Emotional Disruptions in the Therapeutic Relationship: A Study of the Benefits of Reconnection to Subsequent Psychological Development

Holly Hein

EMOTIONAL DISRUPTIONS IN THE THERAPEUTIC RELATIONSHIP: A STUDY OF THE BENEFITS OF RECONNECTION TO SUBSEQUENT PSYCHOLOGICAL DEVELOPMENT

A dissertation submitted to the
California Institute for Clinical Social Work
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
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DISSERTATION APPROVAL PAGE

We Hereby approve the dissertation

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ABSTRACT: Based on the assumption that emotional disruptions are ubiquitous in the therapeutic relationship, this dissertation seeks to explore through qualitative research to specifically study the nature of emotional disruption -- a disruption is perceived as threatening when it disrupts the organization of the therapist's world either internally or externally. In addition,it seeks to study the possible benefits of reconnection to the subsequent psychological development of the patient. The present study was designed to survey and verify those phenomena that occur when a therapist feels emotionally attacked and acts on those feelings of emotional threat by temporarily removing him or herself from an authentic responsive therapeutic connection. It draws upon the proactive relational theorists as it's base who place the therapist in a dynamic relationship to the client in an intersubjective field. A historical review of the literature is given as it pertains to the development from a one-body approach to a two-body approach from which this research question eminates.Ten senior therapists were asked to enumerate those moments in their clinical practice where disconnection occurs and then explain if or how they acknowledge this to themselves and do they acknowledge this to their patients. Further, do they think it is of benefit to the patient and does it contribute to the growth of the patient? Open ended questions were utilized in order not to predetermine categories of response and to maximize the range of possible responses, as well as to discover new phenomena that may be reflected in the responses. The majority of respondents seem to want to remain as indirect as possible in an attempt to protect themselves from the imagined slings and arrows of the profession and possibly the researcher. The more direct the therapists were in regard to their reactions to threat, the more the researcher was able to be attuned to the essence of the disruption and reconnection. When interviewing those therapists who were direct, the researcher had more of an empathic emotionally connected experience. This served to reinforce the importance of maintaining a dynamic two-body approach as the patients seemed to parallel the researcher's experience.

These disruptions seemed to facilitate psychological growth in the patient when communication was authentic and empathically direct on the part of the therapists.

DEDICATION

HERE'S TO MY SCHATZI
WITHOUT WHOSE CONNECTION
I WOULD NOT BE THE PERSON THAT I HAVE BECOME TODAY.

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Holly C. Hein

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CHAPTER I

INTRODUCTION

The therapeutic encounter implies an emotional "challenge to growth" for the patient. As this challenge is variously incorporated by the patient, a variety of reactions occur, including rage, attack, and silence. These reactions are the very fiber of psychotherapy. The impetus for this study is the researcher's interest in exploring how the therapist maintains or restores the therapeutic connection when the therapist experiences sufficient emotional threat from the patient to temporarily retreat from a position of optimal emotional connectedness.

This study will undertake a critical overview of countertransference as the traditional and, until recently, perhaps the only model used to understand therapists' reactions to patients. Having established certain inherent limitations of the classical notion of countertransference as increasingly less able to explain the subtle patient-therapist relationship, this research study introduces and incorporates the theory of intersubjectivity. This study assumes the therapy setting to be an evolving intersubjective field, as such concept has been developed by Stolorow, Atwood, and Ross (1978).

Introduction to the Theoretical Context

Based on the pioneering work of Brandschaft, Stolorow, and Atwood, the therapist's reaction to the patient's

inevitable expressions of emotional attack can be viewed from within the context of the intersubjective field existing between the therapist and the patient. As both Stolorow and Atwood (1987) defined the term, and as will be developed below, the intersubjective field is that reciprocal system which responds to the subtlest of changes in the combined and separate subjectivities which both therapist and patient bring to the therapeutic encounter.

Intersubjective theory, then, constitutes a less hierarchic approach, than does a classical theory, to the therapist's role and reactivity, assuming as it does that the therapist necessarily brings his or her naturally reactive subjectivity to the therapeutic setting (Stolorow & Atwood, 1992). Intersubjectivity does not couch the therapist's tendency to react in terms of lack of vigilance or unprofessionalism. Rather, intersubjectivity implies a natural two-person system of constant emotional and psychic recalibration on the part of both clinician and client, with both members of the tacit therapeutic link responding spontaneously and continuously and in equal measure to covert and overt and positive and negative cues, as these preexist and continue to emerge in a session to session fashion (Stolorow & Atwood, 1992).

As will be discussed in more detail in Chapter II, Stolorow's intersubjective theory provides the framework for this study and the means to analyze the therapist's momentary emotional disconnection. Such a disconnection is not viewed as a hazard or impediment, nor as a breakdown in treatment

due to countertransference run amok. Rather, intersubjective theory allows us to see such therapeutic moments as merely a change in the intersubjective dynamic, which is a far more open and non-pejorative viewpoint. It is Stolorow's intersubjective theory that allows us to propose that breakdowns in the intersubjective field may indeed form a potential basis of dialogue within which two independent subjectivities might be mobilized into heightened communication and deeper understanding.

Theoretical Framework

The theoretical framework can be traced back to several simultaneous changes in classical psychoanalytical thinking here and in England, as discussed in the Review of the Literature. As a starting point, Klein's theories began to suggest that internal drives were not strictly intrapsychic, but were fantasized introjects of drive gratifying experiences coming at pivotal developmental periods.

In this regard, Klein began research on the fantasized good breast and bad breast associated with gratifying and non-gratifying feeding experiences, thus opening the door for classical analysis to consider the influence of external variables interacting with basic drives. Because Klein viewed these introjects as intrapsychic constructs and, thus, did not really account for the psychodynamic influence of the other, her theories remained closed system or one-bodied in nature.

Klein did, however, set the stage for speculation about the impact and importance of outside inputs--the mother,

important others, and fantasized internalizations of significant self and objects--on the development of ego structure and behavior.

Once the fantasized gratifying object came to be considered a variable influencing behavior, a variety of interactional schools--developmental psychology, transactional analysis, object relations, and self psychology--posited a system of needs and behavior that was predicated on a basic tendency to define the self and structure the ego in terms of another.

On the heels of her work, and commencing in the 1950s, several authors gradually began to re-evaluate the classical notion of countertransference and active therapist involvement as a block to treatment. These authors included Heimann (1950), Little (1951), Winnicott (1958), and Racker (1968). This re-evaluation was followed by the work of such authors as Stone (1961) and Zetzel (1956), who speculated more openly about the potential value of introducing the therapist's personal qualities in creating a more humane than mechanistic treatment setting.

The more interactive or intersubjective therapies began to view countertransference as an inevitable outcome of interacting subjectivities. Analytically inclined theorists, such as Grayer and Sax (1986), have attempted to deal with the complexities of countertransference by introducing a less loaded and less negative definition of countertransference. Moreover, authors such as Natterson (1991), Epstein and Feiner (1983), Tansey and Burke (1989), and others began to

suggest that countertransference was capable of being used positively in the advance of the therapeutic process.

For the most part, the central concepts forming the theoretical foundation of this study derive from recent interactional models, such as object relations theory, self psychology, and intersubjective field work. These schools define the ego and sense of self as evolving in a very active and process oriented way from our relations--developmental and adult--with our significant self and objects. As Stolorow developed his theory of intersubjective field and applied it to the therapeutic setting, there were two subjectivities--the patient's and the therapist's--potentially operating in non-negative, non-defensive ways within the therapeutic encounter.

Subjectivity, as applied to the therapist for the purposes of this study, is defined as the totality of experiences, memories, associations, thoughts, recollections, fantasies, images and reactions brought by the clinician to the therapeutic relationship. By insisting that human interaction, of which therapy is a specialized subset, necessarily involves two (or more) dynamic subjectivities, intersubjective field theory allows a theoretical framework from which the therapist is allowed the "space" to respond humanly and humanely to the ebb and flow of treatment.

Moreover, intersubjective theory goes a step further than self psychology by implying that a subjectivity--patient's or therapist's--includes, but is not limited to, pre-existing experiences, memories, thoughts, and

associations, as well as those reactions evoked, modulated, initiated, and spontaneously drawn forth in a continuous process through the interplay between patient and therapist. In this regard, the term intersubjectivity or intersubjective field refers to the therapeutic setting, milieu, or reality created by interacting subjectivities in an encounter to encounter fashion. In this encounter to encounter, ever reforming intersubjective field, incidents of temporary emotional withdrawal by the therapist may occur, be resolved, and occur again without the implication of a long-term deleterious impact.

This new way of seeing the clinical dyad has obvious and far reaching implications for the slowly changing views of countertransference. With relational models and intersubjective field work, countertransference could now be viewed as non-negative. Further, certain aspects of countertransference that allow for the gamut of therapist responses--from disappointment to anger to genuine care--no longer had to be so tightly controlled that one was forced to pretend that they did not exist. The more interactive or intersubjective therapies came to view countertransference as an inevitable outcome of interacting subjectivities acting one on the other.

These authors strongly articulate the view that the traditional model of countertransference delimits therapist involvement in a proactive and positive way. They add that even negative countertransference dynamics can be usefully utilized by the vigilant, self-scrutinizing clinician.

The therapist is, by definition and by tradition, expected to operate from a state of uninvolved dispassionate concordance. Moreover, it becomes clear that research and practice has--as it well should--concentrated on identifying the most positive reactions a therapist can bring to the clinical setting. Negative reactions, such as emotional threat and emotional retreat, are relegated to the therapist's problematic countertransference issues, therapist's own defensive structures, and a need to understand and control these negative roadblocks to therapy.

Countertransference is so ubiquitous a response to any intense and intimate setting of an on-going relationship that it is almost a given. To propose that all instances of less than optimal responses by the therapist (such as momentary psychic retreat at the perception of emotional threat) constitute instances of negative countertransference leaves little room for the therapist to react spontaneously or uniquely in the intersubjective field. This, in turn, limits the possibility of therapists using honest reactive involvement as a vehicle for deepened understanding and patient growth.

This study draws its impetus from the most current and proactive relational theories, whose implications place the therapist in dynamic relation to the client. Specifically, this study takes as its point of departure the relationship suggested by the work of Stolorow (1992), who outlined a mutually influential intersubjective space occurring within the therapeutic setting. Stolorow's two-body approach to

clinical work sets the stage for posing the research question, "What happens when a clinician is not optimally responsive and how might this intersubjective impasse be curative?"

Statement of the Problem

Psychotherapy of any persuasion recognizes that the nature and quality of responsiveness on the part of the therapist is critical to the direction and success of therapy. Just how therapeutic responsiveness or reaction influences therapy remains a fairly new area of study. This is mainly because, for the last hundred years, we have assumed that the optimal connection for the therapist was therapeutic neutrality (Freud, 1912; Fromm-Reichman, 1950; Brenner, 1955; Winnicott, 1965; Langs, 1973; Greenson, 1976; Basch, 1980; Kohut, 1984; Stolorow, 1987; Wolf, 1988).

The traditional psychoanalytic model sees the therapist as the veritable blank screen, reflecting the patient's intrapsychic conflicts, while providing requisite interpretation and insight with sufficient empathy and consistency to allow transformative patterns to develop. Classical models of therapeutic neutrality and countertransference have taken as a given the long history of viewing the therapist as "outside" or "above" the therapeutic dynamic. It has come to be assumed that this extra participatory position is essential for therapist objectivity, therapist effectiveness, maintaining functional therapeutic distance, and therapeutic progress.

Countertransference traditionally had pejorative connotations as something to be avoided, and the primary role of the therapist was to avoid its deleterious effects. The phenomenon of countertransference has been traditionally defined as the enactment by the therapist of his or her own reciprocal processes of projection, identification, and enmeshment vis-a-vis the patient.

Thus, studies on therapists' reactions to patients' aggression have tended to concentrate on the therapist's role as a controller of countertransference and as the dispassionate, yet optimally responsive, observer and insight giver. More specifically, research has focused on the clinician's responsibility to facilitate, ameliorate, analyze, and mitigate rage related patient defenses such as transference, projection, denial.

The necessary "challenge to growth" implied in psychotherapy has an inevitable component of patient defense and patient rage. It is not surprising, then, that studies have concentrated on patient rage and almost ignored the possibility of similar emotional disconnections on the part of the therapist.

Studies of patient rage, when directed toward the therapist, as addressed extensively by Winnicott and others, are voluminous. The conception of the therapist as a human being with the capacity to momentarily retreat when emotional threat is perceived in the clinical setting has been, to a degree, inconsistent with the psychoanalytical model of the distant and tempered clinician. Thus, there has been little

research specifically addressing the notion of therapists' spontaneous retreat.

Purpose of the Study

This study begins from the notion that therapists, as human beings are in a constant intersubjective field vis-a-vis that patient, both experience attack and momentarily retreat from it in the therapy setting. The present study is designed to survey and verify one aspect of the therapeutic process, namely those phenomena that occur when a therapist feels emotionally attacked by the patient and acts on these feelings of emotional threat by temporarily removing himself or herself from an optimally authentic and responsive therapeutic connection.

As such, this study will assess the situations, conditions, and patients' behaviors, as well as their nature, quality, and frequency, that provoke in the therapist the perception that he or she has been emotionally threatened. This study will gauge the actual, as well as postulate the theoretical, nature of therapists' reactions and responses to patients' aggression.

This study will seek out ways in which therapists eventually transform these moments of disconnection into opportunities for continued therapeutic dialogue. This search will begin with the assessment and identification of recurring themes and patterns in therapists' reactions and behaviors with respect to perceived threats. Related to this is the goal of suggesting and verifying that a recognition of and a working through of these disconnections are critical to

honest, optimal patient-therapist attunement and that this relationship holds true both when disconnection involves momentary setbacks as well as what traditionally has been viewed as breakthroughs.

Specifically, this study attempts to assess what sorts of stratagems therapists employ in such situations to "collect" themselves and to reinsert themselves into a positive dialogue that is once again conducive to honest communication, trust, and patient growth. Finally, the researcher hopes that this study will demonstrate how ruptures in the therapeutic connection, caused by the therapist's emotional retreat in response to emotional threat from the patient, if recognized and acknowledged by the therapist, can be used to re-engage the patient in ways that promote the interpersonal depth and facility of the patient-therapist dyad and the patient's personal growth as well as the therapist's.

Research Design and Questions

The research design is qualitative, one in which the therapists are interviewed to elicit their responses as to what they experience and do in those treatment circumstances when they feel sufficient emotional threat to retreat from the therapeutic connection. Specifically, the research questions this study seeks to answer are as follows:

1. Are there instances when a therapist feels emotionally threatened and what does he or she do about it?

2. What are the ways in which the therapist responds to emotional threat?

3. What happens when a therapist cannot handle being emotionally threatened?

4. Does the way in which the therapist responds to the threat and possible disruption progress or hinder the treatment?

As detailed in chapter four, these questions were derived from an original of eight questions that proved to need a more precise focus to deal with the purpose of the study. These questions were as follows:

1. What behaviors do patients exhibit toward the therapist that elicit the perception of emotional threat?

2. Are there categories of threatening or provoking behaviors which reoccur across therapists' reports?

3. What are the subjective and intersubjective experiences which therapists observe in themselves as they become aware that they are feeling emotionally threatened?

4. In what ways and to what extent do therapists respond to emotional threat by disconnecting from an optimal intersubjective field?

5. What happens to the intersubjective field, shared by the therapist and patient--the interaction of subjective experiences--as the therapist disconnects?

6. What are the types of stratagems and tactics reported by therapists which facilitate their reentering the therapeutic connection from a position of non-threatened, honest, empathic linkage?

7. What are the subjective and intersubjective experiences and overt behaviors of therapists as they correct the temporary disconnection?

8. In what positive, growth enhancing ways does the intersubjective field between therapist and patient change when the therapist corrects the temporary disconnection?

Significance of the Study

The potential significance of this study comes from the raising of the hypothesis that the therapist's state of temporary emotional disconnection, if recognized and destigmatized as an indication of negative countertransference to be avoided, can be acknowledged as part of the honest ebb and flow of relationship building. Moreover, this emotional disconnection, and the accompanying working through and resolution, can constitute an arena for deepened honesty and trust between therapist and patient, as well as enhanced patient growth.

This study also has significance to social work in that the study's theoretical foundation, intersubjective theory, is particularly adaptable to clinical social work. Intersubjective theory clearly acknowledges the long lineage of analytical training that allows the social worker to do psychotherapy, but does not focus on the isolated individual or internal drive states, highlighting instead the whole intersocial matrix. Specifically, intersubjective theory assumes the three-fold configuration required of all social work: the person, the situation, and the interaction between them (Hollis, 1964).

Moreover, because of its broad social base and its cultural milieu, clinical social work has had to include many so called borderline patient populations that stricter psychoanalytic models simply dismiss as untreatable. As social workers have to deal with these more reactive, characterologically self-destructive, and confrontational clients, the social work therapist is forced, perhaps more than any other practitioner, to look closely at his or her honest reactions to patients. Social workers are also, because of the less rarefied nature of their patient population, under particular duress to turn moments of impasse into vehicles for growth. Thus, the results of this study have particular value for the practice of social work.

Assumptions

1. This study assumes the idea that, in the therapy setting, the therapist will, at times, lose the capacity to stay emotionally connected and optimally attuned to the patient, due to the therapist's perception of being emotionally threatened by the patient.

2. This study assumes a theoretical sophistication on the part of the respondent-therapists (as deduced from credentials and at least 10 years of experience), such that the concepts and terms used in the questionnaire and interview will be familiar.

3. This study assumes that the participating therapists have undergone treatment or analysis of sufficient depth and duration to render them sufficiently self-aware for the purposes of the study.

4. The therapist-respondents in this study are assumed to be serious therapists able to discern and willing to reveal when they are in a state of temporary emotional retreat from the patient.

Limitations

1. Subjectivity is that complex internalized cognitive and sentient component which experiences such emotional states as a psychic threat. Subjective experience is only available to external knowledge by verbal report from the person having the experience or internal state. As such, subjectivity is not verifiable by a second reliable source; in fact, reliability is a misnomer when applied to studies of subjectivities. More to the point in this study, the patient or other subjectivity involved in the intersubjective dyad cannot be expected to corroborate the therapist's subjective experience of emotional threat. The patient cannot proffer information such as "Yes, I intended a threat," or "No threat was implied or stated," because subjectivity deals with a subtle internalized mutually created reality, not some verification or absolute behavior on the part of either patient or therapist.

2. One person's sense of threat may not be another's and one person's ability to handle this and not withdraw is different from others. Working under the assumption that withdrawl is not the only response to a threat, a limitation is imposed.

3. Due to the small sample size (8), only qualitative

methods may be used and qualitative results and conclusions assumed and addressed. Moreover, because the therapist participants were not randomly selected, only general patterns may be discussed.

4. Since the selection process involved a preliminary questionnaire asking respondents if they had experienced affective disconnection in therapy, and since only those responding "yes" were, by definition, included in this study, there is a degree of experimental bias such that the results must be intended primarily for the purpose of suggesting further research.

Definition of Terms

1. Connection refers to that state in the therapist in which he or she maintains a hovering attuned attentiveness (Freud, 1906), and even sustained affective attention, to the patient during the therapeutic encounter.

2. Emotional retreat occurs when the therapist loses the ability to remain optimally affectedly attuned to the patient's needs and is momentarily out of the therapeutic dyad and focused instead on his or her archaic self and object needs.

3. Emotional threats are any experiences perceived, emanating from the patient, of a sufficiently emotionally threatening nature that the therapist finds himself or herself thrown off center emotionally. This can include any perception of a covert threat (yawning, eyes wandering), or an overt threat (recriminations, verbal abuse).

CHAPTER II

REVIEW OF THE LITERATURE

This review of the literature covers the development of the beliefs surrounding the meaning and use of countertransference in the psychotherapeutic setting. The chapter begins with a review of the development of more modern conceptualizations of countertransference, tracing the origins of its meaning from Freudian notions to more modern, two-bodied concepts. Then, the development of the relational model of the psychotherapeutic setting, from the perspective of its major is presented. This is followed by the implications of the relational model, both for the role of the therapist and for countertransference. The chapter ends with a conclusion, which relates the literature to the researcher's own experience.

Freud implicitly recognized the importance of "the other" and of relatedness to another in the development of the psyche. Through the anecdotal nuances of his writings, Freud tacitly admitted his understanding of the relational components underlying our internal organization of experience and our external expressions in behavior. Nonetheless, his analytical formulations basically consist of a one-body model in which the earliest instinctual fantasy life of the child, and its frustration in reality, are regarded as the crucial factor in permanent psyche structure and potential pathology (Freud, 1934).

