Optimal Responsiveness: An Exploratory Study of the Subjective and Intersubjective Experiences of Psychotherapists

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OPTIMAL RESPONSIVENESS: AN EXPLORATORY STUDY OF THE SUBJECTIVE AND INTERSUBJECTIVE EXPERIENCES OF PSYCHOTHERAPISTS

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by

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THE CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK

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ABSTRACT

OPTIMAL RESPONSIVENESS: AN EXPLORATORY STUDY OF THE SUBJECTIVE AND INTERSUBJECTIVE EXPERIENCES OF PSYCHOTHERAPISTS

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This qualitative study explored the subjective and intersubjective experiences of clinical social work psychotherapists that contribute to their being optimally responsive. This study was an exploration of the cumulative effects of psychotherapists' experiences that led to optimal moments or turning points in the therapeutic encounter. The major questions addressed in this study were:

Question #1: What subjective and intersubjective experiences contribute to psychotherapists being optimally responsive?

Question #2: How does the psychotherapist know he or she has been optimally responsive?

Semi-structured interviews were conducted with nine purposefully selected, autonomously practicing clinical social work psychotherapists. Data from the interviews were content analyzed according to Glaser and Strauss' (1967) method of constant comparative analysis.

The results for question #1 indicated that there are certain precursors that contributed to the psychotherapists' ability to be optimally responsive. It was evident that the impact of specific kinds of subjective and intersubjective experiences shaped their capacity to respond optimally. A Thematic Schema of Optimal Responsiveness was developed as a way of conceptualizing this process.

This study suggests that optimal responsiveness is derived from the psychotherapist's affect attunement to the mutually reciprocal selfobject relationship. This process is referred to as "intersubjective optimal responsivity."

The results of this study broadens the range of therapeutic responses that can be considered optimal. The value of noninterpretative analytic work was a significant implication. The cumulative effects of psychotherapists' experiences emboldened the psychotherapists to risk and move beyond customary parameters.

The results of question #2 identified specific indicators that confirmed for the psychotherapists that they had been optimally responsive with their patient. The findings suggest an initial framework by which the psychotherapist can verify whether their interventions were optimal and therapeutically usable.

This study can serve to heighten psychotherapists' self-awareness, and sensitivity to those subjective aspects of themselves that may contribute to, or limit, being optimally responsive.

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CHAPTER I

INTRODUCTION

The stimulus for this study was my interest in clarifying my theoretical understanding of the occurrence of optimal responsiveness in the psychotherapeutic encounter. That is, I wished to study those aspects of the encounter that contribute to and promote psychological restoration and healing. I am interested in exploring the significant, key, essential, and critical factors that psychotherapists define as contributing to an optimally responsive therapeutic hour.

I am particularly interested in understanding and conceptualizing the contributions of the psychotherapist in the treatment situation. That is, exploring the subjective[1] and intersubjective[2] experiences of the psychotherapist, in

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[1]Subjectivity is described in this context as the totality of the psychotherapist's own experiences, memories, associations, thoughts, recollections, fantasies, images, and reactions that he or she brings to the therapeutic relationship. It is not limited, however, to only those responses and reactions.

[2]Intersubjectivity is described as the interplay between two subjectivities: that of the patient (the observed), and that of the psychotherapist (the observer). This study will explore intersubjectivity from the psychotherapist's (observer's) perspective. In other words, I am specifically interested in examining intersubjectivity from the perspective of the psychotherapist. I will examine the psychotherapist's range of reactions evoked, initiated, and spontaneously drawn forth through the interplay between patient and psychotherapist.

relation to his or her patient, and how this can contribute to optimal responsiveness. I am also interested in identifying those categories of responses that may broaden the psychotherapist's overall range of therapeutic responsiveness. Essentially, this is an exploration of the cumulative effects of the psychotherapist's experience that lead to optimal moments, or turning points, in the therapeutic encounter.

The range of differing perspectives regarding what are the optimal qualities of a psychotherapist is as vast and varied as the psychoanalytic literature. The literature on theory often seems to provide more questions than answers. To organize the multitudinous questions and issues this research raises, there are two major research questions which I will explore:

I. What subjective and intersubjective experiences contribute to psychotherapists being optimally responsive?

II. How does the psychotherapist know he or she has been optimally responsive?

Bacal (1985) described optimal responsiveness as the responsivity of the analyst at any particular moment in the treatment that is therapeutically most relevant to the particular patient and his or her illness. Optimal responsiveness arises "primarily from the psychotherapist's

empathic attunement, although other data also informs the analyst's optimal responsiveness" (personal communication, 4/93). "The optimally responsive psychotherapist conveys a sense of understanding to the patient, feels attuned to his or her patient's experience and - in different ways - which depend upon the patient's level of self-selfobject organization and development" (personal communication, 4/93). Optimal responsiveness may or may not include a verbal interpretation. It includes the psychotherapist's range of reactions, as well as the analytic ambience. Bacal stated, "it is a way of conceptualizing the contributions of the therapist in the treatment situation...optimal responsiveness broadens the outlook for therapists as to what can be therapeutic" (personal communication, 12/89).

