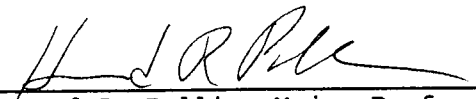
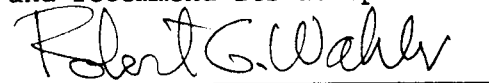


To the Graduate Council:

I am submitting herewith a dissertation written by John Bennett Sproule entitled "Intuition and Insight: The Therapist's Experience of Psychotherapy". 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.

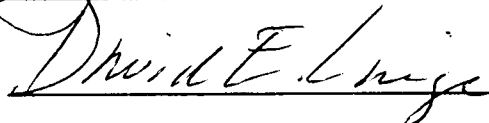

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INTUITION AND INSIGHT:
THE THERAPIST'S EXPERIENCE OF PSYCHOTHERAPY

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

John Bennett Sproule

March 1988

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I am most indebted to all my participants, who took the time to share with me what were clearly among the most significant experiences of their own lives. They truly made this project a mutual one, by putting so much of themselves into it. The opportunity to talk to the participants was invaluable in itself and I only hope that this study remains faithful and does justice to their remarkable narratives.

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ABSTRACT

The purpose of this study was to describe the essential aspects of the therapist's experience of striking events in therapy. Thirteen psychotherapists, who practice psychodynamic or insight-oriented therapy, were interviewed about experiences they had that stood out for them. Nearly sixty instances were gathered in this manner. As a first step, experiences were categorized into four major types: Losing Control, Merging, Connecting, and Recognizing. In Losing Control experiences, there often was a struggle with the patient over who had control of the therapy. In Merging experiences, the therapist usually experienced a frightening confusion of boundaries. In Connecting experiences, deep, empathically attuned communication was established. In Recognizing experiences, the therapist came to see, recognize, or understand something about his or her patient.

These categories provided the preliminary basis for finding the essential themes that described these experiences. By examining the experiences in each category for what held them together as a group, one major and three subsidiary themes were discovered. The overarching theme was Oneness/Separateness. It was most readily seen in Merger experiences where it was characterized by the dialectical pair, fusing/separating. Other pairs related to this theme of Oneness/Separateness were described for other categories. From these descriptions, three sets of pairs emerged as irreducible: the pair Fusing/ Individuating, which concerns identity or Being, the pair Intuiting/Thinking, which

concerns awareness or Knowing, and the pair Undergoing/Acting, which concerns agency or Doing.

These pairs of aspects were discussed in terms of how they clarified some long-standing controversies in the psychoanalytic literature and suggested directions for teaching psychotherapy, communicating psychotherapy experiences, and understanding psychotherapy processes. An effort was made to describe how these opposed aspects are held together in the therapists' experiences. The irreducible tension constituted by these pairs argued for a greater need by psychotherapists to properly heed and find room for non-personal, non-conceptual, and non-intentional aspects in their approach to psychotherapy events.

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CHAPTER I

INTRODUCTION

The aim of this study is to develop an interpretive description of experiences therapists have of those events engaging them during the practice of psychotherapy. As this study will reveal, therapists often have an immediate or intuitive awareness of the therapy situation, which is not necessarily explicit, but provides the ground out of which more formal kinds of understanding develop. Even when therapists are confused and baffled by certain events in therapy, what they say and do seems to reflect an intuitive understanding of what the situation is about. These insights can have a surprising or uncanny quality to them since they do not derive from deliberate efforts to formulate a case. If properly attended to, however, they may provide the material from which a formulation of the case can emerge.

Unfortunately, our tendency is to overlook or even cover up this ground of intuitive and immediate awareness with theories and methods, perhaps reflecting our bias towards the rational. By attending to the therapist's intuitive touch with the unreflected in psychotherapy, this study hopes to provide an alternative starting point for thinking about therapy: a kind of thinking that places more emphasis on the possibility of fostering immediate awareness, than on theory building. By aiming at the therapist's immediate awareness, this study hopes to describe its elusive, but crucial role in the psychotherapy process (Scott, 1982).

The present study did not begin with a formulation of its content and purpose as explicit as that outlined above. The topic only became

apparent as it progressed. This approach may sound undisciplined to our usual view of science as progressing by way of explicitly formulated hypotheses that are then rigorously challenged using "trustworthy" methods. Instead, this study begins by acknowledging that questions precede any application of methods and that all questions aim toward a direction from which an answer is expected (Gadamer, 1975 & 1976). Therefore, this study can be thought of as a disciplined questioning, a turning towards some things that seem significant but are as yet unnamable. In other words, although this study begins in acknowledged ignorance, it seeks to allow an understanding to emerge from this puzzlement by attending to whatever announces itself, however dim and unrecognizable it may be. Allowing faintly conscious and even strange experiences a place in which they can develop their fullness (or incompleteness), should sound familiar to therapists. It is not coincidental that the present study follows an interpretive course similar to that which provides interpretive depth to psychotherapy. In both cases, a discipline of interpretation is used that recognizes--at least in practice, if not in theory--that understanding happens as something more than our personal efforts when experiences are allowed a place to present themselves and we are alert to them.

The previous comments are meant to orient the reader to the way in which this study approaches its topic. On the one hand, I would expect the present approach to have a familiar ring to it since we all have experienced intuitions about people and things. On the other hand, there may be something strange about an approach that does not dismiss intuitions as merely hunches or does not seek to ground itself in

already established bodies of knowledge and/or methods that have shown themselves to be true. It is this effort to decenter understanding from its dominance by reason that may run counter to our culturally familiar and engrained expectations. I hope that the reader will tolerate this strangeness and unfamiliarity because insights that come to us from outside carefully constituted bodies of knowledge also have these traits.

I am sure that no study ever really traces a direct path to its topic, and this study is no exception. It is this very indirection and meandering that we are interested in, as we seek to investigate how the intuitive presents itself in psychotherapy. Therefore, taking a moment to see how this study was shaped by a few key experiences and by the questions that arose from them may be useful for outlining the direction that this study ends up pursuing.

The study arose from the context of my own training as a therapist. In working with patients, I was constantly faced with an overabundance of material that the situation presented, such as what the patient said or didn't say, how he or she acted, and felt, etc. as well as with a similiar array of behaviors and emotions on my own part. Although faced with this apparently endless wealth of potential meaning, I also felt a pressure to respond appropriately; i.e., to do something "therapeutic". Perhaps this is the case for all beginners, but I found myself casting about for techniques and methods to help do the "right" thing for my patients, both in hearing important meanings and in responding to them.

A couple of things occurred that struck me as odd at this time. The more clearly and systematically developed the writings of a

particular author were on how one should go about understanding and responding to the patient, the less I was able to hold these ideas in mind as I was actually doing therapy, and the less they actually helped me grasp and respond to what the patient was saying. On the other hand, those writings that were less systematic and did not necessarily prescribe anything that one should be doing during the therapy were not only more readily borne in mind during treatment; they also seemed to provide concepts and images that helped me relate and respond to the things happening in the treatment.

Paralleling this discovery was feedback I was getting from supervisors and my own sense of how the treatment was going. My efforts to be methodical and "correct" did not seem to be rewarded by greater progress in the treatment. While with therapy cases that did seem to be moving along, I would be hard pressed to say what I was "doing" to induce this. In retrospect, I can recognize how I was practicing some basic technique by adhering to the "etiquette" or ground rules of the setting (for example, by being on time and consistent) and by being attentive and empathically responsive. These factors are generally recognized as important to the technique of psychotherapy, although they provide little in the way of directions for understanding what is occurring or what one is to do with this knowledge.

Initially I tried to focus on how therapy events seemed to elude what appeared to be theoretically sound and well developed techniques by asking therapists to tell me about their experience of sessions where things seemed to be going well. I sought to contact the therapist's stream of consciousness with the hope that it would illuminate how

therapists come to understand their patients. My own experience suggested that the therapist came to his or her insights about a patient by following a spontaneous and non-methodological process rather than a rule directed procedure for "decoding" what the patient said. Simply asking people to recall sessions that went well and what went on in their experience of them proved impractical. The therapists rarely recalled the details of such session. What they seemed to retain was an overall theme, which organized the session's material, or a feeling for the quality of the relationship and the poignancy of the affect during the hour. While specific issues and contents came up and were responded to during the session, such concrete details were not retained in their particularity. Instead, larger themes and feelings came to mind and it was difficult to work back to the concrete. Efforts to elaborate these reports by therapists tended to move in the direction of more abstraction and theory. Therefore, I changed my approach to gain a more concrete sense for the therapist's experience.

I turned to therapists' experiences of sessions that did not go especially smoothly, where events presented some difficulty and a ready understanding or interpretation of what was occurring was not at hand. I had in mind some experiences of my own, which could in some ways be seen as more dramatic instances of the kind of bewilderment I described previously; i.e., when I encountered too much happening in the therapy and lacked guidelines for responding to it. I had in mind times, for example, when I suddenly would find myself overwhelmed with a feeling of anxiety. These unexpected experiences seemed to pick me up and sweep me along, and although I was sure they were connected to things happening

in the therapy, they were beyond my comprehension at the time. My belief was that they probably involved some kind of communication between myself and the patient, but I could not say more about them without falling back upon theoretical explanations appealing to processes of projection and introjection, for example. Therefore, I asked other therapists about times when they were caught up in therapy events, such as powerful emotional occurrences, which they did not understand at the time. Indeed, I found their reports were more concrete and experientially specific, and it is to these reports and their descriptions that we will turn in the results section.

In summary, this study highlights our feel for the pre-reflective, not by conceptualizing it in terms of abstract theories and concepts but by allowing it to guide our attention. The present study follows a path of discovery and uncovering, guided by a sense or direction, and allows things to appear along the way and to present themselves to us, without any need to account for or explain their presence. This type of investigation parallels that of therapists, who are often struck by things, which they cannot yet recognize, and who must discipline themselves to allowing these feelings, ideas, or fantasies to show themselves without prematurely dispensing with them by speaking, acting, or concluding too quickly. This study makes extensive use of description, and in the Results chapter we will group the kinds of experiences that therapists have had to arrive at some revealing dimensions of these experiences. The descriptive analysis presented in the Results chapter will still leave us with something more to do in the Discussion chapter where we will address the apparently more fundamental manner in which these often

contradictory aspects are held together in the concrete experiencing of such events.

CHAPTER II

LITERATURE REVIEW

How is the Therapist's Experience Integrated into the Psychoanalytic Psychotherapy Process?

This chapter will review a sample of representative writings on psychoanalytic psychotherapy with the intention of distilling how the therapist's experience is understood and made use of. The focus on psychoanalytic writings may seem rather limited, but there are good justifications for this delimitation. First, even this restricted domain is extensive; second, the extensiveness of this literature emphasizes the prominence and historical priority the psychoanalytic point of view still enjoys. Third, a psychoanalytic orientation was familiar to all participants, thereby providing a common language. Finally, there are advantages to investigating differences within a single theoretical tradition. The controversies within the psychoanalytic literature will point toward fundamental aspects of the psychotherapy process, which are not readily grasped by any theory, psychodynamic or otherwise. In other words, the problems and inconsistencies of a theoretical approach become more apparent at the subtle levels of a theory, and a broad sweeping review might pass over these problems.

This review also reflects how the present study began. As mentioned, this study was instigated by my own efforts to learn the practice of psychotherapy and one of the first places I turned to for help was to the psychoanalytic literature. My basic questions were these:

how can I hear what is important in what my patients are telling me and what should I do when I hear it? While Robert Langs (1976a, 1978) did, indeed, tell me what to do, something seemed to be left out of his account. There was a gap between the methods that Langs prescribed and my experiences of being with patients. I next turned to Theodor Reik (1948), because the subtitle to his book--Listening with the Third Ear, The Inner Experience of a Psychoanalyst--suggested he might provide an experiential quality from which Langs seemed too far removed. Reik did emphasize the experiential flow accompanying the therapy process; unfortunately, he had little to say about how this was to be used therapeutically. He left the impression that therapy simply cured by making the unconscious conscious. The question remained: how is the experience of therapy integrated with the technique of therapy? Among the other writers I considered, Harold Searles (1979) seemed to come closer to answering this question. He described his experiences of psychotherapy events and tried to integrate them into a theoretical organization of the therapeutic process.

In the following sections, we look at Langs, Reik, and Searles since they serve to stake out important differences in the psychoanalytic literature. After noting these differences, we will go on to see how these findings bear on several major schools of psychoanalysis: classical, Kleinian, self psychology, and British object relations. In particular, we will pay attention to differences in how therapy is viewed as curative and the place of the therapist's experience in this process.

Robert Langs: the Adaptive Context and the Bipersonal Field

Robert Langs (1976a, 1976b, 1978) has made a substantial contribution to the literature on psychoanalytic psychotherapy and his work reviews and synthesizes a broad spectrum of psychoanalytic writings. He draws primarily upon classical and Kleinian theorists but also demonstrates an awareness of British object-relation theory and Kohut's self psychology.

Essential to an understanding of how Langs views the therapeutic process, and the role that the therapist's experience plays in it, are his conceptions of the adaptive context and the bipersonal field. These two concepts form the cornerstones for his theorizing about psychoanalytic technique.

In keeping with the basic psychoanalytic notion of the unconscious, Langs sees emotional disturbances as based on "fantasy-memory constellations" which have a traumatic emotional quality to them and which, therefore, must be kept out of awareness. Symptoms, and other overt expression of the emotional disturbance, indicate that some internal or external stimulus has touched the underlying emotional constellation thereby triggering an indirect expression of the disturbing experience. Patients communicate about emotional disturbances in an indirect fashion since such disturbances are associated with a traumatic degree of anxiety.

These traumatic constellations projectively color one's perception of reality. In other words, the patient's "raw" perceptions and fantasies of a traumatic situation are too threatening to experience or

express directly, so these perceptions and fantasies are unconsciously and automatically "encoded." These encoded communications are referred to as "derivatives" of the underlying, traumatic perception or fantasy which the patient is defending against.

Langs interprets this encoded language of derivatives in the same way Freud interpreted dreams. Freud looked for the day residue which stimulated the unconscious fantasy, and he found it disguised in the dream. Similarly, Langs looks for the "adaptation evoking stimulus" which initiated the patient's response. Langs believes that experiences, which impinge on the patient, are intrapsychically worked over by the patient in an effort to adapt to them. Consequently, the patient's communications reflect this adaptation-seeking organization.

Langs advocates a methodical approach to understanding the meanings of patient material which is informed by his conception of the adaptive-context. "This approach is called trigger decoding since a message is deciphered entirely in light of its stimulus--the experience that set it off" (1983, p. xi). In the treatment setting, the interventions or noninterventions by the therapist provide the most important adaptation-evoking contexts for the patient.

Of course the therapist may make psychodynamic formulations of patient material without taking account of adaptation-evoking stimuli in the present therapy interaction; however, these formulations will fail to touch upon the active unconscious fantasies, conflicts, and perceptions. They will miss the active basis of the current emotional disturbance. Langs labels these inferences, which are not organized around an adaptive context, "Type One" derivatives. They are most useful as

silent initial hypotheses, which become plausible when the adaptive context emerges. By knowing what the context is that the patient is responding to, the therapist is able to transform the patient's words into an unconscious and indirect commentary upon the implications of the therapist's intervention. Formulations that are organized around the identified adaptive-context in this manner are labeled "Type Two" derivatives.

Langs's contention that therapist interventions constitute the most important adaptation-evoking context for the patient leads to his conception of the therapy situation as a "bipersonal field."

The metaphor suggests that every point in the field--every communication, interaction, structure, and occurrence within and between the two members of the dyad--receives vectors from both participants, albeit in varying proportions. Thus, every communication from the patient is influenced to a greater or lesser extent by the analyst, and vice versa. Further, every point in the field is layered and thus requires equal consideration of its realistic and fantasied components (1978, p. 558).

The response of one of the individuals in the therapy dyad cannot be understood apart from the contribution of the other to that dialogue. This assumption underlies Langs's emphasis on the need to focus on the therapist's previous intervention as an adaptive-context in interpreting the patient's manifest material. In addition, the patient's response to the therapist will always reflect a mixture of both veridical perception and transference distortion. Langs designates this mixed quality of the patient's response as "transversal" since such responses transverse reality and fantasy, or non-transference and transference.

Not only are patient responses constituted by mixtures of fantasy and perception, therapist interventions also reflect mixtures of valid

interpretation and countertransference fantasy. The patient's response following an intervention by the therapist provides an indirect commentary on how the patient unconsciously apprehends that intervention. In this way, errors can be discovered and corrected. Interventions are indirectly validated by the patient when new, previously repressed associations, are reported that lend new meaning to prior material or when the patient talks about positive introjects of persons who have functioned constructively in the past. When the therapist is not functioning in a therapeutic fashion, the patient will indirectly allude to this through encoded perceptions of the therapist's error. The patient may even offer indirect interpretations of the therapist's emotional disturbance, which led to the error, or allude to models of more constructive functioning for the therapist. Thus, finding the adaptive context provides the therapist with a key for unlocking meanings within a field of interpersonal and intrapsychic interactions that mingle reality and fantasy.

Langs subsumes the therapist's experience of the therapy process under his "intaking process." Although Langs delineates listening realms beyond the cognitive--such as the interactional and object relational--and enumerates fantasies, intuition, and altered states of consciousness among the experiences that the therapist has available for data, his emphasis is on formulating these experiences into explicit, univocal, and verbalizable ideas. This is the level the therapist must achieve when making interpretations to the patient.

This is where the gap forms between the therapist's immediate experience and Langs's technical advice. Langs seems to endorse a

notion of therapy based on the premise of achieving a literal rendition of reality. Although he acknowledges the nonliteral, such as occur in fantasy and metaphor, such experiences are of no use to the therapist until they are processed into a literal meaning. Langs sees the patient as struggling to adapt to a real situation, though hampered by his or her regressive distortions of this situation. Langs makes this kernel of reality the focus of therapist interventions. Thus, Langs is always attempting to step out of an immediate experience of the treatment situation to gain an objective grasp of what is occurring. Fantasies and intuitions have no useful meaning unless they can be tied to some aspect of the situation and translated into literal statements about this reality.

Theodor Reik: Listening with the Third Ear

Theodor Reik (1948) presents an interesting counterpoint to Langs's "intaking process." He states that his purpose is to show "how new psychological insights are won." However he adds:

I am less concerned with providing my readers with scientifically unchallengeable theories than with giving them an insight into the very remarkable psychological process by which we conjecture and comprehend the unconscious processes in another mind. (1948, p. xi)

Reik contends that: "The organ of psychological observation, and therefore of psychological research and discovery, is to be found within oneself . . ." but this organ ". . . is unknown; more than that--it is unconscious" (1948, p. 10). Therefore, the process by which we observe the unconscious of others cannot be fully described.

In truth, we are incapable of dissecting into all its component parts the process by which we recognize psychological fact. . . . What the analyst is able to perceive and comprehend consciously is probably only a selection that he makes retrospectively, after the event. (1948, p. 132.)

In attempting to observe unconscious processes in others, the analyst makes use of free-floating, hovering, or "poised" attention. This form of attention is reactive, rather than active and selective, and allows impressions to emerge that otherwise might have occurred only in passing. It allows things that are not at the center of attention to take on importance. This receptivity is equally open to internal impressions as it is to external events. In trying to comprehend the experience of others, we need to turn our attention upon ourselves and listen within. Insight into the mind of others is based upon an unconscious comparison of their experience with our own.

In other words, the psychoanalyst who hopes to recognize the secret meaning of this almost imperceptible, imponderable language [of the unconscious] has to sharpen his sensitiveness to it, to increase his readiness to receive it. When he wants to decode it, he can do so only by listening sharply inside himself, by becoming aware of the subtle impressions it makes upon him and the fleeting thoughts and emotions it arouses in him. It is most important that he observes with great attention what this language means to him. What its psychological effects upon him are. From these he can arrive at its unconscious motives and meanings, and this conclusion again will not be a conscious thought-process or logical operation, an unconscious--I might almost say instinctive--reaction that takes place within him. The meaning is conveyed to him by a message that might surprise him much like a physical sensation for which he is unprepared and presents itself suddenly from within the organism. Again, the only way of penetrating into the secret of this language is by looking into oneself, understanding one's own reactions to it. (1948, p. 147).

Reik characterizes this process of unconscious communication as a form of "drive-to-drive" dialogue. Therefore, the process of analytic comprehension is an emotional one; "analysis stirs us up," as repressed

processes in the therapist may come to the fore. Empathy is not a shedding of our self and assuming the self of the other. Rather, the many impressions emanating from the patient

rouse in [the analyst] unconscious impulses and ideas with a like tendency. The unconscious reception of the signals will not at first result in their interpretation, but the induction of the hidden impulses and emotions that underlie them. (1948, p. 357)

What can an analyst teach his younger colleagues in this direction? Very little. He can speak of his own experiences. He can report instances, which have the value of illustrations only Receiving, recording, and decoding the "asides," which are whispered between sentences and without sentences, is, in reality, not teachable. It is, however, to a certain degree demonstrable. It can be demonstrated that the analyst, like his patient, knows things without knowing that he knows them. (1948, p. 144-145)

Surprise is the most characteristic affective accompaniment to recognizing unconscious processes. It expresses the defensive opposition to something known but outside awareness:

Where the analyst's idea penetrates to the profoundest depths of the other's inner life, it may be recognized as the offspring of what is repressed in the analyst and appears to him as something alien. In short, to sum up the matter: The most vital knowledge obtained by the analyst of the unconscious-repressed is, for him too, a surprise. (1948, p. 246)

Reik notes that it is this use of the unconscious as the organ of apprehension that is unique to psychoanalytic methodology. The observation of the other depends upon the analyst's ability to make use of his own experience. Theory and critical reason come into play secondarily, after unconscious perception, conjecture, and insight have yielded their results. Reik contends that a crucial struggle is with inhibitions, which keep hidden meanings out of awareness. Hasty judgements are not

the problem because the "third ear" only touches upon issues; it is not suited to grasping and mastering what it glimpses with sidelong glances.

There is less danger that analysts will be too little logical than that they will be too little psychological in their thought. (1948, p. 392)

Here--and only here--you must leap before you look; otherwise you will be looking at a void where a second before a valuable impression flew past. (1948, p. 145)

Reik, therefore, remains suspicious of efforts "to mechanize and systematize" the process of conducting analysis. What is essential to the practice of psychoanalysis is not so much skillful technique as the "inner truthfulness" of the practitioner.

Though Reik does not allow methods and theories to take a primary position in psychoanalysis, he recognizes the importance of bringing insights into language for them to enter the realm of conscious thinking. He advises, for example, silently formulating into words every idea that occurs to the therapist with reference to analytic data as if he wanted to tell it to the patient or to himself. New expressions are crucial for notions that are outside of our current understanding to be grasped. Reik argues that the great psychologists--and he includes Dostoevski as well as Freud--were "great stylists, creators in the realm of wording" (1948, p. 453).

A pitfall in this use of language is in developing and relying upon a vocabulary of technical terms which may be too far removed from experience. A technical language too easily may become an empty "terminological deposit." "Nothing that does not originate in an experience can become an experience for others" (1948, p. 21). The writings of a psychologist may not directly refer to his or her own personal

experiences but these experiences will make themselves felt in the quality of the work produced.

Reik's concern is not with refining analytic theory or technique; rather he seeks to share his own encounters with the peripheral zone of experience, which we call the unconscious. His work exemplifies the "inner truthfulness" that is crucial to psychoanalytic practice. His emphasis is not on the analyst's proclivity to error and misunderstand--which Langs's technical procedures guard against--rather, Reik invites us to appreciate how much we know about others, even beyond what they can tell us directly. His constant message is to stay close and attend to one's own experience if one wishes to comprehend the experience of others.

Reik succeeds in providing a sense of how a therapist may use his or her experience to comprehend the patient; he has much less to say about how one uses this comprehension, therapeutically. Reik seems to take for granted the formula that psychoanalysis cures by making the unconscious conscious. His primary concern, therefore, is in discovering what the patient's unconscious issues are. In summary, Reik and Langs stake out different areas of investigation, which fail to overlap each other; between them, they seem to omit many important aspects of the therapy process.

Harold Searles: Symbiosis, Identity, and the Therapeutic Process

Harold Searles (1979) has written extensively about his clinical experience which includes work with severely disturbed patients. His ideas have a much broader significance, especially as they bear on the

nature of the psychotherapy process. This section will focus on Searles's important contribution to our understanding of pre-individuated modes of relatedness.

Searles describes two major types of preindividuated relatedness: autism and symbiosis. He further distinguishes between healthy and pathological forms of these relationships. Successive stages develop in the therapy, running from pathological symbiosis, to therapeutic symbiosis, and finally to individuation. Before defining these terms, Searles cautions that it is often difficult, when faced with a striking and significant event in the therapy interaction, to determine just which mode of interaction is occurring. The living, flexible, nature of interactions are too subtle and elusive for simple characterization through "theoretic crystallizations" (1971/1979, p. 134). With this caution, Searles describes pathological symbiosis, autism, and therapeutic symbiosis in the following manner:

The individual who, at the beginning of therapy, gives us to understand that his characteristic mode of relating to other persons is dominated by the ego defense of pathologically symbiotic relatedness, forms with us a relationship in which he is a part of a whole person and we (the therapist) are the other, complementary part. This is in contrast to the autistic patient, who functions as though he himself, or contrariwise the therapist, were the whole--the single conceivable and perceivable and palpable--world. Pathologically symbiotic relatedness also contrasts with therapeutically symbiotic relatedness in many regards. Whereas in pathologic symbiosis the patient and therapist form two relatively fixed, complementary parts of a whole system, in the therapeutic symbiosis both persons function in thoroughgoing and rapidly changing flux and interchangeability, with all parts of potentially whole and separate persons, and, far beyond that, whole and separate worlds, flowing from and into and between, and encompassing, both of them. Also, the affective tone of therapeutic symbiosis is one of liveliness or contentment or fulfillment, while that of pathologic symbiosis is one of

constriction, incompleteness, unfulfillment, or inner disturbance to the point of threatened insanity.

Typically, the pathologically symbiotic patient either coercively puts parts of himself into the therapist, or coercively evokes the therapist's attempt to complete his (the patient's) self, manifested as poignantly needful and incomplete. (1971/1979, p. 134-135)

Patients, at the symbiotic level of functioning, have little healthy ego of their own. During childhood they were faced with a depressed, schizoid, or psychotic mother, "who disturbingly and unpredictably invaded them with her own inner contents" (1971/1979, p. 135). They have become

a constellation of vengeful identifications with other persons, present and past. These identifications . . . are indigestible by [the patient's] ego; hence his effort to rid himself of them, to expel them into the therapist. Consequently, the therapist may find his sleep troubled by the patient who has invaded, and now disturbingly pervades, his whole life. (1971/1979, p. 135-136)

Even in pathological phases of symbiosis, however, one can detect a form of therapeutic striving. Searles frequently emphasizes how it is one sided to view pathological symbiosis as simply the result of the mother's need to have the child remain incomplete and available to complement her own incomplete self. There is also a nascent loving wish on the child's part to remain available to the mother and to help her. In fact, Searles observes that one can discover powerful unconscious feelings of guilt in schizophrenic patients connected to their failure to make their mothers whole and successful parents. Viewed in terms of psychotherapeutic strivings, the pathogenic introjects that comprise the core of the schizophrenic patient (the "constellation of vengeful identifications with other persons") also represent the person's efforts to heal outer reality, especially the mother and her successors, by taking

those ill components into the self in order to free the other from them (1973/1979, p. 421).

A patient functioning at the symbiotic level of relatedness will express, through the transference, his or her need to complete the other. "The more ill a patient is, the more deeply indispensable does he need to become . . . to his transference-mother, the analyst" (1973/1981, p. 421). It is in this area of symbiotic relatedness that the patient is most alive and it is from this situation that the capacity for mature and healthy relatedness will spring. For this to occur, the therapist needs implicitly to acknowledge the patient's indispensableness to his own functioning. This is what the therapist offers to the patient that is new from all prior experiences of symbiotic relatedness, "not an avoidance of the development of symbiotic reciprocal dependency upon the patient, but rather an acceptance of this--an acceptance of the fact that the patient has come to mean a great deal, personally, to him" (1959, p. 17).

This emphasis on reciprocal dependency is even more striking as Searles highlights its manifestation in treating patients in the autistic phase of relating. During this phase, when the patient experiences the therapist as part of the undifferentiated world matrix encompassing the patient, the therapist provides the patient with a kind of exoskeleton or in Khan's words a "protective shield" (Khan, 1963/1974).

The patient needed to come to experience the analyst as being equivalent to the early mother who comprises the whole world of which the infant is inextricably a part, before he has achieved enough of an own self to be able to tolerate the feeling-experience of sensing her as separate from his own body, and the two of them as separate from the rest of the actual world. (1970/1979, p. 163)

In terms of an emphasis on therapeutic strivings in the autistic patient, Searles contends that more is required of the therapist than that he or she function as a protective shield more reliably than did the patient's mother. The therapist needs to accept the patient's functioning as his or her maternally protective shield. If the therapist can immerse comfortably in the patient's autistic world, "the patient can then utilize him as a model for identification as regards the acceptance of such very primitive dependency needs" (1973/1981, p. 426). Though one's first impression of the autistic patient is how unrelated he or she seems to be, the therapist needs to be sensitive to the autistic patient's psychotherapeutic functioning. As he or she did for his or her ego-fragmented mother, the patient provides a protective shield to the therapist, anchoring the therapist's own ego-functioning. What is new this time is that the therapist is integrated enough

to dare to know how indispensably important to him is this patient, this autistic patient who is able meaningfully to relate to him, at first, only as the maternal shield for those least well-integrated components of the analyst upon which the patient's transference to him as an ego-fragmented mother is based. (1973/1981, p. 427)

By allowing the patient to have this role of mother to the therapist, and by the therapist becoming conscious of and comfortable with this function, the patient faces less humiliation, and has a model to identify with, as he or she works toward integrating a need for infantile mothering by the therapist.

The more readily accessible to himself are the therapist's own symbiotic-dependent feelings, the better he is equipped to help the patient to become conscious of similar feelings, so that the patient need no longer act out symbiotic yearnings

through the schizophrenic postponement of individuation. (1975/1981, p. 120).

Only by the therapist coming to terms with the "nuclei of reality" in his or her own functioning, upon which the patient's transference is based, is there hope for the patient eventually to integrate these same components into his or her personality functioning.

Searles observes how little we appreciate that symbiotic relatedness is not confined to infancy and pathology and that it forms an important, though often unconscious, substrate to healthy adult functioning. Even as adults, we constantly experience moments of symbiotic connectedness and re-individuation. For Searles, "human existence is lived largely at a symbiotic level of relatedness" (1966-1976/1979, p. 49).

It is as if [a person's] total identity were an iceberg . . . in which by far the greater symbiotic portion is under the surface, subliminal, in terms of awareness of identity. It may well be that the predominance of personality functioning, even in healthy adult persons, is subjectively undifferentiated, at an unconscious level at least, from the great inanimate realm of the environment--that only in comparatively minor part do we function as subjectively animate human beings; and we function to a still lesser degree--or, perhaps, still less frequently--as predominantly uniquely living human beings. Probably, in waking life we function all the time on all levels simultaneously, in varying degrees; but it is comparatively seldom that the healthy adult person, who is unafraid of simply existing in a predominantly symbiotic relatedness with the totality of the "outside world," need be highly conscious of himself as a uniquely human being. (1966-1967/1979, p. 50).

Returning to his work with autistic patients, Searles observes that:

A development which comes eventually to contribute to the resolution of this autistic mode of relatedness is the analyst's surprised, recurrent, and deepening realization and acceptance of the fact that these two seemingly so separate

worlds, his world and that of the patient, are but separate outcroppings of the unconscious ground joining the two of them. (1973/1981, p. 427)

Searles suggests that we have a frightened attitude towards symbiotic levels of relating and tend to see them as regressive and ego-threatening. Searles contends that only by integrating these symbiotic levels of functioning into our personalities will we have access to creative capacities and energies crucial to our ability to relate to our patients and to our whole world.

Searles's effort to make symbiotic levels of functioning a basis for individuality, rather than conceiving of them as antithetical to identity, leads him to emphasize how identity expresses the person's struggle to achieve a meaningful existence that incorporates knowing both that one is "at once uniquely individual and indissolubly part of the universe" (1965/1979, p. 44). Searles observes that the very word, identity, seems to express this double aspect of set-apartness and sameness, since we use it both when we speak of one person identifying with someone else and when we express what is most unique about ourselves. Searles concludes that these two uses of the word are not really contradictory, "for identity embraces, at once, one's unique self and the world with which that self are one" (1966-1967/1979, p. 70).

An important aspect of Searles's conception of identity, as founded upon preindividuated modes of relatedness, is that it provides

one's potentially most sensitive and reliable instruments for psychologically grasping the outer world.

Man's identity enables him to perceive the world not merely by mirroring it, but, at a symbiotic level of relatedness, by literally sampling it through processes of introjection and projection. (1966-1967/1979, p. 67)

Throughout Searles's descriptions of his clinical experiences, he describes how fluctuations in his own sense of identity provide important data for understanding what is transpiring in the dialogue of therapy. For example, the sense of being essentially nonhuman would be consistent with the transference active during the autistic phase of relatedness in which the patient needs the therapist to be no more differentiated from him than the inanimate world that surrounds him. In contrast, with another patient, the therapist may have the sense of being highly gifted and skilled, which would be consistent with a patient in the symbiotic phase of relating who needs to invest others with the patient's own good qualities to have a more whole and integrated other with whom to relate and identify.

As noted at the beginning, Searles warns us that his concepts do not necessarily provide easy categories for cataloguing therapy events. Nevertheless, developing a theory is very important to Searles. He states, at one point, that a good theory allows him to withstand the onslaught of psychotic thinking in his work with very ill patients. It provides a "weapon" for defending his own sanity and helping the patient regain his. Though Searles is interested in developing theories which describe therapy interactions, he does not wish to reify these concepts into "theoretic crystallizations." In his critique of Jacobson's The Self and the Object World, for example, he complains that "Jacobson's many creative insights are expressed through a Procrustean bed of technical jargon" (1965/1979, p. 39). As previous excerpts from his own writings show, Searles relies upon the descriptive power of language; he

writes in terms of evocative and experience-near metaphors, which avoid abstract metapsychology.

For this reason, Searles's concepts have a somewhat elusive quality, perhaps reflecting the phenomena they describe. Clinical phenomena exist in an interpersonal realm and confound efforts to sort them into aspects of inner and outer reality. The therapist needs to be comfortable participating in the "twilight" quality of the transference relationship and to accept at least some degree of relatedness to the transference object or perception currently active in the relationship. This includes some implicit acknowledgement that the transference is not purely transference, since there are "increments of reality" in the therapist's personality to which the transference is attached.

In conclusion, Searles struggles with the problem of how to write about psychotherapy in a way that retains an experience-near quality. He begins descriptively and makes therapy dialogue his point of departure. He then works towards a theoretical comprehension of what transpires in psychotherapy: a comprehension that remains sensitive to the experiential flow. In doing so, Searles is comfortable with paradox and ambiguity as he treads the line between immediate experience and theoretical conceptualization. Unlike Langs, for whom words must have crystalline clarity, Searles does not turn words into crystallizations. For Searles, the same word can express contrasting meanings. He seems content to allow things to exist at a certain level of ambiguity, neither completely one thing nor another. While Searles manages to convey an experiential feel for the events of therapy, he still borrows his concepts from traditional psychoanalytic theory. The problems inherent

in talking about events in terms of inside versus outside, fused versus separate, real versus fantasy, and conscious versus unconscious remain; though the sharpness between the polarities is softened and blurred.

In short, Langs begins with theory and uses it to grasp experience, while Reik begins with experience and comes close to eschewing theory. Searles also starts with clinical experience but goes on to weave a theoretical framework which attempts to remain in touch with what is immediately given.

The Therapist's Experience and the Major Psychoanalytic Schools

The preceding review of Langs, Reik, and Searles introduces three different attempts to conceptualize the therapist's experience in the therapy process. These different approaches appear to divide along the lines of some long-standing controversies within the psychoanalytic movement, arising from debates over the curative factors in the therapeutic process. The major psychoanalytic schools to be discussed do not have a simple relation to these controversies, such that one school takes one position on these issues and a different school another position, rather these issues are fundamental ones, which must be dealt with, at least implicitly, by each of these psychoanalytic schools. Having these issues in mind may help us to understand what psychoanalysis, as a whole, is striving to come to terms with, as it divides itself into different points of view.

One of the earliest debates centered on the relative role and significance of cognition and affect in therapy. Fenichel described

this controversy in terms of "the eternal Scylla and Charybdis of analytic technique--too much talking versus too much feeling" (1941, p. 99). At that time, Fenichel was responding to those who he felt emphasized the affective processes in psychoanalysis too much, such as Reik, who distrusted theory and warned of its potential to constrict the analyst's understanding of the patient to a "blueprint" (Rangell, 1979/1980 and Valenstein, 1979/1980). This long-standing controversy, between those who argued for "consistent intellectual guidance in technique" (Appelbaum, 1981, p. 32) and those who emphasized the need to "empathically reverberate to the patient's affective experiences" (Rangell, 1979/1980, p. 97), can be traced to the present in the works of Ferenczi, Rank, Reik, Alexander, and Kohut, on the one hand, and those of Fenichel, Hartmann, Eissler and Langs, on the other.

Related to the dispute over the relative role of cognition and affect is the issue of whether the therapist should provide emotional nurturance to the patient or remain neutral. Freud's metaphors of the analyst as a blank screen and surgeon have been cited to suggest that the analyst's proper role is one of neutrality and the only proper activity is interpretation. Ferenczi argued against this, noting that the therapist's detachment would only reproduce the traumatic experience for patients who suffered real and significant deprivations and prevent them from investing in the treatment. This view of the therapy process as involving growth and re-development can be found in the works of Balint, Winnicott, Guntrip, Alexander, and Kohut, although there are wide differences among the classical analysts in how neutrality is viewed, as well.

Kernberg and Langs are representative contemporary analysts who are reluctant to make deviations in standard analytic technique, even with relatively disturbed patients. They eschew Alexander's notion (Alexander & French, 1946) that the therapist provides the patient with a corrective emotional experience by being more benevolently responsive than the original internalized object. Other classical analysts, such as Stone (Langs & Stone, 1980; Stone, 1961) and Marmor (1979/1982), however, place more emphasis on the role of the therapist's warmth and emotional responsiveness to the patient. This controversy about neutrality, and the previously discussed one concerning the relative roles of affect and cognition, appear to be related. Those who emphasize the role of cognition and insight in the treatment process also tend to advocate therapist neutrality while those who emphasize emotional responsiveness tend to view therapy as a place where the patient may finally receive the nurturance necessary for psychological development to resume.

This relation may become clearer if we consider another controversy which involves the status of psychoanalysis as a science. Those who advance the view that psychoanalysis is a science tend to emphasize the prescribed methods and theoretical structure which guides its practice. Langs (1976a, 1976b, 1978) stands as a prominent example of this point of view. Those who implicitly de-emphasize psychoanalysis as a cumulative body of scientific knowledge focus on the artful quality of practicing psychotherapy (Appelbaum, 1981; Storr, 1979; Winnicott, 1962/1965). The relation between the two previous controversies, now, becomes clearer: Those who favor cognitive factors over the affective

and emphasize neutrality as the therapist's proper role tend to view psychoanalysis as a science; those who emphasize the intuitive function of emotions and the nurturant role of the therapist tend to see psychoanalysis as more of an art than a science.

This controversy has been rendered in terms of differences between historical and narrative truth (Spence, 1982). Fundamentally, this difference rests on the relative weight given to reality and fantasy in psychoanalysis. Freud took a critical turn when he postulated that childhood sexual traumas underlying the adult neurosis need only occur in fantasy for them to have an impact on psychological development. Those analysts who emphasize the objectivity of events, against which patient projections stand out as distortions, tend to find a scientific, cognitive approach more suitable, while those analysts who emphasize the significance of the patient's needs, as expressed in fantasy, tend to be less rigorous about neutrality, comfortable being affectively available to the patient, and more concerned with the personal quality of the therapy relationship.

The following sections are devoted to four major strands of psychoanalytic theory: classical Freudian theory, Kleinian theory, self psychology, and object-relations theory. These approaches will be examined in some detail, especially in regard to how they understand the process of psychotherapy and the role of empathy and/or countertransference in this process. These topics will provide the best avenues for revealing the place of the therapist's experience in each of these psychoanalytic approaches. This discussion also will provide the theoretical concepts by which the therapists' experiences in the present study could be

comprehended psychoanalytically. Although this study does not seek to use psychoanalytic theory to interpret the experiences given by its participants, these theories do provide an alternative approach to the present study's data and are probably the concepts and theories that most of the participants in this study would use in understanding their own experiences. Insofar as there is validity to psychoanalytic theory, there should be mutual enhancement between the phenomenological characterization of the participants' experiences presented in the Results chapter of this study and the efforts of psychoanalysts to organize their own therapy experiences discussed in the following sections.

Classical Psychoanalytic View

The first problem is to give an adequate definition as to what is meant by "classical" psychoanalysis. Valenstein (1979/1980) points to the importance of an historical element in this concept. What is considered classical can only emerge in retrospect after views that have been held to be time-tested and authoritative are challenged and modified by new ideas and departures thereby lessening the authoritativeness of the previous, "classical" view. Freud is the authority for classical psychoanalysis; thus, classical and Freudian psychoanalysis are essentially the same thing. Later writers, of course, expanded on Freud's ideas, especially regarding the ego's processes in its defensive (A. Freud, 1936/1946) and adaptive functioning (Hartmann, 1939). These modifications seem to have shifted psychoanalysis from an earlier emphasis on id psychology to the current emphasis on ego psychology. Valenstein suggests the term "neoclassical" psychoanalysis to encompass

these developments in ego psychology. Therefore, the following discussion of classical theory will incorporate both the earlier id psychology initiated by Sigmund Freud and the later ego psychology that flourished under the influence of his daughter, Anna Freud.

The Therapeutic Process

The therapeutic aim of psychoanalysis is to undo the work of repression, make the unconscious conflict between impulse and prohibition conscious, and allow the patient an opportunity to reach a new resolution to a previous impasse (Waelder, 1960). In the process of trying to make patients aware of their conflictual, unconscious desires and the anxiety associated with the conflict, Freud and other analysts soon discovered that patients resisted their efforts. The same forces that originally repressed the prohibited desire now served to keep the patient from experiencing the desire and its accompanying anxiety during treatment. At first, this frustrated Freud's hope of psychoanalysis becoming an expedient cure for neuroses, although analysis of patient resistance soon became a central aspect of the therapeutic process. Resistances represent the active, here-and-now functioning of the patient's unconscious defensive processes. The aim of analysis became one of modifying these defenses and of bringing them to conscious attention so the patient could re-experience the traumatic conflict and bring new resources to bear upon its resolution.

A particular aspect of the patient's resistance to verbal insight deserves special attention; this is the patient's transference to the therapist. Instead of experiencing desires in awareness and memory, the

patient re-enacts or acts-out the conflict of desire and prohibition with the therapist. Although this hinders the therapist's efforts to make the patient aware of the underlying situation through verbal insight, the previous conflict is now alive in the current interaction. This manifestation of unconscious processes in the transference eventually takes the place of the presenting neurosis. As the transference neurosis develops and becomes more prominent, the psychological investment in the original symptoms drains off.

In terms of the therapist's activity, interpreting is widely regarded by classical analysts as the primary psychoanalytic tool. Eissler states that "... for the ideal case the analyst's activity is limited to interpretation; no other tool becomes necessary" (1953, p. 439). Interpretations further the patient's insight into his or her psychological functioning and behavior and the increased awareness that comes with insight is considered the primary agent of change in psychotherapy.

