

I: So therapy has had a really profound impact

P: Yes (laughs) very much so, yeah, I don't where I'd be now if I hadn't decided to do this...yeah I'm glad it exists because I can't really think of another way out -- you know the pre-therapy days, what would I have done, you know? (Laughs) Before the turn of the century what would there be for people like me (laughs). I've tried to work it out in many ways, I do art and I do music. They make me feel better, they're my elixir. I don't do drugs, but I have done them as ways to feel emotional in a little safe way, when my belief was that head and heart can't mix. Well, that was a socially acceptable way to be emotional. And a lot of my art -- I bring in my art to...both therapists that were good I'd bring in my art to and they could see things that I couldn't see, and that was another tool that we used to talk, and especially a lot of this primal stuff that doesn't have words at all is very clearly expressed in some of these pictures I do, and so she's able to read them. It's great. I mean I'll say something that I see, but she'll always see something more, so that's worked out really, really well. But you know that's not enough, that wasn't enough, cause I've been doing art and music all my life too, I guess it was my escape valve. It was enough to let off the pressure, and so that I could survive.

I: But therapy brings something else (Hm huh), even beyond the understanding the therapists bring to your life.

P: I don't understand that last phrase.

I: I don't know if that's right. I guess I was thinking that even if you could have stayed home and interpreted the art as well as you did with your therapist (Hm huh) that it still would not be the same as having been in therapy, (Right, right) that there's, there's something beyond that kind of understanding.

P: Yes, I mean relationship...everything is about relationship. It's about...integrity of an individual and then keeping that integrity and relating to other people, that's at the crux of the paradox. It's that duality of being yourself and then being a part of a group. That's what everything boils down to (laughs). So, and that's what therapy is...being a self, but relating and feeling part of that relationship, but also feeling an integral self (Hm huh). Before this I had no integral self, like I said my soul was out here somewhere watching, you know.

I: So you came to yourself through relating in some way.

P: Yeah, talk about paradox. I mean (laughs). And she has said boundaries...you know boundary, the--like my mother had absolutely no boundaries, while growing up no boundaries, so like everybody was all fused and merged together in my mind, it was like where do I begin and where do they end and I begin and stuff. When you don't have boundaries then you don't have, the way it works is you don't have a sense of self, but strangely enough the more you close doors and say "No I busy now, no don't read my diary" you know don't mess with my life, then the more there is the potential to connect with people (Hm), yo know. So it's paradoxical. That's a good philosophy (laughs)

I: I like it actually.

P: I'm sure there have been a million thesis -- papers written on it (laughs) but it's new to me, I'm liking it.

I: This has been extremely helpful (Good). Is there anything else you want to add?

P: No, I feel like I've said everything, actually I feel like I've said everything.

VITA

David R. Eskra was born in Pittsburgh, Pennsylvania in 1960. He grew up in South Florida where he attended St. Hugh's Elementary and Christopher Columbus High School. In 1983 he graduated from Columbia College, Columbia University with Bachelor of Arts, with a concentration in economics. He was then the coordinator of a food bank in Seattle for year as a member of the Jesuit Volunteer Corps. The next year he worked at a shelter for homeless men and following that returned to school, obtaining an Master of Arts in existential-phenomenological therapeutic psychology from Seattle University in 1988. He completed a placement in the emergency services unit of Mental Health North in Seattle as part of his master degree program. He then worked for two years as a child and family therapist at the Ruth Dykeman Children's Center in Burien, Washington. Mr. Eskra returned to school again in the fall of 1990, entering the doctoral program in clinical psychology at the University of Tennessee, Knoxville. In July of 1995 he began his predoctoral internship at the New York Hospital-Cornell Medical School.