Though he never articulated the exact nature of countertransference, Freud's theories are necessarily based on a psychology of relatedness. The concepts of transference, countertransference, and Oedipal struggle indeed require us to conclude that Freud conceived of behavior and the therapeutic situation in terms of a potentially two-bodied psychology. Yet, the orientation of classical psychoanalysis throughout the 1950s, 1960s, and currently has been centered on a one-bodied or monadic rather than a multi-bodied psychology.

Much of the resistance to viewing therapy as a two-bodied system of reciprocal influence comes from the desire on the part of early analysts for psychoanalysis to behave as a strict science. The requirement of absolute objectivity and empathic distance for the therapist, as well as the mechanistic single body conception of the patient's behavior stem from this bias toward hard science (Mitchell & Greenberg, 1983).

Viewing the individual as a closed system of three isolated, definable variables--the id, the superego, and the ego--driven by the inner engine of instinct, reflects an effort toward parsimonious conception and scientific methodology. But within the kernel of this classical model is the intimation of a psychology of relatedness--the theoretical framework from within which this study emanates.

As Mitchell and Greenberg (1983) have pointed out, the first step to viewing the therapist's role as proactive comes (surprisingly) from within the strictly Freudian drive model.

Indeed some of the most gifted theorists (Klein, 1946; Kernberg, 1963; Winnicott, 1965) who began to formulate a psychology of relatedness, either consciously or by implication, moved to that position from the logical implications of concepts central to the classical analytical tradition (Mitchell & Greenberg, 1983). The theoretical path that led to a proactive posture for the therapist, in light of the strong and long standing precedent of Freudian distance and rectitude, evolved slowly and, in some respects, coincidentally. Slowly, the parascientific mechanistic notion of the psyche and self-development as a closed system of drive satisfaction and conflict resolution came under scrutiny, mainly from the earliest Freudian-based developmental psychologists and then the ego and self psychology schools that followed and came into prominence in the 1930s, 1940s, and 1950s in America and England.

The first step came as Freudian based developmental analysts began to slowly see that the child was not just a composite of instincts, but developed in response to and in relationship with need mediators or significant objects. These objects can be fantasized introjects (Klein, 1946) or real persons (Winnicott, 1945).

Once this switch in theoretical orientation was achieved, the critical formative impact of these "need mediators" to the development of a healthy ego or cohesive self came under closer investigation. From there, it was not a big leap to implicate "the other" in the etiology of maladaptive patterns and psychopathology.

Research and practice moved from a strictly drive schema of behavior and neurosis to a model that allowed for the significantly intervening factor of relationships with our primary need suppliers. Once preeminent developmental theorists proposed that the child was more than its instincts and that both child and adult were motivated by needs to relate to the world and to the other, dysfunctions of the ego and other symptomatologies, from neurosis to borderline symptomatologies, came to be viewed from within this relational context (Tansey & Burke, 1985).

Once the self in relationship with another is seen as causing both psychic health and dysfunction and the therapist viewed as having the role of a resocializing significant other, the therapist's role can be understood from a relational model. Indeed, many early and later therapists were instrumental in suggesting the conceptual and practical parallels between the patient as a presocialized child and the therapist as the optimally socializing parent.

Relational Freudians, or as they have been termed "interpersonal analysts" by Tansey and Burke (1985), stuck to the idea of the therapist as provider of insight about interpersonal derailments. More radical relational theorists actually began sweeping away the hundred-year-old model of required clinical distance, suggesting that the therapist is a reactive element and could respond to the patient in health-inducing ways (Kohut, 1959, 1977).

The degree to which theorists and writers would allow for an active role on the part of the therapist seemed

predicated upon their allegiance to strict Freudian concepts (Mitchell, 1980). At the most classical and conservative end of the continuum, the therapist's role was altered within the slowly evolving relational paradigm to include the analysis and identification of the patient's disruptions in relational patterns.

The most active therapeutic role, at the time, according to Kohut, was proposed by Self psychology. Such a psychology allows for the fact that the therapist may do more than analyze maladaptive self and object relations; he or she may take the patient to and through that point at which self and object derailment occurred.

Self psychology is interactive as compared to strict Freudian clinical distance. However, it stops short of the proactive intersubjective notion that the therapist is involved in a dynamic and reciprocal dyad, with a component of his or her spontaneous internal life brought to the treatment setting which resides outside Freudian rectitude.

As suggested by Stolorow (1992), the most proactive relational model is that of intersubjective space, with its conception of the therapist as an acting and reacting subjectivity, inevitably bringing to the treatment setting, in a dynamic and unedited fashion, an internal and external mental life. Stolorow's intersubjective theory began to give the therapist the space to be a spontaneous entity in the therapeutic setting and allowed a loosening of the stigma associated with emotionally authentic therapeutic reactions.

This evolution of an increasingly relational posture for the therapist necessitated a re-evaluation and redefining of the concept of countertransference as viewed in the Freudian model. The development of this reconceptualization is discussed below.

The Development of the Relational Model

There is a multi-tiered theoretical thrust, which began slowly as far back as the 1930s here and in England. This theoretical conceptualization set the stage for the non-traditional question, "What does a therapist do when he or she loses optimal emotional connection?"

As Mitchell and Greenberg (1983) have noted, the first inroads toward a theory of relatedness for human behavior and therapeutic change began in the first four decades of this century and came from Freudians working on developmental issues within the drive model. Sandor Ferenczi was perhaps the first to publish his ideas on the causal role of the other in development and symptomatology. His early work in the 1930s exhorted the therapist to look to the pathogenic potential in parents' and caretakers' mishandling of the child's complex, normal early needs associated with the emergence of psychosexual stages (Ferenczi, 1928).

Next to contribute to the evolution of a psychology of relatedness was the Englishman Ian Suttie. For Suttie, the most important aspect of mental development was the idea of others and of one's relationship to them. "Man for Freud is a bundle of energies seeking to dissipate themselves but restrained by fear. As against this, I regard expression not

as an outpouring for its own sake, but as an overture demanding response from others. It is the absence of this--a response from others--that is the source of all anxiety and rage, whose expression is thus not automatic but wholly responsive" (Suttie, 1935, pp. 29-35).

Although tied to archaic conceptions of drive, the American Kernberg proposed a self system driven by instinct, but which concurrently integrates aspects of relations with others into an internalized precept of the world and experience (Kernberg, 1965).

Heinz Hartman (1939), was a perserver of Freudian theory. His major contribution to what were the beginnings of a relational model had to do with the ideas of adaptation, as regards to object relations. Hartman suggested beginning with an ego structure that is innately conflict free and that, as we navigate in a necessarily interpersonal world, conflict is born (Hartman, 1939).

Thus, Hartman was among those who suggested an intact innate ego existing outside instinct, as well as one of the first Americans to propose that, in our earliest and mature interactions with others, both adaptive and psychopathogenic conflicts or constructs are formed (Hartman, 1939).

Ronald Fairbairn (1944) rejected the idea that the fundamental link between the self and the object was instinctual drive. He felt that the self, both at primitive and adult levels, was motivated by the seeking of, anticipation of, and experience of others that provided ego integrating contacts and a positive sense of self. For

Fairbairn, instincts were object-seeking (i.e., other-seeking), not pleasure-seeking. In this regard, he viewed Freud's oral and erotic drives not as primary motives, but as techniques of dealing, negotiating, and communicating with significant objects.

Another contribution came from the work of Harry Stack Sullivan in America. Sullivan emphasized parental character as the medium within which personality is structured. Anxiety-free and anxiety-filled areas of functioning in the caretakers set the context within which the child experiences himself or herself (Greenberg & Mitchell, 1983).

Sullivan slowly came to extend the idea of "caretakers" to important self and objects providing nurturing and ego integrating experiences throughout life. According to Sullivan, "There follows from the earliest association of need and tenderness, a natural progression and hierarchical emergence of other infant and mature needs that evolve out of the mother's and other's responses. These evolve from those earliest needs for survival and contact to more complex ways of connecting in later maturational epochs" (Sullivan, 1953).

Another important contribution from Sullivan was the idea of "empathic linkage" between mother and child. As the mother meets the needs of the child and the child responds with satisfaction and pleasure, the mother then reacts with good feelings and positive cues to the infant in a cyclic empathic tie that is mutually motivational.

Sullivan was thus the first to suggest the notion of a two-way reciprocity between a dyad as a system able to create

ego integrating or ego disintegrating experience. As these ideas of developmental reciprocity between infant and mother came to be applied via self psychology to all relationships, including those of adults, the ground was laid for the idea of a reciprocal dynamic intersubjective space existing between therapist and client.

According to Tandey and Burke, Melanie Klein (1946, 1955) put relational interpersonal models back in the arena of the unconscious and helped to merge concepts from analysis with the relational models that were beginning to emerge. Klein suggested that internal drives are not strictly intrapsychic, but are fantasized introjects of drive gratifying experiences coming at pivotal developmental periods. Her research on the fantasized good breast and bad breast, associated with gratifying and non-gratifying feeding experiences, opened the door for classical analysis to consider the influence of external variables interacting with basic drive.

Klein's highly respected writings invited speculation, even in the Freudian camp, about the effect and importance of outside inputs--the mother, important others, fantasized internalizations of significant self and objects--on the development of ego structure and behavior.

Michael Balint was the first psychoanalytic practitioner to suggest that the instinctual drives proposed by Freud, such as sex and aggression, were products of a child's upbringing. "These so called drives have their explanations in the child's individual history and not in innate

structure. Problems around these issues come from the absence of good, loving understanding between the child and the grown ups around him" (Balint, 1961).

D.W. Winnicott, a pediatrician and psychologist, focused on environmental factors in psychological development and pathology. As noted, many of the relational theorists before Winnicott viewed the mother-child relationship as the primary setting in which early and lasting self and object relations evolved, but held on to the notion that the instinctual arena set the limits, features, and outcome of the maternal relationship (recall that, for many of the theories discussed above, "good mother"/"bad mother" internalizations are a function of how the caretaker responds to critical needs/conflicts related to psychosexual stages).

For Winnicott, this causal relationship is reversed. A self system develops as the result of the quality of responsiveness from others, and the libidinal instinctual issues are the vehicle through which these pivotal-self forming interactions express themselves (Winnicott, 1962).

The most vociferous relational schools were the ego and self psychology camps. These schools share with other relational models the basic tenet that the emergence of the self requires more than instinctual motivation and more than the instinctual will to organize experience or order the environment. The self requires the gauge, buffer, and barrier that is the other (Goldberg, 1970).

The basic relational foundation of ego and self psychological schools involves the idea that relationships to

the other which are constant and satisfying lead to structural cohesion and the vigor of the self. In contrast, faulty self and object experiences facilitate the fragmentation and emptiness of the self (Kohut, 1959; Lichtenberg, 1983; Stenn, 1985; Wolf, 1988).

In well written and cogent arguments, ego and self psychologists convincingly state that human beings continue to be motivated by the need to relate long after its survival or drive reducing function subsides. Ultimately, even the drive model adherents that bridged Freudian and relational camps, such as Mitchell, Greenberg, Winnicott, Sullivan and others, came to the conclusion that "relation to other" could be tied to instinct in the earliest phases of infant development, but that the need to relate eventually came to override instinct as an undeniable motivational valence that extended beyond the biologic and psychological limits of instinct.

Most recently, Mitchell and Greenberg (1983) proposed a merger of instinctual and relational models. They state that

> ...within the relational model, psychological meanings are not regarded as universal and inherent bodily experiences. Events are understood as evoked patterns which derive meaning from the way they become patterned in interaction with others. From this viewpoint, what is inherent is not necessarily formative and does not necessarily push and shape experience, but it is itself shaped by the relational context. Indeed the mind employs what anatomy and physiology supply but the meaning of those body parts and processes, the underlying structure of experience and its deeper meanings
>
> derive from relational patterns--from our struggle to maintain connection with another (Greenberg & Mitchell, 1983).

The relational model altered how therapists viewed their role and the freedom they might exercise within that role. The relational model allowed for a fuller range of human responses in the therapeutic encounter. Alterations in the therapist's role, and a loosening of what constituted appropriate clinical involvement, underwent the same gradual evolution as did the relational paradigm.

Implications of the Relational Model For the Role of the Therapist

As developmental theory progressed, it did not take long for these and other researchers to begin to draw a conceptual and practical analogy between the socialization of the infant ego by the optimally responding parent and the resocialization of the fragmented ego or self by the therapist. In a gradual process, ideas gleaned from these developmental Freudians were applied to clinical notions. If important others can cause ego-integrated structure as well as psychopathology, then the therapist, as an important other or significant object, can parallel the curative phases of this process.

At a remarkably early time (the 1920s), Ferenczi began to suggest the very intersubjective notion that the relationship between the analyst and the patient, how it unfolded and its success or failure, lies not with the particular kind of pathology and its resistance to interpretation. Rather, he seemed to suggest, this relationship could be found in the actual nature of the connection between the patient and the therapist (Ferenczi,

1931).

Also at an early stage in the evolution of relational thinking, Suttie wrote that therapeutic process existed outside such Freudian cures as increased insight, recollection of repressed memory, and lessening of unconscious censorship. He saw effective treatment as a process of overcoming the barriers to loving and seeing oneself as loved. He saw the therapist and positive transference as the vehicle for re-establishing these emotive connections (Suttie, 1935).

Kernberg's main contribution to relational practice was his suggestion that there is a parallel between the role of the mother and that of the therapist. The role of the mother as a buffer and mediator of the vicissitudes of instinctual conflict is similar to the role of the therapist as a mediator and buffer for adult expressions of instinctual conflicts (Kernberg, 1935).

Sullivan's introduction of the concept of the therapist as a "participant observer" opened the door for the highly interactive and empathic role. It allowed for a more interpersonal approach and set the stage for later treatment models. His work was primarily responsible for the more comfortable, humane, and less authoritarian therapist stance encouraged by selfobject and self psychology (Sullivan, 1930, 1931, 1936, 1940, 1953). Sullivan's writings make it clear that he saw the role of the therapist as not just that of pointing out distortions in the self system, but as an active re-shaper of these distortions. He foreshadowed Kohut's

intersubjective clinical posture by being one of the first to encourage the appropriateness and indeed curative potential of the therapist sharing personal experiences and injecting his own feelings and views into the treatment setting.

Balint's greatest practical contribution was his articulation of the therapy setting as a necessarily two-bodied system. As early as 1949, he suggested that the unfolding of an analysis is not determined solely by the patient's associations, transferences, nor by the analyst's interpretations, but by an interaction between the two participants (Balint, 1949). Balint stressed the importance of investigating the analyst's contribution to creating the treatment situation--a suggestion that was later picked up and developed in the intersubjective work of Stolorow.

The practical implications of Winnicott's models include the direct parallel he drew between the good enough mother and the good enough analyst who, in the treatment setting, via transference, can reach back and redress the early disturbance. Winnicott wrote that what is important in a clinical setting is not what the analyst interprets, but how the analyst behaves.

By proposing a firmly relational model in treatment, theorists such as Winnicott suggested that the therapist could indeed insert himself or herself into the self and object dynamic and re-pattern derailed object relations by becoming, over time and through judicious combinations of empathy, insight, and interpretation, a healthy self and other experience from which the patient might restructure the

self and generalize to relationships at large. This concept had enormous implications for countertransference practice and theory.

Thus, in the same slow and subtle fashion that the relational model crept into analytical thinking, its implications came to have an influence on the therapist-patient relationship, with more emphasis placed on the therapist's active role and impact in therapy. As Bacal states,

> ...the course of analysis and treatment is not to be attributed to the patient's early life experience alone, but considered also very much a product of the nature of current object relation between the patient, his analyst and the ethos of the analytic situation (Bacal, 1990).

All of these theoretical and practical considerations led to a final development in relational thinking in the form of the intersubjective field as outlined by Stolorow (1989). Stolorow added to the relational model when he observed, again and again, that reaffirmations of patients' experiences--regardless of how defensive or regressive--possessed a tremendous potential to enhance the therapeutic bond, allay patients' state of anxiety, and diminish their defensive strategies so that positive self and object transferences could begin to form (Stolorow, 1992).

Stolorow observed that the therapist's "being there" in an honest and authentic way had great empathic and therapeutic power. His clinical observations identified the nature of this most effective therapeutic response to be one of "hearing and responding to who the patient is at each

therapeutic moment" (Stolorow, 1992).

As Stolorow and others developed this theory of the intersubjective field and applied it to the therapeutic setting, there were two subjectivities--the patient's and the therapist's--potentially operating in non-negative, non-defensive ways within the therapeutic encounter. Here the dynamic reciprocity is not between individuals, but between subjectivities, and Stolorow came to define each participant's subjectivity as the totality of experiences, memories, associations, thoughts, recollections, fantasies, images, and reactions brought by both the clinician and patient to the therapeutic relationship at each therapeutic encounter.

By insisting that human interaction, of which therapy is a specialized subset, necessarily involves two dynamic subjectivities, intersubjective field theory allows a conceptual and practical framework from which the therapist is allowed the "space" to respond humanly and humanely to the ebbs and flows of treatment. Additionally, intersubjective theory goes a step further than self psychology by implying that a subjectivity--patient's or therapist's--includes, but is not limited to, pre-existing experiences, memories, thoughts and associations, as well as those reactions evoked, modulated, initiated, and spontaneously drawn forth in a continuous process through the interplay between patient and therapist (Stolorow, 1989).

In this regard, the term intersubjectivity or intersubjective field refers to the therapeutic setting or

milieu or reality created by interacting subjectivities in an encounter-to-encounter fashion. In this encounter to encounter, ever reforming intersubjective field then, incidents of temporary emotional withdrawal by the therapist may occur, be resolved, be usefully utilized, and occur again without the classically based implication of long-term deleterious impact.

This notion of the therapeutic encounter as a reciprocally reactive and adaptive dialogue between two systems of instinct, cognition, perception, memory and emotion in dynamic interaction is, unarguably, less tidy and scientific than the idea of the therapist as a blank screen. However, unruly as it may be, current thinking (Greenberg & Mitchell, 1983) supports the idea that such an interactive and flexible system more accurately reflects what transpired as we developed in infancy and what transpires as we grow in therapy.

Implications of the Relational Model for Countertransference

Examination of any response on the part of the therapist have tended to fall under the rubric of countertransference. In the course of the evolution of relational models, the nature of countertransference has undergone a thorough analysis. Because of the centrality of clinical distance in the classical model, the predisposition to see countertransference as an impediment to effective treatment has been strong and long lived. With the advent of new relational models, subtle distinctions in countertransference

have been postulated, with certain countertransference responses being seen as less pejorative connotations than others. For example, with object relations theory, appropriate empathy and empathic attunement became elements of effective clinical insight, while other forms of identificatory experiences, such as anger, enmeshment, emotional retreat, were still seen as tremendously negative.

To understand the evolution of countertransference in the context of a proactive relational posture for the therapist, it is necessary to re-examine Freud's position on the phenomenon he basically invented. The first time Freud used the term countertransference was in 1910. "We have become aware of the 'countertransference' which arises in the physician as a result of the patient's influence on his unconscious feelings and we are almost inclined to insist that he shall recognize his countertransference in himself and overcome it" (Freud, 1910, p. 144).

One does not hear Freud mention countertransference again until his 1912 paper in which he presented the following often quoted passage:

> I cannot advise my colleagues too urgently to model themselves during psychoanalysis treatment on the surgeon who puts aside all feelings even his human sympathy and concentrates his mental forces on the single aim of performing the operation as skillfully as possible . . . The justification for requiring emotional coldness is that it creates the most advantageous conditions for both parties: for the doctor a desirable protection for his own emotional life and for the patient the largest among of help we can give him today (Freud, 1912, p. 115).

However, in the next few paragraphs of the same paper, one hears Freud saying that the analyst "must turn his own

unconscious like a receptive organ toward the transmitting unconscious of the patient (Freud, 1912, p. 115). He goes on to make statements that seem to contradict exactly what he previously prescribed in terms of the therapist's maintenance of distance:

> But if the doctor is to be in a position to use his unconscious in this way as an instrument in the analysis, he must fulfill one psychological condition to a high degree. He may not tolerate any resistance in himself which hold back from his consciousness what has been perceived by his unconscious; otherwise he would introduce to the analysis a new species of selection and distortion which would be far more detrimental than that resulting from concentration of attention (Freud, 1912, p. 116).