Interpretation leading to insight is the specific and most powerful agent of the psychoanalytic curative process Correct interpretation and reconstruction depends upon and conveys insight, so that insight may be stated to be a sine qua non of psychoanalysis. (Blum 1979/1980, p. 43)

Strachey's article "The Nature of the Therapeutic Action of Psychoanalysis" (1934/1981) is a classic reference on how transference and its interpretation lead to insight and change. Essential to Strachey's view of the treatment process is the role of the transference.

The original conflicts, which had led to the onset of neurosis, began to be re-enacted in the relation to the analyst Instead of having to deal as best we may with conflicts of the remote past, which are concerned with dead circumstances and mummified personalities, and whose outcome

is already determined, we find ourselves involved in an actual and immediate situation, in which we and the patient are the principal characters and the development of which is to some extent at least under our control. But if we bring it about that in this revivified transference conflict the patient chooses a new solution instead of the old one, a solution in which the primitive and unadaptable method of repression is replaced by behavior more in contact with reality, then, even after this detachment from the analysis, he will never be able to fall back into his former neurosis. The solution of the transference conflict implies the simultaneous solution of the infantile conflict of which it is a new edition. (1934/1981, p. 364).

The transference is but one instance of the patient's tendency to project onto others his or her internal representations of archaic "bad" objects formed through experiences with important others during the individual's early life. Feared objects are attacked to control them; therefore, the re-internalization of objects is colored with aggression. A vicious circle results in which projection and internalization of archaic objects merely maintains them in a dangerous and threatening state. Strachey suggests that therapy is effective insofar as it turns this vicious circle into a benign circle in which the patient's internal objects become less fearsome and, therefore, require less aggression to control.

Before this benign circle can occur, the patient must become aware of some of his unconscious impulses. Strachey suggests that the therapist functions as an auxiliary superego for the patient and, thereby, gives the patient permission to allow small portions of unconscious impulses to become conscious. These impulses will be experienced by the patient as directed at the therapist.

This is the critical point. If all goes well, the patient's ego will become aware of the contrast between the aggressive character of his feelings and the real nature of the analyst,

who does not behave like the patient's "good" or "bad" archaic objects. The patient, that is to say, will become aware of the distinction between his archaic phantasy object and the real external object. (1934/1981, p. 369)

It is critical to this process that the patient retain a capacity for differentiating between the therapist as a real person and the therapist as a projected imago. Thus, the quantity of id impulses must be kept small so as not to overwhelm the patient's reality-testing. The therapist also avoids "real" behaviors for the same reason.

It is a paradoxical fact that the best way of ensuring that his ego [the patient's] shall be able to distinguish between phantasy and reality is to withhold reality from him as much as possible. But it is true. His ego is so weak--so much at the mercy of his id and superego--that he can only cope with reality if it is administered in minimal doses. And these doses are in fact what the analyst gives him, in the form of interpretations. (1934/1981, p. 371-2)

Thus, there are two phases to effective or "mutative" interpretation. In the first phase the patient becomes aware of an id-impulse directed toward the therapist; in the second phase, the patient realizes that the impulse is directed toward a phantasy and not a real object. Therefore the quantity of aggression that must be mobilized is lessened and a more benign image of the object is internalized.

A corollary to Strachey's conception of the therapy process is how trying it can be for the therapist. Mutative interpretations can only be given for an immediate situation in which an id-impulse is active. The therapist is

exposing himself to some great danger . . . deliberately evoking a quantity of the patient's id-energy while it is alive and actual and unambiguous and aimed directly at himself. Such a moment must above all others put to the test his relations with his own unconscious impulses. (1934/1981, p. 377)

What joins Strachey and other classical analysts is their view that the patient's ego must achieve enough distance from what is occurring in the therapy to have insight into how the current situation is different from the transference phantasy. Gill (1979/1981), who places more importance on how the patient's transference is connected to aspects of the current analytic situation, still contends that the patient needs to see that the actual situation to which he or she is responding is open to other conclusions. By the therapist giving the patient an interpretation, the patient is being treated differently than he or she had expected to be treated by the transference figure, and the patient can have a new experience.

Empathy and Countertransference

The literature addressing the role of empathy in therapy is rather sparse and not very satisfactory. Greenson (1960/1981) and Beres and Arlow (1974/1981) agree that there is surprisingly little on this topic. Greenson observes that there seems to be an antagonism between empathy and theory, and Beres and Arlow conjecture that empathy is overlooked because it seems unscientific and requires the author to be too revealing of his own experiences to a potentially critical audience of colleagues. All authors seem to agree on the importance of this ability for the therapist to put himself in the shoes of the patient; although they tend to focus their discussions upon differing views about what psychological processes are involved in this phenomenon. For example, Reik (1948) discusses empathy in terms of an internalization of the other; Greenson (1960/1981) differentiates empathy from internalization

since it is temporary and nondefensive in nature. Fliess (1942/1981) calls empathy trial identification, and Beres and Arlow (1974/1981) define empathy as a transient identification in which the empathizer preserves his separateness from the other. None of these descriptions, however, seems to bring us any closer to what empathy is, which may reflect the difficulty of getting a hold on this phenomenon.

No matter what example I may choose, there is some amount of distortion, because essentially the process of empathy is an automatic process and one observes it only in retrospect. Furthermore, in order to clarify the various events one has to magnify the intervals and separate steps in an occurrence in which much seems to happen very rapidly and perhaps simultaneously. Finally the best examples of empathy and the clearest occur where there is some difficulty in the empathy. (Greenson, 1960/1981, p. 246)

Thus, the path to understanding empathy seems to lead us in an indirect manner through failures of empathy, which are typically discussed within the analytic literature on countertransference.

Annie Reich has written a series of papers on countertransference, which are representative of the classical position on this subject. She (1951/1981) begins by establishing that the analyst's tool for understanding is his or her own unconscious. Freud's dictum that the therapist should listen with free floating attention is meant to assure that the patient material will be absorbed by the therapist's unconscious. However, difficulties can arise in this process; the therapist's own conflicts and unresolved issues may preoccupy him or her and make it impossible passively to absorb the patient material.

The therapist also needs to function as a screen for the patient's transference. This requires the therapist to remain neutral to the patient's emotional expressions; i.e., the therapist cannot respond

emotionally to the patient's emotions. The therapist, therefore, faces a double difficulty.

It is, indeed, no easy task to be able, on the one side, to feel oneself so deeply into another person as the analyst has to do in order to understand, and, at the same time, to remain uninvolved. (1951/1981, p. 154)

Reich defines countertransference, in the proper sense, as the patient coming to represent an object of the therapist's past which finds expression in the therapist's attitudes, feelings, and wishes regarding the patient. In addition, the therapist may use the treatment for acting-out purposes when the therapy, itself, takes on unconscious meanings for the therapist. In this case, though the patient may not be an object of the therapist's transference, the therapist uses the treatment to have unconscious needs gratified.

Reich notes that there is a close connection between the pathological uses of the treatment situation for therapist gratification and the non-pathological use of analysis as a form of sublimated gratification.

We said before that the unconscious of the analyst is his tool. The readiness and faculty to use his own unconscious in that way obviously must have some deeper motivation in the analyst's psychological make-up. (1951/1981, p. 157)

At the root of the therapist's interest and motivation for doing psychotherapy is likely to be found some early needs, as well as efforts at their resolution. For the successful therapist, these issues have been sublimated to the point that they result in a true psychological interest in the other person.

What I should like to stress is that in this case of undisturbed functioning the psychological interest obviously is based on a very complicated 'countertransference', which is desexualized and sublimated in character, while in the pathological examples the conflict persisted in its original form

and the analytic situation was used either for living out the underlying impulses or defending against them or for proving that no damage has occurred in consequence of them.

Maybe we might come to the following conclusion: Countertransference is a necessary prerequisite of analysis. If it does not exist, the necessary talent and interest are lacking. But it has to remain shadowy and in the background. (1951/1981, p. 159)

From a classical point of view, countertransference may be inevitable and even necessary--if properly deinstinctualized or sublimated--however, it basically remains a hindrance to the therapist's proper understanding of the patient. His emotionality clouds his objectivity as an observer, and the behavioral consequents of such affective responses will, in turn, distort the transference, since non-neutral attitudes will be manifest to the patient.

Classical analysts view countertransference as parallel to patient transference since both tend to distort the present situation in terms of previous experiences; however, Langs makes clear that there are important differences in the role they play in treatment. While "transference expressions constitute the primary means through which the patient communicates and lives out his intrapsychic pathology . . . without which true analytic work would not be feasible," countertransference expressions are "by no means a requisite to analytic cure and in no way serve a central curative function in the analytic work of the analyst" (1976b, p. 294). They are inherently disruptive and, at best, may be put to some use. They may provide some information about the patient, but this is not the preferred avenue and an attempt should be made to resolve them as quickly as possible.

Kleinian Psychoanalytic View

Theoretical Shifts

Melanie Klein's writings have led to some major changes in psychoanalytic theory and, to a lesser extent, in analytic technique. Much of Klein's own work retained familiar Freudian concepts since she tried to present her ideas as additions to classical theory not as revisions. Asserting the radical implications of her work was left to those who came later and were influenced by her work. This review will draw heavily upon these more recent followers since they seem to express what Klein was tentatively formulating.

The most radical shift in Kleinian theory is away from Freud's theory of infantile sexuality to an emphasis upon the infant's more general needs for nurturance and the annihilation anxiety mobilized by its frustration. This shift in emphasis from sexuality to nurturance is a subtle one to detect when reading Klein because she continues to use familiar Freudian concepts such as libido and instinct. Within the context of Klein's writings, however, these terms take on new meanings reflecting her new conception of instincts. For Freud, instincts were essentially biological urges rooted in the mucous membranes of the sexual zones (i.e., oral, anal, and genital). The instincts require discharge in a manner that is primarily auto-erotic and only secondarily relational. In other words, the instincts only gradually become detached from the self, following the stage of primary narcissism, to find a secondary attachment to external objects. For Klein, the infant's instinctual life is object oriented from the beginning. The infant

needs nurturance from the onset because there is no possibility of self-satisfaction for these needs. The sexual manifestations of childhood become secondary phenomena, reflecting the child's efforts to master early situations of loss and frustration. Grotstein explicitly states this conclusion.

The Kleinian infant is a whole infant who urgently needs mother for nutrition, evacuation, and for holding. These are primarily biological survival needs. In no conceivable way is sex one of them. "Sexualization" comes about more as a defensively precocious state of excitement in order to alter the awareness of frustration so as primitively to master it. (1980-81a, p. 379-80)

Closely connected to Klein's new conception of the instincts is her expanded understanding of the role of fantasy in psychic life.

The Kleinian instinct is itself a fantasy and is, as such, the autobiographical narrative of the infant's neediness. Instinctual impulses are a priori obtrusions into the infant's awareness and are experienced as fantasies These fantasies are experienced as narratives which attempt to tell a story which helps to organize the impinging data of experience in an attempt to account for it and therefore to master it. (Grotstein, 1980-81a, p. 382)

This notion of instinct as fantasy has important implications for a theoretical understanding of the structure of the psyche and the content of the unconscious. Instincts, qua fantasies, must always be personified and they can only be personified in terms of the self and its primitive relations to primitive objects (i.e., narcissistic objects that are not differentiated as outside the self's control). In contrast to Freud's tripartite structure of the psyche, as id, ego, and superego, Grotstein points out that:

the Kleinian version of instincts as fantasies implies, from the very beginning, the absence of an id and the presence of an instinctual ego which has magical--but magically adaptive--

attitudes towards its objects in order to achieve survival (1980-81a, p. 383).

There is no prior state in which the person is conceived of as having drives but no self or object.

The Kleinian's unconscious is synonymous with their concept of the internal world. Rather than a conception of "seething cauldron" of formless instinctual drives, they conceive of split-off inchoate selves linked with internal objects in a gradient from dominating or controlling objects to passive, helpless objects, all of which are associated with egos. The Kleinian unconscious is always personified and never otherwise. (Grotstein, 1980-81a, p. 387)

Thus, from the Kleinian view, the id becomes equivalent to the infantile aspect of self seeking nurturant contact with an object. Excesses of need, in the face of the infant's limited capacity to avoid frustration, lead to the appearance of apparently autonomous drives existing outside of conscious awareness. In contrast to the classical view that essentially sees the helpless ego needing protection from the dangerous forces of the id, the Kleinian view recognizes the repressive barrier as also functioning to protect the id (infantile self) from an overly autonomous ego.

Paradigmatic Data

It may be helpful to place these theoretical changes into the context in which Klein developed them, that is, within her analysis of young children. It was through this work that Klein developed her inferences about the experience of children, especially the phenomenology of their anxieties. Much of this material was worked out in play and naturally lent itself to the narrative form of fantasy. Another important area in which new concepts were worked out, especially by

Klein's followers, was in the treatment of psychotic patients. As with children, the issues that needed to be addressed did not lend themselves to the classical approach of analyzing defenses in order to free the flow of the associations. Rather, the issue was one of grasping the nature of anxiety which threatened to overwhelm the patient's defensive structures. Grotstein observes that Klein's notion of depth in psychoanalysis is no longer a search for the earliest memories of traumatic experiences, rather depth takes on the meaning of the primitive and the infantile aspects of the self, as they survive and are active in the present.

The Therapeutic Process

Though Klein's theoretical changes imply changes in technique, Kleinian analysts tend to describe themselves as practicing in the manner prescribed by Freud. Neutrality, interpretation, and insight remain key ingredients to change in the therapy process (Segal, 1967/1981). They primarily identify differences in the content of their interpretations. There is more focus upon transference, particularly in terms of fantasy and anxiety. The classical analyst seeks primarily to undo the forces of resistance in order to bring about a free flow of associations. In this way the ego can gain more control over the disposition of instinctual forces.

The Kleinian analyst . . . always feels impelled to reach out towards a needy infant As the Freudian analyst feels justified in not interfering with the flow of associations, the Kleinian feels technically justified in continuing to reach out to contact the infant by designating the maximum unconscious anxiety at any given moment. He is looking for need, not libido or aggression. (Grotstein, 1980-81a, p. 380)

Though Grotstein is highlighting the Kleinian's sensitivity to the patient's needs for nurturance, this should not be taken to mean that the Kleinian analyst seeks to meet the patient's needs for nurturance. In fact, Winnicott has described the Kleinian analysis of psychotic patients as "research analysis" that cannot be therapeutic, because the therapist still maintains the classical analytic stance of neutrality.

Klein's theory implies a greater appreciation for the interactional components of the therapy process since her emphasis upon projective and introjective processes naturally leads to a greater focus upon what goes on between therapist and patient. Madeleine and Willy Baranger's article, "Insight in the Analytic Situation" (1966/1981), is representative of this trend.

The Barangers stress how the field of therapeutic interaction is constituted by the unconscious fantasy of both participants. For example the "urgency point," or the moment in the therapy which calls for an interpretation, does not depend upon the patient alone.

The urgency point is the same as an unconscious fantasy, but it is the fantasy of a pair (which is created within a pair as such). In spite of the "passivity" of the analyst, he is involved in the patient's fantasy. His unconscious responds to it and contributes to its emergence and formation. This fantasy can be defined as the "dynamic structure (of a pair) which, at every moment, confers meaning to the bipersonal field." (1966/1981, p. 384)

Thus, the transference neurosis (or psychosis) is not just the pathological process of the patient; it is a function of the bipersonal field. "Each analyst knows how involved he is in these processes" (1966/1981, p. 384).

The function of the analyst is to let himself become involved --in part--in a specific pathological process of the field in

which he is already partly involved through his relationship with the patient. Consequently, he must try to rescue the patient, and himself as well, since both are participating in the same drama. (1966/1981, p. 384-5)

It is a moment of insight brought about through interpretation which leads to this double rescue of patient and therapist.

The insight that is specifically analytic, is that process of joint comprehension by analyst and patient of an unconscious aspect of the field, which consequently leads to a reduction in the pathology of the field, and the rescue of the respective parts involved. (1966/1981, p. 385)

Essentially, the Barangers describe an oscillating movement in the communicational flow of the analytic field. There are regressive movements, which result in stagnation and paralysis, followed by moments of insight, which lead to freedom and openness in the communications, both interpersonally and intrapsychically.

The interaction of regressive and repetitive phenomena characterizing the analytic situation, necessarily renders it pathological. This is the basic condition by which the analytic situation is able to achieve its therapeutic aims and results. A truly "finished" analysis, if it were conceivable, would manifest itself in a field functioning freely, where no pathological crystallizations were produced. The analytic process can be conceived as the consecutive resolution of all the difficulties which, time after time, prevent communication and mobility in the field. (1966/1981, p. 386)

These authors describe such paralyzed sectors of the field as "bastions," which are created when the patient's efforts to split off experiential aspects of the communicational field find complicity with the therapist--a complicity of resistance and counter-resistance. If these bastions are allowed to continue and are not resolved, a kind of symbiotic parasitism develops.

The most extreme processes in the pathology of the field could be expressed in terms of parasitism of the analyst by the patient. If a part of the work of the analyst is to be

penetrated by the projective identifications of the patient, or to serve as a deposit for the patient's experiences, the session generally finishes by a restitution of what has been deposited. But sometimes the restitution cannot be made (perhaps because the penetration was too violent or invading) and the analyst remains "inhabited" by a part of the patient after the session is over. If the process becomes chronic, the situation resembles a type of parasitism exercised by the patient.

Subjectively, the analyst feels impotent, flooded by the patient. The analytic situation loses its temporal frame and overflows outside the sessions, and the preoccupation about the patient fills the nonanalytic hours. This type of situation is not uncommon when there is a threat of self-destructive acting-out on the part of the patient (possibility of suicide, self-inflicted accidents, psychotic crisis of unforeseeable consequences, etc.). (1966/1981, p. 387)

Insight is the process whereby these alienated aspects of the field are recognized and reintegrated. The Barangers repeatedly emphasize this is a two person process. Recognition and reintegration can only occur "if both feel the urge to do it" (1966/1981, p. 389).

Insight occurs as a symbiotic situation which is one no longer. Insight is the moment in which the joint efforts of analyst and patient are able to make conscious and to formulate the symbiotic situation as such. (1966/1981, p. 389)

Thus, insight involves re-individuation by the participants and leads to a felt change in the quality of communication. Rather than being unconsciously joined by symbiotic complementarity, therapist and patient share a common experience. In the phase of stumbling against a bastion, the observing egos of therapist and patient cannot coincide, because each is in a watchful defensive posture against the other. In the moment of insight, the observing egos differentiate intrapsychically and meet interpersonally. Therapist and patient share the analytic work. Fantasies about the nature of the illness and its cure coincide. These moments, when the two share the same comprehension of the state of

the field and the work to be done, move the treatment forward. The resultant freer communication between analyst and patient coincides with a wider internal communication within themselves. These moments of insight are the authentic gratifications which the therapist can derive from analytic work. After this moment, the fantasies begin to diverge again, as new bits of history and conflict become aspects of the field eventually forming new stumbling blocks to communication and requiring new instances of insight to resolve them.

Countertransference

The preceding view of the therapeutic interaction, as depending upon the mutual understanding of fantasies occurring in a two person field, implies a wider interpretation of what countertransference is and the role it plays in the therapy process. From the Kleinian perspective, countertransference is not simply the therapist's resistance to the patient material or what this material stirs in the therapist. It is a necessary phase of involvement by the therapist with the patient's issues and conflicts. In a sense, the therapist participates in the patient's pathology in order to permit the patient to share in the therapist's insight. More exactly, we should speak of their pathology and their insight, since both are products of the bipersonal field.

Paula Heimann's article "On Counter-transference" (1950/1981) is representative of the Kleinian efforts to recognize constructive aspects of countertransference and widen the scope of the term. She criticizes the view that the analyst is to avoid any but the most benevolent emotional responses to the patient and maintain an unfeeling detachment.

Instead, she argues that the analyst's countertransference offers an "instrument of research into the patient's unconscious."

The aim of the analyst's own analysis . . . is not to turn him into a mechanical brain which can produce interpretations on the basis of purely intellectual procedure, but to enable him to sustain the feelings which are stirred in him, as opposed to discharging them (as does the patient), in order to subordinate them to the analytic task in which he functions as the patient's mirror reflection. (1950/1981, p. 140)

Thus, the therapist needs a "freely roused emotional sensibility" for following the patient's unconscious processes. "Our basic assumption is that the analyst's unconscious understands that of his patient" (1950/1981, p. 141). Heimann goes so far as to contend that the analyst's counter-transference is "the patient's creation" and "part of the patient's personality." Though she does not dismiss the analyst having his own shortcomings, she clearly emphasizes that the already analyzed therapist should be able to distinguish what belongs to himself and not attribute this to the patient.

The title of Roger Money-Kyrle's article "Normal Counter-transfer-ence and Some of its Deviations" (1955/1981) implies the wider interpretation of countertransference which the Kleinians tend to endorse. He believes that a large measure of normal countertransference is based on responding to the patient as if he or she were the therapist's child.

Now, to a parent, a child stands, at least in part, for an early aspect of the self. And this seems to me important. For it is just because the analyst can recognize his early self, which already has been analyzed, in the patient, that he can analyze the patient. His empathy and insight, as distinct from his theoretical knowledge, depend upon this kind of partial identification. (1955/1981, p. 360)

Money-Kyrle believes that when the therapy process is going well there is a rapid oscillation of introjective and projective identification

processes going on within the analyst, which allows him or her to follow and understand the patient's material.

As the patient speaks, the analyst will, as it were, become introjectively identified with him, and having understood him inside, will reproject him and interpret. But what I think the analyst is most aware of is the projective phase--that is to say, the phase in which the patient is the representative of a former immature or ill part of himself, including damaged objects, which he can now understand and therefore treat by interpretation, in the external world. (1955/1981, p. 361)

Under these circumstances, the therapist's normal countertransference response is confined to a feeling of empathy for the patient.

This normal situation is the ideal one, and there will be many periods in which the therapist does not understand the patient. These periods probably result from the patient corresponding too closely to aspects of the therapist's self that are not well understood. When this occurs, the therapist is likely to become stuck in one of the two phases of introjection or projection mentioned previously. What is critical here is how the therapist copes with feelings of guilt that arise from not understanding the patient. Those who tend to accept the guilt are likely to become stuck in an identification with an introjected patient, while those who project the blame are likely to feel stuck with an incomprehensible patient in the external world.

The therapist's experience of being stuck in the introjective phase may be characterized by excessive worry about a session that has not gone well. The therapist may feel that he has "regained some of his own old troubles and become burdened with his patient's as well" (p. 362). Money-Kyrle goes on to state that if the therapist cannot tolerate "the sense of being burdened with the patient as an irreparable or

persecuting figure inside him" he is likely to defend himself by re-projecting the patient, effectively shutting the patient out and preventing the possibility of further understanding. In the process of re-projecting the patient, the therapist may also project or lose a sense of contact with aspects of himself, leading to feelings such as depletion, listlessness, or loss of intellectual potency.

This effort to coordinate the various kinds of countertransference experiences with the kinds of interactions that go on between therapist and patient characterizes many of the clinical papers by Kleinians. Heinrich Racker's article "The Meaning and Uses of Counter-transference" (1972/1981) offers a good example of this effort to understand the therapist's experience in terms of the patient's unconscious processes.

Racker notes that the therapist's intention to understand the patient "creates a certain predisposition, a predisposition to identify oneself with the analysand, which is the basis of comprehension" (1972/1981, p. 181). These identifications can be thought of as resulting in a matching up of each part of the patient's personality with the corresponding aspect in the therapist. Racker calls these identifications "concordant (or homologous) identifications," and they are the basis of what we generally refer to as empathy. In addition to these concordant identifications, there are also identifications by the therapist's ego with the patient's internal objects. Racker calls these later identifications, complementary identifications. They result from the patient treating the therapist as if he or she were one of the patient's internal objects and the therapist, as a consequence, coming to identify with this object. Thus, while the concordant

identifications are essentially processes of empathy and attunement between patient and therapist, the complementary identifications usually represent what has been talked about as countertransference in the narrower definition of the word. In the complementary identification, the therapist "repeats" previous experiences, the patient representing internal objects of the analyst" (1972/1981, p. 182). Racker notes that complementary identifications are often the result of failures or rejections on the therapist's part of concordant identifications. One source of these failures in empathy can be conflicts between parts of the therapist's own personality. In other words, if the therapist rejects aspects of himself, he will most likely reject this in the patient as well. As a result, the therapist is more likely to find himself aligned with the patient's rejecting internal objects instead of with the patient as a whole.

In contrast to the classical analytic view of countertransference, which primarily sees countertransference as an impediment to the therapy process, Racker observes:

Every transference situation provokes a countertransference situation, which arises out of the analyst's identification of himself with the analysand's (internal) objects (this is the 'complementary countertransference'). These countertransference situations may be repressed or emotionally blocked but probably they cannot be avoided; certainly they should not be avoided if full understanding is to be achieved. (1972/1981, p. 183)

Racker goes on to discuss a variety of reactions and experiences that the therapist may go through in response to the patient's unconscious transference. Space does not allow a full review of all these reactions, but they include depressive anxiety (related to fears that the

patient is being destroyed or made ill), paranoid anxiety (related to the patient's aggressive attitudes) well as feelings of guilt, aggression, and boredom.

To summarize the Kleinian view of countertransference, it tends to encompass both the more "normal" empathic identifications with the patient as a whole person and the more problematic, "countertransference" identifications with the patient's internal objects. To use Racker's terms, Kleinian analysts give equal weight to both the concordant identifications and the complementary identifications. As we have seen, concordant identifications tend to annul the relationship between the patient and therapist because they are based on a kind of union. Complementary identifications, on the other hand, are actual, albeit transferential, object relationships, since they involve some kind of differentiation between self and other.

Kohut's Self Psychology

Theoretical Shifts

In Kohut's (1971) first book on the treatment of narcissistic personality and behavior disorders, he separated the vicissitudes of narcissism from the development of libidinal object relations. In effect, he avoided challenging the orthodox Freudian outline of the stages of sexual development, suggesting an addendum, which could complement the current model. This was his original "dual track" theory: the development of psychosexual object relations on one track and the simultaneous development of narcissistic selfobject relations on another track. Though couched in the Freudian language of drives, a shift towards an

experiential view was taking place, since Kohut discussed drives in reference to experiences of tension states and efforts to relieve these states.

Kohut (1977 and 1984) later became more openly revolutionary in his ideas. He saw the development and unfolding of the self as superordinate to the sexual drives and aggression. Affection and assertiveness became the normal qualities of a healthy child, if he or she was supported by a milieu of empathically attuned selfobjects. This reversed the Freudian view of affection and assertiveness as sublimation products of the more primary sexual and aggressive instincts. For Kohut, drives are the disintegration products of a traumatized and weakened self, which appear as the self tries to re-organize and defend itself in the face of overstimulation and hostile competition from the parents.

Crucial to understanding Kohut's theory is his concept of the selfobject. In his early writings (1971), the selfobject was discussed largely in terms of the archaic self investing narcissistic libido in an archaic and undifferentiated object to merge with it and share in its strength and power. Later in life, the archaic selfobject is defensively clung to by the narcissistically injured self in an effort to regain a sense of wholeness and well-being. The manner in which the self clings to its selfobjects is clinically manifest in narcissistic transference. Relations with selfobjects, however, are not solely the regressive products of narcissistic psychopathology since relations with healthy selfobjects are crucial to early development and continue throughout adult life. The adult becomes capable of mature selfobject relations when he or she relinquishes his or her regressive fantasy of

obtaining gratification by merger with an archaic selfobject and, instead, seeks out persons or aspects of the cultural milieu which can provide nurturance in a more realistic manner. Kohut describes this later experience as being "an experience in depth."

When the adult experiences the self-sustaining effects of a maturely chosen selfobject, the selfobject experiences of all the preceding stages of his life reverberate unconsciously. When we feel uplifted by our admiration for a great cultural ideal, for example, the old uplifting experience of being picked up by our strong and admired mother and having been allowed to merge with her greatness, calmness, and security may be said to form the unconscious undertones of the joy we are experiencing as adults. (1984, p. 49-51)

Paradigmatic Data

Kohut defines the field of psychoanalytic psychological inquiry as that which is available to vicarious introspection or empathy. Although the data that he takes as subject matter are not necessarily new, Kohut believes that his theoretical additions allow the analyst to empathically understand features of the patient's personality which were previously misunderstood. In other words, it is not that mirroring, idealizing, or twinship transference configurations were not present during previous analyses; they were not noticed as such. Since these configurations were not understood, patients who presented narcissistic disturbances were often considered ill-suited for analysis. Consequently, Kohut sees a close tie between the clinical range of empathy and theoretical understanding. The one advances with the other.

Therapeutic Process

Empathy is more than just an instrument of observation; it is the factor that moves the psychoanalytic process along. "The gradual

acquisition of empathic contact with mature selfobjects is the essence of the psychoanalytic cure" (1984, p. 66). The first step in this process is the spontaneous mobilization of the self's defects in the transference.

Given the actuating matrix of the psychoanalytic situation, the defective self of the patient with a narcissistic personality disturbance will mobilize its striving to complete its development, that is, that it will try again to establish an uninterrupted tension arc from basic ambitions, via basic talents and skills, toward basic ideals. This tension arc is the dynamic essence of the complete, nondefective self (1984, p. 4)

This mobilization of the transference will be met with by patient resistances and will need to be analyzed, just as in any other analysis. There is a change of emphasis; the transference is not merely a resistance or an effort to repeat instead of remembering. The transference represents the patient's effort to resume his or her development and acquire a fully functioning self. Consequently, the therapist's analysis of the transference does not seek to make the unconscious conscious; the therapist also offers the patient a more mature selfobject relation which eventually replaces the archaic one manifest in the transference.

The key to successful analysis (or the successful development of the self during childhood) is the accruing of psychological structure through the experience of non-traumatic, or optimally frustrating, disappointments and disillusionments. Under the impact of these frustrations, the patient (or child) changes and creatively acquires the capacity to perform for themselves the functions previously met by the archaic selfobject. They learn to search out and make use of the more mature sources of narcissistic nurturance in the milieu. The first

aspect of the curative process is the therapist empathically grasping the patient's inner state. This aspect can be curative in itself since the therapist's acquiring and somehow communicating an empathic understanding remains optimally frustrating. In the analytic setting, the therapist does not act in accordance with the need, despite understanding and acknowledging its legitimacy. The therapist's communications accord with the patient's needs; they do not gratify them. Instead, "an empathic bond is established (re-established) between analyst and patient that substitutes for the de facto fulfillment of the patient's need" (1984, p. 103).

The second aspect of the therapist's therapeutic functioning is the providing of dynamic-genetic explanations. These essentially help to consolidate the change-inducing impact of the first phase. These explanations provide the patient with a more reliable sense of how well he or she has been understood by the therapist. They also provide the patient with an understanding of themselves, which can have a less ephemeral quality to them than just the experience of being understood itself.

To repeat and summarize, then, a successful analysis is one in which the analysand's formerly archaic needs for the responses of archaic selfobjects are superseded by the experience of the availability of empathic resonance, the major constituent of the sense of security in adult life A treatment will be successful because, allowing himself to be carried by the momentum of the analytic process, an analysand was able to reactivate, in a selfobject transference, the needs of a self that had been thwarted in childhood. In the analytic situation, these reactivated needs were kept alive and exposed, time and again, to the vicissitudes of optimal frustrations until the patient ultimately acquired the reliable ability to sustain his self with the aid of the selfobject resources available in his adult surroundings. (1984, p. 77)

Countertransference

While Kohut acknowledges the potential of emotional biases for interfering with the therapist capacity for empathically observing the patient, he regards the effort to maintain complete neutrality on the therapist's part as misunderstanding the nature of the analytic situation. This ideal of scientific objectivity, while still laudable, is an incomplete view of the patient-therapist field.

The cognitive framework sees the analyst only as the observer and the analysand only as the field that the observer-analyst surveys We need an orientation that acknowledges and then examines the analyst's influence in principle as an intrinsically significant human presence. (1984, p. 37)

If we are in a situation in which a human being listens to us in order to understand us and explain us to ourselves, and we know that such listening and explaining will go on for a long time, at first seemingly unlimited time, we are not in a situation that can properly be defined as neutral. On the contrary, it is a situation that, in its psychological impact on us, is the very opposite of neutral--indeed it is a situation that may be said to provide us with the most crucial emotional experience for human psychological survival and growth: the attention of a selfobject milieu, that is, a human surrounding that, via empathy, attempts to understand and participate in our psychological life. (1984, p. 37)

This understanding of the analytic situation should have some consequences on how therapists behave with their patients. Self psychologists should be more relaxed in their work, more easy-going, and less reserved in their emotional availability to patients. In a similar vein, empathic failures are accepted as inevitable and potentially useful. Initially, these breaks in the emotional resonance between therapist and patient will lead to the patient's retreat to the comfort of archaic selfobject relations. However, the therapist may constructively respond by: noting the retreat, searching for the empathic

mistake, non-defensively acknowledging the mistake if there was one, interpreting the meaning of the patient's retreat, and thereby re-opening the channel of empathy, and so on. In sum, while countertransference, in the narrow definition of the word, is to be minimized through self-scrutiny to increase the therapist's ability to understand the patient, this does not mean that the therapist's emotional availability is to be constricted. Kohut's emphasis on empathy, as the therapist's primary means of observing and responding to the patient, decreases concern about maintaining a neutral field of observation, as seen in the classical attitude towards the analytic process. As we will see, self psychology's emphasis on the importance of the therapist's emotional availability to the patient finds a contemporary counterpart in the developments of the British object relations school to which we turn next.

British Object Relations View

Theoretical Shifts

The British object relations school of psychoanalytic theory is not a unified theory; rather, it represents a convergence of some important ideas among a number of psychoanalytic writers, each of whom retains a particular theoretical view. Fairbairn and Winnicott are often identified as the earliest proponents of this departure from classical theory, and Guntrip and Khan have done much to expand upon their work, while also making their own original contributions.

Fairbairn is perhaps the best theorist to begin with, since he makes such a sharp break with fundamental aspects of Freud's theory,

especially in terms of the theory of instincts. Fairbairn sees the individual as needing and seeking others (or objects) to relate to rather than simply seeking pleasure through the discharge of instinctual tensions. The need for a love-relationship is fundamental and pure pleasure-seeking is the result of a deterioration in this natural object-relatedness.

Libido is primarily object seeking (rather than pleasure-seeking, as in the classic theory), and . . . it is to disturbances in the object-relationships of the developing ego that we must look for the ultimate origin of all psychological conditions. (Fairbairn, 1952, p. 82)

A corollary to the individual's need for relations with others is that impulses cannot be considered apart from their relation both to ego and object. There is no primary state in which the drives exist independent of the ego, as is suggested in the classical theory, in which the ego forms secondarily on the surface of the id. Only ego structures seek relations with objects, so impulses are forms of ego structure activity.

Impulses are but the dynamic aspect of endopsychic structures and cannot be said to exist in the absence of such structures, however immature these may turn out to be. (Fairbairn, 1952, p. 88)

Inherent in this shift away from the biologically given instincts is a greater interest in the role of reality. To some extent, Freud shifted away from reality when he realized that his patients' childhood traumas of seduction were primarily fantasies. Fairbairn reconsiders the role of real objects in a person's life. The internalization of objects and the development of the internal object world, as found in Klein's descriptions, is secondary to the experience of unsatisfactory

relations with real objects. In fact, Fairbairn claims only the bad objects

. . . are internalized in the first instance, since it is difficult to find any adequate motive for the internalization of objects which are satisfying and 'good'. (Fairbairn, 1952, p. 93 fn.)

Internalization of objects is essentially a measure of coercion and it is not the satisfying object, but the unsatisfying object that the infant seeks to coerce. (Fairbairn, 1952, p. 111)

Thus, psychopathology is the study of the ego in relation to internal, fantasy objects, while health focuses on the ego's relation to external, real objects.

Of course, psychopathology and health are relative ideas, since frustrations are inevitable, and as a consequence, everyone develops an internal world where frustrations are worked on. Fairbairn contends that the primary result of this internalization process is the splitting of the object into three aspects: a gratifying aspect, which becomes the ideal object, an enticing aspect, which becomes the exciting object, and a depriving aspect, which becomes the rejecting object. The ego splits along similiar lines, as the personality remains tied to these aspects of object relationship. A needy, weak infantile aspect of the self remains tied to the exciting object, which Fairbairn calls the libidinal ego. A rejecting aspect of the self, disavowing needs, remains identified with the rejecting object, namely, the antilibidinal ego. Finally, a portion of the self remains in contact with the external world, though this world is colored by the projection of the gratifying, ideal object into it, which Fairbairn identifies as the central ego.

As Guntrip emphasizes, these internal objects are not mere fantasies.

The child is emotionally identified with his objects, and when he mentally incorporates them he remains identified with them and they become part and parcel of the very psychic structure of his personality. The fantasies in which internal objects reveal their existence to consciousness are activities of the morbid psychic structures which constitute the internal objects. (Guntrip, 1969, p. 22-23)

Thus, psychopathology begins with the simple urgency of the helpless child's needs.

If they are not quickly met, panic and rage develop. The infant's 'need relationship' to the mother then becomes frightening because it has become dangerously intense and even destructive. (Guntrip, 1969, p. 31)

In the face of unsatisfactory object relationships, Guntrip sees the person caught between two threats of losing the self: on the one hand, external objects may impinge upon and overwhelm the self, or on the other hand, the self may find itself in an unsupportive vacuum. The person can experience his or her self as unsupported for several reasons. The object may simply abandon the self for too long; the self's intense needs may seem to have destroyed the object; or the self may withdraw too completely from unhappy relationships. The internal world is a compromise position. It gives the self a place to live in withdrawal from the frustrations of external reality, while continuing contact with objects internally, thereby, arresting the threat of complete withdrawal from object contact and the consequent loss of the self in profound regression.

Guntrip and Winnicott emphasize withdrawal and the related "unthinkable anxiety" of loss of self in an unsupportive environment more

than Fairbairn does. Winnicott, especially, has tried to formulate how the infant and mother interact in order to help the child avoid experiencing a threat of annihilation. The mother's devotion to her child allows her to feel her way into and meet the infant's needs during the period of the infant's absolute dependence upon her care. Experiences of the environment providing the object that the infant has conjured out of its need make it possible for the mother and infant to share a moment of illusion. Through these resulting experiences of omnipotence, the child develops a sense of confidence and security, while, at the same time, his or her internal world is being enriched by the mother's measured presentations of reality. With time, rather than simply conjuring it, the emphasis shifts to the infant finding the object. This process of "finding" still maintains the continuity between inner and outer world. These experiences later determine a person's capacity to play, use symbols, and participate in the shared community of culture. They provide the backdrop of ego relatedness, which makes possible quiet, nonthreatening experiences of being alone.

Building upon Winnicott's ideas about the mother-infant relationship, Guntrip has the following to say about the establishment of a sense of ego-relatedness.

[The well-mothered infant] . . . develops a growing sense of his own ego-wholeness and ego-identity, as a part of his overall experience of being in a reliable, secure, supportive relation to his mother. (Guntrip, 1969, p. 221)

This sense allows the infant to tolerate longer periods of the mother's absence without anxiety.

He has grown to be an intrinsically ego-related child. His feeling about his envioning world is positive and trustful,

and when he is alone he does not feel isolated or mentally out of touch. (Guntrip, 1969, p. 221)

This establishes a natural symbiotic quality to person's experience of self and world.

He feels a profound sense of belonging and of being at one with his world which is not intellectually 'thought out', but is the persisting atmosphere of security in which he exists within himself. (Guntrip, 1969, p. 221)

We begin as literally a part of another person, of 'nature', and only if that basic sense of unity and the security it gives persists as a permanent unconscious foundation, can we sustain separateness and individuality without anxiety. (Guntrip, 1969, p. 267)

Paradigmatic Data

In many respects, the clinical data upon which object relations theory is founded is not new or different from that which psychoanalysis had dealt with before. Fairbairn, in fact, makes a point of taking the familiar data of hysteria and dreams, upon which Freud based many of his theoretical ideas, and reformulating them from an object-relational point of view. On the other hand, Winnicott's dual roles of pediatrician and psychoanalyst put him in a special position to take Klein's concepts about the fantasy world of the infant and integrate them with an appreciation for the role of the mother. ("There is no such thing as an infant . . . whenever one finds an infant one finds maternal care, and without maternal care there would be no infant.")

Perhaps the most striking feature of the object relational writers, of Guntrip and Winnicott in particular, is the personal, self-exploratory quality. Guntrip's (1975) article on his analyses with Fairbairn and Winnicott is a primary example of this, but this quality is

implicitly present in all their writings. As Khan said, in remembering Winnicott:

The practice of Winnicott was anchored in a growing and intricate theory costing him, as he used to say quoting Eliot's verse, "not less than everything," to evolve and elaborate, in personal and clinical experience. (Winnicott, 1958, p. xii)

Therapeutic Process

This emphasis upon the personal comes through in the object-relational view of the therapeutic process. Guntrip has perhaps been most articulate of this in his descriptions of what makes treatment effective.

If the development and maintenance of the ego has become more and more to be seen as the fundamental psychodynamic process, and an ego can only develop in the medium of personal object-relationships, it follows that psychotherapy at any level, but particularly at the deepest level, can only occur as a result of a personal therapeutic relationship. (Guntrip, 1969, p. 310)

The patient has personal needs towards the therapist which are not exhausted by the transfer of infantile eroticism, since he needs his therapist to help him as a real person. When transference analysis succeeds, the patient's realistic emotional needs towards the analyst emerge, and they are none the less realistic for emerging at first in immature forms, belonging to that level of his unconscious childhood life which the analysis has reached and opened up. Psychotherapy depends ultimately on their satisfaction. The patient's infantile ego can only grow in a genuine object-relationship. If the therapist persists in being, in reality, a merely objective scientific intelligence with no personal feeling for the patient, he will repeat on the patient the original emotional trauma suffered at the hands of the parents, which laid the foundations of the illness. (Guntrip, 1969, p. 335)

Guntrip essentially views the therapy process as one of discovering what the patient's needs are, helping the patient to understand these needs, and meeting these needs, so the patient can continue to move

forward. There are roughly three stages to this process of providing for the patient's needs.

First, he needs a parent-figure as a protector against gross anxiety. . . . The second stage involves the analysis of all the ways in which this is interfered with by the legacy of old inadequate relationships with the actual parents and in the family group. This is the transference proper [Third,] . . . the patient begins, at first dimly, to feel that what he really needs is the basically non-erotic love of a stable parent [which allows a sense of relatedness and separateness to develop] The three aspects or stages may be summarized as rapport, transference, and regrowing or maturing. (Guntrip, 1969, p. 336)

Opposing this therapeutic effort to bring forward and meet the patient's needs is the clinical phenomena of resistance. The same forces, which prevented the person from emotionally growing and maturing outside of treatment, are now at work resisting the psychotherapy. As we have noted, when faced with unsatisfactory object relationships, the self becomes divided against itself, and one part of the self, the antilibidinal ego, functions to suppress the expression of unmet needs. It is as if the child, in the face of the frustration of his needs, decided that the environment could not be changed or depended upon, so he went about trying to alter himself, instead, by doing away with needs, weaknesses, and fears.

There are couple of reasons why the patient resists giving up this antilibidinal stance and accepting outside help into his internal world. For one, the antilibidinal ego is the patient's possession of his parents within, so giving up the antilibidinal ego would feel to the patient like he or she was losing his or her parents. Second, the antilibidinal ego is an identification by the person with the bad object, and as such, the self has that much less self of its own. Therefore, if the

patient was to give up the antilibidinal ego, not only would he feel a loss of his parents, but he would also feel a loss of his current personality, leaving only the infantile self in its place.

This understanding of the patient's pathology in terms of real traumas and needs places special demands upon the therapist.

The psychotherapist must be primarily a human being who has faced and sufficiently understood himself to be worthy to be admitted into the patient's private pain and sorrow. He will understand the patient's inner life, not because he has a theory (though if it is a good one, it helps) but because he can feel with and for the patient; and he knows not just theoretically but in his own experience, what the patient is passing through. Sharing in the same humanity with the patient, he is able to identify with him in order to know him. Only that enables the patient no longer to feel alone.