Bacal's conception of optimal responsiveness addresses this writer's search for an organizing principle by which to understand and evaluate those conditions under which lead to the psychotherapist's discovery of the most favorable responses to a given client. Bacal's conceptualization of the contributions of the psychotherapist can provide a broader perspective toward understanding what is optimal in the therapeutic encounter. In addition, by studying this theoretical construct, psychotherapists can enhance their mastery of therapeutic skills.

STATEMENT OF THE PROBLEM

Psychoanalytic writers recognize that the technique of the psychotherapist is often critical in facilitating the necessary therapeutic change. However, there has been a long history of differing points of view on this topic (e.g., Freud, 1912; Greenson, 1976; Langs, 1973; Fromm-Reichmann, 1950; Winnicott, 1965; Brenner, 1955; Kohut, 1984; Stolorow, 1987; Wolf, 1988; Basch, 1980). In addition to differing opinions on technique, it has been unclear as to how the psychotherapist verifies whether his or her therapeutic actions were optimal. This gap was amplified during the 1981 Self-Psychology Conference ("Beyond the Written Word") held in San Francisco; Anna Ornstein pleaded for "... a simple guideline, a way of knowing for the therapist ... a simple way to know at that moment, that the therapist is optimally responsive."

Kohut (1981) believed that "future research in self psychology should concentrate upon the continuum of empathic stages, the developmental line of empathy, from its early archaic beginning to such high levels as barely touching, as barely still having any trace of the original holding that communicates the empathic understanding." (p. 213)

In addition, the classical psychoanalytic viewpoint has conveyed that the sine qua non of treatment is the provision of interpretations to the patient, and as such,

interpretation has been regarded as the optimal response. However, some contemporary psychoanalysts suggest that interpretation may be more restrictive than broadening (Terman, 1988; Natterson, 1991; Bacal, 1985; Stolorow, 1987). That is, the psychotherapist's verbal interpretations may not necessarily coincide with maintaining the highest level of optimal responsiveness to a client. Furthermore, an excessive focus on interpretation as the goal in psychotherapy tends to result in insufficient attention being paid to the contribution of the subjective life of the psychotherapist to the therapeutic encounter.

Examining the subjective and intersubjective contributions of the psychotherapist that promote optimal responsiveness requires an exploration of countertransference, and beyond. Although countertransference has never been a clearly definable phenomena (Natterson, 1991), the literature on the subject has undergone an evolution. Freud (1910) originally coined the term to account for the analyst's transference reactions that were engendered by the particular analytic situation. Traditionally, countertransference has been viewed negatively, as an obstacle which the analyst must recognize and overcome to bring about effective treatment of the patient. Several authors (Heimann, 1950; Winnicott, 1958; Racker, 1968; Little, 1951) attempted to break through the prevailing classical view that countertransference was simply a hindrance to effective psychoanalytic work. Several

theorists (Stone, 1961; Greenson, 1965; Zetzel, 1956) discussed the importance and value of the psychotherapist's personal qualities, which can help to create a human, rather than a machinelike, climate in the analysis. According to Natterson (1991), the phenomenon of countertransference always constituted a threat to new concepts and viewpoints. That is, "countertransference rested on a base of presumed benign, nonidiosyncratic subjectivity" (Natterson, 1991).

The traditional view of countertransference may have prevented psychoanalysts from responding to their patients in a spontaneous and "experience near" approach. According to Natterson (1991), "the purely intrapsychic theory of psychoanalysis deliberately excludes the human transactional component, insists that the optimal analyst only reacts to the analysand, and maintains that idiosyncratic phenomena in the analyst are essentially reactive to the analysis and need to be kept to a minimum." (p. 75)

Contemporary theorists such as Grayer and Sax (1986), perhaps in an attempt to deal with the complexity of this issue, utilized a total countertransference explanation, as follows:

> ... the definition that seems to best capture the real experience of countertransference is that it is the totality of the therapist's experience in relation to a 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)

Although Grayer and Sax expanded on the definition of countertransference, "the basic issue is whether the therapist's psychological involvement in therapy is spontaneous and initiating or reactive and secondary" (Natterson, 1991, p. 75). The psychotherapist's subjective involvement is indispensable and inevitable (Natterson, 1991).

The significance of the personal life of the analyst and its overall effect on the progress of treatment is often emphasized in the psychoanalytic literature. However, nowhere is there a systematic exploration of subjective experiences which psychotherapists have which contribute to optimal responsiveness in the therapeutic encounter. This study is concerned with identifying and exploring the subjective experiences that contribute to optimal responsiveness (i.e. personal life experiences, personal psychotherapy, supervision, consultation, education, etc.)

