COUNTERTRANSFERENCE AND SPONTANEOUS IMAGERY IN THE THERAPEUTIC RELATIONSHIP

GLORIA AVRECH

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COUNTERTRANSFERENCE AND SPONTANEOUS IMAGERY IN THE THERAPEUTIC RELATIONSHIP

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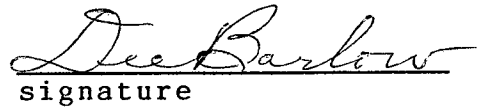
Dee Barlow	Ph.D.	2/20/87	
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ABSTRACT

Countertransference and Spontaneous Imagery in the Therapeutic Relationship

by

Gloria Avrech

The purpose of the study was to investigate therapists' spontaneous mental imagery as a source of information about their countertransference reactions. Relevant theoretical, clinical, and research literature regarding the variables of countertransference and therapist imagery was reviewed and evaluated with regard to the research questions designated for this study.

A qualitative exploratory survey design was used to obtain data from thirty-two Jungian and non-Jungian questionnaire respondents and from seventeen Jungian and non-Jungian interview subjects. A phenomenological-hermeneutic approach was then used to derive findings from the data.

The main findings of the study were the following: (1) there were common patterns in the forms and kinds of imagery which therapists experienced; (2) theoretical perspective was the main variable affecting the therapists' awareness and valuing of their imagery; the frequency with

which they experienced imagery; the understanding, interpretation and information they derived from imagery; their utilization of imagery in treatment, and their opinions regarding the psychological ownership and sharing of their imagery; (3) the other main variables influencing therapist imagery were the therapist's psychological and physical state and the psychodynamics of the treatment relationship; (4) considerable information pertaining to the dynamics of the therapist, the patient, and the therapeutic relationship can be obtained from the investigation of therapist imagery; and (5) two major clinical management issues emerged in the subjects' responses: the question of the psychological ownership of therapist imagery, and the decision regarding the sharing of therapist imagery. The results of this study demonstrate that therapists frequently experience mental imagery in their clinical work, and that such imagery can be a rich, highly relevant source of countertransference data.

Implications for the profession of clinical social work, and suggestions for future research, are also presented.

TABLES

DEDICATION

To the Spirit of Persistence

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CHAPTER I

Statement of the Problem

Introduction

The purpose of this research study is to investigate therapist countertransference as it is revealed in the spontaneous mental imagery which therapists experience during the treatment process. This study reflects three recent movements in the overlapping fields of psychotherapy and clinical social work: the increased study of mental imagery, the heightened interest and research into countertransference phenomena, and the recognition of the relevance of Jungian theory to the social work profession. This study attempts to synthesize certain perspectives of these three movements, and to generate new knowledge useful for clinical social workers.

Mental Imagery

After a long period during which, due to the dominance of behaviorism, mental imagery was rarely studied in American psychotherapy circles, mental imagery has now become a popular research topic. The announcement brochure for the "First World Conference on Imagery," San Francisco, California, June, 1985, stated: "In the last decade, an impressive body of research has demonstrated that rapid and extensive emotional, psychological and physiological changes can be effected through mental imagery." Conference papers were presented on topics such as the use of imagery in psychotherapy; imagery's role in health, illness and healing; the influence of imagery in the educational process; and the relation of imagery to sports, dance, religion, mass media, and politics.

Indeed, the study of imagery seems to have become a fad, at least in California. During the latter part of 1985, the following conferences and courses on mental imagery occurred in Los Angeles: the Ninth American Imagery Conference; a Los Angeles Institute for Psychoanalytic Studies course titled, "The Role of Spontaneous Imagery in the Psychoanalytic Process;" a U.C.L.A. Extension course titled, "Using Imagery in Group Psychotherapy;" and other classes, workshops, and seminars that studied imagery from religious, spiritual,

psychological, and other viewpoints. Far-ranging implications of the study of mental imagery in many areas of human experience are being considered and investigated.

Countertransference

Concurrent with the increased interest in mental imagery, there has been an increase in research into countertransference phenomena, a research trend which first became apparent during the late 1940s. Grayer and Sax, in their unpublished 1981 dissertations for the California Institute for Clinical Social Work, noted that from 1910-1948 only nineteen writings on the subject of countertransference were published. However, the literature published between 1948 and 1978 included 182 new references concerning countertransference. (Sax, 1981, p. 13)[1]

While the current interest in countertransference phenomena probably has many causes, one major influence seems to be the increased willingness of psychodynamically-oriented therapists to attend to their own internal states, and their realization that such attention is, in fact, essential to the conduct of effective psychotherapy.

Sax (1981) outlined particular questions for future research on countertransference, one of which asked: "Can one learn to heighten one's awareness of countertransference

experiences and if so, how?" (p. 147) The present study offers answers to this question.

Jungian Theory

After a period of being extensively ignored, Jung's ideas are receiving more attention and are being more widely utilized by mental health practitioners, educators and researchers. However, within the clinical social work profession, and even within the overall social work profession, the literature has given Jung's ideas only scant attention. Only one recent book, authored by Borenzweig (1984), directly related Jung's ideas to social work. The book's purpose was to acquaint social workers with Jung's principal ideas, and to show the ideas' applicability to work with patients. The book included such topics as Jung's philosophical roots, Jungian concepts of ego and Self, and Jung's ideas about the unconscious, alchemy, dreams, symbolism, astrology, synchronicity, paranormal phenomena, social action, groups, families, and social work values.

Jungian theory constitutes an appropriate theoretical basis and epistemological approach for this study for a number of reasons. As the following quote from his autobiography indicates, Jung had the highest regard for the study of subjective experiences:

> In the end the only events in my life worth telling are those when the imperishable world irrupted into this transitory one. That is why I speak chiefly of inner experiences, amongst which I include my dreams and visions. These form the prima materia of my scientific work. (Jung, 1961/1963, p. 4)

In addition, Jung explicitly attempted to develop an epistemology which would be encompassing enough to prove suitable for research such as in the present study. Jung argued that the study of psychological phenomena required one to include a "psychological standpoint" (1926/1960, pp. 327-328), from which the "facts" of subjective experience would be valued as having "relative validity" (1952/1960, p. 421). Since he was quite aware of the necessity of studying such facts of subjective experience by means of indirect observation, Jung developed a foundation, appropriate for studies such as the present one, based on the assumptions that a relative validity does inhere in investigating imagery as a psychological truth, in viewing imagery as a meaningful topic for psychological inquiry, and in valuing subjects' subjective reports of their own imagery as the most direct source of available data.

Jung's theoretical framework and epistemology are also appropriate for the present study in terms of the wide scope of topics of scientific inquiry which Jung considered appropriate and legitimate. His integration of Eastern and Western philosophical and psychological precepts, and his

introduction of an Einsteinian rather than a Newtonian paradigm into clinical research and theory, have made possible nonlinear and non-deterministic approaches to finding new meanings in psychological phenomena. Similarly, since Jung taught that an individual's internal experiences evolve from a union of mind, body, and spirit, the Jungian theoretical framework tends to view internal experience holistically, and to value psychic activity derived from many different sources as irreducibly meaningful and important. This non-reductionistic valence of Jungian theory is conducive to the content and approach of the present study, which seeks to investigate therapists' imagery and to develop new understandings of the relevance of such imagery to comprehending ongoing therapeutic interactions, especially therapist countertransference.

Research Questions

The principal research question for this study is: What countertransference data and issues can be identified by therapists who remember and utilize spontaneous imagery which they experience during the treatment process?

The subquestions are:

1. Do common patterns appear in the content, kind and form of the imagery which therapists experience during the treatment process?
2. How frequently do therapists experience imagery during treatment sessions? What factors influence this frequency?
3. Do common patterns appear in the countertransference data that therapists can determine by interpreting the imagery which they experience during the treatment process?
4. What similarities and differences appear in therapists' understanding and use of their imagery as countertransference data?
5. Are the differences in understanding and use of imagery related to therapists' theoretical perspectives? Related to other factors?
6. What are therapists' attitudes and experiences toward sharing their imagery with patients?

Assumptions of This Study

The assumptions which underlie the research questions of this study include the following:

1. Countertransference phenomena occur in every treatment relationship, and are to a degree knowable.

2. Patient-related spontaneous imagery can and does occur to therapists during the treatment process.
3. One means of learning about countertransference phenomena is to study therapist imagery.
4. Inherent psychological significance and an enriched understanding of the treatment process can both be derived from studying therapist imagery.

Definitions of Major Concepts

The following are the definitions of the major concepts used in this study. Additional definitions and expanded discussions of some of these concepts can be found in the following chapter.

The Treatment Process

This concept includes all direct and indirect contacts between a therapist and a patient. It includes the first thoughts, feelings, and imagery that a therapist has about a patient; the interaction during the actual treatment sessions; and all subsequent thoughts, feelings, and imagery that a therapist has about a patient even after the therapy has terminated.

Countertransference

Sax (1981) offered the following definition, which is also adopted as a preliminary definition of the term for the current study:

> The whole of the therapist's images, feelings, and impulses. This includes all of the therapist's responses -- conscious and unconscious, feelings and associations, thoughts and fantasies -- to the client, the client's material and affects, and to the interaction between them. . . . [These responses are determined by the] therapist's past relations, realistic and neurotic needs, and by the therapist's identification with the client's personality and internal objects. (p. 8)

This definition is more inclusive than definitions which have been advanced by other researchers. A thorough discussion of the various perspectives is presented in the following chapter.

Imagery

In this study, imagery is treated as an umbrella concept encompassing image, imagination, and fantasy (or phantasy);[2] the word refers to a single image or a series of images, and is assigned a definition similar to the definitions of imagination and image. According to this definition, imagery consists of mental representations or pictures

originating in conscious and unconscious psychic processes, usually without the presence of an external referent.

The imagery discussed in the present study can have content generated from one or more of several modes of psychic experience: sensory (visual, auditory, kinesthetic, tactile, olfactory, gustatory); cognitive-conscious (memories, ideas, thoughts, associations, metaphors, fantasies); emotional; personal unconscious; collective or archetypal unconscious (symbols, myths, spiritual-mystical visions). Actually, memories and fantasies can occur in both the conscious and the personal and collective unconscious modes.

Excluded from this study are experiences of therapists' imagery occurring in night dreams, visionary experiences induced by hallucinogens and other foreign substances, pathological and psychotic mental products such as delusions and hallucinations, and various thought disorders, or obsessions and ruminations. Pathological visionary experiences can be differentiated due to their vivid, persistent quality, and are usually not subject to ego control.[3]

The mental imagery discussed in this study includes all imagery experiences which are potentially available during states of waking consciousness, when the ego is present in all of its capacities, and is able to evaluate, judge, make

decisions, and reflect upon interactions. These imagery experiences are a constant, natural, and intrinsic faculty of the mind, different but equal to the faculties of perception, memory, and cognition. They can connect conscious with unconscious mental activity. Stattman (1980) stated: ". . . imagery is a manifestation of the nonlinear and holistic synergistic organization which links all aspects of the self in a higher ordering process" (p. 96).

Although imagery is available during states of waking consciousness and can be quite vivid, there is a sense of diminished consciousness or "subtle consciousness" when it occurs. These qualities are due to the nature of imagery as a connector and synthesizer of various states of consciousness, and are due to imagery's source in the imaginal world or mundus imaginalis[4], as some Jungians refer to this entity.

The concept of imagery can be distinguished from the concept of countertransference in that imagery is a medium through which countertransference feelings may be expressed. In addition to imagery, countertransference contains direct thoughts, affects, body and behavioral reactions to the patient. Imagery, on the other hand, can include a mental representation of any of these reactions, regardless of whether or not the imagery occurs in the actual presence of an external referent.

Significance of This Study for Clinical Social Work

While a great deal of research has been done, and literature written, on countertransference and imagery, independently of each other, little research links the two concepts in a meaningful way. No empirical social work research, and very little anecdotal literature, links these phenomena. The major research and theories regarding countertransference and imagery are presented in the following chapter. This study builds upon previous research on these subjects, and includes a new attempt at integrating and applying psychodynamic concepts.

In one of the few social work articles related to therapist countertransference, Stewart (1985) wrote: "It seems that one of the important challenges facing clinical social workers is the power of the client's unconscious to induce feelings, and sometimes behavior, in the counsellor" (p. 172). Stewart's paper did not directly investigate therapist imagery as countertransference data, although it did address the larger issue of therapists' patient-induced internal experiences. The present study may illuminate the challenge to clinical social workers outlined by Stewart.

This study seeks to contribute to a deeper understanding of the phenomenon of countertransference and its

relationship to therapist imagery. It is expected that the research will lend support to those who view countertransference as an integral part of treatment, and who consider the therapist's awareness of it to be fundamental to the conduct of effective psychotherapy. An appreciation of the benefits to the therapist of paying attention to internal imagery should be another of this study's results.

In addition, it is expected that this study may illuminate and clarify some of the theoretical, clinical, and research considerations reviewed in the following chapter, such as the concealing and revealing aspects of therapist imagery, and the disclosure or other potential uses of therapist imagery in treatment.

By illuminating and clarifying these and other possible issues, it is expected that this research should help clinical social workers function more effectively as therapists, and can contribute new knowledge in the areas of clinical social work training, education, supervision, and consultation.

Finally, this study may encourage social workers, and especially clinical social workers, to use Jungian-oriented theory, research, and clinical writings in their practice. The utilization of a Jungian approach in clinical research should, it is hoped, demonstrate the meaningfulness and

value of a Jungian approach to clinical work. The long neglect of Jung's farsighted and useful ideas has been a handicap to the clinical social work profession.[5]

CHAPTER II

Literature Review and Theoretical Framework

Introduction to the Literature Review

The opening section of this chapter establishes Jungian thought as this study's theoretical and epistemological foundation. The chapter is then divided into two parts. Part I reviews psychoanalytic and Jungian writings which consider countertransference and mental imagery as theoretical concepts. Related psychoanalytic concepts, which refer to phenomena such as empathy and projective identification, are also reviewed.

Part 2 reviews the psychoanalytic and Jungian clinical writings and empirical research studies that deal with countertransference and therapist imagery; the latter is a subject very few empirical research projects have directly investigated. Empirical writings on therapist imagery by other authors whose orientations are neither psychoanalytic nor Jungian are also reviewed. At the end of Part 2, basic

aspects of psychoanalytic and Jungian writings are integrated into a transpersonal psychological model which is later used in the data analysis.

This chapter does not discuss any writings regarding the use of patient imagery in psychological and physical healing; or imagery's function in sports, religion, education, the arts, and the media; or imagery's biological and neurophysiological origins and character.[1] Writings on these important but tangential subjects are not pertinent to this study's purposes.

Presentation of the Theoretical Framework

The research design, methodology, and epistemological and theoretical basis of this study are derived from Jungian psychology, for several reasons.[2]

First, Jung and his followers have explored mental imagery in breadth and depth, and have written at length about its meaning and value. In his writings, Jung viewed imagery as an expression of psychic activity. His insights concerning the structure and dynamics of the psyche included a fundamental and important distinction between the personal and the collective, or archetypal or objective, unconscious. The personal unconscious was understood as containing

feelings, memories, and internal events from an individual's unique history. The collective unconscious was understood as containing psychic material common to all persons throughout human history. Imagery can be understood as an expression of psychic activity derived from both these unconscious levels.

Second, Jung emphasized, in his work on the treatment dyad, the dialectical and existential character of the therapeutic relationship, which was understood as affecting both the therapist and the patient on conscious and unconscious levels. He stressed the necessity, for effective psychotherapy, of a therapist's awareness of his/her own subjective experience. Like Freud, he recommended self-analysis for the therapist; indeed, he was the first analyst to require his students to undergo analysis while they were in training.

Third, Jung's epistemology was farsighted. His integration of Eastern and Western philosophical and psychological approaches, and his application of an Einsteinian rather than a Newtonian paradigm to clinical research, theory and practice, opened psychological investigation to nonlinear, nonrational, noncausal, and non-deterministic approaches that revealed new truths and meanings in psychological events. The relevance of his

epistemology to this study is further discussed in the following chapter.

Fourth, clinical investigations by trained Jungians have been based on a holistic perception of psychological functioning, according to which an individual's internal experiences have been understood as evolving from a union of mind, body, and spirit. Jung viewed internal experience holistically, and saw primary importance in material derived from many different psychic levels and sources.

Jung's theoretical system and methodology nevertheless include some features which are problematic for this study. He wrote little about the specifics of the therapeutic process and relationship. He did not elaborate on the personal unconscious; the collective unconscious components of transference are dealt with almost exclusively in his most important work on the subject, The Psychology of the Transference (1954/1967). Jung also wrote minimally about psychological development in infants and children. Indeed, he speculated that for certain types of patients, such as young adults with identity problems, the methods of other therapists might work better than his own.

Because of these and other limitations in Jung's theoretical system, his followers have turned to scholarly writings from other schools of psychological thought in order to augment and refine their knowledge and therapeutic

practice. Since the roots of Jung's constructs lie in psychoanalytic theory, and since Jungians continue to incorporate new developments in psychoanalytic theory, research, and practice into their own work, psychoanalytic theory, i.e., the ideas of Freud and some of his followers, are also drawn upon as important aspects of the framework of the present study.

Part 1: Theoretical Studies

In the first part of the chapter, psychoanalytic and Jungian literature which consider countertransference and mental imagery as theoretical concepts are reviewed.

Countertransference: Psychoanalytic Views

Freud (1910/1963) is understood to have coined the term countertransference. He wrote:

> We have begun to consider the "counter-transference" which arises in the physician as a result of the patient's influence on his unconscious feelings, and have nearly come to the point of requiring the physician to recognize and overcome this counter-transference in himself. (pp. 80-81)

Freud recommended that therapists undergo self-analysis in order to ameliorate their countertransference reactions.

Freud expressed a bipolar view of countertransference. Some of his statements imply a view of countertransference as being a pathological response on the part of the therapist, while others suggest that the therapist's awareness of countertransference might aid and enhance the therapeutic process. As Sax (1981) stated: "These two conflicting views of countertransference -- as hindrance and as aid to treatment -- have persisted for almost 70 years" (p. 17). Epstein and Feiner (1979) arrived at a similar conclusion: that the competing conceptions of countertransference as a hindrance and as a means by which the therapist can gain an understanding of the patient's unconscious life have ". . . intertwined, like a double helix, throughout the historical development of the psychoanalytic conception of countertransference" (p. 490).

In practice, most therapists and theorists regarded countertransference as a hindrance until the publication of Winnicott's paper, "Hate in the Countertransference," (1949), which caused a major attitude shift in the psychoanalytic community. In that paper, Winnicott demonstrated that particular feelings which therapists have toward their patients are normal, proper, even necessary for certain aspects of therapeutic progress.

According to Sax (1981), an integration of the modern view of countertransference with an understanding of therapeutic interaction would result in countertransference being neither positively nor negatively valued as such, but rather simply accepted as an integral part of the therapeutic process.

The Totalist view. Epstein and Feiner (1979) posited three psychoanalytic conceptualizations of countertransference: the Totalist conceptualization, which considers all the therapist's feelings and attitudes toward the patient as components of countertransference; the Classical conceptualization, which views countertransference as consisting only of the therapist's unconscious resistance to the patient's transference, in both its neurotic and non-neurotic forms; and the Complement or Counterpart conceptualization, which views countertransference as the necessary role-response correlate of the patient's transference. As mentioned earlier, the first, or Totalist, conception is used in this study.

Racker's contributions. In this study, Racker's theories regarding countertransference are emphasized because they are clear, consistent, thorough, and are representative of the Totalist view; because they

conceptually bridge the gap between Jungian and psychoanalytic theory; and because they have been extensively applied in clinical practice by Jungians of the London School.[3] A body of writings by these Jungians has integrated Racker's theories into their own, and into their own clinical experiences.[4]

Since the present study considers countertransference phenomena in reference to Racker's terminological framework, his basic concepts require discussion. In the following pages, these concepts are presented from Racker's own writings (1968/1976), and from one secondary source, Hunt (1977).

According to Hunt (1977),

> . . . [Racker's] emphasis bears on the patient's role, at every moment, in creating the therapist's affective state. His central thesis is that there is no "normal" emotional state for the therapist, but that the therapist's inner state is continuously, profoundly, and in certain precise and definable ways, responsive to the patient and to what the patient is saying and doing. (p. 97)

As Racker (1968/1976) stated, ". . . another person's unconscious can be grasped only in the measure in which one's own consciousness is open to one's instincts, feelings, and fantasies" (p. 16). To effect this, a therapist should implement Freud's concept of "evenly-

hovering attention." Racker explained the importance of this by stating:

> . . . the analyst creates an internal situation in which he is disposed to admit all possible thoughts and feelings in his consciousness. . . . If the analyst is sufficiently identified with the patient, and if he has fewer repressions than the patient, then the thoughts which emerge in him will be, precisely, those which did not emerge in the patient, i.e. the repressed and the unconscious. (p. 17)

Evenly-hovering attention, Racker claimed, has passive and active components. In the identification process,

> We let the material penetrate into us and at times the chord which was "touched" vibrates immediately; but at other times this reception must be followed by an active process in which we "touch" and detect what has penetrated in us with our unconscious feeling and thinking, so as to be able to finally unite with it. (p. 29)

Racker likened this to a woman's experience during sex.

He also emphasized, however, the importance of the ego in the process, writing that the therapist, like the patient during free association,

> . . . must then also divide his ego into a rational, observant, and a feeling, irrational one. He too must internally give free course to the latter, with all the associations, fantasies, and feelings which arise in response to the patient's material, for only then can the analyst provide what the patient lacks, only by means of this total internal response, free of repressions and of affective blocking. Thus only can the analyst, for instance, reproduce concrete fantasies which the patient feels at bottom [but which are repressed and blocked]. (1968/1976, p. 32)

By introspectively observing his/her own countertransference, the therapist is able to interpret, and clinically utilize, rather than be controlled by, his/her reactions.

Based upon this understanding of the fundamental and integral role of countertransference in the treatment process, Racker proposed a terminology of the components of countertransference. He described two primary components, which he termed "transferred" and "identification." The first of these, "transferred countertransference," Racker described as consisting of "neurotic" and "non-neurotic" elements, and as occurring in "direct" and "indirect" forms. The character of countertransference reactions within the "transferred" component depends, therefore, on whether the therapist's own pathology is interfering with the treatment (i.e., "neurotic" or "non-neurotic" elements), and upon whether the form of the therapist's countertransference response is "direct," in reaction to the patient, or "indirect," in response to a third party (e.g., a referral source).

Within the "identification" component of countertransference reactions, Racker proposed that "concordant" identifications, as experienced by the therapist, provide information about the patient's emotional experience and form the basis for empathy, and that

"complementary" identifications, as experienced by the therapist, provide information about significant early objects in the patient's internal life.

Racker also differentiated between countertransference "thought" and "position," according to the degree of the therapist's ego involvement. In "thought," the therapist's thoughts, fantasies, and associations were described as having minimal emotional intensity, and as being "almost foreign to the ego." In "position," the therapist's ego experience was understood as being very real and intense; the therapist could feel compelled to act it out, and might feel overwhelmed. (Racker, 1968/1976, p. 144).

Of the many case examples which Racker presented regarding the various kinds of countertransference, the following is especially relevant to this study.

> At the start of a session an analysand wishes to pay his fees. He gives the analyst a thousand-peso note and asks for change. The analyst happens to have his money in another room and goes out to fetch it, leaving the thousand pesos upon his desk. During the time between leaving and returning, the fantasy occurs to him that the analysand will take back the money and say that the analyst took it away with him. On his return he finds the thousand pesos where he had left it. When the account has been settled, the analysand lies down and tells the analyst that when he was left alone, he had fantasies of keeping the money, of kissing the note goodbye, and so on. (Racker, 1968/1976, p. 142)

According to Racker, the parallel fantasies of the therapist and patient in this case example could be

explained by the concept of "psychological symbiosis." The fantasies occurred because the therapist's unconscious was sufficiently identified with the patient's. The therapist identified with the patient's impulse to take the money, and thus with the patient's id and ego. But the therapist felt no threat to his objective attitude as an observer. In such a case, Racker wrote, ". . . the danger is rather that the analyst will not pay sufficient attention to [his own] thoughts or will fail to use them for understanding and interpretation" (p. 143). This is an example of a countertransference thought, as opposed to a countertransference position. From such countertransference thoughts, Racker added, "The analyst may guess what is repressed or rejected" (p. 143). Although Racker did not label the kind of identification activated in this therapist, it seems to be primarily concordant.

Racker did not indicate whether the therapist revealed his fantasy to his patient, but it seems safe to assume that he did not. The issue of whether a therapist should tell a patient about his reactions has created a controversy among psychoanalytic thinkers. Racker (1968/1976) stated his position in the following comment:

> Much depends, of course, upon what, when, how, to whom for what purpose, and in what conditions the analyst speaks about his countertransference. It is probable that the purposes sought by communicating the countertransference might often (but not always) be better attained by other means. The principal other means is analysis of the patient's fantasies about the analyst's countertransference. . . . But there are also situations in which communication of the countertransference is of value for the subsequent course of treatment. (pp. 171-172)

Racker obviously conceived of countertransference as a phenomenon which embraces the entire range of the therapist's psychological responses to the patient. Those varieties of countertransference with which this study is concerned include concordant or complementary identifications, in the form of spontaneous countertransference thoughts rather than positions. In order to become aware of one's own imagery, with a clarity sufficient to enable one to describe it, requires a degree of ego disengagement that occurs more often with countertransference thoughts than countertransference positions. Specific instances of countertransference positions are not excluded from this study, however, since certain subjects who have experienced countertransference positions have also been able to utilize clinical supervision, consultation, personal therapy, and/or self-analysis sufficently to facilitate their distancing

themselves from their imagery experiences enough to describe them.

Countertransference: Jung's Ideas

Unlike Freud, Jung, in his writings, discussed the unconscious interaction between the therapist and patient at length, emphasizing the patient's influence on the therapist. For example, he stated:

> The therapist must at all times keep watch over himself, over the way he is reacting to his patient. For we do not react only with our consciousness. Also we must always be asking ourselves, how is our unconscious experiencing this situation? We must therefore observe our dreams, pay the closest attention and study ourselves just as carefully as we do the patient. Otherwise the entire treatment may go off the rails. (Jung, 1961/1963, p. 133)

But, like Freud, Jung wrote relatively little about countertransference as such. According to Fordham, the word appears only twice in his entire collected works (Fordham, 1974, p. 241). Also, like Freud, Jung felt ambivalent about countertransference, in that he saw it both as a dangerous hindrance and as a facilitator of rapport and healing.

Most of Jung's ideas about countertransference appeared in his discussions of treatment, transference, and the dialectical relationship. He drew no theoretical conclusions about it.

In describing the effects of countertransference, Jung stated:

> The countertransference is then just as useful and meaningful, or as much of a hinderance, as the transference of the patient, according to whether or not it seeks to establish that better rapport which is essential for the realization of unconscious contents. Like the transference, the countertransference is compulsive, a forcible tie, because it creates a "mystical" or unconscious identity with the object. (Jung, 1916/1928/1948/1974, p. 59)

He also warned that although transference can facilitate the making of a valuable bond between the therapist and the patient, it entails a danger, ". . . a great one [that] the unacknowledged infantile demands of the analyst may identify with the patient's demands" (Jung, 1912/1974, p. 177).

Emphasizing the importance of the direct mutual effect that the therapist and patient have on each other on conscious and unconscious levels, Jung (1929/1954) wrote:

> For two personalities to meet is like mixing two different chemical substances; if there is any combination at all, both are transformed. . . . In any effective psychological treatment the doctor is bound to influence the patient; but this influence can only take place if the patient has a reciprocal influence on the doctor. You can exert no influence unless you are susceptible to influence. It is futile for the doctor to shield himself from the influence of the patient and to surround himself with a smoke-screen of fatherly and professional authority. (p. 71)

In essence, the therapist is in therapy as much as the patient is. Jung (1929/1954) proceeded by stating: "He is

equally part of the psychic process of treatment and therefore equally exposed to the transforming influences" (p. 72). If the therapist is too distant or disengaged, or impervious to the process,

> . . . he forfeits influence over the patient; . . . there is a gap in his field of consciousness which makes it impossible for him to see the patient in true perspective. In either case the result of treatment is compromised. (p. 72)

Jung (1935/1968) stated that the patient's projection of archetypal contents onto the therapist can create particular difficulties. For example, the projections can unsettle the therapist, even make him/her physically sick. Because of them, ". . . psychotherapists are apt to become a little queer" (p. 173). In his essay on transference, Jung (1946/1974) claimed: "It is inevitable that the doctor should be influenced to a certain extent and even that his nervous health should suffer" (p. 7).

Jung (1951/1954) affirmed that the therapist can provide beneficial therapy even if his/her powers are limited and even if he or she is needing or undergoing his or her own treatment. He insisted: ". . . it is [the therapist's] own hurt that gives the measure of his power to heal. This, and nothing else, is the meaning of the great myth of the wounded physician" (p. 116).

Countertransference: The Post-Jungians

Samuels (1985b) distinguished three schools of post-Jungian therapists: the Developmental, Classical, and Archetypal. (p. 15) He noted that this kind of classification is, to some extent, "a creative falsehood," because different schools' theories overlap, and members of a school might disagree with one another over certain issues. Nevertheless, he added, a classification scheme can contribute towards illuminating the ideas of Jung's followers. In this chapter, the schools to which various Jungian writers belong are stipulated, whenever possible.

The concept of countertransference held by members of the Developmental, or London School, are emphasized in the present study. In this section the ideas on countertransference held by Fordham are emphasized; Fordham was one of the founders of the London School, and probably the most famous exponent of its principles. In general, members of this school have tended to investigate, in their writings, clinical practice aspects of countertransference, rather than its archetypal sources. Influenced by Klein, Bion, Winnicott, Racker, Fairbairn, and other object-relations theorists, London-School theorists usually have adhered to a Totalist definition of countertransference. For example, Machtiger (1982) offered a definition of

countertransference as "the sum total of the analyst's reactions to the patient" (p. 88), echoing the conceptualization of Racker (1968/1976).

According to Samuels (1985b), at the time that Racker was first developing his ideas about countertransference, Fordham, not knowing of Racker's work, first published his concepts of "counter-transference illusion" and "counter-transference syntony."

Fordham (1957) wrote that "counter-transference illusion" occurs when the therapist projects onto the patient unconscious or vaguely conscious materials evoked by a reactivation of some infantile past conflicts, usually unresolved. When that happens, the therapist cannot give the patient effective therapy. He/she must first become conscious of the memories or archetypes in question, then master them. (p. 92)

"Counter-transference syntony," Fordham claimed, occurs when the therapist introjects the patient's projections, ". . . and so act(s) as a receiving set to the patient's unconscious" (Fordham, 1957, p. 92). The therapist thereby "incarnates" a projected image for the patient, which leads to a "primitive identity" interpretable as a "manifestation of the deintegration of the Self" (p. 98). The therapist can find solutions to the patient's problems by examining his/her own particular mental processes which reflect those

of the patient. The patient's projections, as introjected by the therapist, are in this sense understood as providing the therapist with valuable information about the patient.

Fordham (1957) postulated that explanations and interpretations originate from the incarnation of an image.

> . . . it can be just as valid for the analyst to know of the projection through registering its impact upon himself and perceiving it first within himself, as it is by listening to the patient and realizing it as an inference from what the patient says. (p. 98)

Incarnating the patient's image, however, differs from acting it out; and it is often tempting for the therapist to identify with a patient's projection and to behave according to it. For example, a male therapist might come to see himself, and act, as his patient's rescuer: a role syntonic with the patient's need, but incongruous with the therapist's real self. Another danger is that therapist may withdraw from the patient by adopting an explanatory or supervisory role, thereby preventing an incarnation of the necessary image. In such a case, Fordham concluded, ". . . [the therapist] does nothing but isolate the patient just at the point at which [the patient] needs a primitive form of relationship" (p. 99).

In his concept of incarnating the image, Fordham made use of an idea by Plaut, another London School Jungian analyst. According to Plaut (1956), the therapist reacts to

the patient on different levels, and cannot avoid being affected by the patient to a certain extent. Whenever the patient projects almost conscious, personal experience material onto the therapist, the therapist is usually able to limit its effect with little difficulty. However, when the patient projects archetypal material, accompanied by intense emotions, the therapist has more trouble in fending off its impact.

In a later paper, Fordham (1979), elaborating on some of his earlier ideas about countertransference, conceptually separated countertransference from the remainder of the therapist's reactions to the patient, by referring to these as "interactional dialectic" which includes "transitory reactions." He wrote that the development of countertransference turns the entire therapeutic situation into a ". . . mass of illusions, delusions, displacements, projections, and introjections" (p. 209). Countertransference, in Fordham's understanding, actually exists whenever the therapist's various internal mechanisms begin to hinder his/her work with the patient, or when the therapist's "pathological" reactions to the patient come to resemble the patient's transference. The therapist can, however, rectify these problems, and can therefore limit or eliminate his/her countertransference.

One of the reasons for stressing Fordham's ideas in the present study is that they can be directly compared with some of Racker's. Thus, Fordham's "counter-transference illusion" is similar to Racker's "direct neurotic reactions" as an element of the transferred component of countertransference. Fordham's "counter-transference syntony" is similar to Racker's "identification component," which he conceptualized as being divided into "concordant" and "complementary" identifications; "counter-transference syntony" corresponds more closely to the latter. Fordham's "transitory projections," which he understood as differing from countertransference per se, correspond to Racker's "concordant and complementary thoughts," which differ from the phenomena he termed "concordant and complementary positions." Finally, Fordham's "appropriate reactions" and "interactional dialectic" would probably be viewed by Racker as countertransference reactions, but not as neurotic reactions or as hindrances to the therapy.