Transference analysis is the slow and painful experience of clearing the ground of left-overs from past experience, both in transference and countertransferences, so therapist and patient can at last meet 'mentally face to face' and know that they know each other as two human beings.

Only when the therapist finds the person behind the patient's defences, and perhaps the patient finds the person behind the therapist's defences, does true psychotherapy happen. (Guntrip, 1969, p. 352-353)

Winnicott described psychotherapy as two people playing. To understand this, we need to return to his discussion of how the infant develops a relation to the external world while maintaining a vital sense of connectedness with the inner world. Perhaps reflecting his influence by Klein (and in contrast to Fairbairn), Winnicott sees the infant as starting out with an essentially self-created environment. In other words, the experience of need is associated with a sense or fantasy of what is needed. The devoted mother's job to intuit this need and present just that bit of reality that is being hallucinated by the infant. The result is the shared experience of illusion discussed

earlier. The mother goes on providing this simplified experience of reality, and the infant uses this experience to enrich the internal fantasy. As the internal world is enriched and differentiated, the infant becomes increasingly capable of tolerating and dealing with a less than perfect fit between need and reality. As long as adaptation is close enough, even frustrations can be brought into the realm of the infant's omnipotence. In other words, even a traumatic situation, if it is not too overwhelming, if it does not go on for too long, and if it does not lead to annihilation anxiety, can be experienced as a projection from the internal world.

An important aspect of this balancing of inner and outer reality is the development of

. . . an intermediate area of experiencing, to which inner reality and external life both contribute. It is an area which is not challenged, because no claim is made on its behalf except that it shall exist as a resting-place for the individual engaged in the perpetual human task of keeping inner and outer reality separate, yet inter-related.

This intermediate area is in direct continuity with the play area of the small child who is 'lost' in play. (Winnicott, 1951/1958, p. 230 & 240-241)

Thus, psychotherapy, is "the overlap of two areas of playing, that of the patient and that of the therapist" which occurs in this intermediate region delicately balancing the internal world of omnipotent fantasies with "the experience of control of actual objects."

Interpretations will be useful only if they are made within the area of play or, in other words, if the interpretation can be taken into the patient's area of omnipotence and experienced as a projection. In play, this question of inside versus outside is not challenged. The

patient simply finds what he has, in a sense, already given to the therapist. Interpretations from outside the area of play are either experienced as direct impingements or seductions, both of which threaten to alter the core of the self. Therefore, the patient will reject any interpretation that he or she has not already created -- except perhaps when the patient is in a state of deep regression and is depending upon the therapist to intuit his or her needs. The danger in making interpretations that go beyond what the patient has placed into the therapy is that the patient's self will be found by the other before it has experienced itself as being there to be found. It is within this context of the patient's need to maintain the core of the self in silent personal communication with itself, but never in communication with the outside world, that Winnicott frequently states that one of the reasons why he interprets is to establish for the patient the limits of his (Winnicott's) understanding.

Countertransference

Countertransference, like transference, is that which hinders the therapist and patient from meeting fully as two human beings. Generally, the greater danger seems to be that the therapist will be too afraid of his or her emotional responsiveness and, defensively, become too neutral. The therapist needs to be open to a wide range of experiences in interacting with the patient. "The psychotherapist (analyst or analytical psychologist) must remain vulnerable, and yet retain his professional role in his actual working hours" (Winnicott, 1960/1965, p. 160). In other words, the therapist needs to have enough ego

strength to remain professionally involved with the patient without too much strain. Countertransferences are "neurotic features which spoil the professional attitude and disturb the course of the analytic process as determined by the patient" (Winnicott, 1960/1965, p. 162). Thus, the role of the analyst's training analysis is not so much to learn a technique, but to "increase the stability of character and the maturity of the personality of the worker, this being the basis of his or her professional work and our ability to maintain a professional relationship" (Winnicott, 1960/1965, p. 160).

This chapter reviewed major aspects of psychoanalytic literature to glean a sense of how the therapist's experience is integrated into psychotherapy. Langs, Reik, and Searles set the tone for this review by exemplifying some fundamental divergences about how therapy cures. Classical, Kleinian, self psychological, and object relational views were examined, and particular attention was paid to empathy, countertransference, and the process of cure because these topics seemed most pertinent to understanding the therapist's personal experience. Beyond the specific content of what each of these theorists had to say, an impression emerged of how difficult it is to describe and understand the therapy experience. Coming to terms with the therapy dialogue held these divergent thinkers together; the experience of helping others through words was the experiential ground which they shared.

The present study now turns to this same experiential ground, as it faces the task of articulating therapists' experiences of striking events in psychotherapy. The next chapter, on methods, presents how the present study approached this topic. The procedures used were informed

by what therapists do as they apply themselves to understanding patients, on a day to day basis, through dialogue. In this study, the often intuitive and automatic processes of understanding, which therapists rely upon, are made more self-aware by placing them within the context of existential psychology and phenomenological methods.

CHAPTER III

METHODS

We say that we 'conduct' a conversation, but the more fundamental a conversation is, the less its conduct lies within the will of either partner. Thus a fundamental conversation is never one that we want to conduct. Rather, it is generally more correct to say that we fall into conversation, or even that we become involved in it. The way in which one word follows another, with the conversation taking its own turnings and reaching its own conclusion, may well be conducted in some way, but the people conversing are far less the leaders of it than the led. No one knows what will 'come out' in a conversation. Understanding or its failure is like a process which happens to us. Thus we can say that something was a good conversation or that it was a poor one. All this shows that a conversation has a spirit of its own, and that the language used in it bears its own truth within it, i.e. that it reveals something which henceforth exists. (Gadamer, 1960/1975, p. 345)

Introduction: Subject Matter Determines What Methods are Used

The methodology used in this study is committed to allowing the subject matter to determine the researcher's approach. Like the ethologist or the cultural anthropologist, the psychological researcher needs to meet the subject under study on its own grounds. Therefore, the researcher in human psychology cannot allow pre-existing methods to foreclose the range of phenomena available for study. In particular, the methods borrowed from the natural sciences may not be able to do justice to the phenomena that attract our psychological interest. As Giorgi points out, there is an essential obscurity or opacity to that which attracts our psychological interest (Giorgi, 1984). A straightforward application of natural science methodology tends to pass over this essential indeterminateness.

In regard to the topic of this study, the experiences of psychotherapists practicing psychotherapy, what preliminary features must be described, which need to be recognized in choosing an appropriate method of investigation? First, these experiences occur in the interpersonal context of a special kind of dialogue between two persons. This dialogue is framed by the intention of helping one of the participants, the patient, to understand him or herself better, in the sense of improving communications both within the self and with others. We primarily are interested in the therapist's experience of these events, and while we all know something about experience--insofar as we are always experiencing something--there is also something ever-elusive about our experiences. In their pre-reflective immediacy, they seem to overflow our efforts to pin them down conceptually. There is something ultimately personal and even private about our experiences, although this does not mean that they cannot be communicated. Most of the experiences that the therapists described in this study occurred spontaneously; they just happened and challenged the therapist to find something to do with them.

Given the nature of the events to be studied, which appear to be spontaneous experiences, occurring within the context of a therapeutic dialogue, an interview (or another dialogue) seemed to be the most appropriate means for approaching them. An interview approach has the major advantage of paralleling the original context in which the phenomena to be studied occur. An interview always allows things to take shape spontaneously and of their own accord with a minimum of constraint by pre-existing ideas. The unexpected is welcome, here, as it is in therapy. As noted, patients come to therapists seeking to make their

experience of life understood by someone else. Through their dialogue with the therapist, they seek to improve their ability to understand themselves and to communicate with others and the world at large.

The experiences which the therapists in this study describe occur within a context of achieving a shared understanding of the patient's experience. In an analogous manner, I am asking these therapists to help me reach a shared understanding of their experiences. I have asked these therapists to participate in a mutual project, which seeks to understand experiences that they had while practicing therapy. In parallel to the therapy situation, participants and researcher work together to bring what otherwise might have remained a private experience into a communicative field of mutual understanding.

A Brief Review of the Role of Interviewing and Phenomenology in the History of Psychology

The interview has played a significant role in the history of psychology. For example, psychology, as an experimental science, usually traces its beginnings the work of Wilhelm Wundt, whose psychological method included the introspective subject's report of experience (Hearst, 1979). While the structuralists were interested in analyzing this experience into its component sensations, which runs counter to phenomenology's purposes, the effort to study experience by way of asking someone about it sets an important precedent for this study's methodology.

Freud's psychoanalytic method also needs to be recognized for its original status as a research method. In fact, M. Khan (1970/1974)

asserts that the popularization of psychoanalysis as therapy, among laymen and clinicians alike, is a more recent view. Originally, psychoanalysis provided Freud with a method for observing psychic phenomena and testing out hypotheses about the functioning of psychic forces. Memories of past experiences, wishes, and current attitudes could be elicited and understood in terms of their place in the person's present difficulties. The emphasis upon insight as the curative factor in psychoanalysis probably needs to be placed back into this context of research to be properly appreciated. As a psychological researcher insight and conscious understanding were Freud's original purposes and the patient was given the opportunity to share in these endeavors with him.

Piaget's well known "clinical interview" allowed him to study cognitive development. Although Piaget was not interested in experiences, per se, his method involved, for example, asking children about their experience of a demonstration and inferring from their experience the underlying intellectual structure. Although Piaget's assumption about cognitive structures underlying experience differs from phenomenology's starting point, an important insight of his was how fruitful it was to give an individual the freedom to respond spontaneously to a situation and, then, follow that lead.

Even this cursory review makes clear that interviewing has played a crucial role in the history of psychology. Yet, many modern psychologists maintain a distrustful stance towards this potential source of information. It may be allowable for preliminary results but is not adequate for the building of a "scientific psychology". Science requires "trustworthy methods" (O.E.D.), and the experimental methods of

the natural sciences are looked to for models. Unfortunately, psychology risks losing sight of what is unique to its field if it leans too much toward becoming a non-human science of behavior.

Histories of science written by the practitioners of that science are often biased by the prevailing ideology (Khun, 1970). Thus textbooks on the history of systems and theories in psychology tend to reveal their grounding in the current climate of ideas by the manner in which, retrospectively, it seems inevitable that psychologists should think and work as they do, today. An image often used to present the history of ideas is that of a tree, growing up from its roots to the main trunk and then spreading into various branches. Many psychologists would like to view their field as branching off from the main trunk of the natural sciences, along with the other branches of the natural sciences, such as chemistry, biology, and physics, and, thereby, as being firmly rooted in scientific methods. Most textbooks on the history of psychology give one the impression that such is more or less the case. They tend to overlook the complexity of competing ideas about science, experience, and behavior that went on in the late 1800's, especially in Germany, when psychology is reputed to have been born (Hearst, 1979).

Many histories of psychology move quickly to draw some sort of demarcation between psychology and the philosophical roots out of which it evolved, obscuring the complex interconnections between these two domains of knowledge and the mutual impact they had on each other. Wundt's laboratory provides the usual point of departure, because from here psychology is distinguished by its adoption of scientific methods,

regardless of the experimenter's philosophical biases. This is something of an oversimplification of the matter, perhaps motivated by a need to provide psychology with an identity as an independent scientific discipline.

This study cannot provide the historical review necessary to investigate the preceding claims, but it may be helpful to at least mention a few of Wundt's contemporaries. The influence of these individuals is especially important to this study. Foremost among them are Brentano, Stumpf, and Husserl, whose names are associated with the beginnings of the philosophical movement of phenomenology. In fact, phenomenology has had its influence upon the development of psychology, though it rarely has been recognized. Stumpf, in particular, had a great impact upon the thinking of the gestalt psychologists and he carried on a long-standing correspondence with James, who in turn expressed admiration for Stumpf's work. These influences were mutual between phenomenologists and early psychologists, as Husserl read James's Principle of Psychology and was quite taken by it. In many ways Stumpf's works would be the best place to introduce the subject of phenomenology in a psychological context, because he had a more direct influence on important contemporary figures in psychology. His phenomenology is considered less radical than Husserl's and closer to the phenomenological methods that have found a place in the human sciences. Unfortunately, very little of his work is available to the English-reader, while many of Husserl's works have been translated into English (Spiegelberg, 1971). Therefore, a review of the phenomenological "method" and its place in psychology begins with Husserl, although his works are much more philosophical in aim and his

influence is more indirect on psychology, occurring largely through the impact of more modern students of his phenomenology, such as Heidegger, Merleau-Ponty, and Sartre.

The Phenomenological Attitude of Husserl

Although Husserl was a philosopher, psychologists may feel on more familiar ground knowing that Husserl's original training was as a mathematician. In fact, it was his concern for the foundations of mathematics that led him to pursue these sources in philosophy. He became a student of Brentano's and at first sought to use the latter's psychology to establish these foundations. From the beginning, Husserl's work involved a dialogue between science, which he sought to ground upon well-founded principles, and psychology, which he viewed as a field concerned with experience and consciousness. Although Husserl eventually abandoned Brentano's psychology for not being rigorous enough, the two central themes of a well-founded science and its relation to conscious experience, remain throughout his work and establish his relevance for psychology.

Husserl's original project, as presented in his Logical Investigations (1900-1901), was to develop a philosophy free from unexamined presuppositions. He sought to found his philosophy on the solid ground of intuitively given certainties, which may be thought of as equivalent to the a priori axioms that mathematics, for example, founds itself upon. As he was later to state in his "principle of all principles": "Intuition is a source of authority for knowledge, that whatever presents itself in 'intuition' in primordial form (as it were in its bodily

reality), is simply to be accepted as it gives itself out to be, though only within the limits in which it then gives itself" (Husserl, 1913/1962, p. 83, emphasis added). Husserl goes on to illustrate this principle by noting how the natural scientist might appeal to the principle of empiricism, stating that all knowledge of facts is grounded upon an experience or observation of these facts; yet this principle itself is not open to empirical insight. "For that is a principle, an assertion drawn immediately from sources of general insight . . ." (Husserl, 1913/1962, p. 84). Here, we see Husserl attempting to establish a foundation for rigorous, scientific thought in the intuitive experience of "essential insight". This aspect of Husserl's work provides a parallel to the present study's concern about how the models of psychotherapy are to be grounded in the immediacy of the therapist's experience.

Husserl's phenomenology has been described as a system in reverse: "rather than building upwards, Husserl digs deeper and deeper, trying to lay ever firmer foundations for established insights" (Spiegelberg, 1971, p. 75). Though the phenomenological motto is often quoted as "to the things themselves", this needs to be understood in the context of Husserl's fundamental project, to return to the beginnings.

Philosophy can take root only in radical reflexion upon the meaning and possibility of its own scheme. Through such reflexion it must in the very first place and through its own activity take possession of the absolute ground of pure pre-conceptual experience, which is its own proper preserve; then, self-active again, it must create original concepts, adequately adjusted to this ground, and so generally utilize for its advance an absolutely transparent method. (Husserl, 1913/1962, p. 20)

Husserl's return to "things", is to that which is given pre-conceptually. It is an effort to establish a starting point or a foundation for further thought. Insofar as phenomenology is successful, it will be of essential use to both philosophy and the sciences. This notion of Husserl as a beginner seems to represent that aspect of his work which remains most essential to the phenomenological movement initiated by Husserl's ideas. Even though many of Husserl's own aims were abandoned or substantially modified by later thinkers, it is this radical attitude that places him at the beginning of the phenomenological movement.

Phenomenological Methods

A psychology informed by the phenomenological attitude is concerned by the tendency of traditional psychology to expect psychological phenomena to fit pre-existing methods. Although traditional, experimental psychology may assume psychological phenomena can be removed from their contexts, studied in isolation, and rendered in terms of causal explanations, phenomenological psychology assumes that person and world are co-aspects of a bi-polar unity. Person and world co-constitute each other, and one cannot be reduced to or made the causal basis of the other. They are essential aspects of the larger whole of human existence. Therefore, no single method can be presented here as the phenomenological method. "Instead, the phenomenologist employs descriptive methods, with emphasis on the plural. Each particular psychological phenomenon, in conjunction with the particular aims and objectives of a particular researcher, evokes a particular descriptive method" (Colaizzi, 1978, p. 53).

Husserl and The Phenomenological Reduction

Spiegelberg (1971) begins his outline of the phenomenological method with the following statement.

Phenomenology begins in silence. Only he who has experienced genuine perplexity and frustration in the face of the phenomena when trying to find the proper description for them knows what phenomenological seeing really means. Rushing into descriptions before having made sure of the thing to be described may even be called one of the main pitfalls of phenomenology. Description is primarily predication. But predication, as phenomenology has brought out increasingly, presupposes pre-predicative experience. And this pre-predicative experience deserves first attention, even if, for the purposes of communication, we cannot very well dispense with descriptions. (p. 672)

It is this ground of pre-predicative, immediate experience that this study is attempting to describe, as it is present in the therapists' experiences. But, how do we go about achieving contact with these "pre-predicative experiences"? Husserl's phenomenological reduction represents one effort to recover the pre-reflective. "The primary function of all reduction is to prepare us for a critical stock-taking of what is indubitably given, before our interpreting beliefs rush in" (Spiegelberg, 1971, p. 134).

This phenomenological attitude towards the world stands in contrast to the natural attitude and its general thesis that the real world exists out there and about me. This fact-world is the realm that the "sciences of the natural standpoint" seek to describe and understand more comprehensively than "the naive lore of experience is able to do". Yet, this natural attitude is not sufficient for grounding all knowledge. For example, there are other "worlds" that become available with different attitudes, such as the "arithmetical world", which is there

for me when I occupy the "arithmetical standpoint". The natural world does not contain the arithmetical world; they exist separately, as "disconnected", except for their relation to the subject or ego. Therefore, one cannot reduce one to other, and one cannot make one the basis for what we know about the other. The point is not to raise one attitude to pre-eminence above the others, but to emphasize the need to take what is presented through a particular attitude upon its own ground.

In his presentation of the phenomenological reduction in his Ideas (1913/1962), Husserl turns to Descartes's attempt to doubt everything and notes that Descartes's doubting must involve a certain suspension of the general thesis concerning the existence of the fact-world about us. Yet this suspension of the thesis does not mean that we turn the thesis into something else, such as its opposite.

We do not abandon the thesis we have adopted, we make no change in our conviction And yet the thesis undergoes a modification--whilst remaining in itself what it is, we set it as it were "out of action," we "disconnect it", "bracket it". . . . The thesis is experienced as lived (Erlebnis), but we make "no use of it". . . . (Husserl, 1913/1962, p. 98)

Husserl, thus, extracts from Descartes's more specific method of doubting everything, the general notion of suspending one's beliefs, putting them out of action, or a certain refraining from judgement (epokhe--suspension). The result is the living conviction that goes on living without one making any further use of it.

Husserl takes this universal epokhe (suspension) and applies it to the general thesis of the natural world. The aim being to create a new scientific domain for study.

We put out of action the general thesis which belongs to the essence of the natural standpoint, we place in brackets

whatever it includes respecting the nature of Being: this entire natural world therefore which is continually "there for us," "present to our hand," and will ever remain there, is a "fact-world" of which we continue to be conscious, even though it pleases us to put it in brackets.

If I do this, as I am fully free to do, I do not then deny this "world," as though I were a sophist, I do not doubt that it is there as though I were a sceptic; but I use the "phenomenological epokhe, which completely bars me from using any judgment that concerns spatio-temporal existence (Dasein). (p. 99-100)

Thus the phenomenological suspension puts into brackets "all the sciences that pertain to this natural world".

I disconnect them all, I make absolutely no use of their standards, I do not appropriate a single one of the propositions that enter into their systems, even though their evidential value is perfect, I take none of them, no one of them serves me for a foundation . . . as a truth concerning the realities of this world. (Husserl, 1913/1962, p. 100)

What results from this endeavor to begin again? What is it that Husserl believes he has discovered through the phenomenological reduction? "For what can remain over when the whole world is bracketed, including ourselves and all our thinking (cogitare)?" (Husserl, 1913/1962, p. 101) Husserl concludes that it is consciousness itself that remains as a "phenomenological residuum" after the reduction has taken place. Pure consciousness or pure experience is taken for the starting point along with the "correlates of consciousness" on one side and the Ego on the other (Husserl, 1913/1962, p. 101). Thus, consciousness, itself, remains unaffected by the epokhe, revealing its essential intentional or correlational structure, i.e., that consciousness is always consciousness of something. We arrive at a new region of being to be studied by the new science phenomenology. By bracketing phenomena, detaching them from their everyday lived acceptance, and

suspending our judgment as to their "reality" or existence, we concentrate on what is present and obtain the advantage of attending to that which might otherwise be dismissed as not "real" enough to be important.

Heidegger and Gadamer: The Hermeneutic Circle

The philosophical hermeneutics of Heidegger and Gadamer can be viewed as both an alternative and an extension of phenomenology's effort to uncover the larger context of experience that is easily passed over by the natural attitude's beliefs and assumptions about the world. Through its exercise of the reduction, phenomenology attempts to describe the appearance of phenomena apart from our beliefs and judgements about them. As we have seen, it seeks to describe the experience that is prior to our judgements and upon which they are based. Yet, phenomenology recognizes that there is no such thing as a complete reduction; new beliefs and assumptions are always becoming apparent and need to be bracketed in turn (Merleau-Ponty, 1962, p. xiv). With this conclusion phenomenology has arrived at the point of departure for the hermeneutics of Heidegger and Gadamer, who emphasize the historicity of our being in the world. While their discussion of philosophical hermeneutics covers a broad range of phenomena, perhaps the easiest way to introduce it is in terms of Gadamer's discussion of experience.

Gadamer argues that we cannot escape from our prejudices; they constitute an important element of our historical being. In other words, we cannot set them aside as would theoretically be possible if we could perform a complete reduction. Instead, Gadamer contends that what is required is an openness to the new, so our preconceptions may come

into question. Science tends to ignore the historical character of experience and emphasize its repetition, as when it abstracts a universal element through experimental procedures. Gadamer, however, is more interested in experience that does not meet our expectations. When we speak of someone who is experienced, we mean that he is able to deal with a wide range of happenings which may confront him. It is against the background of this being experienced that someone has a new experience. These new experiences, i.e., when experiences do not fit our expectations, are curiously productive. Insight emerges as the outcome of this negativity. Reality is recognized through disillusionment, and the limits of human planning and reasoning become apparent through an experience of human finitude.

That experience refers chiefly to painful and disagreeable experiences does not mean that we are being especially pessimistic, but can be seen directly from nature. Only through negative instances do we acquire new experiences Every experience worthy of the name runs counter to our expectations. Thus the historical nature of man contains as an essential element a fundamental negativity that emerges in the relation between experience and insight [Insight] always involves an escape from something that has deceived us and held us captive Thus experience is experience of human finitude. (Gadamer, 1960/1975, p. 319-320)

Incorporating this hermeneutic insight, Ihde (1977) notes that our investigations begin somewhat paradoxically. One needs some idea of what one is setting out to investigate, but one also needs to approach the phenomena without prejudice. This is essentially what is referred to as the hermeneutic circle. Preconceptions always guide our questions in the direction of the anticipated answer, but it is the thing itself that, in turn, brings our preconceptions into question. Our prejudices

are inescapable but they are constantly brought into question as we risk them through dialogue with the world.

Some General Features of Phenomenological Methods
and the Crucial Role of Examples

In Spiegelberg's (1971) outline of the phenomenological method, he starts with "phenomenological description". This step involves being open to the phenomena while, at the same time, not losing the capacity to observe critically. Making these preliminary descriptions provides guideposts and helps one enter into the phenomena. Even at this early stage, the inexhaustibility of the phenomena forces one to be selective and focus on the central characteristics of the phenomena. Therefore, description inevitably shades into the next step of the method: "investigating general essences".

The process of intuiting essences begins with "intuiting of exemplifying particulars". These examples provide us with "instances that stand for the general essence".

Now it is certainly possible to see these particulars without seeing the general essence. But it is not possible to see them as particulars without seeing the general essence which they particularize. Thus what happens is that on the basis of seeing particulars in their structural affinities we also become aware of the ground of their affinities, the pattern or essence. (Spiegelberg, 1971, p. 678)

Casey (1976), in his phenomenological study of imagining, also emphasizes the crucial role of examples in the phenomenological method.

Phenomenological method as conceived by Husserl takes its beginning not from uninterpreted givens but from carefully selected examples. (p. 23)

Phenomenology treats examples neither as brute facts nor as factual illustrations of conceptual truths. (p. 23)

As an integral part of a phenomenological inquiry, an example thus possesses an indeterminate status; it is neither sheer fact nor pure essence, but something distinct from and located between these two polar terms. (p. 23-24)

In the practice of phenomenology, it is the example itself that is the basic mediating factor; and an example per se is neither perceptual or symbolic, but paradigmatic in character. As truly exemplary, it serves as an indispensable via media between the initial decision to search for the essence of a given phenomenon and the final attainment of insight into this essence. In Husserl's formula it is "on the basis" (auf Grund) of examples, and of examples alone, that the phenomenologist is able to attain eidetic insight. (p. 24-25)

Spiegelberg goes on to describe a method of "lining up particular phenomena in a continuous series based on the order of their similarities". He provides, as an analogy, how the chromatic colors may be arranged in a circle, revealing the pure colors and their shades. Thus, clusters of phenomena can be arrived at based on their "natural affinities".

The final step involves "apprehending the essential relationships or connections" between essences. Through the process of "free imaginative variation", we ask whether all components are or are not essential to the essence we have arrived at previously. We also investigate the connections between various essences in the same way: can we omit or substitute associated essences? If not, we have an essential necessity. Are relations between essences compatible? If they are, we have an essential possibility. Or, do the essences repel each other? If this is so, then the connection is an essential impossibility.

There are a few general comments about examples used in this study that can be made at this point. In the first place, the participants selected examples, which were paradigmatic of their own experiences. These were selected in order to allow the researcher to understand their

experiences of therapy. (As will be discussed in the next section, the researcher, then, has the further task of selecting, from among all these examples, those that best convey the essential aspects of these experiences.) Most of the examples given by therapists were in the form of narratives or stories, which suggests that a particular phenomenological strategy, described by Ihde (1977), was being employed by participants to make their experiences knowable to the researcher.

Ihde describe two types of strategies for helping someone else see a particular phenomenon. These are based on the intentional structure of consciousness, i.e., "every experiencing has its reference or direction towards what is experienced, and, contrarily, every experienced phenomenon refers to or reflects a mode of experiencing to which it is present" (p. 42-43). In one strategy, the emphasis is on the noetic pole of experience (the mode of experiencing something), and one attempts to make the experience available through describing the activity necessary to allow the phenomena to appear. This he calls the transcendental strategy and points to Husserl's project to ground phenomena in the constituting power of the transcendental ego. The other strategy is to use stories and metaphorical devices to immediately set the stage for the appearance of the phenomena. Here the emphasis is on the noematic pole of experience (the appearance of the phenomena). Ihde concludes that it is much easier to use this second, so-called, "hermeneutic strategy" to bring phenomena into appearance than the former "transcendental strategy". Speaking about the perception of reversible and multi-stable figures, Ihde states: "If a background story can be found to allow the third variation to appear, its stability will coalesce

almost instantaneously" (p. 96). In this study, the therapists' experiences seem to have lent themselves to being communicated in the form of narratives about events, though occasionally the noetic or "transcendental strategy" was also used (cf., Example #4: "Parallel regression", p. 130).

Procedures

Researcher's Assumptions

The phenomenological psychologist's first task is to consider his own involvement with the subject to be studied. Since he has chosen this one particular phenomena to study, it must already be meaningful and of some interest to him. Phenomena are not allowed to fall into the natural attitude status of just existing in the world "for themselves". They are considered in their meaningful relation to a subject, the researcher. Reflecting upon one's reasons for being involved with a particular phenomena will begin to highlight pre-conceptions and underlying assumptions about this phenomena. Such pre-existing interests and attitudes toward the subject are not merely identified so that they can be negated, in the hopes of achieving some sort of objective neutrality; rather, they are accepted as an inevitable aspect of human experience and are taken up in a positive manner by interrogating them for what they can tell us about the phenomena. These "prejudices" provide the background against which an investigator's findings will be understood. In fact, the very process of coming to understand the results of a study will involve dialogue between the investigator's prior assumptions and what the study reveals. By making this process as self-aware as

possible, the phenomenological investigator raises this ordinary process to a level of rigor.

Although some of the reasons the present topic was of interest to this researcher were mentioned as part of the Introduction, it seems appropriate to return to them in more detail at this point. As a student, one of the major areas of skill and knowledge I was working to acquire concerned the practice of psychotherapy. While there is a body of knowledge that addresses the techniques of psychotherapy from various theoretical perspectives, such descriptions of technique make it clear that there also is a more subtle aspect to the successful practice of psychotherapy--the so called "art of psychotherapy" (Storr, 1979). Perhaps, like any person who seeks to apply knowledge and make practical use of it, there is a stage of fitting together between the artisan and his tools as these tools gradually become an extension of the practitioner. This process of integrating theoretical knowledge with therapeutic action has been very prominent for me, and I often find myself wishing for definitive guidelines describing the therapeutic process by which the therapist becomes aware of the "latent" meanings in patient communications. This aspect of the therapy process seems very important, because all further actions by the therapist are based on this crucial understanding.

This concern with learning the practice of psychotherapy is a very personal one and not without its attendant anxieties. As I became increasingly aware of my own reasons for doing psychotherapy, the whole realm of the therapist's unconscious gratifications opened up, along with the subsequent guilt for possibly not having helped the patient.

This dilemma seemed to boil down to a problem of hearing patients tell me what was important to them instead of hearing what was important to me.

As described before, it was from this context that I was attracted to the writings of Robert Langs (1976a, 1978). In his work, he describes what he calls the "listening-validating process", which seems to speak directly to the problem of how to discern what within the patient's communications is therapeutically important to them. When reading Langs, I was impressed by the rigor with which he derived methods from a sound theoretical formulation of the therapeutic process. It seemed to be an eminently reasonable approach to a confusing situation. In my efforts to make use of Langs's precepts, however, I encountered significant difficulties. In particular, there seemed to be an incongruity between my on-going experience of the relationship with the patient and the analyzing or listening process delineated by Langs. I sensed that Langs's methods retained a quality external to my actual experience of therapy. They seemed to fit in at another level than that in which I actually experienced the presence of my patients. Perhaps, these methods were too tied to the level of metapsychological theory and failed to cross smoothly into the actual domain of practicing psychotherapy.

The Initial Question

These were the guesses, which I entertained, toward which my experience pointed. It occurred to me that it might be possible to approach the problem of doing psychotherapy from another angle. Rather than

deducing what was suppose to happen from theory, as Langs does, couldn't one go to the experience of the therapist and find out what he or she actually did? My question was whether the prescriptions for what therapists should do were what they actually did. It seemed reasonable to ask therapists about their experience of doing therapy and describe this as fully as possible. I hoped that this would become the basis for making connections between theoretical models of the therapy process and the day to day experience of therapy. My own experience suggested that the theoretical guidelines and prescriptions of technique would be more helpful if they spoke directly out of what the therapist experiences.

The Pilot Study

The first approach to these questions involved a pilot study in which I asked other advanced graduate students about their experience of sessions that they thought had gone particularly well. My hope was that these "good" sessions would provide an opportunity to study what went into successful psychotherapy. I hoped to recover what therapists were aware of as they arrived at insights about what was happening in the therapy. After only a few of interviews, I soon discovered that the sessions that went well were those which were most difficult for the therapists to recall in detail. It seemed that therapists came away from productive sessions with an abstract understanding, or an overall impression, of the session, but it was difficult for them to remember details of what had been said and what they had experienced. One therapist remarked that everything was taken care of so there was no need to remember it or carry it with her.

In response to this, the focus of the interview was shifted to those therapy sessions where things did not go so smoothly. I had in mind experiences of my own where something had been going on during the session that had been very intense and powerful. These experiences stood out so much that I found myself thinking about them long after the hour was over. Not infrequently, I would not understand what had happened at the time of the session but insights would occur as I continued to think about it. By making such experiences the object of interviews, I hoped the details to the sessions could be recalled more vividly. I also hoped that the slower, more deliberate path to understanding and insight would be easier to retrace.

In fact, this change of focus did allow for some very interesting experiences to be recalled by the graduate student therapists interviewed in the pilot study. Especially striking was the quality of immediacy in these retellings. The therapists did not hold themselves back in some neutral or uncommitted stance from which they could first observe and then act. They were immediately a part of what was being discussed and this immediacy seemed to be essential to their participation. There did not seem to be some prior moment for the therapist to determine whether they would allow the event to happen this way or that way; the events occurred and the therapists were part of them.

The most encouraging thing that emerged from the pilot study was a sense for how rich the material was. Many critical areas were touched upon by this investigation, including the interrelationships between language, experience, and understanding within the context of the therapy relationship. These issues re-emerge in the present study, so let us

proceed to an examination of the procedures actually employed in this study.

The Major Study

Co-researchers. The sort of phenomenological research described here makes use of other individuals as "co-researchers" who are asked about their experience of the phenomena being investigated. It is assumed that their descriptions of their experiences are meaningful and capable of revealing essential aspects of the structure of the phenomena. A number of people are asked about their experience to help distinguish what is essential to these experiences from what is more particular to a given case. It is this process of going from the particular experience to what is essential about it, or from the example to what it exemplifies, which is critical to a descriptive method deepening an understanding of a phenomena.

Twenty-two psychotherapists who practice psychodynamic or insight-oriented therapy were initially contacted by letter to request their participation in this study (see Appendix A). Thirteen of those contacted actually participated as co-researchers. An effort was made to recruit the participation of therapists who were considered experienced and well established. Clinical psychologists, psychiatrists, and social workers, working in private practices, mental health centers, and psychiatric hospitals were contacted. Although age and sex were not important criteria, this sample includes both men and women and covers a range of seniority in the field.

The letter therapists received explained that the researcher was in the process of gathering material for his dissertation, and that he was requesting their participation. This would involve an interview focusing on therapy experiences that stood out for them. A brief description of the kinds of encounters that stood out for the researcher was provided to introduce the kind of events of interest. As described in the letter, these experiences often were often intense and emotional--as if something important and powerful was occurring in the therapy interaction. One can be overtaken by these events and in the midst of them without necessarily being clear about what is taking place. These experiences make a remarkable impression, both as they occur and afterwards.

Participation in the study was explained as involving an audio-taped, hour-long interview, following a semi-structured format. To maintain confidentiality, the researcher would be the only person with access to audiotapes; all transcripts and other material gathered from interviews were to be coded. Initial letters were followed up by a phone call to determine whether therapists wished to participate. If they did, arrangements were made for the time and place of the interview, usually at the therapist's office. A few therapists expressed further concerns about confidentiality and the safeguarding of patients' identities. In these instances, further arrangements were made, such as allowing the therapist to review transcripts and edit identifying information.

The interview. The interview was opened by reading the Information and Consent Form (Appendix B) and then obtaining the therapist's signature on it. The researcher reintroduced the topic of the study, elaborating on the letter the therapist had received. At this point, the researcher emphasized that he could only speak to his own experience of striking therapy events and the therapist's experiences might or might not be similiar. In taking his own experience as a place to start, the researcher hoped to establish a sense of sharing some common ground upon which to conduct the interview. He hoped to convey both an interest and sensitivity to these events. It was, in part, an effort to convey a sense that the investigator and the participant were working together, as co-researchers, studying an area of mutual interest and perhaps even puzzlement. Once the therapist began to remember events, which he or she felt were similiar to what the researcher had described, the researcher simply asked questions to help the therapist talk further about the events. He maintained a focus on experiential aspects and asked for specific instances when a type of experience was being talked about in more general terms, though his questioning for specifics had to be tempered by respecting the therapist's need to maintain patient anonymity. Beyond setting the area to be discussed and maintaining a focus on the experiential aspects of these events, each interview was allowed to follow its own course and to be its own creation. The researchers role, as interviewer, was primarily to follow the therapist's lead, to make sure that the interviewer correctly followed what was said, and to encourage the therapist to describe events as fully as possible.

Describing the data. The audiorecorded interviews comprise the data gathered in this study. The next task was to determine and describe what was essential to them.

There are two dialectical movements to the study of these data, comprised by the process of working back and forth between parts of the data and the whole in which they find their place. Within this larger, overall process, there are three general steps. The first step involved categorizing the various stories into a schema of types of experiences obtained. Second, each category was studied in terms of the essential theme or themes that characterized it. Finally, these categories and the themes which characterized them were examined in their relation to each other to see if a set of essential themes could be arrived at, which described the domain of experiences tapped.

In practice, the first step begins with repeatedly listening to all of the tapes and taking notes on each one. In this way, the researcher begins the process of immersing himself in the data. This step also provides a natural point of beginning to interpret the data, since it explicitly draws out the researcher's own pre-understandings. It explicitly exposes what in the interviews is important to him and what he is making of it. His notes condense and organize the material into preliminary themes and make him aware of how he is approaching the data based on his prior understanding and preconceptions about such events. The goal is not to try and eliminate these prior understandings of the data. After all, the data are the result of interviews or dialogues in which the researcher's pre-conceptions played their part in bringing something into expression. The concern at this point is to try and bring these

pre-understandings into greater self-awareness. These initial understandings of the interview later were tested out against what the therapist actually said, when the transcript was made.

These notes also provide a convenient basis for short summaries to be written of each of the narratives. These brief summaries were used as an aid in the next step--arranging therapy experiences into a typology of the kinds of events reported by therapists. This taxonomy was the first step in organizing the diversity and wide range of the data into something systematic, encompassing the whole domain of the data.

Although all the examples were looked at and situated within categories, there were a smaller number of stories that stood out as being especially representative of each category. These narratives could be seen as exemplars of something more general, i.e., a type of therapy experience; therefore, these narratives were studied in more detail. At this point, the focus shifted back to the details of what the therapist had to say; consequently, transcripts were made of these interviews. These transcripts were gradually shortened by eliminating phrases that were less essential to the experience or repetitive of things already said. In the process of arriving at the core what was most important to these representative or exemplary narratives, it became clearer what was essential to the category or type of experience, of which this narrative was an example. As themes emerged from exemplary narratives, they were compared to other examples in the same category to determine if they were descriptive of it. In this process, what was most important to each category became sharper and the distinctions between categories became clearer.

Relations between categories also became more apparent. For example, it previously had made sense to arrange categories along a rough continuum, but not until themes describing each category were drawn out could this sense of continuum be articulated. In this process, some categories were incorporated into others, while distinctions between types became more fully demarcated. As we will see in the next chapter, where the results are presented, the narratives often presented aspects of more than one category, although categories could still be described in such a way as to distinguish one from the other. This was to be an important clue to the final stage of description, which involved discerning essential aspects that cut across all experiences described. In other words, as one began to consider how the concrete examples stood in relation to the types of experiences and how the types of experiences stood in relation to each other, it became clear that another kind of description was necessary; one which focused on how this diversity and difference found its place as part of a single domain.

The above description of the phenomenological method used in this study is itself a schematization, and it would be incorrect to take these steps as a program which directs the investigator in a rigidly prescriptive manner. Rather, these steps delineate a dialectical movement, which traces something more like a spiral than a straight line. There is a continuous movement back and forth between the particular and the universal; each side interrogating and refining the other. The researcher's own assumptions become more explicit, though not with the idea of negating them. These preconceptions carry the researcher's own history of experience with the phenomenon and must come into play when

his dialogues are carried on with the co-researchers about their experience. Psychological phenomena do not exist in themselves, independent of either the researcher or the co-researcher. Both are immediately engaged by these phenomena and, as they enter into a dialogue which seeks to articulate and give expression to these phenomena, both participants find their assumptions "at risk" and their previous understandings questioned by these happenings. An atmosphere of trust is required for such a dialogue of discovery to succeed. The limits to this research are uniquely human in quality. Phenomenological research is limited by the impossibility of uncovering all presuppositions. Therefore, phenomenological studies, while essentially always incomplete, are typically concluded when the people involved are satisfied that they have achieved a significantly deeper understanding of the phenomenon, reflecting aspects of their relatedness to others, to themselves, and to their world.

Meaningfulness versus Accuracy in Psychological Research

Phenomenological psychology represents a challenge to the well established branches of psychology, such as experimental and behavioral psychology, not because phenomenology will ever supplant these endeavors, but because its assumptions and attitude toward psychological phenomena are so different. From within the perspective of traditional psychology, the phenomenological approach to research seems suspiciously subjective, and its results, therefore, seem untrustworthy. It was by adopting the methods and attitudes of natural science that psychology emancipated itself from its former ancillary role to philosophy.

Therefore, it is understandable that approaches to psychological phenomena that do not ground themselves in traditional scientific methodology are viewed as regressive approaches that were superseded by Wundt when he established his laboratory and psychology came of age as a science.

A major criticism of the phenomenological approach is that its results do not lend themselves to replication, so they can never be more than preliminary in nature. In the natural sciences, it is the quantitative demonstration of a phenomenon under carefully specified conditions, which raises an observation from subjective impression to objective fact. Because the demonstration of a phenomenon can be repeated by others, whose own beliefs about the phenomena may differ, a realm of intersubjective agreement is established, independent of the subjective starting points of the researchers. It is this agreement about what the facts are that provides the common ground for scientific debate about how best to explain these facts. From the natural science point of view, only by adopting objective methods of observation can psychology become an empirical science. In an empirical science, conceived within the natural science view, matters of theory are always tested by demonstration or observation, which must be independent of any particular researcher's point of view. In this way, its results are raised to the level of facts.

It is on the basis of assumptions and reasoning such as the above that many traditional psychologists find results of phenomenological research interesting, but unacceptable as "real" data. While the phenomenological psychologist is aware of and concerned by this attitude of her colleagues, from the phenomenological perspective, other issues come

into focus, most importantly the phenomenological status of these facts upon which the traditional scientific approach is grounded. Therefore, before we address traditional psychology's questions about the merits of phenomenological approaches, let us turn to phenomenology's critique of psychology based on a natural science model. The natural science model is itself based on certain assumptions, and these should at least be made more explicit, before they are taken for granted and used as the basis for dismissing the results of phenomenological studies beforehand.

One of phenomenological psychology's important roles has been to provide a counter-point to a natural science definition of psychology (Romanyshyn, 1978). The natural science approach reflects a fundamental bifurcation of the world. With the establishment of the natural sciences, one divides the world into a realm of how it appears to the naive observer and another realm, behind these appearances, of mathematical laws and ideal entities (Gurwitsch, 1967/1978). The common sense attitude becomes "naive", "ignorant", and "in error" relative to natural science view. By providing the real facts and the casual reasons behind the appearance of things, the scientific attitude "corrects" naive errors of common sense. For example, to the common sense view that the sun "rises" in the east and the earth is flat, the scientific attitude provides the facts about the earth's location in the solar system and how the laws of gravity govern its motion.

As Romanyshyn (1978) observes, these scientific facts are, in a sense, "constructions", and fundamental problems arise, if these concepts are treated as though they were discovered in nature. Treating these facts as discovered obscures that they reflect our attempts to

organize our knowledge of the world. This effort, in turn, rests upon our attitudes, our values, and our presuppositions about the world. We should not lose sight of an inherently ambiguous quality to our "facts" of science.

We tend to regard the atom as a discovered reality, and in this sense as a real thing which already exists in nature. The atom, however, does not exist in nature, but rather it exists in relation to an attitude toward nature. Atoms are not real but are ways of real-izing nature. They are not simply a something to be seen but are also ways of seeing. The observed is what it is in relation to the attitude of the observer. In this sense the atom can be called a construction. However, by the term construction I do not mean an idea, and the relation of the observed to the observer is not the creation of the observed. Atoms are neither facts of nature nor ideas of consciousness. Rather, as a construction atoms are meanings which reflect both what can be seen in nature and a way of seeing it. Hence the term construction used with respect to atoms and/or sensations indicates that these realities reflect and require a specific attitude toward the world, a specific way of standing in the world, seeing it, and speaking about it . . . (Romanyshyn, 1978, p. 22-23)

The heart of the natural science criticism of phenomenology is that its methods are not independent enough of the researcher to allow her to be objective; in response to this, the phenomenologist asks what sort of relation of person and world is required for the natural scientist to achieve objectivity. What the phenomenologist notes is that there is an essential transcendence by the natural scientist of the world as it is immediately present to her and to us. The immediate significance and meaningfulness of the world is negated within the natural science view. The natural scientist can justify this, since he or she is not interested in the meaning of an event; the question is not "what does this mean?" but "why does this happen?".