PURPOSE OF THE STUDY

The purpose of this exploratory study was to gather data about the subjective conditions the psychotherapist experiences which contribute to effecting optimal responsiveness in the therapeutic encounter.

The data, which were gathered through the use of semistructured, in-depth interviews, were employed as follows:

1. To identify which events or patterns of events are subjectively experienced by the clinician respondents as contributing to the development of their capacities for optimal responsiveness.

2. To identify whether there is a common pattern or common categories of these experiences among respondents.

3. To identify whether these events or patterns of events correlate with the speculations made in the literature concerning the development of a general capacity for optimal responsiveness.

4. To develop a method of psychotherapist self-evaluation of optimal responsiveness.

THEORETICAL FRAMEWORK

The psychoanalytic literature, starting with Freud, is the initial basis for the theoretical framework of the study. I will be viewing this study primarily from a self psychology perspective, originally based on the work of Kohut. The more contemporary theorists, such as Stolorow, Basch, Bacal, and Wolf, and others who have expanded Kohut's original theoretical constructs will also be included.

SIGNIFICANCE OF THE STUDY

The impact of the psychotherapist's technique is often highlighted in the psychoanalytic literature as being a determining factor in the successful outcome of treatment. The psychotherapist's own subjective experience and contributions to the therapeutic encounter have more recently been emphasized as equally, if not vastly, more important than a mere cognitive understanding of technique (Kohut, 1984; Stolorow, 1987; Natterson, 1991; Basch, 1988; Wolf, 1988). However, it appears there are few studies that have sought to explore the contributions of the psychotherapist that effect optimal responsiveness in the therapeutic encounter.

From a social work perspective, the significance of this study is its relevance to social work's primary focus upon the person within his or her environment. Hollis (1964) explained the psychosocial approach that has been central to social work:

> Casework has always been a psychosocial treatment method. It recognizes both internal psychological and external social causes of dysfunctioning, and endeavors to enable the individual to meet his needs more fully and to function more adequately in his social relationships . . . Central to casework is the notion of "the-person-in-his-situation" as a threefold configuration consisting of the person, the situation, and the interaction between them ... Casework recognizes this interaction as highly complex. (p. 9)

It is perhaps because of this stance that clinical social work psychotherapists recognize that to be optimally responsive a clinician cannot cling to just one technique, such as interpretation.

If the findings of this particular study can successfully identify specific kinds of subjective experiences that enable a psychotherapist to be optimally responsive, this knowledge may be used in a way that can contribute toward enhancing clinical social workers' general knowledge and use of psychotherapeutic techniques. Concomitantly, this knowledge may be useful in enhancing psychotherapist understanding of negative therapeutic reactions, intersubjective disjunction/conjunction, empathic failures, personal biases, and cultural and/or ethnic prejudices.

Bacal's (1988) concerns regarding further inquiry and research in this area illustrates the significance of this study:

> Moreover, apart from the beneficial effect of the analyst's noninterpretative, optimal responsiveness that he provides his patient in regressive states, there is considerable noninterpretative, optimal responsiveness in the course of everyday analytic work - sometimes transitory but sometimes quite prevalent - that is of significant therapeutic benefit. Most analysts know in their heart that this is a crucially therapeutic aspect of all analyses much of the time. But they seldom talk about it, and it is almost never written about, unless its absence produces significant dissonance between patient and analyst, in which case providing it is regarded as a 'parameter' and thus not properly psychoanalytic. Is this because of a tacit belief that this properly belongs to the 'art' of psychoanalytic therapy and any attempt at a scientific consideration of it is not only

> fruitless but would undermine its effectiveness? Or is it mainly because we are uneasy about looking too closely at what we are doing for fear of being unable to justify it in the light of existing theory or according to how we have been trained? I submit this area constitutes another frontier for psychoanalytic study. While this may stir anxieties to which few wish to expose themselves, I believe that the therapeutic rewards would justify the difficulties of the investigation. (p. 130-131)

LIMITATIONS OF THE STUDY

Because sampling is not random, the data is of limited generalizability. But, as exploratory information, the study identifies possible trends in what psychotherapists believe is optimally responsive. Furthermore, it is conceivable that many such observations from advanced practitioners would provide a data source for later quantitative and qualitative descriptive research.

Perhaps the most significant limitation is that what was being defined as optimally responsive by psychotherapists was their subjective appraisal of what was optimally responsive to their patients: however, there is no correlated data from patients as to whether or not what the psychotherapists said, was confirmed as optimally responsive, from their patient's point of view.

ASSUMPTIONS

The first assumption is that all respondents, by virtue of the selection process employed in this study, were skilled in the understanding of optimal responsiveness. It was

assumed that advanced clinicians would be able to discern aspects of their responsiveness in a way that corresponds with Bacal's definition of optimal responsiveness. The second assumption is that a respondent's ability to clearly address the research questions on a subjective level will be influenced by the respondent's theoretical understanding of the concept of optimal responsiveness, their level of education and experience as a psychotherapist, combined with knowledge and advanced training.