Even this early in the theoretical life of the countertransference issue, Freud was unclear and, in many ways, placed himself in both the classical posture of complete distance and the relational posture of judicious involvement.

Very little was written on countertransference after those early comments by Freud until Deutsch (1926) argued that countertransference includes not only pathological responses, but also the process of unconscious identification with the patient through revival of memory traces from the analyst's own developmental experiences that are similar to those of the patient. It is this identificatory process, she stressed, that forms the core of what she termed "intuitive empathy" (Deutsch, 1926).

Reik, in 1937, wrote a book ardently encouraging the therapist to attend to affective signals emanating from

within as vital sources of information for comprehending the patient's unconscious processes. Reik is credited with presenting the first notion of a positive form of countertransference under the rubric "trial identification," a sort of short-lived, non-volatile empathic link (Reik, 1948).

According to Reik, the communicative process goes on unconsciously for both patient and therapist. "It is only by attending to the affective signals coming from within himself that the analyst is able to fathom their hidden meanings and bring into his own consciousness what the patient is unconsciously communicating" (Reik, 1948, p. 154). For Reik then, some sort of countertransference in the form of identification is essential to insight and understanding.

Annie Reich coined the term "transient introjection" to distinguish a positive form of therapist identification that is both controlled and temporary. Unlike Reik, she felt that anything beyond this limited form of identification was deleterious to treatment (Reich, 1960).

Beginning in the late 1940s, Fleiss followed on the work of Reik and suggested that the optimally functioning therapist introjected the "instinctual material" emanating from inside the patient. However, the therapist would experience only the material's quality, not its intensity. Allowing for the experience of temporarily "becoming the subject himself," and referring to this as "trial identification," Fleiss early on proposed the notion that only through this sort of trial identification could the

analyst obtain "inside" or unconscious information (Fleiss, 1942, 1958).

The period between the 1950s and the 1960s, following the object relationists in England (Fairbairn, Balint, Klein, and Winnicott) and the interpersonal, ego or relational analytical camp emerging in America (Kernberg, Hartman, and Sullivan), saw a major re-investigation of the concept and limits of countertransference. As behavior in general, and maladaptive patterns specifically, began to be viewed as interactional, the entire issue of countertransference, its meaning, and impact in therapy also was gradually reworked. Literature on countertransference underwent a restructuring after intersubjective schools took hold. The traditional pejorative view gave way to one in which countertransference itself began to be viewed through a less negative and more interactional and comprehensive model.

Around the late 1950s, several authors altered the classical view of countertransference as a block to treatment (Heimann, 1950; Little, 1951; Winnicott, 1958; Racker, 1968). This trend was followed by the work of such authors as Stone (1961), Greenson (1965), Zetzel (1956), who speculated about the importance and potential value of interjecting the therapist's personal qualities so as to create a human rather than mechanistic and cold treatment setting.

Of these authors, Heimann (1950) is widely credited with paving the way for the totalist perspective. Sounding very intersubjective, she described the analytic situation as a "relationship between two persons" characterized by the

presence of strong feelings in both parties. She strongly suggested that the term countertransference should properly refer to all the feelings that the therapist has for the patient, since the distinction between "realistic" and "distorted" responses based on past experiences is difficult to make.

She asserted that the therapist should utilize strong emotional reactions. Moreover, the therapist is under duress to sustain the feelings stirred in him or her for the purpose of gaining understanding, however without discharging them (as does the patient), and always must subordinate such feelings to the analytical task. "By attending to feelings roused in himself via his patient's associations and behavior, the analyst is best able to reach the 'patient's voice'" (Heimann, 1950, p. 82).

Variations on the theme of a responsive, involved, relational role for the therapist followed on the heels of Heimann in the work of Reik (1948), Winnicott (1949), Berman (1949), Little (1951), and Racker (1953, 1957). Perhaps the strongest spokesperson for a renewed look at countertransference was Racker, who posited the idea that concordant or "matching, self-affirming" identifications with the patient, on the part of the therapist, were a central component of empathy and empathic linkage. Racker, an early and insightful totalist, made the enormous contribution toward intersubjective thinking of presenting the idea that the countertransference reaction, in addition to being a potentially serious barrier if engaged in non-vigilantly,

also could be extremely valuable to the therapist, opening up avenues of insight to the patient which otherwise would remain unavailable (Racker, 1953, 1957).

In the typical to and fro dialectic of theory and counter-theory, the years between 1960 and the mid-1970s were marked by a reaction to relational positions with authors coming out firmly once again in favor of the analyst's professional distance as an element of effective therapy that could not be dispensed with (Reich, 1960, 1966).

Because of inroads into the relational model made by Heimann, Racker, and others, countertransference came to be viewed in terms of a theoretical and practical continuum, conceptualized mainly by Kernberg (1965). He distinguished between the "classical" and the "totalist" approaches to countertransference. The former was seen as restricting the concept of countertransference to therapists' unconscious pathological reactions to the patient that reflect unresolved conflicts in the therapist and, for effective therapy, must be overcome.

In contrast to the "classical" approach, the so called "totalist" or two-bodied approach (two mutually interacting selves), put forth by Heimann, Racker, and others, and further developed by Kernberg, continued to pave the way for intersubjective thinking. The totalist conception views countertransference as including all the therapist's responses to the patient--conscious, unconscious, real, and neurotically distorted. Kernberg's totalist conception anticipated much of Stolorow's concept of interacting

subjectivities in that his totalist view argued that the usual distinction between the therapist's so called realistic perceptions and his neurotic perceptions is fallacious, since perceptions virtually always involve elements of past and present reality fused together. The classicists viewed countertransference as a pathological impediment to be overcome; the totalists viewed it as a potentially useful tool for understanding the patient.

Following Heimann and Kernberg, Schafer (1959) and Kohut (1959) published papers on the idea that a large component of countertransference entails a empathic connection with the patient and that empathy for the client was essential to the therapist's ability to ameliorate past dysfunctional patterns. Positive countertransference was labeled "generative empathy" by Schafer to distinguish it from the negative sort of projective identification that introduced the therapist's unresolved issues into the therapeutic setting.

Grinberg (1962) built on this idea of appropriate empathy and appropriate identification. He coined yet another term--projective encounter identification--to distinguish it from "countertransference reactions resulting from the analyst's own emotional attitudes or from his neurotic remnants, reactivated by the patient's conflicts" (p. 446).

Throughout the 1970s, Kohut (1977), Olinick (1973), and Beres and Arlow (1974) expanded the notion of countertransference as a form of healthy, empathic

identification and stressed the cyclic application of identification, followed by separation at judicious junctures, as constituting the core of appropriate empathy and countertransference. These researchers also stressed "the importance of vigilance and sensitivity on the part of the therapist in his ability to shift carefully from feeling and thinking with the patient to feeling and thinking about the patient" (Olinick, 1973, p. 42).

In the late 1970s and the 1980s, authors such as Buie (1981), Ogden (1979, 1987), Grotstein (1980), Basch (1983), Schafer (1983), moved toward shedding the subtle distinctions between negative countertransference, on the one hand, and appropriate projective identification or empathy on the other. By the 1980s, these authors came to include the entire responsive network of the therapist as a form of countertransference, not only stripping away the term's pejorative ramifications, but allowing therapists the room to have certain strong and varied emotional reactions to patients.

Grayer and Sax (1986) were concerned with dealings with the complexities of countertransference, such as issues of tradition and issues of subconscious motivation. In their comprehensive re-evaluation, they introduce a more ubiquitous and less pejorative definition of countertransference,

> The definition that seems best to capture the experience of countertransference is that it is the totality of the therapist's experience in relation to the particular client, conscious and unconscious, feelings and associations, thoughts and fantasies; it includes the therapist's feelings about the client as well as the therapist's feelings about him or herself (p. 298).

By the 1980s, a gradual shift in the acceptable level of therapist involvement had taken place. Moreover, these new perspectives came to supplant the long-standing traditional Freudian dictum of countertransference as a phenomenon to be avoided at all costs.

The re-evaluation of the potential beneficial effects of negative countertransference, including therapist anger, has been slower to evolve and more recent. These potential benefits are necessarily an outcome of intersubjective field models.

In his book, Beyond Countertransference, Natterson (1991) gives a forthright and bold clinical account of the vital importance that a totalist intersubjective approach plays in treatment and in defining the parameters of patient-therapist involvement. He offers many examples of how he uses a present, active, and authentic intersubjective self to provide new experiences which the therapist is called upon to process and work through. These clinical vignettes exemplify the importance he places on the intersubjective nature of therapeutic action and patient growth.

Natterson suggests that the traditional model of countertransference actually blocks therapists from responding to, or consciously acknowledging the responses of, their patients that are of a spontaneous, non-neutral and more "experience real" nature. He then speculates that these externally imposed blocks to authenticity on the part of the clinician can be as negative as the overenmeshment that occurs in negative countertransference (Natterson, 1991).

According to Natterson (1991), by insisting that the "effective" analyst is one who only reacts to the patient, by insisting that the "effective" clinician is one who brings nothing of his personal dynamic, and by inferring that any idiosyncratic responses on the part of the therapist add an impure, intrusive and reactive element, the purely intrapsychic model of diagnosis excludes the significant transactional component of adaptive and maladaptive behavior. Natterson also speaks, for the first time, of the idea that both love and hate play into the transference and countertransference dynamic, stressing the importance of all these connections to the therapeutic relationship. "This gordian knot of love, hate, and fear that binds us [patient and therapist] is eventually dissolved [through a process of meticulous engagement and vigilance on the part of the therapist] rather than being severed" (p. 19).

Natterson (1991) cogently addresses the issue of an active intersubjective self introduced to therapy by the therapist. As he sees it, the interplay between intersubjective selves enters all aspects of relationship between two people, where intense emotions, questions of values and morals, and other unconscious psychological factors come into play. "Effective understanding of this exquisitely human experience requires involvement of the whole person of the therapist" (p. 206).

Natterson's years of experience and his own self-scrutiny contribute to a fuller understanding of his approach to appropriate involvement and scrutiny of the therapist's

intersubjective self. He never implies that certain forms of patient involvement, including overidentification with the patient, the possible loss of professional validity, and loss of boundaries, are negative, even though they can be blocks to effective therapeutic progress. Natterson explains that if one practices what he terms "meticulous self-scrutiny," the therapist will be able to honestly evaluate the nature of the patient involvement or, in extreme cases, the possible need for referral to another clinician.

In Natterson's (1991) opinion, any subjective elements from the therapist's psyche, no matter how unconventional or extreme, can, when combined with meticulous scrutiny, constitute valuable therapeutic input. "The outcome depends on how carefully and honestly the therapist processes his or her own fantasies and feelings" (p. 210). Essentially, Natterson and all the theorists who overtly and covertly advocate a more active role for the therapist also acknowledge that this role requires greater responsibility and self-awareness on the part of the therapist. There is one difficulty in that there is a minimization of the fact that therapist's has an unconscious with great power.

Searles (1965) sees the anger/hate dynamic, when actively used in therapy, as an opportunity for the patient to transmute the idealized object. This process then moves the patient into an integrated notion of the ego as having many positive and negative functions, under some functional control. For the therapist to understand this process of transmuting the idealized self and moving into the realm of a

realistic and integrated self, that therapist must feel comfortable with expressions of aggression and anger. These are feelings, according to Searles, that accompany any individuation from the idealized selfobject to a whole and healthy one, and which address authentic aggression are a requisite component of this process.

Epstein (1979) carefully monitored his own reactions of rage and found that therapists can effectively and safely communicate anger after the clinician has had a chance to reduce the intensity of the anger to a level at which it is experienced as a frustration or irritation. According to Epstein, this admission of the therapist's own anger enables the patient to come up against another in a safe area, to separate from the idealized object, and to begin to form some self boundaries. Further, Epstein believes that if the therapist can demonstrate his or her ability to tolerate the frustration and aggression that underlies most ego individuation, separation, and ego boundary formation dynamics, then the patient can, through example and object incorporation, learn to tolerate feelings of aggression.

Epstein also points out that therapist aggression may be needed to derail vicious repeating cycles of rage that have psychotic components. He states that a malignant process may be set in motion that actually arrests, rather than facilitates, therapeutic progress, when the clinician allows repeated and intense outpourings of abusive behavior toward the therapist and his or her self boundaries. The success of effective use of rage in therapy will depend upon the

clinician's ability to retain the capacity for rational judgment and observation, intervening in a way that is based on comprehension and an acknowledgement of the interpersonal matrix.

Epstein holds fast to the notion that one must attempt to understand the effective and judicious use of rage in the progress of therapy because instances of acknowledged and resolved anger and emotional disconnection can have a number of profound benefits. Such instances can allow for the establishment of a credible and authentic matrix between client and clinician. In addition, the patient is reassured of his or her interpersonal being and impact, is helped to achieve a tolerable distribution of "badness," and is protected from the consequences of his or her destructiveness by the imposition and constant rehearsal of self-other boundaries. Finally, the patient is less vulnerable to the ravages of unconscious guilt and paranoid anxiety when and if rage is expressed.

Conclusion

When the therapist responds to penetration of his or her ego by acknowledging and actively using the two-self intersubjective stance, that therapist can enable substantial therapeutic progress. In my own work with patients, I have concluded that the humanization of the patient-therapist relationship, and indeed the success of the work, as measured by the extent to which the patient ego becomes integrated over the course of therapy, will depend on the therapist's use of his or her anger and on the recognition of those

instances when the patient, from a therapeutic perspective, best needs to receive such anger.

CHAPTER III

METHODOLOGY

This chapter concerns the methodology of the study. The chapter begins with a discussion of the research design, specifically issues related to qualitative research. This is followed by the procedures for the selection and subjects and a description of the pre-interview questionnaire, which they were administered. The data collection process is then discussed, including the interview guide used to collect the data. Finally the method of data analysis is presented.

Introduction

In keeping with the framework established by Freud, whereby psychoanalysis and treatment are viewed as hard sciences, there was a trend, beginning in the 1960s and gaining full momentum in the 1970s to view human behavior and its investigation as an extension of physical science. The journals of social psychology, developmental psychology, personality, and abnormal behavior were filled from cover to cover with such issues as strictly defined and isolated variables, statistical analyses, and random sampling concerns.

Beginning in the early 1980s, Polkinghorne (1983) began to investigate the viability of such hard science approaches to investigations that hoped to understand subtle human behavior. Drawing on the turn-of-the-century work of Wilhelm Dilthey (1833-1911), Polkinghorne suggested a rigorous but

loosened methodological format for research in the human sciences. Taking his lead from Dilthey, Polkinghorne questioned the positivist model of strictly quantifiable research in the human sciences. As outlined by Polkinghorne, the goal of human behavior research was not to quantify exactly the "dependent" and "independent" variables, but rather to "understand the general order that underlies the process of human existence" (p. 26). Polkinghorne goes on to describe a far subtler and more qualitative endeavor, one in which the researcher attempts to locate, elucidate, and make explicit the organizing themes that render experience meaningful.

Descriptive or qualitative investigation undertakes to explore and clarify some phenomena in which data or knowledge is lacking. Often such research is better termed exploratory in nature. An exploratory approach seeks to discover or revise insights, ideas, and concepts by minimizing preconceived notions (such as therapists never experience momentary emotional withdrawal or react to perceived emotional attack).

Glaser and Strauss (1967) further differentiate between strict scientific theory and grounded theory. In the scientific method, a theory begins and structures the process of investigation and qualitative results prove or disprove the theory in question. According to grounded theory, the researcher is more an observer of life, so to speak. Generic data is gathered in a sound but not strictly scientific format. From this often descriptive data, categories are

generated, and evidence from which the categories emerge is used to illustrate or elucidate the issue in question.

Theory is not viewed as a strict point of departure, nor as an end product of research. Grounded theory is based on research of a topic as a continually evolving process. Because social work is a non-hard science, dealing with a gamut of open-ended and constantly evolving variables from community to culture to socioeconomic status, grounded theory is best applied to social work research.

With this in mind, this study will use the exploratory and descriptive design of grounded theory to gather data on the intersubjective and subjective experiences of the therapist during instances of emotional retreat perceived to be precipitated by the patient. This study also will explore the process and curative potential of emotional reconnection.

It is the hope that this inquiry will provide the basis for further hypotheses and research that will lay the groundwork for future, perhaps more empirically based, studies. This study will, as has been suggested, concentrate on a description of "organizing structures" and "patterns" rather than on a description of cause and effect relationships among strictly controlled variables.

It is important to note that these new approaches to research in the behavioral sciences generally, and social work specifically, do not by any means invalidate wholly statistical, scientific model approaches. The new methodologies do, however, allow for the study of a whole gamut of unquantifiable cognitive processes on the part of

researchers gathering, organizing, and analyzing information on human behavior and psychotherapy.

It is in the spirit of Polkinghorne and his followers that this study and methodology are undertaken. This research is by definition qualitative rather than quantitative. I have set as my goal to locate, as Polkinghorne suggests, patterns and organizing themes that recur in the therapy setting vis-a-vis instances of therapists' emotional retreat.

As a qualitative study, this research makes no claims to random selection of subjects. It acknowledges that there is bound to be some de facto bias, in that therapists are willing to respond to the following questionnaire will indeed be those who are more comfortable with openly discussing successes and frustration in their professional careers.

Research Design

The researcher is particularly interested in exploring the subjective and intersubjective experience of the therapist in those instances that can be schematically described as follows: threat - disconnection - re-engagement. This qualitative study is intended to gain insights into the specific motives and characteristics involved in the series of the three states hypothesized. The researcher hopes to begin to identify ways in which the initial rupture, as well as the style and speed of optimal reconnection, may be utilized for enhanced clinician-patient communication, deepened therapeutic bonding, and patient growth. Thus, for the purposes of this qualitative study, therapists will be interviewed to elicit their responses as to what they

experience and do in those treatment circumstances when they feel sufficient emotional threat to retreat from the therapeutic connection.

Procedures for the Selection of Subjects

Participants were recruited through personal networking by the researcher, who culled them from independent practitioners in the West Los Angeles, Santa Monica, and greater Los Angeles areas. Of those clinicians who were asked to participate, and received the Pre-Interview Questionnaire, only a fraction agreed. Of those who agreed, eight (8) respondents were selected for inclusion in the data gathering phase.

Only those clinicians who met the following criteria were considered for potential inclusion in the study:

1. All participants had at least ten (10) years of practicing as a licensed clinical social worker or Ph.D. or M.A. in clinical psychology, utilizing a psychoanalytically-oriented approach to treatment.

2. All participants had post-degree level training through clinical consultation, supervision, and/or advanced formal training.

3. All participants had personal psychoanalytic psychotherapy or psychoanalysis from a psychotherapist or analyst who utilized a psychoanalytically-oriented approach to treatment.

4. All participants were judged by the researcher to have sufficient life-experience, professional experience, value personal and professional introspection, and were able

to differentiate their own counter-transferential view from the patient's transferential view of therapy.

This method of selecting subjects is what Polkinghorne (1983) refers to as "exemplar," in contrast to random selection of subjects. Respondents were selected for their ability to function as informants who provided rich descriptions of the experience being investigated.

According to Glaser and Strauss (1967), when the purpose of research is model and theory building, the number of cases is less crucial. "Since accurate evidence is not so crucial for generating theory, the kind of evidence, as well as the number of cases, is also not so crucial . . . a single case can indicate a general conceptual category or property: a few more cases can confirm the indication" (p. 30).

Recruitment was initiated by a Letter of Introduction (Appendix A), inviting practitioners to participate in a research study exploring the intersubjective and subjective experience of the psychotherapists during episodes of disconnection during therapy. The clinicians were asked to return a statement and questionnaire to the researcher indicating whether he or she was willing to participate in the research study, and eliciting a battery of preliminary questions (Appendix B). The questionnaire and a return self-addressed, stamped envelope was included with the Letter of Introduction. The participants were assured of confidentiality. The selected informants were "at minimal risk," according to the Department of Health, Education and Welfare Policy on Protection of Human Subjects guidelines as

adopted by the California Institute for Clinical Social Work. The Preliminary Questionnaire (Appendix C) aided the researcher in subject selection and will provide valuable insights to be used in the eventual interview and data collection phase.

Pre-Interview Questionnaire

Prior to participation in the interview, the Pre-Interview Questionnaire (Appendix B) was completed by each respondent (potential subject). This questionnaire is a fill-in and sentence completion survey. The survey took approximately 20 minutes to complete. The subjects were asked to complete and return the survey within two weeks, in a self-addressed, stamped envelope. The survey was developed by the researcher to accomplish the following:

1. To screen those respondents who have been in practice at least ten (10) years and are currently in clinical practice; who utilize a psychodynamic approach to clinical treatment; who have been in or are engaged in psychoanalytically oriented psychotherapy or analysis; and who have had post-degree level training through clinical consultation, supervision, and/or advanced formal training.