The realm of significance is transcended through scientific methods by isolating subject-matter from its immediately given context. The experiment stands as the pre-eminent instance of this dislocation of a phenomenon from an original setting. This new context is designed to support the predication of causal statements. Under specified conditions events become repeatable. This allows them to more perfectly approximate the laws that account for them. Theoretical concepts become tied to bits of our experiential world, as the dependent and the independent variables are isolated and operationally defined. The validity of a model's explanations are usually tested by how well they allow us to predict the outcome within this delimited context; for this reason, the phenomena of scientific study must be observable, measurable, and replicable.

These efforts to insure that results of an experiment are representative of the laws and models that account for them are obtained at the cost of a "practiced ignorance" on the part of the scientist. The very act of assuming the scientific stance of detachment and neutrality toward the subject to be studied reveals a meaningful choice on the part of the scientist; furthermore, the choice of a particular subject matter for study reverberates with the echoes of prior assumptions and beliefs about the meaningfulness and importance of the topic. The natural scientist believes that he or she can ignore this more immediate and meaningful experience of the phenomenon, because the scientist has turned the situation around and given priority to the model, the laws, and the reality behind the appearance of things. What is immediately experienced is only the manifestation of this more "correct" view of

reality, which comes into view with a scientific attitude. What phenomenology attempts to call our attention to is how the scientific world view implies the assumption of a particular attitude and relation between person and world.

When the domain being studied is psychological, the isolation of a phenomenon from the meaningful context in which it was originally located has even more important consequences. The preferred object of psychological study becomes behavior, because it meets the criteria of being observable and measurable. The meaningfulness of experience, as it is pre-reflectively given, is ignored and the whole realm of "interiority" is mistrusted as a source of data. If meanings are considered at all, natural science psychologists go through a process of deducing and inferring meanings from the behavior of the person, rather than studying the meanings that are experientially present to them and to us. Meanings are typically thought of as located inside the person, inaccessible to a scientific observer.

Romanyshyn (1978) contends that this state of affairs reflects a confusion of the concepts of inside and outside with another pair of concepts, visible and invisible. Natural science's preference for the attitude of the detached observer obscures the presence of other attitudes, such as that of the actor. From the perspective of the observer behavior stands out, but from the perspective of the actor experience is most apparent. One is not inside, the other outside. They are both aspects of human action, which is fundamentally a matter of man's relation to the world. Thus, behavior and experience have a figure-ground relation to each other depending on one's attitude at the moment.

By returning the co-aspects of human action (behavior and experience) to their context of man in relation to his world, phenomenology makes experience, as well as behavior, accessible to psychology. The phenomenologist recognizes that man is in constant dialogue with the world and that they co-constitute each other. One can focus upon the one only against the background of the other. An essential aspect of man's relation to the world involves activity and doing, but this reveals that the world is meaningful to man. The meanings apparent in our lived relation to the world are not something that is introduced after the fact and from the outside, as an insistence on the observer's position would require. Meanings are present in the structure of the world as we live in it.

Meaning and experience are not locked away "inside" a person. They reside in the relation of man-in-world. The back and forth of dialectical relationships or dialogues, in the phenomenological perspective, contrasts with the linear thinking of causality. Experience is an aspect of being-in-the-world, and our sharing of the world with others makes our experiences accessible to each other. Phenomenological psychology understands experience as a structure in and of the world, and we share experiences in sharing the same world. I have, for example, access to the other's experience of anxiety, because I also have lived the world anxiously. The anxiously structured world is one that I too can, and have, lived. I do not create this world and its experience; I find myself alive in it. Therefore, the other's description of experience speaks to me from out of the world we live in. I do not "get

inside the other person's head"; I experience an overlap between the horizon of his world and my world through dialogue.

Thus, there seem to be two fundamentally different ways of looking at psychological phenomena, which are based on different assumptions and result in differing attitudes toward phenomena. In overly simplified terms, the natural science approach assumes that the observer's immediate experience of the world needs to be negated so that only "objective facts" are observed; the phenomenological approach starts from this immediate significance and expands upon it. The natural science attitude begins from a position of mistrusting the world as it appears and searches for the clues that will correct our tendencies to be misled and misunderstand the nature of things. The phenomenological attitude marvels that the world is already present in such a meaningful way and that we understand each other with as much depth and clarity as we do.

We can begin to see that this contrast between a natural science attitude and the phenomenological attitude delineates a contrast similar to that, which we discussed within the psychoanalytic literature, between those who emphasize the importance of technique and insight and those who emphasize the role of emotions and empathy. This study employs a phenomenological approach, since it is more conducive to addressing the problem motivating it: the difficulty re-connecting techniques with experience, in the therapy setting, when the theory and technique do not speak directly from the therapist's experience.

Natural science methodology offers a powerful technique for discerning causal relations between phenomena, and is useful to us for gaining mastery and control over these phenomena. We should not be

surprised, however, when it turns out that the findings of science only re-connect with our immediately significant world in a limited fashion, because natural science begins by delimiting those aspects of the world that it will deal with (i.e., they must be objective or independent of personal significance). The findings and results of the natural sciences only take on an immediate significance to us insofar as we adopt an instrumental attitude towards the world, and this state of affairs becomes obvious in the practice of psychotherapy, where it is impossible for the therapist to assume a completely instrumental attitude towards his or her patients.

How does one judge the worthiness of a phenomenological study? In the natural sciences, this issue is discussed in terms of the reliability and validity. The first term, reliability, concerns the potential replication of a study's results, and hinges on how accurately the units being studied are measured. The second term, validity, concerns how closely the units and the content being studied can be said to approximate the model that explains the results. These notions rest on assumptions, which are different from the assumptions that phenomenology begins with; therefore, they cannot be applied to a phenomenological study with any real meaning or internal consistency.

A phenomenological study neither seeks to define units of observation that are independent of their significance to the observer, nor to link these units to a particular model. A phenomenological study begins with the significance of immediate experience, and significance (or meaningfulness) is the criteria by which a phenomenological study is judged. Whereas a natural science study speaks to us from the

transcendent realm of an abstract model--which is then tested against its capacity to allow us to control and predict our more immediate experience of phenomena--a phenomenological study speaks of an immediate experience in the world. Its efforts to make more generalized descriptions should be judged by whether they are true to one's own immediate experience of the world.

In this study, the first point at which we ask ourselves, quite naturally and perhaps without reflective awareness, whether the data are meaningful to us is when we encounter the therapists' presentations of their experiences. It is at this level, which is essentially established by language, that phenomenology is concerned with intersubjective agreement. We judge the therapist's account on the basis of whether it allows us to fuse his or her experience of the world with our own. Are we carried into a world that also seems like a possibility for us? Does the therapist's description speak to us from the horizon of our own world? Does the therapist's world and our own world become one and the same world, as it is present through the medium of language?

The researcher's contribution to the work already done by the co-participants is to provide an interpretation or description that is true to his experience of immersing himself in all of the narratives. Again, the question is whether the researcher's description, which seeks to address both the individual narratives and the whole domain of which they represent parts, speaks from and expands the reader's own experience of the world. The purpose of phenomenological descriptions and the themes derived from them is not to create a technical language; rather it seeks to provide an avenue of approach to an important and meaningful

set of events. A phenomenological study succeeds or fails depending upon how well it provides a place for the reader's, the researcher's and the co-participants' worlds to come together as comprehensively related worlds, described and understood through language.

Therefore the natural science and the phenomenological positions provide contrasting (not competing) perspectives from which to understand phenomena. Since one is not to be reduced to the other, they set up a dialectical tension between them. This study does not seek to resolve this tension, rather its goal is to highlight it and consider its implications for the practice and understanding of psychotherapy.

CHAPTER IV

RESULTS

By interviewing thirteen therapists, fifty-eight different accounts were obtained encompassing a wide variety of experiences. As described in the Methods chapter, all narratives were used in coming to an understanding of the data, although some accounts were more specifically drawn upon to exemplify various aspects of these experiences.

Some of the narratives seemed to call attention to themselves. In these narratives, the therapist's recounting of his or her experience drew the listener into the event with an immediacy and intensity that mirrored the therapist's own immersion in the experience. These dramatic stories appeared to be situated in the midst of the domain being studied, but were difficult to understand by themselves. Too much was going on within them for essential aspects to be easily discerned. Other narratives provided keys for unraveling and describing these more elaborate narratives. They played an important role in highlighting and making figural particular aspects of these more dramatic stories, which seemed to involve a confluence of the various aspects defining this domain.

This chapter follows the path taken in coming to understand the interviews. The sheer quantity of information obtained in the thirteen interviews requires that some reduction of the data be done to describe it. This study relies on particular examples to present that which was gained from looking at the data as a whole. The reader is referred to Appendix D for a complete summary of results, where they are categorized

along the lines of the four types of experiences to be described. In a sense, the reader retraces, in the reverse direction, the path followed by the researcher in coming to understand the data. The researcher had to develop an organization, along the way, which would guide him through the data, describing its essential features. The reader begins with this organization already in hand and, therefore, can more quickly arrive at the essential features of the domain.

Present results are introduced by looking at a detailed narrative, which from the beginning attracted the researcher's attention. This narrative appeared to be located in the midst of the study's domain, as it presented a rich source of information about therapists' experiences. Following this concrete introduction, the process of organizing results into kinds of experiences are presented by looking at representative examples of each category. Based on these categories, three pairs of aspects will be derived which highlight and describe the most essential features of these experiences. The first example will be kept in mind, as a reference point, throughout this process. In other words, what we have to say about other examples, and the organization of essential features deriving from them, should amplify our understanding of what is concretely present in all its complexity in this first example.

Example #1: "He was inside my house!"

This is an experience that I had that was provoked by a young man. He sat in my consultation room for four times with a ponderous appearance. It felt like something heavy was in the room, and I knew easily that I was frightened to be there. Before the fourth interview, I realized that I feared what I was going to hear. Then, in the fourth interview, he confessed that he had been awake at all hours of the night in recent months. He said it was no mystery to him who Dracula and the Wolfman were, because he recognized them clearly in his own behaviors.

"They are not mythical monsters. They are human beings experiencing what I'm experiencing." And he described that he was up at all hours, and he was spying--entering the homes of females, sitting at their bedside, thinking of their vulnerability and how easily he might kill them. He was seducing women into going with him to the woods, and he would proceed with a ritual subduing them, physically tying them up, and--in his account--coming with each episode closer and closer to murdering the women.

I now felt clearer on why I was frightened--and more disorganized, because I was not sure what to do. And my specific question about that was whether I should call the cops or whether I should treat him. I call this a confession, because I felt then, and in some way still feel, that I was immediately worried, not that someone else would die at his hand, but that I would die at his hand. So in a way, my most private communication--which I have never communicated to anyone, except the supervisor whom I called and now to you--my private thought was: "How should I proceed to minimize the chance of there developing a body count around this man, starting with me?" I would rather not die at his hand, and I would rather nobody else did--after I saved my own skin. I had been in practice two years, and been in training for five years. I had for the previous two years not had a supervisor, and I had the conscious notion that, however wonderful and valuable supervisors were, I needed to be responsible alone, in isolation. I think that was a defensive, kind of crazy, sort of notion, but that was the banner that I was flying inside myself--that I was treating patients without benefit of supervision. This case broke the back of that defense very neatly. I knew that I wanted help, and I called my mentor, and he helped me a very great deal.

(Researcher: I'm interested in your description of feeling from the first interview that there was a ponderous quality, a sense of having something heavy in the room.)

As far as I can tell it was emanating from him, and I felt enveloped by it. [The therapist enacts the patient's position as he describes it.] He sat forward in his chair, resting the weight of his torso on his spread and then crossed legs; his eyes fixed on a point in the floor just to one side. His hands clenched tightly in front of him, and he spoke in a very low voice. I had the differential between ponderous and psychomotor retardation, and I decided, correctly as it turned out, that it was not psychomotor retardation. It was his own heavy feeling, his terrible, I would say, anxious grief over the sort of person he had become and how much he both hated, in a moral sense, what he was doing and feared lethal reprisal. So, he was at once both depressed and paranoid, straddling the depressive and paranoid positions.

Well, my supervisor helped me. He was a very sanguine person. I had the gift of being able to receive a sense of being genuinely supported from him, which left me feeling that I really was going to be able to bring the best out of myself to offer to the present situation. I decided that the case could be formulated, that the man was suffering

from a desperate isolation, which we could abridge. I really wanted very badly to help this guy. I decided not to call the cops, and to treat him, and did so. And as it turned out, the treatment by ordinary measures was immensely successful.

There was a curious correspondence in his life and my own--and I'll get more into my experience now--I had a new baby living in the home at that time. My daughter was in the home as a newborn or almost newborn. His wife was pregnant, and in fact his paranoid psychosis and the acting-out had proceeded out of a reaction to his wife being pregnant. He had regressed in his marriage into the quality of a relationship that existed between he and his mother, which was positively awesome. His mother had attempted to drown him as a child--or he told the story that she had. He feared a fatal rejection from his wife in the context of the pregnancy. Well, of course, I was coping with the problem of being a new father myself.

There was a tiny honeymoon period in the treatment in which he seemed to hear that I was going to listen to him and he was going to be able to work this out, and he was very excited and his mood picked up. We were both under the influence of feeling, "Gosh, this is just going to go swimmingly." And then, he came and confessed that that he had spent the night on my front lawn, cradling a deer rifle and fantasizing murdering me and my family. So, I was up against it again. Once again my supervisor helped me see that what I wanted to do was to treat him.

I was not to see my supervisor for a week, and I stuck to that very fastidiously, actually did not break and run. I think I had a kind of combat mentality about this. I felt that I had to go through this, and I had to be faithful to what my resources were and not break and run like a frightened child and cry for help all hours of the day and night and so on. So, I decided to go through with what I was experiencing. His fantasy in that next interview was that he was cutting my head off and throwing it out the window. I was far too anxious to understand why he was so angry with me--why he was so paranoid about me.

It didn't matter. I went home, found my way through the day, preoccupied with this threat, and I realized: "By golly, I am honest to God paranoid myself." I felt that he was out to get me, and I recognized that just because he was out to get me, did not mean that I was not paranoid. I knew that I was in an altered state where I felt the need to have a combat readiness. I could not sleep at night and did not for three nights running. I was down at Sears in a very pseudo-practical way figuring out ways to secure the windows and make it difficult to access the house without making noise at least. I waited until the break of dawn, when the vampires and werewolves go in, to get an hour or two of sleep and would sleep in the afternoon before supper. So, I had to confront the fact that I was clinically paranoid myself and still intellectually dedicated to continuing the treatment for good or ill.

Oh, ok--I should tell you the dream. I went to sleep briefly at dawn on the third day, and in the dream I had a knowledge. I wakened from this same bed--it was in the middle of the night in the dream--I wakened from this bed with a certain knowledge that the patient was in my house. He was inside my house. I knew somehow that I would find him

in the bathroom, and I presume, as author of the dream, that I also knew what I was going to find, so my affect quite matched that. I had a sense that he had murdered my baby and that it would have been done with a knife. And so, as I approached the bathroom with that absolutely selfsame affect that would belong to the idea that one's infant had been murdered--or one's self had been murdered--I saw that he was in the bathroom. He had a sharp edged weapon in his hand, the nature of which I have forgotten, I think an axe. The water in the toilet was brilliant red, and I--thank God for some defenses--I did suppress the image of the body of the child, but that was what I feared: I would see the horror of my infant child murdered. The patient looked at me, and I at him, and we embraced. My conscious sense was that I am going to restrain him with an embrace, but I realized in the dream that there was both restraint and there was an uneasy sense of loving, sheltering, protecting both of us from the horror. When I looked--stepping back in the dream to look at his face--I saw that his face had characteristics that belonged to him. His glasses, as I recalled it, belonged to me. His nose was changed; it was distinctly like my supervisor's. He was a curious amalgam of himself, my supervisor, and me. I picked this one because of your definition: tell me a story where you feel you have been caught up. I think that in the most objective ways, my dream reveals that I was caught; I was absorbed in this. You could scarcely ascribe technical neutrality to what I was doing.

I had that experience, and I went back to see my supervisor and told him how crazy I was. We swapped easily the analogies between my situation with my infant, my rage, the patient's implicit rage. So why does the patient become paranoid with me? My supervisor suggested that I had lied to him, because he had said to me, before he confessed to me what he was doing, "Can I tell you this in confidence?" My supervisor suggested that I had lied to him when I said, "Yes you can." He suggested that the fact was that I was going to do what I thought was best with whatever he told me. Probably that would be to keep it in confidence, but he said this guy is crazy, but he's not stupid. And, he knows that you will do what is best, not let him tie your hands and do what he has made you bargain to do, in return for which you get to hear his story. He's angry at you for lying to him, and he reckons that it's not really clear if you can be trusted. Being angry at you and needing at once to depend on you so much, he has had to escalate his fear into the rage and he wants to kill you. He is simply so dependent on you, and you need to go after that in an analytic way. And I did. I don't think we ever actually reached agreement that really was what had happened, but his reaction to me subsided with my candor with him. We were able to proceed with the issue that he might have been angry with his wife and that was analogous to being angry with me. It was something he could not support. He could not support being angry, for to him anger meant proceeding to destruction of your opposite number. It brought us to the history of his fear--terror at the hands of his mother and a lot of child abuse. The solution to that was, of course, fierce independence on the one hand, and on the other hand a person who required unquestioned possession of his love object--and he had a frail, child woman for a wife. It went very well from there on, and I fairly

promptly recovered from the paranoid state and slept well again. I had a sense of, "By golly, this is a hard way to make a living." Really, when it gets down to hardball, and it's not kind of a neat thing of helping people, stuff like that--that sounds so benign and good. This could be bloody terrifying to assume the responsibility. I felt much better. I have always felt more like a man since tackling that case and going through the valley of being really as frightened as I have ever been.

(You had a sense of the heaviness in his presence and a sense of dreading what he was going to tell you. And I get the sense that somehow that was realized, too, when he did tell you about his nighttime activities and gave you the confession.)

I am interested that you're focusing on that, because I think maybe I'm trying to lead us down the road away from that point. I was in a state of dread, and my first thought was that the dread was very like the affect in the dream--that I would have after all was revealed, everything had been made plain. My fears, my unnamed fears, had been made absolutely specific, painted and described in minute detail. And then I had the affect, the affect was the same. It was an affect as though you were going to learn of bloody murder.

[Pause]

Associations to Macbeth.

[Pause]

And to the potential--that I've recognized in myself and others--of having murderous rage towards someone upon whom I depend.

[Pause]

Well, I suppose I might clean this up a little bit, but it seems to me that I knew what was going on before it was going on. I knew what was going on before it happened, and I had the affect to match. I didn't know exactly what I knew, but my dream later suggests that perhaps I did know precisely that the image of an absolutely vulnerable and perhaps even female person at the mercy of an absolutely murderous male person was a part of me as well as a part of him. And I think the femaleness was in a way a nice--the femaleness and the infancy--was a nice way to externalize and represent my own vulnerability. To displace my own vulnerability onto the female is so common in males, it seems to me.

(I'm not sure I'm following.)

I'm hypothesizing that what he was about resonated with that same complex in me, and I did not need to know the facts to encounter the affect.

Incidentally, I still think it was kind of curious to decide to treat him rather than call the cops. I had that rationalized with my supervisor, and what wouldn't rationalize I displaced onto idealizing my supervisor's wisdom. I didn't worry all that much about the decision, I consciously felt that it was the best decision, but I would be at loss to defend the decision. But it's very curious that in the dream there

is a very powerful sense of taking him on as a project that was as imperative to me as a taking oneself on, taking one's self seriously, getting treatment for oneself, taking your own life seriously, taking your own growth and development seriously. I'm compelled to think that I found a substantial piece of myself in him, and I found it quickly and with precious little data.

(You had a sense of being threatened, being immediately in danger for your life, and apparently you were intuitively correct. The fellow, as it turned out, did spend an evening out in your front yard with a deer rifle.)

Well, remember, he said that he did. No one of, he said, half a dozen or more women that he took to the woods ever blew the whistle, which strained my credulity at the time. He said that he was on my front lawn--this might be worth telling, but I don't know what in the world we'll do with it. He told me late in the treatment without quite acknowledging the infantilism in it that his weapon was not a deer rifle, but a BB gun, and that his wife had taken the BB gun and hidden it from him. Over the years I have thought that somehow I avoided asking him about the lie. He confessed a lie to me that he had represented himself as hauling lethal force around, when actually he had a play gun. I thought, "Boy, I was a whole lot more scared than I had maybe any real need or reason to be." I thought about it as perhaps, when I decided to take him on, I knew that it wasn't as dangerous as it was cracked up to be. What was dangerous, perhaps, was--or in humane terms--was that the poor fellow would be punished rather than treated.

So, that too brings me back to myself and feeling that I'm not really a dangerous person in the land. I really am a person who is perfectly capable of paranoid and depressive reactions, and I certainly had those experiences, but there is nobody really in danger in my life but me.

(There's a curious quality of a kind of objective reality versus psychic reality. What was important was the kind of sharing of the world as this person saw it and experienced it, and in that world everything is of the quality of deadly force. Up until the dream, the dream was some kind of turning point, but prior to that, as you say, you were clinically paranoid yourself, or sharing his experience of the world.)

Yes. Absolutely. And I felt like my own unconscious had been just turned inside out, and my defenses raked off, and I was left really naked, and I had resource only to very primitive defences. Like I found the Shakespearean heart of my fear and greed and murderous rage.

.....
This has just occurred to me, for years, now, I've been wondering what's a boy like me doing in a place like this, in this profession. In the dream, the horror was that I would not reach the person, reach myself, my supervisor, the treatment, the consultation room, I would not--the bathroom, the murderer--I would not get there in time to

prevent this horrible thing from occurring. That was the awful dread as I realize it now. I suppose it to be a tidal wave of understanding that I really had no choice. I really had no choice but to treat him. I think in a way I envy people who would have easily said, "You know, life's too short to devote your energy to this," but I don't think I had a choice. In the same sense that I do not think I had a choice in becoming a physicist or a chemist or a psychotherapist. I had important business there in the bathroom.

First Impressions

The first thing that strikes the reader, as well as the therapist, in this narrative, is an anxious mood that carries foreboding overtones and vague anticipations of things to come. This mood or atmosphere emanates from the patient and is linked to his heavy and ponderous presence in the room. The therapist is frightened and knocked off balance by this experience, as well as by the confession that follows, so much so that he realizes that he wants help with this case and returns to his former supervisor. Together, they are able to formulate the case and recognize that the patient is suffering from "a desperate isolation, which we could abridge," and the therapist commits himself to treating the patient rather than calling the police.

This is not the end of the therapist being dislocated from the familiar. While previously the therapist was primarily dislodged from his usual mode of practicing therapy, the patient's threats and fantasies frighten the therapist into a paranoid state encompassing his whole experience of the world. It is important to note that the therapist decides to stay with the experience and live it through; he does not quickly jump to resolve the experience or get rid of it by returning to his supervisor or terminating the case. There are several facets to this "altered state." First, the therapist is essentially sharing the

patient's paranoid world view, in which lethal reprisals are always a threat and a combat mentality required. This experience also implies a curious blurring of reality and fantasy such that BB guns are high-powered rifles and werewolves and vampires only come out at night. Not only is there a sharing of world views, there is also a blending of identities. This is first recognized in the correspondence between the patient's and the therapist's lives, since both are dealing with the issue of newborns entering their families. It is in the dream (where the boundaries between ordinary reality and psychic reality are most fluid) that the dramatic blending of identities between patient, therapist, and supervisor is explicitly experienced. Again, the therapist is able to return to his supervisor, formulate what is going on, and re-engage the patient in a therapeutic manner.

The narrative ends with the therapist's reflections upon his sense of being compelled to take the case on. This reflection returns us to the anxious foreboding mood that announced the events that followed. The therapist suggests that he did not need to know the facts to encounter the affect. He emotionally resonated with the patient from the beginning. The frightening quality of this experience, perhaps, points to how unfamiliar this aspect of himself was to the therapist. The therapist's statement about having no choice but to treat this case suggests that not only did the patient's issues have great personal significance for him but that he was already immersed in the events from the moment the patient sat down in his consultation room. In other words, there was no point at which the therapist's understanding of the case could have arrived in time for him to hold himself back from his

immediate engagement by the case. The only way for the therapist to understand the patient, as well as that "substantial piece" of himself that was addressed by the patient, was to allow the events to unfold without dissipating them through actions that would have brought premature closure. The moments of objectivity in which the issues of the case were formulated always followed the therapist already finding himself thrown into the midst of these events.

Categorizing the Narratives for Preliminary Themes

There clearly are many important aspects in the above example, and it is tempting to move in and try to interpret the events in terms of, for example, psychoanalytic ideas on countertransference or projective identification, etc. Rather than using pre-developed theories to guide understanding at this stage, let us return to other narratives and situate this first example back into that context. In other words, now that we have looked at one very striking narrative in detail and allowed it to engage us, let us move back to a level of considering the field as a whole and see what sort of organization can be developed.

The first example, and other experiences like it, seem to provide a reference point in the midst of this domain around which other narratives can be located. Among these other narratives, certain stories begin to stand out as presenting a type of experience in a modal way. They seem to define some category or type of therapy experience, and related experiences may be located in relation to them. These other narratives, placed within a category, serve to amplify and fill out

which aspects of these experiences hold them together as a type. They also make clearer relations that exist between categories.

In the following section, examples will be presented, which serve as illustrations of the major types of psychotherapy experiences described by co-participants. These examples provide concrete instances of various therapist experiences and highlight particular aspects of this domain. Although other examples could have been chosen, the following make especially figural the particular aspects of the therapist's experience that characterize a specific category of experience. This chapter, therefore, will focus only on selected examples; the reader is referred to Appendix D for a complete presentation of narratives, where they are grouped under the four categories to be discussed.

The co-participants described these four categories of psychotherapists' experiences: 1) Losing (and Regaining) Control, 2) Merging, 3) Connecting, and 4) Recognizing. Although these categories will be clearer after presenting examples, it may be helpful to introduce these categories in a preliminary fashion. By having in mind what the categories are about, the reader can more easily see which aspects of the narratives are being focused upon.

1) Losing (and Regaining) Control. The stories in this category primarily have to do with how much control the therapist has over the events occurring in the therapy. Frequently, there is a kind of struggle going on between the patient and therapist about who makes what decisions in the therapy.

2) Merging. The stories in this category are held together by the therapist's experience of a typically frightening loss of boundaries,

including the boundaries between self and other, reality and fantasy, and familiar and strange. The previous example, #1 "He's inside my house," is illustrative of this type of experience.

3) Connecting. These experiences have to do with a sense of establishing a deeper, more empathically attuned level of communication between patient and therapist. There are some similarities to the Merging experiences described above, but they involve less confusion of self and other. Instead, there is a more balanced sense of reciprocity to the dialogue.

4) Recognizing: In these experiences, the therapists describe coming to see, recognize, or understand something about their patients. This recognition can range from an intellectual formulation, couched in terms of theoretical concepts, to a more profound, almost existential insight, in which the patient is recognized as a Thou. In these latter forms of recognition, there are similarities to the deep communication described under the Connecting category.

These categories tend to shade into each other and any narrative may show aspects of more than one category. (This is particularly the case with the more central examples, such as Example #1: "He's inside my house.") These four categories provide a way to focus upon and consider, in detail, some salient features of these narratives. In this manner, the categories provide preliminary themes and a place to begin to describe what is essential to all of these experiences.

1) Losing (and Regaining) Control

The narrative which follows primarily illustrates a crisis in the therapist's control over the therapy situation. Other themes can also be discerned; our main concern, at this point, is to exemplify the type of experiences in which this issue of control is the primary issue. Although condensed to varying degrees, all examples retain the therapist's own words.

Example #2: "You ride the whirlwind"

Things that stand out in my mind over time are enormous difficulties that I had during the course of an interview, and very frequently these were confrontations of one sort or another. I am reminded particularly of a patient who was becoming more and more demanding of time and energy. I had been setting the limits with this patient, but somehow they had to push it to the ultimate limit. They threw a fit, and they were crying and carrying on, rolling around on the floor. The end of the session came, and they wouldn't leave. That's a particular kind of encounter that has a real impact. I think the real problem in something like that is you don't have control over what is going on. The patient is insisting that you're suppose to do it one way, and you're saying, no, we're not going to do it that way.

(Do you remember what that was like for you?)

I was sort of looking at the same situation from two points of view, simultaneously. One was that I felt that I didn't have control over the situation, which made me angry at the patient. The other one was that I understood exactly what was going on. It was a deal where you ride the whirlwind and you hope that when it puts you down you land on both feet. When I get angry like that I have to measure exactly how much I'm going to use that to do whatever I feel has to be done--in this case, to get control of the session. With this particular patient I knew I could get control by threatening abandonment. I didn't want to do that. At the same time I was so angry and pissed about being pushed to do that. The patient wanted and didn't want that. Those kind of situations don't happen very often, but they are always the ones that get me most involved. They summon simultaneously both how I feel and what I know, and I have to modulate between the two.

(You described it as riding the whirlwind?)

I'm never quite sure what's going to happen or what the outcome is going to be.

(You described it as riding the whirlwind, like you aren't really in control, but there's a part of you that is able to look at the situation and have some understanding of it, which guides you?)

It's very intuitive. You can ask me afterwards and I can give you all kind of explanations. The thing that I'm aware of at the time is that it's very important for me to exercise my self-discipline. I just can't go popping off. I'll screw up everything I've been working towards with a patient over a long period of time. That's the whole purpose in having these happenings that are precipitated by the patient. They're a test to see, if I'm sufficiently provoked, might I be retaliatory. Yet, you can't let people just piss on you with abandon; there's nothing therapeutic about that at all. You have to have enough self-discipline to know what's going on and to modulate what you feel.

(How did you respond in the case that you mentioned?)

The patient pushed it to the end of the hour, and I got up and told the patient that the hour was over and I was leaving, and I walked out. I had another patient, who I saw in a different office. I let the staff know that they should note what happens. The patient left after about fifteen minutes.

(It ended when you left the office and went on to your next patient?)

No, that ended the happening; it didn't end what was going on. There is no closure until the next time I see the patient. So I just ride the whirlwind. I have no idea what the resolution is going to be until I see the patient next time.

(I'm also interested in what you made of the experience.)

The one thing I have always learned from these things is to trust my capacity to ride the whirlwind and to trust my judgement for what I'm doing at the time I'm making decisions, most of them intuitive. You don't have enough time to think, at times like that. Things are happening so fast; you just play it. The thing that I get, even when I've made really bad mistakes, is trust your capacity to ride. Most of my mistakes, in hindsight, are because the book said I should play it one way, and my intuition said no don't play it that way, and I played it by the book. Those are the mistakes I had most regret about.

(It sounds like an instinctual, intuitive approach, once you get into these events.)

But always with one eye, hopefully, being the observing ego. See, if I get upset, whether its anger or anxiety, to such an extent that my observing ego capacities are impaired, then, following your intuition is not necessarily helpful. One aspect of my intuition with my patient that I mentioned was just to become flat out retaliatory. You lose

sight of what dynamically is being played out, and you lose sight of what, supposedly, you bring to the encounter; some knowledge and discipline.

(Was this particular episode insightful in any ways?)

I think it was for both of us. For one thing it was probably a turning point. After that, the trust issue, which was very big with this patient, was more contained. It was possible for both of us to refer back to that issue, and we spent a lot of time, subsequently, reviewing what that was all about and what had had happened. Control, trust, fear of men, provocation, all those things were played out in that episode. Affectively, they were played out; cognitively, they were reviewed subsequently.

What appears prominently in the above example, as well as in others like it, is the patient's effort to act on and take something from the therapist. There is a coercive effort coming from the patient that is parried by the therapist, resulting in a "confrontation" or test of power over who has control of the therapy exchange. This struggle is not just a nuisance or inconvenience for the therapist; it threatens to undermine his or her very potential for being therapeutic and to foreclose the therapy process. The therapist is called upon to act and to respond to the patient's behavior effectively. His or her competence and skill as a therapist are being put to the test. Behind this test of power and skill, the therapist is also being tested by the patient's problematic behavior in terms of dependability and trustworthiness as a therapist. If the therapist responds effectively, not only is the patient's behavior brought under control and contained, but further working together, on a level of greater trust and mutuality, becomes possible.

Although not the primary focus of this story in terms of illustrating the category of Losing (and Regaining) Control, it is worth

noting how the therapist describes responding to the situation intuitively. While trying to maintain a kind of self-discipline, informed by a more formal knowledge of the situation, the therapist allows the situation to play itself out. This self-control, however, recognizes that the situation is not something necessarily to be controlled. One has to ride it out; one cannot know before hand how it will turn out. (This same decision to go ahead and allow events to develop in their own way can also be seen in Example #1: "He's inside my house" (p. 111), where the therapist decides to go through with the experience of paranoia.) In summary, examples of Losing (and Regaining) Control, are characterized by a effort on the therapist's part to strike a balance between allowing events to unfold of their own accord and of maintaining some degree of control. How the events actually play themselves out may occur anywhere along the continuum between the extremes of being swept along by what is happening to trying to dictate what will happen.

2) Merging

We are already familiar with this category because Example #1: "He's inside my house" (p. 111) is a powerful instance. A primary feature of this narrative was how the therapist's experience blended with the patient's. The therapist found himself drawn into a paranoid experience of the world, which paralleled the patient's, as both faced overlapping issues of rage and dependence. Behind the confusion, there also was a sense that the therapist knew precisely what was going on. This knowledge, at first, was only carried by a feeling or a mood, but it became identifiable as things developed. Other examples of this

category are equally dramatic, and since this kind of experience appears central to the therapist experiences another example may be useful.

Example #3: "Scared to death" experience

I'll tell you about one of the most striking ones that I ever had. This was a really significant thing in terms of working with this patient and in terms of my own development as a therapist. This patient's presenting problem began with that of a symptomatic child who was depressed. I started seeing the parent, but after seeing the parent a couple of times began to get quite concerned about the level of depression that not just the child, but the parent had, also. Eventually, the treatment changed to where I ended up doing primary work with the parent rather than the child. I have never quite had a case that I was as certain was going to explode in disastrous outcomes. Then, of course, the fantasy was that it would be splattered all across the front page. This was going to be kill a loved one and kill yourself kind of thing, and then it's splattered on the front page and so on.

After a while I got obsessed. I became aware of the level of disturbance, and I was concerned about it. I was concerned about it, because no matter what I did, I couldn't seem to find an entry to be able to get a hold of this particular kind of problem diagnostically for myself. One of the problems was that this particular patient was unable to take a whole lot from the therapy. How is it, then, that you help somebody who is going under when they are unable to take or introject any kind of coverage from the therapist? No matter what I did, I couldn't find an entry, which got me even more scared. I kept looking and couldn't find it, and the situation is getting worse. Everything that I would try was flatly rejected. The situation continued to mount. I even go to other colleagues to get some sort of advice. Other highly talented colleagues and all of them are essentially preparing me for this disastrous outcome. I'm listening to how they are responding to me, and they are preparing me for this negative outcome. They are not giving any answers to solving this problem. When I heard that they are doing that, I'm thinking, "Oh shit." So my anxiety is mounting up. I'm looking in the obituaries, shit like that. I can't get rid of thinking about the case for extended periods of time.

Then, these experiences that you were referring to in your letter began to happen and would happen almost consistently. The person would come in, depending on the level of it, if this person was going under, I would end up really being flooded and filled with that affective experience. At times, I was convinced that this person was going to walk in the door, rip out a gun, and blow me away. I was certain at times that this person had a gun on them. Then, other times I was just filled with that level of rage that this person felt, and it would make me cognitively cloudy and light-headed, a sense of being almost faint. Also there was a sense of the room sort of spinning and a sense of being out of control. Out of control rage, as if the whole room were going to start to spin and just spin off from the building that it was attached

to. It was a real weird sort of sensation. Other times it would flip, with all the depressive things mobilized, and the sense was of being smothered with the weight of the depressive elements and the inability to get out from it, just enveloped and swallowed. Then the funny merger with it; I could feel myself resisting it and fighting it and not liking it. Then having it all within me, which would be very uncomfortable, and it would lead me to be filled with so much hopelessness and futility. It was like being underwater and frantically trying to get to the surface. It was all the time that I'm sitting there listening to this person that this kind of thing would go on.

I was getting increasingly more and more scared, feeling more and more vulnerable. I remember talking to somebody about it who I use for a consultant. Eventually, I got to the point of deciding that I was going to go ahead and take a chance with this person. Either, I was going to see this person, hop in there with two feet, and have no guarantee--in fact have the probability that this is a dead person and that I might be dead--to just go ahead, take a chance, and hope that the situation would work, or I would have to get rid of the case. At which time, I was concerned about the effects of getting rid of the case on the individual. I decided that I would go ahead and take a chance, and I was scared for an extended period of time. I had these kind of experiences with this individual over and over again. What eventually happened is that things got settled down with this individual. I saw this individual over a period of five years and the outcome was good. The individual is doing well now, functioning much better than before, has been symptom free for an extended period of time, and there was some structural change that went with this individual as well. So the outcome was positive. This time it worked; sometimes it won't go that way. But I would have those kind of experiences over and over with this individual.

This person had such an internalized sense of badness and so much primitive rage that I was scared of it. What would happen is that this person would make contact with me, and I would feel it. Part of the problem I was having was that there was no reciprocity between us; I didn't feel like I could make a connection. I thought, "Well, ok. What I'm feeling here is this contact. I'm making contact with this person. It's scaring the fuck out of me, but at least there is some sense of connection. If I could tolerate it and go with it, this is where the connection would begin." Once that happened, I got comfortable with it. I would say those experiences happened more regularly than with any other patient I have seen because of the primitive attachment that was there between this patient and myself. It was real primary process, in terms of sharing of boundaries, fusion of boundaries. I would lose track of other objects in the room or the fact that this individual was sitting in this chair and that I was sitting over there. I almost always know about when fifty minutes is up, but I would lose track with this particular individual. A lot of my usual sort of secondary process kinds of measures, or whatever, would not be as operative with this particular individual. There was a primitive crossing over of boundaries, which this individual needed. With some of the others that this has happened, it's happened more transiently. I'll have an

experience of it, kind of come out of it, and it's not as regular. With this individual it was just a constant sort of thing that would go on.

What's really pronounced is the affect, the shared affect, and the blurring of boundaries: the fusion of boundaries, the loss of boundaries, and the merger. The loss of self-differentiation. Loss of all these usual central ego functions, like time and spatial realities. It's like when you watch a movie and you forget that you are in the audience.

As with Example #1: "He's inside my house" (p. 111), the most salient feature of this experience is the frightening and disorganizing effect it has on the therapist. The content of this fear is likewise focused on the intensity of destructive, homicidal-suicidal impulses. As with the first therapist, this therapist seeks advice from his colleagues, but, in this case, their approach is to prepare the therapist for the high probability of some very negative outcomes. Meanwhile, the therapist's anxiety is mounting and shifts to include more than just his concern about the outcome of the case; he begins to undergo frightening altered states of consciousness. In this unusual state of mind, in a manner similiar to the first case, the boundary between what is real and what is fantasy is confused, and the therapist wonders, for example, whether the patient really has a gun or not. There is also a merger of experience and a sharing of boundaries, such that it becomes unclear who's experience belongs to whom. Depending on the state the patient is in when he arrives, the therapist frequently finds himself filled with the patient's affective experience. He experiences, for example, out of control rage and suffocating despair. He doesn't like having these unfamiliar experiences and struggles against them.

Despite warnings from his colleagues, and an increasing frequency of unsettling and confusing experiences, the therapist decides to go

ahead and commit himself to treating this case. He arrives at a formulation of these disturbing experiences as moments of contact with this person: the very connection that he previously felt was lacking and therefore made it impossible for him to help this patient. The experiences continue, but the therapist gradually feels more comfortable with them, and things eventually settle down.

Although less explicit in this example, one again detects a sense in which the therapist must take the case on and go through these experiences. This therapist describes the case as being a challenge or a test of his faith in the effectiveness of psychotherapy. He tries to keep a part of himself from becoming involved in this case, to protect himself from its uncertain outcome, but he finds that this does not work. He has to fully commit himself to the treatment to be effective. Although he does not talk about his need to commit himself to the case in terms of the dim recognition of aspects of himself in the material, as does the therapist in the first example, in both instances it is by immersing themselves in the feelings that are stirred by the case and allowing them to develop that an understanding of the experience emerges. Though the merging (or "fusing") of the therapist's and the patient's experiences seems to be the most central feature of this story, again, other features can also be seen. The therapist commits himself to the unfolding of an event that he realizes he cannot control or manage, as do the therapists in Examples #1 and #2. The periods when the therapist is able to formulate the case come after he has made this commitment. The therapist recognizes that these merger experiences are also the beginnings of a connection with this patient.

3) Connecting

The focus in the following example is on the particular emotional "atmosphere" between the patient and the therapist which facilitates the communication of experiences in a more significant manner. It is a subtle emotional attunement, which may go unnoticed, although it makes possible a greater depth to the psychotherapeutic dialogue.

Example #4: "Parallel regression"

Another kind of encounter that I find fascinating but don't really understand I call parallel regression. If a patient is moving into a more primitive mode, I also move into a more primitive mode. It's like someone were dreaming, and you were a part of their dream. But you aren't fused, your part of the dream is different from theirs, but they are collaterally related.

(Can you recall an example?)

It's hard to do. Like a dream, they have an elusive quality. I notice it after the fact. The first time I began to notice this happening was, at the end of the session, the patient would say, "I was really regressed." I realized I had been regressed, too. I may not notice it at all unless something focuses my attention on it.

(An example would be helpful.)

It's really hard to do.

I remember one. The patient was using the couch and started talking about early memories. It was old material, but with a different quality. They were more caught up in it. It had to do with isolation. I remember feeling almost tearful. The patient was conveying an affective state. We had been through the material before. The patient got more into it and began to cry. I was reminded of similar experiences in my own life, though they were different.

It's a resonance; like a sympathetic vibration in music. I don't think this would have happened--the patient wouldn't have gone there unless I was regressed, too. Content-wise, I hadn't experienced what the patient had experienced, but affectively I was familiar with the patient's experience.

(Regressive?)

Content isn't that important. The content has a quality of diffuseness. It's a state of being more than anything else. The important

thing is that affectively we were in the same place. I was a participant observer in the classical sense.

It wouldn't have happened that way if they were alone. The mental contents would be different. If they were alone, it would be more like dreaming.

By dream-like, I mean things flip around, content-wise. What seems to be important is affect. What I'm aware of is that if I don't respond to the patient, I limit the patient's capacity to regress.

This is not the same as fusion, because I am always aware of myself as separate. The patient may fuse with me, but that's something else.

Sometimes patients sort of unplug, come back a week later, and plug back in.

(There's a shared atmosphere.)

Atmospherics. Content is almost irrelevant; it's just a vehicle.

I find these fascinating; I don't know if much is written about them. Probably because the experience is destroyed when you put the word to them. It's like trying to elucidate fog and going out to put some in a mason jar.