Several other American, English, and European Jungians have written important papers on countertransference. These include Davidson (1966), Lambert (1972/1974), Jacoby (1984), as well as Stein and his fellow contributers to the first issue of Chiron (1984), which featured articles on transference and countertransference.

Gordon (1968/1974), another London School theorist, summarized the consensus of most post-Jungians:

> Each analyst must constantly ask himself whether what he feels in relation to the patient stems from his own still unconscious and unintegrated conflicts or whether it is a necessary and matching reaction to the unconscious drama the patient needs to re-enact. And he must decide whether to communicate to the patient his own emotional reactions and, if so, in what form and when. (p. 181)

Related Psychoanalytic Concepts

Empathy, projective identification, projective counteridentification, and intermediate or transitional space are important psychoanalytic concepts which are relevant to this study, since they denote therapeutic phenomena which are related to countertransference and therapist imagery. The first three of these concepts can be described as components of countertransference and as potential sources of therapist imagery, while the phenomenon of an intermediate space can be conceptualized as both a source from which, and a location within which, countertransference and therapist imagery can occur. The scope of the present study allows only brief reviews of these concepts as they have been developed in the psychoanalytic literature. The following section presents

brief discussions of appropriate writings on these concepts by knowledgeable theorists.

Empathy. Reik (1948/1983) discussed the subjective experiences of the therapist during treatment sessions, mentioning the ambiguity of the term empathy. He described how signals which refer to impulses and ideas hidden in the patient's unconscious may activate similar impulses and ideas hidden in the therapist's. However, this activation does not have the same effect as simple identification. Rather, it manifests itself as a resonance which is then experienced by the therapist because of a change that takes place in his/her ego. The resonance resembles the sensation of resonance which actors sometimes experience when they allow characters' feelings to become their own.

According to Reik (1948/1983), the process of empathy works as follows:

> Through induction of unconscious impulses, the psychical possibilities of the observer's ego are realized for a moment. In other words, by means of the repressed content in the manifestation of the other person, a latent possibility in the observer's ego becomes actuated for an instant. This image of the ego, turned to psychical reality, is projected into the external world and perceived as an object. (p. 360)

Reik (1948/1983) added that this temporary transformation of the ego is " . . . followed by projection,

whereby the transformed ego is thrown outward and perceived as a psychological object" (p. 360). Comprehension of the patient's material derives from such an empathetic process. "We can only comprehend the spirit whom we resemble" (p. 361).

Arlow and Beres (1974) defined empathy as a projection of one's own personality into the personality of another, in order to facilitate understanding. Using Kohut, Fliess, Greenson, and other as references, they noted that empathy resembles both merging and the mother-child bonding experience. Despite the fact that they found documented data on empathy to be scare, Arlow and Beres presented clinical examples of empathy on the part of therapists. Their examples included instances of therapist imagery.

For Arlow and Beres (1974), empathy is understood as involving both trial identification and separation from the object; empathetic experiences are modified by the level of ego development and the particular affective response which is enagaged. The therapist has feelings about, as well as with, the patient, and at times shares the patient's affect, even if the therapist's mood differs from that of the patient.

Empathetic understanding is complicated, and involves various kinds of identifications as well as related fantasies, e.g. identifications with the patient and at

times with the patient's internalized objects. In the process of differentiating empathy from related phenomena, however, Arlow and Beres (1974) distinguished empathy from intuition. They suggested that intuition, conceived of as immediate apprehension of a thought or fantasy, does not involve identification. Nevertheless, empathy can lead to intuition, which facilitates interpretation and insight.

A number of theoreticians have disagreed with each other about empathy; Reich (1960), for example, disagreed with those mentioned above. She rejected the Totalist view of countertransference and adopted instead the Classical, and thus would not have agreed with Racker's view of empathy as being a significant component of concordant countertransference identifications. She stated:

> The capacity of empathy is, of course, based upon the fact that in the unconscious we are all endowed with the same strivings, but I must emphasize that what may be a homeopathic dose for one may be strongly cathected for the other. In the case of the analyst the process of identification and externalization is cathected with minimal amounts of energy and must have been preceded by a far-reaching process of neutralization. . . . Thus, the analyst never loses sight of the patient as a separate being and at no time feels his own identity changed. (Reich, 1960, p. 391)

According to Reich's (1960) perspective, then, whenever a therapist feels affected to the point of identity change, a countertransference reaction is taking place, and no countertransference reaction of any kind is beneficial.

When confronted with one, the therapist should acknowledge its existence, and try to overcome it. Reich thereby made a distinction between empathy and countertransference proper, seeing in the latter an "intense emotional force" which can obtrude into the mutual unconscious reflection occurring between the therapist and patient.

Projective identification. Grotstein (1981) defined projective identification as ". . . a mental mechanism whereby the self experiences the unconscious phantasy of translocating itself, or aspects of itself, into an object for exploratory or defensive purposes" (p. 123). In this conceptualization, the self is viewed as seeking to rid itself of unwanted split-off aspects or fantasies by entering an object to actively control it, or to passively disappear into it.

However, as Grotstein (1981) asserted, these mechanisms are by no means always defensive; he observed that

> . . . projective identification is responsible for vicarious introspection and, in its most sublimated form, for empathy. . . . As a primary mechanism for communication, it exists first between preverbal infants and their mothers, but is also residual in adult life as a form of affective communication. (p. 123)

During projective identification, an object which was previously separate becomes a ". . . container for the

alienated and neglected contents, or confused with it through identification." A person's projective identification can affect an object by creating a stage of fused unity with the object; by linking with, or invading and controlling, the object; by evacuating disowned aspects of itself; by externalizing itself; or by communicating to other intrapsychic aspects of itself as well as to external objects. (pp. 123-124)

According to Grotstein, Klein originated the concept of projective identification and viewed it as a basic infantile mechanism which occurs concomitantly with the mechanism of splitting. Grotstein accepted Klein's ideas, and considered all projective identifications to be essentially intrapsychic, regardless of whether they are healthy, neurotic, or psychotic.

Projective counteridentification. Grinberg (1979) first described the therapist's projective mechanism of counteridentification. He stated that this process

> . . . is brought about by the particularly intense use of a psychopathic modality or the mechanism of projective identification of the patient. As a result of the pathological quality of this mechanism, the patient is able to induce different roles, affects and fantasies in the analyst, who unconsciously and passively feels himself "carried along" to play and experience them. (p. 226)

Grinberg (1979) distinguished projective counteridentification from countertransference reactions which have resulted from the therapist's own emotional attitudes and neurotic remnants being activated by the patient's conflicts. In projective counteridentification, the therapist is a passive object of the patient's projections and introjections; his/her emotional responses may or may not be due in part to his/her own internal conflicts, which have been activated or intensified by the patient's material. In countertransference reactions, on the other hand, the therapist is an active object of the patient's introjections and projections, which he/she selectively assimilates, works through, and projects back onto the patient by means of interpretations.

Grinberg (1979) decribed projective counteridentification as an experience in which

> The analyst may have the feeling of being no longer his own self and of unavoidably becoming transformed into the object which the patient, unconsciously, wanted him to be (id, ego or some internal object), or of being compelled to experience those affects (anger, depression, anxiety, boredom, etc.) the analysand forced into him. (p. 231)

However, these processes, countertransference and projective counteridentification, are never completely isolated from each other. Instead, they occur

simultaneously, usually overlapping, one or the other dominating, in each interaction.

Bollas (1983) echoed this view when he wrote that patients

> . . . recreated their infantile life in the transference in such a determined and unconsciously accomplished way that the analyst is compelled to relive elements of this infantile history through his countertransference. (p. 1)

Bollas (1983) therefore recommended that the therapist pay attention to, and express, his/her mental states, even if he/she is unable to understand their meanings. There are actually two patients in a session, he felt, and two complementary sources of free associations. (pp. 2-3) In keeping with this understanding, Bollas urged the therapist to function as a "transformational object," and to provide a "process identity" by which the patient's cohesion and sense of self could be developed. (p. 5) The therapist, by allowing him/herself to be affected, disturbed, and even made "situationally ill" by the patient, "plays" with the patient and allows spontaneous thoughts, emotions, and feelings to arise in the "potential space" between the patient and him/herself. Thus the therapist can provide the patient with a voice, verbal representations, and interpretations which can assist in effectuating the patient's internal cohesion. (p. 7) These processes of

reciprocal interaction and influence between the therapist and patient were also of great interest to Jung and, as described below, to Winnicott.

The intermediate area. Winnicott has fundamentally influenced many of the psychoanalytic writers mentioned above. His ideas, including the notion of the transitional or intermediate area, which were derived in part from certain ideas of his mentor, Klein, have been widely applied in clinical work. Like Klein, he understood the therapeutic relationship as being fundamentally symbolic of the mother-child relationship.

In his fixing a metaphorical location for psychic interaction, Winnicott (1971) wrote: "Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist" (p. 38). This overlap was understood as being neither part of the psyche nor external to the person, but rather intermediate, ". . . between the inner reality of the individual and the shared reality of the world . . ." (p. 64). In his view, a similar playing area is part of the mother-infant relationship.

In an earlier paper on the same subject, Winnicott (1951/1975) concluded:

> This intermediate area of experience, unchallenged in respect to its belonging to inner or external (shared) reality, constitutes the greater part of the infant's experience and throughout life is retained in the intense experiencing that belongs to the arts and to religion and to imaginative living and to creative scientific work. (p. 242)

Within this intermediate area, transitional objects, such as an infant's stuffed animals or fantasies or an adult's valued possessions, can be experienced as being imbued with life and meaning. In therapy, the therapist can at times serve as a transitional object, or, in Bollas' terminology, a transformational object, for the patient.

The emergence of this intermediate area is developmentally essential for a person's individuation and separation from parental images. Within its boundaries the psychoanalytic object-relations therapist carefully examines emergent imagery and the effects of such early-formed and long-enduring mechanisms as identification and empathy.

Fantasy and Imagery: Psychoanalytic Views

Singer (1974) wrote that classical psychoanalysts, deeming conscious mental imagery to be relatively less significant, tended to concentrate on the analysis and interpretation of dreams and transference phenomena.

Freud established the classic psychoanalytic attitude toward imagination and fantasy, so a review of his ideas about them will provide a frame of reference for considering his followers' ideas and for interpreting the interview data of the present study.

The word "fantasy" has been spelled "phantasy" by most English psychoanalytic writers. In this study, the former spelling is used, unless it appears in a quotation in which it is spelled "phantasy." According to Laplanche and Pontalis (1967/1973):

> . . . the German word "phantasie" means imagination, though less in the philosophical sense of the faculty of imagining (Einbildungskraft) than in the sense of the world of imagination, its contents and the creative activity which animates it. Freud exploited these different connotations of the German usage. (p. 314)

Freud (1908/1953/1975) wrote that as children mature, their play gives way to adult fantasies. The adult

> . . . builds castles in the air and creates what are called <u>daydreams</u>. . . . most people construct phantasies at times in their lives. This is a fact which has long been overlooked and whose importance has therefore not been sufficiently appreciated. (p. 145)

In an earlier discussion of the relationship between hysterical symptoms and fantasy, Freud (1905-06/1953/1975) stated that hysterical symptoms are

> . . . no longer to be regarded as direct derivatives of the repressed memories of childhood experiences; but between the symptom and the childhood impressions there were inserted the patient's phantasies (or imaginary memories), mostly produced during the years of puberty, which on the one side were built up out of and over the childhood memories and on the other side were transformed directly into symptoms. (p. 274)

The topographical postion of fantasy is not clear in Freud's writings. Laplanche and Pontalis (1967/1973) explain that Freud's principal concern seems ". . . to have been less with establishing . . . differentiation than with emphasizing the links between [the] different aspects," or between the different topographical positions in which fantasies occur. (p. 316)

In his most complete metapsychological description of fantasy, according to Laplanche and Pontalis, Freud (1915/1953/1975) justified the concept of the unconscious, and presented a topographical model which included the conscious, unconscious, and preconscious systems. In discussing the derivatives of the unconscious, Freud also discussed normal and neurotic fantasies which appear in the formation of dreams and symptoms, and stated that, ". . . in spite of their high degree of organization, [they] remain repressed and therefore cannot become conscious" (p. 191). He elaborated upon this comment by stating:

> On the one hand, they [fantasies] are highly organized, free from self-contradiction, have made use of every acquisition of the system Cs. and would hardly be distinguished in our judgement from the formations of that system. On the other hand they are unconscious and are incapable of becoming conscious. Thus qualitatively they belong to the system Pcs., but factually to the Ucs. Their origin is what decides their fate. (pp. 190-191)

In Freud's view, fantasies usually originate in infantile experiences, and express a wish for the fulfillment of missing drive satisfactions. He described fantasy as ". . . the fulfillment of a wish, a correction of unsatisfying reality" (Freud, 1908/1953/1975, p. 146). He postulated two types of motivating wishes, which are often intermixed: ambitious and erotic. In our fantasies, he wrote, we move among three time zones. A current event is linked to an infantile memory of wish fulfillment, and so creates a need for future wish fulfillment. "Thus past, present, and future are strung together, as it were, on the thread of the wish that runs through them" (pp. 147-148).

Frued observed that adults, in contrast to children, tend to sheepishly conceal their fantasies, making it necessary for the therapist to elicit them. A patient's symptoms, dreams, slips of the tongue, and other such expressions indicate to the therapist the active presence of unconscious fantasies. One elicitation method which Freud used in his early practice involved touching his patients'

foreheads, which was a method of eliciting visions popular in the nineteenth century. In his later practice, however, Freud almost always used free association. (Epstein, 1981, p. 24).

Freud discussed "primary process thinking," which is governed by the "pleasure principle," as well as another kind of thinking which was understood to be governed by the "reality principle." He noted that fantasy is a "thought-activity" which has been split off. It is ". . . free from reality testing and subordinated to the pleasure principle alone" (Freud, 1911/1953/1975, p. 222).

Laplanche and Pontalis (1967/1973) observed that Freud

> . . . sets the internal world, tending towards satisfaction by means of illusion, against an outside world which gradually imposes the reality principle upon the subject through the mediation of the perceptual system. (p. 315)

However, they also have claimed that Freud refused to let himself be restricted to a choice between

> . . . one approach, which treats fantasy as a distorted derivative of the memory of actual fortuitous events, and another one which deprives fantasy of any specific reality and looks upon it as merely an imaginary expression designed to conceal the reality of the instinctual dynamic. (p. 315)

McCann (1982), somewhat disagreeing with Laplanche and Pontalis, noted that by calling fantasy primary process thinking, Freud

> . . . relegates it to the realm of the archaic, maladaptive, irrational and unrealistic, essentially condemning the imaginal as neurotic, regressive and symptomatic. (p. 45)

The controversy over Freud's attitude toward fantasy might well have stemmed from the ambivalence on his part, as expressed by the lack of clarity in his writings about fantasy. Among Freudians, two principal schools of thought regarding fantasy have arisen in response to this split; these are discussed in the following section.

Although Freud's writings, in contrast to Jung's, do not postulate a collective unconscious in the psychic structure, they do include serious consideration of the psychic role of myths, and consider the mythological connotations of fantasy. For example, he related a patient's obsessive images to, among other things, a Greek myth, which he described as an "antique representation" of the goddess Demeter. (Freud, 1916/1953/1975, p. 388) On the other hand, Freud was capable of viewing myths as nothing more than aggregate expressions of unconscious wish fulfillment. In an earlier paper (1908/1953/1975), he concluded that ". . . it is extremely probable that myths,

for instance, are distorted vestiges of the wishful phantasies of whole nations, the secular dream of youthful harmony" (Freud, 1908/1953/1975, p. 152). From a Jungian perspective, Freud thereby reduced mythology to personal infantile experience, and relegated it to the personal unconscious.

Fantasy and Imagery: Post-Freudian Views

Shapiro (1970) has identified two distinct psychoanalytic schools of thought on imagery. The first, which includes the views of Arlow, Beres, Fisher, Horowitz, Kanzer, and Warren, as described below, primarily views imagery as a concealer of unconscious instincts and impulses. For members of this school, according to Shapiro,

> . . . the visual images can be conceived of in the same light as a screen memory: an innocuous picture presented to screen displaced affect. . . . [Images] are also dynamically similar to dreams, in that they are brought about by a topographical regression, but differ from dreams in that the plastic representation is more evident; there is less distortion than in dreams and the relations to preceding material is often clearer. (p. 210)

The second school, which consists of other psychoanalytically oriented writers described below, among them Hammer, Reyher, and Kubie, primarily views imagery as a revealer of unconscious material. Shapiro has noted that

these writers see ". . . the visual image, because of its primitive form, as the direct voice of the unconscious, an expression of the impulse itself rather than a defense against impulses" (p. 210).

These two schools, according to Shapiro, can be clearly distinguished by their respective views on interpreting dreams. For the first, the dream's manifest content is understood to be a cover screen; for the second, it is understood as directly expressing focal conflicts. The latter school's perspective on imagery is more compatible with that of Jung and his followers. In the sections which follow, the contributions of theorists who constitute these two schools of thought are described in more detail.

Imagery which conceals. Arlow, a Freudian ego psychologist, developed and expanded Freud's ideas about fantasy and imagination. He accepted Freud's contention that unconscious fantasy is related to the psyche's attempt to fulfill infantile wishes, and added:

> . . . fantasy activity, conscious or unconscious, is a constant feature of mental life. In one part of our minds we are daydreaming all the time, or at least all the time we are awake and a good deal of the time we are asleep. . . . The private world of daydreams is characteristic for each individual, and represents his secret rebellion against reality and against the need to renounce instinctual gratification. Fantasy reflects and contains the persistent pressure emanating from the drives. (Arlow, 1969, pp. 5-6)

Arlow discussed the grouping of fantasies around certain instinctual wishes, and understood the communality of fantasy-life elements from one individual to another to be a result of similarities in biological development. This communality, according to Arlow, establishes an empathetic base for communication, religion, and art. (p. 6) Using Freud's structural hypothesis as a basis, he speculated that ego functions mediate the interaction between external stimuli and unconscious fantasies; that there is not a distinct separation between unconscious and conscious fantasies; and that the ego and superego, as well as the id, are involved in the generation of both conscious and unconscious fantasies. He observed: "The contribution which unconscious fantasy makes to conscious experience may be dominated by defensive, adaptive and self-punitive trends as well" (Arlow, 1969, p. 25). In effect, then, Arlow basically elaborated Freud's views, but assigned primary importance to the ego, and he explicitly viewed fantasies as having useful and beneficial functions.

Another ego psychologist, Beres, disagreed with Freud's perspective, which he felt was too narrow. He detected in Freud's writings a perception of a distinction between psychical and material reality, and a conviction that unconscious mental activity is the true psychic reality.

Beres (1960) claimed that psychic reality is composed of conscious and unconscious primary process and secondary process imagination. He defined imagination as ". . . the capacity to form a mental representation of an absent object, an affect, a body function, or an instinctual drive" (p. 327); and in addition, he claimed that it is a process whose products are images, symbols, fantasies, dreams, ideas, thoughts, and concepts. As such, it is a ". . . ubiquitous component of human psychic activity unique to man" (p. 327). Imagination does not oppose reality, Beres maintained, but rather ". . . has, as one of its most important applications, adaptation to reality" (p. 327).

Beres considered imagination to be either a primary or secondary process, depending upon the instinctual energies it discharges. Thus he would probably have agreed with Kris that primary process imagination is normal, and can serve the adaptive needs of the ego.

Horowitz (1983) discussed various manifestations of imagery in both normal and pathological functioning. In a comparatively thorough study of the issues, he catagorized types of images, reviewed circumstances which stimulate image formation, investigated neuro-biological influences and psychodynamic aspects of image formation, and discussed strategic uses of imagery in psychotherapy.

Although Horowitz defined any thought representation having sensory qualities as an image, his book emphasized visual imagery, which he considered to be the most common kind. He catagorized images according to their vividness, context, content, and interaction with differing modes of perception. (p. 6) Making use of recent brain and psychological research, he constructed a model in order to illustrate the relationship between images and other thought representations. His model includes three systems for representing percepts, memories, ideas, and feelings: enactive thought, which involves body activity associated with the brain's cortical motor regions and the limbic system; image representations, which depend primarily on the brain's right hemisphere, and which link sensory input with ideas and feelings; and lexical thought, which is coordinated by the brain's left hemisphere, and which, for the most part, is expressed in words. (p. 86)

In the original 1978 edition of his book, Horowitz noted that images can

> (1) yield information; (2) establish empathetic understandings; (3) release and work through conflicts and warded off ideational and emotional constellations; and (4) transform mood and attitude. (p. 328)

He also added that data gained from patients' imagery can be important in diagnosis and treatment.

In the 1978 edition, Horowitz also discussed the formation of therapist imagery, but did not discuss its use as countertransference data. He urged the therapist to be cautious in revealing his/her imagery to a patient. Whenever the formation of the imagery is blocked, or if the therapist's images are not congruent with the patient's images or emotional state, Horowitz wrote, the therapist should consider the clarity of the patient's material, or should determine whether resistance in the patient, difficulties in the therapeutic relationship, or countertransference are inhibiting his/her imagery.

Certain psychoanalytic clinicians have explicitly studied patients' imagery. Kanzer (1958) described patients' free association imagery experiences, and presented his theory of the function of imagery, emphasizing that it serves the patient's regressive resistances. He also emphasized the importance of the connection between imagery and "day residue," the therapeutic environment, and the therapeutic relationship. He considered the clinical significance of the patient's regression toward imagery, especially at moments of resistance. In his summary, he concluded that free association includes a constant oscillation between imagery and ideation.

Warren (1961) examined in depth the visual images experienced by certain patients during therapy sessions.

Reinforcing Kanzer, he observed that the visual image functions ". . . as a transient, uneasy resting place for the conflict-laden instinctual impulses" (p. 508). Close attention to visual imagery, he felt, can provide a therapist with ". . . a clue to prevailing instinctual drives and the ego's corresponding defensive measures" (p. 508). Warren recommended evoking the patient's images in order to overcome resistance when free association has been interrupted.

Imagery which reveals. Whereas the theoreticians mentioned in the previous section considered mental imagery to be primarily a defense mechanism, those reviewed in this section view it as a revealer of unconscious material. Many practitioners of this persuasion systematically utilize imagery in their clinical work with patients.

While discussing aspects of expressive therapy, Robbins (1980), described the role of the psychoanalytically-oriented expressive therapist as one who ". . . creates or discovers through verbal metaphor bridges forming a link between non-discursive and discursive communications" (p. 15). The expressive therapist uses imagery in order to help patients find concrete expression for their psychic processes. Robbins understood imagery to be an inherent aspect of human experience.

Robbins' (1980) thesis is that imagery must be perceived as part of a developmental object-relations context, within which ". . . the therapist offers reparative responses that facilitate a differentiation of meaningful symbols within the patient's ego" (p. 107). By changing a patient's imagery, the therapist can integrate polarities and splits, and can thereby effect changes in the patient.

According to Robbins (1980), imagery can work as a vehicle of therapeutic communication on many levels. It can serve as a transitional object, assisting the patient to achieve an integration of "inner and outer reality." It can also help the therapist overcome the patient's resistance, elicit diagnostic information, and instigate a kind of holding, coenesthetic relatedness between therapist and patient.

Hammer (1978) presented ideas similar to those of Robbins. He described the use of imagery-laden poetry in reaching and concretizing images which were latent in the patient's psyche. He proposed a method of interpretation which employs imagery in order to help the patient achieve insight and to realize his/her feelings.

Victor (1978) developed Hammer's ideas, advocating a sparing therapeutic use of mythical interpretations of imagery. According to Victor, mythical interpretations can facilitate patients' associations and assist them in

contending with resistance and conflict-laden material, especially those patients who struggle with "stark contradictions," split transference, and split introjects. (p. 238)

The above psychoanalyic post-Freudian writings pertain primarily to the patient's experience with mental imagery rather than the therapist's. They are included in this chapter because aspects of their observations about the dynamics of imagery formation apply to therapist as well as patient imagery, whether it is concealing or revealing. It should be noted that these writers have mainly considered visual imagery, which is generally understood to be the most common kind of imagery.

Fantasy and Imagery: Jung's Views Regarding the Conceptual Framework

Jung's respect for subjective experiences, and his sense of the fundamental and intimate connections between imagery and other psychic activity, are pervasive throughout his writings. Indeed, according to Battista (1980), " . . . Jung dedicated his life to understanding the relationship between imagery and psychological development" (p. 113). This fundamental connection between imagery and

psychological development is based upon Jung's understanding of psychic functioning.

According to Jung (1961/1963),

> Everything in the unconscious seeks outward manifestation, and the whole personality too desires to evolve out of its unconscious conditions and to experience itself as whole. (p. 3)

It follows, then, from this understanding that memories, imagery experiences, and myths are all essential expressions of this outward manifestation of the personality.

Jung's interest in his own subjective experiences first appeared during his childhood, and his extensive investigations of these and of his patient's subjective experiences arose during the early years of his clinical practice, at the time that he had begun to transcribe his patients' accounts of their fantasies. He came to feel that he could not help his patients unless he ". . . knew their fantasy material from his own direct experience . . ." (Jung, 1961/1963, p. 179); and he was convinced that this unconscious material had to be grounded in external reality. For Jung, this external ". . . reality meant scientific comprehension. I had to draw concrete conclusions from the insight the unconscious had given me -- and that task was to become a life work" (p. 188).

Jung never developed a systematic theory of imagery. Instead, he scattered insights, fleeting ideas, and complex speculations concerning imagery throughout his writings. In his writings, Jung gave the words "fantasy" and "imagery" the same meaning, but used the term "fantasy" more often. His concerns and basic conceptions, like those of any other thinker, changed during the course of his life, so a logical exposition of Jung's thinking on imagery would be beyond the scope of the present study. For this study, certain important issues are extracted below and discussed separately.

Tracing the history of Jung's ideas on imagery, Frey-Rohn (1974) noted that Jung's original views were, like Freud's, based on a theory of wish fulfillment, according to which unfulfilled wishes were understood as stirring a regression in the libido and as motivating the creation of imagery. (pp. 76-78)

According to Frey-Rohn, Jung's Symbols of Transformation (1911-1912/1976) expanded upon these views and ". . . initiated a new epoch in the development of Jung's thought" (p. 78). In this volume, Jung observed that imagery seems to move in cycles, and that imagery serves to compensate for the limited scope of the individual's conscious awareness. This was an early and fundamental idea, which pointed towards a holistic and integrative view of the psyche, and

which has been used by Jungians as a basis for the interpretation of dreams and other forms of mental imagery.

Jung (1911-1912/1976) also outlined two kinds of thinking:

> . . . in childhood we go through a phase when archaic thinking and feeling . . . rise up in us, and [then] all through our lives we possess, side by side with our newly acquired directed and adapted thinking, a fantasy-thinking which corresponds to the antique state of mind. (p. 27)

"Directed" thinking, then, is entirely conscious, while "fantasy-thinking" is entirely or partially unconscious. This distinction parallels Freud's concept of "primary and secondary process" thinking, and some research findings concerning functions of the brain's right and left hemispheres. Jung, however, went further than Freud in formulating his distinctions.

In pointing out the archaic character of "fantasy-thinking," Jung also postulated the existence of collective unconscious sources of creativity which are independent of personal unconscious motivations, and began moving away from Freud's "reductive, personalistic" hypothesis. Although Freud's thinking contained roots of the archetype concept, Jung was the first theorist who expanded and developed this concept. Jung (1921/1976) drew a clear distinction between images arising from the personal

unconscious and those arising from the collective unconscious.

> I call the image primordial when it possesses an archaic character. . . . A personal image has neither an archaic character nor a collective significance, but expresses contents of the personal unconscious and a personally conditioned conscious situation. (p. 443)

In another context (1921/1976), Jung stressed that the psyche is a vital process which is constantly creating imagery, and that imagery is ". . . the clearest expression of the [varied and highly complex] specific activity of the psyche . . ." (p. 52). Imagery, therefore, is ". . . no conglomerate [but] a homogenous product with a meaning of its own, a condensed expression of the psychic situation as a whole" (pp. 442-443), including both conscious and unconscious aspects of the psychic situation.

Jung (1921/1976) also described three types of fantasy: voluntary, passive, and active. Voluntary fantasy consists of images which a person wills. Passive fantasy consists of images which occur while a person is relaxed or partially asleep; in addition, certain subtypes of passive fantasy can indicate psychological abnormalities, e.g., the images of psychotics. Active fantasy, on the other hand, consists of images which a person can alter and guide, and which do not overwhelm the person. This type of fantasy is utilized as a component in the technique of active imagination, and

appears in some of the therapist imagery experiences discussed later. In these experiences, the therapists remained in control of their fantasies and their egos were involved to a considerable degree. Both passive and active fantasy, according to Jung, included unconscious contents which have erupted into consciousness, but active imagery also includes a unification of the conscious and unconscious aspects of the daydreamer's personality, as expressed in the specific imagery.

Jung (1921/1976) also distinguished between "fantasm" and "imaginative activity," both of which include the basic features of fantasy experiences, as described above. According to Casey (1974), "fantasm," for Jung, is restricted to figments which can reach the surface of the mind and thereby become conscious. (p. 2) "Imaginative activity" is a more general process, as part of the mind's total creative activity. Finally, the process of imagination is ". . . an image-making, form-giving, creative activity, active and purposeful. Images [have] a life of their own; symbolic events [develop] according to their own logic" (p. 2). The basic source of psychic activity, Jung observed, is in the archetypes, which inform and preform imaginative activity and produce an effect ". . . by structuring and subtending the specific imagistic contents which the active imaginer puts in dramatic form" (p. 5).

The preeminent status which Jung accorded to imagery experiences is made clear in his theory of the interaction between the human psyche and experience. Jung (1926/1960) theorized that the ego complex does not make up the entire human mind; rather, it is enclosed within a larger consciousness, the psyche, which

> . . . consists essentially of images. It is a series of images in the truest sense, not an accidental juxaposition or sequence, but a structure that is throughout full of meaning and purpose; it is a "picturing" of vital activities. (pp. 325-326)

Jung's concept of the psyche implies an epistemological view which challenged the standpoint of much of the scientific thinking of his day. He asserted instead that there is

> . . . nothing that is directly experienced except the mind itself. . . . It is my mind, with its store of images, that gives the world colour and sound, and that supremely real and rational certainty which I call "experience" is, in its most simple form, an exceedingly complicated structure of mental images. . . . What we know of the world, and what we are immediately aware of in ourselves, are conscious contents that flow from remote, obscure sources. I do not contest the relative validity of either the realistic standpoint, the esse in re, or the idealistic standpoint, the esse in intellectu solo; I would only like to unite these extreme opposities by an esse in anima, which is the psychological standpoint. We live immediately only in the world of images. (pp. 327-328)

This view profoundly influenced Jung's treatment methodology, by postulating a world of images similar to that of Winnicott's "intermediate area," except that it is

broader, deeper, and more centrally located in Jung's theoretical overview.

Fantasy and Imagery: Jung's Views Regarding Treatment Methods Facilitating the Transcendent Function

Jung regarded two of his treatment procedures, the constructive method and the active imagination technique, as the principal means of illuminating, developing, and giving expression to the patient's "transcendent function." According to Jung (1916/1960), the transcendent function was

> . . . a psychological function comparable in its way to a mathematical function of the same name, which is a function of real and imaginary numbers. The psychological "transcendent function" arises from the union of conscious and unconscious contents. . . . the conscious and unconscious seldom agree as to their contents and their tendencies. This lack of parallelism is not just accidential or purposeless, but due to the fact that the unconscious behaves in a compensatory or complementary manner toward consciousness. We can put it the other way round and say that the conscious behaves in a complementary manner towards the unconscious. (p. 69)

Jung (1916/1960) pointed out that one of the aims of therapy is to change conscious attitudes by bringing the conscious and unconscious concerns of the individual closer together. This function was termed transcendent ". . . because it makes the transition from one attitude to another

organically possible, without loss of the unconscious" (p. 73). In practice, the therapist mediates the transcendent function by helping the patient to bring the conscious and unconscious concerns together.

Jung felt that the process of coming to terms with a counterposition represents ". . . a tension charged with energy and creates a living third thing . . . a movement out of the suspension between opposites, a living birth that leads to a new level of being, a new situation" (p. 90). He added that work with the transcendent function ". . . forms a valuable addition to psychotherapeutic treatment. . . . It is a way of attaining liberation by one's own efforts and of finding the courage to be oneself" (p. 91).

The constructive method. The constructive method, as articulated by Jung, focuses on synthesis. It is concerned with the elaboration of products of the unconscious, e.g., dreams. Jung (1921/1976) summarized this by stating:

> The aim of the constructive method . . . is to elicit from the unconscious product a meaning that relates to the subject's future attitude. . . . [It] seeks to elucidate the symbolically expressed meaning in such a way as to indicate how the conscious orientation may be corrected and how the subject may be in harmony with the unconscious. (p. 423)

He noted that the symbolic expression of unconscious materials anticipates the future, is oriented toward a goal,

and has a "purposive" or "prospective" function. Therefore, the free associations of a patient are ". . . considered with respect to their aim and not with respect to their derivation" (p. 423). Jung (1921/1976) criticized Freud's reductive analysis, which he distinguished from the constructive method, for having reduced ". . . fantasy to causal, elementary instinctive processes;" for having rejected ". . . the principal of imagination; and for having treated fantasies as merely signs, representing something else" (pp. 60-62).