2. To screen and assess respondents' conceptual and operational understanding of the occurrence of emotional retreat by therapists; to screen and assess these therapists wiling to candidly discuss and reveal themselves with respect to this topic.

3. To allow respondents an opportunity for introspection, reflection, and identification of clinical

experiences where emotional disconnection occurred in response to perceived emotional threat from patients (intersubjective experience) and to allow similar introspection regarding their reactions, adjustments, and internal psychic experience around disconnection (subjective experiences).

Data Collection

Polkinghorne (1983) suggests that the "face-to-face encounter provides the richest data source for the human science researcher to understand human structures of experience" (p. 267). Thus, data for this study were collected through individual, semi-structured, open-ended, in-depth interviews with clinical social workers and/or clinical psychologists.

An interrogatory stance was utilized to elicit data that describe clinicians' subjective and intersubjective experiences at the times of emotional threat to disconnection to reconnection. The interview was used to collect qualitative data, providing a "guided conversation to enlist rich, detailed material that can be used in qualitative analysis" (Lofland, 1974, p. 76). According to Polkinghorne (1981), "in qualitative designs the instrument of data generation is the data gatherer. Although qualitative designs sometimes incorporate data generated by test instruments, their primary data consist of observations by researchers and subject statements produced in interviews conducted by the researchers" (p. 185).

Finally, researchers engage with their sources in enough depth to be allowed access to more than surface responses. The aim is to move from collected disconnected bits of information to gathering more interconnected and related information. This movement is accomplished in qualitative data gathering by a somewhat personal and open exchange with data sources (Polkinghorne, 1983). "The qualitative interview is conceived of as a discourse or conversation" (Polkinghorne, 1983).

Interview Guide

Primarily open-ended questions were utilized in order not to predetermine categories of response, to maximize the range of possible responses, and to discover new phenomena that may be reflected in the responses. This approach is especially well suited to this particular study because the phenomenon under study has not been previously reported upon in the literature. Any attempt on the part of the researcher to precategorize possible responses would bias the data and reflect her experience rather than the experience of the interviewees. It was anticipated that each participant would have unique experiences, beliefs, thoughts, and feelings, about his or her experience.

Semi-structured interviews, organized around topics and probe questions (Appendix E) were utilized to elicit the experiences, beliefs, thoughts, and feelings of each participant. The intent of the interview was not to generate the same information among respondents, but to allow for variations and differences related to the topic. The topics

and probe questions provided subject areas within which the interviewer was free to explore, probe, and ask questions that would elucidate and illuminate that particular subject. The researcher remained free to build a conversation and to word questions spontaneously, so as to establish a conversational style focusing on the research topic. Topics and probe questions did not need to be covered in a specific order. The topics were as follows:

Topic 1. The therapist identifies those instances in which he or she has felt the need to retreat emotionally during a therapy session in response to some perceived emotional threat from the patient.

This topic assists the respondent in recalling occurrences in which he or she experienced emotional distancing. The respondent is asked to specify what internal and external cues experienced by him or her were signals of emotional distancing. The respondent also is asked how he or she registered or operationalized this emotional distancing. The responses could include distractedness, overly intellectualized responses, sleepiness, thoughts wandering, resentment toward patient, and self doubts.

Topic 2. The therapist is asked to recall and discuss those behaviors on the part of the patient which he or she perceived as sufficiently threatening to require momentary emotional distance.

Here the therapist is asked to discuss, in some comparative framework, the behaviors on the part of the patient that seem the most emotionally threatening and why.

These behaviors could include overt rage, attacks on professionalism, personal attacks, condescension, silence, and acute regression.

Topic 3. The respondent is asked to speculate about the nature and frequency of temporary emotional distancing during therapy that seemed unrelated to the behavior of the patient.

This topic provides a descriptive baseline to assess if temporary emotional retreat on the part of the therapist is a necessary aspect of the intersubjective reality of doing therapy.

Topic 4. This topic gauges how reconnection is effected and if there is any therapeutic value to the schema described by: threat to disconnection to re-engagement.

Because this study is based on the hypothesis that therapy is an intersubjective space that is continually evolving and responding to temporary shifts and dynamics, it follows that moments of functional retreat for the therapist are a "fact" of doing therapy. As a corollary to this hypothesis, the study wishes to investigate the notion that authenticity, on the part of the therapist, with respect to the schema of threat to retreat to re-connection, can become a means, through genuine discussion, disclosure, and analysis to lead to a deepened therapist-client understanding and patient growth. In this regard, this topic will attempt to assess the outcomes of retreat to reconnection and considering such circumstances as whether the patient becomes calm or more agitated, the interlude is noticed by the patient, and how the therapist handles these instances. The

latter can include responses such as proceeding as if nothing happened or making the rupture in his or her optimal emotional connection a topic for authentic therapeutic dialogue.

Data Analysis

The data collected from the interviews will be analyzed according to what Glaser and Strauss (1967) describe as the constant comparative method. The four stages of this method involve the following: "(1) comparing incidents applicable to each category, (2) integrating categories and their properties, (3) delimiting the theory, and (4) writing the theory" (p. 105).

Glaser and Strauss (1967) purport that the constant comparative method of analysis generates theory more systematically by using explicit coding and analytic procedures. The discovery and proposal of a theory is grounded in patterns that emerge from actual data. According to Polkinghorne (1991),

> the purpose of qualitative analysis is to develop a statement delineating a structure or pattern of relationships that organize the phenomenon under investigation into a unified whole . . . Qualitative analysis produces a type of understanding that comes from "knowing" how a part is related to other parts and to the whole (p. 191).

Additionally, Polkinghorne (1991) further describes the process of qualitative analysis as a downward helix:

> Each turn in the helix can be broken down into a series of steps. First, the researcher reviews and re-reads the data. Second, units of the data (actually sentences or paragraphs) that express a single theme are identified by terms that designate the category or theme into which they fit. Usually

> an abbreviation or shorthand code is assigned to the theme to facilitate the marking (hence, the term coding). The marks identifying the themes are most often placed in the left margins of the data pages . . . Third, units with the same theme are collected together and analyzed to ascertain their common elements. In later stages of the analysis, the researcher looks for relations that might hold among the themes. Both of these procedures use the back-and-forth technique of noticing a possible commonality or relation. Checking to see if it holds with the data, revising the description in light of that check, and then going back to the data until a 'best fit' description is reached. Fourth, the researcher searches for contradictory data that could break up the unity that the descriptions are beginning to uncover (p. 198).

The audio taped interviews were transcribed and then coded. Major topics and themes were highlighted, and the themes were categorized. The themes were constantly compared and checked until a "best fit" description was reached. Evidence of contradictory data were explored. The categories were analyzed to explore their relevance to any recurring patterns or theory. The themes were culled in an effort to generate hypotheses about the subjective and intersubjective experience of the therapist during instances of emotional retreat and reconnection.

CHAPTER IV

RESULTS

This chapter presents the procedures used in the data collection phase of the study, as well as the results of these procedures. The chapter begins with an overview of the methodology, followed by a discussion of the pilot study and the resultant changes made in the actual study. Then the initial data coding process is discussed and the revised research questions are presented. The demographic information is then delineated, followed by the data coding process and the results of this process as relevant to each research question. The chapter concludes with a summary.

Overview of the Methodology

This qualitative study was exploratory in nature, undertaking to describe and clarify how the therapist maintains or restores the therapeutic connection when the therapist experiences sufficient emotional threat from the patient to temporarily retreat from a position of optimal emotional connectedness. Moreover, this study sought to determine whether such a disruption, and its consequent restorative action, furthers or hinders the progress of the treatment and patient growth.

For the purposes of this study, the researcher interviewed therapists to elicit their responses as to what they experience and do in those treatment circumstances when they feel sufficient emotional threat to retreat from the

therapeutic connection. The therapist participants were chosen for their ability to be exemplars and, more specifically, had to meet four criteria, as detailed in Chapter III.

Pilot Study

A pilot study was conducted with four of the therapist participants. The purpose of the pilot study was to evaluate the effectiveness of the semi-structured interview in eliciting the experiences and perspectives of therapist participants in relationship to the research questions. Specifically, the researcher was concerned with how forthcoming participants would be in discussing perceived instances of emotional threat and how they deal with such threats.

The researcher found that the participants exhibited a tendency to intellectualize, to go off on tangents, or to "talk around" the subject. The researcher felt that the general nature of the interview questions may have played a part in the type of responses elicited. Thus, the researcher decided to modify the interview questions. One of the researchers' major concerns in reformulating the interview questions was to inform the participants about the study, in order to engage them in a dialogue, without using interview questions which were leading. Thus, the researcher made the questions more specific, but retained their open-ended nature. The modified questions were more specific to connection, disconnection, and therapists' experiences of these events.

In keeping with the ideas of Polkinghorne (1983), in the semi-structured interview, the researcher utilized a rigorous but loosened methodological format, one which is appropriate for research in the human sciences. This format enables the researcher to "understand the general order that underlies the process of human existence" (p. 26). More specifically, an interrogatory stance was utilized to elicit data descriptive of the participants' subjective and intersubjective experiences in regard to those treatment circumstances in which they feel sufficient emotional threat to retreat from the therapeutic connection. The researcher attempted to develop a conversation and to word questions spontaneously so as to make the interview setting as naturalistic as possible. The intent of the interview was to allow for differences and variations related to the research topic. This methodological format utilized enabled the researcher, when analyzing the data, to locate, elucidate, and make explicit the organizing themes that render experience meaningful.

Actual Study

The data were drawn from a total of seven interviews. The researcher used the modified questions and found that they elicited responses which were less intellectualized and more clinical and experiential as compared to the responses obtained in the pilot study.

The researcher believes that, because the participants knew and trusted the researcher, they were able to be relatively forthcoming during the interview process.

Nevertheless, the researcher found that the therapist participants were reluctant to be taped. The researcher believes that participants may have been fearful of being judged by the researcher, lest they expose themselves as therapists and as individuals. Further, some of the participants would not acknowledge that they had ever experienced a disruption or a disconnection in the therapeutic process. Finally, the researcher found that the more experienced the clinician and the more they had dialogues with their colleagues, the more comfortable they were in exploring the issues of disconnection and reconnection both with themselves and with the researcher.

Initial Data Coding and Revised Research Questions

All interviews were transcribed. In the initial coding of the data, the researcher attempted to use the eight research questions, as presented in Chapter I. The researcher found, however, that the participants' responses did not lend themselves to the relatively tight boundaries of each of the research questions. The participants' responses, which described various aspects of the therapeutic process, generally spanned two or more research questions. The researcher found that it would have been an overmanipulation of the data to have tried to force the participants' responses to fit discretely into individual research questions. Further, the researcher found that the responses appeared to correspond only to certain research questions, almost to the exclusion of others.

After an unsuccessful attempt to code four of the interviews, using the eight research questions, the researcher decided to re-evaluate the appropriateness of their use in coding the data. The researcher referred back to the topics and probe questions, discussed in Chapter III, in which she set out the four topics to be covered in the interview. Using these four topics as a guideline, the researcher then developed four research questions, which combined the essential aspects of the original eight. The new research questions are as follows:

1. Are there instances when a therapist feels emotionally threatened and what does he or she do about it?

2. What are the ways in which the therapist responds to emotional threat?

3. What happens when a therapist cannot handle being emotionally threatened?

4. Does the way in which the therapist responds to the threat and possible disruption progress or hinder the treatment?

The researcher used the four new research questions to code the transcripts from the seven interviews. She found that these questions facilitated the coding of the data and resulted in a more balanced addressing of the research questions. The data, which are discussed below, are based on the use of these four research questions in the coding process.

As background to the data analysis, the demographic information pertaining to the participants is presented. To

protect the confidentiality of the subjects, there is no reference to specific identifying characteristics such as age, ethnicity, or unique contributions to the field of social work. Circumstances of either therapist or patient, which were sufficiently unique to threaten anonymity, are not presented.

Demographic Information

The final sample consisted of seven therapists, four male and three female, all Caucasian. All therapists were known to the researcher and were identified by the researcher as: (1) having experienced a disruption by the patient in the course of treatment and (2) utilizing a perspective which included the concept of the intersubjective field, in which the therapist and patient each constitute a subjectivity within this field. All therapist participants met the selection criteria described in Chapter III.

Of the seven therapists who participated in this study, two are social workers holding doctorates in social work, two are psychologists, holding doctorates in psychology, and three are psychoanalytic psychiatrists, holding doctor of medicine degrees.

All therapists have participated in psychoanalytically-oriented psychotherapy or psychoanalysis as patients. All are currently engaged in private practice, primarily employing a psychoanalytic or psychodynamic orientation, having received appropriate training; three were trained as strict Freudians, but none currently subscribes to this perspective. Overall, the therapists utilize a variety of

perspectives, including strict Freudian, ego psychology, object relations, and interpersonal theory. One of the therapists has been in practice for 15 years. The remaining six have been in the practice of psychotherapy for up to 28 years.

Data Analysis

The initial coding of the data was accomplished through a method of analysis outlined by Corbin and Strauss (1990), Glaser and Strauss (1967), and Polkinghorne (1983, 1991). As proposed by these authors, each interview was transcribed and then coded by research question for themes and categories. The themes were reviewed, analyzed, compared and, as appropriate, expanded or collapsed. Categories are the specific components stated by the psychotherapists and comprise portions of the theme. The final coding for Research Question 1 yielded two themes; for Research Question 2, four themes; for Research Question 3, two themes; and for Research Question 4, one theme.

The use of themes is not intended to imply that there is a discrete order of experiences which therapists go through when responding to emotional threat and when reconnecting with the patient. Rather, there was an overlap of themes among the psychotherapists interviewed. As such, clear distinctions between themes were difficult to make.

Despite the difficulty of making clear distinctions, the themes are reflective of the varying contexts, conditions, dimensions, similarities, and differences, among the therapists interviewed, in regard to responding to emotional

threat and reconnecting with the patient. In this regard, Strauss and Corbin (1990) state that, "The discovery and specification of differences among and within categories, as well as similarities, is crucially important and at the heart of grounded theory" (p. 111). As such, grouping of the data according to repeated relationships between properties and dimensions of categories was delineated as specifically as possible.

In addition, the themes are reflective of the core issues involved when responding to emotional threat and reconnecting with the patient. The themes reappear throughout the interviews and subsequent research questions dovetail one another in the occurrence of such themes. In this regard, several of the quotes cited have been used to illustrate more than one theme.

Data Analysis Relevant to the Research Questions

Research Question 1. Are there instances when a therapist feels emotionally threatened and what does he or she do about it?

As noted above, the analysis of the data relevant to Research Question 1 yielded two themes. Each is discussed below.

Theme 1: The composition of the disruption and whether it is perceived as threatening versus nonthreatening.

All therapist respondents agreed that disruptions occur in the therapeutic process. However, there was disagreement as to whether the disruption constituted a threat. The

determination of the threatening or nonthreatening nature of the disruption stems from the therapist's, and his or her understanding of the patient's, subjective realities. Specifically, the manner in which the disruption is experienced by the therapist determines whether the disruption will be perceived as threatening or nonthreatening.

A disruption is perceived as threatening in a number of circumstances, including when it disrupts the therapist's organization of his or her world, touches upon the therapist's unresolved or imperfectly resolved issues, or poses a threat to the therapist's physical or economic well being. Conversely, a disruption which does not affect these areas is perceived as nonthreatening. In such instances, the therapist may experience a feeling of excitement due to his or her recognition that patient growth is occurring and that the disruption, if handled in a therapeutic manner, can contribute to further growth.

The therapist respondents indicated varying perceptions of the meaning of the disruption. Therapists 1, 2, and 3 held the most encompassing view of the disruption. They expressed the belief that their perception of the disruption, and whether it constituted a threat, stemmed from both their objective and subjective realities, as well as their understanding of the patient's unresolved past and present reality. All acknowledged their vulnerability to feeling threatened under certain circumstances.

Therapist 1 provided an excellent summary of the circumstances under which a disruption is experienced as threatening.

> The threats would come from a number of sources. The threats would come from a patient disrupting some way I have of organizing the world, first. Secondly, from touching on any unresolved or even resolved imperfectly, because all problems are resolved imperfectly, conflict inside me. Third, a threat to my physical well being through some aggressive act or fear of such an aggressive act. Fourth, a threat to my economic condition so that I was worried that this patient was going to take some legal action which was adverse to my interest.

Therapist 2 indicated a belief that, when patients disrupt the therapeutic process, they are working out an unresolved issue from the past. As such, when he first becomes aware that a disruption is occurring, the feeling is one of excitement.

> When a patient is learning how to express disgruntlement or annoyance or irritation or whatever with you, and they were not able to do that with important attachment figures in their past then you know. I can maybe feel a little bit tweaked by some of the criticism that they give me or some of the comments that they give me. But, and I do feel those feelings as a momentary sense of embarrassment or a little tiny bit of shame or self-consciousness. But at the same time, the more powerful feeling is one of excitement or one of joy or happiness or progress.

Therapist 3 discussed instances of disruptions which were either objectively or subjectively experienced as threats. A disruption which threatens the therapist's property is perceived as a more objective threat than one in which the therapist experiences an injury to an area of vulnerability. Both types of disruptions are cited below.

> I felt angry at a patient who would constantly pick at the wallpaper next to the couch. I had asked

> him several times if he could desist. One day he dismantled it by tearing a piece off, saying that he paid me enough to do whatever he wanted.
>
> A patient started to talk about how sick he felt watching people aging. How disgusted he was when someone was sick. I thought that he was probably relating something about my arthritis to me. . . . Because my arthritis is a fact. I live with it. I suppose on some level, I didn't want to deal with his reactions to my narcissistic injury.

Therapists 5 and 6, in contrast to Therapists 1, 2, and 3, while acknowledging the presence of disruptions in the therapeutic process, do not make the distinction between those which are threatening and those which are not. Therapist 5 views the disruption as a manifestation of the patient's past.

> He was very, very angry. I mean, you know, I guess I don't know where this comes from theoretically, but I know that some patients have to get angry with you because there have been times in their life that they've been angry and you have to show that they're right.

Therapist 6 appeared unable to define what constitutes a disruption. She was, however, able to identify reactions in herself which indicate that a disruption is occurring.

> I get a feeling, you know, like a very quick sensation, when I know that something is being pushed in me... Sometimes I get angry... Sometimes I feel impatient. And that's to be distinguished from feeling that the patient is working on something and I've heard it for the thousandth time. That doesn't make me impatient. But I do sometimes feel impatient. I do get frustrated.

Therapists 4 and 7, while acknowledging the presence of disruption, did not acknowledge that a disruption can be threatening to the therapist. Therapist 4 views the presence of disruption as indicative of a defect in the therapist.

> Clearly nobody likes to come out in the community and say, "I'm defective in this way." I've got a very strong pathological inclination to do that, which is not good for me. It's very hard to control it. But that's not a thing a therapist, that is not to the therapist's advantage to speak personally about their, about serious shortcomings in themselves. I mean that might be the cruelest thing that is... These things are like built-in characterological problems. And you're not inclined to talk about things. I think that people more or less self-supervise themselves. And you know, when you catch trends that you, things that you do, you yourself do, that you can correct, that becomes extremely informative. It's all informative but that also is something you're more likely to be able to talk about. If you catch things in yourself that you are stuck with because of your own inadequacies or whatever, you're not likely to talk about them. You might learn from it still.

Finally, Therapist 7 maintains that disruptions are part of the patient's unconscious loop, which causes the patient to continually re-enact his or her personal history.

> I don't take them as disruptions--disruption by definition is something that breaks into an established "whatever's-going-on" pattern. I don't take it that way. I take it as part of this tape--as part of the communication (between the patient's unconscious and conscious).
>
> Like I said, 20 years ago--but at this point, it is not a disruption, it is something we both need to know.

Theme 2: The inevitability of the disruption and its perceived intentionality (conscious versus unconscious).