The prominent aspect to this experience is the ongoing, empathic, emotional attunement. In the previous three examples, especially the "scared to death" experiences, there is also emotional connectedness, although the quality is different. The connection is lacking in reciprocity between therapist and patient, lacking in boundaries, and overwhelmingly confusing. In someways, the previous examples seem to lay the ground for the kind of empathic attunement described in this example, #4. The sort of emotional connectedness described is subtle and unobtrusive. It can be present without being noticed at all. It exists more as the background against which certain kinds of therapy experiences become possible for the patient. In contrast to merger kinds of experiences, separateness exists between what the patient and the therapist are experiencing. ("You aren't fused.") The experiences are similiar, the affect is congruent, but the therapist identifies the experience as comprised of his own material. When one tries to make

this attunement aspect of the therapy events figural, it seems to slip away. Like the dream-state to which this therapist likens these experiences, one is in these experiences without being aware of being in them, and one only becomes aware of them as one leaves or "wakens" from them.

There are many other examples that could be given from this category. As the examples in Appendix D show, they frequently involve a breakthrough in the patient's defensiveness and the establishment of a new level of relatedness where more affectively charged and meaningful material is communicated. This level of communication is often described as more playful, though it can still border on the uncanny, as when fantasies or affects that the therapist experiences seem to match very closely the patient's own feelings and fantasies.

4) Recognizing

Under the heading of Control, the emphasis was on the patient's impact upon the therapist, under the heading of Connecting, the emphasis was on the patient and therapist being together, while under this heading, Recognizing, the emphasis is on the therapist reflecting upon the patient as other. These experiences seem to span the range from more immediate or contemplative experiences, in which the patient is recognized as a "Thou," to more cognitively oriented reflections in which the dynamics of a case are clinically formulated. There is considerable range among the kinds of experiences that are grouped under this heading; yet, they all have a quality of coming to see something, as in an "aha!" kind of experience. I have provided two examples of this category to help convey a better sense for the range that is spanned.

The first experience (Example #5: "Moments of recognition") focuses on the more existential insight of recognizing something fundamental about the human condition, which seems to emerge from a moment of deep, but wordless, communication in which both patient and therapist are touched and affected. It shows similar aspects to the category of Connecting. The second example (Example #6: "Glimpses of the pathology") is also a moment in which the therapist has an insight into the patient's experience, and this knowledge affects and changes the therapist. This experience does not have the same reciprocity between patient and therapist, and it leaves the therapist in a more objective and clinical stance.

Example #5: "Moments of recognition"

I'm recalling, now, the sense of taking another person seriously. Moments of contact, when you permit yourself--I'm not saying it's voluntary, however you do that--when you permit yourself a recognition of that person's pain and the seriousness of their life, are extremely moving moments. To me, it's centered around looking in the person's eyes and not being afraid to see into them and not being afraid to let them see into you. Having a sense of how serious it all is. It often comes out around suicide. I've many times been involved with people who I thought were likely to kill themselves and recognizing that with someone and recognizing that it's not a mental illness to want to kill yourself or seriously consider that alternative. It's a very serious way of thinking about your life and the conditions under which it's worth living, taking responsibility for it. The decision to live or die is a very human act, a very central human activity.

One of the issues in treating people who are seriously disturbed, or seriously concerned with themselves, however you want to think about it, depends on whether you are willing to to be the most important person in their lives. Whether you can stand that without being so guilty and or conflicted about it that you push it away or so over gratified by it that you take advantage of it in an exploitive sense or whatever. But the other side to that, which I haven't thought so much about, is that it means letting patients be important to you. I do think there's an asymmetry, because I don't think it's the case that any one patient is the most important person in my life or that my patients collectively are. But as individuals, I do think they really

do have to be important to you, in the sense of your really encountering the events.

I think the whole issue of the kind of impact that patients have on therapists is not very well understood or thought about. We know about countertransference, but I'm not talking about that. I'm talking about the ways in which knowing that person and being involved with them in a serious relationship changes you. It must. At the very least you gain experience. That's almost trivial. In anthropology, if you think of the relationships between informants and anthropologists, close relationships develop. If you look at the history of the psychoanalytic movement, the number of patients that have become colleagues of analysts is pretty significant, especially in Europe. And if you talk about really serious physicians, and I mean life saving physicians, if you get to know them--like this one, who was an oncologist, was telling me, "I never treat my friends, but all my patients become my friends. It eats me up; I don't know what to do about it."

In this first example the emphasis is on how the patient, when allowed to address the therapist as "Thou," has an effect and changes the therapist. This sort of impact upon the therapist is different from the impact of the patient described in Example #2: "You ride the whirlwind" (p 122). The effect that the patient has in this experience results from the mutual openness and reciprocity in the dialogue rather than from any efforts by either participant to coerce or change the other. One can see aspects of connecting in this example; the therapist even refers to these as moments of contact and makes mention of how friendships can develop out of the patient-therapist relationship. What seems peculiar to this example is how the therapist is confronted by or addressed by this patient as a uniquely significant individual. The therapist comes to see or hear this patient in all his or her individuality. Beyond the affective resonance that was highlighted under our discussion of Connecting, there is an understanding that occurs as the therapist recognizes and allows the patient to address him uniquely and humanly as a Thou.

The following example provides some contrast to the preceding example by highlighting understanding in a more cognitive manner which also downplays the aspect of Connecting.

Example #6: "Glimpses of the pathology"

I was working with a not psychologically sophisticated individual, who has zero interest in learning about himself. It irritates me that a third party is paying for his treatment, which he needs, but he has no interest in it. Sometimes the facade drops and I get a glimpse of what is behind it. Then, I feel less irritated and can be more objective and therapeutic. It's not that the relationship improves or I feel closer in an interactive way, but it changes how I feel. I am more empathic, more patient, and more therapeutic. I have more understanding, and it allows me to pace with him.

Another patient is this obsessive, controlling, but bright young man. He grates on your nerves because of his obsessional need to control. He's rather schizoid with few friends, but I find myself in this battle with him about who's in control. At times, though, things change. I see the person behind the defenses, when he allows them to be dropped. He's scared and lonely. This changes the way I feel about him. I'm no longer doing battle with the defenses, and I have a window to the core of the pathology. I get a chance to look on through the defenses to the lonely, scared part.

Another example is this needy, octopus-like patient. He needs everything; he's like an empty pit. "Do you have coffee? Can I use the phone?" He would eat my bookshelf if it were digestible. The tendency is to say to him, "You want more than I can give." It came up that, as a child, he had found his parents, after the father had killed the mother and, then, himself. This information softened me. I can allow myself to give more. It triggers something maternal-paternal in me. I find that I need to watch my therapeutic distance with him. When he revealed this information, there was an immediate change in me. At first it was kind of a shock; then, "Oh, I understand why you do this." It allowed me to be more in tune with him and his needs. It's clearer what to do with him, because I know why he acts the way he does. I know he doesn't need coffee, and although I can't be his mother or father, I can help him deal with it.

The focus in Example #6 is upon how the therapist's insight into the patient's condition allows him to regain his therapeutic stance. For example, he sees the patient's behavior in a new light and is able to be objective about his feelings toward the case. He can now be more

responsive and in tune with the patient's real needs rather than just being reactive to the patient's prickly exterior. The therapist recognizes something more about his interaction with the patient than he was emotionally aware of previously. In a way somewhat similiar to the therapist in Example #2: "You ride the whirlwind" (p. 122), the therapist's objective insight helps him temper his emotional response to the patient.

Summary of Types of Experiences

I. Losing Control

Characteristics. These experiences are often precipitated by the patient's effort to coerce something from the therapist. If the therapist over-reacts, the situation may get out of hand and end the therapy. As he tries to maintain a degree of control, the therapist may experience himself as swept along by the events, but if the therapist can tolerate these experiences, they often lead to a better therapy relationship.

Example. #2: "You ride the whirlwind" (p. 122). The patient becomes increasingly demanding of the therapist, eventually refusing to leave the office at the end of the hour. The therapist feels he is being pushed to his limits, and is tempted to retaliate. Instead, he maintains a degree of self-control and objectivity, which allows him to "ride" the situation out, responding primarily on an intuitive level.

II. Merging

Characteristics. These experiences are characterized by a frightening loss of boundaries between self and other and between reality and fantasy. There is a confusion of the patient's and the therapist's experiential states, which often have to do with primitive aggression. There may be a movement from these fusion states, for example, with a supervisor, during which the experiences are temporarily separated out and formulated. These moments are typically followed by a return to the more confused condition. This oscillating movement in and out of the confused states seems to gradually lead to greater differentiation.

Examples. #1: "He's inside my house" (p. 111). The therapist takes on a paranoid patient who is struggling with homicidal impulses. The therapist's fear of the patient's threats leads him into paranoia, too. Underlying this confusion, there is a striking correspondence between their lives, which facilitates an overlapping of unconscious issues.

#3: "Scared to death" experience (p. 126). The therapist is working with a patient who is struggling with homicidal-suicidal impulses. The therapist experiences states of confusion and affective merger with the patient's emotional states. The therapist allows himself to go with these experiences and eventually recognizes them as moments of primitive contact with the patient, which the patient needs.

III. Connecting

Characteristics. A deeper, empathically attuned communication emerges between patient and therapist. It is often characterized by a special, emotional atmosphere they share. In contrast to Merging experiences, the therapist retains a sense of individual identity; therefore, these experiences are less obtrusive and unpleasant.

Example. #4: "Parallel regression" (p. 130). A shared affective state, which is recognized after the fact, makes possible a more meaningful communication. The therapist affectively resonates with the patient's regressed, emotional state, while retaining a sense for how his own experience is different from the patient's.

IV. Recognizing

Characteristics. The therapist comes to see, understand, or recognize something important about the patient. These experiences range from a wholistic appreciation of the other, as when the patient addresses the therapist as a Thou, to a more objective, clinical grasping of the patient, as when the patient is seen (understood) in terms of some theoretical formulation.

Examples. #5: "Moments of recognition" (p. 133). A moment of contact in which the therapist realizes the seriousness of the patient's pain. This may occur, for example, when the patient seriously considers the question of whether to go on living. The therapist realizes how central a human act this decision is.

#6: "Glimpses of the pathology" (p. 135). The therapist describes times with some difficult patients when he could see past their facades to the issues hidden behind them. These moments do not necessarily bring the therapist and the patient closer together, but they allow the therapist to be more objective and maintain a more therapeutic, non-reactive stance.

Essential Aspects

The previous section attempted to highlight the differences among four categories of experiences that therapists had; although considerable overlap and similarity also could be seen. Trying to account for shared characteristics brings us to the next level of description; a level which recognizes that there are aspects essential to all of these experiences and that such aspects exist in a particular relationship to one another.

An Overarching Theme: Oneness and Separateness

Let us reconsider Example #1: "He's inside my house" (p 111). Though the most striking aspect of this narrative was the merger of the therapist's and the patient's experience, there were other features of the story that could have been coded under other categories of therapist experiences. For example, after the first interview, the therapist returned to his former supervisor and together they formulated the case (Recognizing). Following this, the therapist found himself increasingly swept along by the therapy events. His daily routines were dramatically altered to accommodate an increasingly paranoid response to the patient

(Losing Control). He came to a decision to let these events run their course and to go through with what he was experiencing without trying to manage them externally (Losing Control: "you ride the whirlwind"). As a result, he has the dream involving himself, the patient, and the supervisor (Merger), which he and his supervisor interpret in terms of unconscious issues over which he and the patient are identified (Recognizing). This time formulating the case allows patient and therapist to differentiate from each other. Consequently, the fusion is replaced by a more mature level of relating, which is based on empathy and separateness (Connecting). Finally, the therapist ends his account with a comment on how he had to heed the way in which this case made a claim on him. He felt compelled to take the case seriously, in the same fashion in which he needed to take his own life seriously (Recognizing: "moments of recognition").

Throughout this story, there seems to be a dialectical movement, hinging on the theme of personal boundaries. In the experiences of Merger, for example, ordinary boundaries become confused and the usually clear distinctions between self and other and between reality and fantasy are obscured. The sense of Losing Control, which the therapist also goes through, carries a feeling of being taken up or absorbed by events, such that one's usual sense of freedom is minimized.

In contrast to these experiences of boundaries being obscured, changed, or crossed, there are other moments when such familiar boundaries are re-established. This is most apparent when the therapist formulates the case (Recognizing). These moments allow the therapist to take a more objective stance, which is sharply different from the

experiences of Merger against which he struggles. The therapist seems to regain some of his more usual sense of orientation and identity. As a result, the formerly dramatic shift between familiar and unfamiliar states gradually become modulated and exist in a kind of balance. This is apparent in the therapist's emerging sense of being connected to the patient. Such connection is based on the therapist's empathic understanding of the patient's issues, which involves an identification with the patient, but the therapist, now, retains a sense of being separate from the patient.

The therapist also regains a paradoxical sense of control when he decides to go through with (undergo) such experiences rather than trying to avoid them. In this case, the therapist chooses to allow events take their own course, free of his efforts to control them. Again, things settle into a kind of balance, and both freedom and constraint come to find their place.

It may be useful to look more closely at the four categories of therapist experiences in terms of this theme of Boundaries or, more generally, the experience of Oneness/Separateness. Clarifying this underlying theme should make more understandable how therapist experiences reveal characteristics of more than one type of experience; on this basis it should become possible to describe how such experiences stand in relation to each other. Table 1 summarizes the manner in which the theme of Oneness/Separateness appears in each of the four categories of experiences.

In the first column of Table 1, "Categories", the four types of therapist experiences are presented: Merging, Connecting, Recognizing,

TABLE 1

VARIOUS APPEARANCES OF "ONENESS" AND "SEPARATENESS"
IN THE DIFFERENT CATEGORIES

<u>Category</u>	<u>Oneness</u>	(Relationship)	<u>Separateness</u>
<u>Merging</u>	Merging Fusing [Figural]	(Exclusive and non-reversible)	Individuating Separating [Absent]
<u>Connecting</u>	Empathizing Resonating Attuned [Figural]	(Conjunctive; figure/ground)	Separating [Background]
<u>Recognizing</u>	Communing Intuiting [Figural or Absent]	(Exclusive but reversible; either/or)	Objectifying Formulating [Figural or Absent]
<u>Losing Control</u>	Coerced Undergoing Embedded Determined Submerged [Figural or Absent]	(Exclusive but reversible; either/or)	Free Controlling Acting Choosing Transcending [Figural or Absent]
	[Figural]	OR (Conjunctive; figure/ground)	[Background]

and Losing Control. In the second column, "Oneness", the characteristic descriptions which could be seen as instances of the major theme of Oneness (e.g., "Merging", "Empathizing", etc.) are listed for each of these four categories. In brackets, the manner in which these characteristics appear has been described (e.g., as "Figural"). The fourth column, "Separateness", presents the characteristic descriptions which could be viewed as instances of Separateness. In brackets, the manner in which such characteristics are apparent is described. The third column, "Relationship", is meant to capture how the Oneness and Separateness characteristics for each category occur together as a pair (e.g., in Connecting experiences, Empathizing and Separating are both present, though empathizing is Figural and Separating is Background). Relationships between Oneness and Separateness characteristics will become clearer as each category of experience is considered in turn.

Looking at the Merging experiences in Table 1, we see that the Oneness aspects of merging and fusing are figural and stand out against the absence of the Separateness aspects of individuating or separating. The relation between these two sets of terms seems to be an exclusive, non-reversible, condition. In other words, if individuating were present, the merging aspect would disappear and one no longer would be involved in an experience of Merging.

The Connecting experiences demonstrate a different relationship between Oneness and Separateness. The figural Oneness aspects of empathizing and emotional attunement take place against the implicitly present background of simultaneous separateness. They both need to be present. Without the presence of separateness, one would be describing

Merger experiences; without the presence of empathy, one probably cannot speak of Connectedness.

In the Recognizing experiences, we again find an exclusive relationship between the Oneness aspects of communing and intuiting, on the one hand, and the Separateness aspects of objectifying and formulating, on the other. In other words, one is either experiencing a sense of communion with the other as a Thou, or one is objectifying the other as an It; one cannot experience both aspects simultaneously. In contrast to the Merging experiences, one can have either the Separateness aspects figural or the Oneness aspects figural, moving from one form of Recognizing into the other and thereby making a reversible situation possible.

A similar, either/or, reversible relationship appears with experiences of Losing Control. One can move from undergoing to controlling or vice versa, although the one negates the other. Though this is the more typical experience, many of the stories also present a figure/ground relationship more like that described for the Connecting experiences. In this experience, the Oneness aspect of undergoing is figural while it takes place against the background of Separateness. The therapist has chosen to undergo what he or she is experiencing; thus, Separateness is implicitly present as a background.

Using Table 1 as a guide, it becomes simpler to describe the movement already noted in Example #1: "He's inside my house" (p. 111). The first phase of merging is followed by times of objectifying the case. Eventually, the separateness necessary for formulations co-exists with the oneness present in merging, and an empathic understanding of the case becomes possible. At the same time, the sense of being swept along

by events is modified by the therapist's decision to undergo these experiences. This simultaneous experience of choosing and undergoing leads to the dream, which expresses an intuitive understanding of the patient. It also emphasizes the fundamental way in which the patient is addressing the therapist, which cannot be ignored.

Table 1 was constructed along the theme of Oneness/Separateness underlying all four categories, which suggests that the categories provide only a preliminary outline of what is essential to therapist experiences in treatment. Looking at the various aspects of Oneness/Separateness in Table 1, it is possible to simplify things. This is most easily done on the Separateness side, where the notion of separate occurs twice: once under Merging and again under Connecting. Thus, we can reduce things to three general aspects of Separateness: Individuating, Thinking, and Acting. On the Oneness side, it is less clear whether things can be simplified in the same way although the Oneness aspect of empathizing is experientially close to the Oneness aspect of intuiting, insofar as both are immediate ways of knowing the other.

Such similarity suggests that the Oneness side of Table 1 can also be simplified to three more general notions: Fusing, Intuiting, and Undergoing. Again, we can match up Oneness and Separateness terms in pairs. The first pair remains Fusing/Individuating and describes a theme concerned with the therapist's sense of identity. The second pair is the previous Undergoing/ Acting theme, and describes the therapist's sense of agency. The final pair is Intuiting/Thinking which describes the therapist's mode of awareness or of knowing the patient.

These pairs are presented in Table 2, where gerunds have been used to label the themes. In contrast to nouns, which tend to imply that we are dealing with static entities existing independently of ourselves, gerunds seem to emphasize that themes are manifestations of a living, changing, human phenomena.

TABLE 2

OVERARCHING THEME AND ESSENTIAL ASPECTS OF THIS THEME
IN THERAPISTS' EXPERIENCES

<u>Boundaries:</u>	Oneness	Separateness
<u>Being</u> (Identity):	Fusing	Individuating
<u>Doing</u> (Agency):	Undergoing	Acting
<u>Knowing</u> (Awareness):	Intuiting	Thinking

At this point, we have moved to a level of abstraction which is as far from the concrete level of the actual narratives as can be justified by present procedures. At the same time, these three pairs of terms (Fusing/Individuating, Undergoing/Acting, and Intuiting/Thinking) seem sufficient to describe the essential features of the experiences related by therapists in this study. These three pairs seem to articulate the dimensions upon which therapy dialogue moves. In a similar fashion to the overarching theme, of which these are more specific instances, they describe dialectical tensions that therapy aims to bring into harmony.

Neither aspect of these paired processes can be reduced to or take the place of the other without disturbing the psychotherapeutic dialogue. It is the co-presence of both that makes the dialogue work. Not surprisingly, for a study that focuses on striking psychotherapy interactions, the events that therapists describe tend to emphasize the preponderance of one of the Oneness/Separateness aspects at the expense of the other. In many examples, one sees a movement towards integrating the initially most salient aspect (e.g., merging) with the other (e.g., separating). Experiences that are typified by the co-presence of Oneness and Separateness aspects in some sort of balance, such as experiences of empathic connection with the patient, seem to be closer to the end points of psychotherapy. Those experiences emphasizing the preponderance of Oneness or Separateness alone--for example, the experiences of merger or of being controlled by the patient--seem to be closer to the beginning point of therapy.

In the next chapter, the nature of the relation between these paired terms will be considered in more detail. By expanding upon how the members of these pairs are irreducible and need to be treated together, the following discussion hopes to clarify and better articulate the difficulties that psychotherapists encounter in trying to develop theories and techniques, which remain grounded in an immediate experience of therapy.

CHAPTER V

DISCUSSION

Results of the present study suggest that therapist experiences of psychotherapy may be characterized by a dialectical tension created across the boundary of Oneness and Separateness. While such dialectical tension is probably discernible in any dialogic event, therapist experiences exhibit this tension in unique ways. For example, one of the most striking instances of boundary tension occurred as Example #1: "He's inside my house" (p. 111), where the therapist found himself living through events beyond the boundaries of familiarity. The therapist felt as if he had lost the protective boundary delimiting his usual self and was flooded by unpleasant, alien experiences. ("I felt as if my own unconscious had been just turned inside out, and my defenses raked off, and I was left really naked") This disruptive confusion of identity was accompanied by a sense of no longer being in control and of simply being swept along by events; at the same time, this confusion seemed to take place against the background of some sort of intuitive understanding of what was happening.

The tension in Example #1 seemed to be created by the therapist's efforts to come to terms with these dislocating and unfamiliar experiences. Oneness experiences had to be allowed alongside with experiences of Separateness, and a back and forth movement occurred, as the therapist alternated between confused merger and lucid separateness. Eventually, both sides of the Oneness/Separateness boundary seemed to settle into co-existence and the therapist had a sense of achieving a new level

of well-being both for himself and the patient. ("I felt much better. I have always felt more like a man since tackling that case and going through the valley of being really as frightened as I have ever been.")

Experiences such as these suggest that therapeutic dialogue seeks to bring together contrasting aspects of Oneness and Separateness without reducing one to the other. The outcome of this effort is seen, for example, in experiences of Connecting. In Example #4: "Parallel regression" (p. 130), the therapist describes experiences of empathic attunement with patients; such attunement involves aspects of both identification (i.e., fusion) and separateness vis a vis the patient. The tension across the Oneness/Separateness boundary, however, does not achieve a final resolution with moments of attunement; rather dialogue appears to follow a dialectical path. Phases of balance and harmony are followed by one or another aspect re-asserting itself as the dialogue continues to search for new forms of wholeness to balance the tension between contrasting aspects.

Oneness aspects are emphasized in many of the examples since they tend to be so striking and, therefore, so memorable. They stand out, in stark contrast, against the background of more familiar experiences of Separateness (i.e., of being a separate individual who is capable of acting freely and with deliberate awareness). Experiences of Oneness have a sort of indigestible quality to them since they neither can be ignored nor rendered in terms of the familiar. The aim of this chapter is to describe how aspects of Oneness and Separateness stand in relation to each other and how they underlie the dynamic movement of the psychotherapy dialogue.

Before proceeding to discuss the pairs Fusing/Separating, Acting/Undergoing, and Thinking/Intuiting, a few words of caution concerning the phenomenological status of these terms are in order. One pitfall to be avoided is in reifying them by treating them independently of the examples in which they were given. These aspects are not elements out of which phenomena are to be re-constructed: they are not the "real nature" of things nor are they the "causes" behind them. The aim is one of description, not explanation. The themes arrived at present what emerged as most essential to these therapy events; yet the wholeness of these occurrences overflows conceptual labels and we can never exhaustively describe these phenomena. This is not to say that we cannot become aware of and communicate about these events in their wholeness; simply to indicate that this cannot be done on the basis of constructing a technical or artificial language.

There is an inherent dialectic between concrete examples and the essential aspects used to describe them; a dialectic of part to whole. In proper balance, examples and essential aspects present the results of this study in a meaningful way. If there is too much sheer particularity and concreteness, the events remain opaque and ineffable and do not exemplify anything. If there is too much emphasis upon the "essential aspects", the results become too abstract and irrelevant to experience.

This part/whole dialectic seems to be a more general manifestation of the dialectical tension between Oneness and Separateness with which the therapists struggled in their experience of therapy events. Since this study's approach to its topic has tried to reflect efforts at

understanding engaged in by therapists, it is not too surprising that there are parallels. The purpose of this chapter is not to build a model or elaborate a theory explaining experiences gathered in this study. Its purpose is to highlight and emphasize relationships among descriptive aspects already delineated.

Boundary Dialectics in the Psychoanalytic Literature

The existing therapy literature, surveyed in Chapter II, has already introduced a discussion of dialectical tension across boundaries. In comparing Langs's deliberate efforts to formulate the meaning of a case with Reik's more intuitive approach, the Knowing dialectic of Intuiting/Thinking was foreshadowed. Searles also was considered, since he attempted to bring the intuitive and the conceptual together in his practice and writing.

Long-standing controversies within the psychoanalytic movement have been thematized in terms of contrasting pairs, such as between feeling and thinking, nurturance and insight, art and science, narrative coherence and objectivity. The fact these controversies have not subsided suggests it is impossible to reduce one pole of the controversy to the other. Both aspects need be heeded and given a place in understanding the practice of psychotherapy.

With these dialectical controversies in mind, the major schools of classical, Kleinian, self, and object relational psychoanalysis may be discussed in terms of how they attend to therapist experiences of psychotherapy. We now can see that the classical approach emphasizes the Separateness pole, especially in terms of Thinking (i.e., cognitive

insight). The classical analyst attempts to move psychotherapy dialogue in the direction of an overt expression of unequivocal meanings (Langs 1976a, 1976b, 1978). An implication to this emphasis is that the patient's ordinary interactions are viewed as too skewed in the direction of Oneness. Therefore, it becomes necessary to shift the emphasis in the other direction towards Separateness, Acting, and Thinking. As a consequence, classical analytic writers (e.g., Kernberg, 1975; Blum 1979/1980; Langs & Searles, 1980) tend to reduce or minimize the tension between Oneness and Separateness by giving preference to Separateness aspects and trying to subsume Oneness under them.

The Kleinian approach maintains some of the classical emphasis upon separateness, since it, too, delimits the analyst's role to neutrality; i.e., the therapists only appropriate activity is to give interpretations to the patient (Klein, 1951/1981; Segal, 1967/1981). At the same time, we begin to see a greater emphasis on aspects of Oneness. For example, the therapist's identifications with the patient are highlighted, and intuitions that result become meaningful communications. Furthermore, the therapist's own communications (or interpretations) to the patient are framed in terms of fantasies, shifting the focus to the imaginative instead of the literal. The gratification of needs is still abstained from, although the therapist directs interpretations at the patient's current, deepest level of anxiety, thereby requiring the therapist to maintain a responsive attunement with the patient. There is, thus, a greater tension in the Kleinian approach between aspects of Oneness and Separateness than is true of the classic analytic approach (Grotstein 1981, 1984). The Kleinian therapist affirms Separateness as

a necessary aspect of treatment by maintaining a neutral, analytic stance; despite this stance, aspects of Oneness also are given weight by stressing the roles of fantasy and attunement.

The tension between Oneness and Separateness becomes even more central in Self psychology. Here tension occurs between the therapist's empathic attunement with the patient and a failure to gratify patient needs (Kohut, 1984). There is a constant interplay between the therapist's functioning as an empathic selfobject, partially merged with the patient, and the therapist's separateness from the patient. The self psychologist's aim is to move the therapy dialogue along towards the Separateness pole while maintaining aspects of Oneness. This is done by replacing archaic forms of Oneness with more mature forms as empathy substitutes for fusion.

Object relational writers emphasize the reality of the patient's need for relationships and the therapist's role in meeting these needs (e.g., Winnicott, 1971; Guntrip, 1969; Khan, 1974; Balint, 1968). As with self psychology, the most figural tension is that between the patient's wish to withdraw and relate exclusively with fantasized objects and the therapist's effort to move the patient into a dialogue with the external world. This work is impeded primarily by the patient's anxiety about loss of objects by separation. The therapy dialogue must meet a portion of the patient's needs in order for the patient to relinquish a dependence on fantasized relationships (Guntrip, 1969). The proper proportion of Oneness to Separateness depends upon the patient's needs at the moment. Winnicott's (1951/1958) discussion of the experience of illusion illustrates this effort to harmonize

aspects of Oneness and Separateness (or in his terms, fantasy and reality) in interpersonal relationships. Winnicott stresses that it is crucial for people to develop capacities (such as play) to bring the dialectical aspects of Oneness and Separateness into communication with each other. In Winnicott's theory, this tension between fantasy and reality is the fundamental issue we all must deal with throughout our lives (Winnicott, 1971).

Boundaries

To understand the results of this study, it is necessary to discuss dialectical tensions created by boundaries. Gestalt psychologists (Kohler, 1947) introduced this term in their work on figure-ground relationships. As they noted, every figure implies a background that must be taken into account when describing a perceptual event. In more general terms, it can be stated that every boundary, which demarcates some thing, also implies a beyond the thing--an other side to the boundary. It is not possible to have one without the other. A boundary demarcates a difference, and the two contrasting aspects are not independent of each other. They need to be taken together to describe any event in its wholeness.

Psychoanalysis also has roots in the dialectic described by boundaries. The most essential boundary that Freud described was that between conscious and unconscious. Though this topographic model was later superseded by the structural model (where the crucial boundary was drawn between the ego and the id), a very important point remained: we are more than we typically recognize ourselves to be. We usually identify

ourselves with consciousness, but who we are extends beyond this familiarity. From the beginning, psychoanalysis was founded upon the idea that we simultaneously are delimited by certain borders and intimately connected with what is on the other side.

Another important boundary in psychoanalysis is that between reality and fantasy. This distinction is not unrelated to the boundary between ego and id, since the former's province is reality and the latter's wish-fulfillment. Managing the boundary between reality and fantasy, as noted by Winnicott (1957/1958), is a fundamental problem which people must come to terms with throughout their lives. Classical psychoanalysts rightly emphasized the importance of being able to separate and distinguish fantasy from reality. Object relational analysts balanced this view with their own emphasis on how our lives can only be creative and enriched if we find a way to allow reality and fantasy to have contact with one another. By considering both of these points of view, a recognition emerges of our vital need for certain boundaries along with our need to maintain some kind of communication across boundaries. Borders (and the contrasting aspects they delineate) must be taken into consideration to come to terms with the totality of our being.

Charles Scott: Boundaries in Mind

Boundaries and Awareness

The title of Charles Scott's book Boundaries in Mind: A Study of Immediate Awareness Based on Psychotherapy (1982) suggests that it should have something to say about tensions created across boundaries.

In this work, Scott describes boundaries as essential constituents of awareness. Since awareness is constituted by difference, awareness can only occur insofar as there are boundaries. This view is reminiscent of gestalt psychology's observations about figure-ground relations. Scott goes on to assert that awareness is not a "subjective" activity. He supports this by focusing his study on experiences of immediate awarenesses in which boundaries, themselves, become apparent. He refers to these states of awareness as boundary or border awareness and they are often distinguished from experiences of ordinary awareness (i.e., awareness associated with personal identity or a familiar sense of self) by their strangeness. The borders constituting awareness become apparent when we find ourselves on the other, unfamiliar side of them. It is difficult to attribute personal agency to an experience in which one finds one is no longer one's "familiar" self. Scott claims that attending to border awareness provides the key to understanding ourselves "in the full sweep of the awareness of which our intellects and personal identities form a part" (Scott, 1982, p. ix).

Instead of giving preference to more familiar and comfortable aspects of awareness encompassed by the boundaries of identity, rational thought, and intentional activity, Scott emphasizes the importance of non-personal, non-cognitive, and unintentional aspects of awareness. The present study has also come to recognize such aspects as relevant, grouping them under the major theme of Oneness. Since the two projects overlap in this area, Scott's discussion and results of the present study should be mutually informative. What Scott has to say about boundary awareness should provide an interpretive context for

experiences described in this study; examples provided by the present work should concretely fill out themes elaborated by Scott's more philosophical approach. Both studies share the question of how both to describe and to come to terms with experiences that bring us to the limits of our personal selves and beyond. In other words: how can we describe the inherent tension of awarenesses at the border?

Being: Identity and Boundary Awareness

Awareness is constituted by differences and this includes awareness of personal identity. Our identity is formed, for example, as we discover how we are different from the world, from our parents, and from others. Desires, interests, and concerns provide important sources for differentiating things; consequently most experiences of awareness are associated with an accompanying sense of identity, a subjective "self".

In addition to awarenesses having this sense of personal identity, we sometimes experience an awareness that takes us to (or even across) the boundary of what we familiarly describe as "being ourselves". Some of the examples in this study, are powerful instances of such dislocating occurrences: experiences that threaten us with the possibility of "possession, loss of a sense of identity, [and] a failed capacity to be one's own answer" (Scott, 1982, p. 96).

The positive aspect of these non-personal and dislocating events is that they call attention to how our being encompasses more than the domains that we typically inhabit.

As beings we are the differences that are set against our identities. In those differences our awareness happens as dream, fantasy, intuition, and break of common sense. Those awarenesses often seem foreign to us. Our awareness at first

seems vast to us in comparison to the consciousness that we own as ours in particular. We tend to disown our extended awareness, to refuse the otherness of our own being by trivializing it or by attributing the awareness in difference to other beings, to dark outer regions, or whatever. But we are the dreams and fantasies and breakages that happen in mind. Their excess of our identity and character does not deny the living nature of their event. Only the absoluteness of the limits of identity, individual and cultural, for our own being is denied. (Scott, 1982, p. 96)

Dislocating experiences confront us with a problem:

We, as individuals who must cope and be some "who" or other, cannot reside at once in all the dimensions of our being. Nor can we perpetually cross borders without losing our particularity. We are dwellers. We are each aligned with some aspects of our being while we are distanced and even alien to others. To try and be in all of them is like trying to be a god, and destruction of person appears to be inevitable if one persistantly, with some success, denies the limits of his/her rootage and dwelling place. (Scott, 1982, p. 89)

How are we to maintain a personal sense of identity, while also acknowledging that "in being who I am in particular, I am in my awareness beyond my particularity in common with all" (Scott, 1982, p. 59)?

Scott turns to mythology for help describing these extra-personal experiences. Since myths provide a self-aware media for conveying experiences, they help to make events understandable. Similar to examples used in this study, myths are illustrative and illuminating. Scott introduces the myth of Hermes to characterize occurrences of boundary awareness. Hermes' name is derived from the Greek word herm: a four-cornered stone used to mark pathways and delineate borders. Hermes marks out differences and sameness but is not concerned with the order within any region--he does not take sides. "He seems to give, without judgment, place and word to whatever is" (Scott, 1982, p. 21).

In his role as guide, Hermes is not to be confused with being guide of the way. "He is a guide in the sense that he marks and makes apparent the other, the strange, the dark, the unfamiliar, the mystery-in-this-context" (Scott, 1982, p. 18). His name is associated with unexpected experiences in which we are guided across borders, in and out of aspects of ourselves and our world that are excluded by our everyday routines.

Being with Hermes on ways and borders is an experience of being alert in a setting that far exceeds the consciousness characteristic of our personal character and identity. His myth imagines us accompanying a kind of shooting star to a region of awareness where ordered security is not a primary principle of life, where accuracy is not a measure of truth, . . . and where the presentation of whatever announces itself is a source of attention, no matter the practical consequences. Being with Hermes is being open to the borderline of words, ideas, situations, and circumstances. Being with him involves that remarkable capacity of being in something and also being aware of a beyond-this-something with which we have a kinship that seems strange right now. (Scott, 1982, p. 19)

These awarenesses at the boundaries of our identity bring to our attention the inherent tension in our being between who we habitually are, when we are feeling ourselves, and the commonality that we have with the other side of the boundary. The Merger kind of experiences described in this study, in which the Fusing aspect was most figural, place identity into a larger context of Being from which it stands out as a figure against a background. To the perspective of personal consciousness, the immediate experiences of these therapists felt foreign (e.g., "I was in an altered state I was clinically paranoid."), and overwhelming (e.g., "It was like being underwater and frantically trying to get to the surface."). These experiences also served to put therapists in touch with unfamiliar aspects of self ("I found a

substantial piece of myself in him."). The implication is that a context of awareness larger than personal consciousness is necessary to interpret events that dislocate a familiar sense of self.

Knowing: Immediate Awareness, Intuiting, and Interpreting

During moments of immediate awareness, one is in touch with aspects of being that transcend personal identity; these experiences are not an intellectual or reflective knowledge of things.

Immediate states of mind are always intuitive, as distinct from conceptually objective, and they are often affective. One usually can approach such states by following feelings, staying uncritically alert with affect, or giving focus to emotions. (Scott, 1982, p. x)

We do not make these states of mind; we live them. They reflect "our alertness as we live" and "how we are immediately in the immediacy of what is" (Scott, 1982, p. 1 & 3). Descriptions offered by therapists of intuitively understanding a case provide good instances of immediate awareness. For example, the therapist in Example #1: "He's inside my house" (p. 111) was alerted that there was something more going on with the patient by the mood invoked in him. ("It felt like something heavy was in the room, and I knew easily that I was frightened to be there.") By following this feeling, as it developed into the therapist's own paranoia and his dream about the case, a more reflective awareness emerged.

The present study described Intuiting as one of the essential aspects of therapists' experiences. For Scott, intuition brings a person into communication with the larger context of awareness and being, of which our personal consciousness and identity are a part.

Intuition does not happen as a procedural process, as a methodologically developed structure of concepts, or as a step by step understanding or as a personally arbitrary activity. It is seeing into or in something as it happens. . . . Intuition . . . usually involves drawing near to things. It is not an abstracting gaze, but is touching awareness, alert in proximity, intimacy of a sort

As one intuitis one is deeply in touch with the whole situation of awareness. (Scott, 1982, p. 8-9)

Given this quality of "touching awareness," it is not surprising that therapist intuitions, even if incorrect, should lay the ground for improving connectedness between therapist and patient. The therapist in Example #3: "Scared to death experience" (p. 126), thought at times the patient had a gun and was going to shoot him and, although these intuitions proved incorrect, they provided the beginning of a personal connection that had been missing previously.

Scott calls the larger context of awareness, with which intuition puts us in touch, mind.

Mind is the occurrence of awareness that has within it multiple directions. At the same time, it is our immediate awareness, an immediate sense of its own occurrence. I know of nothing else in the universe like mind, this self-aware event that encompasses conscious and non-conscious relations and that is lived by a particular person as a surpassing enormity of directions, depths, mysteries, meanings, and other powers and experiences with which he/she can be only vaguely in touch. (Scott, 1982, p. 25)

Mind "transcends our particular points of view, dislocates those regions of familiarity that dominate or define us" (Scott, 1982, p. 27). The non-personal experiences of merging and fusing, mentioned in the previous section, place us in immediate touch with the transcendent realm of mind.

From the perspective of personal consciousness, mind is beyond what we feel knowledgeable about or familiar with. It seems elusive and

illusionary so we sometimes tend to dismiss mind as fantasy. In examining the roots to the word fantasy, however, Scott shows that it carries meanings that convey essential facets of mind. Fantasy has the same Greek root as phenomenon, namely phainein, which means to show or to appear. "The word rightfully means 'coming to visibility' or 'appearing' and carries with it an overtone of the in-breaking of the unexpected or of the unknown into a region of knowing" (Scott, 1982, p. 28). The words fantasy and phenomenon connote how things happen in mind by presenting themselves; they express the quality of things coming forth as events.

Mind is not just a subjective realm, some kind of interior region set against the exterior world. Mind is the occurrence of all kinds of events--world events. Everything presents itself in mind as world event to our worldly presence. Mind is not a subjective project. Everything that occurs in mind--whether visual, cognitive, or imaginative events, etc.--happen with meaning and awareness; but not by our making. The sheer presence of things, as we mind them, is interpretive.

The world happens as relations among things that are themselves structures of awareness as one lives through them. . . . Like fantasy, world is lived out and lived through, often when we do not know what we are doing or why. (Scott, 1982, p. 46)

The meaning of the word interpretation needs to be reconsidered in light of the eventful occurrence of the world and immediate awareness. It is not necessarily a controlled, subjective activity. Although the English definition of the word carries the Roman connotations of apprehending something in such a manner that there is a simultaneous presence of awareness and order (e.g., to explain, to construe), the Greek word,

hermeneuein, does not carry this connotation of order. The Greek emphasis is on the sheer presence of things. For Scott, interpretation is the coming into presence of things with our own presence. Meanings that show forth in this manner may not fit our expectations or desires to master things; they put us in touch with the larger event of how we co-happen-in-the-world with things--how we participate in world events. Interpretations are not self-contained; they expression our life in world and mind.

Implicit in this discussion of interpretation is a notion of truth different from the usual one. Our tendency is to understand things in terms of substantives and, therefore, to associate truth with certainty and exactness.

We tend to want the real to be something that is exactly as it is--literal, not fictional or imaginal or fantastic. We tend to want to be free of our gazes and regards, to be in touch with how things really are. Really then means out there, by itself, just as it is without regard for my regard of it. So we seek to be exact. If we can get a predictive bead on where something is headed or developing we suspect that we are knowing it in its situation. And we measure. Our goal is an honest exactness, unshaded by deception, speculation, imagination, or even history. (Scott, 1982, p. 29)

When we center our interpreting upon the eventfulness and showing forth of things, truth becomes self-disclosure (Heidegger, 1927/1962, p. 56). Our concern is how faithfully to present something.

Something is its own truth as it comes to be present or is available as something. . . . Our word truth has the Anglo-Saxon history of meaning faithful and constant. It may be taken to approximate the Greek sense of unhiddenness [alethia]. How something is apparent and abiding is its truth. (Scott, 1982, p. 52)

Certainty is not necessarily the proper standard for evaluating interpretations.

Interpreting as it is lived out is itself the reality to be focused on. . . . A final issue for all interpreting is life in mind, not accuracy within a field of reference, and no interpretation is true that weakens passion for being, regardless of its accuracy, tightness of method, and capacity to hold things in what appears to be deathless certainty. (Scott, 1982, p. 54-55)

These thoughts emphasize the need to appreciate immediate states of knowing, such as intuiting, in a manner different from how we judge efforts to be scientific and/or objectively conceptual. We live interpretations, and how they effect our being as they are lived is the critical issue.

Many experiences reported in this study can best be understood from the perspective of therapists living through interpretations in which the sheer occurrence of events is meaningful. Returning to Example #1: "He's inside my house" (p. 111), the therapist spent several days living through a state of paranoia for which he had no clear understanding at the time; yet this experience eventually increased his understanding of himself and the patient. The dream that he had, at that point, was an event that had to be lived through before its significance could be appreciated. In instances less dramatic than Example #1, stories relate how a previous interpretation came to grief (cf, Example #8: "If you've gone to college you can never be psychotic", p. 202) or how a previously theoretical interpretation came alive (cf, Example #44: "It's different when you see it with your patients", p. 234); in all of the examples, however, understanding was something lived. We experience immediate understanding quite apart from our efforts to think about and objectify things; their co-occurrence with us is meaningful.

Doing: Freedom and Eventfulness

To review what already has been said, we began with experiences of boundary awareness, states of mind that take us to the edge of--and sometimes beyond--the range of our familiar identities. Boundary awareness brings to our attention how we have a kinship with what is strange and excluded by habits of staying within familiar borders. Immediate awareness is not personal consciousness. It tells how we are co-present with other presences and live events interpretatively. The issue is not whether we interpret but how we interpret; this implies that there is a way to comport ourselves appropriate to how events are born in mind.

We have already reflected on the world as a non-substantial event. We are noting now that how things are apparent involves a purposeless occurrence of being, . . . which is something like a call to that dimension of us which is not the same as who we are in particular. Freedom, in the sense of being open in this openness of the world, a non-prescriptive place, totally the opposite of a compulsive mentality and quite different from a subject who intends something, names a way of occurring that is different from a state of volition. It names the occurrence of human being, our being able to be other than who we are, our being able to transcend our past, to change fundamentally, our being able to be, and so forth This freedom is part of the truth of human being, part of its occurrence and its presence, and it is in common with the eventfulness of the world. (Scott, 1982, p. 52)

It is through experiences of indifference that we find ourselves in accord with how the world happens. How events occur indifferently to our desires, wishes, and intentions puts us in touch with a fundamental aspect of our being and that of the world.