Hall (1977) cited amplification as an important component of the constructive method. Derived from Jung's word-association experiments, amplification ". . . consists of eliciting from the patient his associations to [a] dream motif" (p. 130). It differs from the psychoanalytic technique of free association, which starts with an image and then moves away from it in a sequence of associations, in that it involves the patient's continuing to elaborate upon a given image for as long as the situation requires. Associations gathered by the constructive method can illuminate conscious, personal unconscious, and collective unconscious activity and issues. O'Connell (1986) extended this understanding by suggesting that archetypal amplification in a "secured-symbolizing/context-plus field" can be used to illuminate symbolic contents and establish a

a historical and cultural "context of meaning" for understanding dreams and waking imagery (p. 32). She also noted that " . . . amplification is a circular rather than linear enhancement of the original image" (p. 35), which thereby elaborates the products of the unconscious.

The active imagination technique. The active imagination technique, as developed by Jung, treats "spontaneous fantasies" as fragments of unconscious material; he explained that such fantasies usually have ". . . a composed and coherent character and often contain much that is obviously significant" (1916/1970, p. 78). In order to facilitate the free play of these fantasies, Jung recommended such activites as drawing, painting, body movements, automatic writing, and work with plastic materials. (1916/1960, pp. 82-84) He also instructed that the patient should write a dialogue between the ego and the unconscious, "the other voice." (pp. 88-90) Jung considered the active imagination technique to be

> . . . the most important auxiliary for the production of those contents of the unconscious which lie, as it were, immediately below the threshold of consciousness and, when intensified, are the most likely to irrupt spontaneously into the conscious mind. (p. 68)

Casey (1974) observed that the active imagination technique involves a two-part process consisting of 1) "a general

movement from the unconscious to consciousness," or in Freud's terms, from primary to secondary process; and 2) the "subsequent elaboration and unfolding" of imagery and fantasies which have emerged into consciousness. (pp. 2-3)

In addition, Jung (1916/1960) discussed at length other potentially useful methods of bringing unconscious material to the surface of consciousness in order to develop the transcendent function. Emerging unconscious issues may manifest themselves in certain phenomena, e.g., dreams, " . . . ideas 'out of the blue,' slips, deceptions and lapses of memory, symptomatic actions, etc." (p. 77) which he dismissed as being less useful because of their fragmentary character. He recommended the reductive method for dealing with the psychological problems which instigate these phenomena.

Fantasy and Imagery: Post-Jungian Views

As discussed below, the divergence of perspectives among post-Jungians regarding imagery is clearly shown in the difference of opinions between members of the Developmental School and members of the Archetypal school.

The Developmental School.

The Developmental, or London, School of post-Jungian theory has tended to emphasize the

interaction of psychological development, as expressed in object relations theory, with the main features of Jungian theory and therapy. Members of the Developmental School have produced relatively few theoretical writings regarding imagery per se. However, certain Developmental School clinical writings, reviewed below in Part 2 of this chapter, have discussed patients' imagery in detail, and some of these have also discussed aspects of therapists' imagery.

In his representative theoretical paper on fantasy, Plaut (1966) developed the thesis that the ability to imagine constructively is closely related to trust and to the establishment of a coherent ego. Like Jung in his Tavistock lectures, Plaut functionally distinguished fantasy from imagination; fantasy refers to images ". . . which fail to act as symbols and are not used because they refer to frustrated wish fulfillments," whereas imagination refers to images ". . . which, through closer integration with the ego, are valued, can become symbols or are in other ways useful, and so find their place in the inner life of the individual" (p. 114).

Plaut (1966) examined his own cases which demonstrated the relationship between ego development and imagination. He concluded:

> . . . until a sufficiently coherent ego is established use cannot be made of fantasy as imagination. All conscious content, as Jung sees it, consists of images (mental representations) but this does not mean that imagination, i.e. the capacity to form images and to recombine these images into new patterns, is functioning. (Plaut, 1966, p. 116)

Toward the end of his paper, Plaut warned against the use of methods designed to stimulate imagination before such ego functions as trust and discrimination have developed.

Davidson (1966), like Plaut, developed certain of her ideas on the relationship between ego development and imagination in relation to a number of Winnicott's concepts, e.g., transitional phenomena and intermediate space.

Another set of Developmental School writings have related Winnicott's concepts directly to fantasy and imagination, as Jung conceptualized them. Fordham (1977), for example, traced the source of active imagination to transitional objects and phenomena, and pointed out how particular experiences with transitional objects and phenomena had facilitated the development of Jung's own sensitivity to imagery.

Goodheart (1981) presented his own developmental model, and indicated step-by-step connections between a number of Winnicott's ideas and Jung's early ideas. He mentioned, for example, that the phenomenon Winnicott had understood as being transitional space Jung had understood as being a

womb-like transformative container. He also observed that Jung's language is more imagistic and symbolic than Winnicott's. (p. 16)

Finally, O'Connell (1986), in her discussions of Winnicott's ideas and those of other theoreticians, suggested that the intermediate space of transitional phenomena resembles Goodheart's "secured-symbolizing field" as well as Jung's field of the transcendent function or symbolic transformation, in which techniques such as amplification and active imagination occur. O'Connell recommended silent rather than verbal amplification on the part of the therapist in order to keep the symbolic interactional field intact.

The Archetypal School. Members of the Archetypal School have extensively investigated the nature, sources, and functions of images, and have expanded Jung's ideas on imagery by showing certain images to be significant and meaningful in themselves, due to their origin in the collective unconscious and their function as expressions of archetypes. Introducing this school's basic premises, Durand (1971) wrote:

> Images have many more ways of establishing relationships than do concepts. . . . The image adds the whole gamut of synchronicities, special relationships, relationships that are due to the multiple manifestations of color, form and assonance. The image has a specific logic of its own, which requires complete surrender to the principle of identity as well as its famous corollaries: non-contradiction and exclusion of the middle. Having abolished the chronology of time and the three-dimensionality of space, the image is not bound by linear thinking and bivalent logical sequences. It relates on the basis of analogies . . . (p. 90)

Although these observations are true of certain characteristics of all imagery, Durand's intention was to describe imagery which expresses aspects of the unconscious. He agreed with Jung in his assumption that the image is ". . . neither part of the world of phenomena, subject to pure reason, nor is it part of the 'transcendental subject'" (p. 90).

Hillman (1979), the most famous member of the Archetypal School, documented the historical and cultural changes which have resulted in Western cultures' minimizing of the value of the image. The Catholic Church made a "subtle and devastating" distinction which deprived images of their inherent authority by conceptualizing a dualism of spirit and body rather than retaining a tripartite view of the cosmos as being composed of body, soul, and spirit. This dualism resulted, according to Hillman, in a

distinction ". . . between the image as such, its power, its full divine or archetypal reality and what the image represents, points to, means" (p. 56). Hillman felt that Jung was a fundamental leader in reversing this historic process by reviving respect for the image, the tripartite cosmos, and the soul.

Similarly, Corbin (1972) observed that ". . . despite all our effort, . . . [the term] imaginary is equated with the unreal, with something that is outside the framework of being and existing, in brief with something utopian" (pp. 1-2). On the basis of his studies of the Islamic philosophical tradition, Corbin postulated distinct levels of reality: worlds, spheres, and/or regions which correspond to various organs of perception. These worlds form a triad consisting of the physical, sensible world; the terrestrial and sidereal universe of human and "sphere" souls; and the supersensible world of "angel" souls. (pp. 6-7) Thus, between the abstract and the empirical worlds

> . . . is a world that is both intermediary and intermediate . . . the world of the image, the mundus imaginalis: a world that is ontologically as real as the world of the senses and that of the intellect. This world requires its own faculty of perception, namely imaginative power, a faculty with a cognitive function, a noetic value which is as real as that of sense perception or intellectual intuition. (p. 7)

Another prominent theoretician, Avens (1980), contended that imagination is the primal force and basic reality of human life. In Avens' view, Hillman had defined the soul as ". . . the imaginative possibility of our nature, the experiencing through reflective speculation, dream, image and fantasy . . ." (p. 31). From Avens' perspective, Hillman had taken Jung's ideas to a logical extreme by aiming, ". . . at nothing less than an 'imaginal reduction'" (p. 34). Avens meant by this that for Hillman the

> . . . soul itself is a fantasy image: we are always in one or another archetypal configuration, or in one or another fantasy. . . . To live psychologically means to imagine things. . . . Man is primarily an image maker and our psychic substance consists of images; our existence is imagination. We are indeed such stuff as dreams are made of. (p. 34)

In addition, Avens added, "Image and meaning are identical; as the first takes shape, so the latter becomes clear. Actually, the pattern needs no interpretation and portrays its own meaning" (p. 37).

Another theorist, Barry, stated that the image is ". . . an irreducible and complete union of form and content. . . . Image is both the content of a structure and the structure of a content" (Barry, 1974/1982, p. 64).

Watkins (1977), yet another member of the Archetypal School, demonstrated a particular concern about rational interpretations of the imaginal and about attempts to reduce

the imaginal to the conceptual. In her view, a person should simply experience imagery, rather than subjecting it to theoretical interpretations. Accordingly, she recommended

> . . . repeating the images over and over again, allowing them to expand (visually, mentally, in painting, writing, movement), to set in our consciousness their non-linear history, [enabling] us to begin to grasp and feel them" (p. 142).

The radical advocacy of the imaginal realm, as articulated by members of the Archetypal School, has been criticized by other Jungians. For example, Odajnyk (1984) cited Hillman as a representative of the Archetypal School, and criticized him for having misquoted Jung and for having misunderstood Jung's intentions. According to Odajnyk, Jung grounded imagery in the emotions and instincts, in such a way that images can be said to have something beneath or behind them and can thereby make us aware of underlying archeypes; they should not, therefore, be superficially interpreted. "For Jung, images are the visible aspects of the underlying invisible archetypes" (p. 44). Odajnyk added that Hillman had moved from one extreme to another, by making the soul and images seem superior to the "literalness" of the mind and body. (pp. 44)

Actually, the differences between various Jungians are somewhat complementary, and it is possible to organize their

contributions in an overview which integrates their divergent perspectives to a degree, as discussed below.

Fantasy and Imagery: Integrating the Contributions of Jung with the Views of the Developmental and the Archetypal Schools

Stein's (1978) paper, in which he attempted to clarify Jung's approach to interpreting imagery, provides a basis for a possible integration of various Jungian ideas on imagery. Stein considered image and interpretation to be complementary modes of representing unconscious structures and processes. He stated that just ". . . as images form a 'language' for archetypal contents, interpretation provides in turn a 'language' for images" (p. 91).

According to Stein (1978), Jung felt that

> . . . modern psychology treats the products of [personal and collective] unconscious fantasy-activity as self-portraits of what is going on in the unconscious psyche about itself. . . . A dream or fantasy image is . . . a representation in the sense of being a self-presentation of a structural or dynamic unconscious substratum of the psyche. (p. 94)

However, according to Stein, Jung was uncertain about the content which fantasy activity portrays. The archetypal sources are unclear, the representations are "not surely conscious," and the contents of the unconscious are actually unknown. Jung (1936/1954/1980) expressed this position by

stating: "Every interpretation necessarily remains an 'as-if'. The ultimate core of meaning may be circumscribed, but not described" (p. 156).

According to Stein, a question of reference does arise in connection with the concept of self-portraiture: "What do the images (self portraits) say of the content of which they are self representations?" (p. 95) Stein suggested the use of a dual focus to help in answering this question, a focus which is directed toward both the image itself and toward the unconscious substratum that it represents. Stein observed that the

> . . . dual focus necessitates a kind of interpretation different from what it would be if the image were only a "sign" pointing away from itself and thus disappearing behind its obligation to refer attention elsewhere (Freud); different also from what it would be if it were based on purely aesthetic considerations (the Romantic [or purely archetypal] approach) which would fix attention only on the image. The image as self-portrait both holds attention on itself and refers attention to its place of origin, obliging interpretation to look both ways also. (pp. 95-96)

Stein applied his dual focus approach to both personal and archetypal images, and found that the dual focus frees the therapist to pragmatically pursue the best course of action for any given patient; it avoids the reductionist extreme, yet maintains an archetypal perspective. In addition, it is consistent with Samuels' observation that post-Jungians of all schools make little distinction

between the archetypal and personal layers of the unconscious, and instead basically tend to interpret images according their patients' individual circumstances and ego stengths. (Samuels, 1985b, p. 53)

A dual focus for interpreting imagery is clinically useful, but because this study investigates therapist imagery as a source of countertransference data, a single focus on the interpretation of therapist imagery to elucidate therapists' perspectives regarding countertransference issues is used in analyzing the interview data. This focus necessarily grants secondary status to the images themselves, a result which should not be understood as implying that the images themselves have been considered unimportant.

Summary of Part 1

In the presentation of the theoretical framework which preceded Part 1 of this chapter, an attempt was made to establish a theoretical framework for this study by reviewing relevant psychoanalytic and Jungian writings. Jungian psychology was presented as the epistemological, methodological, and theoretical basis from which the study was derived. Jung's ideas on countertransference and imagery, although first conceived early in this century, are

still fundamentally modern. In his writings, Jung did not explicitly link therapist imagery to countertransference, but he did imply connections between these phenomena. Certain of his followers' descriptions and analyses of these connections are briefly discussed in Part 2.

The concept of countertransference was explored in Part 1 of this chapter. A Totalist view of it, as exemplified in the ideas of Racker (1968/1976), was adopted for use of the term in the present study. Jungian and post-Jungian ideas on countertransference were reviewed, and Racker's ideas were also linked to those of Fordham (1957, 1974, 1977, 1978, 1979). Racker and Fordham were found to differ mainly in their views of the unconscious. Fordham accepted the hypothesis of archetypes originating in the collective unconscious, while Racker did not. Nevertheless, Racker's contributions are especially important for this study because he conceptualized therapist imagery as an aspect of countertransference.

The phenomena of empathy, projective identification, projective counteridentification, and the intermediate space, all of which are important psychoanalytic concepts, were briefly discussed because they represent important aspects of the therapeutic relationship, form essential components of countertransference, and indirectly influence therapist imagery.

Also reviewed were psychoanalytic writings on imagery; these included writings which viewed it as being defensive, regressive, and concealing, as well as writings which viewed it as being a discloser of unconscious material.

Most of the writings reviewed in this section discussed patients' experiences with imagery, but this literature was considered pertinent to the present study since it was assumed that the underlying psychological dynamics of imagery formation are the same for both patients and therapists.

Finally, Jungian theories on mental imagery were reviewed. The Jungian theorists seemed to agree, upon several important issues, with a number of the psychoanalysts, and particularly with the ego psychologists. Plaut (1966) observed that the following premises have been accepted by writers in both camps: (a) mental imagery has a legitimate psychotherapeutic status; (b) fantasies play a crucial part in psychological symptom formation and mental conflicts, and in the transformation of psychic energies; (c) primary process fantasy thinking is active and creative throughout life, and is not necessarily pathological or maladaptive; (d) no sharp line separates primary process from secondary process thinking; and (e) ego regression can serve the ego. (pp. 123-127) The Jungians are in particular

agreement with those psychoanalysts who view imagery as a discloser of unconscious material.

However, there are clearly areas in which opinions diverge. Jungians, for example, tend to believe that imagery, which is inherent in the psyche, is an elemental component in psychic activity, an autonomous, spiritual, and creative expression of the archetypes underlying human experience. This belief is consistent with Jungian opinion that the collective unconscious, the deepest layer of the psyche, plays a formative, integrative, and growth-enhancing part in creating imagery.

Freudians, on the other hand, tend to connect unconscious imagery with primary process or fantasy thinking, which is related to the libido, ego development, and ego defenses. For Jungians, an id and personal drives concept of the instincts is considered to be too narrow. (Plaut, 1966, p. 123)

Nevertheless, the Jungian theorists have been divided over the interpretation and use of mental imagery. As reviewed above, those of the Developmental School have viewed imagery and have used it in treatment, as Jung himself did, as a discloser of the dynamics and processes in the individual's personal and collective unconscious. The members of the Archetypal School, however, have maintained that imagery reveals nothing, and have therefore used it in

treatment for its own intrinsic properties. As was shown, Stein's (1978) paper represents a compromise position between those two, integrating the perspectives of a variety of Jungians.

Part 2: Clinical and Research Studies

The second part of this review of relevant literature discusses clinical and research studies which were prepared by therapists and researchers of various theoretical orientations, and which were concerned, more directly than the writings reviewed in Part 1, with the available empirical evidence regarding experiences of therapist imagery and countertransference.

Imagery as Countertransference Data: Psychoanalytic Clinical Studies

This section reviews several psychoanalytic writings which considered imagery derived from various sense modalities as countertransference data. Most of the reported imagery was spontaneous, but the imagery considered in one of the studies was willed.

Reik (1948/1983), in many of his book's case examples, related his understanding of some of his own subjective

experiences to his understanding of patients' dynamics. His book serves as a useful introduction to the ideas of the shorter, more recently published analytic studies discussed later in this section.

Reik (1948/1983) exhorted his reader to look inward, stating: "The organ of psychological observation, and therefore of psychological research and discovery, is to be found within oneself" (p. 10). Reik instructed that the therapist, when asking the patient to relax and free associate, should do the same, and should observe his/her own feelings and impulses without interrupting these with the preoccupations of theoretical knowledge or past experience.

According to Reik (1948/1983), the therapist hears not only what the patient's words explicitly say, but

> . . . also what the words do not say. He listens with the "third ear," hearing not only what the patient speaks but also his own inner voices, what emerges from his own unconscious depths. (pp. 125-126)

Reik therefore advised the therapist to attend to deep subjective perceptions, on the basis of his own experiences in understanding his patients.

> What emerges from the depths can only be caught with something originating in the depths. . . . The analyst who absorbs the noises and voices of the day too keenly will never hear the secret fountain that speaks loud only in the night. (pp. 270-271)

Ross and Kapp (1962), in the earliest of a series of clinical studies on imagery and countertransference, influenced by Reik, suggested an "innovative" technique that includes a self-analysis by the therapist of his/her own unconscious reactions to the patient and to the patient's transference. In this self-analysis

> . . . the visual images of the analyst in response to his patient's descriptions of dreams are used by the analyst as a starting point for the uncovering of previously unconscious countertransference. (p. 655)

Ross and Kapp (1962) stated that the images which a therapist experiences during the report of a dream

> . . . appear to be an instance of the unconscious activity of the analyst's mind, caught as a snapshot, in the process of responding to the unconscious activity of the patient's mind. [These visual images form a new version of the patient's dream and] portray the mind of the analyst as well as that of the patient. (p. 646)

The authors clearly concluded that the therapist's images portray dynamic and genetic unconscious elements of the therapist's countertransference. Ross and Kapp (1962) presented, as evidence of these processes, five case examples of countertransference problems which therapist imagery had illustrated, including instances of a therapist's resistance having impeded a patient's movement, a therapist having competed with a patient, and a therapist's having defensively identified with a patient.

Kern (1978) built up on Ross and Kapp's work; following the contributions of Freud, Racker, and Reik, he noted that a therapist's free-floating attention might evoke visual images. He reported upon a number of visual images he had experienced during treatment sessions, most of which had been derived from either his patients' verbalizations and/or his own empathetic memories. Reflection upon these images led him to comment:

> It is as though the patient is responsible for the foreground action -- the script of the event being described -- while his analyst is unwittingly producing unfamiliar props, the static backdrops, which complete the visualized pictures of the patient's activity. (p. 21)

In his analysis of these backdrops, which were evident in four case examples, Kern discovered

> . . . indications of unconscious attempts to obscure, misunderstand and deflect the patient and myself from the analytic work. In short, they were indications not of empathy, but of unconscious countertransference, the forms of which contained both transferred fragments or conflictual early object relations and projected early self-representations. (p. 27)

Schamess (1981), in one of the few papers by a social worker cited in this study, discussed the impact on therapists of patients with severe characterological problems. Schamess mentioned that therapists' induced affective responses have been widely written about, but

". . . less attention has been paid to the behavioral responses that disturbed patients routinely evoke from therapists" (p. 245). He considered such behavioral responses to be part of a reciprocal interaction in which the patient and therapist replay an earlier dyadic relationship in the patient's life, with the therapist playing the significant other. The therapist's task is to interrupt this established interactional pattern, and so enable the patient to internalize the therapist in a new way.

It should be noted that Stewart (1985), also a social worker, writing in response to Schamess, also discussed therapists' induced behavioral responses. She used six clinical examples that focus on boundary issues to demonstrate her ideas.

These two papers are mentioned here because of their focus on countertransference reactions and the patient's impact on the therapist.

Another psychoanalyst, Jacobs (1983), reviewed certain aspects of the therapist's emotional reactions to objects in the patient's internal world. The patient brings a cast of internalized characters into the office, and the therapist may respond to these characters in many different ways. The particular way

> . . . in which the analyst responds to material about his patient's objects depends not only on his understanding of the patient and the transference developments at any given time, but also on the impulses, affects, fantasies and defenses evoked in him in response to the mental representations he has formed of those objects. These representations exist apart from, although they may at times supplement and augment, countertransference reactions that develop in response to the patient's transferences. . . . The latter reactions arise when particular transferences touch on and awaken dormant conflicts in the analyst. (pp. 624-625)

Jacobs (1983) observed that these reactions by the analyst occur because

> . . . the analyst's listening state of mind allows for the emergence in him not only of spontaneous associations, but of fantasies and memories that are closely linked to past and present self and object representations. (p. 633)

Jacobs detailed case examples in which, as a result of these processes, the therapist had projected onto the patient's internalized objects his/her own conflicted internalized objects.

Althofer (1983), developing the studies cited above, contended that by focusing upon mental imagery a therapist is able to sharpen his/her coenesthetic sensory receptivity and to facilitate his/her "good-enough mothering," both of which nurture the development of empathy. Althofer discussed a case example in which a patient's transference attitude had become obvious to the therapist " . . . through

a gestalt composed of visual, kinesthetic, rhythmic, postural, facial, gestural and behavioral cues" (p. 49).

Bady (1984) continued the investigation started by Kern (1978), adding theoretical insights by Kernberg, Schaefer, and others. She discussed two case examples of visual and kinesthetic imagery experiences, which she considered to be indicative of empathy and countertransference. In her view, empathy is considered a vital part of countertransference and treatment, but Bady concluded that countertransference can block as well as facilitate empathy. The two interconnected experiences, Bady stated, ". . . become both, potentially, a double-edged sword or the path to the end of the rainbow" (p. 531).

Poland (1984), in a short paper, considered themes similar to those of Bady's research. He discussed a baseball simile which had spontaneously and suddenly occurred to him during a session with a patient, analyzing its relation to both the patient's and his own material, and questioning whether this experience should be called a countertransference reaction. Poland stated that the term had lost specificity for him since it had been given so many different meanings in the literature. Interestingly, he cited no previous sources on countertransference.

Another researcher whose work is pertinent is Caccia (1984), who presented a vivid description of her experiences

of sensory imagery during a session with two ten-year-old boys. She discussed, in relation to this, the critical role of the mother for the baby, and of the therapist for the patient, as containers of evacuated psychic material and projections.

Simon (1984) discussed a self-analysis which had been instigated by a treatment session experience of visual imagery that was "strikingly similar" to the patient's imagery. He stated that the ". . . confluence of the two [imagery experiences] was indeed startling [and] indicated a state of silent, deep empathetic communication between my patient and myself" (p. 261). Simon found that the imagery itself communicated "reproach, isolation and misunderstanding" (p. 261), but that the mutual experiencing of it suggested ". . . an intensity of affect and a joint preparedness to experience something not previously acknowledged" (p. 265).

Simon (1984) also revealed that he had weighed the advantages and disadvantages of telling his patient about his imagery experience, and had decided against doing so, because he had felt unsure about the transference and countertransference dynamics at that moment. He concluded his study, after a brief review of the psychoanalytic literature on extrasensory perception, by presenting the hypothesis that phenomena similar to extrasensory

perceptions and confluent therapist-patient imagery experiences occur when the therapist is less available to the patient, and when the patient is working on ". . . some important unresolved communication issue that is not being apprehended by ordinary means" (p. 276). Simon noted that if his hypothesis is correct, it lends support to the position that the therapist should tell the patient about his/her own inner experiences, since such a disclosure could facilitate mutuality and communicative understanding.

Finally, Ripin's (1983) study described his work with a patient who had enraged him. In order to deal with his rage, Ripin willed specific fantasies, such as visualizing himself hurting the patient in various ways. His fantasies were always of short duration, and he reported that after having them, he had no longer felt tense, and was better able to listen. In time, these fantasies became humorous. He also reported that his need to will them disappeared after a few sessions, which enabled him to continue seeing the patient for a few more years.

These personal, anecdotal, psychoanalytic studies all indicate a courage, on the part of these researchers, to use their imagery experiences for self-analysis and self-understanding, and for diagnosing and treating their patients' problems. In most cases, the writers interpreted the meanings of their imagery experiences from a reductive

personalistic viewpoint, often tracing their images back to their own childhood sources. For the most part, these therapists did not choose to share their imagery with their patients.

Imagery as Countertransference Data: Jungian Clinical Studies

It seems that no Jungian clinical study that discusses therapist imagery refers to it as countertransference data per se. However, many clinical studies by Jungians and by Jung himself have utilized therapist imagery experiences to augment these researchers' understandings of aspects of themselves, their patients, and the therapeutic relationships in which these imagery experiences occurred. One example of this approach to utilizing therapist imagery is shown in a number of sources pertaining to the development and refinement of the therapist's transcendent function, which is a component of countertransference. In the following section, several important Jungian writings which have utilized therapist imagery in these ways are reviewed.

Jung (1935/1968) outlined a case example in which a male therapist, who was not particularly interested in his female patient, had become aware, during a session, that he

was experiencing a sexual fantasy about her. Jung used this clinical example to support his view that compensatory phenomena occur in the therapist as well as in the patient; he commented that such therapists' fantasies contain important

> . . . information from their unconscious, that their human contact with the patient is not good, that there is a disturbance of rapport. . . . [Such a fantasy] covers the distance and builds a bridge. . . . These fantasies can be visual; they can be a certain feeling or a sensation -- a sexual sensation, for instance. They are invariably a sign that the analyst's attitude to the patient is wrong, that he overvalues him or undervalues him or that he does not pay the right attention -- that correction of his attitude can also be expressed by dreams. (p. 162)

Moore (1975) noted that Jung did not describe how the patient's transcendent function grows and is experienced by the patient's forming ego; instead his focus was on his patient's fully developed adult ego. Her thesis is that "The transcendent function has its origins during [the era of ego formation] growing side by side with the growth of the ego in a mutual interaction" (pp. 164-165), and that the therapist's imagery experiences can provide important diagnostic information about the patient's issues in traversing this developmental sequence. Moore offered case examples in support of this thesis, including her experience of an image of a baby-bottle nipple, which she related to a patient's feeding problem.

Whereas Moore focused on the development of the patient's transcendent function, Powell (1985) investigated the development and refinement of the therapist's transcendent function. For Powell, a therapist's clarification of his/her own affective process is considered very important, particularly in treating patients with faulty ego development, and an essential approach to this clarification is through paying attention to the therapist's imagery. She observed:

> My own transcendent function or my capacity to allow unconscious feelings, often apparently irrelevant, to filter through and swim up into consciousness, was of increasing help to me in relating to my patients. (p. 31)

Powell described this process in the following manner:

> My experiences were not always clear and sometimes would come to fruition only after some time had elapsed. Then an image would emerge spontaneously out of my introspection and give me a clearer understanding of the patient's problems which had hitherto been eluding me. Sometimes this occurred when I was engaged in reflection during or after sessions, and occasionally in my own dreams. (p. 33)

Powell offered several clinical case examples. In one, following a session she had painted a picture which reflected a hidden truth in a patient's family situation. In another case, she had experienced during a session a vivid fantasy of herself as a head and genitals, without a

relating center. She felt that this image represented her patient's ". . . bodily feeling and my feelings of helplessness . . . related to his feelings of infantile helplessness" (p. 38).

In her discussion of this material, Powell linked a number of Jung's ideas to corresponding concepts of Winnicott, Bion, and Kohut. She noted that her awareness of her inner experiences had facilitated her empathy with, understanding of, and insight into her patients' inner experiences, as well as reducing impediments to these connections with her patients. Powell also found that a number of her imagery responses had reflected her patients' struggles with early relationships with their mothers. By receiving the patients' communications in mind and body, she had been able to mediate their painful images and feelings and to facilitate growth and play in them.

As a consequence of his interest in "the analyst's own ontology," or the analyst's "way of being in the [therapeutic] process" (1982, p. 113), Schwartz-Salant described an inner-process scrutiny method which includes the therapist's paying attention to kinesthetic experiences for clues concerning the patient's mental processes. He observed that this method provides him with clues even before any countertransference has developed. In reference to a particular case, Schwartz-Salant reported that his own

sense of the patient had became most acute when he ". . . followed the imaginal process while . . . actively aware of being in my body" (p. 114). He continued to describe his own experience by stating:

> In the state of merger I had created by the shared imagination technique, I experienced body innervations that went along with the patient's production or resistance to images. But after they had produced their images, if I went back to the ones that created bodily changes in me, I always found that much more material was nearby. (p. 115)

Elaborating upon this process, Schwartz-Salant distinguished the somatic unconscious, which he considered a very significant source of data, from the psychic unconscious. He stated:

> By being close to the body, we can use our reactions to learn about the other person, but we must also be able to filter out our own personal reactions . . . In fact this is a much easier process working near the somatic unconscious than the psychic unconscious. By not having to know we are much less involved in power-motivated countertransference reactions. (1982, p. 125)

This process is especially useful, Schwartz-Salant felt, when the therapist is working with patients whose psyches are split off from consciousness and are hidden behind narcissistic personalities. Several clinical examples in support of this observation were offered. Schwart-Salant also noted, in reference to clinical examples in which he had shared his imagery experiences with

patients, that patients seem to have no difficulty in disagreeing with him, or in correcting his visions; it seemed evident to him that sharing his imagery had not controlled patients' spontaneous visions.

In a later paper, Schwartz-Salant (1984) investigated sexual acting-out as an aspect of both transference and countertransference. He included a provocative example of his sharing imagery with a patient.

> At this point something unusual happened. As I was aware of the incestuous link she [the patient] had with her brother, I experienced an erotic energy field between us. She also experienced it. As we both felt this energy, which seemed like something between us, my consciousness lowered a bit and, just as in active imagination, I saw a shimmering image, which partook of both of us, move upwards from where it was near the ground. I told her this. She said, "Yes, I also see it, but I'm afraid of it." I continued to share what I saw and experienced. I saw the image between us as white; she saw a kind of fluid that had a center. . . . A feeling of timelessness pervaded (and of equality in power and sensuality.) . . . A sense of kinship, a brother-sister feeling, was clear to both of us. (pp. 16-17)

In another paper (1986), Scwartz-Salant developed a number of his ideas, including the concepts of the "subtle body" and "liminal state," by linking them directly to counterpart ideas of Winnicott (1971), Corbin (1972), and Samuels (1985a); he also referred to concepts developed by Jung (1946/1974), and related object-relations and Jungian theories to case examples involving therapist imagery.

Schwartz-Salant (1986) wrote that when he lowers his consciousness, as in active imagination, imagery spontaneously rises in him from the "body-psyche field." He warned that considerable analytic work must precede a therapist's sharing of "subtle-body" erotic imagery, and that while ". . . the transformational process cannot occur without erotic energies, a spiritual reference point is critical" (p. 45).

All of the Jungian clinical studies reviewed in this section stated or implied a belief that imagery is a fundamental part of the therapeutic process and of the therapist's treatment experience, in that the therapist's imagery reveals important information about therapeutic interactions. These researchers emphasized the therapist's active and conscious use and sharing of his/her own imagery as a means of evaluating and assisting patients, particularly those with severe personality disturbances.

Therapist Imagery: Psychological and Psychoanalytic Research Studies

Three empirical studies, unpublished dissertations by Hoffman (1977), Adler (1980), and McCann (1982), have surveyed phenomena which are very similar, or adjacent, to

the issues investigated in the present study. These are therefore discussed in some detail below.

Hoffman's (1977) study, written from a phenomenological-humanistic viewpoint, applied certain social psychological theories to the exploration of therapists' uses of imagery. Her purpose was to determine the extent to which therapists perceive, accept, and use their imagery in their clinical work. She investigated her subjects' imitations of patients' imagery as well as the use of their own mental imagery, even though she did not usually stress imitation as a concept in her own work. In her study, she explored ten therapists' personal and clinical use of their own imagery. Hoffman also discussed the advantages and disadvantages of using imagery in treatment, and proposed a program for training therapists about these issues. However, she did not stress intrapsychic dynamics, and never referred to the term countertransference.

Most of Hoffman's subjects told her that they use some form of imitation, and many said that they experience imagery during treatment sessions. The latter group reported different approaches and purposes in their use of their imagery, even though they all reported that they use it as a means rather than as an end. Hoffman found that a significant porportion of her "rational" and "logically

socialized" subjects felt a bias against imagery, and viewed it as somewhat threatening.