DEFINITION OF TERMS

Optimal responsiveness is defined as the responsivity of the analyst that is therapeutically most relevant at any particular moment in the context of a particular patient and his or her illness (Bacal, 1985). Optimal responsiveness is an analytic concept that is distinct from the concept of the "parameter" and the "corrective emotional experience," which are devices that are essentially nonanalytic, but deliberately planned and actively initiated by the therapist (Bacal, 1985). The optimal responsiveness of the therapist/analyst is "determined by the position of the patient on the developmental line of his self-object relations, and on his position on the developmental line of internalization of, and capacity for, empathy" (Bacal, 1985). It is the analyst's role to provide for an analytic ambience that is optimally responsive. Optimal responsiveness "refers to the therapist's

acts of communicating his understanding to his patient" (Bacal, 1985). It is the psychotherapist's "...acts of communicating with his patient in ways that that particular patient experiences as usable for the cohesion, strengthening, and growth of his self. The analyst's communications that are therapeutic are experienced by the patient as the provision of a multiplicity of selfobject functions" (Bacal and Newman, 1990, p. 256).

Empathic attunement is defined as the psychotherapist conveying understanding and accurate responsivity to the patient, in a manner which results in the patient feeling understood. According to Wolf (1988)," ... we conceptualize that the empathic intuneness allows the patient's self to use the therapist as a selfobject that is experienced as part of its own self structure ... the patient's self is thus strengthened and experiences itself as more cohesive with an increased sense of well-being." (p. 37)

Intersubjectivity, according to Atwood and Stolorow (1984) is described as follows:

> Psychoanalysis is pictured here as a science of the intersubjective, focused on the interplay between the differently organized subjective worlds of the observer (therapist) and the observed (patient)...the observational stance is always one within, rather than outside, the intersubjective field...being observed a fact that guarantees the centrality of introspection and empathy as the methods of observation...Psychoanalysis is unique among the sciences in that the observer is also the observed. Patient and analyst together form an indissoluble psychological system, and it is this system that constitutes the empirical domain of psychoanalytic inquiry. (p. 41)

Attunement is a term originally used to describe a process by which the parent matches the feeling state of the child, a transaction which powerfully influences the shape of the inner state (Terman, 1988). It is a way of perceiving or sharing internal states. The shaping, molding, and structuring of internal states may occur by way of the vicissitudes of attunement (Terman, 1988). According to Stern (1985) by selective attuning, the parents create a "template for the infant's sharable interpersonal world." (p. 142) Stern (1985) holds that the experience of attunement shifts attention away from simple external behavior to "what is behind the behavior, to the quality of feeling that is being shared." (p. 142)

Self Psychology was developed and elaborated by Kohut and his colleagues focusing on the psychoanalytic concepts of narcissism and the self. Self psychology emphasized the "vicissitudes of the structure of the self and of the associated subjective conscious and unconscious experience of selfhood. Self psychology recognizes as the most fundamental essence of human psychology the individual's need (1) to organize his or her psychological experience into a cohesive configuration, the self, and (2) to establish self-sustaining relationships between this self and its surround that have the function to evoke, maintain, and strengthen the structural coherence, energic vigor, and balanced harmony among the constituents of the self" (Wolf, 1988, p. 183-184).

According to Wolf (1988), Selfobject "is a term often used imprecisely to describe the form, or the function, or the participating persons or objects in the specific types of relationships that are associated with the structuring of the self. Precisely defined, a selfobject is neither self nor object, but the subjective aspect of a self-sustaining function performed by a relationship of self to objects who by their presence or activity evoke and maintain the self and the experience of selfhood. As such, the selfobject relationship refers to an intrapsychic experience and does not describe the interpersonal relationship between the self and other objects" (Wolf, 1988, p. 184).

CHAPTER II

Literature Review

OPTIMAL RESPONSIVENESS

Optimal responsiveness is defined by Bacal (1985) "as the responsivity of the analyst that is therapeutically most relevant at any particular moment in the context of a particular patient and his illness. Empathy or vicarious introspection is the process by which the therapist comes to understand the patient by tuning in to his inner world. Optimal responsiveness, on the other hand, refers to the therapist's acts of communicating his understanding to his patient" (p. 202).

From a self psychology perspective, Bacal diverts from Heinz Kohut's (1977) concept of "optimal frustration." In addition, it is a far cry from the classical Freudian view of the analyst as a "blank screen" or remaining "neutral."