It is a non-caring, non-desiring, non-differentiating dimension that we are sensitive to when we know, for example, that we die without regard for our interests, that we change regardless of how we change, that meaning occurs in spite of what meanings there are, that being is regardless of our

desires, that personality and character occur no matter what their content. (Scott, 1982, p. 96)

We tend to think of ourselves as intentional beings, projecting ourselves into a future and controlling our destinies; we also already are taken up into events, before we exert a moment of choice. "We are drawn into an event of truth and arrive, as it were, too late, if we want to know what we ought to believe" (Gadamer, 1975/1960, p. 446). The intuitive experiences of the therapists in Examples #1: "He's inside my house" (p. 111) and #3: A "scared to death experience" (p. 126) are good examples of this. The freedom Scott is talking about is not the freedom to withhold ourselves from events; it is the free occurrence of events and the corresponding orderless dimension of our being.

The occurrence of non-intended events can be threatening to us as particular individuals. Such events threaten to absorb us in their sheer indifference and contingency. Consequently, we try to protect ourselves by redoubling our efforts to control what is happening. We ". . . feel the threat of merger and loss of identity in all dimensions of relating with others that do not involve clarity of intention and a sense of control" (Scott, 1982, p. 68).

Paradoxically, Scott suggests that we can best answer and be open to the indifference of the world and our being by intending not to intend. This movement was apparent in how the therapists in Examples #1 and #2 dealt with their experiences of Merger. They decided not to try and modify their experiences; not to try and hold themselves back from the events they were undergoing.

By allowing the phenomena to be as they come forth. By deeply letting go of our interests regarding things we may find

ourselves both aware and in the immediacy of what comes forth.
(Scott, 1982, p. 84)

Scott contends that in this manner human being becomes a place for disclosure of whatever is there to present itself. In states of immediate awareness (which would include dreams, fantasies, intense emotional experiences, etc.) we discover that we occur as events of openness to world-events.

When I see that my being occurs as situated openness for how things are, when I find that disclosure is the interpretive key for human being, I see that appropriate awareness on my part does not necessarily involve activity. I find that disclosure does not occur like the activity of a subject occurs. Rather my activity is aimed at release from activity. I seek to allow world-openness without interference. (Scott, 1982, p. 84)

Description rather than "methodologically structured and justified intelligence" is the most appropriate way to talk about these events of awareness.

Describing is a way of giving place and apparentness to something (i.e., it is a way of ex-posing) At best the movement and meaning of the words will articulate the movement and meaning of the event so that an immediacy of insight can take place. (Scott, 1982, p. 10)

Disciplined, non-interfering attention to things is not easy and our tendency is to try and find a method to help us. Scott notes that even the descriptive field of phenomenology has fallen into this trap of trying to establish a rigorous method instead of a rigorous discipline "for letting things be as they are in their occurrence."

Proper Fit and Wholeness

Scott has called attention to how experiences of unfamiliarity and dislocation bring us into communication with important, impersonal

aspects of ourselves. Although it is easy to remain closed to such unfamiliar aspects, we do so at an expense to our well-being.

The problem of how to integrate unfamiliar aspects of being with familiar aspects touches on an issue that frequently brings people into treatment. In general terms, people come into treatment when they are feeling either closed off to important aspects of their being (e.g., neurotic patients who rely heavily on the defense of repression) or not sufficiently bounded and individuated from aspects their existence (e.g., borderline psychotic patients who confuse their interpersonal relations with projective and introjective defenses). Such personal issues come into play, set the therapy dialogue off in a particular direction, and create dialectical tensions we have described. The tensions in the person's daily life, as well as in the therapy dialogue, cannot be resolved either by simply doing away with boundaries or by fortifying them. Both extremes are detrimental to well-being.

The results of this study highlight the manner in which the contrasting Oneness and Separateness aspects of therapeutic dialogue can strain and skew therapy relationships in one direction or another. While this focus on extreme experiences helps to distinguish contrasting aspects and to highlight the tension between them, it has less to say about how such aspects fit together and what their relation is to each other. In this section, Scott's understanding of how involuntary, impersonal, and non-conceptual experiences of awareness are capable of having a place in our lives will be examined to see if it can shed some light on ways in which the Oneness/Separateness aspects of therapy can be brought together.

Identity and communing. Though it is somewhat artificial to deal with each pair of aspects separately, since they co-occur, we will follow this straightforward procedure and turn first to the aspects of Fusing/Separating. As noted, experiences of immediate awareness have a non-personal quality to them. They transport us beyond our usual sense of who we are. Immediate awareness is not the same as personal consciousness. These intuitive awarenesses overtake us in such a manner that we cannot appropriate them as our own. Therapist descriptions of experiences of Merging convey the foreignness and the disturbance to one's identity that Fusing aspects can have. In the psychoanalytic literature, Searles (1979) has written extensively about these changes in the therapist's identity that occur as the larger background of symbiotic relatedness comes to the fore. As Scott describes it, one finds oneself grown and expanded into these immediate events and consequently knows the threat of being absorbed or possessed by these awarenesses.

Our identities take shape against the background of discovering that we are different from things and other people, yet "as beings, we are the differences that are set against our identities" (Scott, 1982, p. 96). How can we accommodate the non-I? Previously, we noted that our interests, desires, and intentions are powerful motives in differentiating those things on which our sense of identity is based. Yet, there are moments when our interests and desires recede and we discover ourselves indifferent to events. This indifference accords with the non-prescriptive freedom of the world and we find ourselves open to our own being as a world-event. When we allow awareness of this to grow, in

Scott's words, we commune with what is present. By appreciating our being as an event of disclosure, both the personal and the non-personal aspects of our occurrence find their place.

Communion happens as the disclosure of beings without prescription in the clear openness of human beings It is release to the realm of appearances, a release in which one's own particular identity fades back and awareness occurs without desire or interest That disclosiveness is not one's own. It is the world-openness that pervades all occurrences which one discovers him/herself to be in and with and of. Communion is accord in disclosiveness. (Scott, 1982, p. 86)

In interpersonal relations, experiences of communion are spoken of in terms of I-Thou occurrences (Buber, 1923/1970; Friedman, 1985). Such experiences happen in therapy; often they may be mistaken for personal intimacy, feeling close, or being accepted. The fundamental dialogic contact that occurs in I-Thou experiences is not a personal experience. It is more like the discovery of "an unexpected and non-personal commonality."

One way to deny these kinds of events is to turn them into special communications from each other or from someone or something else. They come from no one in particular. They are little disclosures beyond the boundaries of interest and concept that are by no means extraordinary, unless the ordinary be defined in such a way as to exclude them. (Scott, 1982, p. 77)

This kind of experience was noted in one variety of Recognizing experiences, exemplified by Example #5: "Moments of recognition" (p. 133). In this example, the therapist was deeply aware of how human a choice it is to face the question of under what conditions life is worth living. Not infrequently, these experiences happen in silence, as the therapist relaxes his or her intentions and allows the disclosiveness of events to occur. The dialectical tension, Fusing/Separating, finds integration in

experiences of communing where we are open to impersonal dimensions of being without losing personal boundaries.

Doing and heeding. Can we bring the dialectic of Undergoing/Controlling into accord, while not overemphasizing one at the expense of the other?

One way in which we can find ourselves different from our ordinary selves is when we are indifferent, desireless, or absent in attitude. This radical kind of freedom-to-be accords with the free occurrence and sheer eventfulness of being. By fostering an absence of attitude (i.e., intending not to intend) we are open to hearing events in their wholeness. It is in such moments of indifferent contemplation that aspects of both Undergoing and Controlling find their place.

Awareness in this case happens as a non-interfering region of acceptance which is not under what we ordinarily call intentional control. This very openness accords with the event of things, their coming forth or opening up, so that their happening, not so much what they are for or their contextual significance, but their happening is their kinship in awareness. Happening resonates happening, and this resonance without subject or object is the serenity of contemplation. (Scott, 1982, p. 76)

Scott conveys this attitude of non-interfering contemplation by drawing upon the meanings of the word, to heed. Heed is related to the German word, Hut, meaning cabin or small dwelling, while the English word, heed, includes meanings of special care and attention. Therefore, we can speak of heeding as providing a housing in which fantasies, words, appearances, etc. are given special care and attention. For example:

In therapy, a dwelling of care takes place in which fantasies, words, and presence are heeded. They may consequently bear

out what ever they present and mean. They may take their own measure in this dwelling. One heeds them as one steps back from them to give them their room, their place, their recalling mindedness. (p. 142)

The therapist can be said to dwell, linger, and tarry with fantasies, feelings, and thoughts that occur; living another dimension of awareness which may well seem irrelevant to our usual consciousness. This non-prescriptive openness was apparent in therapist efforts not to interfere with what unfolded in treatment. For example, the therapists in Examples #29: "I participate in their needs" (p. 222) and #22 "Oh, I'm in the closet with her know" (p. 216) both silently allowed fantasies to guide their understanding of the situation. In the psychoanalytic literature, Bion's (1967/1981) advice to begin each session free of memory and desire seems particularly apt.

Knowing and meditative thinking. This leaves the final dialectic, Intuiting/Thinking, to be examined. Scott described intuitions as immediate awarenesses that are more affective than conceptual. These immediate, intuitive experiences put us in touch with awareness as a non-subjective event. We have already described how we may allow events to occur free of our intentions. We step back and "undergo a subtle experience of not being in control" (Scott, 1982, p. 138).

Awareness (or mind) happens. And we can be alert with that awareness when we learn how to step back of intentional consciousness and to allow the awareness of events to take place in our presence. We then see that we can be involved in the awareness that transcends our own particular consciousness. (Scott, 1982, p. 139)

Scott suggests that there is a form of meditative thinking that derives from non-intentional awareness which is different from our

conceptual knowledge about things with its connotations of intentionality and use. Following Heidegger, Scott notes that the word, think, is related to the word, thank. One form of thinking (or "thanking") can bear something in mind in a welcome, grateful, and favorable way. He further comments on the roots to the word, thing, which has the old meaning of assembly, as for negotiating and adjudicating matters. "Things are gathering and excluding occurrences," which "bring many elements together" and have their own histories, destinies, and affinities (Scott, 1982, p. 147).

From these ideas, Scott arrives at a notion of meditative thinking open to the non-conceptual immediacy of intuitive awareness. Again, the focus is on the disclosive quality of awareness.

Thinking as an alert state of being conscious and as centered with something or other allows the thing its immediacy, its posture, its way of including and excluding, its direction and bearing

Thinking can happen as alert release to the immediacy of things, a non-interfering predisposition that allows entertainment without a person's being host/hostess In meditative thinking we discover that alertness can grow as things are borne in mind without interference in their assembling, legislating, adjudicating presences

This kind of thinking, which is immediate alertness with immediate things, impresses me as an important basis for interpreting As a basis for interpreting, however, meditative thinging [sic] engenders awareness not formed by concepts, but by non-conceptual events. When I am free for the non-subjective immediacies of mind, I am free for interpretations which aim toward exposure with things, rather than conceptual justification. (Scott, 1982, p. 148)

Non-conceptual thinking was uncovered in the intuitive experiences that therapists in the present study described. Scott interprets such intuitive events as partaking in the wholeness of mind, i.e., one is immediately in touch with transcendent facets of mind that provide the

background to more ordinary awareness. While it is not possible to grasp events in their wholeness, one can foster and discipline an attitude from within events that is characterized by an openness to whatever may be disclosed. Interpreting is how we live through the disclosure of world-events, and by openly heeding events, relations to ourselves, to others, and to the world can be described (or minded).

Well-being. Mind is an event of awareness in both its particular and its common aspects, which "develops as a whole of its parts, while the parts themselves develop their own particularities and differences" (Scott, 1982, p. 149). We are in touch with our wholeness when we are our own event, yet we always experience this event of awareness (whole) in our own particular way. These differences in mind are non-reducible; they are the borders in mind that constitute awareness.

Scott suggests that it is possible to "allow differences without antagonism, opposition without rending hostility, refusal without hatred" (Scott, 1982, p. 149). He takes as his example Greek drama to illustrate how disorder, insanity, and madness can find their place in the play which is not conquered by their presence. The drama, as a whole, presents madness and provides a place in which it can occur. It allows us to dwell with madness. Similarly, Scott suggests there is a notion of soundness of mind, right measure, appropriate fit, or soundness of heart (the Greek word, sophrosune), which does not necessarily order events, but which gives them a proper place to present themselves. From this follows Scott's notion of well-being.

Well-being is a whole event that pervades the parts, is not dominated or overcome by the parts, and provides an awareness

that transcends any particular perspective. It is not an order. It is a pervasive, non-determinate awareness that has reached immediate awareness of itself. That is the meaning of "measure" when proper balance and soundness are at issue. The measure is found as the parts resound and reflect their whole, very much like genius in playwrighting and in acting. (Scott, 1982, p. 152)

We are the differences, as well as the identities; we maintain our touch with the wholeness of mind by fostering an alertness to borders, contradictions, and shadows, which ground all identities. We cannot interpret human events only in terms of dominant aspects without risk of reducing events to a constellation of characteristics that lack feeling for (or sense of) the whole. The present study confronted this problem after the categories and aspects of therapists' experiences were described. The tension that held these aspects together, but did not allow them to be reduced to one another, still needed to be addressed. The relations among aspects gave these experiences their dynamic, living quality. Unless the quality of these relations also was included in the description, one had an analysis of events into parts, but one lacked an interpretation that could be fully understood--that is, an interpretation that could be lived. This study would have failed to expose how many of therapist experiences concerned efforts to bring opposing parts together and create a whole which could properly hold and disclose them.

Implications for Psychotherapy

The current study grew from one person's attempt to learn the practice of psychotherapy. Experiences of talking with patients led to questions about the status of theoretical explanations and techniques. This study did not aim at developing an instrumental knowledge of

psychotherapy; rather it sought to recover the essential aspects of therapist experiences in which theory and technique are grounded.

The relation of theory to experience is crucial to the problem of how psychotherapy experiences should be communicated. Traditionally, psychotherapists have followed the example of other sciences and developed theoretical models to organize and explain their experiences. While efforts to describe and understand by way of theoretical explanation are certainly worthwhile, they involve a circularity that leads to problems. The models usually define what phenomena are worthy of investigation and tend to limit the methods by which data can be gathered and presented. New findings that result from looking outside the domain of the prevailing model or that result from using new methods of inquiry usually end up being labeled "unscientific." This forces proponents of a new point of view to set up a competing paradigm (Kuhn, 1970). Many of the competing psychoanalytic schools mentioned in this study may be attributed to such a process. Debates between schools are often unproductive, since they focus on the level of competing theories and, thereby, lose sight of the experiences out of which these theories should speak.

If we turn to how psychotherapy is taught, theory seems to play a more ancillary role. Learning psychotherapy stems primarily from a student's work with a supervisor and often is augmented by the student's personal psychotherapy. This implicit recognition of the priority of experience over theory is occasioned by the impracticability of relying upon theoretical models to communicate psychotherapy experiences and their meaning.

The role of the supervisor and the training therapist reflects a tradition for transmitting knowledge that antedates the scientific one. The student essentially undergoes an apprenticeship and within this relationship information primarily is passed on in oral form. This tradition of orally transmitting an understanding of the world is embodied in epic poems, myths, religious stories, and folk tales which continue to find their place in contemporary culture. This narrative tradition stands in marked contrast to the modern, scientific accumulation of knowledge; yet it seems to carry its own timeless validity. In the present interviews, therapists often attempted to convey something that was embodied in descriptions of their experiences. Their stories conveyed lessons, often hard won, about what being a therapist and doing psychotherapy is about. Asking therapists about these experiences tapped into this tradition.

These reflections suggest a need to reconsider the role and importance of the case history, as a teaching device for communicating knowledge about psychotherapy. Although case histories and clinical vignettes have played a crucial role in the development of models for explaining psychological structure and the process of psychotherapy, this primarily has been shaped by the natural science tradition. In other words, the case histories are presented as "facts" or data upon which the theoretical model is based. Spence (1982) has criticized this approach and suggests that this use of case histories and clinical examples is not scientifically rigorous enough. Based on the natural science assumptions with which he begins, his case is well-made, although he overlooks the possibility of such stories being meaningful in

another way, which is not dealt with by debates over the objectivity (or subjectivity) of the "data".

This study has repeatedly demonstrated that there are more immediate modes of knowing that do not require objectification of data, or deliberative activity by a knowing subject. Such modes of knowing have their own form of presentation: a kind of disciplined description. From this perspective, the measure of truth is not accuracy of statement; it is faithfulness of presentation, i.e., disclosiveness. The telling of the clinical story becomes the re-occurrence of the experience, not as a historical fact, but as the event itself. The words of the story immediately present something to us and we are taken up in its event. We dwell with what is presented, and heed what it tells.

Although such (self-aware) descriptions cannot replace a scientific approach to knowledge, scientific methods should not supplant this more immediate touch with events. The practice and understanding of psychotherapy requires both forms of knowing their proper place. They are different, and we will end up the poorer if we reduce this difference. Unfortunately, this seems to have happened as narratives have been adapted to fit a scientific context. To try to make something "hard" out of these stories would be a mistake.

This need for more than theoretical concepts to communicate therapy experiences brings us back to the nature of these experiences. Often they involve a significant impact on the therapist's identity. This has been discussed in terms of therapists finding themselves grown into, expanded by, and taken up by therapy events. This quality is paralleled in the telling of therapy events when a listener also finds his or

herself taken up by and expanded by these narratives. The present study has described such experiences in terms of Oneness aspects, namely Fusing, Intuiting, and Undergoing. Though perhaps in not so dramatic a fashion as presented in some examples, therapists frequently face the task of allowing Oneness modes of experience to occur; the difficulty is not to deny or negate these (chaotic) experiences. Experiences with aspects of Oneness should be appreciated in a positive and less fearful way. Although such experiences may threaten one's usual sense of identity, they also provide a direct awareness of how mind--lived by each of us in our own particular way--occurs as more than personal consciousness.

What place do experiences with aspects of Fusing, Intuiting, and Undergoing have in the therapy process? What do they tell us about how a therapist is therapeutic? Such events emphasize how the therapist's role is not always one of Acting; these events demonstrate how the therapist finds him or herself caught up in events that are not of his or her making and aware of things of which he or she has not conceived. Though sometimes swept along by events that are not directly under his or her control, a dimension of awareness also unfolds in the therapy dialogue. If the therapist allows an event to occur, something will be disclosed. There are both intentional and non-intentional aspects to therapy, and both need to come into play. At times, the emphasis will be on technique, managing the situation, or providing coverage for the patient; at other times, the therapist's role will be to do nothing than to provide a setting in which events and things are allowed to develop and to attend to them as they do. As the therapist tolerates the kinds

of dialectical tension this study has described, the patient also can allow the tension of contradiction a more fitting place in his or her life.

The non-subjective, unintentional, and immediate aspects of experience must find their place in the practice of psychotherapy just as they must find their place in each of our lives. As we describe, teach, and practice psychotherapy, we are continually trying to find a balance among these elements. The aspects described in the current study (Fusing/Individuating, Intuiting/Thinking, and Undergoing/Acting) remain in opposition to each other; yet they are held together within the larger context of awareness or experience. Perhaps therapy would be simpler if we opted to treat events in terms of one pole of the dialectic or other, and it is always tempting to subordinate experience under the more familiar aspects of personal consciousness and intentionality. By doing so, however, we lose touch with the larger whole--which we have been trying to depict by such words as event, disclosure, mind, experience, and awareness--that provides a place for the occurrence of individuality, consciousness, and intention.

BIBLIOGRAPHY

BIBLIOGRAPHY

- Alexander, F., & French, T. M. (1946). Psychoanalytic Therapy, Principles and Applications. New York: Ronald Press.
- Appelbaum, S. A. (1981). Effecting Change in Psychotherapy. New York: Jason Aronson.
- Arlow, J. (1980). The genesis of interpretation. In H. P. Blum (Ed.), Psychoanalytic Explorations of Technique (pp. 193-206). New York: International Universities Press. (Original work published in 1979)
- Balint, M. (1968). The Basic Fault. New York: Brunner/Mazel.
- Barrett, W. (1958). Irrational Man. New York: Doubleday.
- Bion, W. (1981). Notes on memory and desire. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 259-260). New York: Jason Aronson. (Original work published in 1967)
- Burt, E. A. (1954). The Metaphysical Foundations of Modern Science (rev. ed.). New York: Doubleday. (Original work published in 1924)
- Baranger, M., & Baranger, W. (1981). Insight in the analytic situation. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 383-390). New York: Jason Aronson. (Original work published in 1966)
- Basch, M. F. (1983). Empathic understanding: a review of the concept and some theoretical considerations. Journal of the American Psychoanalytic Association, 31, 101-126.
- Blum, H. P. (1980). The curative and creative aspects of insight. In H. P. Blum (Ed.), Psychoanalytic Explorations of Technique (pp. 41-69). New York: International Universities Press. (Original work published in 1979)
- Blum, H. P. (Ed.). (1980). Psychoanalytic Explorations of Technique: Discourse on the Theory of Therapy. New York: International Universities Press.
- Buber, M. (1970). I and Thou. New York: Charles Scribner's Sons. (Original work published in 1923)
- Casey, E. S. (1976). Imagining. Bloomington: Indiana University Press.
- Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), Existential and Phenomenological Alternatives for Psychology (pp. 48-71). New York: Oxford University Press.

- Dapkus, M. (1982). A Phenomenological Analysis of the Experience of Time. Unpublished doctoral dissertation. University of Tennessee, Knoxville.
- Eissler, K. (1953). The effects of the structure of the ego on psychoanalytic technique. Journal of the American Psychoanalytic Association, 1, 104-143.
- Epstein, L., & Feiner, A. H. (Eds.). (1979). Countertransference. New York: Jason Aronson.
- Fairbairn, W. R. D. (1952). An Object-Relations Theory of the Personality. New York: Basic Books.
- Friedman, M. (1985). The Healing Dialogue in Psychotherapy. New York: Jason Aronson.
- Fischer, W. F. (1978). An empirical-phenomenological investigation of being-anxious: an example of the meanings of being-emotional. In F. Valle & M. King (Eds.), Existential and Phenomenological Alternatives for Psychology (pp. 166-181). New York: Oxford University Press.
- Fenichel, O. (1941). Problems of Psychoanalytic Technique. Albany, N.Y.: Psychoanalytic Quarterly.
- Fliess, R. (1981). The metapsychology of the analyst. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 235-242). New York: Jason Aronson. (Original work published in 1942)
- Freud, A. (1946). The Ego and the Mechanisms of Defense (C. Baines, Trans.). New York: International Universities Press. (Original work published in 1936)
- Freud, A. (1980). The role of insight in psychoanalysis and psychotherapy--introduction. In H. Blum (Ed.) Psychoanalytic Explorations of Technique (pp. 3-7). New York: International Universities Press. (Original work published in 1979)
- Freud, S. (1973). The interpretation of dreams. In J. Strachey (Trans. & Ed.), The Standard Edition of the Complete Psychological Works of Sigmund Freud: Vol. 4-5. New York: International Universities Press. (Original work published in 1900)
- Freud, S. (1973). The dynamics of the transference. In J. Strachey (Trans. & Ed.), The Standard Edition of the Complete Psychological Works of Sigmund Freud: Vol. 12 (pp. 97-108). New York: International Universities Press. (Original work published in 1912)

- Freud, S. (1973). Recommendations to physicians practicing psychoanalysis. In J. Strachey (Trans. & Ed.), The Standard Edition of the Complete Psychological Works of Sigmund Freud: Vol. 12 (pp. 111-112). New York: International Universities Press. (Original work published in 1912)
- Gadamer, H. G. (1975). Truth and Method. New York: Crossroad Publishing. (Original work published in 1960)
- Gadamer, H. G. (1976). Philosophical Hermeneutics (D. Linge, Trans. & Ed.). Berkeley: University of California.
- Gill, M. M. (1981). The analysis of the transference. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 69-82). New York: Jason Aronson. (Original work published in 1979)
- Giorgi, A. P. (1984). Towards a new paradigm for psychology. In C. Aanstoos (Ed.), Exploring the Lived World: Readings in Phenomenological Psychology (West Georgia College Studies in the Social Sciences, Vol. XXIII, pp. 9-28). Atlanta: Darby Printing.
- Greenacre, P. (1981). The role of transference. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 17-23). New York: Jason Aronson. (Original work published in 1954)
- Greenberg, J. R., & Mitchell, S. A. (1983). Object Relations in Psychoanalytic Theory. Cambridge: Harvard University Press.
- Greenson, R. R. (1981). Empathy and its vicissitudes. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 243-249). New York: Jason Aronson. (Original work published in 1960)
- Grinberg, L. (1981). On a specific aspect of countertransference due to the patient's projective identification. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 201-206). New York: Jason Aronson. (Original work published in 1962)
- Grinberg, L. (1979). Countertransference and projective identification. In L. Epstein, & A. Feiner (Eds.), Countertransference (pp. 169-191). New York: Jason Aronson.
- Grosskurth, P. (1986). Melanie Klein: Her World and Her Work. New York: Alfred A. Knopf.
- Grotstein, J. S. (1980-81a). The significance of Kleinian contributions to psychoanalysis: I. Kleinian instinct theory. International Journal of Psychoanalytic Psychotherapy, 8, 375-392.

- Grotstein, J. S. (1980-81b). The significance of Kleinian contributions to psychoanalysis: II. Freudian and Kleinian conceptions of early mental development. International Journal of Psychoanalytic Psychotherapy, 8, 393-428.
- Grotstein, J. S. (1981). Splitting and Projective Identification. New York: Jason Aronson.
- Grotstein, J. S. (1982-83). The significance of Kleinian contributions to psychoanalysis: III. the Kleinian theory of ego psychology and object relations. International Journal of Psychoanalytic Psychotherapy, 9, 487-510.
- Grotstein, J. S. (1982-83). The significance of Kleinian contributions to psychoanalysis: IV. critiques of Klein. International Journal of Psychoanalytic Psychotherapy, 9, 511-536.
- Grotstein, J. S. (1984). The higher implications of Langs's contribution. In J. Raney (Ed.), Listening and Interpreting (pp. 3-20). New York: Jason Aronson.
- Guntrip, H. (1969). Schizoid Phenomena Object Relations and the Self. New York: International Universities Press.
- Guntrip, H. (1973). Psychoanalytic Theory, Therapy, and the Self. New York: Basic Books.
- Guntrip, H. (1975). My experience of analysis with Fairbairn and Winnicott. International Review of Psychoanalysis, 2, 145-156.
- Gurwitsch, A. (1978). Galilean physics in the light of Husserl's Phenomenology. In T. Luckmann (Ed.), Phenomenology and Sociology (pp. 71-89). New York: Penguin Books. (Original work published in 1967)
- Hartmann, H. (1939). Ego Psychology and the Problem of Adaptation. New York: International Universities Press.
- Hearst, E. (Ed.). (1979). The First Century of Experimental Psychology. Hillsdale, NJ: Lawrence Erlbaum Assocs.
- Hedges, L. E. (1983). Listening Perspectives in Psychotherapy. New York: Jason Aronson.
- Heidegger, M. (1962). Being and Time (J. Macquarrie, & E. Robinson, Trans). New York: Harper and Row. (Original work published in 1927)
- Heimann, P. (1981). On counter-transference. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 139-142). New York: Jason Aronson. (Original work published in 1950)

- Husserl, E. (1900-1901). Logische Untersuchungen. Halle: Niemeyer.
- Husserl, E. (1962). Ideas (W. R. Boyce Gibson, Trans.). New York: Collier Books. (Original work published in 1913)
- Ihde, D. (1977). Experimental Phenomenology: An Introduction. New York: Paragon Books.
- Khan, M. M. R. (1974). The concept of cumulative trauma. In M. Khan, The Privacy of the Self (pp.42-56). New York: International Universities Press. (Original work published in 1963)
- Khan, M. M. R. (1974). Toward an epistemology of the process of cure. In M. Khan, The Privacy of the Self (pp.42-56). New York: International Universities Press. (Original work published in 1970)
- Khan, M. M. R. (1974). The Privacy of the Self. New York: International Universities Press.
- Kernberg, O. F. (1981). Countertransference. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 207-216). New York: Jason Aronson. (Original work published in 1965)
- Kernberg, O. F. (1975). Borderline Conditions and Pathological Narcissism. New York: Jason Aronson.
- Klein, M. (1975). The Psychoanalysis of Children (A. Strachey, Trans.). Delacorte Press. (Original work published in 1932)
- Klein, M. (1981). The origins of transference. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 9-15). New York: Jason Aronson. (Original work published in 1951)
- Kohler, W. (1947). Gestalt Psychology. New York: Mentor Books.
- Kohut, H. (1959). Introspection, empathy, and psychoanalysis: an examination of the relationship between mode of observation and theory. Journal of the American Psychoanalytic Association, 1, 459-483.
- Kohut, H. (1971). The Analysis of the Self. New York: International Universities Press.
- Kohut, H. (1977). The Restoration of the Self. New York: International Universities Press.
- Kohut, H. (1984). How Does Analysis Cure? (A. Goldberg, Ed.). Chicago: University of Chicago Press.
- Kuhn, T. (1970). The Structure of Scientific Revolutions (2nd Ed.). Chicago: University of Chicago Press.

- Kundera, M. (1984). The Unbearable Lightness of Being (M. H. Heim, Trans.). New York: Harper & Row.
- Langs, R. (1975). The patient's unconscious perception of the therapist's errors. In P. Giovacchini (Ed.), Tactics and Techniques in Psychoanalytic Therapy (pp. 239-250). New York: Jason Aronson.
- Langs, R. (1976a). The Bipersonal Field. New York: Jason Aronson.
- Langs, R. (1976b). The Therapeutic Interaction. New York: Jason Aronson.
- Langs, R. (1978). The Listening Process. New York: Jason Aronson.
- Langs, R. (Ed.). (1981). Classics in Psychoanalytic Technique. New York: Jason Aronson.
- Langs, R. (1981). Interventions in the bipersonal field. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 279-302). New York: Jason Aronson. (Original work published in 1978a)
- Langs, R. (1981). The adaptational-interactional dimension of countertransference. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 217-232). New York: Jason Aronson. (Original work published in 1978b)
- Langs, R. (1982). Countertransference and the process of cure. In S. Slipp (Ed.), Curative Factors in Dynamic Psychotherapy (pp. 127-152). New York: McGraw Hill.
- Langs, R. (1983). Unconscious Communication in Everyday Life. New York: Jason Aronson.
- Langs, R., & Searles, H. (1980). Intrapsychic and Interpersonal Dimensions of Treatment. New York: Jason Aronson.
- Langs, R., & Searles, L. (1980). The Therapeutic Experience and Its Setting. New York: Jason Aronson.
- Leavy, S. A. (1980). The Psychoanalytic Dialogue. New Haven: Yale University Press.
- Little, M. (1981). Counter-transference and the patient's response to it. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 143-152). New York: Jason Aronson. (Original work published in 1951)
- MacGillivray, W. (1985). Embodiment and Ambiguity: A Phenomenological Investigation of the Lived-Body. Unpublished doctoral dissertation, University of Tennessee, Knoxville.

- Malin, A., & Grotstein, J. (1981). Projective identification in the therapeutic context. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 391-396). New York: Jason Aronson. (Original work published in 1966)
- Marmor, J. (1982). Changes in psychoanalytic treatment. In S. Slipp (Ed.), Curative Factors in Dynamic Psychotherapy. New York: McGraw-Hill. (Original work published in 1979)
- Merleau-Ponty, M. (1962). Phenomenology of Perception (C. Smith, Trans.). London: Routledge & Kegan Paul.
- Money-Kyrle, R. E. (1956). Normal countertransference and some of its deviations. International Journal of Psycho-Analysis, 37, 360-366.
- Neuber, P. B. (1980). The role of insight in psychoanalysis. In H. Blum (Ed.), Psychoanalytic Explorations of Technique. New York: International Universities Press. (Original work published in 1979)
- Ogden, T. H. (1979). On projective identification. International Journal of Psychoanalysis, 60, 357-373.
- Olinick, S. L. (1980). The Therapeutic Instrument. New York: Jason Aronson
- Palmer, R. (1969). Hermeneutics. Evanston: Northwestern University Press
- Pollio, H. R., Barlow, J. M., Fine H. J., & Pollio, M. R. (1977) Psychology and the Poetics of Growth. Hillsdale, NJ: Lawrence Erlbaum Assocs.
- Racker, H. (1981). The meaning and uses of countertransference. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 177-200). New York: Jason Aronson. (Original work published in 1972)
- Rangell, L. (1980). Contemporary issues in the theory of therapy. In H. Blum (Ed.), Psychoanalytic Explorations of Technique (pp. 81-112). New York: International Universities Press. (Original Work published in 1979)
- Reich, A. (1981). On counter-transference. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 153-159). New York: Jason Aronson. (Original work published in 1951)
- Reik, T. (1948). Listening with the Third Ear: The Inner Experience of a Psychoanalyst. New York: Farrar, Straus, & Co.

- Romanyshyn, R. (1978). Psychology and the attitude of science. In R. Valle & M. King (Eds.), Existential and Phenomenological Alternatives for Psychology (pp. 18-47). New York: Oxford University Press.
- Roth, S. (1987). Psychotherapy: The Art of Wooing Nature. New York: Jason Aronson.
- Scott, C. E. (1982). Boundaries in Mind: A Study of Immediate Awareness Based on Psychotherapy. New York: Crossroad Publishing.
- Searles, H. F. (1959). The effort to drive the other person crazy--an element in the aetiology and psychotherapy of schizophrenia. British Journal of Medical Psychology, 32, 1-18.
- Searles, H. F. (1978-79). Concerning transference and countertransference. International Journal of Psychoanalytic Psychotherapy, 7, 165-188.
- Searles, H. F. (1979). Identity development in Edith Jacobson's The Self and the Object World. In H. F. Searles, Countertransference and Related Subjects: Selected Papers (pp. 36-44). New York: International Universities Press. (Original work published in 1965)
- Searles, H. F. (1979). Feelings of guilt in the psychoanalyst. In H. F. Searles, Countertransference and Related Subjects: Selected Papers (pp. 28-35). New York: International Universities Press. (Original work published in 1966)
- Searles, H. F. (1979). Concerning the development of identity. In H. F. Searles, Countertransference and Related Subjects: Selected Papers (pp. 45-79). New York: International Universities Press. (Original work published in 1966-67)
- Searles, H. F. (1979). Autism and the phase of transition to therapeutic symbiosis. In H. F. Searles, Countertransference and Related Subjects: Selected Papers (pp. 149-171). New York: International Universities Press. (Original work published in 1970)
- Searles, H. F. (1979). Pathologic symbiosis and autism. In H. F. Searles, Countertransference and Related Subjects: Selected Papers (pp. 132-148). New York: International Universities Press. (Original work published in 1971)
- Searles, H. F. (1979). The function of the patient's realistic perceptions of the analyst in delusional transference. In H. F. Searles, Countertransference and Related Subjects: Selected Papers (pp. 196-227). New York: International Universities Press. (Original work published in 1972)

- Searles, H. F. (1979). Countertransference and theoretical model. In H. F. Searles, Countertransference and Related Subjects: Selected Papers (pp. 373-379). New York: International Universities Press. (Original work published in 1975)
- Searles, H. F. (1979). Transitional phenomena and therapeutic symbiosis. In H. F. Searles, Countertransference and Related Subjects: Selected Papers (pp. 503-575). New York: International Universities Press. (Original work published in 1976)
- Searles, H. F. (1979). The analyst's participant observation as influenced by the patient's transference. In H. F. Searles, Countertransference and Related Subjects: Selected Papers (pp. 577-581). New York: International Universities Press. (Original work published in 1977)
- Searles, H. F. (1979). Countertransference and Related Subjects: Selected Papers. New York: International Universities Press.
- Searles, H. F. (1981). Concerning therapeutic symbiosis. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 419-428). New York: Jason Aronson. (Original work published in 1973)
- Searles, H. F. (1981). The patient as therapist to his analyst. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 103-135). New York: Jason Aronson. (Original work published in 1975)
- Segal, H. (1981). Melanie Klein's Technique. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 397-408). New York: Jason Aronson. (Original work published in 1967)
- Slipp, S. (1982). Curative Factors in Dynamic Psychotherapy. New York: McGraw-Hill.
- Spence, D. P. (1982). Narrative Truth and Historical Truth. New York: Norton.
- Spiegelberg, H. (1971). The Phenomenological Movement. The Hague: Martinus Nijhoff.
- Spitz, R. A. (1980). Countertransference: comments on its varying role in the analytic situation. In H. P. Blum (Ed.), Psychoanalytic Explorations of Technique (pp. 441-455). New York: International Universities Press. (Original work published in 1979)
- Sterba, R. F. (1975). The formative activity of the analyst. In P. Giovacchini (Ed.), Tactics and Techniques in Psychoanalytic Therapy. Vol. II: Countertransference. New York: Jason Aronson.
- Stone, L. (1961). The Psychoanalytic Situation. New York: International Universities Press

- Storr, A. (1979). The Art Psychotherapy. New York: Methuen.
- Strachey, J. (1981). The nature of the therapeutic action of psychoanalysis. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 361-378). New York: Jason Aronson. (Original work published in 1934)
- Tower, L. E. (1981). Countertransference. In R. Langs (Ed.), Classics in Psychoanalytic Technique (pp. 161-175). New York: Jason Aronson. (Original work published in 1956)
- Valenstein, A. F. (1980). The concept of "classical" psychoanalysis. In H. Blum (Ed.), Psychoanalytic Explorations of Technique (pp. 113-136). New York: International Universities Press. (Original Work published in 1979)
- Valle, R. S., & King, M. (Eds.). (1978). Existential-Phenomenological Alternatives for Psychology. New York: Oxford University Press.
- Von Eckartsberg, R. (1978). Person perception revisited. In R. S. Valle, & M. King (Eds.), Existential-Phenomenological Alternatives for Psychology (pp. 182-202). New York: Oxford University Press.
- Waelder, R. (1960). Basic Theory of Psychoanalysis. New York: Schocken Books.
- Winnicott, D. W. (1958). Collected Papers: Through Pediatrics to Psychoanalysis. London: Tavistock.
- Winnicott, D. W. (1958). Hate in the countertransference. In D. W. Winnicott, Collected Papers: Through Pediatrics to Psychoanalysis (pp. 194-203). London: Tavistock. (Original work published in 1947).
- Winnicott, D. W. (1958). Transitional objects and transitional phenomena. In D. W. Winnicott, Collected Papers: Through Pediatrics to Psychoanalysis (pp. 229-242). London: Tavistock. (Original work published in 1951).
- Winnicott, D. W. (1965). Counter-transference. In D. W. Winnicott, The Maturation Process and the Facilitating Environment (pp. 158-165). New York: International Universities Press. (Original work published in 1960)
- Winnicott, D. W. (1965). The aims of psycho-analytical treatment. In D. W. Winnicott, The Maturation Process and the Facilitating Environment (pp. 166-170). New York: International Universities Press. (Original work published in 1962)

Winnicott, D. W. (1971). Playing and Reality. London: Tavistock.

Zac, J. (1972). An investigation of how interpretations arise in the analyst. International Journal of Psychoanalysis, 53, 315-320.

APPENDIXES

APPENDIX A

LETTER OF INTRODUCTION TO POTENTIAL PARTICIPANTS

Dear Participant,

I am beginning the process of gathering material for my dissertation. I am writing to you and other senior level clinicians to request your help and participation. As will become clear when I describe my study further, this sort of research is based on the unique and indispensable contribution by each participant, of his or her personal experiences as a therapist.

This particular study aims at learning more about the process of psychotherapy. Its approach stems, in part, from the work of phenomenological psychologists, who previously have used it to investigate occurrences from daily life, such as the experience of anxiety, the perception of time, and the feeling of being understood. This kind of research emphasizes the meaningfulness of what people are aware of as they participate in particular events, and it depends upon people, such as yourself, describing what their experience of these events is like. In this study, my objective is to talk to you and other therapists, about your experience of doing therapy as you come to understand your patients. I am specifically interested in encounters that stand out for you. Because this study will explore and map out a domain that has not previously been described, I cannot fully characterize the phenomena of interest. I can, however, describe some general features of my own experience, which provided a starting point for this study. I hope to give you in this fashion an idea of the kind of experiences in which I am interested, though the experiences that come to your mind may be different from my own.

As mentioned above, I am concerned with encounters that stand out for the therapist during the course of psychotherapy. For me, these experiences often involve an intense and frequently emotional reaction to something in the current interaction with the patient. It is as if something important and powerful is occurring, which overtakes me, and I find myself in the midst of it. I may or may not be very clear about what is taking place at the time, but these experiences make a great impression on me.

I realize that this description continues to leave the area of study somewhat vague; however, I do not want to restrict the study prematurely by over describing or delimiting the phenomena. My own previous experience, as well as that of others, has indicated how it is counterproductive to lead the person being interviewed too much by way of numerous and detailed questions. In other words, the exact nature and description of this study's subject matter will only become apparent as the study progresses.

Your participation in this study will involve an audiotaped interview of one hour in length. I will be asking you to tell me about encounters that you have had with your patients, which stand out for you. The interview will follow a semi-structured format in which my role involves setting the topic of the interview and following that up with questions to help clarify and expand on the experiences that you describe. Nothing other than the interview will be required of you; there are no forms, questionnaires, or rating scales to fill out. The information obtained in these interviews will be held in strictest confidence. All audiotapes, transcripts, and any other data will be coded by number and identifiable only through a master list. I will have sole access to this list, which will be destroyed at the completion of the research project, along with the audiotapes and other identifying information.

I hope that you will find the topic an interesting one to think about and discuss. This type of research values and depends on people taking the time and effort to describe their experiences. My plan is to get in touch with you by phone to ask if you would be interested in participating in this research. I will be happy to answer any questions or further describe aspects of what is involved at that time. If you are willing to participate, I will also use this opportunity to arrange a convenient time and place for the interview. I am well aware of the constraints on the time available to you, and I am willing to come to your office in order to conduct the interview.

Thank you for considering this invitation. I look forward to talking to you about this in the near future.

Sincerely,

John B. Sproule
Primary Investigator

Jack Barlow, Ph.D.
Dissertation Committee Member

APPENDIX B

INFORMATION AND CONSENT FORM

I am presently engaged in collecting data for my doctoral research in Clinical Psychology and I would like to ask you to participate by sharing with me some of your experiences as a therapist.

I want to talk to you and other therapists about your experience of doing therapy and coming to understand your patients. I decided to use interviews or conversations as my method of investigating aspects of the therapy process, because psychotherapy, itself, is a special sort of dialogue. This research partly stems from the work of phenomenological psychologists who previously have used it to investigate experiences from daily life such as anxiety, decision-making, and the feeling of being understood. This kind of research emphasizes the meaningfulness of what people are aware of as they participate in particular events, and it depends upon people, such as yourself, sharing their experiences. I specifically want to ask you about encounters with your patients that stand out for you. It is expected that this research will contribute to the body of knowledge concerning how therapy occurs and what takes place during this process.

Your participation in this study, if you volunteer, will involve an audio-taped interview of one to two hours in length. The information obtained will be held in the strictest confidence. All audiotapes, transcripts, and any other data will be coded by number, and will be identifiable only through a master list. Only the researcher will have access to this master list, which will be kept by the researcher in a secure place. After completion of the research project, the master list, the audio-tapes, and any identifying information will be destroyed.

If you agree to participate in this research, please understand that you are free to withdraw at any time, without questions. Hopefully, you will find the topic an interesting one to think about and discuss, as I do.

If you have any questions at this point, or any point later on in the study, please do not hesitate to ask. You will be given a copy of this information and consent form to keep, should you wish to contact me at any time about this research project.

John Sproule
U.T. Psychology Clinic
Austin Peay Building
Circle Drive
University of Tennessee
Knoxville, TN 37916

Telephone: 974-2161

I have read the above information and consent form, and I agree to participate in this project.

Signature: _____ Date: _____

APPENDIX C

LIST OF EXAMPLES

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APPENDIX D

FURTHER EXAMPLES OF RESULTS' CATEGORIES

1. Losing and Regaining Control

The first two examples that follow emphasize Losing Control in a very concrete manner. In these two examples, the issue seems to be the physical control of the patient's behavior and the therapist's own self-control. In the first, Example #7: "I think finally I'm getting some therapy," the therapist responds to the patient's passive-aggressiveness by angrily preventing him from leaving the room, and in the second, Example #8: "If you've gone to college, you can never be psychotic," the therapist is faced with a patient who has flown into a murderous rage.