The disruption was regarded by all therapists as inevitable and was considered to have a ubiquitous nature. When considering the intentionality of the disruption, the therapist respondents took into consideration whether the patient's behavior appeared to be related to the present

interaction between the patient and therapist (conscious) or whether it related to the patient's past issues or intrapsychic structure (unconscious). Disruptions can be understood as intentional versus unintentional and as occurring in the present versus in the past (in the patient's intrapsychic structure). However, these different classifications cannot be viewed as four finite categories or even as a two-by-two configuration. Rather, they are intertwined and even inseparable. For example, if a therapist understands a disruption as originating in the patient's past or in the intrapsychic structure, he or she would be inclined to view it as unintentional. Conversely, if a therapist understands a disruption as originating in the present interaction between them, he or she would be inclined to view it as intentional. As such, the perceived source of the disruption varied by each therapist.

Therapists 1 and 2 tended to view the disruption as unintentional. They believe that a disruption is related to the patient's past and intrapsychic structure, but that it is demonstrated in the present vis-a-vis the interaction between the patient and therapist. In addition, both Therapists 1 and 2, while viewing disruptions as inevitable and unintentional, acknowledge that there is also the potential for intentional aspects, such as physical or economic threats.

Therapist 1 understands the disruption to be an opportunity to achieve insight into the patient's past, particularly where the patient's original failures occurred.

He believes that the patient's intrapsychic structure has produced the need for a disruption. In addition, he believes that biological or physiological factors, such as hormones or diet, can result in the patient causing a disruption.

> It's in that failure of the patient to maintain that connection that much can be learned about where the original failure took place in that patient's life, assuming that the therapist can experience the disruption in therapy as productive and constructive and not so disorganizing that it cannot be mastered.

> Most of the time I would . . . bring up the disruption to understand what must produce such a disruption and what potential events inside the patient's psychology or in the patient's history had produced the need to produce this disharmonious assault.

> If you discern that there was nothing that had happened in the outside world and you discern that there were not other external variables affecting this person and you felt it was related to some conflict with you, the standard psychoanalytic technique would be to relate it to the transference. The problem with that is, it might or might not be related to the transference. It could be hormonal, it could be dietary, it could be any number of things.

Therapist 2 takes a perspective similar to Therapist 1, holding that the patient's intrapsychic structure has produced the need for the disruption. Moreover, Therapist 2 believes that the patient causes the disruption so that he or she can learn how the therapist deals with it.

> This is an old familiar way of relating for her. This wasn't new. It was a fallback, you know, a trapped animal kind of response.

> When a patient is learning how to express disgruntlement or annoyance or irritation or whatever with you and they were not able to do that with important attachment figures in their past, then you know.

> The patient will do to you what was done to the patient. It's different from projective identification, but the idea being that a patient wants to learn how you cope.

Therapist 7 also views the disruption as unintentional and, similar to therapists 1 and 2, believes that the disruption is an expression of the patient's past or intrapsychic structure. However, she does not see the disruption as "disruptive"; rather, as noted above, she maintains that disruptions are part of the patient's unconscious loop, which causes the patient to continually re-enact his or her personal history. In keeping with this perspective, Therapist 7 does not see a need to work with the disruption. While Therapists 1 and 2 view the disruption as unintentional, they believe in the necessity of exploring it. Therapist 7, in contrast, equates the unintentionality of the disruption with insignificance and, as such, does not feel compelled to explore its meaning for the therapeutic process or for the patient's growth.

> So I would consider it that way (the unconscious as historical) . . . it's a tape playing, it's this tape that we have . . . it's my everything . . . If we can find it together, splendid. If you can, your obligation is to find it. And if you can't find it here . . . there's no obligation.

Therapists 5 and 6 see the disruption as intentional. Therapist 5 feels that certain patients are not capable of fully relating to the therapist. Further, Therapist 5 does not appear to have the theoretical underpinnings which could help her determine whether a disruption is threatening and

what its meaning is for the therapy as a whole. She assumes that a disruption is a manifestation of the patient's past life.

> A supervisor of mine once said to me that there are some patients who will never keep you company and some patients who will.

In regard to one patient in particular, Therapist 5 was clear that a disruption had occurred, but did not use it as an opportunity to explore its meaning with the patient.

> And, I mean, she'd do things like--like this is very obvious. She'd come into my apartment and she'd put her feet on my couch--like her soles on the couch. I said, "take your feet down." She'd screw around with the money and she knows I get annoyed with that. Or one time she called me and I'm a very deep sleeper. I thought she called me at 4:00 in the morning, I didn't know what time--and then I said to her the next thing, "Why did you need to call me at 4:00 in the morning?" She said that it was 5:30 or 6:00. I said, "It wasn't an emergency. Why did you need to call me?"

In general, Therapist 6 feels that all disruptions are intentional. However, her understanding of the patient mitigates her resulting anger.

> I point it out and I say, "Look, you know this is an inflammatory statement geared to get me." . . . But I don't feel the anger because now I understand what she's about.

Therapist 6 presented an instance in which the patient clearly knew that she was disrupting the therapeutic relationship. Both patient and therapist knew that the patient's actions would be considered a threat to the therapist. However, the exploration of the threat led to the therapist's greater understanding of the patient.

> There's one that stands out very, very clearly because I never thought I would do what I did and it had a remarkable result, of one patient I have.

> And, you know, I have my office at home. And the patient, and there's preferential parking and patients every now and then, a few patients ask me if they could park in the driveway and I say no because it disrupts the next person coming up the driveway. This one patient came and said to me one day, "I parked in your driveway." And this was after I told her that she couldn't. So I got angry. And I just said to her, "Why?" . . . But I don't use the word why. . . . So it just came out like that and what she said, I will never forget. I don't think either of us will ever forget. She said, "Well, I know you're going to hate me sooner or later, so I thought I'd just get it over with."

Therapist 3 views disruptions as either intentional or unintentional. He cited the case of an intentional threat, one in which he believed that the patient was trying to provoke him into experiencing the patient's perception that everything was destroyed once the patient did something aggressive.

> We were not able to change his sense of detachment until we made it more understandable. We ruptured a pattern of interaction in which the patient was not able to change; if he destroyed, he was always destroyed in return.

In another instance, Therapist 3 viewed the disruption as unintentional, even though the therapist found it threatening. The threat arose from the therapist's vulnerability, as seen in a previously cited example.

> A patient started to talk about how sick he felt watching people aging. How disgusted he was when someone was sick. I thought that he was probably relating something about my arthritis to me. . . . Because my arthritis is a fact. I live with it. I suppose on some level, I didn't want to deal with his reactions to my narcissistic injury.

Finally, Therapist 4 sees the disruption as an irrelevant issue because, as noted above, he believes that

the presence of a disruption is indicative of a defect in the therapist. For Therapist 4, there is no way to engage in any dialogue about, or to use the disruption for, patient growth because he is too ashamed of his perceived shortcomings. Rather, he discussed how disruptive he might be if he dared to address this "nonissue" and thus bring his defective character to his patient's attention.

> Are you asking why someone doesn't sacrifice themselves on the altar for the common good? "Look, I mean I'm fucking up my patients, you know. If you pay attention to how I'm ruining things, you may do a better job." You're not seriously expecting somebody to say that?

Research Question 2. What are the ways in which the therapist responds to emotional threat?

As noted above, the analysis of the data relevant to Research Question 2 yielded four themes. Each is discussed below.

Theme 1: The therapist's physical and emotional awareness and subsequent internal dialogue.

Therapists 1, 2, 3, 6, and 7 indicated their awareness of a disruption, followed by an internal dialogue. Although the depth of their descriptions varied, in general, they spoke of awareness in terms of physical sensations and emotional reactions and spoke of their internal dialogue in terms of self-exploration and self-analysis as it relates to their affective internal world. Therapist 5 also indicated an awareness of a disruption, which she was able to recognize through her experience of anger; however, once aware, she did

not follow up with an internal dialogue. Finally, Therapist 4 did not address the issue of awareness of a disruption.

Therapist 1 did not speak directly about certain physical or emotional aspects of awareness that he has experienced. Rather, he discussed the subtleties of how one can sense that something is askew or become aware of a disruption.

> There (are) myriad possibilities, subtleties in which these aspects of disconnectedness or conflict can manifest themselves. Could be in a look or not a look . . . (a) change of posture.

Therapist 1 then spoke of how a therapist uses an internal dialogue and self-analysis to understand and work through the disruption.

> The way it's ordinarily mastered is through the therapist having a dialogue with himself or herself about where the disruption occurred, why it occurred, what conflicts have been touched on, thinking through, and doing a piece of self-understanding and self-analysis.

Therapist 2 spoke directly about his awareness and his subsequent self-examination.

> In those situations, I usually get a heightened sense of awareness. I don't get sleepy or emotionally distant. I usually get a heightened sense of awareness and, if it's mild, I find it interesting and I'm intrigued by it and I'm curious about it. . . . I do feel these feelings as a momentary sense of embarrassment or a little tiny bit of shame or self-consciousness. . . . I also go through a loop of self-questioning and self-examination during those times. If there's something I've done that justifies this attack, where it's a co-constructive situation and what's my part in this. And an early on differential that I try to make in my mind is, is this progressive that this patient is doing this? Or is this a sign of a rupture? In other words, in a sense, is this a therapeutic failing of mine? Because that

> differential becomes very important in terms of my countertransference responses as well as my interventions.

Therapist 3 makes only brief mention of sensing that something is "askew," focusing more on his self-dialogue.

> I handle it by first looking at where my experience may have touched off the threat. Then I will pose a question as to whether there is a sense in our experience, in our dyad, that something has gone askew.

Therapist 6, similar to Therapist 2, directly addresses her awareness and internal dialogue. She relates the physical sensations to her knowledge that something is being "pushed" in her and emphasizes the importance of self-analysis.

> I get a feeling, like very quick sensations, when I know that something is being pushed in me. And then I make note of it and I will decide whether or not to bring it up. And the first thing that has to happen is that I decide whether or not what's happening is part of my underlying dynamics that I have to keep working on within myself and in my peer group. Anything unresolved . . . I don't raise with a patient because they're my issues, not the patient's. So first I have to distinguish which of those it is and usually it feels quite different, actually. I've become, over the years, fairly clear at distinguishing and the more clear I am at distinguishing, then the freer I feel to raise it with the patient.

Therapist 7, similar to Therapists 2 and 6, clearly acknowledges her experience of awareness and the necessity for self-analysis. She also points out that if a therapist cannot effectively analyze his or her awareness, consultation should be sought.

> I take all these things diagnostically... So what I have always told my students... is that if something happens within the hour--you get sleepy, your mind wanders, you're thinking about what to

> get for dinner, whatever...half of it belongs to you, half of it belongs to the patient. The (responsibility) to yourself is to analyze both sides. If you can't do it yourself, get help with it--which is the point.

Therapist 5, as noted above, also indicated an awareness of a disruption; however, her awareness is indirect, coming about through her experience of anger. In addition, once she becomes aware of a disruption, she does not follow up with an internal dialogue. Without self-exploration and self-analysis, Therapist 5 is unable to examine the meaning of the disruption with the patient. Indeed, as discussed in the context of theme 2, Therapist 5 does not use the disruption as an opportunity to explore its meaning with the patient. After the incident, described under theme 2 (and cited in a briefer version below), Therapist 5 expresses how she is unable to bring the incident up with the patient.

> So I got angry. And I just said to her, "Why?"...But I don't use the word why...So it just came out like that and what she said, I will never forget. I don't think either of us will ever forget. She said, "Well, I know you're going to hate me sooner or later, so I thought I'd just get it over with."
>
> I feel that I function a great deal internally...I sometimes don't verbalize. I am not able to verbalize exactly what is going on.

Finally, Therapist 4 does not directly speak of being aware of a disruption. Yet, he does acknowledge that it occurs and indicates its importance as a pivotal opportunity for patient growth. However, as noted in the discussion of theme 1 and theme 2), Therapist 4 views the presence of a disruption as indicative of a defect in the therapist. As

such, his internal dialogue is one of shame and self-recrimination, which does not enable him to explore the meaning of the disruption with the patient (which is why, in his words, the "opportunity is missed").

> I'm sure it happens. With the result that an opportunity is missed. I suppose you could think of it in terms of derailment. I haven't given it a lot of thought, but I would suppose that it would be to some kind of critical and major area out (of the reach for both people to deal with). That could be pivotal. I mean that could be exactly the part that needs to be reached, though. I don't think there's any question that it could happen.

Therapist 4, however, as discussed in theme 1 (and as cited in a briefer version below), is too ashamed to address the disruption. To do so would be to admit to himself and to the patient his characterological defects.

> Clearly nobody likes to come out in the community and say, "I'm defective in this way." . . . If you catch things in yourself that you are stuck with because of your own inadequacies or whatever, you're not likely to talk about them. You might learn from it still.

Theme 2: Subsequent reactions as intellectual and empathic.

The initial reaction represents a bridge between intellect and affect, developed through the constant going back and forth in the therapist's self-dialogue. Depending on a number of factors, including how long the patient has been in treatment, whether the patient's structuralization has changed over time, and whether there is a repetition of the disruption, the self-dialogue takes into account the

therapist's understanding of the patient's structuralization and the patient's ability to handle an exploration of the disruption.

The development of an empathic initial reaction comes from therapist allowing himself or herself to suspend judgment and to listen to the patient's view of the world. To the more seasoned clinician, who has a high level of attunement to the patient, the patient's structuralization is not as important as the patient's view of the world in regard to the formulation of the initial reaction.

The therapist's intellect determines the likely meaning of the disruption and where it may fit. From this understanding, the therapist determines how to keep the connection going. The therapist's understanding of the meaning of the disruption enables him or her to respond empathically to the patient. In this way, one cannot separate the intellectual from the empathic.

The therapists' responses ranged across a continuum from intellectual to empathic. Therapists 4 and 7 had initial reactions which were clearly intellectual. Therapist 4, as noted above, views the presence of disruption as indicative of a defect in the therapist. To address the disruption would be to admit to the patient his characterological defects. Nevertheless, he admits that the presence of a disruption is pivotal.

> I'm sure it happens. With the result that an opportunity is missed. . . . That could be pivotal. I mean that could be exactly the part that most needs to be reached, though.

Therapist 7 also expresses an initial reaction which is intellectual. She remains in an intellectual mode, further exploring the disruption with the patient, but without exhibiting an empathic response.

> The moment I become aware of it, generally within three to eight seconds, it feels like an eternity, but it is never that long. And I go back and return and seek to ask again that which was just said. If it was about a dream, tell me that part of the dream again. Whatever it is, I just go back over to find out what that was about.

Therapist 1, similar to Therapists 4 and 7, expresses an initial intellectual reaction. However, there is an empathic view which underlies his intellectual understanding.

> Most of the time I would use whatever the disruption is in some therapeutic fashion and, either at that moment in time or later, bring up the disruption to understand what must produce such a disruption and what potential events inside the patient's psychology or in the patient's history had produced the need to produce this disharmonious assault.

Therapists 2 and 3 display initial reactions which are empathic. Through their emotions and empathic understanding, they are able to develop an intellectual understanding. Both use their thoughts to give words to their emotional reactions. Therapist 2 uses his empathic sense of the patient to maintain the connection and to react in a way which will enhance the patient's growth.

> The patient will do to you what was done to the patient. . . .What I was providing for her, hopefully, was the new experience . . . that a caregiver could tolerate her rage without attacking or abandoning. . . . (In order to do this,) I allow everything to go before me like a screen. . . . I think it's critical that you let yourself do that. Because, otherwise, you're denying the reality of what's happening at the moment.

Therapist 3 also uses his empathic stance to maintain the connection and to further patient growth.

> There is a sense in our experience, in our dyad, that something has gone askew. . . . I had to directly address that there was something wrong between us and perhaps, together, we could figure it out. The expression on the patient's face was one of relief, and I noticed his body relax. . . . My world seems to grow each time I am able to use my subjectivity to help another develop their subjectivity.

Therapist 6 also evidences an empathic response, but her attunement is toward herself, rather than toward the patient. She is emotionally aware of who she is, but does not have a concomitant awareness of the patient, nor does she move from an empathic response to intellectual understanding. Nevertheless, she follows through on her emotions.

> And I just said to her, "Why? You knew that this would annoy me. Why did you do this?" And it was an uncharacteristic response because I very rarely say "why." On the couch, it's different (I say), "What made you . . ." But I don't use the word "why." So it just came out like that and what she said, I will never forget. I don't think either of us will ever forget. She said, "Well, I know you're going to hate me sooner or later, so I thought I'd just get it over with." If I hadn't responded and she did it, she did make me angry. Not that she made me hate her, but she wanted to see how far it would go, probably. Well, she knew, in her subjective reality, it was going to go to my hating her. So I might as well start now.

Therapist 5 seems to need to employ an intellectualization in which she views the disruption as the patient's problem, thereby compartmentalizing the patient. Perhaps this is a defensive and protective response, but it is not empathic attunement, where the intellect is used to further the deep understanding of the patient.

> I mean, she's a beast. She's very borderline, and I get angry and she'll come in and she'll say, "don't get angry with me." And I'll say, "well, do you see that your behavior is provocative?"

Theme 3: The response to emotional threat as empathic and intellectual.

The therapists' responses to emotional threat contained empathic and intellectual aspects. Empathic responses involved using the self directly to repair the disconnection, while intellectual responses focused on what the patient did or was doing at that moment. Therapists tended to work in either an empathic or an intellectual mode.

Therapist 3 was the only therapist who predominately worked in an empathic mode. He brings himself and his reactions to the patient directly into the therapy session. He even employs body language, going so far as to physically move into the therapeutic field.

> The work seems much less futile and less fractured as dissociated parts of the patient's self become structured and integrated. Then parts of my self can be reworked. To me, it is a gift. I have to admit that the most important tactic is honesty. To be as honest, even about what might be confusing, has always been of benefit and helps in the establishment of an empathic link. I lean into the field between the patient and myself when speaking. Or I will sometimes stay very still in order to not threaten the patient as I speak. Each individual is very different. Sometimes there is mutual smiling, tone of voice change, eye contact. . . . For me, it is essential to find a place to like the patient. . . . I may actually talk about my experience and wonder about theirs to see if anything may enhance our being together.

Therapists 2, 5, 6, and 7 work in a predominately intellectual mode. Therapist 2, while aware of his emotional reactions, limits what he will say in response to a

disruption. However, underlying his intellectual response is an empathic understanding of the patient.

> I do feel those feelings as a momentary sense of embarrassment or a little tiny bit of shame or self-consciousness. But, at the same time, the more powerful feeling is one of excitement or one of joy or happiness or progress. (But I would voice this) very, very, very cautiously. If the person is . . . entering uncharted territory and they're fearful, almost always in a situation like this, they're fearful of a repetitive response. And so mostly what I'll interpret is the fear of repetition. . . . I'm very cautious about sharing anything other than the following two things: I will interpret it. . . . "I can understand how difficult this is for you given the way your father used to react to you when you got angry." And the other thing I try to convey is a calm, relaxed demeanor. So sometimes the way I convey it isn't even through words. I mean I'll just say, "I'm interested to hear more about this" or "I'm pleased that you can say it." That's sometimes dangerous to say with the patients I work with because . . . very easily it gets turned into a feeling of being shamed or belittled. You know, you have to be really careful. Or the other reaction that I get sometimes with that is, "Oh, well, you're not taking it seriously. You think it's cute that I'm angry. You're not even connected to me. You're so far above me that my anger is meaningless to you." (I would express it as hurting me) only in the following two circumstances: staying on the branch where it's progressive, okay, and staying on the branch where it's progressive and mild. In those circumstances . . . I almost will never volunteer that because I'm afraid of derailing them again. You know I don't want them to feel that they've hurt me in some way that stops them from being expansive in this arena. And so I'm very hesitant to say something about that except when the patient really wants to know and needs to know.

Therapist 5 also works in an intellectual mode and, similar to Therapist 2, will limit her responses. However, unlike Therapist 2, when she does respond, she is not direct about her reactions and does not appear to work from a place

of empathic understanding. Rather, she focuses on what she sees the patient doing.

> I don't think I'll say it directly, "I'm angry." I'll say more like, "I don't understand what is going on." I think people pick up (when you're angry). . . . And I'll say, "well, do you see that your behavior is provocative?"

Therapist 6, similar to Therapists 2 and 5, uses intellectualized responses, pointing out what she sees the patient doing. She uses herself, but not in an empathic manner. Rather, she uses herself metaphorically as a means to determine what may be going on with the patient. For Therapist 6, reentering the therapeutic field involves asking the patient why he or she is doing something.

> I point it out and I say, "Look, you know this is an inflammatory statement geared to get me." Of course, I talk to her about it. But I don't feel the anger because now I understand what she is about. But I certainly say, "This is geared to make me angry and let's look at why."