Transmuting internalization was Kohut's central vehicle for structuralization and therapeutic change. Kohut (1977) purported that new psychic structure was built through the process of transmuting internalization (via optimal frustration). However, the concept of transmuting internalization may also have some incongruities regarding the therapeutically beneficial effects of optimal frustration:

> Man can no more survive psychologically in a psychological milieu that does not respond empathically to him than he can survive physically in an atmosphere that contains no oxygen...the analyst's behaviour vis-a-vis his patient should be the expected average one - i.e., the behaviour of a psychologically perceptive person vis-a-vis someone who is suffering and has entrusted himself to him for help. (Kohut, 1977)

According to Bacal (1985) Kohut never arrived at a satisfactory answer to the problematic question, "What is optimal?"

Self-psychology as a theory presupposes that psychopathology results from a failure of environmental response to the needs of the child's developing self (Bacal, 1985). In both cases, the relationship is a product of the interaction of two vulnerabilities and two capacities, those of the parent and those of the child, and later, those of the analyst and those of his patient (Stolorow, Brandchaft, & Atwood, 1987). To be understood can be deeply gratifying and is perhaps the most important function performed for us by our selfobjects (Bacal, 1985).

OPTIMAL FRUSTRATION

Kohut's concept of transmuting internalization (1971) rested firmly on Freud's theory outlined in Mourning and Melancholia (1917). It consists of the following: 1) the patient's receptivity for introjects, 2) the "breaking up" of the aspects (psychological functions) of the object via optimal frustration; and 3) the depersonalization of those

aspects of the object, and their transformation into an integral part of the patient's psychic structure. For Kohut, (1971) the internal structure, then performs the functions which the object used to perform for the child. The well-functioning structure, however, has largely been divested of the personality features of the object.

Kohut utilized the concept of transmuting internalization throughout his thinking and writing from 1971 on. Even in his last work How Does Analysis Cure? (1984), he continued to enshrine the concept of optimal frustration as central to the process of transmuting internalization. Since then there have been numerous critiques and expansions regarding the process of optimal frustration leading to transmuting internalization (Bacal, 1985; Terman, 1988; Ornstein, A., 1988; Tolpin, P. 1988; Wolf, 1988; Stolorow, 1983; 1987).

For instance, Stolorow (1983) believed that although Kohut in The Restoration of the Self (1977) dispensed with his more mechanistic constructions and framed his subsequent formulations in terms of a developmental phenomenology of self-experience, the implications of this theoretical shift for psychological structure formation were never worked out (p. 23). Stolorow (1983) distinguished several different kinds of new growth that may occur within an intact selfobject tie. He described the first as a growth in "fundamental functional capacities," which are involved in the maintenance of self-cohesion, self-continuity and self-esteem. He cites

examples such as self-soothing, comforting, and mirroring-functions that are performed by the selfobject and then taken over by the patient or the child. He felt that the performance by the selfobject is the sine qua non for their appearance in the patient (1983). Stolorow (1987) explained further that "this developmental process, however, may be **experienced** as a reorganization of intersubjective space, whereby the analyst's selfobject functions become enduring features of the patient's own self-experience...here the term **internalization** may be correctly applied" (p.23).

Stolorow (1983, 1987) described the second developmental process embedded in Kohut's concept of transmuting internalization as "the structuralization of self-experience" (1987, p. 23).

> The analyst's consistent acceptance and empathic understanding of the patient's affective states and needs regularly come to be experienced by the patient as a **facilitating medium** reinstating developmental processes of self-articulation and self-demarcation that had been aborted and arrested during the formative years. These certain articulations and structuralizations of self-experience are directly promoted in the medium of the analyst's empathy, a process that need not include internalization per se. (p.23)

Furthermore, another component of self-structuralization is internalization proper - "those enduring reorganizations of the subjective field in which experienced qualities of the mirroring or idealized selfobject are translocated and assimilated into the patient's increasingly differentiated self-structure" (Stolorow, 1983). (p. 287) This aspect of

the process follows the scheme set down by Kohut - "internalization" occurs with repeated optimal absences of the function required from the selfobject (Terman, 1988). This is facilitated by the psychotherapist's empathic attunement and conveyance of his or her understanding of the patient's experience of these optimal absences.

Stolorow, Brandchaft and Atwood (1987) believed that the above described developmental processes are not fueled by optimal frustration. On the contrary, they occur with an empathicors maintained that an empathic-introspective mode of inquiry is one which encourages and fosters an "experience near" rather than an "experience distant" therapeutic stance. In other words, the patient experiences the presence of the psychotherapist's response(s), rather than their absence or withdrawal. It is the psychotherapist's optimal empathic or optimal responsive engagement with the patient which promotes the patient's experience of being understood.

The concept of optimal frustration was then seen as a remnant of drive theory. Kohut derived this concept from Freud's (1923) notion that "the ego is that part of the id which has been modified by the direct (frustrating) influence of the external world". (p. 25)

Terman (1988) argued that the theoretical emphasis on frustration has neglected the importance and variety of patterns that are generated in transaction, in which a variety of responses and fulfillments play central roles in the

construction of self experience, meaning and expectation. Additionally, Terman believed that it is the "dialogue of construction" that characterizes structure formation. Essentially, the psychotherapist participates in an affective dialogue with patients, and by way of that essentially "gratifying," repeated dialogue (gratifying because it conveys intimate understanding, and implicitly, in-depth involvement) self-structure is formed (Terman, 1988).