Hoffman discussed the issue of ownership of therapist imagery, and wrote:

> . . . facility with imagery and imagination are related to uniqueness of therapeutic style. At the same time, when a therapist's imagery is considered in relation to his/her patients, he/she must also be aware that this personal imagery carries the stamp of individual uniqueness and therefore can only touch on or be an event in the existence of the patient. That is, a therapist might be advised against assuming that his/her personal imagery and imagination has foundation in a patient's being. On the other hand, in the process of taking in some of the patient's being the therapist by means of his/her own imagery can tap into the events of a patient's existence. (pp. 24-25)

Hoffman (1977) listed potential counterproductive effects of the use of imagery in treatment: (a) it can intimidate the patient, (b) it can obliterate interpersonal boundaries which had previously been inadequate, and (c) it can stimulate the therapist's narcissistic tendencies. She noted that a fatigued, ill, or preoccupied therapist should not reveal his/her imagery to a patient, because doing so could make the patient uncomfortable with the image, reinforce the therapist's withdrawal from the patient, and trigger subsequent images which do not relate to the process or content of the treatment.

Nevertheless, Hoffman concluded that the benefits of imagery use far outweigh the drawbacks. She described the

following potential uses of imagery in treatment:

> . . . to cut through the presented material; to join a patient in their imagery or on their own fantasy trip; to project ahead of the patient; to clarify something in the patient's presentation that seems puzzling, confusing or missing; to instruct the patient about concepts or treatment . . .; to focus on the meaning of the patient's presentation or therapeutic process; . . . to become aware of personal reactions to the patient's presentation; . . . to record it for future use; to guide the search for what a patient might be avoiding; to share a personal experience with the patient. (p. 117)

Hoffman contended that therapist imagery can clarify and enrich the understanding of the self and other, and can stimulate the patient's awareness.

Like Hoffman's study, Adler's (1980) qualitative and phenomenological study has a cognitive-humanistic orientation. The study stressed the interpersonal and communicational components of imagery, and it also outlined the advantages and disadvantages of a therapist's using imagery in treatment. Adler also suggested a training program. Unlike Hoffman, however, Adler did refer to countertransference, but she only considered it as a disruptive factor, hindering treatment.

As a study which stressed interpersonal factors, Adler's study found that imagery is an important component in the patient-therapist communication process. She observed that the sharing of imagery, with the cognitive and affective

impact which it imparts, can foster intimacy between the therapist and patient. Adler also noted that her interview subjects ". . . [said] that imagery occurred in part as a function of their feeling active connectedness with their clients" (p. iii). She found that self-confidence and emotional comfort on the part of the therapist can help instigate therapist imagery, and that this emotional comfortability on the part of the therapist is a function of his/her feeling neither too close nor too distant from the patient.

McCann's (1982) exploratory and descriptive study investigated the processes by which a therapist's mental imagery and imaginal phenomena emerge, are subjected to intrapsychic operations and processes of symbolic transformation, and potentially impact the therapy. The research problems and dilemmas involved in this study were thoroughly explored, and she carefully considered such issues as the abundance of terminological confusions and difficulties inherent in such a complex investigation. McCann constructed a theoretical model which integrates the findings of experimental research on mental imagery, psychoanalytic and transformational theories, and her own clinical experiences. She also presented the systems model which she had used in translating these theoretical abstractions into a set of questions for the interviewing of

twenty-seven psychoanalytically oriented therapists.

According to McCann (1982), her findings suggested that

> . . . the image functions to organize, synthesize, and transform basic experience in multi-modality sensory representations, which enable the therapist to understand complex states of mind otherwise inaccessible. . . . [Imagery] if mediated by empathetic interpretation . . . can have considerable impact on the therapy. (Abstract)

During the interviews, McCann did not explicitly focus on countertransference as a topic, but she found that many of her subjects brought it up on their own. Therefore, after the first few interviews, she specifically asked her subjects about countertransference if they did not raise it as a topic. She observed that

> . . . of the 27 respondents, only three felt countertransference inappropriate and of little or no significance for explaining mental imagery. One of these rejected it outright, the other two defined [it] in the "classical sense," in contrast to the "totalist" approach . . . (p. 137)

McCann found that many of her subjects were not able to discuss countertransference without introducing the topics of projective identification and empathy, which both they and she considered as being interpenetrated with countertransference. (p. 137)

Those findings of McCann's study which are most relevant to this study are that (a) mental imagery plays ". . . a central role in the various dimensions of human experience from sensation and perception through affection, cognition, and conation to behavior and therapy;" (b) imagery contains many cognitive functions, such as informing, thinking, remembering, and sensing; (c) mental images contain affective states; (d) the symbolizing activity of the mind is constant rather than intermittent; (e) an autonomous imaginal realm exists in the mind, and develops according to its own logic; (f) ". . . the image can express simultaneously the particularity of the patient's condition in the here and now and the universality of human experience, connecting the patient to all of mankind;" (g) imagery occurs in the transitional space; (h) imagery is ubiquitous in therapy; and, most significantly for the present study, (i) therapists use their imagery experiences to inform themselves about their patients and to make decisions concerning interpretation and intervention. (McCann, 1982, pp. 166-172)

In summarizing her study, McCann (1982) wrote:

> To deny the role of imagery can only reduce and diminish potential richness and enlightenment for therapists, and . . . might limit the empathetic relationship to the patient's total experience. (p. 172)

Therapist Imagery: Jungian Research Studies

Three Jungian research studies, as reported in the writings of Dieckmann (1974 and 1976) and Blomeyer (1974) from the Berlin Group, and by Samuels (1984 and 1985a), have extensively researched therapist imagery and are therefore discussed below.

The Berlin Group consisted of five, then four, Jungian analysts, whose research procedure involved the recording of their patients' and their own treatment session emotional fluctuations, and discussions of the analysts' observations in group meetings. Dieckmann (1976) stated that during the three years this research was ongoing the group members observed

> . . . not only our own highly charged emotional attitudes as they arose, but also subliminal ones, fantasies, feelings and the psychosomatic affects arising from the unconscious. The idea was to relate what we observed as arising in ourselves with what the patient was saying at any given moment. (p. 25)

During the first phase of their research, they also investigated the archetypal dreams of thirty-seven patients; during the second phase, the randomly selected dreams of twelve were investigated. (Dieckmann, 1976, p. 26)

The principal results of the research are the following:

1. A "most astonishing fact . . . [was] the complete correspondence between the analyst's and the patient's associations. . . . every fantasy, emotion and so on, arising out of the analyst's unconscious (sometimes very personal) was connected either with the patient's associations that he was describing at a specific moment or else shortly following the patient's fantasy. In many cases the analyst's associations anticipated the associations of the patient" (p. 26).

2. Resistence is a problem shared by both patient and analyst, "notwithstanding the latter's training and experience . . . fears and anxieties in countertransference emerge out of the personal unconscious or belong to the ego complex, while the collective unconscious has the tendency to encourage the process of individuation" (p. 27).

3. Also noted was ". . . an astonishing increase in the phenomena of synchronicity, especially in sessions with archetypal dreams and high emotional stress" (p. 27).

4. The fact that ". . . all dreams, crucial situations and associations, not only of the analyst but also of the patient, were related as well to our group situation" (p. 29).

5. The observation that ". . . all events have a certain aspect of a priori unity. . . . The archetype of the Self operates not only within each individual but between us all" (p. 30).

One example mentioned in the study involved a thirty-year-old male psychotic patient; during this patient's 108th session, the therapist thrice experienced an image of a single rose. Later the group interpreted the rose as an anima symbol which implied a search in the therapist for wholeness, with which to heal the split in the patient's self. During the session after the group meeting, the patient talked about a spontaneous image which he had

experienced during the previous sesson and several times afterward: a span of "scorched earth stretching as far as the eye could see upon which there grew just one rose" (p. 28). This example indicates, according to Dieckmann, that a therapist's unconscious is ". . . a highly sensitive receiver for obsessive fantasies which the patient has. . . . the self constellates the synchronicity of fantasies in two persons" (1976, p. 28).

From their research, the Berlin Group enlarged on previous definitons of transference and countertransference, in order to include within these phenomena the components of projective and syntonic processes. They theorized four different levels of the unconscious at which transference and countertransference may take place: the subjective, the objective, the personal, and the collective.

In an earlier paper, Dieckmann (1974) had offered many case examples and had observed the processes which were apparently involved in phenomena such as therapist-patient parallel imagery experiences. He explained:

> . . . the perception of subliminal signals results in an unconscious assimilation of the patient's experience on the symbolic level. Secondly, an accomodation occurs whereby archetypal factors are constellated in the collective unconscious of the analyst which seek to guide the process. Both the assimilation and accomodation conditions are brought into consciousness in the particular process of accomodation. (p. 80)

The study included an example in which the therapist experiences a spontaneous image of wild boars, which he mentions to his patient. The patient reveals that he had experienced a fantasy of visiting a park where wild boars live. Dieckmann (1974) noted: ". . . experience has taught us that it is just these subliminal associations that stir up essential and analytically important details . . ." (p. 81).

This study found that causal analysis is insufficient for explaining countertransference data and phenomena similar to those involving extrasensory perception. Dieckmann (1974) observed:

> In a deeper layer underlying the analytic situation there is a synchronistic process regulated by the self, a process that cannot yet be differentiated further for lack of the requisite conceptual tools, and for the investigation of which we must summon up the courage and open-mindedness to venture into unknown realms far removed from the conventional disciplines. (p. 83)

The views of the Berlin Group on phenomena involving extrasensory perception can be compared with Simon's (1984) and O'Connell's (1986) more recent ideas, as described above. Simon (1984) hypothesized that therapist telepathic experiences coincided with breakdowns in therapist-patient communication; O'Connell (1986) hypothesized that confluent or telepathic therapist-patient imagery may occur when the therapist and patient are interacting in the "secured-

symbolizing/context-plus" field. This field is one of three interactional fields originally hypothesized by Goodheart (1980), a Jungian analyst who was also influenced by the ideas of Langs (1977). The results of the Dieckmann research, in combination with the findings of O'Connell and Goodheart, bring Simon's hypothesis into question; it seems that complementary imagery can occur whether or not the patient-therapist communication is adequate, and it also seems that a number of different variables are involved.

The ideas in Samuels' study (1985a) most clearly parallel the underlying thesis of the present study. Samuels' research focused on countertransference experiences in which the therapist's reactions seemed to have been induced by unconscious communications from the patient. He stressed that he was not studying neurotic countertransference, although a clear delineation between neurotic and non-neurotic countertransference is difficult to make. Samuels based his work upon the understanding that the therapist's inner world is the "via regia" into the inner world of the patient.

Samuels (1985a), like Racker, hypothesized that ". . . there are two rather different sorts of usable countertransference -- though both may seem as communications from the patient" (p. 52); these are reflective and embodied countertransference. In reflective

countertransference, the therapist's feelings mirror those of the patient. For example, a therapist who is not depressed might come to feel depressed because of a patient's depression. In reflective countertransference, the therapist experiences the patient's here-and-now state. In embodied countertransference, the the therapist expresses the emotional experience of significant objects in the patient's life. For example, a therapist might feel depressed because a patient is undergoing an inner experience with a depressed parent. In embodied countertransference, the therapist experiences ". . . an entity, theme or person of a longstanding, intrapsychic inner world nature . . ." (p. 52). Samuels also noted that one problem for the therapist is that these two kinds of countertransference can feel the same.

In order to research his thesis, Samuels wrote a letter, which included a series of questions, to thirty-two therapists who had formerly been in supervision with him. These therapists were asked to provide a few case examples of countertransference which had resulted, in their views, from patients' unconscious communications. Twenty-six of the therapists replied, providing fifty-seven case examples.

The replies confirmed the validity of Samuels' two categories, and gave him a basis for conceptualizing a set of distinct response groups, which he labelled "bodily and

behavioral," "feeling," and "phantasy." He referred to responses in all three of these groups as images, ". . . because they are active in the psyche in the absence of a direct stimulus which could be said to have caused them to exist" (Samuels, 1985a, p. 57).

Samuels found that patients with instinctive problems, e.g., difficulties with sex, aggression, or food, are more likely to trigger reflective or embodied countertransference reactions than other patients. On the basis of this finding, he concluded: "What is highlighted, therefore, is the special part that may be played by the body in the patient's evocation of countertransference in the analyst" (Samuels, 1985a, p. 57). This finding strongly supports similar observations presented by Powell (1985) and by Schwartz-Salant (1986).

In both his study and his lecture on the same subject, Samuels (1985a, 1984) offered several case examples. In one from the lecture, an obese woman was discussing with her female therapist her feeding during infancy. The therapist experienced a sudden image of the patient ". . . expanding and filling the whole room, incorporating me and everything in it. Then she receded and was back in her chair, normal size" (p. 2). Samuels (1984) concluded that

> . . . for whatever reason, her patient wanted to keep her out; expanding in the way described would do just that. The analyst could then see more clearly how the patient had experienced her mother and could adjust her interventions accordingly. (p. 2)

In order to explain his examples and findings in theoretical terms, Samuels (1985a) departed from the ideas of such theorists as Jung, Fordham, Heimann, Langs, Racker, and Kohut, whom he had cited earlier, and employed Corbin's mundus imaginalis concept, which he linked to the countertransference phenomena that he had investigated. He stated that these phenomena

> . . . are intermediate; in-between the patient and analyst, and also in-between the analyst's conscious and unconscious. . . . For the patient, the analyst is an in-between, a real person and also a transference projection. For the analyst, the world he shares with the patient is also the patient's imaginal world. . . . My suggestion is that there is a two-person or shared mundus imaginalis which is constellated in analysis. . . . the analyst's ego is a special kind of ego, highly permeable and flexible and having as its central mediating function the operation of the sluice gates between imagination and understanding. . . . In the analyst's countertransference we see equivalents of the patient's internal reality, even though the sensory data for the analyst's experience are missing. Hence the rationale for referring generally to these countertransferences as images. (pp. 58-59)

Samuels (1985a) also attempted to counter anticipated objections to his ". . . poetic, metaphorical, imaginal explanation for the mysterious workings of countertransference" (p. 55) by suggesting that his concept

of the mundus imaginalis might resemble the alternative perceptual system posited by the Berlin Group. He further argued that his mundus imaginalis hypothesis fleshes out the concept of projective identification in that it postulates its basis and its motive.

Finally, it is worth noting that Samuels suggested that the concept of the mundus imaginalis could be used to integrate the perspectives of the Developmental and Archetypal Schools of post-Jungian theory. He observed that

> We can place the interaction of the patient and the analyst firmly within the imaginal realm without forgetting that there are two people present. . . . If the idea of a two-person mundus imaginalis is taken seriously, then we must regard the interpersonal in terms of the psyche speaking, the imaginal in terms of an avenue of communication between two people. (p. 264) . . . We need to envision our field of reference as seamless and continuous so that ostensible "images" and ostensible "interpretive communications" do not get separated, nor one gain ascendency over the other on the basis of a preconceived hierarchy of importance. (Samuels, 1985b, p. 265)

An Integration of Psychoanalytic and Jungian Ideas Related to Countertransference Imagery

Wilber (1977) synthesized a range of insights from several philosophical, religious, and psychological traditions in a manner which can be used for integrating Jungian and psychoanalytic ideas in this study and for the

discussion of the study's findings. In his book's introduction, he wrote:

> The thesis of this volume is, bluntly, that consciousness is pluridimensional, or apparently composed of many levels; that each major school of psychology, psychotherapy, and religion is addressing a different level; that these different schools are therefore not contradictory but complementary, each approach being more-or-less correct and valid when addressing its own level. (p. 11)

In Wilber's view consciousness, like electromagnetic radiation, can be diagrammed as a vertical spectrum.

In a later book, Wilber (1981) focused directly on psychotherapy, and associated different therapies with the spectrum's different levels.

> Generally speaking, you will find that a therapy at any given level will recognize and accept the potential existence of all of the levels above its own, but deny the existence of all those beneath it. (p. 13)

Psychoanalytic thought and interpretations of imagery and countertransference phenomena are related for the most part to consciousness at the "persona" and "ego" levels, while Jungian thought, which is related to these two levels, also is related to consciousness at the "total-organism" and "transpersonal levels." Wilber contended that "unity consciousness" is man's natural self, and that ". . . every level of the spectrum can be understood as a progressive

bounding, or limiting, or constricting of one's real self, of unity consciousness and no-boundary awareness" (p. 73).

Psychic processes at the persona level are related to a split between the conscious and the unconscious. Certain aspects of the personality, e.g., the self-image, are split off from consciousness, repressed, and often projected outward. Processes at the ego level unite personal unconscious and shadow elements, and are related to the psyche-soma split. Wilber's descriptions of the persona and ego levels are directly influenced by Jungian definitions of the concepts of persona, shadow, and ego. Processes at the total-organism level bridge the psyche-soma split, and are related to a split between the total organism and the physical and cultural environment. Processes at the transpersonal level unite the organism with the environment, and are related to a split between the personal and the collective unconscious. Processes at the unity consciousness level mend all psychic splits, and reveal, Wilber (1977) stated, an identity with the entire universe, the "eternal and timeless reality" (pp. 11-12). In order to heal psychological wounds, one must descend the spectrum by dissolving boundaries and by re-owning projections.

Countertransference imagery can originate at any level of the spectrum and can provide information about the therapist, the patient, and their interaction. Corbin's

(1972) mundus imaginalis and Schwartz-Salant's (1986) subtle-body realm can be related to the transpersonal level; Winnicott's (1971) area of illusion can be related to the ego level; and Racker's (1968/1976) classification of countertransference phenomena can be related to the persona and ego levels. Both Fordham's (1957) and Samuels' (1985a) classifications encompass all the levels except that of unity consciousness.

Summary of Part 2

In this second part of the chapter, the small array of existing psychoanalytic, humanistic, and Jungian clinical and research writings which are pertinent to this study have been reviewed. All of these studies were conducted during the last three decades, and some of these were unpublished doctoral dissertations. Although the writers have differed over the issues of how to approach and interpret therapist imagery, all seem to have agreed that it provides useful information about the therapeutic interaction, such as countertransference data, and that awareness of it can enrich the therapeutic process.

The psychoanalytic and Jungian studies on therapist imagery also reveal a courageous, adventurous, and imaginative spirit on the part of their writers in their

struggles to understand their inner worlds and their reactions to their patients. Of the many other therapists who most likely experience imagery during treatment sessions, many may misunderstand or simply disregard these experiences.

Few empirical studies have been conducted about therapist imagery and countertransference. Those reviewed in this part of the chapter have shown that countertransference phenomena can produce perceptible, and sometimes vivid, mental imagery, and that therapists can become aware of their imagery as well as derive countertransference data from these experiences. These studies have also revealed new paths for future research and exploration. It is this researcher's hope that the present study, by exploring the psychodynamic informational aspects of therapist imagery, can potentially advance the understandings begun by other researchers.

The concluding section of this part of the chapter reviewed the ideas of Wilber (1977, 1981), and presented a model useful for integrating aspects of the Jungian and psychoanalytic perspectives presented in the chapter and facilitating the discussion of the present study's findings.

In the following chapter, the research design and the specifics of the methodology employed to investigate this study's research questions are presented.

CHAPTER III

Research Design and Methods

In this chapter, the rationale and specific implementations of this study's design and methodology are described. The first section reviews the epistemological and methodological considerations which shaped the present study's scope, intent, and design. Following this is a section which details the research design, with portions assigned to restating the research questions, describing the study's sample of subjects, introducing and explaining the instruments used in the study, and describing the procedures employed in collecting and analyzing the data. The final section of the chapter presents the limitations of the study.

Epistemological and Methodological Considerations

The method and design of a research project are influenced by the researcher's philosophy of science and

epistemological viewpoint. For this study, Jung's epistemological perspective and the humanistic post-positivistic methodology of Polkinghorne are the primary influences.

The epistemological dilemma which Jung faced was the difficulty of reconciling his respect for empiricism with his respect for phenomenological meaning for such phenomena as religious and spiritual experience. Jung (1926/1960) attempted to reconcile these "opposites" by uniting "the realistic standpoint" and "the idealistic standpoint" in a posited "psychological standpoint." (pp. 327-328) According to Jung, the psychological standpoint brings "relative validity" to such phenomena as God, ghosts, and spirit, all of which represent "facts" of subjective experience.

Jung also carefully considered the nature of an appropriate methodology for the study of psychology, including the realm of subjective experiences. He wrote:

> The psychological investigator is always finding himself obliged to make extensive use of an indirect method of description in order to present the reality he has observed. Only in so far as elementary facts are communicated which are amenable to quantitative measurement can there be any question of direct presentation. But how much of the actual psychology of man can be experienced and observed as quantitatively measurable facts? (Jung, 1921/1976, p. 408)

Actually, Jung used both "objective" and "subjective" data sources for his research investigation; and his collected works are filled with the results of investigations structured according to various research designs, including theoretical, exploratory, and descriptive approaches. His data collection methods included extensive reviews of relevant historical literature, interviews with patients, word-association tests, and self-analyses.

According to Jung's perspective on epistemology and methodology, imagery is a product of psychic activity which cannot be directly investigated, because no investigator can directly observe another person's mentation. Subjects' fantasies or imagery experiences are not, therefore, empirical or metaphysical "facts," though a relative validity does inhere in them as facts of subjective experience. This validity is also derived from the attempt to understand imagery as a psychological truth, in approaching it as a meaningful subject for psychological inquiry. Finally, it can be stated that subjects' reports of their own fantasies and imagery experiences are the most direct sources of data available for this kind of research.

Jung's relativistic, phenomenological approach is congruent with the post-positivistic approaches described by Polkinghorne (1983), who surveyed the literature on human

science research methodology, and explored ". . . what kinds of methods can be constructed in order to provide the best possible answers to questions about human actions and creations" (p. 4).

Polkinghorne's (1983) thesis is that

> . . . in post-positivist science various systems of inquiry, each providing internal coherence and meaning to a research project, can be useful in developing knowledge. (p. 5)

> Science becomes the creative search to understand better, and it uses whatever approaches are responsive to the particular questions and subject matters addressed. Those methods are acceptable which produce results that convince the community that the new understanding is deeper, fuller, and more useful than the previous understanding. (p. 3)

Giorgi (1983), a fundamental figure in the field of phenomenological research, stated that psychology as a natural science has leaned heavily on the assumptions and premises of realism, empiricism, and positivism. He noted, however, that such assumptions and premises are not useful for studying such psychological processes as perception, expectations or anticipations, and imagination, and he therefore recommended a phenomenological approach to such psychological processes, since the assumptions and premises of positivism, realism, and empiricism ultimately block access to "the psychological."[1]

To investigate an experience such as mental imagery or imagination, the phenomenologist, rather than itemizing the facts of human experience, the "materiality" and "sensory-perceptual" givens, should observe how they appear to consciousness. Giorgi (1983) wrote:

> The problem of psychology therefore is not to account for realities but precisely "reality as experienced," which means reality in a specific mode of presence. . . . In other words, instead of "physicalizing persons" phenomenology "experientializes things." (p. 218)

Giorgi developed a number of methods for phenomenological psychology, according to Polkinghorne (1983), including processes in which the researcher ". . . begins with individual descriptions of an experience, and from these descriptions comes the more general descriptions of phenomenological structure" (p. 210).

Taylor and Bogdan (1984) linked qualitative research methods to a phenomenological perspective. They pointed out that the phenomenological researcher seeks understanding and meaning through qualitative and inductive methods such as participant observation and in-depth interviewing.[2] They defined qualitative research methodology as ". . . research that produces descriptive data: people's own written or spoken words and observable behavior" (p. 5). Taylor and Bogan also enumerated ten aspects of qualitative research methodology, the first of which is an explanation of the

hermeneutic, or interpretive, approach to the analysis of descriptive data.

> Researchers develop concepts, insights, and understandings from patterns in the data, rather than collecting data to assess preconceived models, hypotheses, or theories. In qualitative studies researchers follow a flexible research design. They begin their studies with only vaguely formulated research questions. (p. 5)

Post-positivist phenomenological and hermeneutic approaches are incorporated in the present study's research design. Indeed, the research can be understood as an investigation into the workings of therapists' minds, with the intention of discovering the possible underlying patterns, structures, and meanings in their experiences of mental imagery during the treatment process. In the following section, the specifics of this research design are described.

Research Design

An exploratory survey design was used for this study. Selltiz, Jahoda, Deutsch, and Cook (1965) explained that ". . . many exploratory studies have the purpose of formulating a problem for more precise investigation or of developing hypotheses" (p. 51). Other functions of an exploratory survey include increasing the investigator's

familiarity with the research subject, clarifying concepts, establishing priorities for future research, gathering information regarding possible research, and providing a census of problems in a given field. Similarly, Finestone and Kahn (1975) concluded that the general purpose of exploratory studies ". . . is to prepare for more systematic research in an undeveloped field" (p. 61). They enumerated, as more specific purposes, ". . . the conceptual definition of variables and ways to measure them, the search for useful hypotheses, the development of methodological approaches, and the investigation of the feasibility of research" (p. 61). Finestone and Kahn added that designs and methods such as these are necessarily informal, flexible, variable, and combinable.

Given the limited previous research on the topic of the current study, as presented in the review of the literature discussed in Chapter II, an exploratory survey design was selected for this study.

This exploratory study, using a survey approach for the collection of qualitative data, was also structured in terms of two distinctly different sampling groups. On the basis of this researcher's review of the preexisting literature, it was concluded that there might well be important differences in the experiencing of mental imagery by therapists who subscribe to a Jungian theoretical

perspective, as compared to other psychodynamic therapists. Therefore, in order to best facilitate a sampling which would investigate this possibility, it was decided that the study's data would be collected from two different sample groups. (The specific means by which these two sample groups were selected and recruited are described below, in the subsection "Participants.")

This sampling process generated a group of Jungian-oriented therapists with various professional backgrounds, and a group of clinical social workers with various psychodynamic orientations. For the remainder of this study, the former are referred to as "Jungians," and the latter, because of their various theoretical orientations, are referred to as "non-Jungians." Sampling from two distinct groups of clinicians also allowed for a comparison across professional as well as theoretical lines, and the numerous theoretical and professional orientations in the two groups provided a rich source from which to draw this study's findings.

The design of the study also was structured in terms of planning two phases of data collection; the first of these involved a survey questionnaire, and the second of these phases involved the in-depth interviewing of a smaller group of individuals who had responded to the questionnaire. (Detailed explanations of these data collection instruments

and procedures are presented below, in the subsections "Instruments" and "Procedures.") The rationale for this design was to make the results of this study meaningful and useful for as large a variety of psychodynamic clinicians as possible. It was intended that the generalizability of the results would be enhanced by the number of subjects surveyed through the questionnaire, while the findings would be more suggestive clinically if the questions were explored in intensive interviews.

Research Questions

The design of the study was organized in a manner which would facilitate the investigation of a principal research question and six subquestions. As stated above, the principal research question of this study was: What countertransference data and issues can be identified by therapists who remember and utilize spontaneous imagery which they experience during the treatment process?

The subquestions which this study explored were:

1. Do common common patterns appear in the content, kind and form of the imagery which therapists experience during the treatment process?

2. How frequently do therapists experience imagery during treatment sessions? What factors influence this frequency?
3. Do common patterns appear in the countertransference data that therapists can determine by interpreting the imagery which they experience during the treatment process?
4. What similarities and differences appear in therapists' understanding and use of their imagery as countertransference data?
5. Are the differences in understanding and use of imagery related to therapists' theoretical perspectives? Related to other factors?
6. What are therapists' attitudes and experiences toward sharing their imagery with patients?

Participants

The therapists who participated in the study by responding to the questionnaire and to the interview are referred to below as the questionnaire "respondents" and the interview "subjects" respectively, though it is actually the case that all of the therapists who were interviewed had also initially responded to the questionnaire.

Recruitment of questionnaire respondents. The sampling method used to recruit questionnaire respondents was a combination of random and accidental (i.e., volunteer), and purposive sampling. From the Los Angeles section of the roster of the Society for Clinical Social Work, fifty fellows, or every fourth fellow, were randomly drawn. Fifty more potential respondents were then purposively selected from the roster of the C. G. Jung Institute of Los Angeles; these individuals were also Los Angeles area residents. The criterion for the purposive sampling of the potential Jungian respondents was that these individuals needed to live within a twenty-five mile radius of the center of Los Angeles.

Selection of interview subjects. Purposive sampling methods were used to select, from the respondents to the questionnaire who volunteered to be interviewed, those subjects who would be interviewed. The interview subjects met all of the following criteria:

1. The subject must have had five or more years post-professional-degree experience, and a California license.
2. The subject had to have a psychodynamic orientation, although no specific theoretical perspective was required. (Psychodynamically oriented clinicians

were chosen because it seemed that they would be most likely to utilize countertransference in treatment situations.)

3. The subject had to acknowledge that he/she made use of countertransference in working with patients, although the subject could understand countertransference according to whatever definition he/she chose.
4. The subject had to have experienced and utilized imagery while working with patients, and had to be able to recall the imagery.
5. The subject had to provide direct therapeutic services to patients, either as a member of an agency or as a private practitioner.

From those subjects who volunteered to be interviewed, and met all of the relevant criteria, eight Fellows from the Society for Clinical Social Work and nine members of the Jung Institute were interviewed, creating a sampling of seventeen interview subjects. Of the eight non-Jungians, seven were female and one male, and of the nine Jungians, five were male and four female.

Instruments

Two instruments were designed for and used in the study: a Survey Questionnaire and an Interview Schedule.

Survey Questionnaire. The Questionnaire contains three principal parts. Part I asks the respondent questions regarding demographic data revelant to this study; Part II asks about the respondent's ideas regarding countertransference; and Part III asks about the respondent's experiences with mental imagery. Following these parts, the Questionnaire concludes by asking the respondent if he/she would participate as an interview subject regarding the same research interests. (Refer to the Questionnaire, in Appendix C.)

Interview Schedule. The final version of the Interview Schedule was derived from two similar earlier versions, which were pretested with two subjects, in order to evaluate the content and structure of the preliminary interview instrument. Interview data derived from these pilot versions were then used to develop a final Interview Schedule, which differed from the preliminary instruments in that its clarity, coherence, and consistency were

improved, and its questions and concepts were more pertinent to the research topic.

The Interview Schedule (see Appendix D) is divided into four parts. Part 1 consists of general questions about the subject's experiences with mental imagery. Part 2 addresses the ways in which a specific treatment relationship might affect the frequency, content, and meaning of the subject's imagery. The questions regarding this deal with the subject's passive experiencing of imagery. Part 3 investigates the subject's active use of imagery in treatment. Part 4 explores certain of the subject's recollections concerning a representative and meaningful case example during which he/she experienced imagery. A series of questions in Part 4 were calculated to elicit answers that might reinforce or contradict the subject's answers to earlier questions. Part 4 closes with an open-ended request for any other comments the subject might wish to make concerning experiences with mental imagery during the treatment process.

Procedures

In the following subsection, the procedures which were utilized to collect the study's data are described. Before these are discussed, however, the means of insuring

participants' informed consent in the study are presented.

All individuals who participated in this study signed one or both of two Informed Consent forms (as shown in Appendix B). One was signed by those who filled out the Questionnaire, and the other was signed by those who volunteered to be interviewed. To ease participants' potential apprehension about participating in the study, an outline of the research procedures was included with both forms, along with the names and telephone numbers of people who were available to answer the participants' questions.

Data Collection. The one hundred clinicians selected by the sampling method described above were sent the questionnaire, and asked to fill it out and mail it back within two weeks. Of the one hundred copies of the questionnaire which were mailed to potential respondents, thirty-two were returned; twenty of these were from Jungians, sixteen of whom completed the questionnaires, and twelve of these were from non-Jungians, ten of whom completed the questionnaires.[3]

The seventeen questionnaire respondents who both indicated a willingness to be interviewed and who also met the necessary criteria were telephoned, and mutually convenient times and places for the interviews were arranged; all except one were interviewed at their homes or

offices, and the one exception was interviewed at the C. G. Jung Institute. Each interview lasted approximately an hour and a half. Each was tape recorded, and a few rapid notes were taken by this researcher.

Data analysis. The Survey Questionnaire was used to screen potential interview subjects and to provide a basis for the understanding of the interview data. The responses to each question were tabulated, and the tabulations provided a basic description of the subject groups and established all of the respondents' uses of countertransference and imagery in treatment.[4]

The data collected from subjects' responses to the Interview Schedule were analyzed according to the hermeneutic, or interpretative, phenomenological method, as described earlier in this chapter. From the subjects' interview responses, a number of patterns, themes, issues, insights, and meanings were identified, and these are presented in the following chapter. The small size of the interview sample made quantification of this data for the most part unproductive. Nevertheless, certain group characteristics could be appropriately shown with proportions and percentages, and when such data quantification seemed warranted, it was used.

Limitations of the Study

An exploratory survey using untested original instruments has inherent limitations, and the following limitations of this study may have influenced the findings.

1. A small volunteer sample of clinicians was interviewed. Because the sampling method was not purely random, the results of the interviews cannot be generalized. However, the results of the questionnaire, which were submitted to a random and purposive sampling of two large groups of clinicians, are more generalizable than the interview data.
2. The study is limited to clinicians living and practicing in Southern California, and cannot be generalized to other geographic areas.
3. The study required the subjects to be as honest, self-disclosing, and accurate in their responses as possible in order for the findings to be accurate, and the subjects' recollections may have also been distorted due to the passage of time.

These limitations were deemed acceptable for the study, in consideration of its exploratory nature and the inherent subjectivity of the data involved.

The findings of the study are presented in the following chapter, and in the last chapter these findings are

evaluated in reference to the concepts and conclusions of previous research.