Therapist 7 uses intellectual involvement to help the patient understand his or her unconscious loop. Similar to Therapist 6, she uses herself metaphorically, as a means to point out what the patient is doing. Similar to Therapist 2, she will limit what she says to the patient. However, her limits do not appear to be based on an empathic understanding of the patient.

> It's a tape playing, it's this tape that we have; it's my everything. . . . I always ask my patient to help me out. If there is an impasse and the person feels I'm misunderstanding something, I won't argue about it. I'm not going to say, I understand you're the one. I would never say that.

Therapist 1 discussed responses that come from both an intellectual and an empathic position. However, he generally favors more intellectual responses.

> I might show them my feelings, but generally, that I don't find too useful because it puts the focus on me and my feelings rather than on whatever is going on with them. And it's an issue to be understood in terms of what's going on with them. By showing (them their) impact, they can become alert to an aspect of their personality that they formerly didn't know about. But that's the exception rather than the rule.

Therapist 4, in keeping with his view of disruption as being caused by a defect in the therapist, does not address the issue of reentry into the field. By implication, once he becomes aware of a disruption, his focus turns inward into his assumed characterological defects. In essence, he, rather than the patient, leaves the field.

Theme 4: Limit setting as a response to emotional threat.

Limit setting, as a response to emotional threat, has two aspects. One aspect is the therapist setting limits on what the patient can do and generally involves such concerns as destruction of property or violence. The other aspect is the extent to which the therapist limits his or her involvement with the patient in terms of understanding and working through the disconnection.

Therapists 2 and 3 indicated that they set limits with patients. However, these limits are not discussed with the patient until they are violated. Therapist 2 discussed his work with clients who had the potential to physically threaten him.

> I mean I was close to . . . I didn't get to the point of shaking, but I was close to the point of shaking. . . . And she never got violent with me. If she had gotten violent with me, I would have ended the session. But she never got physically violent with me, so I let her do it. She did it several sessions in a row. Well, it was reparative for her in that I tolerated it, I didn't attack her back. And the limits continued to be set on her and they needed to be set.
>
> I became enraged at that point! . . . I thought, I want to get rid of this patient, how do I transfer this patient off my hands. If I do, she's going to kill me. . . . Being a therapist is not worth dying for.

At one point, Therapist 2 brought someone into the session to help maintain the therapeutic limits. When limits were violated, he terminated the therapy.

> This guy sat in on the session and had to take the patient down because . . . he did try to attack me twice, bit the shit out of the male nurse. Kicked him in the balls once. It was a scene out of a movie. . . . So there's an example where I got very angry and I used the anger very forcefully to terminate the work.

Therapist 3 stated his limits in response to the destruction of his property.

> I felt angry at a patient who would constantly pick at the wallpaper next to the couch. I had asked him several times if he could desist.

Here the therapist was forceful, but did not have to terminate.

Therapist 7 also set limits, but her limits sought to restrict her involvement with the patient. She does not view herself as having to enter into a dialogue with the patient because, as noted above, the disruption is part of the

patient's unconscious loop. More specifically, her limits concern what she can say to the patient.

> Well, you're asking if I say to my patient, "I noticed that my mind just wandered?" Never, that is an intrusion into the patient's time. That's why we don't do various things with patients. That's why we have boundaries and limitations and we adhere to those

Therapists 1, 4, 5, and 6 do not address the issue of limits. By inference, Therapist 4 would feel that the therapist's defects define the limits of therapy because the therapist thinks that, when a disruption occurs, it is the defect of the therapist; therefore, it is an indication of a limit to therapy.

Research Question 3. What happens when a therapist cannot handle being emotionally threatened?

As noted above, the analysis of the data relevant to Research Question 3 yielded two themes. Each is discussed below.

Theme 1: The therapist's assessment of his or her adequacy in handling the emotional threat.

This issue was directly addressed by only one therapist. Two therapists indirectly answered the question and, through their responses, a sense of their adequacy was inferred by the researcher. The remaining four therapists did not address this issue.

Therapist 3 was the one participant who addressed the issue of what happens when he cannot handle being emotionally

threatened, indicating that he was able to recognize his limitations and chose to refer his patient to another therapist.

> I have been fortunate enough to have few circumstances where I could not resolve being emotionally threatened. But I can remember one instance in which I truly did not like the patient and realized that I would only repeat his experience of less than adequate connection, and I referred him to another therapist. This was difficult; I had to mourn and deal with my own limitations.

Therapists 1 and 2 indirectly addressed this issue, but both conveyed a sense of adequacy. Therapist 1 spoke to the issue by focusing on the profession as a whole, especially those who are seasoned clinicians, who would not be diminished by getting consultation for themselves. He also discussed how therapists intellectually distance themselves by interpreting to themselves the analytic reasons for the occurrence of the disruption.

> If the conflict is too severe to resolve individually, then the therapist can, either formally or informally, seek some kind of consultation to help him or her understand what is going on.

> The real issue was that the therapist could not tolerate a degree of anger...that the patient (felt). (This) generated a...reaction (of moving away) in the therapist. (For to) fully (take on) the anger of the patient was so disruptive to (the) therapist that (he) had to dodge it or get out of the situation in one way or another. (The therapist) talked about...being unable or unwilling to accept fully that rage, particularly when (one is) trying to help and (to) see (oneself) in a different kind of way.

Therapist 2 spoke of an incident in which he terminated a patient. However, this was after he had made a concerted

effort to reconnect after the disruption. His sense of adequacy enabled him to choose termination as best for the patient.

> And so I was so fed up with all the problems and all the difficulties and all the troubles, that I wrote the patient a letter and I told her that she had created this situation which now made it impossible for me to work with her and that I was very sorry to do this because I felt that our work had been good, but that I could not continue to work with her. And I wrote her a termination letter and I gave her three names.

Therapist 4 also does not directly address the issue of what happens when a therapist cannot handle being emotionally threatened. Similar to Therapist 1, he focuses on the profession and, as has been noted, he believes that defects in the therapist are the source of disruption.

> Yeah, I mean I suppose that common inadequacies among trained professionals are not something that anybody (wants) to talk about. We like to talk about difficulties that you have to teach beginners to avoid; that feels comfortable.

In contrast to Therapists 1 and 3, however, he conveys a sense of his inadequacy. This is seen in his discussion of a presentation at a professional meeting.

> I don't think he put it this way, but it came across fairly clearly. Saying, there's no excuse for an analyst having no balls. . . . But it wasn't a terribly concealed, emasculating kind of (statement), and it was done out of passion. He wasn't trying to ridicule somebody. He was outraged that anybody would be that much of a patsy that they could be intimidated that way. And yet most of us are. I am all the time and these guys are really good, strong, trained. They were in various ways (intimidated), too, by various intimidating and angry patients. And they were really describing the situation. But so it's still hazardous to do it, but despite the hazard, people are doing it.

Therapists 5, 6, and 7 did not address the issue of what happens when a therapist cannot handle being emotionally threatened. Therapist 7 merely remarked that she will refer the patient out.

> I always give the patient the option of consultations.

Theme 2: The disconnection as temporary or permanent.

The therapist-patient disconnection, as stemming from the disruption, can be either temporary or permanent, depending on the perspective and actions of the therapist. For some therapists, the disconnection is either always temporary or always permanent. For other therapists, the duration of the disconnection depends on the therapist's response to the disruption.

Therapists 1 and 3 view the disconnection as temporary. They are seasoned therapists who know how to handle a disruption so that a reconnection with the patient is established. Therapist 1 believes that there is always some way that the disconnection can be overcome, that the therapist is responsible for ensuring that the disconnection be temporary.

> It would never happen for that length of time of being disengaged, not for years. I'm talking about hours. With certain people, you can recognize the depth of the disorder and the magnitude of the issues to be overcome. It's sometimes quite real. ...And that can be taxing and make one despair for brief periods. But there's usually always something that you can do or some way you can be of use or some way that you can overcome that despair.

Therapist 3 works from an empathic stance, in which he stays within his subjectivity and uses it to reconnect with the patient. In this way, he ensures that the disconnection will be temporary.

> Then I will pose a question as to whether there is a sense in our experience, in our dyad, that something has gone askew. . . . We seemed to work through his feelings as well as my own, but the treatment seemed bogged down, didn't seem to be going anywhere a month later. I decided that I had to directly address that there was something wrong between us and, perhaps together, we could figure it out. The expression on the patient's face was one of relief, and I noticed his body relax. . . . We ruptured a pattern of interaction in which the patient was not able to change; if he destroyed, he was always destroyed in return.

Therapists 2 and 5 did not state whether they saw the disconnection as temporary or permanent. Therapist 2 discussed his responsibility in causing the disconnection and how he reconnected with the patient. Specifically, he acted in such a way as to prevent the disconnection from becoming permanent.

> But I have been sharp or snapped a couple of times. And I didn't lose the patient, but I almost lost the patient. And it was very minor, what I said. I mean it was not like, I didn't start yelling. I've never yelled at a patient. I didn't start yelling. I didn't start attacking, I got defensive and I have . . . the potential for a very sarcastic, razor-sharp kind of comment. . . . And so I do have that within me and a small version of that has slipped out once or twice, maybe four or five times over the course of 12 years. And it's very bad when it happens. . . . I don't think I've ever lost a patient over it, but I've had patients not show up then for the next appointment and I had to call them. And then, of course, I apologize profusely for it. . . . I don't think, not that I recall have I lost a patient. That's the main reaction that I've done that I've regretted.

Therapist 5, similar to Therapist 2, discussed her responsibility in causing the disconnection and how she reconnected with the patient. Specifically, she also acted in such a way as to prevent the disconnection from becoming permanent.

> In the past there have been occasions where one very intact patient I had, I called up after the session. I said, "I really hope I didn't come on too strong in the session with you. You know, I meant what I said, but I hope I didn't sound too (unintelligible) with you . . ." She came in the next time and said, "I really appreciate your calling me."

For Therapist 7, the disconnection can be either temporary or permanent. As noted above, she maintains that the disruption is part of the patient's unconscious loop, which causes the patient to continually reenact his or her personal history. If Therapist 7 can successfully explore the disconnection with the patient, then the disconnection will be temporary; if not, then it will become permanent.

> I would consider . . . it a tape playing. . . . If we can find it together, splendid. If you can, your obligation is to find it. And if you can't find it here,...there's no obligation. I always ask my patients to help me out. . . . Tell me where you think I'm misunderstanding. Tell me how I can ...be more objective, how I can understand better. Help me out. If that doesn't work over time, it becomes absolutely blocked...and it's a dead issue now. I always give the patient the option of consultations...It's a large city, with many people ...get a consultation; you've got to take care of yourself.

Therapist 6 does not address the issue of whether the disconnection is temporary or permanent. Finally, Therapist 4, as noted above, views the presence of a disruption as

indicative of a defect in the therapist. As such, he does not address the disruption, causing the disconnection to become permanent.

Research Question 4. Does the way in which the therapist responds to the threat and possible disruption progress or hinder the treatment?

As noted above, the analysis of the data relevant to Research Question 3 yielded one theme. This is discussed below.

Theme 1: The direct response to the threat progresses the treatment.

All therapists indicated, either directly or indirectly, that the addressing and proper handling of the threat and possible disruption progress the treatment. Each therapist differed in his or her view of the way to respond to such a threat. Therapists 1, 2, and 3 held similar views in regard to what progresses the treatment, including knowledge of psychodynamic theory, self-knowledge, self-exploration, and knowledge of the patient. In addition, Therapists 2 and 3 mentioned the importance of modeling.

Therapist 1 indicated that the therapist always will fail the patient. However, it is in the failure of the patient to maintain the connection that progress can occur, as long as the therapist has the knowledge delineated above.

> Following the Winnicott model, that a therapist will always, if not almost always, fail a patient and it's in that failure of the patient to maintain that connection that much can be learned about where the original failures took place in that patient's life, assuming that the therapist can experience the disruption in therapy as productive and constructive and not so disorganizing that it

> cannot be mastered. The way it's ordinarily mastered is through the therapist having a dialogue with himself or herself about where the disruption occurred, why it occurred, and what conflicts have been touched on, thinking through and doing a piece of self-understanding and self-analysis.
>
> To the issue you're raising,though, that the center point in our mind is, can this be used therapeutically? Yes, it can be used very (therapeutically). The disruptions,potential disruptions are inevitable, they are often repetitions from the past or the way in which the patient disrupts the therapy or forces the therapist to disrupt the therapy and are often extremely significant, if not the most significant aspect.
>
> (Therapists need to really know themselves in order to really address issues of disruption), although I leave room for certain exceptional people who are instinctual... In a general run of the mill situation, 99.99%, yes, the more a person understands about themselves, the better.

Therapist 2 also discusses the importance of theoretical and self-knowledge. In addition, he points out the importance of modeling.

> I have the potential for a very sarcastic, razor-sharp kind of comment. . . . Well I grew up also around a bunch of people that attacked me all the time, in my own childhood. And so one of my weapons became my intellect. And I could say really cutting, nasty, nasty things which would shut them up. I mean they'd start crying. They'd start crying and, you know, how horrible to say such a mean thing, but that was better than being attacked.
>
> They want to learn a new way and they'll learn it once removed. They'll learn it by modeling. And so you're modeling for them a different way of responding to a traumagenic situation. And so you know, I try to remind myself of those theoretical concepts when I'm amidst this, but not to replace the emotions that I'm going through. They just help me channel and direct my work. And so I let myself feel it.

> But what I was providing for her, hopefully, was the new experience, on the one hand, that a caregiver could tolerate her rage without attacking or abandoning. And the second thing that I demonstrated to her was when you're in a trapped situation, there is a way to just regulate your emotions so that they don't get you.

Therapist 3 holds the same view as Therapist 2 of what progresses the treatment. Specifically, he emphasizes knowledge of psychodynamic theory, self-knowledge, self-exploration, knowledge of the patient, and modeling.

> We were able to piece together the patient's sense of a lack of continuity of being. This patient had felt strange and experiences were not able to change his sense of detachment until we made it more understandable. We ruptured a pattern of interaction in which the patient was not able to change; if he destroyed, he was always destroyed in return.

> My world seems to grow each time I am able to use my subjectivity to help another develop their subjectivity. The work seems much less futile and less fractured as dissociated parts of the patient's self become structured and integrated. Then parts of my self can be reworked. To me it is a gift.

> I found this to be a growing experience for me since I had to acknowledge that attachment has many unconscious links to our ability to be relaxed and heal.

> I remember a time that I made a terrible faux pas. I got angry at a patient's passivity. I guess it stirred up something in myself. The patient's response to that was to laugh--he laughed at how imperfect I was and told me he was less afraid to be imperfect. This actually made him less passive. So one of my limitations brought out more capacity in him which he had hidden from even himself to accommodate to his earlier environment.

Therapist 3 also demonstrated a willingness to create a new reality through the resolution of the old reality.

> It occurs in my view that it (the disruption) has the potential of setting up a dialogue for a new experience, a new way of experiencing, not thinking about reality.

Therapists 6 and 7 also discuss the importance of self-knowledge and knowledge of the patient. Therapist 6 expressed a concern with separating her issues from those of the patient.

> (The more work I resolve, the more I feel that myself, as an instrument, can facilitate their growth and development.) Because I'm more confident that when I'm feeling something that seems to be coming from them, that it really is between us, but having to do with their issues rather than my issues.
>
> But I don't feel the anger because now I understand what she's about.

Therapist 7, while using self-knowledge and knowledge of the patient, also discusses the importance of ongoing analysis.

> The whole course of treatment would become different because of all of the years of experience and training.

Even in negative, it is positive in this work once it is analyzed. So you just want to figure out what it means.

> I do think that any interaction in that bond, that link between the two people there is something totally new that's occurring that has to be defined as you go along.

Therapist 5, in contrast to Therapists 1, 2, 3, 6, and 7, does not discuss the importance of knowledge. Rather, she focuses only on the necessity of working through the break.

> I think that people get better from breaks in--and this is I think what Kernberg talks about--from working through the break in the treatment . . . and if they can work through the breaks, (they get better).

Finally, Therapist 4 does not address whether the way in which the therapist responds to the threat and possible disruption progresses treatment. As has been discussed, he believes that the disruption is caused by defects in the therapist. By inference, Therapist 4 would feel that a therapist must rid himself or herself of defects before he or she can progress the treatment.

Summary

This chapter has presented the procedures used in data collection, an overview of the methodology, including the pilot study and changes in the actual study, the initial data coding process, the revised research questions, demographic information, the final data coding process, and the results of data coding as relevant to each research question. In answering each research question, the responses of the therapist respondents are discussed and then verbatim citations from the transcripts are presented to support such discussion. Chapter 5 will contain a discussion of these findings, particularly how they relate to the theoretical concepts presented in the Review of the Literature in Chapter 2.

CHAPTER V

DISCUSSION AND CONCLUSION

This study is based on the knowledge that therapists, as human beings in an intersubjective field with the patient, experience attack and momentary retreat during the therapeutic process. As such, this study assessed the situations, conditions, and patients' behaviors, as well as their nature and quality, that provoke in therapists the perception that they have been threatened. Further, this study considered those phenomena that occur when therapists feel emotionally threatened by the patient and act on these feelings by temporarily removing themselves from an optimally responsive therapeutic connection. Finally, this study sought to determine the ways in which therapists eventually transform these moments of disconnection into opportunities for continued therapeutic dialogue and patient growth.

The therapist respondents in this study were known to be theoretically sophisticated as deduced from credentials and at least 15 years of experience. Moreover, all respondents had undergone treatment or analysis of sufficient depth and duration to render them sufficiently self-aware for the purpose of the study. Finally, the therapist respondents were assumed to have the ability to discern and to be willing to reveal when they were in a state of temporary emotional retreat from the patient.

Data from the interviews were coded according to a method of analysis outlined by Corbin and Strauss (1990), Glaser and Strauss (1967), and Polkinghorne (1983, 1991). As delineated by these authors, interviews were transcribed and then coded by research question for themes and categories. The coding procedure and analyses indicated an overlap of themes among the interview data. As such, clear distinctions between themes were difficult to make. Nevertheless, the themes reflect the varying contexts, conditions, dimensions, similarities, and differences, among the therapist respondents, in regard to their response to emotional threat and the process of reconnection with the patient.

In this chapter, the results of the data analysis, as they pertain to the four research questions, are discussed in light of the literature regarding the intersubjective field and, more specifically, the therapist's subjective and intersubjective experiences. The concept of the intersubjective field incorporates the notion of the therapeutic encounter as a reciprocally reactive and adaptive dialogue between two systems of instinct, cognition, perception, memory, and emotion in dynamic interaction. This stands in distinct contrast to the idea of the therapist as a blank screen and to the potential for a disruption to have a long-term deleterious impact on the therapy process. The presence of the intersubjective field underlies the idea that, in the therapeutic encounter, incidents of temporary

emotional withdrawal by the therapist may occur, be resolved, and be usefully utilized to enhance the therapeutic bond and to encourage patient growth.

This chapter begins with a presentation of the findings, pertinent to the four research questions, and their relationship to the literature on the intersubjective field. As discussed in Chapters I and IV, these questions are as follows: (1) Are there instances when a therapist feels emotionally threatened and what does he or she do about it? (2) What are the ways in which the therapist responds to emotional threat? (3) What happens when a therapist cannot handle being emotionally threatened? (4) Does the way in which the therapist responds to the threat and possible disruption progress or hinder the treatment? The discussion of the findings relevant to the research questions is followed by a discussion of the researcher's subjectivity as related to the therapist respondents. Then, the implications of the findings for clinical social work are presented. Finally, the chapter concludes with recommendations for further research.

Discussion of Findings Relevant to the Research Questions

Research Question 1. Are there instances when a therapist feels emotionally threatened and what does he or she do about it?

As discussed in Chapter IV, the analysis of the data relevant to Research Question 1 yielded two themes: (1) the composition of the disruption and whether it is perceived as

threatening versus nonthreatening and (2) the inevitability of the disruption and its perceived intentionality (conscious versus unconscious). All therapists agreed that disruptions occur in the therapeutic process and that they are inevitable. Whether the disruption was considered threatening or nonthreatening depended on the therapist's, and his or her understanding of the patient's, subjective realities, including the therapist's personal history, intrapsychic structure, theoretical stance, and years in practice. More specifically, a disruption was perceived as threatening when it disrupted the therapist's organization of his or her world, touched upon the therapist's unresolved or imperfectly resolved issues, or posed a threat to the therapist's physical or economic well being. Conversely, a disruption which does not affect these areas was perceived as nonthreatening. In making such a determination, the usual distinction between the therapist's so called realistic perceptions and his or her neurotic perceptions is fallacious, since perceptions virtually always involve elements of past and present reality fused together (Kernberg, 1965).