Ornstein (1988) suggested that what might be optimal in a therapeutic dyad is the response which facilitates a "therapeutic dialogue" (p. 157). Through this dialogue, the psychotherapist gradually deepens the patient's profound understanding of his or her own subjective experiences and their genetic roots. Tolpin (1988) suggested that the major role of frustration is to act as the background stimulus for an understanding reengagement with the patient. He continued, "the indispensable ingredient for the development of a healthy self-organization or for a successful analytic endeavor. . . is the optimal empathic engagement of the analyst and the patient" (p. 162).

DEVELOPMENTAL PERSPECTIVES

Developmental psychologists postulate that the infant acquires relatedness based on a complexity and variety of transactions. Terman (1988) suggested by looking at

developmental phenomena, the research studies suggest that the child develops patterns and capacities (e.g., speech, cognitive schemes, self) in transactions with the caretaker.

Vygotsky, a Russian psychologist, was one of the first of the developmentalists to systematically explore the importance of environment in the creation of the child's conceptual world. Vygotsky viewed all higher cognitive functions as originating in the actual relations between people - infant and caregiver. For Vygotsky (1978), "an interpersonal process is transformed into an intrapersonal one" (p. 57). Thus, development and structuralization of the mind evolves out of human relatedness.

Kaye (1982) is even more emphatic about the importance of the parental role in creating and structuring the infant's mind. He viewed the infant as an apprentice who is induced into a societal system by the goals and techniques of the parent. Kaye stated that there is " ...a great deal of asymmetry in the relations between parent and infant, so that the temporal structure that eventually becomes a true societal system will at first only have been created by the parent, making use of built-in regularities in infant behavior rather than actual cooperation or communication" (p. 53). For Kaye, it is the parents who "frame" the child's behavior. Kaye describes seven frames which the caretaker provides for

the child: 1) nurturant; 2) protective; 3) instrumental; 4) feedback; 5) modeling; 6) discourse; and 7) memory. They are outlined and described by Kaye (1982) as follows:

> 1) In the nurturant frame, adults nourish, comfort, clean, console and fondle infants. An important point about nurturance in the early months is that it often carries its own guaranteed concordance between parent and infant goals...The nurturant frame is perhaps the most reliable channel for parent-infant intersubjectivity.
>
> 2) The protective frame is one that adults provide in a general sense by keeping the infant within earshot and by keeping dangerous objects out of his reach, as well as in a very specific sense by creating bounded spaces within which new accomplishments can be tried.
>
> 3) In the instrumental frame, an adult carries out what appears to be the infant's intention...The instrumental frame, then consists of the adult monitoring the infant's behavior (usually in relation to objects), interpreting the infant as having a certain intention, and partially or completely fulfilling that intention.
>
> 4) The feedback frame, provides more consistent or more salient consequences to the child, for his own action, than the physical world itself would provide...The feedback frame does more to build the edifice of approving and disapproving caretakers, and to lay the foundation for perception of self, than it teaches about physical safety.
>
> 5) The modeling frame, occurs when an adult performs some action and then waits for the child to try to imitate it...this instrumental frame provides a model for imitation whether the adult was intending to do so or not...At the same time, he makes himself into a person among persons; imitation ceases to be a matter of assimilating features of isolated acts and begins to be an exchange of roles in a continuing dialogue with others.

> 6) The discourse frame, creates a conversation-like exchange, not necessarily involving vocalizations. Discourse begins when the two partners' actions are still not equivalent in any respect.
>
> 7) Lastly, there is the memory frame. To the extent the parent has shared experiences with the infant - know what objects have intrigued him, what he has been able and unable to do with them, what he has imitated, what feedback he has received from objects and from people - the parent can use that information in making choices about what to offer, what to do for the infant, what to demonstrate, what kinds of feedback to use, and so forth. In short, the adult's memory, especially to the extent that it is a shared memory with the infant, itself provides a frame organizing the infant's subsequent experiences. (pgs. 77-83)

By shared memory, Kaye does not mean that the information is encoded or represented in the same way, nor that it has the same meaning to both people. Rather, he suggests that they have shared experiences, which usually take different forms in the two individual's different memories. That is precisely why the adult's memory provides a useful frame for the infant's activity, because the adult often has a symbolic representation of what the infant represents in a sensorimotor schema (pgs. 82-83).

Kaye suggested that any of these frames can, but need not, take the form of a game. He explained further that "in adult-infant interaction, a game is any routinized interaction in which the adult takes turns and pretends that the infant is taking turns, follows rules and pretends that the infant is aware of them, and acts as though they both are enjoying it" (p. 82-83).