Example #7: "I think finally I'm getting some therapy"

The first one that stands out, almost in a chronological sense, was the very first hospitalized patient that I ever had, who kept telling me that he was there for rest and psychotherapy and was only getting the rest. Then, one day he got up to leave the room, and I barred the door. I ended up throwing him back into his chair. It was from that point on that the therapy relationship changed radically. On the one hand, I had felt very guilty about what I thought was having lost control of myself. I also knew I wasn't going to let him out of the room, because, then, how would I explain it to my supervisor that my patient had walked out on me.

We ended up wrestling, but the next session we had, he said, "I think finally I'm getting some psychotherapy." Which has always perplexed me, because I was wondering if he would ever come back again. He was waiting when I came to pick him up on the ward.

This patient had asked me a question that I couldn't answer: why had I picked him to work with? I hadn't; he was assigned to me. In my fury, I had said, "I didn't pick you. No one could possibly pick you if they were given a free choice." I had said things like, "You're a poor excuse for a human being. Where did you get a notion that you are entitled to psychotherapy?" He said, "I'm going to write to my congressman and tell him that you're not doing anything for me." While I

think I could laugh part of that off, I think I was also scared by it. The vision of some letter going out saying, "I have this therapist by the name of so and so. He doesn't know what he's doing." So in that sense, I guess I felt very anxious about what was going to happen. Especially if this got back to the supervisor at the university. At the same time, it wasn't a question of getting back to my supervisor, because I went to talk to him about it. He found it very humorous.

I think what probably was most upsetting to me, because it was a real paradox, was how could this inept man, who had to come into a hospital because he couldn't make it on the outside, be the one who ultimately controlled by future? For all the people to decide what my future would be.

Example #8: "If you've gone to college, you can never be psychotic"

The next big thing that stands out was this session I had with this guy who's a CPA. I remember thinking, "Gee, I don't understand why he's in here [the hospital]." I kept thinking, "He's an accountant with obsessive-compulsive features; he should be seeing somebody on the outside." But as it turned out, he was a little more fragile than I had thought. One day, we were having a session, and it involved something about going home for Thanksgiving. He didn't want to talk about it. I kept saying, "We're going to talk about this." Finally, he got so furious that he got up, grabbed the table, and broke off a leg from it, and he started going after me. I was racing down the hall thinking, "If that son of a bitch ever gets close to me, he's going to crack my skull wide-open." I was really terrified. Given my background, I'm not one who's likely to yell out for help. I did that time. It took eight aides to subdue him. He was fighting like crazy. The turning point came, as he was thrashing around and calling me every name in the book; he said, "If you didn't have all these people to help you, I'd kill you." I don't know how it was that I had the presence of mind to say, "Did you ever think that I have people to help me, and you never have any one to help you?" All of a sudden, he just stopped.

I went to talk to my supervisor that afternoon, and he said, "Hmm, sounds like you had a really powerful session. What do you plan to do for an encore, tomorrow?" I said, "I'm not going to see him anymore." He said, "Well, you're the only one who could see him." At that time, I was very big on Sullivan, and I said something about him needing Sullivan. I remember my supervisor saying, "Sullivan's dead. You're all we got." Then he very concretely said, "What would be the conditions necessary for you to be willing to work with him?" I said, "I want him drugged enough to knock out a horse. I want him chained to a bed. I want an aide nearby." For each thing that I said (thinking the response will be, "I'm sorry; we can't do that") he would just say, "Done. That's done. That's done. Anything else?" I couldn't think of anything else.

So I went back. They didn't tell me the aide was going to stay outside and lock the door, while I was inside with the patient, who was in fact drugged very heavily and was chained to the bed. He looked up

at me and very drowsily said, "Is that you, you mother fucker?" I said, "You better believe it." He started dragging the bed across the room, and he said, "I'm going to get you." I kept circling around the bed to make sure that it stayed between me and him. Then, at one point, he said, "Why can't we discuss this like two reasonable people?" I said, "Because you're a fucking animal, that's why, you're not a reasonable person." He said, "Come on. We're both college graduates." He's saying this in a slurred, dragged out voice, and I'm still remembering him chasing after me with that table leg yesterday. Even now, drugged up, he's still mustering enough energy to come after me. I said something about, "We're still going to talk some more about you going home for Thanksgiving." With that he lifted up the bed, and it came crashing down again. It didn't go anywhere, but a big noise. The aide looked in saying, "Is everything OK?" I said, "Well, I'd feel better if you didn't have the door locked, just in case."

He eventually got out. I really did help him; got him back to work as an accountant. I felt very good about that one ultimately. It always stands out for me because of the violation of my assumptions about how college graduates can be crazy, too. I had this very rigid notion that, if you've gone to college, you can never be psychotic. You might be, like I felt I was, fucked up, but never do anything like that.

The next example, Example #9: "Well, what are you going to do now?" has less to do with overt aggression, but it again demonstrates a struggle over issues of power and control.

Example #9: "Well, what are you going to do now?"

It wasn't so much the verbalization. This woman opened up her blouse. It was the first time that I had ever been in a situation where sex was being flaunted. I remember thinking, "It's a good thing she's flat chested, otherwise God knows what I would would do." It enabled me to feel that I could maintain my integrity and my ethics.

(As long as you can maintain a certain aesthetic distance.)

Right. I remember thinking to myself, "Gee, you can come out doing the right thing for the wrong reason." Just a couple of inches of flesh are all that stood between me and being very unethical. I remember just sitting there, and she's saying, "Well, what are you going to do now?" I said, "I'm not going to do anything different than when you had it on. If you want to have a session with it off, that's up to you." She got furious, put it back on, said that I was nothing but an uptight son of a bitch. She wanted me to prove to her that I wasn't uptight.

(It sounds like she was trying to make you feel pretty defensive.)

Yeah, this was a straight power ploy, now, when I look back at it. Subsequently, I learned that with a previous therapist she had had sexual relations. This was sort of a pattern for her. Be seductive with men, then be very degrading of anyone that would take her up on it.

(It is almost as if she said, "This is my problem. This is what I'm coming in for. I don't have good control over my impulses. Let me show you what I mean." Then, when the therapist responds in kind, "Well, you're no better than I am.")

Right, a good way of looking at it.

(It sounds like none of that was going on in your mind at the time. It was simply, "Well, at least she's flat-chested.")

Yeah, it served to avoid any kind of real arousal. I think in part the very way she did it was so out of context. It was just she opened up her blouse. The way she looked to me was like someone just getting undressed.

The following example, Example #10: "I would drown too," carries overtones of the therapist being tested by the patient. Issues of control are in the fore, but they seem express a more fundamental issue dealing with trust. This seems similiar to the example cited in the Results chapter to illustrate this category, Example #2: "You ride the whirlwind."

Example #10: "I would drown too"

One of the patients that I worked with was chronically suicidal and had made numerous very serious suicide attempts. She had been in the hospital for two or three months and had not been out on pass, because of her chronic suicidal attempts. I felt real bad about the fact that she had been in the hospital for such a long time without getting out, literally. So, I volunteered to take her out on a weekend pass, which she wanted very badly. A critical incident in my work with her occurred while out on the pass and walking along the river. She looked at me and she asked me what would I do if she jumped in the river and tried to drown herself. Without hesitating, I said, "I would drown, too, because I would jump in with you and try to pull you out." That was a critical moment in our work relationship, because she knew I meant it, and I knew I meant it. She realized how committed I was to pulling her out of that river--and pulling her out of the river of psychosis. That was a big turning point in he work on the unit, in her work with me in

psychotherapy, because she started trusting me. After that time, she started bonding and trusting me as she never had been able to with anyone before. So, it was a dramatic change and something I've never forgotten.

(Can you say something more about what that was like for you, deciding to take her out on the pass?)

Well, it was a new one for me. I had never taken a patient out on a pass before. Having come up in a psychoanalytic tradition, I felt a little apprehensive and uneasy about it. Yet, I knew, this was good for her and not really beyond the bounds of a reasonable therapeutic interaction, because she needed more reality contact and not less. I was apprehensive about how she would act. Would she deteriorate while we were out? Would I be able to handle it? She was much stronger than I was. What would I do if I couldn't handle it? I had taken responsibility for a patient and certainly would be legally, as well as ethically, liable for anything that went wrong. I felt like I was really taking a lot of chances, by taking her out, and yet, felt that it was the decent human and humane thing to do. I felt that there was a good chance that it would have a facilitating and therapeutic effect, and I knew how badly she needed to be out in the world for a little while with someone. It felt good, and it felt scary.

(What was it like for you when she said, "What would you do if I jumped in the river?")

When she said that, a cold chill went through me, because I knew she was thinking about doing it. She was psychotic and capable of making those attempts. Part of her would have loved the drama of her therapist watching her die. On the other hand, she was also asking a more profound question: Did I care about her and how much did I care? She got her answer.

The next example, Example #11: "If you don't tell me what you're using the tape for, I will be angry," demonstrates the tension between the patient, as she tries to get the therapist to conform to her needs, and the therapist, as he strives to maintain an interpretive, clinical stance in the face of her mounting anger at him. Ironically, the therapist finds himself appeasing the patient at a later date, but the patient, by then, is in a position to let him know that she does not need his appeasement.

Example #11: "If you don't tell me what you're using the tape for, I will be angry"

I asked this patient if I could tape a session with her and explained the reasons I wanted to do this and who would be seeing it. She agrees to my taping the next session.

The next session, she comes in and starts by mentioning that she is anxious about being taped, but she goes on to talk about an argument that she had with her supervisor. Then, she starts talking about the tape again, and then back to being angry with her supervisor. I asked her if she was angry about being taped. She said, "No." and I said, "That's what I mean; isn't that curious?" She replies that I have every right to tape her, since this is a teaching clinic. Then, she asks me what I intend to do with the tape. I replied, "You're looking to me to collaborate with your not getting angry by inventing a rationalization." "If you don't tell me what you're using the tape for, I will be angry," and she ends by storming out of the room. I remember feeling anxious, because she was really pissed off. I easily could have and wanted to give the session a mutual ending. The important thing about this is not that I felt anxious; it illustrates the analysis of the defense of the warded off impulse in the transference.

Her father had sexually molested her as a teenager. She handled this by being bitchy with him. Later in life, there was this incident of her being bitchy with him, and it is followed by him having a fatal heart attack that day. She realized that his complaining of how he felt that day was due to his being sick. After a period of psychotic-like depression, she ended up idealizing him with the result that she couldn't be angry with him.

I had to terminate with her somewhat prior to the time she was ready herself. She was angry with me about this. About ten months after we terminated, she is in distress again. I told her, if she can come to where I am now, we can have a couple of sessions and try to understand what is going on. It turns out that it is the anniversary of her father's death. She was having a reaction to the termination and the anniversary of his death. I offered to make a referral for her in the city where she now lived. This was delayed by the other therapist's vacation. I wrote to apologize and explain the delay, and she responds by telling me not to worry; she can find a therapist herself. I realized that I was trying to be a nice guy, so she wouldn't be so angry.

What was important in all this was the struggle not to appease her anger. The paradox is that I ended up doing just that, but she had gotten enough out of the therapy not to take me up on it.

Example #12: "I sure felt angry," again, demonstrates the confusing and overwhelming quality that a patient's rage can have on the therapist, leaving him unsure of how best to respond in a therapeutic manner. Example #13: "I was in awe of her anger" also depicts the

therapist's amazement at the patient's rage. Though in this case, it seems less disturbing to the therapist, perhaps because it is not being expressed directly at the therapist.

Example #12: "I sure felt angry"

I was terminating with an on-going therapy group. This was the last day that I was there. Issues included people's feelings about my going. I had my own mixed feelings. This borderline woman in the group was very angry. She kept goading me and trying to stir something up. I dealt with it by overlooking it. At the end of the group, she said something derogatory, and I ignored it. She confronted me and went into an angry tirade. I felt instantly angry, but she ended the encounter by walking out. I don't know if I did the right thing in dealing with her, but I sure felt angry. I thought that to deal with her remarks would be to short change the others in the group. I let her be angry, and she walked out. It ended things on a sour note.

Example #13: "I was in awe of her anger"

The divorced parents of a child had told her, "You work hard, and we'll take you out of the hospital." But, the mother had second thoughts and secured an injunction barring the father from taking her out of treatment. The patient was suppose to be discharged on that day at noon. I had to tell her that she wasn't leaving; she has a temper. She just sat there staring she was so rigid. I had a little fear for my safety, but I mostly in awe of her anger. It just filled the room. It wasn't an impulsive anger; it was like a volcano building up steam. I thought, "Boy, this is going to be a hell of an explosion when it comes."

Another thing was I knew how hard it was going to be for her to leave the office and tell everyone on the unit that she wasn't going to go. The humiliation of others saying, "I told you so." I had a kind of empathy for her, but I knew it was the best thing for her. I was split. I was awed, scared, glad she was staying, but I also felt bad for her.

While the previous three examples pointed to how the therapist can be thrown off balance or unsettled by the patient's anger, the next two examples demonstrate how unnerving it can be to have a patient suddenly become psychotic during a session.

Example #14: "I knew at that moment she had lost it"

An adolescent girl had always maintained how much she loved her 18 month old brother. Her parents had mentioned how, one time, she had been dancing around with the infant and tripped and fallen. She had protected the baby when she fell and it wasn't injured. I brought this up with her one session, and she got this very strange look; she was just stopped cold--frozen, like a freeze-frame. I had this feeling like cold fear. I knew at that moment she had lost it. I felt like, "Oh, shit. This girl is gone." I had a lot of mixed feelings. Part of me was worried about what would happen, but the observing part of me knew we were getting into something we needed to get to.

Example #15: "She was not there in the room with me"

Any time someone starts to go psychotic, it's scary. I had a woman who started to describe a rape she endured. It was one of those things where she stopped being in the room with me. Her voice changed, and she went on describing the event. The, she stopped talking. She was not there in the room with me. That was frightening, I could get nothing out of her. It took several minutes for her to come back.

With this person, I didn't have the feeling that we had hit on something. I was scared and I didn't feel this was therapeutic. With some patients you can feel that the bond is strong enough for you to be their ego and bring them back. But, I had only known this patient for a few weeks.

In the following example, Example #16: "What it's like to be a beginning therapist," the emphasis is, again, on the therapist being thrown off stride by what occurs in the session, but in this case it is new and unexpected material that catches the therapist by surprise.

Example #16: "What it's like to be a beginning therapist"

When I started internship, I was scared and green. I was seeing a man who would ride a bus in 60 miles for treatment. What stood out was a sense of guilt that I wasn't giving him enough. He would come in and just talk, almost dominate the sessions. Perhaps he was afraid of what would come out. Then one day he just stopped. I noticed the shift and felt a little anxious. He said, with eight minutes left in the session, "There's one thing more . . ." and he went on to tell me about his wearing woman's underwear. I remember a sense of panic, "What do I do now?" A sense of inadequacy as a therapist. What I was hearing was unexpected and not decipherable to me. Like if I was playing football, and the other team lined up in a totally new formation.

I was able to go back to my supervisor, who said, "Good, some new material" and predicted that the patient would back off from what he'd brought up. We eventually worked through his feelings of losing his wife and his feelings of inadequacy. This incident has always been an anchor point for what it's like to be a beginning therapist.

The following example, Example #17: "I felt . . . kind of lost," also presents an event in which the therapist begins to feel overwhelmed as he struggles to figure out how to respond to a difficult situation.

Example #17: "I felt . . . kind of lost"

I got a call from a man, who was desperate about what to do with his wife. She was a young, attractive woman, but she was also a borderline and beginning to come unglued. I agreed to see them that night, which was unusual, because I don't get that many emergencies. She had a quality about her that you didn't know what she was going to do next. She had a history of taking off impulsively. After talking to her it was clear that she needed to be in a hospital. I wanted to talk to her husband, but she wouldn't sit there with us. She agreed to sit in the lobby, but I was concerned enough to ask the secretary to watch her. While I was talking to the husband, she left. I was concerned, but I didn't know what to do. I didn't know how dangerous she was or likely she was to do something foolish. Yet, I didn't want to over-react and make her feel that the net was coming down on her either. I told her husband that she had left and that he should check on her, but he acted funny about it. He just wanted to continue talking. Finally, I had to insist that he do something. I felt both scared for the patient's safety and kind of lost. I didn't know if I needed to get more active and do something or not. The husband seemed to be psychologically paralyzed. This was late at night, and I was feeling somewhat out of my element. I was telling my secretary and the husband what to do, and I was feeling stretched by all this.

It turned out she had just gone out to get something to eat. I recommended hospitalization, but they waffled. It was three or four days before she went into the hospital.

The next two examples have been saved for the end of this category, because they provide a kind of transition to the next category, Merging and Separating. While the issues of control stand out most figurally in both Example #18: "I could actually see the boundary around her" and Example #19: "We were bound together forever," the events take place

against a background of the patient and therapist being joined or Merged in some ways. In both cases, the issues being dealt with in the therapy have to do with primitively organized aggression.

In the first of these two examples, Example #18: "I could actually see the boundary around her," there are aspects of all four categories that can be discerned. In addition to the patient's poorly controlled behavior (Losing Control) and the disturbing impact that this has on the therapist (Merging), the therapist also remarks upon how establishing some limits with this patient provided the beginning of a relationship (Connecting) and how this case made understandable for the therapist the notion of "ego coverage" (Recognizing).

Example #18: "I could actually see the boundary around her"

This one really stands out in my mind. A lot of information came together in an experiential way. Things that I had read and talked to others about, theoretical things.

This patient was just absolutely out of control, drinking, substance abusing, beating people up, and the therapy started with this person being out of control. The patient came in drunk and high, cussing and threatening to beat me up. I hadn't worked with a lot of out of control people before that, so there were a lot of things that I might have understood intellectually, but didn't have a lot of experience with. There was a lot of focus on the the content, and it was really clear what was going on, but there was something missing. The focus didn't ever serve to settle this person down. The third or fourth session, in the middle of the session, I remember thinking that something had to be done to get it under control. I put some limits into the therapy, saying that the patient could not come in high anymore, that the patient wasn't going to beat me up, those kind of things. That wasn't the thing that was striking, what was striking was that I had a hallucination at the time that I did it. What I saw was a box around this person. It was clear that the control of the therapy had shifted. As I was saying these things, I knew that the therapy could work. I could actually see the boundary around the patient. I had finally gotten the therapy contained in a way that we could start working on things. It was contained within that room, whereas before it had really been out of control. Actually some very good things happened after that in the therapy.

(While this was coming together, you literally saw the patient contained in a box?)

Yes. Sort of a clear, kind of cloudy, had a little bit of color to it. It definitely was a box around the person. The person was so loose, and so chaotic that the patient aroused those kind of feelings inside of me all of the time. It was just a very primitive situation. I think that is probably why it happened that way, too, such a concrete form. The whole situation was so primitive.

(This case stirred up a lot of chaotic feelings in you the whole time you were working with it.)

Oh, yeah. Up until that point. After that point, I still felt the same things, but not in the same way. It seemed to more manageable. I remember with that same person, I had an image one time--this was several months after--that this person was a little child and that there was a rope--I didn't see this one literally; this was more a metaphorical kind of thing--but there was like a rope around the person, and we were sitting outdoors and there was this cliff there, and there was just enough rope so the patient could always go up to it, but not enough so that the patient could go over it. That was always the sense that I had in the therapy after that.

I think that's when I understood the notion of ego-coverage. You get inside the person, almost literally, and take over some of their functions. You can see it work. It's one thing when therapy is more content oriented, when somebody has enough of an ego that you talk about things and insight makes a difference. With somebody like this, all it does is stimulate more impulses and gets them more upset. I knew that there was a difference before that, but I didn't know what the difference was and I didn't know how to do it.

(What became of that sense of something missing and what was that sense like?)

I didn't feel like it was missing after that. I remember thinking about the issue of control, that I clearly didn't have control of the treatment. I think what I felt was missing--and what was missing--was a therapeutic container, a hold. I didn't have a hold on the person. There wasn't any connection between us, and I think that's what the container is. There's a connection, and it's built on certain ground rules, but it's also built on the belief that there's something constructive that's going to happen between people. Once I understood that I didn't feel so much like something was missing.

I didn't use the content for insight after that. I used the content for coverage, to keep things contained, to build things, as opposed to uncovering things. It was to build certain kinds of abilities.

(You described it as almost being inside; can you say something more about that?)

There is a feeling that you are working from the inside. How to describe that. Its like when you work with small children. You watch them, and then you see what they are capable of doing and what they are not capable of doing. When you get a sense of what they are not capable of doing, then you assume that for them and do that for them. If you are working with an adult, you verbalize that's what is occurring, so it can become a higher level function for them and go through verbal means. With little kids you just do it.

It's probably that there isn't any distinction between inside and outside with someone like this, and there's not much sense of boundaries. What you are doing is building boundaries. You make an alliance with, however small, that constructive part of their personality. In that sense, you feel like you are inside. From there on, you start building boundaries around these other things, which are just out there.

Like the preceding example, the next one, Example #19: "We were bound together forever," also contains a number of different aspect that could be focused upon. The aspect to be emphasized, which places it between the Losing Control and the Merging categories, has to do with the patient's angry and desperate effort to maintain the therapist in a position of meeting her "sybiotic" needs. In addition, there is a sense that in going through the depression accompanying the loss of the sybiotic merger, a different higher level of relating has become possible (Connecting).

Example #19: "We were bound together forever"

This case was an extremely bright woman, who was talented and very creative, but profoundly disabled and limited. Things would fail, because she would become psychotic and have a manic episode or she would have what she called depressions, but they were more disheartened, schizoid withdrawals.

She came to the first hour and heard that someone would be listening to her and she could have therapy. She could think about outgrowing her madness, and she was thrilled. She went home and promptly became psychotic. She called me in a dissociated state and spoke in a terrified little girl voice. "She's here, in the house. She's going to kill me. She said she's going to kill you." Then, she disappeared from the phone. I could here breathing, but gone somewhere, inaccessible to anything I had to say to her. Then, there was no longer any breathing and there was an open circuit. I was worried and frightened and

wondering what the hell was going on. Then, she came back to the phone, and it was an absolute female monster. In a guttural, growling voice that reminds you of the Exorcist she told me in no uncertain terms that I was damned to hell for trying to take her away from me. "She's mine, and you'll not get her. If you mess with her, I am going to kill her and you."

We worked on all of the above, and she advanced, at an admittedly snail's pace, to increasingly, as I would put it, genuine abandonment depression experiences. She was increasingly, intellectually and affectively, in touch with the knowledge that she simply had to experience letting me go if she was to be really well and to really belong to herself and be done with this.

The abandonment depression had proceeded to a level where I wondered, will she submit to that much pain. I got my answer, in a sense. She was in that pain, and then, she dissociated, which she had not done in two or three years. She dissociated at the end of the hour, went silent, and into a deep schizoid withdrawal. When she came back out of that, she reappeared as a somewhat modulated female monster. She looked me dead in the eye, and with all the scathing powers of a paranoid female, she told me what a horrible, useless, son of a bitch I was: "What a trick, what a deceitful trick. My only defense, my only means of surviving in this world is to appreciate what a worm you are. Playing with me and how I feel. Doing it for years on end. Stealing my money and me not able to do a god damn thing." She slammed out in that state of mind.

We were far enough along, much different from earlier times when I would have been more frightened of the lethal potential, that I felt tired of it. I was in a state of mind, where she was going to have to decide. If she was going to cast that devil out, fine; if she was going to turn it loose and have it kill people, that was fine. I believe I was prepared for her death. I knew that it wasn't going to be any fun; it's going to be painful. I understand you got one or two coming in a lifetime, and I haven't had mine. If this is it, so be it. I didn't do anything to manipulate her environment or rescue her from her state. Nothing.

Next session, she came in, and I had an experience of dread and knowledge. I had the knowledge that she was packing a weapon in her purse. That really got my attention, though I don't know that I was that effective with it. If I had really been my ideal self, I think I would have done something different. I might have said, "I have something that supersedes anything you have to say. I'll tell you that I'm scared to death, and I'm scared to death, because I believe that there is a weapon in your purse." Where might we have gone from there, if I had the courage of my own convictions?

Well, I was soon to pay the price for my lack of courage, because she slumped through the interview and scathed me again, but her energy was down. She was more depressed and hopeless about things. I felt that the danger of suicide was much more real, and I was thinking of possible suicide-homicide. I was certainly a perfect target for that; it was a marvelous solution for abandonment depression. We got to the point that it was the end of the session, and I said, "Stop. I've heard

the state of mind that you're in, and my best clinical judgement is that you must be in a hospital." My feeling was that's the only way she can have that abandonment depression without running an insupportable risk of suicide. She got up as if to leave, and I said, "You didn't understand me. You must be in a hospital."

She bolted out the door and got past me, and as I walked with her, she skillfully dropped her hand to her side, which put her hand dead in the middle of her purse. She dropped the purse; the purse fell away from a gun, and she stuffed it into her belly. My whole life passed before my eyes; I was right beside her. I just dived to knock the gun away from her belly. The best chance we've all got here is to push that gun to the side. I used all the force I had and knocked her down. It's a wonder it didn't break bones. I wound up holding her until the struggle quieted down.

That marked the turning point; she turned and worked just in a straight line from there on.

(What strikes me in this experience is a kind of intuition of what is going on. It's like you have already had a chance to read the script.)

Oh, yes.

(And now you are in it.)

It has the force of reality for me, now. I feel it was real. What was real for me was that phone call. That's when she became my patient. It was not in the first interview, but in the phone call. We were bound together forever, and I waited years for the denouement, that combat with her internal object world when the demon would either die or be cast out. It seems to me that I knew the demon pretty well; it was an eerie feeling.

(When she left the session, the time before she came back with the gun, your sense of that was: This is it. I'm not going to do something different. A fish or cut bait kind of decision?)

It was a becoming a man kind of experience. I knew I had met the devil. I was prepared for an all out try to beat the devil. Also, I wasn't going to be seduced by the devil. I had read Harold Searles's Collected Papers, and he talked about the formation of the pre-ambivalent symbiosis. The hallmark of that was you felt quite in love with the patient, and the patient felt in love with you. You knew it; they knew it. You were in it. You might be there for a year, two years, three years, five years, but sooner or later, he said, somebody is going to get tired of it. "We're separate; that's it." At that moment, you felt you had converted from treating a psychotic person, who lived through these primitive identities--the devil incarnate and so on--lived there, dwelled there, to a more neurotic personality structure. I had very much the sense that, "I know what is real about you. I know precisely where you are in treatment. I know exactly where I am and who

I am. I know who you can be and who you are. I'm willing to go to the mat with you, but you are going to have to decide." I felt very free with that. I really had forgotten that she would probably like to take somebody with her. I had sort of resigned myself to she was going to have to decide. It could go either way.

2. Merging and Separating

This next example provides an instance of the therapist experiencing a confusing merger with the patient, but in this case the content of the experience has to do with psychosis instead of suicidal impulses.

Example #20: "We're both swirling in psychosis"

I've also had the scared to death, terror ones, not because of suicide-homicide [referring to Example #3: A "scared to death" experience], but heading into impending psychosis. There have been times, in which I sat with patients, and I know they're crazy and they know they're crazy. We're both sitting there, as they're swirling in psychosis, and I'm sitting there swirling with them. Initially, that one was scary, too. The difference between that one versus the suicide-homicide ones was in terms of the kinds of negative outcomes, like death. With psychotic people, when I've had it with them, it was more just pure fear in losing control, without concern about outcomes and consequences. Somehow with these populations, the consequences have not been there like with the other ones. It's the sense of chaos, the room kind of spinning, and the sense of, "Oh, this person is kind of crazy." I have more perspective on the affect. The first thought I always have is, "This person is kind of crazy," or "This person is threatening to go in." With this kind of population, this will happen relatively frequently, because you lapse in and out of it with them.

This next example picks up on a previous one, Example #3: "A scared to death experience." In this case, the therapist has the experience of being flooded with the patient's affective experience after the patient has left the session.

Example #21: "Time-release capsule" of affect

This patient had a very similar character structure and defensive constellation [to the patient in Example #3: "A scared to death

experience"]. This individual, while not killing others, was very close to a lethal suicide attempt. I remember being concerned about it, talking about it and so forth. After the session, the individual left, and I was all by myself, not with the patient. I had just come out of the rest room, stopped to have a cigarette, and got the same experience, except the patient was no longer in my office. I was flooded with the sense of out of control-ness, decompensating toward a paranoid end of things. I just felt like the suicidal impulse was in me. I was not as scared of it this time. I remember being just kind of woozy. In fact, I sat down. I thought, "Whoa!" and I thought about the patient and about what we had talked about. The thought I had was, "Well, at least the patient left it with me." I think the patient was thinking about doing it that day and had left it with me. That patient is doing fine, continuing in therapy, and has worked through it, and so forth. But that was weird, because the patient was gone and it happened. So, there was a time-release capsule effect to this one.

The next example focuses on how the therapist can use his experience of merger or attunement with the patient's experience to maintain a kind of understanding and unconscious communication with the patient.

Example #22: "Oh, I'm in the closet with her now"

I've noticed that often some of my colleagues, if they know about a particular case, they very often immediately say, "Oh, he's really crazy" or "This person is schizophrenic." They often have a much more objective point of view. Not objective in the sense of devoid, but objective in the sense of object, on outsider. Often I find that I don't have the same kind of perception. Often my perception is much more of an attunement perception. Like with one particular patient that I worked with, the original complaint was about an ex-spouse. How that person wasn't giving their child enough structure and it was going to ruin the child's life. What I noticed about myself was a kind of a sensitivity that I had to the patient, but that I would never take to the point of saying, "Boy, this person is really crazy." In fact, the patient was psychotic at times, but I would never go that far as to say, "Oh, this person is having a schizophrenic break." I had a certain kind of attunement to this crazy part of the patient, where I was able to put up with it. This case put me through the wringer at times. A lot of phone calls in panic states. I noticed some counter-transference reactions where I would become very anxious like the patient or very worried that this person would become litigious and sue or something. What I noticed was that a lot of these states really were almost projective-introjective processes. These were really the issues that the patient had. All I did primarily was hold the line with the patient in the sense that I didn't jump in.

Sometimes it was a very moving sort of experience, in the sense that some of the plight, for example, of this person's childhood would make me very sad as we talked about it. The patient really had a bad childhood in fact. That's what I mean by that kind of attunement, and it allowed me to make some direct interpretations about what a particular experience would be. One particular experience the patient had as a child was to often hide in the closet alone, especially when things got too loud and angry and crazy in the household. During periods in the therapy the patient would come in and shut their eyes and talk to me. I remember very clearly, my first reaction was: "Oh, I'm in the closet with this person, now." I didn't say anything. The patient went on for a while that way, about a couple of weeks. Six months later, I brought it up, again, in a different context, and said, "Yeah, I was in the closet with you." The patient laughed and said, "Yeah." It made sense to the patient, too.

(In certain ways, being that attuned to this case, you kind of lived the world as the patient lived it, and it gets harder to decide what the boundaries are. You kind of accepted the patient's boundaries?)

That's true, but on the other hand, it got to a point in the course of the treatment where I realized that the patient's anxiety was just getting out of hand. It was just too much for this person. I learned that because it was too much for me, too. So, the patient was put on some medication, and it in fact helped a lot. It didn't seem to hamper that much, in terms of the therapy. Around that time the patient got quite mad about it. Not about the medication, but because all of a sudden this person began to feel separate from me. I said, "Maybe the problem is, before all this you felt that I was the same as you are." The patient said, "Exactly." I began to see that there was a point to the fusion. With what this person was trying to work out, the patient needed someone to be in a sense fused with them, but there was also a defensive aspect to it. The defensive aspect is that if we're the same then I'll never have to change. Of course that left the patient in a very bad spot, because if we're the same, then the patient was also subject to projections of all the things that this person had inside: fears and stark sadistic feelings.

The next four examples pick up on the notion of the therapist's experience being correlated with something that the patient is dealing with, which was illustrated in the prededing example. The first example presents an instance of the therapist's fantasy being strikingly similiar to a dream that the patient ends up talking about.

Example #23: Unconscious communication

This wasn't necessarily a turning point in the therapy, but it was an episode that taught me something about how it is that people unconsciously communicate in some manner. I was working with a young woman who had suffered a terrible setback and had a schizophrenic reaction to it. Her house had burned down. For the first year of therapy there was very little spoken, a lot of long silences. On this particular day, I remember my mind was kind of wandering, fantasies were coming to mind. I had this one fantasy of standing on top of University Hospital and I was quietly watching the cars go back and forth, back and forth. I thought that was kind of an odd day dream, that was sort of the experience of it. I thought maybe this has something to do with our relationship, so I said, "Do you ever get the feeling that we're just passing time?" using the idea of cars just passing back and forth. She said, "I don't know, but it makes me remember a dream that I had last night." So she started talking about the dream and lo and behold the dream was of driving down the highway towards University Hospital in order to be hospitalized. I thought that was really strange, just the coincidence of the dream that she had had, the actual geography, and the fantasy that I had had, which were very much in correspondence to one and other. I didn't make anything of it; I didn't tell her about the fantasy, but it did make me think in terms of the level at which people might communicate. It seemed too coincidental to just be written off as sheer random coincidence.

It taught me a couple of things. One is that I can have that kind of attunement with certain kinds of patient, especially schizophrenics. I often use it diagnostically. The other point was: it really struck me how sensitive we probably all are and don't realize it to that kind of attunement. I wonder if it isn't the basis for empathy and for counter-transference fusion. If those phenomena aren't sourced in the same ability to identify, at some primitive level, with somebody.

In the next example, Example #24: "Well, something must be going on here," the therapist's anxiety announces that the patient is apprehensively getting ready to move to a new level of working on the therapy issues.

Example #24: "Well, something must be going on here"

It seemed like nothing in particular was happening. We were talking about many of the same things that we had already talked about. I remember one session feeling just very anxious, almost to the point of feeling fear. I could feel myself being very very tense. I remember thinking, "Well, something must be going on here; I don't know what it is." I zoomed through all the things in my life that might have resulted in that, but it didn't seem like that was the issue. I remember

thinking about it for awhile after that, and if something like that occurs, you have to trust that something is going on in the therapy. The next session, the person came in and started talking about how all the symptoms that he had at the beginning of treatment had started up again. This was maybe a year from the beginning of the treatment. I remember feeling very briefly the anxiety that I had felt, and then, it just went down. I wasn't feeling it. I made some kind of interpretation that it was very likely that the therapy had shifted another level. He had been working through, prior to that, but it was like it was going to shift down to a deeper level. I'm sure that's what the fear and anxiety was about. The level prior to that, there had been some very emotional times, and then, it had been intellectualized in a lot of ways.

In the next example, the therapist's experience of disorientation indicates that the patient is talking about something, for the first time, that is confusing to them.

Example #25: "I'll feel that too."

I've had times where I felt like laughing hysterically, or I felt like the room was starting to spin, or real intense sadness. These are related to things that come up later or to things that are going on with somebody who might be feeling real loose. I have noticed that, at times, when somebody talks about something for the first time and it's very confusing and disorienting for them, I'll feel that. I'll feel that sense of real disorientation. I'll look at them and it's clear to me that's what's going on.

In the next example, the therapist's desire to laugh hysterically indicates that the patient is going to talk about something that would be really "crazy."

Example #26: "I've had times where I felt like laughing hysterically"

The times that I feel like laughing hysterically, I usually think that it's going to be something really crazy and that it would make the person feel really crazy. It's not something that's funny. It's that kind of very intense laughter where somebody is very afraid that, if they say it, they are going to go crazy.

This one patient had a very, very, very disturbed mother, and sometimes, when he would talk about her, I would have that sense. The things that he would describe would be pretty crazy, but for him, there

was no affect associated to it. All the affect was isolated from any descriptions. For most people, if they are talking about their own parent, it would be devastating, absolutely devastating. The split was very great, and at that point, I had the feeling of wanting to laugh. Laugh at something that was so crazy.

My reaction to that usually has to do with chaos and if their affect is isolated from it. If somebody is feeling it and describing it, I don't have the urge to laugh. If the affect is really isolated for them, and it has to do with something that would just be absolutely chaotic, and the person must have felt just absolutely helpless, that in my mind would be the kind of situation that would threaten to make somebody go crazy. If you think of a little kid in a situation where people are acting really crazy and not taking care of that child, and then the person is able to recall it, but it's all split off, that's usually what that reaction for me has to do with.

This next example is also suggestive of the therapist having some sort of unconscious merger with the patient, but it never becomes clear what the merger means.

Example #27: "I would have this impulse to jump up and throttle him"

One that came to mind, I call an unusual countertransference reaction on my part. A young man that I was seeing was using the couch, and I would listen to him go on and on. What I noticed about him was that he seemed to be giving me a summary report of what was going on mentally, rather than telling me straightforwardly. I commented to him about that several times. In the midst of all that, I would notice, when I was quiet and he would go on giving these summary reports, I would have this impulse to just jump up and throttle him, literally, to kill him. It was very clear that was what it was, a feeling to attack him, to choke him to death. I was somewhat surprised by it; it didn't particularly frighten me or anything, but I remember being surprised by it.

I knew from his history that when he was a young boy, before the age of five, the father was physically abusive of him. Often the patient remembered that experience as one of surprise. He would come in after having played, and his father would fly into a rage and spank him. So, I always suspected it had something to do with that, but it never clicked. I was concerned enough to bring it up to a consultant of mine, who was just as puzzled as I was about it. His only suggestion was that I had him on the couch too soon. He suggested that I invite him to not lie down. I think he keyed more into the countertransference reaction that I was having and the fact that the guy was giving these summary reports of what was going on. So, I invited the patient to sit up, or if he wanted, to lie down, whatever he wanted, walk around if he wanted to. He got up from the couch and in the course of the therapy never returned to it, but the therapy went along fine. I never had that

reaction again. It happened three or four times. It was startling enough to surprise me.

(Was there irritation with him?)

Very mildly. He was a procrastinator in every aspect of his life. He had tremendous resistance to do psychotherapy, as exemplified by the summary reports. I would find his withholdingness irritating, but certainly nothing to warrant that kind of reaction. This was very different, qualitatively different. This was wanting him throttled.

3. Connecting

This first example provides a very good instance of the therapy relationship moving into a new form of connectedness.

Example #28: "The quickening of the case"

What I call the quickening of the case is becoming aware of some undercurrent of emotion between the two of us, in which there is a sense of connection. Something dramatic occurs that almost grabs a response from me. This one patient's style was one of extreme constriction; the patient was so suffused with shame anxiety that this person was unable to work. The patient was also quite paranoid, vigilant, and pretty desperate. The first months that the patient worked with me were extremely uncomfortable. This person could scarcely speak; the patient was so uncomfortable and pain filled. The patient was with me about eight months when this event occurred. This person had spent a significant portion of childhood in a prisoner of war camp. We had a change of office, and the size and configuration of the office was reminiscent of the cell. This necessitated making a change to another office, and it got the patient so mobilized that the person was able to express something of the fear, the rage, and the shame that was felt. In contrast, the material up to that time had been very concrete and centered on here and now problems. This somehow impelled the patient into an "I" position and to be more revelatory. The significant thing, which was a turning point for both of us, occurred sometime while the patient was expressing this desperation. It was so palpable to me that I felt compelled to share something. I told the patient that my mother had been mentally ill. Not the sort of thing that I would typically do at all. It was an exchange; I was giving something that was very private of mine. The revelation seemed extremely apt, because the patient was stuck in a prisoner of war camp with a haughty, rejecting, crazy mother. So, the thing I gave made me most like this person. It changed the atmosphere; from that point on, the patient began to relate work in fantasy. In dreams, the patient had an infancy and childhood all over

again. The bond between us was a very strong emotional one, like between a parent and a small child.

(Could you say a little more about what the palpable quality of the patient's desperation was like for you?)

The patient really talked very little. It was the appearance; the way the person held their body; the flushes the person would get. The eyes were rage filled. This person looked as if they were so full of murderous feeling that they were just about to explode out of their skin. The body was rigid and stiff. The only movement would be a kind of writhing. There was a sense of great constriction. The patient would start to say something, then choke it off.

(It was an attempt to bridge, then, and establish some kind of contact, so the patient could share that with you?)

These are not planned things, but they are evoked. It's an intuitive reaction in response. It is an attempt to bridge, to comfort, and to let them know that there is empathy. An image for it is that on this bridge the two have come together and a new form of life or a new form of communicating has come into being. You stay with that while the person works on their individuating and is finally able to separate.

Prior to this dramatic experience, I had a bottled up feeling. I would absorb the feelings that the patient had. When the hour was over, I would feel frustrated, anxious, even frightened. I had reason to feel those things. This patient was a very rageful person, and much later, the patient was able to tell me that they were afraid that they might kill me. I was feeling the ebb and flow of this person's rage, while all the time something else was getting talked about or not talked about.

With the establishment of the sort of connectedness described in the previous example a kind of play and playing out of roles becomes possible between the therapist and the patient. The two following examples both illustrate aspects of this play.

Example #29: "I participate in their needs"

There evolves a pseudo-relationship or play relationship, which is a special form of communicating unique to me and my patient. I enter into the transference and participate in their needs. I participate in my own feelings, and the images that come to me instruct my response or interaction with the patient. I remember one very haughty person, who had a very effective, but somewhat brittle, intellectualizing defense. A rather dour person, though functioning very well. The person was

really in therapy for self-exploration. The patient was on the couch, and the atmosphere between us had been somewhat distant and formal, like a couple of rabbis sitting around knocking back and forth profound ideas. We had stripped away enough of the defensiveness, so the patient was beginning to allow small pains and small feelings to surface. It seems to me that the first time that this person began to get into this mode I had a fantasy of being a mother sitting in a rocking chair beside the crib and watching this person with loving eyes. I didn't ever express that fantasy verbally, but the kind of material that was produced corresponded with my fantasy. I felt as though we had communicated without words. I often feel that my patients and I communicate some rather complicated ideas or pictures or feeling states in this way. I don't remember the words that were used, but the patient did become more relaxed. Mostly, it was a silent hour; the patient just enjoyed being passive and admired. This characterized the quality of our interaction for quite a long while afterwards. Oftentimes there will be words that convey it, so it gets into a kind of play. This patient talked about being in the crib and rattling the slats of the crib. Then, the person was able to get up, climb out, and walk over to me. Then, the patient was able to walk over to the door. The quality of the interaction was quite different from the kind of vigilant, uncomfortable feeling that I had while we were in our intellectual, dialectical stage.

(In this experience, there's a sense that a relationship is formed at this point?)

Yes, there's an experience of a breakthrough. A breakthrough of the defense or of the barrier that has existed between me and my patient. The barrier is bi-lateral. When it gets pricked or exploded or dissolved, it does have the dramatic quality of feeling like a great release. Then, after that, the work takes on a quality of play.

(When you describe there being a sense of relief, there's a sense of change for you, too?)

Yes, my patients change me. It takes a while for the patient to position me so that I can participate in meeting his or her needs. They have to train me into it. Sometimes it's easier and sometimes it's harder. The prior period of intellectual jousting is very important, much more for some than for others. This patient's defenses had to be pricked and I had to be a good enough fencer to find the place where it hurt and intellectually and verbally penetrate or lay open that one sealed over spot. That's the surgical part, that's the groundwork. When there isn't this wall between us, I can perceive their needs and their fantasies of what they need me to be. I am present and involved in a very different way, in a much less cerebral way, than I have been before. We have a relationship that is quite different from what we had before.

As a footnote to the end of this next example, the therapist makes some comments about how it becomes possible to shift perspective with these experiences. The therapist describes being able to step out of the immediate experiencing of the event and recognize what is going on more cognitively (Recognizing) and then step back into the event.