As seen in Chapter IV, Therapist 1 addressed the variety of circumstances under which a disruption is experienced as threatening, including those which disrupt the therapist's organization of the world or touch on his or her issues.

> The threats would come from a number of sources. The threats would come from a patient disrupting some way I have of organizing the world, first. Secondly, from touching on any unresolved or even resolved imperfectly, because all problems are resolved imperfectly, conflict inside me.

The notion that the therapist always will have unresolved issues also implies that patient's disruptions, and their perception as threatening, are an inevitable occurrence.

In other situations, the threatening nature of the disruption is more objective. Therapist 3 discussed such a circumstance.

> I felt angry at a patient who would constantly pick at the wallpaper next to the couch. I had asked him several times if he could desist.

Underlying the inevitability of disruption and the thrust toward repair is the knowledge that human beings are motivated by the need to relate even when survival is not an issue. This need to relate is brought into bold relief in the context of Balint's (1949) articulation of the therapy setting as a necessarily two-bodied system, characterized by the interaction between the two participants. Sullivan's introduction of the concept of the therapist as a "participant observer" opened the door for the interactive and empathic role allowed the therapist in object relations and self psychological treatment models. Stolorow (1989) further described therapeutic interaction as one that actually creates and enhances each participant's subjectivity. Subjectivity is, then, an adjective describing the totality of experiences, memories, associations, thoughts, recollections, fantasies, images, and reactions that are brought to each therapeutic encounter. Once the course of treatment is considered a product of the current object relations between the therapist and patient, as well as the "ethos of the analytic situation" (Bacal, 1990), the

therapist cannot be dispassionate, and the potential for the therapist to feel vulnerable to the patient becomes an important consideration.

The vulnerability of Therapist 2 can be seen in his sense of embarrassment, shame, or self-consciousness.

> I can maybe feel a little bit tweaked by some of the criticism that they give me or some of the comments that they give me. But, and I do feel those feelings as a momentary sense of embarrassment or a little tiny bit of shame or self-consciousness.

Therapist 3 reported feeling threatened by a perceived injury to an area of vulnerability.

> A patient started to talk about how sick he felt watching people aging. How disgusted he was when someone was sick. I thought he was probably relating something about my arthritis to me. . . . Because my arthritis is a fact. I live with it. I suppose on some level, I didn't want to deal with his reactions to my narcissistic injury.

Therapist 4 became aware of his shortcomings, and inherent vulnerability, through his perception of the patient's experience of him.

> I'm defective in this way. . . . These things are like built-in characterological problems.

In regard to the inevitability of the disruption, Epstein and Feiner (1979) make reference to patients' repeating cycles of rage. He holds fast to the notion that the therapist must attempt to understand the judicious and effective use of rage in the progress of therapy because instances of acknowledged and resolved anger and emotional disconnection can have a number of profound benefits.

Therapist 7 alluded to the inevitability of patients' disruptions, viewing them as part of a repeating cycle. However, implied in her perspective is her absence from the intersubjective field.

> I don't take them as disruptions--disruption by definition is something that breaks into an established whatever's going on pattern. I don't take it that way. I take it as part of this tape--as part of the communication (between the patient's unconscious and conscious).

Research Question 2. What are the ways in which a therapist responds to emotional threat?

As discussed in Chapter IV, the analysis of the data relevant to Research Question 2 yielded four themes: (1) the therapist's physical and emotional awareness and subsequent internal dialogue, (2) subsequent reactions as intellectual and empathic, (3) the response to emotional threat as empathic and intellectual, and (4) limit setting as a response to emotional threat.

All therapists, either directly or indirectly, indicated their awareness of a disruption, which was generally followed by an internal dialogue. They spoke of awareness in terms of physical sensations and emotional reactions and their internal dialogue in terms of self-exploration and self-analysis. The dialogue also takes into account the therapist's understanding of the patient's structuralization and his or her ability to handle an exploration of the disruption.

The initial reaction of the therapist represents a bridge between intellect and affect, developed through his or

her internal dialogue. An empathic initial reaction comes from the therapist suspending judgment and listening to the patient's view of the world, and the therapist's intellect determines the likely meaning of the disruption. Empathic responses involve using the self directly to repair the disconnection, while intellectual responses focus on what the patient did or was doing at that moment. Importantly, the therapist's understanding of the meaning of the disruption enables him or her to respond empathically to the patient. In this regard, Ferenczi (1931) was ahead of his time in suggesting the very intersubjective notion that the relationship between the analyst and the patient, how it unfolds and its success or failure, could be found in the actual nature of the connection between the patient and the therapist.

Over fifty years later, Greenberg and Mitchell (1983) have argued for the necessity of conceptualizing the therapeutic encounter as a reciprocally reactive and adaptive dialogue between two systems of instinct, cognition, perception, memory, and emotion in dynamic interaction. Further, Stolorow (1989) observed that the therapist's "being there" in an honest and authentic way has great empathic and therapeutic power. As seen in Chapter IV, the honesty and authenticity of therapist 2 is evident in his vulnerability in response to a disruption by the patient.

> In those situations, I usually get a heightened sense of awareness. . . . and, if it's mild, I find it interesting and I'm intrigued by it and I'm curious about it...I do feel these feelings as a momentary sense of embarrassment or a little tiny bit of shame or self-consciousness.

The sense of Therapist 3 "being there" is seen in the honest examination of his possible contribution to something being askew in "our experience."

> I handle it by first looking at where my experience may have touched off the threat. Then I will pose a question as to whether there is a sense in our experience, in our dyad, that something has gone askew.

Therapist 3 also demonstrates his "being there" and his authenticity and honesty by bringing himself and his reactions to the patient directly into the therapy session. He even goes so far as to rework parts of himself in response to the therapeutic encounter. Importantly, he treats the patient as an equal partner in the therapeutic endeavor, opening himself up if he believes that it will enhance their being together.

> The work seems much less futile and less fractured as dissociated parts of the patient's self become structured and integrated. Then parts of my self can be reworked. To me it is a gift. I have to admit that the most important tactic is honesty. To be as honest, even about what might be confusing, has always been of benefit and helps in the establishment of an empathic link. I lean into the field between the patient and myself when speaking. Or I will sometimes stay very still in order to not threaten the patient as I speak. Each individual is very different. Sometimes there is mutual smiling, tone of voice change, eye contact...For me, it is essential to find a place to like the patient...I may actually talk about my experience and wonder about theirs to see if anything may enhance our being together.

Therapist 5 demonstrates another type of authenticity and honesty when she describes her impressions of and reactions to her patient. She is very much "being there" with the patient when she tells her patient that her anger is

provocative. She is trying to figure out why the patient has to behave this way, and such an honest confrontation has the potential to lead to empathic understanding.

> I mean, she's a beast. She's very borderline, and I get angry and she'll come in and she'll say, "don't get angry with me." And I'll say, "well, do you see that your behavior is provocative?"

In contrast, several of the therapists were, for a variety of reasons, unable to self-disclose. As seen in Chapter IV, Therapist 4 seemed almost ashamed to address the disruption. As such, he would not be able to consider self-disclosure.

> If you catch things in yourself that you are stuck with because of your own inadequacies or whatever, you're not likely to talk about them.

> Therapist 5 is not direct about her reactions. I don't think I'll say it directly, "I'm angry."

Finally, Therapist 7 would not disclose to the patient; rather, she turns the situation back on the patient or views the situation as the patient's unconscious loop (tape). As such, she attempts to have the patient seek of what happened.

> The moment I become aware of it . . . I go back and return and seek to ask again that which was just said. If it was about a dream, tell me that part of the dream again. Whatever it is, I just go back over to find out what that was about.

> It's a tape playing, it's this tape that we have; it's my everything. . . . I always ask my patient to help me out. If there is an impasse and the person feels I'm misunderstanding something, I won't argue about it.

Stolorow (1992) further suggests that both the therapist's and patient's intersubjectivity includes, but is not limited to, preexisting experiences, memories, thoughts,

and associations, as well as those reactions evoked, modulated, initiated, and spontaneously drawn forth in a continuous process through the interplay between patient and therapist. Therapist 1 spoke of how he uses the disruption in the interplay as a means to explore the patient's psychology and history.

> Most of the time I would use whatever the disruption is in some therapeutic fashion and, either at that moment in time or later, bring up the disruption to understand what must produce such a disruption and what potential events inside the patient's psychology or in the patient's history had produced the need to produce this disharmonious assault.

Annie Reich (1960) views the communicative process as occurring unconsciously for both the patient and therapist. Accordingly, she believes that some type of countertransference, in the form of identification, is essential to insight and understanding. "It is only by attending to the affective signals coming from within himself that the analyst is able to fathom their hidden meanings and bring into his own consciousness what the patient is unconsciously communicating" (Reich, 1937, p. 199).

Natterson (1991) takes a similar perspective. He explains that if one practices "meticulous self-scrutiny," the therapist will be able to honestly evaluate the nature of the patient involvement. According to Natterson, any subjective elements from the therapist's psyche, no matter how unconventional or extreme, can, when combined with meticulous self-scrutiny, result in valuable therapeutic input.

As noted, all therapists spoke of an initial awareness of the disruption, followed by an internal dialogue. As seen in Chapter IV, Therapist 1 spoke of how a therapist uses an internal dialogue and self-scrutiny to understand and work through the disruption.

> The way it's ordinarily mastered is through the therapist having a dialogue . . . about where the disruption occurred, why it occurred, what conflicts have been touched on, thinking through, and doing a piece of self-understanding and self-analysis.

Therapist 2 goes through a process of "meticulous self-scrutiny" before deciding how he will respond to the patient.

> I also go through a loop of self-questioning and self-examination during those times. If there's something I've done that justifies this attack, where it's a co-constructive situation and what's my part in this. And an early on differential that I try to make in my mind is . . . is this a therapeutic failing of mine? Because that differential becomes very important in terms of my countertransference responses as well as my interventions.

Therapist 6, similar to Therapist 2, engages in self-scrutiny in which she assess whether the disruption is part of her underlying dynamics and whether she needs to work on certain unresolved issues.

> I get a feeling . . . when I know that something is being pushed in me. And then I make note of it and I will decide whether or not to bring it up. And the first thing that has to happen is that I decide whether or not what's happening is part of my underlying dynamics that I have to keep working on within myself and in my peer group. Anything unresolved . . .

Finally, Therapist 7 believes that self-scrutiny is so important that if a therapist is unable to adequately assess

himself or herself, he or she should seek "help" (possibly consultation or therapy).

> So what I have always told my students...is that if something happens within the hour...half of it belongs to you, half of it belongs to the patient. The (responsibility) to yourself is to analyze both sides. If you can't do it yourself, get help with it--which is the point.

Fleiss (1942, 1958) further developed Reich's (1960) view that some type of countertransference, in the form of identification, is essential to insight and understanding. Fleiss proposed the notion that only through a process of trial identification could the analyst obtain "inside" or unconscious information. According to Heimann (1950), this process can be helped along by the therapist utilizing strong emotional reactions. Moreover, Heimann believes that the therapist is under duress to sustain the feelings stirred in him or her for the purpose of gaining understanding, however without discharging them (as does the patient), and always must subordinate such feelings to the analytical task. "By attending to feelings roused in himself via his patient's associations and behavior, the analyst is best able to reach the 'patient's voice'" (Heimann, 1950, p. 82).

Racker (1953, 1957) takes Heimann's concept a step further, positing the idea that concordant or "matching, self-affirming" identifications with the patient, on the part of the therapist, are a central component of empathy and empathic linkage. In addition, he presented the idea that the therapist's reaction, in addition to being a potentially serious barrier if engaged in non-vigilantly, also could be

extremely valuable to the therapist, opening up avenues of insight to the patient which otherwise would remain unavailable.

Therapist 3, as well as his patient, benefited from the therapist's trial identification.

> My world seems to grow each time I am able to use my subjectivity to help another develop their subjectivity.

Therapist 6 used trial identification to mitigate the anger at her patient she otherwise would have felt.

> I point it out and I say, "Look, you know this is an inflammatory statement geared to get me." Of course, I talk to her about it. But I don't feel the anger because now I understand what she is about.

In another instance, Therapist 6 sustained the feelings stirred in her for the purpose of gaining understanding, but subordinated such feelings to the analytical task.

> And I just said to her, "Why? You knew that this would annoy me. Why did you do this?" And it was an uncharacteristic response because I very rarely say "why."...So it just came out like that and what she said, I will never forget. I don't think either of us will ever forget. She said, "Well, I know you're going to hate me sooner or later, so I thought I'd just get it over with." If I hadn't responded and she did it, she did make me angry. Not that she made me hate her, but she wanted to see how far it would go, probably. Well, she knew, in her subjective reality, it was going to go to my hating her. So I might as well start now.

Kohut (1977), Olinick (1973), and Beres and Arlow (1974) further developed the concept of the therapist's countertransference (or response to disruption) as a form of healthy, empathic identification and stressed the need for

the therapist to be able to shift, when appropriate, from feeling and thinking with the patient to feeling and thinking about the patient.

As seen in Chapter IV, Therapist 1 spoke of how he moves from an understanding of his feelings to a focus which considers what is going on with the patient.

> I might show them my feelings, but generally, that I don't find too useful because it puts the focus on me and my feelings rather than on whatever is going on with them. And it's an issue to be understood in terms of what's going on with them.

Therapist 2 expressed the need to be cautious about what he shares with the patient for fear of the patient feeling shamed or belittled.

> I'm very cautious about sharing anything other than the following two things: I will interpret it. . . . "I can understand how difficult this is for you given the way your father used to react to you when you got angry." And the other thing I try to convey is a calm, relaxed demeanor. So sometimes the way I convey it isn't even through words. I mean I'll just say, "I'm interested to hear more about this" or "I'm pleased that you can say it." That's sometimes dangerous to say with the patients I work with because . . . very easily it gets turned into a feeling of being shamed or belittled. You know, you have to be really careful.

Therapist 6 makes certain that she determines what are her issues in order not to raise them with the patient.

> I don't raise it with a patient because they're my issues, not the patient's. So first I have to distinguish which of those it is and usually it feels quite different, actually. I've become, over the years, fairly clear at distinguishing and the more clear I am at distinguishing, then the freer I feel to raise it with the patient.

Therapist 7 is also careful not to let her self-awareness turn into an intrusion into the patient's time. Moreover, she believes that therapist boundaries and limits are for the benefit of the patient.

> Well, you're asking if I say to my patient, "I noticed that my mind just wandered?" Never, that is an intrusion into the patient's time. That's why we don't do various things with patients. That's why we have boundaries and limitations and we adhere to those.

Finally, limit setting also was used as a response to emotional threat and has two aspects. One aspect is the therapist setting limits on what the patient can do, generally involving violence or the destruction of property, and the other aspect concerns the extent to which the therapist limits his or her involvement with the patient in terms of working through the disconnection. In regard to the latter aspect, there is scant literature which addresses the issue that, at times, what is tolerable for the therapist becomes the defining element of where limits are set and how they may be used to further or hinder the growth of the patient.

In regard to the former (growth enhancing) aspect of limit setting, Kernberg (1965) addresses this by his suggestion that there is a parallel between the role of the mother (one of whose functions is limit setting) and that of the therapist. He stated that the role of the mother as a buffer and mediator of the vicissitudes of instinctual conflict is similar to the role of the therapist as a mediator and buffer for adult expressions of instinctual

conflicts. As discussed in Chapter IV, Therapist 2 used limit setting to maintain the connection and to enhance patient growth.

> The patient will do to you what was done to the patient. . . . What I was providing for her, hopefully, was the new experience . . . that a caregiver could tolerate her rage without attacking or abandoning

In this way, Therapist 2 served as the mother/therapist who is a mediator and buffer for instinctual conflicts.

In another instance, the limits sets by Therapist 2 were intended to protect him, but at the same time, were reparative for the patient.

> And she never got violent with me. If she had gotten violent with me, I would have ended the session. But she never got physically violent with me, so I let her do it. She did it several sessions in a row. Well, it was reparative for her in that I tolerated it, I didn't attack her back. And the limits continued to be set on her and they needed to be set.

Therapist 3 also functioned in the role of the good mother when he took the initiative to express concern about the relationship between the patient and himself. By doing so, he became a buffer for his patient's expression of internal conflict.

> There (was) a sense in our experience, in our dyad, that something ha(d) gone askew. . . . I had to directly address that there was something wrong between us and perhaps, together, we could figure it out. The expression on the patient's face was one of relief, and I noticed his body relax.

In another instance, Therapist 3, similar to Therapist 2, set limits to protect himself. When followed by an

exploration of the meaning of the patient's actions, these limits also have the potential to be reparative for the patient.

> I felt angry at a patient who would constantly pick at the wallpaper next to the couch. I had asked him several times if he could desist
> .

This made it possible to be direct, set limits, and respond in, what might have been seen as a disruptive, but was seen as a courageous, manner and as a willingness to take a risk.

Research Question 3. What happens when a therapist cannot handle being emotionally threatened?

As discussed in Chapter IV, the analysis of the data relevant to Research Question 3 yielded two themes: (1) the therapist's assessment of his or her adequacy in handling the emotional threat and (2) the disconnection as temporary or permanent. What was significant about the data relevant to this research question was that only one therapist directly addressed the issue of assessment of one's adequacy in handling the emotional threat, while two therapists indirectly addressed this issue. The remaining four therapists did not deal with the issue of assessment of one's adequacy in relationship to emotional threat. However, in regard to the issue of whether the disconnection is temporary or permanent, five of the seven therapists thought this relevant.

Three therapists dealt with the issue of assessment of one's adequacy in handling the emotional threat; they viewed the disconnection as temporary. They are seasoned therapists and are deeply knowledgeable about and comfortable with their

fears, limitations, and aggressive impulses. Moreover, they are comfortable with their own anger. As a result, they are able to handle a disruption so that reconnection with the patient is established. In this regard, they embody the conceptualization of the therapist as the optimally socializing parent and serve as examples of Kohut's (1959, 1977) suggestion that the therapist also reacts and can respond to the patient in health-inducing ways.

As seen in Chapter IV, Therapist 3 was the only therapist who directly addressed his adequacy in responding to the emotional threat. What is significant about his response to the patient is that, even though he views the disconnection as temporary, he was willing to make the disconnection permanent, by referring the patient to another therapist, because he felt that this was a health-inducing response.

> I can remember one instance in which I truly did not like the patient and realized that I would only repeat his experience of less than adequate connection, and I referred him to another therapist. This was difficult; I had to mourn and deal with my own limitations.

Yet, in another instance, it is clear how he works from an empathic stance, in which he stays with his subjectivity and uses it to reconnect with the patient, ensuring that the disconnection will be temporary.

> Then I will pose a question as to whether there is a sense in our experience, in our dyad, that something has gone askew. . . . We seemed to work through his feelings as well as my own, but the treatment seemed bogged down, didn't seem to be going anywhere a month later. I decided that I had to directly address that there was something wrong between us and, perhaps together, we could figure

> it out. The expression on the patient's face was one of relief, and I noticed his body relax.

Of the four therapists who did not address their adequacy in handling emotional threat, only two addressed the issue of whether the disconnection is temporary or permanent. Both viewed the disconnection as having the potential to be either temporary or permanent. Therapist 5 discussed how she was able to reconnect with a patient, implying that she was able to keep the disconnection from becoming permanent.

> One very intact patient I had, I called up after the session. I said, "I really hope I didn't come on too strong in the session with you. . . . She came in the next time and said, "I really appreciate your calling me."

Therapist 7 stated that the disconnection could be either temporary or permanent, depending on the therapist's success in exploring the disconnection; however, she implied that such success depended on the patient's willingness to explore the disruption, that the therapist, after a certain point, is under no obligation.

> I would consider . . . it a tape playing. . . . If we can find it together, splendid. If you can, your obligation is to find it. And if you can't find it here, . . . there's no obligation. I always ask my patients to help me out. . . . If that doesn't work over time, it becomes absolutely blocked . . . and it's a dead issue now. I always give the patient the option of consultations.

Both Therapists 5 and 7 appear to be ambivalent as to whether they might be responsible for the disruption becoming permanent. Further, one could infer that these therapists are afraid to address their own subjectivity.

That four of the therapists did not address their adequacy in handling emotional threat is significant. Even in this small study, the therapist respondents were loathe to admit that there are certain issues which they feel inadequate to address. Moreover, this unwillingness demonstrates how difficult it is to view oneself as adequate in the face of being emotionally threatened. Therapist 4 appears to speak for these therapists.