It is the parents who provide essential functions and regulations for the child, that continually draw the child forward into a more challenging apprenticeship. A dialogue evolves between parent and infant, via the respective frame. It is the parent who has the memory, expectations, and skills, and by virtue of these, the child moves into transactions that eventually create a shared symbolic system and a structure of goals and intentions (1982).

Kaye argued that these frames enable a parent to recruit the infant into a joint task, or to enter into a task in which the infant is already engaged, so as to provide practice, feedback, experience in turn-taking, and demonstrated solutions to problems on which the infant is working. The result is nothing less than "shared meaning" between infant and adult (p. 8), and "intersubjectivity," or a shared understanding between individuals (p. 32). Kaye posited that shared intentions imply shared meaning or intersubjectivity, which requires some sort of vehicle by which two partners can have access to one another's representations of the world (p. 119).

Trevarthen and Hubley (1978) described the development of primary intersubjectivity in the second and third months after birth, as follows:

> The changes of communication throughout the first year appear to be principally due to differentiation of a highly complex, general intersubjectivity which is manifest very early in rudimentary form...This function identifies persons, regulates motivation and intention toward

> them, and simultaneously forms rudimentary acts of speech and gesture in patterned combinations and sequences. It also provides internal images of face and hand movements for the identification and imitation of the expressions of others. Acts of adults that signify interest and understanding to other adults are selectively perceived by 2-month-olds, too, and taken as analogous to their own acts of like form. When the mother expresses excitement or pleasure it stimulates a function in the infant that is capable of generating a mirror or complementary act. Proof of these propositions is to be found in the communications of primary intersubjectivity that develop into elaborate form in the second and third months after birth. (p. 213)

These authors believe the transition to secondary intersubjectivity occurs around the sixth month.

Stern, a psychoanalytic developmentalist and researcher in the field of infant observation, conducted a longitudinal study of infants and their mothers. Stern (1985) identified four phases of development of the self that take place during the first two years of life: 1) the sense of emerging self, 2) the sense of core self, 3) the sense of subjective self, and 4) the sense of a verbal self. Stern posited that self and other are distinguished very early, and that the "other" plays a crucial role in the function of the self. In addition, the third phase, the sense of a subjective self, which emerges approximately at seven to nine months, has the greatest implications for development of the capacity for relatedness and intersubjectivity.

> The potential properties of a self and of an other have been greatly expanded. Selves and others now include inner or subjective states of experience in addition to the overt behaviors and direct

> sensations that marked the core self, the capacity for relatedness and the subject matter with which it is concerned catapult the infant into a new domain of intersubjective relatedness. A new organizing subjective perspective about the self emerges. (p. 125)

Stern differentiated and distinguished the concept of affect attunement from other clinical terms and concepts (i.e. mirroring, imitation, intersubjectivity, echoing, empathy). Although these concepts overlap with one another, attunement is a distinct form of affective transaction in its own right (p. 145). "Affect attunement is a particular form of intersubjectivity that requires some processes that are unique to it" (. 144). Stern posited three general features of a behavior that could be matched and thereby form the basis of an attunement: intensity, timing, and shape.

Affect attunement is of particular significance in that it focuses on the "quality of feeling that is being shared...and attunement the predominant way to commune with or indicate sharing of internal states...attunement renders feeling" (p. 142). The implications for clinical work are summarized as follows:

> It is clear that interpersonal communion, as created by attunement, will play an important role in the infant's coming to recognize that internal feeling states are forms of human experience that are shareable with other humans. The converse is also true: feeling states that are never attuned to will be experienced only alone, isolated from the interpersonal context of shareable experience. What is at stake here is nothing less than the shape of and extent of the shareable inner universe. (pgs. 151-152)

Bowlby (1979) a British psychoanalyst, teacher, and researcher, formulated attachment theory as the genesis of healthy and unhealthy parent-child relationships. Bowlby developed the concept of "internal working models" to describe how the infant's sense of self and other unfolds through interaction with the primary caregiver. The individual's particular model is the framework that is enduring, and has significant implications for the capacity and quality of future attachments. Bowlby described attachment behavior as follows:

> Briefly put, attachment behaviour is conceived as any form of behaviour that results in a person attaining or retaining proximity to some other differentiated and preferred individual, who is usually conceived as stronger and/or wiser. Whilst especially evident during early childhood, attachment behaviour is held to characterize human beings from the cradle to the grave . . . The particular patterns of attachment behaviour shown by an individual turn partly on his present age, sex, and circumstances and partly on the experiences he has had with attachment figures earlier in his life. (p. 129-130)

Winnicott, a British psychoanalyst, emphasized environmental factors and maternal care as influencing the psychological development of the infant. In his Theory of the Parent-Infant Relationship (1960) he emphasized the quality of the mother-infant relationship, that is, "the infant and the maternal care together form a unit" (p. 39). Winnicott viewed the development of the self as primarily derived from the quality of the responsiveness of the object. Winnicott drew a parallel in his writings between the "good enough

mother" and the good enough analyst. It is the qualities of the analyst that provide and hold the patient, thereby enabling the analytic work to unfold.