CHAPTER IV

Presentation of the Findings

This chapter presents the data obtained from the questionnaire respondents and interview subjects. These participants are derived from two sample groups, classified as Jungian and non-Jungian. The Jungian sample group was selected from members of the Los Angeles Jung Institute and the non-Jungians were selected from members of the Society for Clinical Social Work living in the Los Angeles area. Since the questions and answers relate to subjective experiences, the data are necessarily subjective. They are organized according to their relevance to this study's research questions.

Questionnaire Findings

The questionnaire contains three principal parts, as described in the previous chapter. Part I asks the respondent questions regarding demographic data relevant to

this study, Part II asks about the respondent's ideas regarding countertransference, and Part III asks about the respondent's experiences with mental imagery.

The sixteen Jungian and ten non-Jungian respondents share a number of similar demographic characteristics. For example, in the Jungian group the respondents' average age is 52 and in the non-Jungian group the respondents' average age is 53; in the Jungian group the average years of clinical experience is 19 and in the non-Jungian group the average years of clinical experience is 18. A large majority in both groups reported that they hold a Totalist definition of countertransference, that they use countertransference in their work, and that they view it as a help rather than as a hindrance. Almost all the respondents, both Jungians and non-Jungians, further indicated that they experience mental imagery during treatment sessions, and a majority in both groups use their imagery for interpretation and self-analysis.

The data for these similarities are presented Table 1.

Table 1

Attributes Shared by Questionnaire Respondents

	Jungians (n=16)	Non-Jungians (n=10)
1. Age		
Average years	52 (16)	53 (10)
Range	34-72	32-76
2. Clinical Experience		
Average years	19 (16)	18 (9)
Range	6-36	8-35
3. Definition of Countertransference (%)		
Totalist	63% (10)	80% (8)
Classical	31% (5)	20% (2)
Other	6% (1)	0% (0)
4. Utilizes Countertransference in Treatment (%)		
Yes	100% (16)	90% (9)
No	0% (0)	10% (1)
5. View of Countertransference: Help/Hindrance (%)		
Help	63% (10)	80% (8)
Hindrance	13% (2)	20% (2)
Other	31% (5)	10% (1)
6. Experiences Mental Imagery during Treatment Sessions (%)		
Yes	94% (15)	100% (10)
No	6% (1)	0% (0)
7. Utilizes Mental Imagery in Treatment (%)		
Yes	100% (14)	90% (9)
No	0% (0)	10% (1)
8. Specific Use of Mental Imagery Is Used (%)		
Interpretation	75% (12)	90% (9)
Self-analysis	81% (13)	90% (9)
Technique	44% (7)	50% (5)
Other	13% (2)	10% (1)

Note. Numbers in parentheses stipulate the number of respondents who answered the questions.

Some of the respondents did not answer certain questions, and did not explain why.

Most of the respondents' definitions of countertransference fall into one of two categories: Totalist and Classical. Totalist definitions were given by 63% (10) of the Jungians and 80% (8) of the non-Jungians. The following example is a Jungian's Totalist definition:

> Feelings, body sensations, images that arise in me in response to my patients; actually, whatever gets evoked in me, including memories, mythical images, a smell. A tension or release in my body tells me about our moment-to-moment relationship.

The following example is a non-Jungian's Totalist definition: "The . . . response of the therapist to the client's personality, characteristics, behavior, etc."

Classical definitions of countertransference were given by 31% (5) of the Jungians and 20% (2) of the non-Jungians. The following is an example of a Jungian's Classical definition:

> The therapist's response to the patient's unconscious complex or projection. It may also involve the therapist's response to his/her own complex which is activated by the patient's projection.

Two non-Jungians' Classical definitions are "A normal, expectable transference reaction to a patient that can give clues to the therapist when recognized," and "The projection

of feeling, thoughts, wishes by the therapist onto the patient, often unconsciously."

One definition of countertransference given by a Jungian respondent did not seem to fit into either the Totalist or Classical catagory. However, it did seem to fit into Epstein and Feiner's (1979) third category of definitions, as discussed above in the review of the literature. This Jungian defined countertransference as "The projection onto the patient of some role or roles that arise out of the unconscious process of the therapist." While it is more Classical than Totalist, this definition primarily implies a social-psychological, interactional, or complementary view of countertransference.

Important differences in the two sample groups were found in relation to the variables of practice orientation, gender, highest professional degree, and professional license.[1] The practice orientation of the two samples were different in each of the samples chosen. One sample described their orientation as Jungian. A majority of the non-Jungian respondents described their orientations as psychodynamic and psychoanalytic.

The practice orientation results are presented in Table 2.

Table 2

Practice Orientations of the Questionnaire Respondents

Stated Orientation	Jungians (n=16)	Non-Jungians (n=10)
"Jungian"	100% (16)	0% (0)
"Psychodynamic"	38% (6)	90% (9)
Other Psychodynamic: "Psychoanalytic," "Ego Psychology," "Object Relations"	19% (3)	80% (8)
"Behaviorist" and "Systems"	19% (3)	40% (8)
"Humanist" and "Existential"	25% (4)	10% (1)
Other	6% (1)	20% (2)

Note. Respondents were instructed to select as many practice orientations as actually described themselves.

The respondents' answers to the question about gender indicate that 69% (11) of the Jungians are male, and 31% (5) are female, whilethe non-Jungians have Masters-Level Degrees.

The last major difference between the two questionnaire

For the question about the respondent's highest professional degree, responses were grouped into two categories: Masters-Level Degrees, which includes M.A.'s and M.S.W.'s: and Advanced-Level Degrees, which includes Ph.D.'s, D.S.W.'s, and M.D.'s. Of the Jungians, 25% (4) reported that they have Masters-Level Degrees and 75% (12) have Advanced-Level Degrees. All the non-Jungians have Masters-Level Degrees.

The last major difference between the two questionnaire sample groups relates to professional licenses. 56% (9) of the Jungians hold psychology licenses, while all the non-Jungians hold clinical social work licenses. Certain respondents in both groups hold more than one license. For example, 30% (3) of the non-Jungians hold marriage and family counseling licenses in addition to a clinical social work licenses.

The limitations of the sampling created a strong association between practice orientation and gender, highest professional degree, and professional license. This association reflects inherent characteristics in the entire sample. The Jungian respondents' gender distribution and variety of professional degrees and licenses reflect the Jung Institute's admittance of applicants of both genders with various degrees and licenses. In addition, all the respondents from the Jung Institute described themselves as

having "Jungian" practice orientations, as well as other orientations by which they described themselves. Most of the respondents from the Society for Clinical Social Work, like others on the society's roster, have "psychodynamic" or "psychoanalytic" orientations, M.S.W. degrees, and L.C.S.W. licenses. Almost all of these respondents are women; like most of this country's social workers, they reflect a historic pattern in the profession.

In response to the question regarding kinds of clinical practice, 94% (15) of the Jungians and 70% (7) of the non-Jungians stated that they are in private practices. 30% (3) of the non-Jungians work in hospitals and 20% (2) work in agencies. A few of the respondents in both groups work in other settings, and a few work in more than one. The relatively high percentage of non-Jungians employed in institutions apparently reflects the nation-wide percentage of social workers employed in institutions.

Moderate differences appeared in the Jungians' and non-Jungians' responses to the question, "What kinds of images have you experienced in your clinical work?" On the whole, the Jungians reported experiencing more different kinds of imagery than the non-Jungians did. The results are presented in Table 3.

Table 3

Kinds of Imagery Experienced by Questionnaire Respondents

	Jungians (n=16)	Non-Jungians (n=10)
Visual	100% (15)	90% (9)
Auditory	66% (10)	40% (4)
Verbal	87% (13)	60% (6)
Taste	33% (5)	0% (0)
Smell	47% (7)	0% (0)
Kinesthetic	66% (10)	40% (0)
Touch	27% (4)	20% (2)
Bodily Sensations	93% (14)	70% (7)
Feelings	100% (15)	100% (10)
A Combination	60% (9)	40% (4)

According to the respondents, all but one of them have experienced visual imagery; all of the respondents reported that they have experienced feeling imagery. A large majority in both groups also stated that they have experienced bodily sensations. A minority of the Jungians reported that they have experienced taste, smell, and touch imagery; while no non-Jungians indicated that they have experienced taste or smell imagery, and only a few stated that they have experienced touch imagery. Among both the Jungians and the non-Jungians, verbal imagery was the kind of imagery reported fourth most frequently. On the average,

the Jungians indicated that they have experienced seven kinds of imagery, while the non-Jungians indicated that they have experienced five kinds.

Some of the questionnaire responses were idiosyncratic. The most unexpected and illuminating of these were the responses to the question, "Do you find that your countertransference is a help or a hindrance in your conduct of effective psychotherapy?" "Both" was the preferred answer of some respondents in both groups. A Jungian wrote: "Sorry -- not just to split hairs, but it really is both." A non-Jungian, who thought countertransference a hindrance, wrote: "If unrecognized -- or so strong or emotion-laden that it is difficult to respond in terms of the patient's rather than my own need."

Summary of the Questionnaire Data

The Jungians and non-Jungians showed a number of intergroup similarities. Most of the respondents in both groups are middle-aged, and have considerable clinical experience. All are in private practice and use either Jungian or psychodynamic theories, among other orientations, in their work. Almost all of the respondents utilize countertransference in their work, and most of them defined it in Totalist terms. Most of the respondents view it as a

help, rather than as a hindrance, in the conduct of effective therapy.

Almost all the respondents, both Jungians and non-Jungians, also experience and use imagery in their work, and they use it principally for interpretation and self-analysis. Respondents in both groups reported experiences of multimodal sensory imagery, but most of the respondents stated that they experience feeling and visual imagery more frequently than they experience other kinds. Finally, sampling limitations created major differences between Jungian and non-Jungian respondents in practice orientation, gender, professional degrees, and professional licenses.

Interview Findings

Seventeen volunteer subjects were interviewed. The small size of the interview sample made quantification of that data unreliable. However, responses were treated by proportions and percentages when warrented.

Overall, the interview subjects' demographic profiles were very similar to the demographic profiles of the questionnaire respondents.

The Results of the Research Questions

The principal research question was, "What countertransference data and issues can be identified by therapists who remember and utilize spontaneous imagery which they experience during the treatment process?" This main research question was answered by data relevant to the following sub-questions.

1. Do common patterns appear in the content, kind, and form of the imagery which therapists experience during the treatment process? The data reveal no clear patterns in the content of subjects' imagery. Indeed, in the approximately sixty-five case examples volunteered by and elicited from therapists in both interview groups, the content of the imagery varied strikingly. The examples included very few of the same visual, kinesthetic, or feeling images experienced by more than one subject.

Common patterns do, however, appear in the kinds and forms of imagery most often experienced. A majority of both the Jungian and non-Jungian interview subjects stated that visual dynamic imagery was the kind and form of imagery which they experienced most often. As an example of this kind and form of imagery, one non-Jungian reported that she

saw scenes from a movie while working with a particular patient.

Three Jungians and three non-Jungians stated that they have also experienced kinesthetic imagery. A typical Jungian response indicating experience with such imagery was the following interview subject's report:

> Often when someone is talking to me, I'll have a sense in my body where there's something going on. . . . I may, for example, feel like my face feels frozen and it's tight . . .

Three non-Jungians explained that past events in their lives often figure in their imagery experiences. One of these subjects, while talking about the visual aspects of certain of her memories, commented:

> I sometimes get images, when a person speaks of not fitting in, of where they might fit in, and it's usually in a traditional society that makes room for people with a wider range of skills. . . . I often get a flash of Greek villages, and people who are in my office just fleetingly take on the image of someone pulling a boat up out of the water because of an approaching storm.

This therapist had lived in Greece for many years.

2. <u>How frequently do therapists experience imagery during treatment sessions? What factors influence this frequency?</u> Overall, the data strongly suggest that the frequency of the subjects' imagery experiences is affected

by their theoretical orientations. Seven of the nine Jungians said that they experience imagery daily with every patient, whereas only one of the eight non-Jungians said that she experiences imagery daily. A few non-Jungians said that they rarely experience imagery. One non-Jungian subject explained that she experiences imagery

> . . . infrequently enough so that I very much notice it. I am not someone whose mind is wandering off into imagery that often. It serves me to pay attention to why, because I am not off all the time.

The times when the subjects' imagery experiences occur fell into no discernible intergroup patterns. Most of the Jungians reported that they experience imagery during all their waking activities. Most of the non-Jungians indicated that they experience imagery only during treatment sessions, if at all.

Several factors were found which can influence the frequency, triggering, timing, and character of therapist imagery. The subjects all reported emotional, physical, and environmental factors which can facilitate or impede their experiencing of imagery. Both Jungians and non-Jungians identified the following as facilitators of imagery experiences: relaxation, openness, alertness, disengagement, objectivity, and empathy on the part of the therapist; the freedom of the therapist's consciousness from intrusive

thoughts, willful control, and preoccupation with his/her own psychological concerns; physical comfort in a comfortable environment; a light and quiet atmosphere; unusual body conditions such as pregnancy; vivid metaphors and similes in the patient's speech; intersection of the patient's and therapist's psychological processes; and expressions of intense emotional material or reports of dreams on the part of the patient.

The non-Jungians stressed the importance of a patient's verbalizations and the therapist's and patient's mutually intense affective involvement as triggering factors of therapist imagery, while most of the Jungians did not emphasize these factors. Indeed, only one Jungian identified patients' suffering and turmoil as a factor that triggered therapist imagery. The non-Jungians described their own feelings as at times facilitators, and at other times impediments, of their experiences of imagery. "The imagery comes, I suspect," one non-Jungian said, "when I pick up something, an intensity plus meaning that is not being expressed verbally."

Both Jungians and non-Jungians identified the following as impediments to therapist imagery: exhaustion, anxiety, emotional upheaval, illness, preoccupations, obsessions, or an intellectualizing attitude on the part of the therapist; the intrusion of the therapist's own processes

into the therapy; the therapist's own complexes being affected; overinvolved verbal interactions with the patient; emotional distance from the patient; misunderstanding the patient; the patient's expressing him/herself in abstract rather than descriptive or concrete terms; the patient's being loud and restless; working in a counseling rather than a psychodynamic mode; an environment which feels too cold or hot; and the presence of too much noise in the environment.

The influence of the patient's specific problems and pathology seemed to impress the subjects in highly varied ways. Although patients' problems can affect the character and frequency of therapist imagery, several subjects in both groups found the effect difficult to evaluate. Indeed, five Jungians and three non-Jungians felt that patients' problems did not affect their imagery at all. Within both groups, subjects differed over whether or not developmentally regressed patients, such as those with borderline conditions, triggered extraordinarily vivid or intense imagery, or triggered an increase in the frequency of imagery experiences. Some subjects thought that such imagery is relatively lifeless and infrequent, due to the therapist's reflexive defenses against the patient's primitive unconscious material. However, others felt that the primitive content of the patient's communications made

their imagery extraordinarily vivid and frequent. One Jungian who voiced the latter view mentioned, for example, how a patient's use of the primitive defense of splitting affects her: ". . . I'll get a sense of feeling discarded in that moment and then I'll realize that that's what's happening to the patient."

Several subjects in both groups said that other factors affect their imagery more strongly than the degree and intensity of patients' problems. One such factor is the time that a patient has been in treatment and the frequency of the patient's sessions. Five of the nine Jungians and half the non-Jungians stated that frequent sessions over a long period, which usually deepen a therapeutic relationship, seemed to instigate frequent, vivid, and meaningful imagery.

Another factor, deemed by some subjects to be much more important than the preceding factors, is the character of the therapeutic relationship and the therapist's feelings toward the patient. Eight of the nine Jungians and five of the eight non-Jungians postulated that the character and emotional qualities of the relationship affect their imagery, and all the Jungians as well as five of the eight non-Jungians reported that their feelings toward their patients affect their experiencing of imagery. Among both the Jungians and the non-Jungians, the consensus was that a

therapeutic bond which is close in its rapport and empathy inspires imagery that is mutual, broad, deep, and relevant. One non-Jungian reported that ". . . the more deeply I know someone, the more easily imagery comes." A Jungian exemplified the Jungian group's attitude when he articulated the following understanding:

> The stronger the bond, the easier it is to share the imagery and to feel confident that the imagery is meaningful and has value. In other words, is correct. Where that is not a strong bond, it can be difficult to get any confirmation . . . meaningfulness out of it.

Another non-Jungian, in a dissenting response, stated that as a therapeutic relationship develops over time, her imagery tends to occur less frequently, perhaps because more material can be expressed verbally and consciously.

A majority of the subjects in both groups volunteered responses indicating that while positive feelings toward a patient facilitate imagery, negative feelings toward a patient do not necessarily impede it. The data suggest that it is the intensity of the therapist's feelings, rather than the positive or negative character of the feelings, which is the most important factor in facilitating imagery. For example, one Jungian, who tends to easily experience kinesthetic imagery, commented in the following manner upon her relationship with a boring patient:

> When I start feeling these heavy rocks on my body, I tell her and she responds to that. . . . I feel weighted down by their stuff when I'm not in a real empathetic bond. I just experience kind of what's not working in the relationship.

Although it is the intensity of the therapist's feelings that facilitates his/her imagery, the therapist's fondness or dislike of a patient seems to primarily influence the character of his/her imagery. For example, while discussing the imagery which occurs when he likes a patient, another Jungian stated:

> I just think my immediate reaction is that I would have less angry, hostile imagery come up, probably. That's my gut reaction. . . . I would get less of the shadowy imagery.

A non-Jungian, in a similar and typical comment about the impact of negative feelings on imagery, indicated that when she is angry or dislikes patients, "I'll have more angry images, but that's because they [the patients] are probably angry. When I like them better, or when they are less angry, I have more sad or happy images."

Another Jungian gave a lengthy example of experiencing an image which he found to be very debilitating. During sessions with an elderly female patient whom he disliked, he repeatedly saw her as "this terrible old crone." He realized, he said, that his imagery was reprehensible. He

was in a dilemma about continuing to be this woman's therapist.

> I felt it [the imagery] was blocking the emotional rapport between myself and the client. It was difficult for me to be honest. I couldn't confront her with my experience of this wicked old crone . . .

Eventually this therapist and his elderly patient had a falling out over one of his ground rules, and she returned to her previous therapist.

Finally, one non-Jungian expressed a minority opinion among non-Jungians by reporting that, in her experience, empathetic bonding with a patient inspires less frequent imagery than an estranged relationship does. She stated that whenever her feelings for a patient become problematic, she feels more "in touch" with her imagery. Indeed, she took this opinion slightly further; for her, feelings and imagery are independent of each other.

In general, the Jungians' and non-Jungians' responses regarding the impact of the therapist's feelings and the therapeutic relationship upon the therapist's imagery reveal considerable consensus between the two groups, and indicate an advanced level of clinical sophistication in subjects from both groups.

The interview reponses also revealed some marked differences among subjects. For example, questions related

to which factors actually trigger therapist imagery elicited antithetical responses from the subjects in both sample groups. These differences included subjects' belief that a strong and close therapeutic bond with the patient facilitates therapist imagery, while other subjects voiced the belief that a weak therapeutic bond and feelings of estrangement from the therapist facilitate therapist imagery. Similarly, some subjects stated that therapist imagery is facilitated by the therapist's feeling calm, or self-confident, or physically comfortable, or focused, or by engaging in therapeutic encounters with new patients. In direct contradiction to these, other subjects insisted that therapist imagery is facilitated by the therapist's feeling agitated or inadequate, or physically uncomfortable, or distracted, or by interacting with patients with whom the therapist is already thoroughly acquainted.

Although data were collected on two other factors which subjects felt might have affected therapist imagery, the patient's progress and the therapist's sense of adequacy, no clear consensus emerged from either sample group on what effects, if any, these two factors produced.

There was some agreement among the subjects regarding certain other factors that promote imagery. The subjects mentioned that imagery is provoked by primitive and bizarre material from the patient; therapeutic interaction on deep

symbolic levels; avoidance of an issue, especially an unresolved sensitive issue, on the part of the patient; a blockage in the treatment's progress; and inadequate verbalizations on the part of the patient.

3. Do common patterns appear in the countertransference data that therapists can determine by interpreting the imagery which they experience during the treatment process?[2] The data indicate that therapist imagery can be described in terms of certain recurrent patterns. On the whole, the major patterns which the data reveal are the same in both sample groups, and can be related to individual and interactional psychodynamics in both the therapist and the patient. These patterns are described below, along with the case examples which illustrate them.[3]

The patterns of therapist imagery in this first set of examples relate to therapists' psychodynamics. The responses in this set of examples reveal that therapist imagery can provide information concerning a therapist's bonding and empathy with a particular patient. For example, one Jungian subject provided two case examples which reflect this dynamic. In one example, he had "identity fantasies" related to an aggressive businessman patient. In the other case example, he had a series of romantic, protective, parental, and identifying fantasies related to a bisexual female patient. In both cases, his identification

facilitated the formation of a positive treatment bond with the patient and strengthened his empathic response.

Therapist imagery can also indicate the general character of a therapist's relationship with a patient. For example, a Jungian subject's erotic and voyeuristic visual imagery suggested, among other things, how he was distancing himself from his female patient, objectifying her rather than seeing her as a person.

Therapist imagery can reveal a therapist's empathetic identifications with a patient's attitudes. For example, one non-Jungian experienced a combination of feeling and visual imagery which developed from a patient's reports of experiences related to her father walking to church. This therapist's imagery expressed her empathy and identification with her patient's sadness, fear, and sense of abandonment.

In addition, therapist imagery can reveal a therapist's identifications with a patient's significant internalized objects. In one Jungian's second case example, he described how his feeling imagery of anger seemed to be in part related to his complementary identification with a significant object in his patient's life, her husband.

Subject's responses show that therapist imagery can reveal areas of treatment which have been avoided or ignored. The previously referred to Jungian's case example also illustrates this dynamic. His anger at his patient,

who had made considerable progress and was talking about terminating, made him aware that she had not allowed herself to express her own anger during her treatment, and was not yet ready to end it.

Therapist imagery can provide information about a therapist's projections onto a particular patient. Another Jungian subject, in his case example, described how he had projected student-daughter images onto a female patient. In different case example, a female Jungian subject described how she had projected an archetypal hero image onto a male patient.

Other data obtained in this study indicate that therapist imagery can clarify a therapist's unconscious attitudes toward a particular patient, as a non-Jungian's case example illustrates. She reported an attitude clarification which resulted from an imagery experience evoked by a movie; she realized that she had been empathizing with her patient's experience of humiliation.

Another finding is that therapist imagery can identify a therapist's clinical problems with a particular patient. A Jungian, in her second case example, reported having experienced during a session vivid images which were affectively charged and which were related to her relationship with her own daughter. Her imagery, and her sharing of it with her patient, identified for this

therapist her difficulty in handling this patient's negative mother transference.

In addition, therapist imagery can provide data regarding a therapist's present and past, conscious and unconscious, psychological dynamics. A non-Jungian's case example, which included her experiencing memory imagery from her concentration camp years, illustrates this. Although this therapist's reaction to her experience was strong, she did not let it impede her work with the patient. However, the session left her wondering whether she should confront her traumatic memories again.

Finally, the data demonstrate that therapist imagery can reflect a therapist's present and past, neurotic and non-neurotic, unresolved conflicts. A Jungian's first case example, in which memories of her separation from her family during her teen years were triggered by a patient's discussion of a pending move, illustrates this aspect of therapist imagery.

In addition to relating to, and providing information about, the therapist's own psychodynamics, therapist imagery can also provide a range of information concerning a particular patient's psychodynamics and interactions with a particular therapist. The patterns in the following set of examples relate to such dynamics and interactions. The data reveal, for example, that therapist imagery can reflect

aspects of a patient's problems. A non-Jungian, in her case example, experienced a series of visual images of an adult patient's mother and of the patient as a child. These images illuminated for this therapist the patient's borderline problems, which seemed to stem from the patient's symbiotic relationship with her dominating and seriously disturbed mother.

Therapist imagery can reveal a patient's current unconscious psychic situation. A Jungian subject's image, in his first case example, of an adult female patient as a teenager having her first sexual experience symbolized for him his patient's psychological virginity.

In addition, therapist imagery can reveal the nature of a patient's current feelings toward the therapist. In a previously mentioned non-Jungian's case example, she reported that she had experienced a series of visual images related to a young borderline woman. Her image of a girl having tantrums at being separated from her mother revealed to this therapist the patient's anger at her temporary loss of merger with her.

Therapist imagery can also illuminate a patient's transference projections, whether these are positive, negative, or neutral. As represented by a Jungian's imagery in his case example, the whole therapeutic interaction between himself and a young woman had been colored by a

professor-student and father-daughter dynamic. The patient projected onto this subject an archetypal and personal unconscious image of a professor-father, and he willingly incarnated this image for her. For a while, this transference projection had created in him a sense of grandiosity.

Other case example data reveal that therapist imagery can indicate a patient's progress in healing. Another Jungian subject provided an example of this in her dream image of herself in a communal bath, with her borderline patient standing dressed beside it. For this therapist, the image indicated the patient's progress in separating from her, and foreshadowed a termination of treatment in the near future.[4]

Finally, the data demonstrate how therapist imagery can provide guidance to the therapist regarding his/her future work with a particular patient. In one non-Jungian's case example, her memory of a scene from Tolstoy's Anna Karenina illuminated for her the problems of a male patient, warned her of a possible lost opportunity for the patient, and gave her ideas for interventions which could help him make progress in resolving a major problem and complex.

As indicated by the diversity of case examples described above, therapist imagery can provide considerable countertransference data regarding the therapist's and

the patient's psychodynamics, and the therapeutic interaction.

4. What similarities and differences appear in therapists' understanding and use of their imagery as countertransference data? This research question is considered in conjunction with the data regarding the following research question: 5. Are the differences in understanding and use of imagery related to therapists' theoretical perspectives? Related to other factors? Pronounced differences and similarities were found in how the Jungians and non-Jungians understand, interpret, and use their imagery. Theoretical orientation emerged as the variable which was the most related to differing treatment and utilization of the imagery. Other possible factors, such as age and gender, seemed to be unrelated to the differences or similarities in the data.

The theoretical orientations of the two groups were obviously different. All the Jungians are Jungian oriented, of course, and 90% (8) of the non-Jungians are psychoanalytically oriented. Subjects in both groups, however, stated that they also use other practice orientations, the primary ones being psychoanalytic and object relations theory.

A major theoretical difference between the Jungians and non-Jungians was revealed in the fact that the Jungians

considered their imagery to originate in both the personal and the collective unconscious, whereas the non-Jungians considered theirs to originate, and indeed could only originate, in the personal unconscious. This difference affected not only the kind of imagery reported by subjects from each group, but also their data-derived interpretations regarding their countertransference, and their uses of their interpretations in their clinical work.

Both groups obtained similar patterns of information from their imagery, and expressed similar views concerning which of their personal unconscious dynamics could affect their imagery. Subjects in both groups thought that their imagery contained information about the dynamics in themselves, their patients, and their therapeutic interactions. Furthermore, subjects in both groups felt that their imagery provided data about the patient's psyche, problems, feelings, drives, values, attitudes, transference, development, progress, and prognosis.

Theoretical differences between the two groups, however, affected the interpretations regarding these data which were emphasized by the subjects. For example, although subjects in both groups stated that their imagery gave them information about a particular patient's development, the non-Jungians stressed this factor considerably more than did the Jungians. In addition, the effect of this

difference was made even greater by the fact that the Jungians and non-Jungians had different conceptions of patient development.

One Jungian stated that her imagery conveys roughly four kinds of information about the patient's development. Information of the first or second kind, related to emotions and body sensations, she described as occurring to her through a "felt sense." Information of the third kind provides her with an indication of the character of the patient's defenses, e.g., projective identification. Information of the fourth kind relates to material from the patient's collective unconscious. She offered an example of what she meant by the latter variety of information. She recalled having watched a patient, who was struggling with several issues, moving in her office. Suddenly she felt the room fill up, and saw a large mother figure appear. She sensed that the patient was giving birth. She stated:

> There's been a Great Mother figure there and she [the patient] hasn't told me about it. I'm just watching while she [the Great Mother figure] is lying there quietly; but it's something at that moment that feels larger than either of us.

In contrast, a non-Jungian offered an example of a "bizzare" imagery experience which had occurred during a session with a long-term borderline patient. A recurring visual image of a bowel movement was annoying her, and she

had wondered why she kept experiencing it with this patient. Then, an answer had come to her: "Because he's at the anal level." She added: "And then I thought, it was because he was shitting on me, and that seemed to clarify the situation. He was really dumping." This realization had helped her to perceive the patient's developmental level, as well as to realize why she had been feeling such resistance to her recurring image.

One non-Jungian subject's theoretical perspective seemed to dramatically differentiate the imagery she experiences from that experienced by other subjects. Although this subject adheres to both Freudian and Jungian theories, she emphasizes in her clinical work the cross-cultural aspects of her imagery and their roots in the theories of Karen Horney. She feels that her Neo-Freudian cultural orientation adds breadth and depth to her understanding of patients. When working, for example, with an elderly Mexican man, she might momentarily imagine a scene of Mexican village life, and then reflect upon the priviliged status which her patient might enjoy there because of his age. In addition, this idiosyncratic subject stated that she gains useful insights from studying ancient literature, particularly Indo-European ballads and folk tales, and Greek and Roman classical literature.

The theoretical differences between the two sample groups might also account for the fact that the Jungians work much more explicitly and actively with their own and their patients' imagery than the non-Jungians are inclined to do. For example, several Jungians discussed how they encourage their patients to become aware of their own imagery, through creative writing (e.g., poetry), clay modeling, sandplay, drawing, or painting; through structured movement, yoga, stress-reduction, or relaxation exercises; and through guided imagery, active imagination, or dreamwork. These subjects encourage their patients to actively express unconscious contents with these techniques during therapy sessions as well as at other times.

Many of the Jungians reported that they use their imagery to help them understand not only their patients and various aspects of the therapeutic process, but also their own psyches and psychic development. They seek from their own imagery what they ask their patients to seek from theirs.

All the Jungians indicated that they have, at one time or another, talked about their imagery experiences with their patients. One had painted his imagery in the presence of patients, and another had told patients imagery-related jokes.

Finally, one Jungian stated that she uses her imagery not only as a basis for interpretation, but also as a device to disrupt the patient's mental set. She reported: "I'll take an image and develop it rather vividly and then reapply it back to the person's situation." She finds this technique especially helpful for patients who are overly intellectual; in her view, images "go directly to your emotional understanding."

According to their own reports, the non-Jungians are much more restrictive in their use of their imagery than are the Jungians. The non-Jungians indicated that they use theirs principally for insight and for guidance in interpreting patients' material which seems to contain metaphoric or symbolic content. None of the non-Jungian subjects spontaneously reported that they use their imagery experiences for personal development; however, one stated that she uses art or play techniques with patients, and another stated that she uses a specific imagery technique.

Six of the non-Jungians reported that, on the infrequent occasions when they do use their imagery, they use it to help them understand the treatment process or to verbally communicate empathetic understanding to their patients. Four non-Jungians discussed having approached their imagery with concepts and techniques learned from psychoanalytic dream interpretation.

One non-Jungian indicated that she uses her imagery to help patients distance themselves from their situations, i.e., develop self-observing egos. According to this subject's report, she might say to a patient:

> Imagine that you are me and you are looking at a recent college graduate but you see her as a child who is needy, hurt, depressed and angry. How would you feel about that person?

A few non-Jungians discussed having utilized their imagery to help them understand their countertransference reactions. One of these subjects explained that she understands spontaneously occurring imagery as a signal that something in herself requiring self-analysis is being stirred. She thereby views her imagery as an intermediate step which precedes, and which can be utilized to prevent, acting-out.

Finally, one non-Jungian stated that she uses an idiosyncratic imagery technique. She askes her patient to visualize images related to a psychological issue which is problematic for the particular patient. She reported that she once asked a male patient with dependency issues to picture the person he most depended on, and he imagined a mother stroking a baby. With this technique, this therapist uses her patients' imagery rather than her own, and

apparently deflects from herself some of her patients' intense transference feelings.

6. What are therapists' attitudes and experiences toward sharing their imagery with patients? All nine of the Jungians and five of the eight non-Jungians reported that they share their imagery with their patients. Seven of the Jungians stated that they share theirs routinely, but none of the non-Jungians stated that they do so.

Members of both groups indicated that certain criteria have to be met before they share their imagery with their patients. Non-Jungians seem to follow these criteria more closely than the Jungians do.

One criterion relates to patient problems and diagnoses. The patient must have a sufficiently strong ego and no severe boundary problems, according to the majority of the subjects. The patient should be able to psychologically tolerate the therapist's imagery; one of the Jungian subjects articulated this by stating that the patient should be able to move beyond his/her "egocentric sphere" and be able to incorporate the therapist's material into his/her work. One of the non-Jungian subjects expressed this criterion by stating that the patient has to be ready to listen to an aspect of the therapist's psychological experience, rather than being overwhelmed by a need to experience only his/her own material.

Another criterion, according to most of the subjects, is that the therapist should know the patient well and should understand the character of his/her therapeutic relationship with the particular patient. A corollary of this, according to the subjects, is that the therapist and the patient must trust each other before imagery sharing can be of assistance to the patient.

The patient's transference also needs to be evaluated, the subjects explained. Certain kinds of transference can make imagery sharing problematic, and the therapist can avoid particular problems if the character of the transference is first carefully evaluated. For example, a patient who feels unimaginative and inadequate vis-a-vis an idealized therapist might feel even more diminished if the therapist were to share rich and vivid imagery. If the therapist knows about such potential difficulties in a patient's transference beforehand, he/she can refrain from sharing imagery which might otherwise upset the therapeutic rapport.