> I suppose that common inadequacies among trained professionals is not something that anybody (wants) to talk about. We like to talk about difficulties that you have to teach beginners to avoid; that feels comfortable.

The relative willingness of therapists to assess and acknowledge their inadequacies is directly related to their effectiveness in responding to disruption. An intersubjective approach views the therapist's reaction to disruption or countertransference as including all the therapist's responses to the patient--conscious, unconscious, real, and neurotically distorted. Depending on what is touched off in the therapist, he or she may or may not feel adequate to handle the emotional threat. If therapists can make themselves aware of their responses to the patient, acknowledge their responses to themselves, and be willing to expose their responses to the patient, then they can respond to the threat in an growth enhancing manner and ensure that the disconnection will be temporary.

Schafer (1959) labeled positive countertransference as "generative empathy," to distinguish it from the negative countertransference which might come about as a response to

pressure from the patient. Yet, the researcher contends that even if the therapist's unresolved issue are brought to the fore, the therapist can still respond in a growth enhancing way. The key is for the therapist to be willing to use himself or herself authentically, with each individual's style. Otherwise, the therapist cannot provide a corrective experience. In this regard, Natterson (1991) has stated that "the outcome (of the therapeutic process) depends on how carefully and honestly the therapist processes his or her own fantasies and feelings" (p. 210).

Therapists 1 and 2, who indirectly addressed the assessment of their inadequacies, both demonstrated a willingness to make themselves aware of their responses to the patient, acknowledge their responses to themselves, and expose their responses to the patient. As such, they have the capacity to ensure that a disconnection will be temporary. Therapist 1 believes that there is always some way that the disconnection can be overcome, that the therapist is responsible for ensuring that the disconnection be temporary.

> But there's usually always something that you can do or some way you can be of use or some way that you can overcome that despair.

Therapist 1 also indicates that, if necessary, he would not be diminished by seeking consultation.

> If the conflict is too severe to resolve individually, then the therapist can, either formally or informally, seek some kind of consultation to help him or her understand what is going on.

As seen in Chapter IV, Therapist 2 chose to terminate a patient, but only after he had made a concerted effort to reconnect after the disruption. His sense of adequacy enabled him to choose termination as best for the patient.

> I told her that she had created this situation which now made it impossible for me to work with her and that I was very sorry to do this because I felt that our work had been good, but that I could not continue to work with her.

As discussed above, the willingness of therapists to assess and acknowledge their inadequacies is directly related to their effectiveness in responding to disruption. Further, depending on what emotional responses are touched off in the therapist, including aggression and anger, he or she may or may not feel adequate to handle the emotional threat. In this regard, Searles (1965) noted that, for the therapist to move into the realm of a realistic and integrated self, he or she must feel comfortable with expressions of aggression and anger, both in the patient and within himself or herself. Epstein and Feiner (1979) monitored their own reactions of rage and found that therapists can safely and effectively communicate anger after they have had a chance to reduce the intensity of the anger to a level at which it is experienced as irritation or frustration. According to Epstein and Feiner, the admission of the therapist's own anger enables the patient to come up against another in a safe area, to separate from the idealized object, and to begin to form some self boundaries. Conversely, if a therapist cannot acknowledge his or her anger, or feel comfortable with the

patient's expressions of aggression and anger, the therapist cannot provide a safe area for the patient.

Therapist 1 discussed how therapists intellectually distance themselves from a patient's anger by interpreting to themselves the analytic reasons for the occurrence of the disruption. However, in the process, the therapist removes himself or herself from the intersubjective field and, as such, cannot provide a safe area for the patient.

> The real issue was that the therapist could not tolerate a degree of anger . . . that the patient (felt). (This) generated a . . . reaction (of moving away) in the therapist. (For to) fully (take on) the anger of the patient was so disruptive to (the) therapist that (he) had to dodge it or get out of the situation in one way or another. (The therapist) talked about being unable or unwilling to accept fully that rage, particularly when (one is) trying to help and (to) see (oneself) in a different kind of way.

Research Question 4. Does the way in which the therapist responds to the threat and possible disruption progress or hinder the treatment?

This is the most critical of the four research questions. The answer to this research question is crucial for determining whether dealing with threat and disruption is a beneficial aspect of the therapeutic endeavor. If the response to threat and disruption does not advance treatment, then the answers to the other three research questions become irrelevant.

Importantly, all therapist respondents felt that the direct addressing and proper handling of the threat and possible disruption progress the treatment. Overall, the therapists felt that knowledge of psychodynamic theory, self-

knowledge, self-exploration, and knowledge of the patient are important to progressing the treatment.

The literature contains very little information on the potential for threat and disruption to be constructive to the therapeutic endeavor and to patient growth. However, there is literature dating back to 1935 in the work of Suttie (1935). Suttie saw effective treatment as a process of overcoming the barriers to loving and seeing oneself as loved and the therapist and positive transference as the means for reestablishing emotional connections. It can be inferred from his remarks that, through positive transference, the therapist and patient can establish and reestablish emotive connections. Moreover, the process of establishing and reestablishing emotional connections allows for treatment to be effective and helps the patient to overcome barriers to loving and being loved.

Therapist 3 alludes to the disruption's potential to allow for new ways of relating to the world and, perhaps, connecting.

> It occurs in my view that it (the disruption) has the potential of setting up a dialogue for a new experience, a new way of experiencing, not thinking about reality.

Therapist 5 also address the potential of the disruption to lead to patient growth.

> I think that people get better from . . . working through the break in treatment . . . and if they can work through the breaks, (they get better).

Over fifty years after Suttie (1935), Stolorow (1992) observed that reaffirmations of patients' experiences--

regardless of how defensive or regressive--possess a tremendous potential to enhance the therapeutic bond, ease patients' anxiety, and diminish their defensive strategies so that positive self and object transferences could begin to form. Stolorow's "reaffirmations" can be understood as an empathic stance which enables therapists to deal with their own regressive and defensive posturing and which serves as a vehicle to establish a bond that will withstand rupture and provide a foundation for the establishing and reestablishing of emotive connections. Further, it is only through the process of threat, disruption, and reconnection, on a repeated basis, that a bond is formed and continually deepened.

Therapist 3 alluded to such a process when discussing a patient with whom he worked through the disruption and, as a result, who was able to rid himself of his sense of detachment.

> This patient had felt strange and experiences were not able to change his sense of detachment until we made it more understandable. We ruptured a pattern of interaction in which the patient was not able to change; if he destroyed, he was always destroyed in return.

Writing at about the same time as Stolorow (1992), Natterson (1991) discussed the idea that both love and hate play into the transference and countertransference dynamic and emphasized the importance of these connections to the therapeutic relationship. "This gordian knot of love, hate, and fear that binds us [patient and therapist] is eventually dissolved [through a process of meticulous engagement and

vigilance on the part of the therapist] rather than being severed" (p. 19). He also addressed the concept of an active intersubjective self introduced to therapy by the therapist and contended further that the interplay between intersubjective selves enters all aspects of a relationship between two individuals, where intense emotions, questions of values and morals, and other unconscious psychological factors come into play. Empathic understanding of the therapeutic experience, and the intersubjectivities of both individuals, requires the involvement of the whole person of the therapist.

In his discussion of both the "gordian knot of love, hate, and fear" and the interplay between intersubjective selves, Natterson (1991) emphasizes the importance of the active involvement of the therapist's intersubjective self. Therapist 3 clearly demonstrates such involvement, and his consequent personal growth, in his discussion of his work with patients.

> My world seems to grow each time I am able to use my subjectivity to help another develop their subjectivity. The work seems much less futile and less fractured as dissociated parts of the patient's self become structured and integrated. Then parts of my self can be reworked. To me it is a gift.
>
> I found this to be a growing experience for me since I had to acknowledge that attachment has many unconscious links to our ability to be relaxed and heal.

Discussion of the Researcher's Subjectivity as Related to the Therapist Respondents

In keeping with the purpose of conducting research for a dissertation, the researcher, a woman, found the process to be both educative and growth enhancing. In learning about the different ways in which therapists express themselves, the researcher was struck by the disparate reactions of the therapist respondents. The majority of the respondents seemed to want to remain as indirect as possible, perhaps in an attempt to protect themselves from the imagined slings and arrows of the profession and, possibly, from the researcher. Where therapists were indirect, it was difficult to ascertain the true affective experiences in the exchange between themselves and their patients. This limited the researcher's ability to grasp and to empathize with what transpired in the intersubjective space between them and their patient.

The more direct the therapist respondents were in regard to both their positive and negative reactions to threat, the more the researcher was able to be attuned to the essence and imperative nature of the disruption and the reconnection. When interviewing such therapists, the researcher had more of an empathic, emotionally connecting experience as compared to the more intellectual experience of interviewing the less direct therapist respondents.

As a result of interviewing the more direct therapist respondents, the researcher, strengthened her commitment to her own growth as a therapist, as a human being, as a thinker, and as a researcher. She also increased her

willingness to risk involvement with her patients and potential criticism vis-a-vis the profession as a whole. Finally, it must not be overlooked that the researcher's reactions and perspectives are limited by her education, years of clinical practice, and self-knowledge, as well as other factors. In this sense, she is as dependent on these factors for her assessment of the therapists as the therapists are dependent on these factors for their assessment of their patients.

Implications for Clinical Social Work

Social work in the multi-cultural United States necessarily entails a cross-cultural approach to treating the individual and the family. In this regard, it is not sufficient to confine one's understanding to intrapsychic forces; social workers must have an understanding of our clients in terms of their entirety, which includes not only the client as an individual and as a member of a family, but as part of their cultural context.

In addressing the implications of the study's findings for clinical social work, one must first acknowledge that the focus of the study was highly specialized and delimiting. Unfortunately, it was not possible to take the research questions and apply them to understanding the importance of a multi-cultural approach when studying disruption and its resolution. In this regard, the researcher, who is Caucasian and Jewish, wonders what her findings might have been if she had been of another cultural background or had any of the therapists interviewed and the patients they treated been

from another culture. Yet, she believes that any theoretical stance must be viewed from a two-bodied approach when working with clients of other cultural backgrounds because it takes the whole of their experiences, psychological, sociological, and biological, into account.

Often, social workers find themselves working with clients whose backgrounds are often vastly different than their own. While it is important to be knowledgeable about other cultures, this is not always practical. Thus, one way to bridge the potential gap between two individuals of disparate cultures is for the therapist to take an intersubjective approach to what occurs in the therapeutic process.

When taking the social work perspective, which is "the person, the problem, and the place," the social worker's view of dysfunction, disruption, and threat must, by necessity, be responsive to each cultural variation. In this regard, the researcher wonders how many social workers take into consideration the profound differences in culture as they pertain to early development and to the reenactment of one's intrapsychic structure in the therapeutic setting. Thus, to overcome the inherent limitations of working with clients of disparate cultures, one must approach treatment from the perspective that, if one is willing, all experiences between two subjectivities can be understood with time.

Given that all therapist respondents came from a psychoanalytic background, the researcher feels it important to note that psychoanalytic psychotherapy appears to limit

the patient population to a majority, educated population and, further, its practitioners tend to be drawn from this same population. As such, many psychoanalytic psychotherapists have not yet confronted issues of multiculturalism. In contrast, social workers see a broad range of individuals from a wide spectrum of socioeconomic status and educational and cultural backgrounds.

As stated above, social work, or any other helping profession, in the multi-cultural United States necessarily entails a cross-cultural approach to treating the individual and the family. Social workers, in response to the needs of the multi-cultural populations we serve, are learning to view treatment as an intersubjective experience between two subjectivities and what takes place in the space between these subjectivities as healing and growth producing. Thus, having a social work background is of great assistance to the therapist who wishes to work with multi-cultural populations.

Social workers have fought long and hard to be professionally respected. While psychologists and psychiatrists have tended to have a more narrow focus, encompassing the individual, alone or the in the context of his or her family, or in the context of his or her biological structure, social workers have viewed the individual through a broader lens, encompassing his or her cultural background, as well as the society at large. We need to recognize that we are now entering a time when the social work approach to treatment and the skills that social workers possess can serve as models for other "helping" professionals. And,

perhaps, social workers finally will receive the recognition and respect which they have earned.

Recommendations for Further Research

The recommendations for further research are as follows:

1. The researcher was not able to take the research questions and apply them to understanding the importance of a multi-cultural approach when studying disruption and its resolution. Thus, a topic for further research could be "Is disruption viewed differently in different cultures and how might that influence the therapeutic process and the course of treatment?"

2. Of those therapists who were the most self-disclosing with the researcher and direct with their patients, all were male. Thus, a topic for further research could be "Is there a relationship between the gender of the researcher and that of the respondents and the ability to be self-disclosing?"

3. Finally, the researcher found that the willingness of therapists to acknowledge their inadequacies was related to their effectiveness in responding to disruption; however, the results also suggested that, if a therapist experienced sufficient shame in regard to his or her inadequacies, he or she was rendered unable to adequately respond to the disruption. Thus, a topic for further research could be "Does the ability to recognize, embrace, and work through one's shame enhance the therapist's ability to reconnect and result in both patient and therapist growth?"

Conclusion

There was no outstanding finding for all therapists found that there were disruptions. Each therapist's experience of disruption was different. Their theoretical and emotional positions colored their use of themselves as well their techniques in handling these disruptions. The subtleties and broad spectrum in which they might use themselves to repair the disruptions seemed to depend upon the therapist's comfort and capacity to deal with their own personal internal and external worlds. The presence of shame, interfered with the therapist's ability to be subjectively open. In my opinion, therapist is an instrument. in order for this instrument to function to its optimal capacity, a deep understanding of self and a tolerance for one's assets and limitations, is crucial to assist another to develop.

The work that was begun by trying to understand the interaction and reaction of subjectivities colliding and exchanging with one another leaves me even more curious and interested in further pursuing this complex and intricate topic.

Appendixes

Appendix A.
Introductory Letter

HOLLY HEIN
Licensed Clinical Social Worker
333 Euclid
Santa Monica, CA 90403
(310) 394-1926

Dear Colleague:

I am writing to as your participation in a research study. I am exploring instances of emotional disconnection on the part of the therapist and attempting to discuss within that framework, how therapists handle these for optimal therapist-patient communication. My study uses an exploratory design and will attempt through individual interviews to identify from the therapist's perspective, common patterns of experience in response to emotional threat. There is no better way to understand this than by taking with the with the psychotherapist who can tell me what his/her experience has been.

This research study is in partial fulfillment of my doctoral degree and is being chaired by Dr Philip Rmgstrom of the California Institute for Clinical Social Work.

The selection of interviewees will begin with the collection of data taken from a Pre-Interview Questionnaire. If the results of your survey responses to indicate I will be contacting you to see if you would be willing to participate in an approximately one hour, tape-recorded interview. As is consistent with research protocol appropriate measures will be taken to protect confidentiality.

If you are willing to give of your valuable time and of yourself in this way, please complete the enclosed survey, and return it within two (2) weeks in the self-addressed, stamped envelope provide.

I sincerely appreciate your consideration of this request and thank you in advance for your participation.

Sincerely,

Holly Hein, MSW

Appendix B.

Pre-Interview Questionnaire

PRE-INTERVIEW QUESTIONNAIRE

Section 1.

1) Number of years in clinical practice _____.

2) Which of the following best describes your primary, top affiliation? Indicate the % of your involvement in each category that applies:

   a) Private practice (full time) _____ (part-time) _____
   b) Hospital: psychiatric _____ medical _____
   c) Outpatient clinic _____
   d) Family service agency _____
   e) Community mental health center _____
   f) Other
      (specify)_____

3) Which of the following most closely approximates your primary theoretical orientation: (Indicate the % of your total involvement with each category that applies)

   a) Cognitive/behavioral _____
   b) Humanistic/existential _____
   c) psychoanalytic/psychodynamic:
      - Classical Freudian analysis _____
      - Ego psychology _____
      - Object relations _____
      - Self psychology _____
      - Other (please specify) _____

   d) Family Systems _____
   e) Other (please specify) _____

4) Personal psychoanalytic psychotherapy received:
   _____Yes _____No

5) Post-M.S.W., Post-Ph.D., Post-M.D. training (check all that applied)

   a) Clinical consultation _____
   b) Supervision _____
   c) Advanced formal training _____

Appendix C.

Preliminary Questionnnaire

PRELIMINARY QUESTIONNAIRE

1.

Can you recall instances where you experience yourself momentarily retreating form the therapeutic connection?

Yes No

2. If you answered yes to the above, how do you experience this disconnection?
(Please describe briefly when possible on the lines provided)

bodily discomfort

sleepiness

defensive or provocative remarks

mind wandering

trite generalizations

other regression to more primitive ego states

("Why am I bothering with this person?" "Who needs this grief?" "Who do I think I am trying to 'fix' these broken people?")

other experiences\reactions not mentioned above

3. Can you recall what it is you experience coming from the patient that illicits these various recoiled or retractive responses?

Page Three

Comment on the following as possible answers to Question Four above:

patient disapproval

rage

cynicism

hopelessness

Page Four

attacks on your professional competency

inappropriate intimacy

patient's regression to acutely primitive ego states
(e.g.: threats, rocking, eroticising the therapist, silence)

4. Can you discuss circumstances NOT alluded to above under which you feel that an essential part of yourself is attacked to the extent that you would like to or actually do recoil momentarily from the therapeutic connection.

Appendix D.
Informed Consent Form

INFORMED CONSENT FORM
California Institute of Clinical Social Work

I , hereby willingly consent to participate in An Exploratory Study of the Intersubjective and Subjective Experiences of Psychotherapists research project of Holly Hein(Principal Investigator) and Holly Hein L. C. S. W. (Investigator) of
the California Institute for Clinical Work.

I understand the procedure as follows:
1. A one hour tape recorded interview will occur in a private confidential setting to be arranged between myself and the researcher. I understand that I may refuse to answer any questions without penalty, and that I may withdraw from the study at any timealso without penalty.

2. I am aware that there is minimal potential risk for emotional discomfort involved in participating in this study. However, if this should happen I will be able to contact the researcher who will make provisions for me to receive professional help for a reasonable and limited time.

3. I understand that this study may be published and that confidentiality will be maintained and that my anonymity will be protected unless I give written consent to such disclosure. The interview will be conducted by Holly Hein L.C.S.W. .

4. I have been informed that the inerview will be taped for pruposes of data analysis. I have also been advised that my name will not appear on the tape and at the completion of the study the tape will be errased. I realize that without my consent I will not be identified in any publication or presentation of information gathered as part of this study.

DATE: SIGNATURE:

_____

Appendix E.
Topics And Probe Questions

This topic will assist the respondent in recalling occurrences in which he/she experienced emotional distancing. The respondent will be asked to specify what internal and external cues in him/her were signals of emotional distancing. How did the therapist register or operationalize this emotional distancing him or herself?

- Distractedness
- Overly intellectualized responses
- Sleepiness
- Thoughts wandering
- Resentment toward patient
- Self doubts

TOPIC II. The therapist will be asked to recall and discuss those behaviors on the part of the patient which he perceived as sufficiently ego threatening to require momentary emotional distance.

Here the therapist will be asked to discuss in some comparative framework what behaviors on the part of the patient that seem the most emotionally threatening and why:

- Overt rage
- Attacks on professionalism
- Personal attacks
- Condescension
- Silence
- Acute regression
- etc.

TOPIC III. The respondent will be asked to speculate about the nature and frequency of temporary emotional distancing during therapy that seemed unrelated to the behavior

This will provide some descriptive base line to assess if temporary emotional retreat on the part of the therapist is a necessary aspect of the intersubjective reality of doing therapy.

TOPIC IIV This topic will try to gauge how reconnection is effected and if there is indeed any therapeutic value to the schema described by Threat → Disconnection → Re-engagement.

Because this study is based on the hypothesis that therapy is an intersubjective space that is continually evolving and responding to temporary shifts and dynamics, it follows that we are assuming here that moments of functional retreat for the therapist are a "fact" of doing therapy. As a loose corollary hypothesis, the study wishes to investigate the notion that authenticity on the part of the therapist with respect to this schema of Threat → Retreat → Re-connection might in fact become a medium or vehicle whereby through genuine discussion, disclosure and analysis, a deepened therapist-client understanding might arise. In this regard this topic will attempt to assess the outcomes of Retreat → Reconnection: is the patient calmed or more agitated; is the interlude noticed by the patient; how does the therapist handle these instances:

- Proceeding as if nothing happened
- Making the rupture in his/her optimal emotional connection a topic for authentic therapeutic dialogue

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