Example #30: "Nurturance and attachment" experiences

The nurturance and attachment experiences are when I end up feeling filled with this sense of parent-child sorts of things. It will happen with a patient who is pretty regressed in a healthy, Balint, therapeutic regression. Often times with patients who are on the couch. These all occur with patients who are really engaged with me emotionally. They'll get talking about dynamics about their family or issues relevant to them, in terms of nurturance and attachment things, and I'll often have very satisfying kinds of experiences of: They are the child and I am the parent. For a brief moment of time, I am their parent and they are my child. It's not just that they are responding to me as if I were their father or mother, or I to them as if they were my child. Those are very pleasant. I find myself feeling just really nurturant and really attached and really focused on them, often beaming, often delighted. The only experience I have similiar to it, outside of it, is when I'm having a great time with my wife or with some of our children. I'm having fun with them, and I'm just playing with them. It will be close to that kind of experience, only with a patient. It's kind of irrelevant to content per se, but sometimes it will be because they are actually talking about something and a similiar dynamic gets played out.

(Is there a particular time that stands out, now?)

This a female who is high functioning and very successful. I've seen this patient in therapy longer than I've seen anybody. An unavailable father who was kind of distant. The father liked her, but he had more trouble moving with little girls than he did with little boys. She experienced even more rejection as she moved towards femininity an the onset of sexuality.

She's highly successful and into mastery and can do all these things, but she doesn't want to talk about any of that stuff. In fact, we will sometimes go six months, and I don't know anything that's going on in her life. Instead, she just wants to play. She'll come in and talk about what age she decides to be today. She'll come in and say she wants to be four today, and she is four and just wants me to be her father playing with this four year old. She's funny, playful, joking, and doesn't want to do anything particularly seriously. She'll kind of crinkle herself up on the couch talk about wanting me to call in to work and give an excuse that she's sick today. There are a lot of sexual

seductive things, and she's able to talk very facilely about those sorts of things. She's delightful, and the sense that I always have is that she never really had this kind of unconditional attention from her father, for essentially feeling her narcissistically, and even more so, when she made the transition from little girl to young woman with the onset of sexuality and femininity. She's never been able to combine sexuality and femininity and involvement, and is now doing it. She does that all with me. It's like she's kind of showing off and exhibiting herself, and I'm suppose to be pleased, and I am and don't have to fake that. She's very attractive and makes a very attractive proposition. Any adult man would be very interested in taking her up on the offer. I don't do it, because it would be destructive, but I do feel it. She knows that I feel that way, and we have an agreement that we're not going to do anything. So, she's very free with that, and it's delightful in terms of spending the time with her.

The way it first got started, she would talk about the lack of any kind of mirroring from her father and the sense of distance, and as she would talk about it, I would be very much in touch with feeling how lovable and engaging she was. The connection was just really strong and powerful with her, and anybody would want it with her. It was always such an incongruous arrangement with her: She'd talk about her experience with her father, on the one hand, and I would be filled with experiencing her as just the opposite.

Those are the pleasant ones when they happen, if they have nurturance and attachment aspects to them. The more emotionally engaged and involved the patient is, the more the nurturance and attachment aspects are there with the sexuality. Sometimes I'll have those kind of experiences, either turned on or I am aware of sexual things going on, but they are with patients who are not as emotionally involved. Sexuality is just more of a body, rather than running through attachment and nurturant sorts of things. Those are not as strong, emotionally, in terms of the power of them. Those with nurturance and attachment components are very powerful.

With some of them that are more intense and so forth, I can't get it, at first, all the time. It may occur to me a couple of sessions later, in terms of what goes on. Other times I'm on to it. There are times when I get on to it right when it's happening. That is an interesting sort of thing, because then I'll be experiencing it, notice it, it clicks cognitively, and I can flip out of it real fast. It's almost like a 1, 2, 3 kind of thing. When those happen, the thing that I am also aware of is being kind of tickled and feeling good, because I think to myself, "Oh, there are some good things happening here." It's very quick like, "I am her father, she is my daughter, given where she is at, given her dynamics, this should happen." It's real fast, and then I'm out of thinking about it technique-wise and I'm back into it. Being able to step back, get perspective from the experience, and then go back. It's like a dream that you wake up from and you go back to sleep and start the dream right from where you left off. That's what I like, when that happens. I like when that happens. Much like I like, when I wake up from a dream and think about it and fall back asleep and pick up on it. I generally like that. That almost always happens with dreams

that I like or are in the final outcome significant in some way. It's like that.

The next three brief examples seem to echo the themes present in the three previous examples. The first of these examples, Example #31: "It's like they are ready to take a journey with you," focuses on the beginning phase of establishing the new level of connectedness, and the two Examples following this one, Example #32: "It's that going back and forth and practicing" and Example #33: "Why don't you leave the monster here with me?" both focus on the playing out of roles.

Example #31: "It's like they are ready to take a journey with you"

This is not a particular instance, but it's nice when this sort of thing happens. Adolescents come into treatment and often insist that there's nothing wrong with them. They resist, and you confront them with what's been happening with them. Then, they begin to let things out; they might let you glimpse some of what they might be feeling. Then, you see a transformation. They begin to let you know that they feel some pain. There's a change in their affect, a change in their voice. They might be teary-eyed. I feel like now we can work. We're getting to the real stuff. You finally have touched on something. It's like they are ready to take a journey with you. It's like that exciting relief of knowing that you are finally on the way. Consciously, they too know what it's all about.

Example #32: "It's that going back and forth and practicing"

I remember working with a little out of control four year old. He sometimes would get the soldiers, horses, and planes out. He would build fences and put the wild horses in them. Then, he would have the plane crash into it, and the animals would get loose. I would rebuild the fences and round up the horses.

I remember telling him sometimes that he would need to be patient, like when he would want to paint or something, and he took that. When we would shift roles, I would say, "Hurry up. Hurry up" and he would say "Be patient." It's that going back and forth and practicing.

Example #33: "Why don't you leave the monster here with me?"

The patient was a woman who use to do self-destructive things to herself. She had a vicious anti-libidinal ego. Any time something went well, she would always exhibit something self-destructive. We got to the point where we were calling it names, and I would have to do a lot of that because, if she did it, she would suffer for it. If I put this in words, she could sit back and laugh about it. It's like that with a kid. You let them know that you are tougher than the monster. We were talking about her anti-libidinal ego, and I suggested that she leave it with me. So, she picked out a place in the room to leave it. She warned me, when she came back, I would have probably done something destructive to myself.

Another thing that becomes possible in the therapy with this new sort of connectedness is the emotional atmosphere that the therapist in Example #4: "Parallel regression" described. The next example illustrates the importance of this special emotional atmosphere for the patient to be able to experience certain critical events in real emotional depth.

Example #34: "That's my father's finger"

I remember one that didn't involve so much my attunement as my observation. It was a patient that I had seen in therapy a number of years. Often when I am talking to patients I can pick up on when they are getting very regressed, especially when they are using the couch. I often think that very important things go on, even though they won't be remembered by the patient. That's typically been my experience with people, that the patient will often not go back and say, "It was that time when I was laying on the couch and this experience and that experience was really curative." In fact, what they tend to do is forget those; they repress those experiences. The curious thing is that I remember them, very clearly remember them.

One is this man who I'd seen for a number of years. A very obsessive-compulsive man who had come in with very odd kinds of phobic complaints. He had been raised in a family by a father who worked for the railroad, and around the time when he was five years old, the father had had a horrible accident. He had fallen between two cars in a very remote part of the country on an icy, cold night. He just rolled out of the way enough that the train car ran over his arm and pinched the upper part of his arm in half and rolled down a finger. During the course of therapy, the patient remembered that very vividly. He remembered, as a child, following this episode, being startlingly frightened

and depressed for a number of years, as he would go back and think about losing his father all together. He would have fantasies of his father getting up, injured, and running after the train, because this was a very remote area, and if he had not gotten back on the train, he would have in fact died. He was able, even though he was injured, to get back on the train.

I remember this one particular session. He was reclining on the couch, and he had been talking about his mother and had been talking about his father, and he kind of drifted off into this sort of a very floating, dreaming kind of state. He was wandering here and talking about this and he talked about that. He stopped right in the middle of the session and he looked at his hand. I said, "What's going on?" He said, "That's the finger." I said, "What finger?" He said, "That's the finger that the train ran over." The words that he used made it clear that here was a subjective experience of that being the finger. What he noticed was that he was rubbing the finger this way, and he went on to remember that his father use to do that, too. I didn't say anything about it, but I felt that was a very important part of the therapy. It had something to do with an identification with the father and working out some very hidden, complicated reaction to all this. I remember the sense that I had about the interview was that the patient was kind of floating and going here and going there, in a relatively calm quiet sort of way, and then he was struck by a behavior that was going on, which seemed to be relatively unconnected. Yet, he had been talking about his father and the accident. He had been talking about the accident and his memory of his fear that his father could have been caught out there and died. He would play this over and over again in his mind as a child. Then, he noticed his finger. He himself noted that he thought that was peculiar that while he had been talking about this he himself was rubbing the same finger. It was almost as if he was soothing his father's injury. It had an eerie quality to it, as I was sitting there listening to him. I remember that. I didn't feel anxious or upset, it was just kind of an eerie quality.

This next example, also, focuses on the experience of emotionally moving moments in the therapy process, but the therapist notes that these were spread over a series of interchanges and no one event stands out in particular. The therapist, more reflectively, raises the issue of what role these moments of contact and recognition play in the therapy process and states that they are not curative in themselves, rather the psychotherapy technique is.

Example #35: "There was no one event, but a series of events"

This patient was in the horse business. She was afraid of dying. It was vaguely philosophical, but also a real terror. I find myself wanting to tell you all about her. This horse is going to have a foal. It was born with some difficulty, but it survived. She was moved by being able to save the foal's life. She is more attached to non-human objects, because she doubted her ability to do for others. The horse eventually did die, but through her long struggle to help it, she could see it improving a little. These episodes were very moving for me, too. She was experiencing herself as something good in the world, and I heightened her awareness of this. There was no one event, but a series of events.

What I am recounting isn't psychotherapy. It's a reaction to your questions about my experiences I've had in psychotherapy relationships. I don't recall my patients as patients or in terms of therapeutic moments, but I know I treat my patients. It occurs in the context of a relationship, but what I don't recall may be what is impacting on them. The treatment is what is valuable to them, although it is not emotionally most salient in my memory. These moments of recognition [Example #5: "Moments of recognition"] are important, but they aren't sufficient. It's the question of how much does the relationship cure versus it's being a vehicle for therapeutic technique.

This next two examples highlight the role of the therapist's intuitive and empathic understanding of the patient in order to maintain the therapy relationship and the therapy process.

Example #36: "Good technique but wrong dynamics"

I remember a mistake I had made. I was working with a woman with a dual personality. She had a real problem in her self-structure, early disappointments with her parents. One week she brought in a large pillow for me that she had made by hand. In proper analytic technique, I said we would have to understand this. She promptly said, "You don't want it" and threw it away. I had not counted on the narcissistic investment in what she was doing for me. I felt shocked and sad when I realized how I had injured her. I was angry at myself for using good technique but with the wrong dynamics. She had problems on many fronts and I had guessed wrong. It taught me about the prevalence of narcissistic needs. We were able to get back together and learn from it.

She came back many years later and brought in her baby. She had reintegrated. It's very memorable to have a patient come and tell you what a difference treatment has made.

In therapy, you are always using your reactions to try and understand what is going on. The patient who brought in the pillow is an instance of this. Here, my feelings of getting my needs gratified (that

is, of being pleased and wanting the pillow) obscured my view of the patients needs. A break in the empathy occurred.

Example #37: "It was an intuitive decision,
but it brought the therapy back to life"

Sometimes, you can see two or three levels going on at the same time, and you need to decide which one you can connect on. A patient, one time, was talking about issues of approval and passivity. At the same time, another theme was going on about belongingness. I remember thinking that the standard thing to do would be to stay on the level of approval-seeking issues. Doing that, I remember thinking that there was too much distance occurring. I commented on the other level and felt that it helped things along. It was an intuitive decision, but it brought the therapy back to life.

The next two examples point out how the therapist's involvement with the patient allows him or her to understand the patient better than other can who are not so involved with the case.

Example #38: "I knew who she was, but she couldn't tell"

This was with an inpatient that I saw several times a week. I remember the intense dependence from the patient and how intensely involved I was. It's a back and forth thing; if the patient's involved, the therapist is involved. I remember being able to anticipate things. Things she did would look strange to others, but I could understand them, being so involved. A crisis would come up, and I could see the dynamics. I didn't feel particularly anxious, because I knew I could step in. It was a case of somebody really using treatment.

One time she got really dressed up and looked years older. She got very agitated and couldn't settle down. She was almost psychotically anxious. When I saw her, she was pacing around in a large room. Then, she looked in a mirror and thought she was her mother. I knew who she was, but she couldn't tell. I was able to work with that and settle her down.

Example #39: With a relationship schizophrenic patients
become understandable

I was working with a therapeutic community for acute schizophrenics. In the process, I learned intuitively how to fill in the gaps in their associational chain. I was also teaching a seminar on schizophrenia and asked one of my patients to come and talk. He gave what I thought was a good presentation of what being schizophrenic was like,

but after he left one of my students asked, "What did he say? He was so crazy." It struck me how much rapport I had with him. It also said something about schizophrenia. After awhile, you are able to establish a relationship with them and you can understand them. I had become unconscious of my ability to fill in the gaps. Also striking was how these schizoid and withdrawn patients would continue, over the years, to call me or look me up to let me know how they were doing.

These next two examples point to the therapist's level of involvement with his or her patients. They are affected by the changes that the patient demonstrates, for example.

Example #40: "There's a personal risk in working with these patients"

I have gradually become convinced that psychoanalytic technique works. It happened over time. It's always a delight to see that you can be potent using these techniques. If you do interpret defense before impulse, sure enough, here comes some new material. Just doing psychotherapy is a mystery to me.

I have a patient, now, who was hospitalized in other states for psychosis. She gets depressed and cuts on herself. She's an ambulatory psychotic. She hates her mother, and she has a lot of trouble with me. Last week she told me, "For the first time since high school, I'm happy. I want to think about killing myself, but I can't do it anymore." She said that for awhile she had been angry with me, because she couldn't kill herself while being attached to me. It's very dramatic to have someone tell you that life is worth living.

You don't know what the outcome is going to be. There's a personal risk in working with these patients. It's more than just risking the time invested in a case that won't turn out or one's personal prestige, etc.. I don't talk about it; I don't know if it's ok, but how fond I am and attached I get to these patients. In one sense it's very structured, but I still am personally invested.

Example #41: How difficult it is for adolescents
to acknowledge attachments

One of the most difficult things for an adolescent is making attachments and saying that things matter to them. These are really powerful moments, when the kid says, "I care about you." "I know you care about me." "I'll miss you." Etc.

This girl had been in treatment about 14 to 15 months, before she went on to other treatment centers. She always had trouble experiencing positive feelings and there had been a long period of negative transference. Only after she left could she say in letters how she felt. She came back, later, and met with the treatment team. She presented me

with a picture she had made. After that, I ran into her by accident, and she said how difficult it had been to come back. She also spoke of the picture and how hard it had always been to say she cared about me. It mad me teary-eyed. I knew the courage it had taken to do that. I also felt good that she had gotten so much out of the treatment.

The next two examples have been saved for the end of this category, because they provide a point of transition to the next category, Recognizing. The first of these two, Example #42: "I don't feel anything," presents an instance where the therapist's experience of the relationship is also diagnostic of the patient's form of psychopathology. The second example, Example #43: "People laugh . . . before they cry," seems to have more to do with the "moments of recognition" that the therapist in Example #5 described.

Example #42: "I don't feel anything"

The other one's that it's occurred to me with are narcissistic patients. These are different. These occur when I've been with these individuals for awhile and I notice that there's no real attachment or involvement. Sometimes it occurs when they start to talk about their attachment and involvement with me, but I don't feel it--it's not there. I do have thoughts, when that occurs, about things like narcissistic bubbles, relating out of narcissistic orbits, the grandiose self, and I understand that kind of stuff. I'm sure that's part of what goes on, but it's a weird feeling to be sitting there with them, and they are saying this one thing, but you don't feel like anything is there. I can get the sense that I'm talking to a robot or to an Invasion of the Body Snatchers or Stepford Wives kind of person. I'm very aware of the sense that there's something missing with the attachment. I don't feel the connection, which is an odd thing, because I think these other experiences [that the therapist has talked about] occur because of the connectedness and the affect that is passing back and forth. With this particular individual, there's still connectedness and affect passing back and forth, but it's in the form of the absence of affect passing back and forth and the lack of connection. It's like at one level up or something. When I have that experience with them, it's the first experience of the connection and the attachment, even though it's based on recognition of no attachment and no connection. I'm sitting there thinking, "I don't feel anything," but the very fact that I don't feel anything and recognize with this person that I don't feel anything is the first connection I make with this individual. It's the way it

always is with them. It's at the meta-level that it's occurring, as opposed to something that's more directly flowing.

Example #43: "People laugh . . . before they cry"

There are so many funny things that happen. People are quite courageous even to engage any of these internal issues, that's what strikes me. Even mess with them at all.

This woman was telling me the other day, when she came in she thought she had one problem, that it would be taken care of fast, what the hell was going on. This is going to take a long time, won't it?

There are a lot of funny things; people laugh at them. They do a lot of crying and carrying on, but they also laugh. Things actually are very funny when you get down to it.

People can joke about their pathology. I remember working with a family one time, and what needed to be done was for the father to get more active with the kid and for the mother to be able to sit back. The session started out and she asks, what can she do? I said, "Sit back. Sit still. Let him do it." So then every time I'd try to talk to them, she'd come in and say, "What can I do?" I'd say, "Sit still. Sit back. Let him do it." It just kept repeating over and over and over. Then, at very end, she said it again, and I said, Sit still; let him do it." And she started talking about how her mother use to say that she was born wiggly.

The stubbornness of people is funny to me, the stubbornness of the pathology. You can keep coming up against it and up against it and up against it. Even to the point where it's defined, where it's being talked about; it's labeled, but it just keeps coming back and coming back. For some reason that seems humorous to me.

It's the way people work; it really isn't enough to know. It's not enough to have an awareness of it. You can even lay it out, and it can be the most absurd scenario, and it doesn't make sense in terms of reality, and you can sit there and you can laugh at it, because people just keep doing it and doing it. It's like a bottom line that we all do it. I think that must be why it's funny.

Then, there's a thing that sometimes happens after that, if somebody gives it up, there's a sense of sadness. I remember this one woman who just kept going on and on for a long time. Then she started talking more about her parents divorcing and what that was like, a number of loses that she went through. Then, she just hit the sadness, and you could see the other things kind of fade into the background. At those times it's so clear why somebody would hang onto it, to stay away from that. That's kind of a unique experience. I don't think, it happens a whole lot, those periods of real sadness. Somebody just feels sad and there's just nothing else. The rest of the shit has just cleared away and somebody just experiences sadness. When that happens, that has a real impact on me, when I see somebody who is in that pain, because there is nothing that you can really do. It doesn't have to do with coverage; it has to do with being with somebody when they feel

something, and there's not a whole lot you can do. It's active, but it's not active like ego coverage. You are two separate people.

I was thinking how it gets to the point where people get the drift of exactly what it's all about, and they go, "Oh no! This is fucked. What am I doing here?" That's funny too, because they are right. It's a real choice point. For some reason that experience is very amusing to me. Maybe it has to do with that there's not a whole lot else to be done with it. You can take a look at it and laugh, followed by the sadness a lot of the time.

(I was thinking of Freud's expression about turning neurotic despair into ordinary sadness. "So, this is what it's all about, just a new kind of feeling shitty.")

Masterful shitty. Tolerable, contained, masterful--but it's still there. If I think about it, people who get to that point, they laugh, too. People laugh when they get to that point, I mean, before they cry, but they do laugh.

4. Recognizing

The next several examples all seem to convey the sense theory coming to life for the therapists. Theory and experience come together with an "Aha" quality. These are described as learning experiences and seem to mark milestones in these therapists' development as therapists.

Example #44: "It's different when you see it with your patients"

I use to be cynical about psychodynamic psychosexual development. I thought you only saw it in Fenichel, for example. I was more into object-relations and self-psychology. I was seeing in treatment this woman with mild depressive problems. One day this sane functional woman said to me, "I just have this strong impulse to eat you and take your place." I said to myself, "This sounds like oral dynamics to me." It was a critical moment of my development as a psychoanalytic psychotherapist. It shocked and flabbergasted me, but I was also very excited. I thought this is great. I was also excited about the progress the patient was making. I felt we were really getting somewhere. Previously, I had based my expectations on what people had told me. It's different when you see it with your patients.

Example #45: "You don't see many things in this profession that are tangible"

This is an internship case that taught me a lot about family dynamics. The patient was losing her hair. I could see how much tension there was in the household. When I worked with the parents to improve their marriage, then, her hair grew back. That was dramatic. I was so much in awe. The reality of the family dynamics; the power of emotions. You don't see many things in this profession that are tangible, but I am satisfied that in this case it was the family dynamics.

Example #46: "It was wonderful to see how all the pieces fit together"

Child work is dramatic, because you can change the environment through working with the parents and see dramatic changes. For example, in working with this school avoidant child, I had offered her an individual, empathic, abreactive experience, but in the process, I had uncovered that there was a chronically ill sibling. The patient needed to be ill in order to not be shoved aside. It was wonderful to see how all the pieces fit together.

Example #47: "It's not just theory"

I remember reading a lot of therapy books and thinking, "Where do people get this stuff? They must be making it up, because I never have these kind of experiences." I remember talking to a consultant about this, and he said, "Just wait."

This woman patient started coming on to me. I had felt that something was amiss, and I would point this out to her. Then, she brought up a dream about me, and I thought, "Oh . . . !" She mentioned a Parade magazine article stating that eight percent of therapists have sex with their patients, and she asked me if I was one of those eight percent.

I felt discomfort and I was anxious. But there was an "Aha" aspect. We've turned another chapter. I've read about this, and now, I've experienced it. We also worked through it, so there was a sense of accomplishment. It's not just theory; it's happening.

Example #48: "I had read about this, but not experienced it"

This was an adolescent girl. We had been real close. Typically with teenagers in treatment, you have to go after them a bit. With her, I'd say, "Well?" and she'd go.

Suddenly, she didn't want to see me anymore. Finally, she painfully admitted she was attracted to me. Not sexually, but she wanted me as her dad. She idealized me and compared me to her real father.

Again, I experienced a sense of, "Gee." I had read about this, but not experienced it. I also felt sad for her. I sort of felt like, in someways, "I wish I could be your father."

An intensification. A sense of closeness between us that becomes intensified. It reminds me of what a supervisor said, "This will be the first real relationship that they will have had." With this patient, I was struck by how intense this was.

Example #49: "Pyschiatric phenomena in vivo"

I was working with a borderline adolescent girl. She was bright, insightful, and also angry and hysterical. This work provided a chance to see psychiatric phenomena in vivo.

She had seen the movie E.T., and this became a metaphor for her to talk about the symbiotic relationship between she and her mom. She talked about how ET and Elliot were and how they separated. For she and her mom, something like that would be experienced as death. As soon as the movie came up in the session, I knew what was going to come up. The therapist's unconscious mind clicking in with the patient.

With this girl, it was very painful to let go. I'm usually not tearful at discharge ceremonies. It was a wrenching experience; I had a sense of what it was like between she and her mom. There was a sense of sadness. I had seen her change. She wormed her way into your heart. She had kind of grown up in the course of her treatment.

Example #50: "Now, I dread a little returning from vacation"

I had gone on vacation. Again, this was a learning experience. I experienced the patient's rage. When I came back, she told me she wanted a different therapist. She had been seeing a substitute therapist. At first, I felt hurt and confused; finally, I realized she had missed me. Now, I dread a little returning from vacation, because you catch the wrath of your patients.

The following example contains a number of illustrations of characteristics that attract the therapist's attention as good prognostic signs and indications of the patient's efforts to use the therapy.

Example #51: Characteristics that grab the therapist's attention, such as change, spunk, courage, and perseverance

One person who stands out is a borderline schizophrenic. He was depressed and uneasy with people, and he tended to respond indirectly to others. Many of his psychotic manifestations were ways of being indirect. When he would break down and cry, showing his real feelings, this would always grab my attention. He's not so secret and indirect as he use to be. I use to have to almost read a road map to understand what

he's saying; he was so disguising. These would be instances in which he's more direct and the content is affectively laden.

Other instances that stand out are changes. People are afraid to take initiative or assert themselves. I was working with a young man in a therapy group. He rarely acts. For him to say something in the group about not having responded to cues from another member was for him a big step. People begin to show some sign of spunkiness, a sign of hope. He was beginning to see opportunities.

So, patients being able to take risks, make some changes, show some spunk, or begin showing an emerging strength--these are the sorts of things that attract my attention.

Another thing that I notice is when people start to take or show some pleasure in what is happening to them, like this one woman. She is spunky, volatile, adventuresome and in someways likable, but she is afraid to get involved in more intimate ways. She has been involved lately in a longer relationship, and she's fought hard not to let him get away with things. Previously, she had been married to a narcissistic person and tolerated his including his ex-wife in their family. She use to always be doing someone else's bidding. She is beginning to be able to recognize and assert her needs in interpersonal situations. This is in contrast to her previous role of meeting other people's needs, for example, acting as a go-between for her separated parents.

Another example is this woman who tends to make a good impression and you would assume that she's successful and stable. We worked on her excessive need to re-assure others. She tends to please others so that she can get from them. Her mother had been demanding, critical, and ungiving, which left her with excessive needs to please others. The change has been that she can give up relationships that aren't working for her. She's able to say that she won't stay in a relationship that isn't meeting her needs. She use to keep trying, like pumping a dry well, and as a result, she would end up self-doubting and feeling angry and insecure. Her new tendency is to assess these relationships more, and she shows the strength to tolerate the not having something now, in order to get something else later.

The other thing that grabs at me, which is probably true in all treatment relationships, is the ability to accept responsibility for what they do. An example is this woman who has been depressed and angry for years. She would feel the same way towards me, particularly when I didn't say anything. She would interpret that as my taking advantage of her. She had developed a pattern of feeling inadequate, which lead to her not wanting to do anything. She would look for someone to take care of her. An angry little girl waiting for and daring some man to meet her needs. We began to explore how she felt so deserving that she was entitled to feel wronged. This attitude of entitlement relieved her of any need to see if she could do anything to change things. It was a step for her to see that maybe she played a part in sustaining the depression and the misery. If patients can do that, you have a good prognosis.

Another thing that I admire is the willingness to stay with it, to persevere. Like this young man that I talked to you about earlier, the borderline schizophrenic. His ability to continue trying, even with all

that misery. I find that hopeful for him, and I think I communicate that to him, even if not in words. I have seen this guy for close to ten years.

The next example is in contrast with the previous one, for it focuses on the characteristics of patients that are negative indicators for the treatment's prognosis.

Example #52: Characteristics of the patient
that indicate a poor prognosis

Then there are those that grab my attention in a more negative way. For example, this thirtyish lesbian with symptoms of anxiety and panic. I began to sense that she was a baby and told her she had a lot of growing up to do. She didn't like that. The following session she told me that I couldn't accept her sexual orientation and was condescending. But, I really didn't like her. Her stance was one of externalizing and blaming others. I could understand her being frightened and suspicious, but I sensed her unwillingness to accept responsibility. I don't think we could have worked together. Maybe she was so afraid; perhaps I said some things too early. However, they are infant tyrants, and the therapy doesn't go anywhere when this is the predominant element.

The other side of the coin are the runners; they duck out. They are immature characters, often with some kind of addiction. They come in with a crisis; then, they leave. I have begun to see it more quickly. I challenge them by telling them that I don't think they are going to stick. They haven't stuck to anything up until now. They are frustrating and hard to work with, because they don't stay long enough to be desensitized to the anxiety such that they needn't avoid it.

I am expecting a man to call who I'll tell I won't work with him for now and that, later, we will need to clarify limits and expectations. Unfortunately, they put me in a parenting role. It gets tiring. I give them the benefit of the doubt, but eventually I get angry.

This next example is described by the therapist as a "mental benchmark." It becomes the experiential anchor for the diagnostic category, bi-polar disorders.

Example #53: "A mental benchmark for the manic-depressive patient"

I find myself remembering some bad things that have happened to me. I did an intake on this agitated woman with a bi-polar disorder. She came over and sat on a glass topped coffee table right in front of me,

very close. She asked if this bothered me, and I think I said, "No." But it did for a couple of reasons: she intruded on me, and I was worried that the glass top could break. She didn't seem to be in very good control of herself. This experience provided a mental benchmark for the manic-depressive patient, the direct experience of the hostility that is just below the surface.

The following example demonstrates a number of aspects of the therapist experience, especially the aspect of Connecting, but it has been placed under the Recognizing category to highlight the moment of shared recognition of this patient's doomed future.

Example #54: "He couldn't get enough of my hope"

This was a boy I had been seeing, first as an inpatient, then as an outpatient. He had stopped coming, then he returned. He had had a rotten childhood with lots of physical and sexual abuse. He was bright, but really screwed up. I had been talking to him about getting into a long-term treatment hospital. He had done well when an inpatient. He said to me once, "Here I am walking a line. Over here is the hospital; I see all the good over there. Then, over here are the hostile destructive impulses: drugs, screwing around, stealing. I know that's there, and I know I'll be dead in a few years." He couldn't do it. He couldn't go back to a hospital, even though he wanted it. It was like he could see the promised land, but he couldn't get to it. There was an intense longing and despair. I just wanted to pick him up and say, "It'll be all right." I was making these arrangements for him; I could just feel the longing for the brief experience that he'd had. The destructive impulses were too strong. He was willing to go along with me, but he couldn't get enough of my hope. Inside he believed that he was doomed.

This next example deals with experiences of nurturing the patient, which suggests that it is not unrelated to the Connecting category, however it is included under the Recognizing category since it illustrates the therapist's effort to come to understand the dynamics of this process and how to most effectively be nurturing to the patient.

Example #55: Therapist as nurturant object

There is another one, and it's the one that Winnicott probably spent his career thinking about and writing about: the quality of nurturance between the therapist and the patient. The mothering relationship, the holding environment, that whole business. Winnicott observed it in its natural setting, so to speak, as a pediatrician. He would see mother and infant in this kind of dynamic interaction, particularly the emotional aspect of it. As a therapist, if the therapy gets really going, it's the crucial ingredient, but it's one that we explicitly understand very little about. It's a curious phenomenon. It's what make the world go round. Everybody seeks it out; everybody wants it; everybody's had some experience with it. Even those who have been most damaged have had some kind of experience with it, with someone who's nurturing and responsible. We all wish to recreate it; we all seek after it; we're never satisfied that we got enough of it. It's the crux of the therapy encounter, and it fascinates me because we have so little formal understanding of it.

If a patient doesn't perceive that you as a therapist have it available for their use, there's no therapy. The purpose of therapy is to somehow create this nurturant ambiance, so the patient can re-examine what the hell is the matter with them in a relatively safe context.

It's my contention that male therapists probably have very strong feminine identifications, the good one's. I don't consider nurturing the exclusive preserve of women, but there's a willingness to do this in an explicit fashion. Robert Burns describes this Scottish hero as "a man among men and a child among children." It's that quality, the capacity to give, to emotionally enter into, without expecting something in return.

(Can you tie these ideas to some kind of experience where these were figural?)

I'm aware of it all the time as a therapist. I think patients become aware of it only gradually. They look back on it reflectively, sort of the historical review of therapy, and say such things as "I don't understand how you could stand me when I was like so and so" or "You're the only person I've ever known who doesn't seem to hate me," stuff like that. I'm aware of it in the sense that I am called upon to take care of and take care of them. Often times when they're not even aware of it.

For example, going back to this patient who threw a fit [Example #2: "You ride the whirlwind"], I'm aware of it in the sense that, if I have an observing ego at a time when I'm very stressed by what is going on in an interview and I do what's in the best interest of the patient, that is a nurturant, parenting function. I could easily get in a mind set where, as I said, I just become very retaliatory, and I'm sure it would gratify my wish for injuring them, getting even, and give them a taste of their own medicine. Part of the nurturant, caring aspect of a therapeutic encounter is we have to some control over that. Just like a parent.

(It's a sense of being asked, in many ways, to do something for them?)

Not being asked; asked implies a specific request. It's an expectation that is there; it's just expected. I mean a child comes in the world expecting to be taken care of. They don't inquire as to your credentials. They don't ask you whether you feel like it or not; they just expect it.

I don't think we understand very well the dynamics of why it is, as a therapist, one's willing to nurture. For example, there's a lot of talk about "burn out." I'm convinced that people who have "burned out" have used up their capacity to nurture, and I don't want to burn out. If I don't understand the dynamics of it and how it works in my life, in relationship to my patients, I will burn out. I'll get sick and tired of taking care of them; in which case, I won't be any good to them.

You notice it all the time, because it's this constant drain on your energy, your emotional energy, your intellectual capacity. I think a lot of therapists do a lot things, which they think is nurturing, but it's just spinning their wheels, wasting their energy. They're putting it in the wrong place. For example, this is a ridiculous example, but to try and feed a child that is already full of milk just doesn't make any sense. To feed a child that's very hungry makes a lot of sense. There's an element of timing in this business of being the nurturant object. You have to have the capacity to discriminate what's required by the situation. If you constantly are making mistakes and misapply your energy, you're going to burn out very fast. It has its limitations.

There are a lot of times I go home at night, and I don't want to talk to anybody. I don't know that this issue is systematically addressed. For example, in child rearing, it's just assumed that your suppose to take care of and parent endlessly. Well, that's nonsense, just sheer nonsense. Parents run out of energy and rather fast. From a therapist's point of view, it's the same problem. It amounts to: how do you modulate your energy to use it effectively and have some left over for the next hour. Certain patients will go through certain phases when they are extremely demanding. Your head tells you that you have to gratify them; you have to give to them at that time.

The next example follows up on the previous one, since it also illustrates the therapist's efforts to come to terms with the motivations for wanting to help others.

Example #56: "A person must have to do it"

Doesn't it make you wonder if the people you are talking to are also afflicted with the compulsion to help? I may have mentioned I had a compulsion to talk to you. I mean I have given you a gift. I have

given you a couple of really wonderful stories, and I'll manage the best I can to feel fine about that. I ask you only to realize that these stories must be treated carefully. Isn't it funny that the compulsion of the caretakers that you are talking to, like my initial confession that I feared that I might not be of help to you, became: I must help you. I have to do something. I can't examine a sanguine, at ease, mature young person, age 22, deciding to go into psychology because he loves people but hates money. I just don't really believe that; a person must have to do it.

The next example also presents a therapist's reflection upon his therapy experiences; in this case, the therapist's thoughts turn to the meaning of the experiences that he has described for this study.

Example #57: Reflections on the meaning of the therapist's experiences

I think they're a good thing when they happen. I believe that they are always a good thing, even if they are dealing with negative sorts of things. I believe that as I believe that it's the object relationship that cures in therapy. I think that it points to some sort of connectedness that is going on. Conceivably, it could be pathological, as well as constructive. But I think about it and try to see what it means. What the impact of it is and that kind of stuff. I think that it points to something happening, some sort of definitive connection with myself and the patient. In that sense, I think that they are good things when they occur. It says that there is something really going on. I think most of the time they say things about more pre-oedipal sorts of affective states, as opposed to so-called higher order affects, oedipal layered affects, or more sublimated kinds of things. They're below that. They're the equivalent of what I remember in my own therapy, when I would be on to an issue and I would say there's no words to describe this. There's just the affect. For the longest time I would use words to describe that thing. These affective states would come on me; I'd be in one of them; I don't know what the fuck was going on; but here it is. In someways, I think that these things are that way, too. They kind of occur, and then after the fact, you might be able to get enough distance to put secondary process on it.

The last example is also of the therapist reflecting upon an aspect of the therapy process. Here, the therapist notes how the patient and the therapist recall different events from the therapy as having been most critical.

Example #58: "What I took for granted, she didn't"

What I see as important is not necessarily what the patient sees as important. This one patient called, during a suicidal period, while I was in a session with another patient. She takes these pills after she calls me. She felt, later, that I was angry with her because she had tried to kill herself. I was angry, but because she had treated me so shabbily. She knew when the session would be over. I had her come in and use an empty office during this time. Another time in the therapy, we had sat on the floor together, and I had her hit a pillow to get out the anger. It had seemed silly to me, and we ended up stopping that and just sitting on the floor and talking. This had stood out for her, while I would have thought that allowing her to use the empty office was more significant. What I took for granted, she didn't and what she took for granted, I didn't.

APPENDIX E

SUMMARY OF RESULTS FOR PARTICIPANTS

The results of this study are based on my interviews of yourself and twelve other therapists, which provided over sixty descriptions of experiences that occurred during the course of psychotherapy. My approach to dealing with these narratives was to treat each experience as a whole. This was done by, first, looking at the ways in which the experiences were similar. This led to a categorization of the narratives into four major kinds of experiences. These are described below as the Losing Control, Merging, Connecting, and Recognizing types of experiences.

1) Losing (and Regaining) Control: The stories in this category primarily have to do with how much control the therapist has over the events occurring in the therapy. Often these experiences are precipitated by the patient's effort to coerce something from the therapist. In some instances, the therapist experiences him or her self as swept along by events, while he or she struggles to maintain a degree of self-control. If the therapist over reacts, the situation may get out of hand and end the therapy. If the therapist can tolerate these experiences, they often lead to a better therapy relationship.

An example of this category was an instance of what the therapist described as "You ride the whirlwind". In this case, the patient became increasingly demanding of the therapist, eventually throwing a fit and refusing to leave at the end of the hour. The therapist experienced himself as pushed to his limits and was tempted to retaliate with rejection. Instead, he maintained some degree of self-control and objectivity, riding the situation out. He described himself as responding to the situation on a largely intuitive level.

2) Merging: In the most powerful instances of this kind of experience, there is frightening loss of boundaries between self and other and between reality and fantasy. There is a confusion of the patient's and the therapist's experiential states, which often have to do with primitive aggression. There may be an oscillating movement in and out of these fusion states (for example, with a supervisor or colleague), when the experiences are temporarily separated out and formulated, but these are often followed by a return to the more confused condition. Gradually, this oscillating movement can lead to greater differentiation.

In one example of this kind of experience, the therapist takes on a paranoid patient who is struggling with homicidal impulses. The therapist's fear of the patient's threats leads him into becoming paranoid, too. Underlying this confusion, there appear to be striking correspondences in their lives and an overlapping of unconscious issues. In

another example of this category, the therapist is working with a patient who is struggling with homicidal-suicidal impulses. The therapist experiences states of confusion and affective merger with the patient's emotional states. The therapist allows himself to go through with these experiences and eventually recognizes them as moments of primitive contact with this patient, which the patient needs.

3) Connecting: In these narratives, a deep, empathically attuned communication emerges between patient and therapist. It is often characterized by a special, emotional atmosphere, which is shared by the two. In contrast to the Merging experiences, the therapist retains a sense of his or her own identity, consequently these experiences are much less obtrusive and unpleasant.

An example of this type of experience was described by the therapist as an instance of "parallel regression". It was characterized by a shared affective state, often recognized after the fact by the therapist, which made possible a more meaningful communication by the patient of past experiences. The therapist experienced himself emotionally resonating with the patient's regressed state, while still retaining a sense for how his own similiar experiences were different from the patient's.

4) Recognizing: In these experiences, the therapists describe coming to see, recognize, or understand something about their patients. The content of this recognition can range from an objective, clinical formulation of the patient in terms of theoretical concepts to a more profound, sometimes existential, insight into the patient as another person, a Thou.

An example of the first kind of Recognizing was described by the therapist as "glimpses of pathology" behind the facade of some difficult patients. These glimpses of the patient's hidden issues did not necessarily bring the patient and therapist closer together, but they did allow the therapist to be more objective and maintain a therapeutic, non-reactive stance. An example of the second kind of Recognizing was described as a "moment of recognition": a moment of contact in which both patient and therapist recognized the seriousness of the patient's issues. For example, the patient seriously considers under what conditions life is worth living, and the therapist realizes how central a human act this decision is.

After categorizing the experiences, it became apparent that the types of experiences reflected more fundamental, underlying themes. These were arrived at by considering what about the experiences held them together as a type. The Merger kind of experiences suggested an underlying theme of opposing aspects, Oneness and Separateness. In the Merger experiences, this theme is dialectically represented by the pairs merging/individuating and fusing/separating. The other categories were also examined in terms of this overarching theme, Oneness/Separateness. This is presented in the following table.

VARIOUS APPEARANCES OF "ONENESS" AND "SEPARATENESS"
AMONG THE DIFFERENT CATEGORIES

	<u>Oneness</u>	(Relationship)	<u>Separateness</u>
<u>Merging</u>	Merging Fusing [Figural]	(Either/Or; exclusive; non-reversible)	Individuating Separating [Absent]
<u>Connecting</u>	Empathizing Resonating Attuned [Figural]	(And; figure/ground)	Separate [Background]
<u>Recognizing</u>	Communing Intuiting [Figural or Background]	(Either/Or; exclusive; reversible)	Objectifying Formulating [Figural or Background]
<u>Losing Control</u>	Coerced Undergoing Embedded Determined Submerged [Figural or Background]	(Either/Or; exclusive; reversible)	Free Controlling Acting Choosing Transcending [Figural or Background]
		OR	
	[Figural]	(And; figure/ground)	[Background]

After looking at the four categories of therapists' experiences in terms of how the overarching theme of Oneness/Separateness is present, it became possible to identify those aspects that were most essential for describing these experiences. On the Oneness side of the preceding table, this was done by extracting the notions of Individuating, Thinking, and Acting. On the Separateness side of the table, this was done by extracting the notions of Fusing, Intuiting, and Undergoing. These aspects of experience form opposing pairs. The pair Fusing/Individuating is concerned with the theme of the therapist's sense of identity. The pair Undergoing/Controlling describes the therapist's sense of agency. And the pair Intuiting/ Thinking characterizes the therapist's mode of awareness. The three pairs of essential aspects are summarized in the following table.

OVERARCHING THEME AND ESSENTIAL ASPECTS OF THIS THEME
IN THERAPISTS' EXPERIENCES

<u>Boundaries:</u>	Oneness	Separateness
<u>Identity:</u>	Fusing	Individuating
<u>Agency:</u>	Undergoing	Acting
<u>Awareness:</u>	Intuiting	Thinking

After having identified the four major kinds of experiences and having derived from these an overarching theme and its three modes of appearance, the next task was to describe more completely the relationship between these terms, especially the dialectical tension between the pairs. This was done by returning to issues raised earlier in the study and re-examining them in the light of these pairs of themes. In particular, the gap between theories of psychotherapy and the immediate experience of doing psychotherapy was taken up, along with long-standing controversies within the psychoanalytic tradition, such as those between emotion and insight as curative agents, psychoanalysis as a science versus an art, and the relative roles of reality and fantasy. An effort was made to understand how these opposing pairs could not be reduced to one or the other but nevertheless seemed to held together as a whole, giving the pairs an experiential quality of dynamic tension.

Charles Scott's description of mind as a non-personal, non-conceptual, non-intentional event of awareness, which is lived in a particular way by each of us, was turned to as a possible context for seeing how the pairs of aspects could be fit together and understood as parts of a whole. In particular, it was concluded that irreducible contrasts are a fundamental feature of experience, and the pairs of aspects described in this study fit well with the contrasts that Scott described as constituting awareness in general.

The irreducible quality of the three pairs of aspects has implications for how we communicate about, teach, and understand psychotherapy. In brief, an argument was made not to overly objectify the experiential ground of the therapy dialogue by trying too hard to grasp therapy events with instrumental concepts. To try too hard to explain experiences in theoretical terms misses their living quality, which we know intuitively and can communicate about non-objectively through descriptions and stories, such as those you and the other therapists gave in the interviews. In more general terms, the point to be is that we live our interpretations of the world more fundamentally than we make them.

VITA

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