The timing of the imagery sharing and its purpose are other critical factors which were mentioned by the subjects. One Jungian subject stated, for example, that he tries to intuit when a patient's mental state is such that sharing might serve a therapeutic purpose. Another subject indicated that he chooses to share his imagery at a critical

moment if he thinks that it might benefit the particular patient, and if he determines that a miscalculation on his part would not damage the particular patient's psyche.

A final criterion expressed by the subjects is that the character of the imagery must be appropriate; this criterion pertains to a number of related implied questions, e.g., should dark, angry, horrifying, disgusting, or destructive imagery ever be shared with patients? A few subjects spontaneously expressed concerns about sharing such imagery; however, this may have been due to the fact that no interview question directly addressed this issue. A Jungian subject volunteered that she does not share any imagery which a particular patient might perceive as too negative or critical, and a non-Jungian subject stated that she sometimes shares disturbing imagery, provided that she is certain that the patient has sufficient ego strength to tolerate it.

The Jungian subjects disagreed with each other about the extent to which they advocated sharing negative imagery with patients. As mentioned earlier, one subject admitted her willingness to share uncomfortable or painful sensations with patients, as well as such feelings as boredom or sleepiness, whereas another subject stated that he did not choose to share with an elderly woman a grotesque image which he experienced during a session with her.

All the subjects who share their imagery with their patients reported that they share it verbally. Some of the Jungian subjects reported that, in addition to straightforward verbal expression, they share theirs by means of poems or stories; four Jungian subjects stated that they share theirs by means of painting, drawing, sandplay, and clay modeling. As mentioned earlier, only one non-Jungian indicated experience in using artistic media as a treatment device.

The Jungians' and non-Jungians' evaluations of the consequences of sharing imagery, when deemed appropriate, were on the whole positive. The benefits which they reported include a wide range of effects, such as the patient's relief and relaxation in sensing the therapist's empathy, the patient's sensing the therapist as a "good mother," the revelation of aspects of the patient's unconscious material, and the liberation of the patient from emotional and cognitive ruts which had previously confined him/her. Other subjects reported beneficial effects such as the activation of psychological growth and development in the patient, the triggering of needed action on the part of the patient, the deepening of the patient's self-understanding and awareness of new concepts, and the enhancement of the patient's awareness of his/her cultural roots.

The subjects responses indicated that sharing imagery can produce the following results: the therapist can connect in one operation to the patient's conscious, unconscious, and four ego functions: thinking, feeling, intuition, and sensation. The sharing can potentially strengthen the therapeutic relationship, and the consequent feelings of trust, intimacy, and mutuality on the part of both the therapist and the patient. The sharing can facilitate and vitalize the treatment process. It can allay feelings of isolation in both parties. It can activate the therapist's own processes, and increase the therapist's objectivity. The sharing of therapist imagery can also potentially facilitate a positive transference, and illuminate psychological concepts. By sharing imagery, the therapist can express ideas which are difficult to verbalize, role-model respect for the unconscious and for the imagery itself, and confer a sense of meaning, affirmation, and self-confidence. "It's the meat of the therapeutic process," stated one Jungian. "It helps!" reported a non-Jungian subject.

Subjects in both sample groups mentioned the following potential problems in sharing therapist imagery: doing so can mislead or misguide the therapeutic process, since imagery can be interpreted in numerous ways. It can discourage the patient from developing his/her own imagery

experiences, causing him/her to feel impinged upon by the therapist. The patient may perceive the sharing as an intrusion or violation, and therefore resist it. The patient may also be unable to understand or relate to the imagery, or may feel overwhelmed by too much understanding. If he/she is not receptive to imagery experiences, the patient might feel intimidated or unworthy. Other subjects expressed concerns about the potentially damaging effects to the process aspects of the therapy: sharing can narcissistically injure the patient, making him/her feel devalued; inappropriate imagery can silence the patient, thus stopping the therapeutic process and/or aggravating a wound or complex; if the patient is psychologically fragile and unprepared, the sharing can fragment the patient and make him/her less stable. A number of subjects mentioned ways in which sharing therapist imagery can complicate the patient's transference, which can happen when, for example, the patient's role projection onto the therapist differs from the role assumed by the therapist in sharing the imagery. In addition, the sharing can distort the patient's image of the therapist, e.g., make the therapist seem awesome or magical, thereby complicating the transference. Other patients, according to study subjects, might react to such interactions as these by idealizing and intensifying

their transference reactions. Finally, therapists can react to such idealization with ego inflation.

Although most of the subjects in both sample groups agreed in their willingness to selectively share their imagery with patients, and in their assessments of the advantages and disadvantages of imagery sharing, the Jungians were more enthusiastic than the non-Jungians about their sharing experiences. According to their comments, most of the non-Jungians view imagery sharing as problematic, and those who do share their imagery do so on the average less often than the Jungians. Nevertheless, five of the nine Jungians recounted disruptive imagery-sharing experiences, and only two of the eight non-Jungians reported such disruptions. It is probable, though, that the Jungians reported more disruptive sharing experiences simply because they share their imagery with patients more often than the non-Jungian subjects.

Related Issues from the Interview Data

Certain other issues emerged from the data as clearly interesting to the study subjects. These were neither directly asked about nor anticipated by this researcher; they were not included in the research and interview questions.

The first of these issues concerns the psychological ownership of a therapist's patient-related imagery. Does it belong to the therapist, the patient, or to their therapeutic relationship per se? A therapist's position on this fundamental issue partly determines what information he/she culls from patient-related imagery, and whether and how he/she uses this information in treating patients.

Although most of the subjects believed that therapist imagery belongs to both the therapist and the patient, some stated that it belongs to the therapist, while others stated that it is induced from the patient. The former subjects are mostly non-Jungians, a few of whom are insistent in their views on this issue, while the latter are mostly Jungians.

The subjects from both sample groups who brought up this issue all seemed troubled, to about the same degree, over how to resolve it. However, their ideas about factors which might impede a conceptual determination of the ownership of therapist imagery were more readily articulated than were their ideas about any criteria which could actually be used to resolve such questions.

Impediments to conceptually determining ownership, which were mentioned by these subjects, include the presence of imagery with confusing content; imagery which is meaningful only to the therapist; imagery which occurs when the patient

seems detached or withdrawn, or which occurs in a therapeutic relationship that lacks closeness, mutuality, and rapport; imagery which occurs when the therapist lacks self-confidence, or when the therapist is preoccupied, tired, sick, or struggling with psychological problems. The Jungians indicated that they did not let these impediments curtail their use and sharing of their imagery, while the non-Jungian subjects seemed to view these impediments as obstacles, and as reasons to restrict their use and sharing of their imagery with their patients.

Subjects in both groups mentioned a number of experiences which contribute to a clearer determination of the ownership of therapist imagery, such as self-knowledge, self-acceptance, personal therapy, supervision, and consultation. One Jungian subject reported that she gathers information relevant to this issue by tuning in to her body, during treatment sessions, in order to get a "felt sense" of her imagery, which she believes assists her in determining the degree to which the imagery belongs to her. Another Jungian subject stated that he asks his patient for direct feedback after having shared his imagery, or looks to the patient for indirect confirmation of the imagery's relevance and meaning.

It is accurate to summarize this issue by stating that, for a number of subjects in both groups, the ownership issue

is a pervasive clinical management concern, which requires constant attention and a great deal of self-analytic and interactional investigation.

Another issue which emerged from the data concerns the manner in which therapist imagery is interpreted. As mentioned earlier, the Jungians and non-Jungians gain information from, and interpret, their imagery in clearly different ways. All of the Jungians use Jungian theory as their interpretative guide, whereas most of the non-Jungians use psychoanalytic theory. Therefore, even if a therapist strictly interprets his/her imagery in relation to his/her own particular countertransference, rather than utilizing other explanations, the number of available modes of interpretation add to the complexities involved in the therapist's deciding how to interpret and use the imagery, and in determining whether and when to share it.

However, a considerable diversity in modes of interpretation also appears among the subjects within the Jungian group and within the non-Jungian group. For example, a non-Jungian said that her concentration-camp imagery related entirely to her own psychodynamics, arising from memories of her actual years in a concentration camp. She did not indicate how this imagery might be related to early developmental deficits or conflicts in herself, nor did she consider whether it might be patient-induced. Both

of these interpretative possibilities, developmental and projective-identificatory, are additional explanatory hypotheses available to a therapist with a psychoanalytic orientation.

Similarly, a Jungian subject discussed his vision of a patient living alone in her apartment as if the vision had arisen from patient-induced unconscious shadow material, although other explanatory hypotheses could be considered. A London School Jungian might have interpreted this image as a possible indicator of developmental issues in the subject related to parent-child separation, an Archetypal School Jungian might have considered the image to be a symbol of the isolation of the subject's anima, and a Classical School Jungian might have amplified the image with related myths or fairy tales.

Another issue that emerged from the data concerns the occurrence of confluent imagery experiences, i.e., the same imagery occurring in the minds of two people simultaneously. A few subjects in both groups mentioned therapist-patient confluent imagery experiences, but the Jungians mentioned more of them. During their accounts, the Jungians seemed to be struggling harder than the non-Jungians to conceptually understand this phenomenon.

During the interviews, at least four subjects, three Jungians and one non-Jungian, reported confluent imagery

experiences. One Jungian reported an intense experience of visual and kinesthetic imagery, which a patient had also experienced, related to the patient's brain, and another Jungian reported father-professor and daughter-student imagery which a patient had also experienced.

A third Jungian spontaneously discussed two experiences of confluent imagery. In the first, he and a patient had both imagined the patient travelling to Europe. In the second, the female patient mentioned earlier had been talking about her affection for her husband while imagining herself living alone in an apartment. This subject, in simultaneously experiencing the patient's unconscious fantasy, had sensed her true feelings for her husband.

One non-Jungian spoke at length about a patient who had experienced, simultaneously with herself, kinesthetic imagery which suggested a primitive nursing attachment process. The experience had troubled this subject, and instigated some later self-analytic work. When she then reconceptualized her patient's problems, she decided that they reflected the presence of an earlier developmental stage and defense mechanisms which were more primitive than she had initially thought.

Such shared, possibly telepathic, imagery experiences provide, like other kinds, data on the patient, the therapist, and the interaction between them. According

to one Jungian subject, such experiences can create, for both the therapist and the patient, a special intensity in their connection and a sense of mutual understanding. They can make the therapist feel validated in his/her enhanced empathy with the patient.

Summary of the Interview Findings

Data collected from Jungian and non-Jungian interview subjects were presented in this section, organized in reference to this study's research questions. A few unanticipated but potentially important issues which emerged from the data were also presented. The findings provide the following tentative answers to the research questions.

1. Do common patterns appear in the content, kind and form of the imagery which therapists experience during the treatment process? There were no common patterns in the content of the imagery experienced by the subjects, but there were common patterns in the kinds, or sensory modalities through which images are perceived, and in the static or dynamic forms in which images are experienced.

2. How frequently do therapists experience imagery during treatment sessions? What factors influence this frequency? The variable which was most strongly associated with the frequency of the subjects' imagery experiences was

theoretical perspective. The Jungians reported more frequent imagery experiences than did the non-Jungian subjects.

Subjects in both groups identified certain factors in common which influenced the frequency of their imagery experiences, the most important of which were the character of the treatment relationship and the therapist's feelings toward the particular patient.

3. Do common patterns appear in the countertransference data that therapists can determine by interpreting the imagery which they experience during the treatment process? Common informational patterns emerged in the countertransference data obtained from the subjects' imagery. The principal patterns of information could be categorized as relating to the psychodynamics of the subjects and their patients, and to the interactions between them.

4. & 5. What similarities and differences appear in therapists' understanding and use of their imagery as countertransference data? Are the differences in understanding related to therapists' theoretical perspectives? Related to other factors? There were areas of agreement and areas of disagreement in the subjects' understandings of imagery and in their use of it in the treatment setting. Again, the principal differentiating

variable in regard to these issues was theoretical perspective.

The Jungians tended to interpret their imagery in relation to both the personal and collective unconscious, whereas the non-Jungians tended to interpret theirs in relation to the personal unconscious alone. One non-Jungian stood out from both groups in that she reported that she interprets her imagery in relation to a culturalist perspective.

The Jungians reported that they use their imagery more frequently than the non-Jungians claimed they do, both for treatment purposes and for self-analysis and self-development.

6. What are therapists' attitudes and experiences toward sharing their imagery with patients? Most of the subjects stated that they share their imagery with patients, when appropriate. However, more Jungians than non-Jungians indicated that they share theirs, and the Jungians also indicated that they share theirs more frequently with patients than the non-Jungians do. Subjects in both groups reported that they use similar criteria in deciding when it is appropriate to share their imagery, and that they hold similar views on imagery sharing's advantages and disadvantages. Nevertheless, the data demonstrate that the

Jungians tend to value more highly than the non-Jungians do the advantages of therapists sharing their imagery with patients.

A few unanticipated but important issues also arose from the data. The first of these was a concern for determining ownership of the imagery, a concern which was shared by subjects in both groups. Does a therapist's imagery relate primarily to the therapist's own psychodynamics or primarily to the patient's own psychodynamics? The Jungians stated that they did not regard this issue as an obstacle to their using and sharing their imagery in treatment, whereas the non-Jungians stated that they did regard this issue as a valid cause for restricting the sharing of their imagery experiences with patients.

Another issue which could be deduced from the data pertained to the criteria therapists use in interpreting their own imagery. How does a therapist decide what the content of his/her imagery means? Once again, theoretical perspective seemed to be the principal differentiating variable.

A final issue emphasized by the subjects was the occurrence of confluent-imagery experiences. Subjects in both sample groups mentioned examples of such experiences, but the Jungians seemed to be more interested than the

non-Jungians in understanding their significance and their possible telepathic aspects.

CHAPTER V

Discussion of the Findings

Several approaches will be used to explore the implications of the results of the research. The first section examines the major findings with reference to writings discussed in the literature review. The second section discusses the central implications of these findings for clinical social work. The third section considers the study's implications for future research. This chapter closes with a summary and final conclusions of the study.

Major Findings of the Study

In the following section, the major findings of the study are considered and discussed in reference to the empirical and theoretical literature. The findings are related to the two sample groups: Jungian and non-Jungian. The Jungian group consists of members of the

Los Angeles Jung Institute. The non-Jungian group consists of members of the Society for Clinical Social Work. The majority of this latter group hold a psychoanalytic orientation and none of them are Jungian oriented.

Content, Kinds, and Forms of Therapist Imagery

The first main finding is that there were no common patterns in the content of the imagery experiences reported by the interview subjects, but that there were common patterns in the kinds and forms of imagery which both the questionnaire respondents and the interview subjects reported. In other words, the data clearly indicate that the kinds of therapist imagery experiences which were reported were perceived through the same sensory modalities, and the therapists also reported that the form in which imagery was experienced was mainly dynamic rather than static. All the subjects stated that they experience imagery in their clinical work, and a large majority also indicated that they experience dynamic, visual, feeling and kinesthetic imagery.

On the whole, the data show that the questionnaire respondents experience feeling imagery most frequently, with visual imagery the next most frequent modality of perceived imagery. However, all of the interview subjects, both

Jungians and non-Jungians, experience visual dynamic imagery most often. One could speculate that this inconsistency in the questionnaire and interview results may have been caused in part by differences in the phrasing of certain of the two instruments' questions. Another explanation is the possibility of an actual difference in the questionnaire and interview sample populations. The interview subjects may have experienced especially vivid visual imagery and therefore may have been more accessible to discussing and exploring this imagery than the questionnaire respondents were.

The finding that visual imagery is experienced most frequently by the interview subjects is consistent with previous literature. Horowitz (1978/1983) focused on visual imagery because he found that it was the most frequently experienced kind of imagery. Similarly, the clinical study of Warren (1961) utilized patients' visual images during treatment sessions; Ross and Kapp (1962) studied therapist visual imagery as a portrait of dynamic and genetic unconscious elements in the therapists' countertransference; and Kern (1978), having been influenced by Ross and Kapp's paper, explored therapist "backdrop" visual countertransference imagery. None of these three clinical studies stated why visual imagery was the sensory modality which they focused upon, but it is reasonable to

speculate that visual imagery was chosen because it is the the most frequent and accessible kind of imagery experienced by psychoanalytically oriented analysts and their patients. This speculation is further supported by the research of McCann (1982), in which visual imagery was emphasized and found to be the most frequent kind of imagery perceived by her subjects. Finally, it should be noted that recent research on the physiological aspects of image formation theorize an inherent connection between imagery and visual-sensory modes of perception.[1]

In addition, some of the Jungian and non-Jungian interview subjects indicated that they frequently experience body or kinesthetic imagery. Interestingly, more non-Jungians than Jungians understood their body imagery experiences in terms of a conceptual framework by which they could interpret sensory-memory images. This result is consistent with Althofer's (1983) study of therapists' multimodal sensory imagery. Furthermore, it is logical that this difference of emphasis on sensory-memory images may have stemmed from individual subjects' theoretical orientations, in that a large majority of the non-Jungians subscribe to psychoanalytic theories which emphasize unconscious repressed infantile experiences and memories as bases for symptom formation. Freud (1908/1953/1975) even wrote about the effects of infantile memories upon the adult

imagination. Considering these aspects of Freudian theory, it may be that Freudian ideas on the impact of unconscious memories influenced the imagery which this study's non-Jungian subjects experience, as well as the probability that the non-Jungian subjects would more readily relate their own body or kinesthetic imagery to a conceptual framework which prominently emphasizes the effects of sensory-memory images.

Aspects of Therapist Imagery Influenced by Theoretical Orientation

Theoretical perspective very clearly seems to be the main variable related to many aspects of therapist imagery. The factors related to this variable include the degree to which therapists value and are aware of their imagery, the frequency with which they experience imagery, the understanding and information which they derive from their imagery, how they utilize their imagery in clinical work, and their attitudes regarding the psychological ownership and sharing of their imagery. As the following discussions make clear, this finding dominates the collected data.

Before reviewing these aspects of therapist imagery, however, it should be noted that the research design of the present study precludes a definite conclusion regarding the specific influence of theoretical orientation upon the

aspects of therapist imagery listed above. This is the case not only because the research design of this study is qualitative and exploratory in nature, but also because the data and data analyses employed do not lend themselves to the support of causal hypotheses. The present study was instead designed to find meanings and patterns in its responses, and this goal has been reached. Future research, which could more directly isolate and investigate the phenomena described in specific hypotheses, would be required in order to state with confidence that one particular factor had been found to clearly influence another particular factor. In the case of the factors under consideration, this means that future research would need to control for other potentially intervening variables, such as therapist personality typology and dynamics, therapist life stage, professional development and background, previous experience with imagery, and the gender, cultural, and genetic background of the therapist, prior to concluding that theoretical orientation is the main factor influencing many aspects of therapist imagery. Since no such research currently exists, and since the obtained data clearly indicate an association between these factors, this researcher chose to proceed with the interpretation of obtained results in the most logical manner available. The supposition was made that theoretical orientation may well,

in fact, centrally influence several aspects of therapist imagery, and pertinent findings of other researchers, or trends in the literature, were then considered in support of or in rebuttal to this claim.

Awareness and valuing of imagery. The Jungian subjects tended to be more aware of their imagery and to invest it with more heuristic value than did the non-Jungians. For example, 13% more Jungians than non-Jungians responded to the questionnaire. This result is surprising, since this researcher is a clinical social worker and all the non-Jungians in the sample were also clinical social workers; one would have thought that more social workers than Jungian therapists would have responded out of a sense of professional loyalty. One could speculate that the reason for this result is best explained by differences in professional training, which is directly influenced by the theoretical perspectives of the educators and the students. The training of American social workers, which is the training background of the fifty non-Jungian questionnaire recipients of the present study, historically has not emphasized social workers' awareness of their imagery, its relationship to countertransference, or their use of it in treating patients. In contrast, Jungian therapists are explicitly trained to investigate their own imagery

experiences and those of their patients. Jungian theory gives more fundamental value to imagery as an important manifestation of psychic functioning than does Freudian theory, in which imagery is evaluated more ambivalently. Therefore, one plausible reason for more Jungians than non-Jungians having responded to this study's questionnaire is that more of the Jungian recipients, being professionally alert to and curious about their own imagery, were interested in therapist imagery as a research topic.

In fact, a few of the Jungian interview subjects seemed to be primarily participating in this study in order to use it as a vehicle for promulgating their beliefs in imagery. Two subjects stated that they were participating in order to help the study find an audience. A few of the non-Jungian interview subjects stated that they had previously paid little attention to their imagery experiences, and were participating in this study to learn about therapist imagery as a phenomenon. Two subjects revealed, after their interviews had been completed, that having answered the questionnaire and interview questions had motivated them to pay more attention to their own imagery.

It is, however, possible that there were other reasons for the difference in response between Jungians and non-Jungians. As stated previously, factors such as personality typology and previous experience with imagery might

influence a therapist's choice of practice orientation, and consequently be fundamentally more important as variables than theoretical orientation. However, given the subjects' comments, and the lack of data supporting other explanations, the critical factor seems to have been the impact of subjects' theoretical orientation on their awareness and valuing of their imagery experiences.

Frequency of therapist imagery. According to their reports, the Jungians experience imagery more frequently than the non-Jungians do. This basic difference may well correspond, once again, to theoretical differences between the two groups.

Freud has extensively influenced psychoanalytically-oriented social workers' attitudes toward imagery and fantasy. In his observations of his contemporaries, he noticed that adults tend to conceal and to be ashamed of their imagery. (Freud, 1908/1953/1975, p. 146) He related imagery to primary process thinking, and to id impulses seeking gratification. (Freud, 1911/1953/1975, p. 222) Some of his early followers' psychoanalytic ideas emphasized the defensive and wish-fulfilling aspects of fantasy, although later followers modified his ideas, stressing fantasy's useful and adaptive aspects. (Shapiro, 1970)

Jungians, on the other hand, not only view imagery as a

revealer, rather than as a potential concealer, of unconscious processes, they also view the experiencing of imagery as virtually synonymous with the psyche. (Jung, 1921/1976, p. 52) These theoretical differences between psychoanalytic and Jungian theory seem to be reflected in this study's findings, in that the Jungian subjects seem to experience imagery more frequently, and to acknowledge doing so more comfortably, to themselves and others such as this researcher, than do the non-Jungian subjects.

One can speculate that there are other possible explanations for why the Jungians were aware of experiencing imagery more frequently than the non-Jungians. For example, perhaps those individuals who have more imagery experiences due to certain personality characteristics tend to gravitate to Jung's ideas. However, the volume of psychoanalytic theoretical and clinical literature on the topics of imagery and fantasy seems to contradict this speculation. Psychoanalytic theoreticians, such as Freud (1908/1953/1975, 1911/1953/1975, 1915/1953/1975), Beres (1960), Arlow (1969), and Horowitz (1978, 1983) have extensively explored and discussed the concept and dynamics of mental imagery and seem to demonstrate considerable awareness of this phenomenon. Psychoanalysts, such as Kanzer (1958), Warren (1961), Ross and Kapp (1962), and Kern (1978) have detailed their clincial experiences with imagery in either the

patient or the therapist. Instead, perhaps it is the ambivalent or negative connotations regarding imagery in the psychoanalytic literature, and the opposite valuation in Jungian theory, that are influencing the experiences of the non-Jungian and Jungian subjects, respectively.

Utilization of Therapist Imagery in Treatment. The questionnaire respondents and interview subjects, Jungians and non-Jungians alike, were almost unanimous in stating that they use their imagery in treating patients. In both groups, most of the questionnaire respondents use their imagery for interpretation and self-analysis, but more non-Jungian than Jungian respondents indicated that they use theirs as part of a specific treatment technique. Among the interview subjects, the Jungians use their imagery more often and in more diverse ways than the non-Jungians do. Perhaps this disparity between the questionnaire and interview findings results from the fact that the Jungians consider their attention to their own imagery to be such an integral part of their therapeutic work that they tend to view their use of their imagery in treating patients as reflexive, rather than as part of a specific treatment technique. As in other instances, the basis for these differences probably lies in the effects of theoretical orientation, although the small size of this study's sample

and other elements in the research design permit no more than speculation on this point. Logical support for this possibility exists in that psychoanalysis, "the talking cure," traditionally stresses verbal interventions during therapy, while Jungian therapy often includes artistic and other non-verbal interventions as well. In cases in which a psychoanalyst might refer a patient to an adjunctive therapist for such therapeutic interventions as dance, art, or poetry therapy, a Jungian analyst would probably incorporate these techniques into his/her own work with the patient.

Understanding, interpretation and information obtained from therapist imagery. There seemed to be clear differences between the Jungian and non-Jungian subjects in how they understood their imagery. This understanding influenced how they interpreted their imagery and the types of information they obtained from it. The main difference related to the differing conceptual and theoretical frameworks employed by the psychoanalytically oriented therapists and the Jungian oriented therapists. The data reflected the divergences in psychoanalytic and Jungian theoretical and clinical conceptions of the two main variables in this study, countertransference and imagery, as described in the review of literature. An example of a

major difference between these two theoretical frameworks is in their conceptualization of the unconscious. In Jungian theory the unconscious contains two layers, the personal and the collective, while in psychoanalytic theory the unconscious contains only the personal layer.

In a related difference between the Jungians and non-Jungians, only the Jungian subjects attempted to name the source of their imagery experiences. For example, one Jungian stated that her imagery had originated in "the objective autonomous psyche." This difference is consistent with the literature reviewed above. Of the psychoanalytic writers, only Winnicott (1971), thoroughly considered and wrote about this issue. He posited, as the source of imagery, a psychic "area of illusion" or "transitional space." On the other hand, several Jungian writers discussed the sources of psychic imagery. Goodheart (1980) postulated a "secured-symbolizing field;" Corbin (1972) and Samuels (1984, 1985a), following Jung himself, described a source of imagery in the mundus imaginalis. Schwartz-Salant (1986) understood the roots of imagery as lying in the "liminal state," or the "subtle-body" realm. All of these writers considered subjective experiences to arise in an imaginal and real, but not concrete, area of overlap between the conscious and unconscious layers of the psyche. Jung's (1916/1957/1960) "transcendent function" can be seen

as a psychic process which takes place in that area, and which partially defines it. The imagery which results from this process is both accessible to ego-consciousness and is also expressive of unconscious attitudes, feelings, and reactions.

Ownership and sharing of therapist imagery. There were major differences in how the Jungians and non-Jungians related to the issues of psychological ownership of therapist imagery and the sharing of their imagery with their patients. These two clinical management issues are discussed at length later in this chapter. For the purposes of this preliminary discussion, it should be noted that the interview subjects seemed to be using their theoretical perspectives to guide them in relating to and resolving these issues. In brief, the psychoanalytically oriented non-Jungians were much more concerned about therapist-patient boundary issues and the treatment frame, or structure, than were the Jungians. Consequently, the non-Jungians were more cautious in sharing their imagery with their patients, and they tended to not use their own imagery directly in treatment. In addition, they tended to view their imagery as related more to their own dynamics than to those of their patients. The ways in which these differences reflect conceptual differences which are evident

in the literature are discussed later in this chapter.

Again, one could speculate upon other possible explanations for the differences between the Jungian and non-Jungian subjects with regard to their opinions about differentiating the psychological ownership of therapist imagery and about the sharing of their imagery with patients. For example, such variables as stage of treatment, frequency of sessions, patient diagnosis and ego strengths, rather than therapist theoretical perspective, might be found to influence therapist's opinions regarding the ownership and sharing of imagery. However, no specific data in this study emerged in support of such alternative explanations, and the literature does not suggest that these other variables are important influences upon therapist imagery. Further research would, therefore, be required in order to more rigorously investigate the influence of these other variables, or to determine with certainty that theoretical orientation critically influences therapists' attitudes about the ownership and sharing of imagery.

There are, however, factors other than theoretical perspective which have, the findings suggest, an effect on therapist imagery.

Aspects of Therapist Imagery Influenced by the Therapist's Relationship with the Patient

A number of aspects of therapist imagery are apparently influenced by other factors which specifically pertain to the particular therapist's readiness and capacity for relating to his/her patient, the bond existing between the therapist and a particular patient, and the therapist's countertransference feelings in reaction to the particular patient.

Therapist's physical and emotional state. A number of the participants from both the Jungian and the non-Jungian groups agreed that imagery occurs most easily when the therapist is calm, rested, healthy, focused, and not preoccupied or distracted. This finding is consistent with the advice of a number of clinicians and theorists. For example, Freud (1912/1963) urged the therapist to maintain an "evenly hovering attention," and Racker (1968/1976), in developing the implications of Freud's ideas, advised the therapist to allow the patient's material to "penetrate him." Similarly, Reik (1948/1983) advised the therapist to relax, as in free association, and to listen with the "third ear." Among the Jungians, Fordham (1957) described the therapist as a "receiving set" for the patient's unconscious

projections, and Schwartz-Salant (1986) postulated that the lowering of one's consciousness, as in active imagination, facilitates the experiencing of imagery. It would seem, therefore, that the therapist needs to be relaxed, on the one hand, in order to let imagery enter his/her consciousness, and also needs to be alert, on the other hand, in order to become conscious of imagery.

Therapist's bond with the patient. Regardless of theoretical perspective, most of the interview subjects indicated that a strong, close, and intense therapeutic bond facilitates imagery formation and awareness, and facilitates imagery regarded as being relevant and meaningful. There is very little literature on this subject, so this finding contributes importantly to the clinical knowledge base in this area. The one research study that is related to this finding, Adler's (1980) study of the interpersonal components of therapist imagery, is consistent with the finding. In her study, she stressed that imagery formation is the result of the therapist's active connection with the patient, and that it is the cause of greater therapist-patient intimacy.

Paradoxically, other evidence in the data contradicts this finding. A minority of the subjects in both groups reported that their imagery experiences were more frequent

when the treatment bond was weak or distant. While there is also very little literature on this subject, Jung (1935/1968) mentioned that he had experienced imagery which suggested that there was a loss a rapport between himself and a patient. However, it is not clear whether or not Jung believed that a loss of rapport per se had facilitated imagery formation. Future investigations regarding this aspect of therapist imagery apparently should seek to determine if therapist imagery is facilitated whenever the bond with the patient is very strong, as well as when it is very weak, and whether or not the latter case represents an attempt by the therapist to regain rapport.

Therapist countertransference feelings. A majority of the subjects in both groups seemed to agree that therapist positive countertransference feelings rather than negative countertransference feelings facilitate imagery formation, awareness, and frequency. This finding represents a potentially significant contribution to the literature, since no other researchers have made observations upon this interaction.

Differences of degree rather than substance emerged from the data in connection with this finding in terms of the effects of differences in the subjects' theoretical perspectives. The first difference was that the

non-Jungians demonstrated a stronger emphasis, in their discussions, on the affective components of their imagery experiences; they focused upon countertransference feelings and their own relationships to imagery experiences more than did the Jungians. In addition, the non-Jungians more strongly emphasized potential countertransference problems and imagery-related problems than did the Jungians. On the whole, as mentioned above, the Jungians showed more awareness of their imagery's significance, but the non-Jungians showed more awareness of their imagery's affective components and meanings.

Although no writings cited in the review of literature address these differences, intergroup theoretical and conceptual differences clearly seemed to be the principal cause. The non-Jungians, as social workers, were probably trained to provide psychodynamic psychoanalytic therapy, which enjoins a therapist to carefully observe treatment parameters and therapist-patient boundary issues, and to respond to the patient's and his/her own affective experiences. The non-Jungians were also most likely not trained to observe their own mental imagery. The Jungians, on the other hand, were much more likely trained to observe their imagery, and were apparently trained to be less conservative and concerned about therapist-patient boundary issues.

Countertransference Information Obtained from Therapists' Imagery

A final major finding of this study is the wide, varied, and richly meaningful scope of countertransference information which can be made available by considering therapists' imagery experiences. The collected data contain a great deal of information about countertransference which can be deduced from therapists' experiences with imagery in the therapeutic relationship. Although the interview subjects were not asked direct questions about their working conceptualizations of countertransference and their uses of it in their clinical practices, their answers to the interview questions contained, in the aggregate, patterns of countertransference information concerning the therapist, the patient, and their interactions. In the discussion which follows, these informational patterns are described in reference to the findings of earlier researchers and theorists.

Countertransference information concerning the therapist. The first important pattern pertains to information which therapist imagery can provide about a therapist's identifications and empathy with, and projections onto, a particular patient, as well as the

significant objects in that patient's life. An example of this is one non-Jungian's feeling imagery of sadness, fear, and abandonment, and her coincident visual imagery of a little girl watching her minister father, which symbolized the non-Jungian's empathetic identification with her patient. Another form of empathetic imagery is demonstrated in a Jungian subject's feeling imagery of anger which symbolized his identification with a significant object in his patient's life, the patient's husband.

The examples described above, and others cited in Appendix F, present therapist imagery which is indicative of empathetic relating, and thus, in keeping with the framework of a number of researchers, a component of countertransference. For example, Reik (1948/1983) used empathy as a major descriptive concept concerning the therapist's involvement with the patient. He discussed how the patient's unconscious activates the therapist's unconscious whenever an empathetic transformation of the ego occurs. Similarly, Beres and Arlow (1974) wrote about empathy in terms of projection; the patient projects his/her personality onto the therapist, and aspects of trial identification, merging, and separation occur during this process. McCann (1982) described how empathy, projective identification, and countertransference were interwoven in the data obtained by her research. Bady (1984) echoed

McCann (1982) by viewing empathy as a vital part of countertransference. Finally, in a study similar in its findings and interpretation to those of the present study, Powell (1985) discussed how a therapist's awareness of subjective experience, such as imagery, facilitates empathy, can facilitate reconstructive interpretations, and can also diminish therapist acting-out.

Three theorists, Racker (1968/1976), Fordham (1957), and Samuels (1984, 1985a), included in their closely interrelated countertransference models the working components of identification, projection, and empathy. These three theorists stipulated in their basic categories of countertransference reactions whether a given countertransference reaction was understood in their respective views as being neurotic or healthy. These theorists postulated that within healthy countertransference, a reaction can be an empathetic identification with a patient's attitudes, feelings, and responses, or can be a complementary identification with the experiences or feelings of significant objects in the patient's inner world. In the latter form, the therapist can identify with, or can project his/her own material onto, the patient's significant objects.

Knowing these configurations of potential countertransference reaction can assist a therapist in

understanding his/her patient's dynamics and his/her own mental states and role in a particular therapeutic relationship. Such an understanding can therefore assist the therapist in avoiding potential pitfalls and in searching for interventions which are not based upon impulsive acting-out or upon harmful identifications. Thus, the interpretation of specific countertransference configurations from therapist imagery can heighten the therapist's alertness to changes in the therapeutic interaction so that he/she can support the development of "the transcendent function" (Jung, 1916/1957/1960), or, in psychoanalytic terms, act as a "transitional object" (Winnicott, 1975) or as a "transformational object" (Bollas, 1983).

Besides identifying areas of empathy and related processes of projection and identification, therapist imagery can also provide important countertransference information concerning the therapist's clinical problems with patients as a function of the therapist's psychodynamics. For example, in a Jungian's second case (in Appendix F), her imagery demonstrated that she had experienced a neurotic reaction to a female patient, and this reaction subsequently interfered with the treatment and contributed to its failure. This example from the data is consistent with the findings of a number of clinical

studies. For example, Ross and Kapp (1962) found that therapist imagery can portray unconscious countertransference dynamics, such as therapist resistance, competitiveness, and defensiveness. Kern (1978) noted that therapist "backdrop" images can reflect unconscious attempts in the therapist to "obscure, misunderstand and deflect;" the imagery reflects conflictual early object relations from the therapist's past. Similarly, Grinberg (1979), in discussing projective counteridentification, described how a therapist can act as a passive object for patient projections and can, due to his/her own pathology, introject these projections and then allow them to influence his/her behavior. Finally, Jacobs (1983) examined therapist imagery and demonstrated how it can reflect the therapist's emotional reactions to objects in the patient's world; the therapist's dormant conflicts, which comprise another potentially important component of countertransference, were shown to be in evidence in the therapist's imagery.

Countertransference information concerning the patient. If one considers therapist imagery as a phenomenon induced by the patient, rather than as only a product of the therapist's psychodynamics, more patterns of countertransference information emerge, providing a range of information about the particular patient.

Induced therapist imagery can reflect the patient's conscious and unconscious situation including his/her problems, conflicts, and dynamics. A therapist's imagery can be described as continuously changing, varying from detailed representations to vague ephemeral impressions. At any moment during this flux, clues which potentially illuminate one or more of the patient's problems may appear.

The wide divergence of types of patients' issues, any of which may be revealed by countertransference information contained in therapist imagery experiences, can be illustrated by reference to a highly comprehensive typology of problems, such as that of Wilber. According to Wilber (1979), psychological problems or boundary splits, as he referred to them, can occur at any level of consciousness. The term "boundary split" refers to any limiting or splitting off of an aspect of an individual's real self. Wilber's levels of consciousness include: the "persona" level, the "ego" level, the "total-organism" level, the "transpersonal" level and the "unity consciousness" level; he proposed that different therapeutic techniques are effective for problems occurring at each of the different levels. This study's case examples (described in Appendices (E & F), if categorized in terms of Wilber's (1977) typology, would illustrate an extremely wide variety of

patient's issues and could be related to all of Wilber's levels of consciousness except the last.

In one Jungian subject's case example, his imagery revealed the true, unconscious, "shadow" attitude of his patient. She had been speaking from her "persona" while talking about her love for her husband. In fact, she had unconsciously wanted to leave him, and this therapist's fantasy of the patient living alone in an apartment had reflected the patient's unconscious "shadow" material. Other psychological issues such as this can be found on Wilber's persona level.

Most of the imagery in both the Jungians' and non-Jungians' case examples reflects "ego" level functioning. Such imagery reveals countertransference information about a patient's ego functions, identity formation, object relations, adaptations, affects, drives, and psychosexual development. A non-Jungian's image, in her case example, of a child who felt terrified and angry at being abandoned by a maternal figure typifies imagery which occurs at this level. This therapist's imagery thereby revealed to her essential information regarding the primitive developmental stage at which her patient had been functioning when she was struggling with her therapist's temporary absence.

On Wilber's "total-organism" level, consciousness is reactive to biological, environmental, and cultural

conditions, any of which can be reflected by therapist imagery. A non-Jungian's imagery, of an Irish family in its indigenous cultural context, typifies imagery from this level.

According to Wilber, psychological issues arising from the collective unconscious are expressed at the "transpersonal" level. Therapist imagery from this level tends to be especially deep, powerful, vivid, and numinous. One Jungian subject's fantasies of himself as a hero, rescuer, rapist, and child, as well as the co-seeker, with his female patient, of a "Great Mother" figure, reflected deep archetypal processes which had been activated in both the patient and himself. This therapist's imagery provided important countertransference information about many of his patient's problems, in addition to information about the nature of his identification with her.

The "unity consciousness" level, Wilber's last, is reached in real life, according to him, by very few people. On this level, the real self is authentically present, united with all other phenomena; no more splits in the self occur at this level, nor is the self split off from the universe. None of the obtained imagery from the interview subjects' case examples illustrate this level, because in all of them a boundary split had occurred at one level or another.

Therapist imagery can also reveal information about the effects of therapy on various processes and components in the patient's psyche, such as transference projections or denied, ignored, or avoided psychological issues; and can also provide countertransference information about the patient's progress, regeneration, and his/her specific needs for future therapeutic work. The imagery in a non-Jungian's case example, which involved a scene from Tolstoy's Anna Karenina, illustrates this in that it indicated to this therapist necessary areas of future work for her and her patient.

The richly meaningful and varied countertransference information concerning the therapist's psychodynamics, the patient's psychodynamics, and the interaction between them demonstrate the fundamental value which an awareness and study of therapist imagery can provide to the clinician. By paying attention to his/her imagery, the therapist can gain considerable knowledge regarding his/her countertransference. The findings of this study, therefore, clearly provide a substantial answer to Sax's (1981) question: "Can one learn to heighten one's awareness of countertransference experiences and if so, how?"

Clinical Management Issue: Ownership of Therapist Imagery

Although unanticipated by this researcher, clinical management issues related to therapist imagery were spontaneously raised and emphasized by the study's interview subjects. In view of the degree of emphasis placed upon a few of these issues by the subjects, it was decided to report upon and discuss them in some detail.

The first of these issues related to discerning to whom the imagery psychologically belongs, or who "owns" the imagery; and the second issue related to the therapist's decision to share or not share his/her imagery with the patient. As is discussed below, these issues also impinge upon each other in the clinical practices of this study's subjects.

In answering the interview questions, several subjects in both sample groups raised the ownership issue on their own initiative. They all seemed equally concerned about it, but it appeared from their discussions that the Jungians do not allow this concern to impede their utilization and sharing of their imagery as much as the non-Jungians do. Therefore, in terms of everyday clinical practice, it can be stated that a number of this study's subjects refrain from sharing their imagery with their patients specifically because of the difficulties involved in determining whether

such imagery psychologically belongs to the therapist or to the patient.

Subjects in both groups seemed to agree in their identification of factors which make determining the ownership of therapist imagery difficult. These factors include imagery which the therapist perceives indistinctly, diminished rapport in the relationship, emotional distancing on the part of the patient, and preoccupation or fatigue on the part of the therapist. The subjects also agreed in identifying therapy, analysis, self-analysis, supervision, and consultation as important resources which can assist the therapist in determining the ownership of therapist imagery.

Subjects in both groups agreed that it is difficult to identify methods of discerning the ownership of imagery during therapy sessions and that it is similarly difficult to identify criteria for such discernments. A Jungian subject speculated that a therapist might gather important clues by eliciting direct and indirect feedback from the patient on the relevance and value of an image the therapist had shared with the patient. Another subject speculated that the therapist might benefit by attuning him/herself to a bodily "felt-sense" of ownership regarding the therapist's imagery. A few subjects in both groups, however, avoid the issue of imagery ownership altogether by discussing with

patients only imagery which the patients verbalize during therapy sessions.

While no theoretical or clinical writings discussed in the review of literature thoroughly address the issue of the ownership of therapist imagery, several studies regarding countertransference reactions in general considered aspects of the issue. For example, both Hoffman (1977) and Gordon (1968/1974) set forth the conceptual factors involved in the issue of ownership of therapist imagery in terms of the following formulation: In the therapist's reactions, what belongs to the therapist's own unconscious dynamics, and what amounts to an induced response to the patient's dynamics? In the following discussion, aspects of the present study's findings, as well as those in other studies, which pertain to each of these reactions are presented. First, however, findings which pertain to the possibility that therapist imagery belongs to both the therapist and the patient are considered.

Therapist imagery as belonging to both the therapist and the patient. According to their comments, most of the interview subjects understood their imagery as being related to a certain extent to both the therapist and the patient. This view of the issue parallels early writings of Freud (1910/1963) and of Jung (1929/1954), as well as a recent

study of Simon (1984), in terms of these theorists' emphasis upon reciprocity in the therapeutic relationship.

In addition to these theorists, a few psychoanalytic and Jungian theorists focused on the treatment relationship and proposed comprehensive conceptualizations of countertransference, according to which the therapist's experience of countertransference feelings could be described as belonging to both the therapist and the patient. Racker (1968/1976), for example, distinguished "transferred" and "identification" components in countertransference; in the former, the therapist's reactions were understood as relating primarily to his/her own dynamics; in the latter, the therapist's reactions were understood as relating primarily to the patient's dynamics. Similarly, Fordham (1957) included in his classification of countertransference reactions the categories of "illusory" countertransference, which pertains to the dynamics of the therapist, and "syntonic" countertransference, which pertains to the dynamics of the patient. As can be seen from these examples of comprehensive conceptualizations of countertransference, there are logical precedents in the literature for understanding therapist imagery as belonging to both the therapist and the patient.

Therapist imagery as belonging to the patient. Some of the Jungian subjects assumed that their imagery related principally to the patient's conscious and unconscious dynamics. This perspective is consistent with that of a number of psychoanalytic and Jungian theorists.

For example, both Schamass (1981) and Stewart (1985) investigated patient-induced behavioral responses in the therapist, and concluded that the therapist can at times feel impelled to reenact early dyadic relationships from the patient's inner world. Such induced responses as these are particularly triggered by patients who have severe characterological problems and interpersonal boundary issues. Both Reik (1948/1983) and Arlow and Beres (1974) discussed therapist empathy as a potential revealer of information about the patient. Grotstein (1981), in a similar vein, described the patient's defense mechanism of projective identification and its potentially profound effect on therapist imagery: the patient unconsciously "translocates" infantile mother-infant concerns and feelings into the therapist, who then can become a "container" for these feelings. Finally, Grinberg (1979) identified a pathological therapist response which could be activated by the patient's unconscious, and termed this process "projective counteridentification." In this process, as well as in other interactions described above, psychodynamic

issues of the patient can have profound influence upon the therapist's subjective experience, such as the therapist's imagery.

Those Jungian writers who understood therapist imagery as being primarily related to the patient's dynamics include Dieckmann (1974, 1976) and his group of researchers, who stated that therapist imagery can be influenced by the patient's dynamics. Moore (1975) also wrote about ways therapist imagery can be related to patient dynamics; in the case examples she presented, therapist imagery was seen as reflecting early oral and merging needs of the patient. Powell (1985) described how therapist imagery can symbolize the therapist's function as a container for the patient's projections and for the patient's early struggles with the maternal object. Similarly, Samuels' (1985a) research focused on therapist countertransference reactions as induced unconscious communications of the patient.

Finally, although Schwartz-Salant (1982, 1984, 1986) viewed therapist imagery as a source of information about the treatment relationship, his primary concern pertained to patient-induced imagery experienced by the therapist.

Therapist imagery as belonging to the therapist. A majority of the non-Jungian subjects assumed that their imagery belonged principally to themselves. This

perspective is consistent with such psychoanalytic writings as that of Kern (1978), who stressed that some of the "backdrop" therapist images which he studied were found to be related to early conflicts of the therapists who had reported them. Ross and Kapp (1962) emphasized that although therapist imagery belongs to both the patient and the therapist, many unconscious therapist reactions require investigation. Jacobs (1983) described the internalized conflicts, affects, impulses, fantasies, and defenses which had been instigated in the therapist in response to his/her own mental representations of significant objects from the patient's inner world. Another researcher, Bady (1984), demonstrated that the imagery which she had experienced and which at first seemed to be empathetic, had actually resulted from her attempt to defensively distance herself from the patient.

Although most of the Jungian writers cited in the review of the literature discussed therapist countertransference reactions as induced patient material, Jung himself (1935/1968) indicated that therapist imagery could occur as a product of compensation mechanisms, and could reveal problems in the therapist's attitude toward the patient.

As the subjects' perspectives and those of the researchers and theorists cited in the literature review

indicate, the issue of the ownership of therapist imagery is very complex, in that it is related to the sources of countertransference, a phenomenon which is similarly complex.

Clinical Management Issue: Sharing of Therapist Imagery

Data regarding the second clinical management issue, which pertains to therapists' decisions about sharing their imagery with patients, is presented in the previous chapter, in the answer to the research question: "What are therapists' attitudes toward sharing their imagery with patients?"

While most of the subjects in both groups indicated that they share their imagery with patients, a larger majority of the Jungians share theirs, and on the whole they share their imagery experiences more frequently than the non-Jungians. These preferences parallel the opinions of earlier researchers and theorists.

Although no writer has addressed imagery sharing as a major subject, the Jungian and psychoanalytic writers who discussed it demonstrated approximately the same degree of concern about the issue. Schwartz-Salant (1982, 1984, 1986), a Jungian, is a slight exception in that he

has occasionally chosen to share very frankly his imagery with patients.

Among the psychoanalytic writers who have addressed this issue, Racker (1968/1976) cautioned therapists against directly verbalizing their countertransference reactions to patients. Horowitz (1978) urged caution in sharing imagery, particularly if the imagery indicates blocking by the patient, or is incongruent with the patient's images or psychic states. He advised the therapist to be alert to the clarity of the material, the patient's predisposition to resist, and the transference and countertransference difficulties in the particular therapeutic relationship. On the other hand, Robbins (1980), Hammer (1978), and Victor (1978) advocated the benefits of selectively sharing imagery by using either verbal metaphors or nonverbal artistic devices. Simon (1984), while admitting that he did not share his imagery with his patient, envisioned possible benefits in selective future sharing of his imagery experiences.

Among the Jungian writers who have addressed this issue, Schwartz-Salant (1986) advocated selectively sharing imagery, while O'Connell (1986) advocated an alternative technique: silent amplification in the symbolic interactional field. She added, however, that in other

interactional fields selective sharing might prove beneficial.

As previously reported, a number of the interview subjects require, prior to sharing imagery, an evaluation of the character of the therapeutic bond, the state of the therapeutic process, the character of the imagery itself, and the particular patient's problems, diagnosis, and transference; none of the subjects share their imagery with every patient. This finding augments the preexisting literature, since most earlier researchers have not stipulated imagery-sharing prerequisites. Schwartz-Salant (1986), however, recommended as prerequisites mental consolidation in the patient and an analysis by the therapist of the patient's transference, splitting, and projective identification.

Many controversies and unanswered questions concerning imagery sharing persist, such as: Should imagery be shared with a highly disturbed borderline patient? Should imagery be shared even if the therapeutic relationship is distant or strained? Should imagery be shared even if the imagery is negative or threatening? These questions require further research, along with research into the broader issues related to imagery ownership, imagery interpretation, and the sharing of other countertransference reactions.

Clinical Social Work Implications of the Study

The main finding, that extensive information about the therapeutic relationship can be obtained from the study of therapist imagery, generates its principal clinical social work implication, which is that clinical social workers can obtain considerable professional benefits by paying more attention to their own mental imagery.

This study's data reveal that the Jungian interview subjects, in comparison with their non-Jungian colleagues, pay more attention to their imagery experiences, value them more, and utilize them more frequently. It seems that the non-Jungians feel, like many other social workers, Freud's original ambivalence toward countertransference reactions, including their own imagery. This adds credence to Hoffman's (1977) contention that most psychoanalytically oriented clinicians are reluctant to study or disclose their own mental imagery.

Another of this study's implications is that, due to the many benefits which can result from therapists' self-observation and analysis of their own imagery, a concerted effort should be made to train clinical social workers to be prepared to undertake this kind of self-observation. Educators, supervisors, and consultants should therefore be trained to help these therapists understand their own

imagery, and to use it in treating patients.

Another implication of this study is that, considering how Jungian theory can enrich clinicians' understanding and appreciation of therapist imagery, it would be useful for more social workers to be exposed to this theory.

Implications for Further Research

Implicit in this exploratory study are many questions and topics which could serve as bases for future research projects. For example, an investigation could be conducted into which factors, other than theoretical perspective, most strongly influence therapists' awareness of their imagery, the frequency with which they experience imagery, and the countertransference information they obtain from their imagery. Factors which could be examined include the gender, race, cultural background, age, professional experience, personality dynamics, and professional training of the therapist. A determination of the conditions and/or factors which might cause a particular therapist to pay attention to his/her imagery, or, conversely, the conditions and/or factors which might block a particular therapist's awareness of imagery experiences, could prove to be useful research. The ways in which the patient's problems, diagnosis, and progress might affect the therapist's

imagery could be a useful topic. Intensive research into the clinical management issues of the ownership and sharing of therapist imagery might prove interesting and helpful. So could an investigation of the effects of various elements in the treatment relationship upon therapist imagery, e.g., emotional closeness or distance, strong or weak affects in the patient and therapist, appointment frequency, and treatment longevity. One possible future project is a follow-up study of this study's interview subjects, in order to determine if and how their participation in this study might have altered their imagery experiences.

Finally, a special area of possible future research is therapist-patient confluent imagery experiences. Four interview subjects, three Jungians and one non-Jungian, reported imagery experiences which occurred simultaneously with patients' experiences of identical imagery. Such experiences of confluent imagery were briefly mentioned by earlier researchers, e.g., Blomeyer (1974), Dieckmann (1974, 1976), and Simon (1984). It would be useful to explore this phenomenon further, in order to understand its impact, if any, upon therapeutic interactions, and to determine why it sometimes occurs.

Summary and Conclusions

The purpose of this study was to investigate therapists' spontaneous mental imagery as a source of countertransference data. Relevant theoretical, clinical, and research writings, most of which were influenced by psychoanalytic and Jungian theories, were reviewed and considered in regard to the variables of countertransference and therapist imagery. A qualitative exploratory survey was used to obtain data from thirty-two Jungian and non-Jungian questionnaire respondents, and from seventeen Jungian and non-Jungian interview subjects. A phenomenological-hermeneutic approach was then used to find, in this necessarily subjective data, the similarities, differences, and informational patterns expressed in these therapists' experiences with imagery.

The findings of this study constitute the basis of its answers to its research questions, and the primary source of its implications concerning the profession of clinical social work and potentially beneficial future research. The principal findings, as derived directly and indirectly from the data, are the following:

1. There were no common patterns in the content of therapist imagery, but there were common patterns in the form and kinds of imagery which therapists experienced.

2. The main factor influencing therapists' awareness and valuing of imagery; the frequency with which they experienced imagery; the understanding, interpretation, and information they derived from imagery; their utilization of imagery in treatment; and their opinions regarding the ownership and sharing of therapist imagery was the theoretical perspectives of the therapists.

3. Other factors which influenced therapist imagery included the therapist's emotional and physical state, the therapist's treatment bond with the patient, and the therapist's countertransference feelings toward the patient.

4. Considerable information regarding countertransference can be obtained from studying therapist imagery. This information concerns dynamics in the therapist, the patient, and in the therapeutic relationship.

5. Two clinical management issues emerged during the interviews: the psychological ownership and sharing of therapist imagery. The subjects did not present clear criteria for resolving the first issue, but they did present clear criteria for determining prerequesites regarding the second.

6. There is considerable material within this study which can form the basis of future research.

Because this study's data are grounded in a clinical research context, they reveal uses, both advantageous and

disadvantageous, and possible meanings for therapist imagery. The data demonstrate that therapist imagery can transform, unite, synthesize, and represent a wide range of highly relevant clinical information. Therefore, the data add clinical breadth, depth, and substance to the earlier research on therapist imagery and countertransference by such researchers as Fordham (1957), Racker (1968/1976), Hoffman (1977), Adler (1981), McCann (1982), and Samuels (1985a).

The results of this study make clear that therapists experience mental imagery during sessions with patients, and that such imagery can provide countertransference data and can inform the therapist about the therapeutic relationship. This study enlarges on previous clinical literature in that it explores some of the patterns of countertransference information which therapist imagery can provide, and outlines the more important issues and questions related to such imagery. Since it is exploratory, this study represents only the earliest stage in an investigation which, if taken further, could prove highly beneficial.

CHAPTER NOTES

Chapter I

1. Sax (1981) and Grayer's (1981) dissertations included the same literature review chapter. In order to avoid repetition in the present study, only the literature review of Sax is mentioned in the text, though the same literature is included in the works of both these researchers.

2. The following are relevant definitions of other related concepts:

Image. "A mental picture of something not necessarily real or present" (American Heritage Dictionary of the English Language, 1981).

Mental Representation. A relatively permanent mental image of anything that has previously been perceived. (Rycroft, 1968, pp. 141-142)

Imagination. "The formation of a mental image or concepts of that which is not real or present" (American Heritage Dictionary of the English Language, 1981).

Campbell (1981) offered an additional definiton:

> A synthesis of mental images into new ideas; the process of forming a mental representation of an absent object, an affect, a body function, or an instinctual drive, the results of which process are images, symbols, phantasies, dreams, ideas, thoughts, and/or concepts. (p. 310)

The results of imagination can either be imaginary, i.e., unreal, or imaginative, e.g., artifacts or solutions to problems. (Rycroft, 1968, p. 69)

Fantasy or Phantasy. The following are accepted psychoanalytic definitions of these terms:

> A product of mental activity which usually exists in the form of images or ideas . . . [Generally there is a wishful quality involved in fantasy, and this can lead to action or can be defensive.] (Moore and Fine, 1968, p. 46)

> A product of imagination consisting of a group of symbols synthesized into a unified story by the secondary process. The phantasy may originate from conflicts secondary to unsatisfied instinctual wishes or secondary to frustration in external reality; it may be a substitute for action, or it may prepare the way for later action; it may afford gratification for id impulses, it may serve the ego as a defense, or it may subserve superego functions by providing imagery on which moral concepts, for example, are based. (Campbell, 1981, p. 462)

> Imaginary scene in which the subject is a protagonist, representing fulfillment of a wish (in the last analysis, an unconscious wish) in a manner that is distorted to a greater or lesser extent by defensive processes. . . . Phantasy has a number of different modes: conscious phantasies or daydreams, unconscious phantasies like those uncovered by analyses as the structures underlying a manifest content, and primal phantasies. (Laplanche and Pontalis, 1967/1973, p. 314)

The usage of the terms "fantasy" and "phantasy" in the present study is further clarified in Chapter II.

3. Night dreams are not discussed or specifically investigated in this study, although some isolated instances of these are considered because certain interview subjects referred to them as sources of imagery experiences which these subjects subsequently utilized during treatment sessions.

4. The mundus imaginalis was first conceptualized by Corbin (1972).

5. In this study, the term "patient" is used instead of "client," and "therapist" is used instead of "counselor" or "analyst," unless the latter terms are explicitly stated as such in verbatim quoted material.

Chapter II

1. Information on such subjects can be found in the writings of such researchers and theorists as Sheehan (1972), Singer (1974, 1975, 1978), Shorr (1974, 1980), and Sheikh (1979, 1983a, 1983b), among others.

2. Because Jungian theory is the principal theoretical and therapeutic orientation referred to in this study, the

use of imagery for symptom abatement by behaviorists, hypnotists, and neuro-linguistic programmers is not discussed, nor is the use of imagery in religious or mystical practices.

3. The London School is a group of English Jungian analysts who have emphasized psychoanalytic object relations theories and Kleinian concepts in their work.

4. Post-Jungians who have employed Racker's theories include Davidson (1966), Gordon (1974), Lambert (1974), Fordham (1974, 1978 and 1979), and Samuels (1984, 1985a).

Chapter III

1. The parallel between the ideas of Giorgi and Jung in regard to the appropriate methodologies for investigating psychological phenomena is quite evident.

2. In her unpublished study, McCann (1982) mentioned that she had used a variety of data collection methods, including questionnaires and face-to-face interviews. She noted that several problems cropped up during one phase of the questionnaire inquiry process, and that in-depth interviews therefore produced the best results.

3. Of the six respondents who did not fill out a questionnaire, three Jungians explained that they had been too busy, a fourth returned the questionnaire with no comment, one non-Jungian offered imminent retirement as the reason for not completing the questionnaire, and the other returned the questionnaire with no comment.

4. The variables of countertransference and imagery were examined in association with the variable of theoretical orientation, through the application of the Chi-square and Cramer's V. The statistical results were not emphasized in this study, however, due to the small size of the sample.

Chapter IV

1. Since the data revealed a clear difference related to practice orientation between the two sample groups, statistical analyses on the variables of gender, professional degree, and professional license were conducted in order to evaluate the obtained strength of association. The Chi-square and Cramer's V were the statistics used for these analyses. All three variables yielded an interactive result at the .01 level of statistical significance,

indicating that a strong association had been found between each of these variables and that of practice orientation.

The obtained numerical results for the three variables are as follows: gender (Chi-square 10.5, Cramer's V .635), professional degree (Chi-square 16.34, Cramer's V .793), and professional license (Chi-square 10.6, Cramer's V .639).

These results are not stipulated in the body of this study because they relate to obvious and inherent differences between the two sample groups, and because the size of the sample was too small and had not been selected by a strictly random procedure, so accurate generalizations could not be drawn from these particular results.

2. The word "interpretation" is defined, for the purposes of the third research question, as a process of obtaining information, understanding, and meaning from experienced phenomena.

3. These case examples were extrapolated from the case summaries which appear in Appendix F.

4. This case example is included, even though it contains dream imagery, because the imagery had been subsequently recalled by the subject and then had been utilized during treatment sessions.

Chapter V

1. Information on the physiological aspects of visual imagery can be found in the articles on Epstein and Finke in the Brain/Mind Bulletin, March 24 and May 26, 1986.

APPENDIX A

Letter to Potential Interview Subjects

February 1, 1986

Dear Colleague:

I am a doctoral candidate at the California Institute for Clinical Social Work, and am currently working on my dissertation. For my research project I am planning an exploratory study of therapist mental imagery as a source of countertransference data.

Mental imagery includes mental representations or pictures originating in conscious and unconscious processes, usually without the aid of an external referent. Such imagery often occurs during states of normal waking consciousness, and derives from all the sense modalities. It can take the form of visual pictures or fantasies; fragments of songs, stories, movies or poems; bodily sensations; the therapist's feelings and memories.

There is considerable research on the use of mental imagery to heal clients or patients with physical and emotional problems, and on the concept of countertransference, but very little research on the meaning and use of therapist mental imagery during the treatment process. The purpose of this study is to enrich our understanding and knowledge of our own experience of our therapeutic work and thereby to enable us to better help our clients or patients.

I hope that the above ideas interest you and that you would be willing to assist me in my research by taking a few minutes to fill out the enclosed questionnaire. Some of the questionnaire respondents will be selected to participate in a one-and-one-half-hour interview. Please help me by filling out the enclosed questionnaire, signing the Informed Consent Form, and returning them to me by February 14, 1986.

Thank you for your cooperation.

Gloria Avrech, L.C.S.W.

APPENDIX B

Informed Consent Forms

CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK
INFORMED CONSENT FORM

I, _____
consent to participate in the research project entitled: Therapist Spontaneous Imagery and Countertransference in Clinical Practice.

The procedures of this study have been approved by the dissertation committee of Gloria Avrech, M.S.W., chaired by Ruth E. Bro, Ph.D.

I understand the procedure to be as follows:

1. Completion of a questionnaire and an Informed Consent Form by the party whose signature appears below.

2. All information will be held in strictest confidence, and the anonymity of the research subject will be protected by the following methods:

a. The investigator, Gloria Avrech, is the only person who will score the results of the questionnaire.

b. The written materials will be destroyed as soon as the study is completed, or by January, 1987, whichever is sooner.

c. The names of the participants will not be used in any way.

d. The presentation of this material in report or publication, will exclude the identification of the participants of this study.

The following individuals will be available for consultation if any concerns arise as a result of participation in the study or procedure:

Gloria Avrech, M.S.W. -- 818-792-9483
Ruth E. Bro, Ph.D. -- 213-395-1270
Rosemary C. Lukton, D.S.W. -- 415-843-1888
Dean, C.I.C.S.W.
P.O. Box 241710
Los Angeles, CA 90024

I understand that I may withdraw from the study at any time without penalty.

Date:_____ Signature:_____

CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK
INFORMED CONSENT FORM

I, _____
consent to participate in the research project entitled: Therapist Spontaneous Imagery and Countertransference in Clinical Practice

The procedures of this study have been approved by the dissertation committee of Gloria Avrech, M.S.W., chaired by Ruth E. Bro, Ph.D.

I understand the procedure to be as follows:

1. Completion of an audiotaped one-and-one-half-hour interview and an Informed Consent Form by the party whose signature appears below.

2. All information will be held in strictest confidence, and the anonymity of the research subject will be protected by the following methods:

a. The investigator, Gloria Avrech, is the only person who will score the results of the taped interview.

b. The taped interview will be erased and the written materials will be destroyed as soon as the study is completed or by January, 1987, whichever is sooner.

c. The name of the participants will not be used in any way.

d. The presentation of this material in report or publication will exclude identification of the participants in this study.

The following individuals will be available for consultation if any concerns arise as a result of participation in the study or procedure.

Gloria Avrech, M.S.W. -- 818-792-9483
Ruth E. Bro, Ph.D. -- 213-395-1270
Rosemary C. Lukton, D.S.W. -- 415-843-1888
Dean, C.I.C.S.W.
P.O. Box 241710
Los Angeles, CA 90024

I understand that I may withdraw from the study at any time without penalty.

Date:_____ Signature:_____

APPENDIX C

Questionnaire Instrument

Questionnaire

Part I

1. Age: _____ 2. Gender: _____

3. Highest Professional Degree: _____

4. Licenses: _____

5. Years of Post Degree Clinical Experience: _____

6. Practice Orientation: (Check all that apply)

[ ] Psychodynamic	[ ] Jungian	[ ] Other (Specify)
[ ] Behaviorist	[ ] Psychoanalytic	_____
[ ] Gestalt	[ ] Systems	
[ ] Existential	[ ] Humanistic	_____

7. Kind of Clinical Practice: (Check one)

[ ] Private	[ ] Hospital
[ ] Agency	[ ] Other (Specify) _____

_____

Part II

1. How do you define countertransference? _____

_____

_____

_____

2. Do you make use of the concept of countertransference in your work? (Check one) [ ] Yes [ ] No

3. Do you find that your countertransference a help or hindrance in your conduct of effective psychotherapy? (Check one) [ ] Help [ ] Hindrance

(OVER)

Part III

Mental imagery is defined as mental representations or pictures originating in conscious or unconscious processes, usually without the presence of an external referent.

1. Have you ever experienced mental imagery in any form in your clinical work? (Check one) [] Yes [] No
   If yes, please answer the following questions:

2. What kinds of images have you experienced? (Check all that apply)

   [] Visual (scenes, pictures, etc.)
   [] Auditory (words, songs, music, etc.)
   [] Verbal (poems, stories, myths, plays, etc.)
   [] Taste (sweet, sour, etc.)
   [] Smell (musty, floral, etc.)
   [] Kinesthetic (stretching, constriction, etc.)
   [] Touch (warm, soft, rough, etc.)
   [] Bodily sensations (chills, changes in breathing, nausea, tingling, etc.)
   [] Feelings (sadness, anger, fear, etc.)
   [] A combination (pictures and sounds, smells and words, or tastes and words and sounds, etc.)
   [] Other (Specify) _____

   _____

3. Do you use your mental imagery during treatment? (Check one) [] Yes [] No
   If yes, how? (Check all that apply)

   [] To aid interpretation to clients or patients
   [] For self-analysis or self supervision
   [] As material for a specific therapeutic techinque or method
   [] Other (Specify) _____

   _____

   _____

Would you be willing to be interviewed on this topic for approximately one and one-half hours? (Please check one)
[] Yes [] No
If yes, please fill out the following:

Name: _____

Address: _____

Phone: (Home) _____ (Work) _____

What times and place would be most convenient for you?

_____

_____

_____

Thank you,

Gloria Avrech, L.C.S.W.

APPENDIX D

Interview Schedule

Interview Schedule

Part I: Imagery

1. What kinds of imagery do you experience most often with patients?
   a. Arising from a sensory modality? (e.g., visual, tactile, auditory, etc. or a combination)
   b. Arising from a recalled personal experience?
   c. Arising from feelings?
   d. Relating to a poem, story, film, myth, dream or play?
   e. Arising from other factors?

2. What is the form of the imagery that you experience? A single or a series of images? Please describe.

3. How frequently do you experience imagery related to patients?

4. When are you most likely to experience imagery related to patients?

5. What physical and mental states facilitate or impede your experience of imagery during the treatment process?

6. What environmental conditions facilitate or impede your experience of imagery during the treatment process?

Part 2: The Treatment Relationship

1. Do patients' problems and diagnoses seem to make a difference in the nature and frequency of the imagery that you have? If so, how?

2. How do frequency of contact and length of treatment affect your imagery?

3. Does the nature and quality of your therapeutic relationship have a bearing on the kind and frequency of imagery that you have? If yes, how and why?
   a. How might the absence or presence of rapport affect your imagery?
   b. How might closeness or distance in the relationship affect your imagery?
   c. How might superficiality or depth of connection affect your imagery?
   d. How does your perception of your patient's emotional

reaction to you affect your imagery?
e. Does your sense of your patient's perception, conscious or unconscious, or your role affect your imagery?

4. Do your feelings toward the patient affect your imagery? If yes, how?
   a. How do your positive or negative feelings toward the patient affect your imagery?
   b. How does your sense of empathy toward the patient affect your imagery?

5. How does your imagery reflect your psychological understanding of the patient?

6. How might your perception of your adequacy as a therapist and your sense of patient progress affect your imagery?

Part 3: Use and Application of Imagery in Treatment

1. What theories and concepts do you use in trying to understand the meaning of your imagery? How do you apply these theories and concepts to your imagery in your work with your patients?

2. What information do you obtain from your imagery?

3. In what specific ways do you use your imagery in treatment?

4. Do you ever share your imagery with a patient?
   a. Under what conditions do you share it, or don't share it?
   b. How do you share it?
   c. What do you see as the benefits and drawbacks resulting from such sharing?
   d. Do you notice any changes in the patient, in you, in the relationship, and/or in the course of treatment as a result of such sharing?

Part 4: Case Example

1. What is a memorable and representative example of imagery that you have experienced related to a patient? Please describe this example in as much detail as possible.

2. When did you have this imagery, and what was going on between the two of you? What were you doing when the imagery occurred?

3. What was your physical and emotional condition when you experienced this imagery with your patient?

4. What were your thoughts and feelings about the patient when you had this imagery?

5. What do you think the patient was feeling and thinking when you were experiencing your imagery?

6. How do you understand this example of imagery related to a patient?
   a. What does it mean to you?
   b. What information does it convey?
   c. How does it reflect psychological dynamics in you, the patient, the relationship?
   d. Why do you think you had the imagery at that time?

7. In general what are your thoughts, feelings and plans regarding this patient?
   a. What positive and negative feelings do you have toward this patient?
   b. What are the patient's main problems and diagnoses?
   c. What treatment approach are you using with this patient? What modality? What techniques?
   d. What are your treatment goals? What is the extent of progress?
   e. How often and how long have you seen this patient?

8. Is there anything else that you would like to add regarding your experience of imagery with this patient?

9. Are there any other comments that you wish to make regarding your experience of mental imagery in the treatment process?

APPENDIX E

The Pretest Subjects and Their Case Examples

The Pretest Subjects and Their Case Examples

Two different pretests, each using one of the earlier versions of this study's Interview Schedule, were given to two selected pretest subjects. The data obtained from these subjects are in some respects similar, and in other respects slightly dissimilar, to the data obtained from other subjects' responses to the final version of the Interview Schedule. In order to maintain confidentiality, the two pretest subjects are referred to below as P1 and P2.

The first pretest was given to a female therapist, aged 54, who has had more than eleven years of post-license experience as a marriage, family, and child counselor. She has an M.A. degree, and described her practice orientation as a synthesis of Jungian and systems theories.

Like most of the Jungian subjects, she stated that she has experienced imagery often, and has frequently been aware of it. She differs from the other Jungians in that she has used her imagery actively, in many diverse ways, quite frequently in her work. Her imagery is vivid, and seems to arise from deep collective unconscious levels of her psyche. Her clinical work and imagery are infused with her sense of spirituality, which she has consciously

developed, to a greater extent than of any of this study's other subjects.

P1 offered the following as an example of her imagery:

> I saw a new couple last night and about ten minutes into the session I had the image of there being between the two of them a wall and I saw it in red-orange light. It was like a huge block between them, a block of metal, out of 2001, between them. So my hit was that there was a huge block around their sexual connection.
>
> So, I said to them, "I'm seeing a huge block between the two of you. A wall. And I'm wondering where you are with your sexuality." Well, that's where they're stuck! So, we immediately went to the heart of where they are stuck rather than wasting a lot of time.

Images represent a place of intuitive wisdon and truth, according to P1. She noted in describing her practice of sharing her imagery with patients: "Most people are delighted and amazed and awed and intrigued and relieved. There's an excitement with the imagery . . . a sense of hope that comes out of it." This subject concluded her pretest interview by stating:

> I'm really dedicated to following my intuition, and support and encourage clients and other people to follow their intuition. It's a wisdom place. . . . I think spirituality has a lot of imagery in it. Meditation has a lot of imagery in it. I am very much for the integration of East and West as well as the left and right hemispheres of the brain. . . . Using imagery can get them into that healing place fast because I don't think it's the logical mind that needs healing. It's the emotional intuitive mood that needs it.

The second pretest subject is a male Jungian social worker, aged 39, who has had six years of post-license clinical experience. Like other social worker subjects, he reported that he has experienced different kinds of imagery, has experienced imagery with most of his patients, and experiences it a few times each day. He admitted that he sometimes feels emotionally out of touch with his imagery. However, like other Jungian subjects, he considers imagery to be constant and ubiquitous. He differs, however, from all the other interview subjects in that he most frequently experiences auditory imagery, such as songs.

Once, while watching a boy patient making a sand tray which included Christmas themes, even though Christmas was several months away, P2 found himself spontaneously whistling a Christmas carol. P2 stated that he had known that this boy's relationship with his father had been very troubled. He commented, in reference to this imagery experience:

> There was a sense of something in my soul, sort of affirming. . . . The image was coming to me that perhaps [the patient] was feeling contained. . . . I think we were connected quietly. . . . It caught me by surprise. I just started whistling. . . . I was quite touched because I was aware that it pertained to what was going on. The awesomeness of the connection. . . . It was like something between our souls, he with his sandtray and me with my whistling. . . . It told me something about the work going on right at that moment. . . . Something was getting reconstructed, something maybe positive with the father.

APPENDIX F

Interview Subjects' Case Examples

Interview Subjects' Case Examples

The following are summaries of some of the case examples which were provided, by both Jungians and non-Jungians, in response to the the principal question in Part 4 of the Interview Schedule:

> What is a memorable and representative example of imagery that you have experienced related to a patient? Please describe this example in as much detail as possible.

Each example is described below and the therapist's primary associations and understandings are then mentioned. In order to maintain confidentiality, the Jungian subjects are referred to below as J1, J2, J3, etc., and the non-Jungian subjects are similarly referred to as NJ1, NJ2, NJ3, etc.

Jungian Case Examples

J1 gave an example from her work with a depressed, withdrawn, hypochondriacal patient with sexual problems. He was a scientist, who was cold, formal, and "very separated from his body," according to J1's description. J1 experienced the following visual and kinesthetic imagery during a session with this patient:

> I experienced that he left his body and was on top of his body looking down at his spine and he was in his brain and there were all these colors in his brain . . . and all these lights flashing and he was trying to get back in his body and all he saw were these lights. . . . I felt as though some part of my body was in his body moving with him, even though I wasn't moving. . . . And I felt this kind of trembly energy in my body . . . myself, literally shot up his spine. . . . There was a feeling of movement and color and there wasn't much sound.

While the therapist had been experiencing this imagery, the patient had spontaneously stated:

> I'm standing at the top of my spine in my brain, looking down, seeing all these lights and I don't understand why all this is happening in my brain. It's very exciting up here.

For J1, this imagery experience suggested that her patient had been starting, at that point, "to live in his body rather than in his mind." She had not tried to interact with him during his experience, she reported, but rather had allowed herself to be a container for him, and a conduit for the powerful healing energy that she had felt was moving through her to him.

J1 thought that the patient had also been revealing to her that he had previously felt potent and masterful in his brain and nowhere else. For him, the imagery had been magical, and had made him feel more powerful and alive. J1 continued:

> It seemed important to me that there was light inside his body, because his previous imagery had been of being devoured by the Great Mother or he being this devilish creature who was doing all these terrible things to people.

Although this patient had many significant problems, he eventually improved, according to the therapist; among other things, he returned to school and started to meet women. J1 had paid attention to this patient's imagery because she "got the jolt of it." She felt that she had identified with the patient because of her identification with an aspect of this patient's personality.

> I get caught in my brain when I get overworked and exhausted; and I feel very mechanical like I'm going through the motions of everyday life but am not really connected to it.

J2 selected an example in which she had used a patient's dream image and a dream image of her own in several treatment sessions. The patient, a lesbian divorcee with a child, had been nearing termination at the time. She had initially shown borderline symptoms which had included separation and merger issues and depression, and she had attempted suicide. The patient was obese, while J2 is thin. In this patient's dream, she had begun a therapy session by hugging J2, after which they had both rolled about, intertwined, on the carpet. In J2's dream, she and the patient had been at a communal bath, but the patient had

been fully dressed, standing outside the tub. The patient had come there to tell J2 that she was going to date a man of her own race.

J2 stated that she had often used, in her sessions with this patient, the image of the two of them rolling on the carpet. For her, the image was not sexual, but instead suggested two attracted parts, a self and a Self, embracing or entangled like animals. This image symbolized, for J2, the constellation of the patient's self. "It's . . . like the ego and Self relationship," she explained. The patient had struggled to separate from this therapist many times, and this image from the patient's dream therefore indicated a successful separation, according to J2, in that it demonstrated the patient's internalization of the therapist.

J2 interpreted her own dream image as a metaphor indicating that the patient was ready to move on to the next stage of her development, which was to psychologically live outside of and apart from J2.

J3 offered an example of an image which had affected his entire involvement with a patient, and which had significantly influenced their therapeutic relationship for a time.

The patient was a young female graduate student who had problems regarding father-daughter relationship issues. J3 experienced a recurring image of himself as a professor and

the patient as a student of his. He explained how this this dynamic had occurred by stating:

> This was something that truly she was structuring. She would ask me any number of questions, the nature of which involved rather technical answers; which was her way of avoiding her personal work. . . . Because the role fit so well, I enjoyed being the professor and I would launch into these long answers.

When the patient realized what she was doing, she rebuked the therapist. He stated that this had been "momentarily really very devastating," but that afterward, their work together had become more constructive. The patient came to feel more secure and learned to confront authority figures.

J3 reported that this imagery had given him insight into how this patient had probably treated various male authority figures. He felt that he and the patient had become caught in the patient's complex; he had experienced ". . . a great desire to please her. . . . In a sense, I was telling her what she wanted me to tell her. I was avoiding what she wanted me to avoid." The patient's resemblance to J3's daughter had also enhanced J3's vulnerability, since he had wished that his daughter, an independent and assertive girl, would have related to him as the patient had.

J4 described an image, which he had experienced during a session, of a married female patient living alone in an apartment. He had then shared this image with the patient,

and she had admitted with surprise that she had simultaneously been thinking about the same thing. This image had occurred to the patient while she was talking about her love for her husband and while the therapist was simultaneously realizing that he had been focusing on her avoidances and contradictions. J4 had sensed that the patients' statements had no connection with her unconscious; his experience of his own physical discomfort at this point had made this intimation even stronger. "The unconscious was on her planning her own apartment and thinking of a divorce. She was not in touch with her shadow. I was!" This therapist's bodily feeling-sense had been one of boredom, and his consciousness had been adrift in the concerns of his own daily life. According to J4, experiences such as these indicate that the patient's unconscious concerns are too removed, and that the therapeutic work is not deep enough.

In her relationship with her husband, J4 stated, the patient had been replicating her relationship with her perfectionistic and demanding mother: she had been trying to be the good girl for her perfectionistic and demanding husband. This patient had been unable to stand on her own against her mother, and similarly had been unable to stand on her own against her husband. This therapist therefore

considered the shared imagery of his patient living alone in an apartment as having been very healthy for her.

J5 offered two examples of imagery he had experienced with patients. In the first, he had experienced a dramatic image during a session with a female patient who had had many abortions and who was about to have another. In his fantasy the patient had been an eager teenager who was about to begin her first sex act and who had then been caught. J5 had considered the image to be so powerful that he had decided to share it with the patient. He reported that the patient had reacted very strongly against this image.

> It made her totally crazy. She really had a total breakdown, a crisis where she thought she couldn't continue with [her therapy]. . . . I lost connection to her history.

The situation, however, had then resolved itself quickly. The patient had realized that ". . . she was psychologically a virgin, that she really has never had sex. . . . and she's in her unconscious about sexuality and pregnancies."

The second and more detailed example occurred during a session with a female patient, a blocked writer with marital problems who was "out of touch" with her "shadow." The patient, who had idealized this therapist, had progressed to a point at which she was considering terminating. Although

J5 thought that she optimally needed more therapeutic work, he had accepted the pending termination.

At this point, the patient had been discussing, as she had also discussed during previous sessions, her plans to attend an out-of-town workshop. Shortly after having finished talking about her husband's support for her plans, in contrast to his previous objections to the possibility of her traveling, J5 had been suddenly surprised by an intense anger. This patient's discussions about attending workshops had never angered him before; indeed, he had approved of the idea.

Initially, J5 had thought that he had been feeling competitive with the workshop leader, then he had decided that some affect, probably anger, must have been lacking in his work with this patient. He did not share his anger with her when she had talked about her travel plans, but afterward he had informed her of his intent to charge her for the sessions which she would miss, which had infuriated her.

This therapist decided that his anger had been caused by the husband's attitude shift. In a sense, it had compensated for the husband's lack of anger and "potency in the marital relationship." "I think that it kind of came up in identification with him and compensated for the husband-

father-lover who didn't carry the relationship," J5 reported. He confessed that it usually takes him some time to deal with angry feelings. "I cannot respond immediately, I have to wait." He considered his anger at this patient as having been compensatory, and as having been related to separation and abandonment issues which had been insufficiently addressed in the treatment. He distinguished those issues from termination issues, adding that he is similar to this patient in that he sometimes denies feelings of separation and abandoment. J5 indicated that he feels vulnerable to ". . . that feeling of somebody going off as if I didn't exist, not that they shouldn't go off, but somehow the reality of the relationship needs to be conscious and carried." This therapist also emphasized that his positive feelings for the patient had not been affected by his powerful imagery, or by his patient's angry reaction to him.

J6 also provided two examples of imagery experiences. In the first of these, he had experienced "identity fantasies" related to a patient who was an aggressive and successful businessman. While working with this patient, this therapist had imagined himself doing some of the activities he thought the patient had done, such as competing in a sport. He had also fantasized the patient doing activities which he had done, such as reading

paperback books by Jung. Sometimes J6 had imagined the patient and himself talking together, in a locker room. In these fantasies, this therapist had imagined that the patient would be internalizing his values, and that each of them would be learning from and sharing ideas with the other. The establishment of an imaginal relationship of equality with this patient had helped J6 to understand the patient's aggressiveness and to encourage him to relax, according to this therapist.

In the second and more detailed example, this subject's imagery concerned a patient who was a bisexual woman with marital problems. She had deep narcissisitic injuries which had originatated in her infancy experiences. While working with this patient, J6 had experienced romantic and protective fantasies; he had sometimes seen himself as comforting her in a sensuous and sexual way. At other times, he had imagined himself as an infant, with her as his mother.

This therapist felt that on one level the patient had projected onto him "the good parent," and he had in turn projected onto her "the child." On another level, J6 considered that he had seen her as a "vulnerable woman who needs affection," an image which had stirred him sexually; he had seen himself as the "conquering hero, . . . who conquers a foreign country and rapes all the women." On

yet another level, this therapist had felt himself "joining her in the descent . . . sinking into the Great Mother;" he had shared with her a need to "return to the feminine and to integrate the feminine" in his psyche.

Another subject, J7, also gave two examples. In the first of these, she had experienced a memory image of her childhood home of origin, while working with a depressed divorcee who was contending with a professional identity crisis. The divorcee had been planning a long trip with her lover, which would have necessitated a painful separation from her older children. As the divorcee had been discussing this, J7 had visualized her own childhood home, which she had left at age eighteen. Over the years, this therapist had become aware of unresolved separation feelings about her own family; her marriage and the birth of her child had prevented her from dealing with those feelings, and at this point they had been revived by her patient's work.

In her second example, an example of powerful feeling imagery, J7 described her work with a defensively controlling patient, a "little girl" in her thirties. This woman's father had died when she was eight, and she had had a very bad relationship with her mother. J7 and this woman clashed in their first session, and in subsequent ones. For her, the therapist had been unable to do anything correctly,

and the therapist had felt that the patient was manipulating her. Once, while the patient had been talking about a problem related to her mother, J7 had suddenly felt shaken by a memory of a complementary problem related to her own daughter, and had burst out crying. The patient had then scowled, expressing her transference perspective that the therapist had been seeking solace from her, and that she had resented this just as much as she had resented having to take care of her mother. The patient had subsequently quit treatment, giving as her reason that the therapist's office was inconveniently located for her.

J7 felt that she and the patient had been unable to work through the negative transference. She added that she had felt very uncomfortable during sessions with this patient, in that she had felt prohibited from honestly expressing her feelings and too anxious to please the patient. However, she had not realized how uncomfortable the patient had made her feel. Perhaps this therapist had even disliked the patient. J7 reported that she does not allow herself to become angry with patients, which probably contributed to her anger at herself for having allowed this patient to take advantage of her.

J8 offered an example of a visual image from a dream which had been very meaningful in regard to his countertransference. During the period of his work with a

with a woman who had severe anxiety, problems in her relationships with men, and a hysterical and obsessive neurosis, he had dreamed of looking at her lying nude on his sofa, her pubic hair and vagina prominently displayed. This therapist had then shared his dream with the woman, and it had become the basis for some of their therapeutic work. In the dream, the woman had sexually attracted the therapist, but his desire to stare at her had also embarrassed him. When J8 had experienced his dream, he had been single and unaccustomed to male-female relationships, which frightened him. In addition, he had felt sexually aroused by the patient. He later decided that his erotic-voyeurisitc image had related to their relationship. He stated that he had felt a

> . . . recurring and deep experience of her being sort of exhibitionistic. I mean walking around with her breasts flouncing, and then complaining like hell that men didn't treat her nicely.

J8 reported that his patient had been unconscious of her behavior, and that her animus had been needy and hostile. She had evinced primordial relationship problems, including an alienation from her parents which had been exacerbated by her inability to separate from them. She had also felt used by men, and she had disliked them.

When he had shared his dream imagery with her, she had become upset, on one level, and had expressed a fear of being raped. However, on another level, she had perceived the paradox of her situation: she had tended to put herself on display because she had wanted to be a pleasing object, but doing so had not secured for herself the type of relationship which she had really wanted.

The image had represented the way J8 saw this patient, he stated, and had indicated key problem areas regarding the patient, e.g., trust and security in her relationships with men. The imagery also had revealed the sexuality implied in this particular treatment relationship. Indeed, it had exemplified the sexuality in all psychotherapy, in that sexuality is a basic form of relationship in the psyche, according to J8. The imagery exposed this therapist's role of being a "professional voyeur;" it had offered him an objective view of his relationship with this patient. At the time, he had just finished graduate school and had questioned his own ability to deal with his patient's fears and anxieties. He reflected:

> I was afraid of her, in a sense. So I would put her up in this display-case kind of framework so I could look at her. So it [the imagery] brought up all those images if how I wasn't really dealing with her as a person.

J9 offered as an example a visual image which had originated in a patient's use of the active imagination technique. This therapist had conducted a great deal of imagery work with the patient, who was a very gifted hypnotic trance subject. During her work with him, the therapist had also been in a kind of hypnotic state, and had vividly seen his images as well as those which had arisen in herself. During an extended active imagination session, the patient had experienced an image of himself as a knight jousting with a black knight in a forest. In this imagery, the patient had taken up his lance at the urging of a seductive and dangerous lady, who had perhaps been a witch. He had then killed the black knight, only to discover upon lifting the helmet's visor that the knight was his father.

According to J9, this patient's parents had been divorced when he was quite young, and he had frequently battled with his father at the instigation of his mother, which had caused the patient chronic problems. The patient had then worked with J9 on his relationships with his parents, and had later returned to therapy in order to work on problems which he had been having with his girlfriend; the girlfriend had been replicating his childhood double bind by asking him to metaphorically fight for her and to rescue her, and then agrily rejected him when he attempted

to do this. The therapist reported that she had interpreted to the patient: "You're back in your armor again. You're falling into this pattern again, being someone else's knight and getting involved in fighting battles that aren't yours at all." According to J9, the patient had been inextricably trapped in the hero archetype, and had been in a constant struggle with the negative mother. She also added that her countertransference toward him was positive; she both liked and admired him. This therapist admitted an inclination to project the hero archetype onto this patient, rather than seeing him as a human being in need of help, since he personified most of the therapist's favorite masculine traits.

Non-Jungians' Case Examples

NJ1, a classical Freudian therapist, provided a case example of transference imagery which he had metaphorically interpreted according to his understanding of his patient's and his own mutual feelings. This case example appeared in a previously published paper which NJ1 had written. The patient was a male with severe anxiety, fears of going crazy, identity problems regarding his sexuality and his career choices, and had a number of difficulties with his father. During this study's data collection interview, NJ1

had read from his paper his analysis of several of his patient's dreams, commenting on his own use of the patient's imagery.

The patient's apparently active transition into homosexuality had particularly concerned NJ1. He stated that he had felt ". . . very close to [the patient]. I felt as if he were my favorite son." This subject offered one of this patient's nightmares as a demonstration of his work with patient imagery. He quoted the patient's description of the dream: "I'm in a big car which Father drives along the side of a mountain. After several hairpin turns, the car spins out of control and we plunge over the cliff."

NJ1 stated:

> I tell him, because of his rage against his father's rage, "You wish your father dead. But your guilt at your thought murder is so great you mete out the same punishment against yourself." I did not verbalize my role in this dream. It is implicit.

This therapist's interpretation of his patient's imagery is a transference interpretation; it includes no direct reference to his own countertransference reactions.

NJ2 offered several examples in her answer to the interview item which requested instances of therapist imagery. Referring to one, she discussed her work with a Catholic, middle-class, immigrant family from Ireland, consisting of a widow with two sons in college. According

to this subject, the family was "struggling with the tradition of alcohol in Ireland." She explained that alcohol consumption was "indispensible to the social fabric of that society," and added:

> . . . here are three people who are trying not to become alcoholics as were their husband and father. . . . There's a tremendous pull to identify in a positive way with this father, because he had positive qualities, but also to be on guard, in the negative sense, because of the destructive impact of the drinking on them.

Visual fantasies which NJ2 had experienced related to drinking in the Irish family and in traditional Irish society frequently occurred to the therapist while she had been working with these three people. She thought that this imagery, complemented by her own background knowledge of Irish culture, had helped her to understand the family's "defensive structure and resistance and the impact of their roots on their problems." Her imagery, she noted, "heightened [her] understanding of the fear and despair in their background." Prior to her involvement with this family, this therapist had visited Ireland several times, and considered herself well acquainted with certain Irish mores and traditions. During her interview for this study, NJ2 did not discuss her own personal dynamics in relation to the family; and while showing some awareness of the family's

psychodynamics, she focused most of her comments on the case's cultural ramifications.

Another therapist, NJ3, gave an example of a combination of feeling and visual imagery which had been triggered by her first patient at a postgraduate psychoanalytically-oriented institute. She described this patient as a woman in her late twenties who had presented vague problems which included depression and a lack of heterosexual relationships. The therapist admitted that the patient had bored her.

During one session, the patient had started to discuss her problems with dyslexia, which had not, according to NJ3 previously been an important focus in their work. The therapist stated that while the patient had been talking: "I suddenly had this concentration camp image. And I thought, 'This is strange.' . . . and it was about then that I had seen that movie." The movie to which NJ3 was referring was From Mao to Mozart, a documentary. In one scene in this movie, according to this therapist, a Chinese director of a music school had talked in an unemotional voice about his humiliation during the Cultural Revolution: he had been forbidden to teach, imprisoned (his family had been allowed to visit him only on Sundays), and for a time, he had been confined to a closet underneath the stairs. NJ3 stated: "It

was someone talking about being humiliated and having his sense of self taken away."

During the following weeks after this imagery experience, the therapist had begun tying together her memories of the movie and concentration camp images. She stated: "Somehow I thought of adults having everything taken away, rendered, perhaps, inhuman, having no rights . . ." Her imagery and its meanings had instigated a shift in her attitude toward the patient; she began to realize the power of the dyslexia's effect, and the patient apparently sensed the shift in NJ3's attitude, because she then began to talk more openly about her learning disability. Eventually the patient progressed to the point of being "sufficiently integrated to marry and have a child."

NJ4 offered as an example an image of hers which had stemmed from an incident related to her by a female patient with problems in her career choices and in her personal relationships. During one session, this patient had spoken of an experience she had had when she was seven years old: her father, who was a minister, had just left the house to go to church. The patient, who had been sick and in bed, had gone to a window and had wanted to call him back, but he had been rapidly walking away, with the wind blowing his robes. NJ4 called the image which she had experienced in reaction to the patient's memory "almost scary . . . a

menacing, superhuman figure." She had visualized the father's shoulders as broad and his robes as black and ". . . loosely flowing and flapping around him as he walked, alone, along dark . . . desolate wind-swept land." She had also visualized the child, her patient, "pressing up against the window." The therapist stated that the anecdote had made her feel ". . . sort of sad; and probably a little bit of anger because the imagery I got was very much of abanodnment."

NJ4 thought that this imagery had encapsulated a great deal of psychic material. It added to her understanding of the patient's feelings, identifications, and history; it illuminated an abandonment experience in the patient's childhood, and it dramatically depicted aspects of the patient's conflicts with her father. According to this therapist, this patient had identified more with her father than her mother. Her father, a career military chaplain, had been forced to leave his family for overseas duty during World War II. After the war, he had returned home with emotional scars, caused in part by his early discharge from the military, and these had seriously affected his daughter. The father's career achievements had been disrupted by his early discharge, and his daughter, as an adult, was unhappy in her job, and according to NJ4 did not

"have a really firm sense of identity in the way of career or work."

This therapist admitted that her own elaboration of her patient's material reflected certain aspects of her personal issues. She had also identified with her own father, who had similarly participated in World War II. After the war, his work had kept him away from home much of the time, and NJ4 could see herself as the child her patient had described, standing at the window and wanting to call out, but instead passively waiting and watching. She felt that she had had a problem with her own passivity, which she characterized as "having an impulse and inhibiting it, stifling it."

Another subject, NJ5 recalled a series of visual images which had been triggered by a patient in her mid-twenties who had suffered from identity confusion, relationship problems, and a separation anxiety disorder. Once, when NJ5 had needed to undergo surgery, the patient had responded to the news "by falling apart and coming unglued and getting angry," and by threatening to commit suicide. This therapist stated that during sessions with this patient, she had experienced many visual images related to little children. She had visualized, for example,

> . . . a child having tantrums, being angry at being separated from Mother, being left with the babysitter, being angry and not wishing to be connected with Mother after a separation, being frightened of Mother's disapproval.

This therapist also understood her imagery as related to

> . . . an enraged child who feels a loss of merger, a child who feels basically unempathized with, a child who has not worked adequately on containing and inhibiting her aggression and feels fearful of the aggression that she is imposing and projecting.

NJ5 remarked that these images had "helped me deal with what she was doing."

After this therapist had returned home to convalese from her surgery, the patient had made intrusive emergency phone calls and had demanded frequent contacts. NJ5 reported that her imagery had then helped her to control her negative countertransference and to sustain her empathy with the impatient patient. She had realized that the patient had needed a clear structure and firm limits in their relationship, just as a child would have needed. She therefore worked out a structure and realistic limits with the patient, and this process enabled her to be more empathic.

A Kleinian who is increasingly influenced by the approach of Kohut, NJ5 felt that her imagery reflected universal conflicts as well as her own psychological

dynamics. By means of her intense work with this patient, she had become more aware of the child inside herself, although she also differentiated between the patient and herself in that she was aware of having self-control and of having the capacity to maintain her own boundaries. In this case she had been able to help the patient to perceive and maintain boundaries of the patient's own.

NJ6 offered as an example a series of visual images which had been evoked by a borderline female patient in her mid-thirties; this patient had experienced generalized anxiety, depression, suicidal ideation, and problems with her colleagues at work. In one imagery experience, NJ6 had visualized the patient's mother as a "big, hulking person, without a face," with "a dark, voidish background" behind her. During another session, she had experienced ". . . other images like of a child sitting on the ground and the mother had all these psychotic kind of delusions, like about witches and other very superstitious kinds of things." The therapist stated that she had often imagined the patient as a child, seemingly merged with her mother.

NJ6 reported that her imagery helped her to feel "a series of affects related to the patient," which had included "being sort of at one with the patient at the moment." The imagery had confirmed, she thought, her intellectual grasp of the patient's dynamics, and had given

her a picture of ". . . a mother who merged with her child. . . . The facelessness and the big hulk were evidences of that and also her [the mother's] unreceptivity to [the patient] as a separate person." During the data collection interview, it also occurred to NJ6 that her image of the child sitting on the ground might have related to her experiences with her own mother.

Another subject, NJ7, provided an example of imagery from a personal memory which had been stirred during a session with a young adult male who was passive-aggressive and depressed. This patient had been discussing in detail his deep emotional response to the movie Shoah, a nine-and-a-half-hour documentary about Nazi concentration camps. As the patient had been talking, NJ7, who is a concentration-camp survivor, had experienced that she, "was there!" She stated:

> He was telling me about a barber who had been at Auschwitz in the extermination camp who was clipping the women's hair before they went to the ovens. Well, I went through that. And he was telling the interviewer that he didn't shave the heads, he clipped them, because they still had the fiction, to prevent panic, that the women were just being deloused. And I wanted to say, "No! That's not true. They shaved them bald." I think that was the one [description] that hit me the most.

The patient, a Jewish convert who had not known that his therapist was a survivor, had been visibly shaken while he

had been talking to her. NJ7, meanwhile, had been experiencing "this ominous feeling in the stomach." According to her, this patient had stated that the Jewish people physically survived, but not emotionally. At this point the therapist had thought: "Little do you know! Your therapist is one of them and I did just fine!" NJ7 stated that her own experience in the camps ". . . just sits there undigested. But I don't really feel that I need to open up, or want to open up, because I am doing O.K." She felt that her imagery had not been at all related to the patient's psychological dynamics, but rather had belonged to her exclusively; she added that it had not interfered with her ability to work with the patient.

NJ8 offered an example of visual and dramatic imagery which had been evoked by a male patient who was in his early fifties. This therapist described him as a professional man who was a bitter, paranoid, overly cautious, and high-functioning borderline with low self-esteem, bleak and conflicted interpersonal relationships, worries about being rejected, and painful interactions with his suicidal son. The patient was well read in Russian fiction; during one session, while this patient had been talking, NJ8 had remembered a scene from Tolstoy's Anna Karenina, a scene in which

> . . . two of the minor characters are walking in the forest to collect mushrooms, and they are acquainted, both single, man and woman, and the question is will he ask her to marry him or not? And he never speaks of it; she never speaks of it; and they don't marry and are single through the rest of their lives. So the unconsummated verbal encounter between man and woman.

Because the patient had read the novel, the therapist had then shared her image with him.

The patient, the therapist explained, had found his parents very difficult to please; he had not felt close to either of them. He had particularly felt that his mother was his enemy, an attacker rather than a supporter. As an adult, he was reserved and defensive in his relationships with other people, particularly women, and hardly ever revealed his feelings or wishes.

NJ8 stated that her imagery from this scene from Anna Karenina had been evoked by her awareness of her own sex and the patient's, and by his defensive style, a style which was characterized by silence, the therapist added, ". . . lest he be rejected, not knowing that the other might be really waiting for him and needing him to take an initiative." For the therapist, her imagery especially suggested the patient's relationship with his son, which had become the principal focus of the session. The son was in college, and although the patient had been worried about him, he had not

been able to bring himself to contact him. Apparently, he had felt that the son had to initiate the contact.

Although NJ8 considered herself to be a meaningful contact in this patient's life, she wondered:

> How can he bridge across that gap? . . . Part of that pain he was expressing to me was that. . . . Could he ever get close enough to another . . . and could he let this opportunity with his son pass and the two never be close?

This subject's purpose in sharing her imagery with the patient had been to demonstrate to him that she felt his despair, and to communicate to him the warning which she had perceived in her imagery: "to not let opportunities pass." She had hoped that her imagery would bring into being that needed bridge, and would bring home to the patient the message ". . . that the opportunities are passing. Why lose them? And that it can be a loss for both [him and his son]."

"I think the image also stuck with me because I can get myself into similar traps," NJ8 acknowledged. She divulged one of the principal reasons that she had become a therapist: to make contact with feelings in herself and others. Her family had denied and avoided feelings, she stated, and had not displayed them, so the family members had become isolated from each other. "It is still a struggle to be able to articulate feelings," she stated.

"They do not come so easily for me." She also acknowledged that she had needed to concentrate on not holding back with this particular patient. "I want to make that contact about feelings and with his feelings, and encourage him to live and not grow morbid and withdrawn."

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