In summary, the contributions from developmental psychology and object relations emphasize the critical significance of the first relationship - that of parent/caretaker and infant. The quality of the relationship between the infant and the caretaker profoundly influences the quality of shareable, subjective experience. This primary relationship has crucial implications for the psychotherapist and patient relationship, specifically within the intersubjective field.

The literature on optimal responsiveness indicates that it is the psychotherapist's attunement, optimal empathy, and understanding that draws the patient forward. Optimal responsiveness is the psychotherapist's acts of communicating his or her understanding to the patient through an evolving dialogue. The psychotherapist does this by empathic attunement to the patient's inner world.

What is not evident from the literature, however, is how the psychotherapist is to identify what is optimally responsive with a particular client, or when he or she has been optimally responsive. Nor does the literature address what aspects of the psychotherapist's subjective experience of the intersubjective relationship contribute to optimal

responsiveness. It is the objective of this study to provide some preliminary answers to these questions, by examining clinicians' experiences in making these determinations.

Chapter III

Methodology

INTRODUCTION

Dilthey (1833-1911) was the primary architect of the anti-positivist movement in the human sciences (Polkinghorne, 1983). He contributed significantly to the development of alternative research methodologies for the human sciences. Dilthey opposed the positivist viewpoint that human problems could be solved by applying methodologies similar to those employed in physical sciences. The positivist tradition might also be called a single-method tradition, rooted in the physical sciences (Polkinghorne, 1983).

For Dilthey, the goal of human science is ... "to understand the order that underlies the process of human existence, an order that provides the form for experience" (Polkinghorne, 1983, p.26) and "to make explicit the organizing themes that render experience meaningful..." (Polkinghorne, 1983, p. 29).

In his review of the response to positivism, Polkinghorne (1983), outlined Dilthey's perspective on the task of the human sciences as follows:

> The human science researcher uses verstehen [to understand] in addition to other modes of cognition. Starting with experience as it is given and including its meaningfulness, the researcher uses all of the tools of knowledge available as he or she seeks to describe, as accurately as

> possible, the organizing patterns by means of which the experience appears with the particular sense that it has. These tools - all of which are necessary - include observation, logical reasoning, comparison, classification, abstraction, hypothesis framing and testing, and analysis by means of statistical techniques. But along with information obtained with these methods, the human scientist must also take into consideration the information that is developed by the use of verstehen. Dilthey emphasized the interdependence of the kinds of knowledge required to understand the full, concrete experience of life (p.30-31).

RESEARCH DESIGN

It is in keeping with the task of the human sciences that this study is undertaken. For purposes of this phemenological study, clinical social work psychotherapists have been interviewed to elicit their perspectives as to what constitutes optimal responsiveness during a therapy session. I am particularly interested in exploring the subjective and intersubjective experience of the psychotherapist, in relation to his or her patient, and what contribute to optimal responsiveness. Research questions were formulated to address the concerns of this study: 1) What subjective and intersubjective experiences contribute to psychotherapists being optimally responsive? and 2) How does the psychotherapist know he or she has been optimally responsive?

Descriptive inquiry has as its object the exploration and clarification of some phenomena where accurate information is lacking; often such research is explicitly labeled exploratory research (Forcese and Richer, 1973). This study is

exploratory in nature. An exploratory approach seeks to discover, revise insights, ideas, and concepts by minimizing preconceived assumptions.

Glaser and Strauss (1967) explained grounded theory as having merit in its ability to predict, explain and be relevant to researchers and laypersons alike. Additionally, they explained that theory for the human sciences cannot be separated from the process by which it is generated. Grounded theory is derived from the data. This approach is in contrast to the logico-deductive approach in which theory is deduced from a priori assumptions.

In addition, according to grounded theory, categories are generated from the data; the evidence from which categories emerge is then used to illustrate the concept. Theory is not viewed as an end-product, but it is a continually evolving process.

This study utilized an exploratory design to gather data on the intersubjective and subjective contributions of the psychotherapist that facilitate optimal resonsiveness. It is hoped that this inquiry will provide the basis for further hypotheses that will lay the groundwork for future empirical and descriptive studies. This study concentrated on a description of organizing structures rather than a description of cause and effect relationships among variables.

SAMPLING PROCEDURES

Participants were recruited through personal networking by the researcher. The sample was obtained from several potential sources. First, members of independent clinical consultation groups in the West Los Angeles, San Fernando Valley, and other areas were solicited as prospective subjects. Secondly, students, faculty, and alumni from the California Institute for Clinical Social Work were solicited to participate in this study. Additionally, the most recent California Society for Clinical Social Work membership directory was a final source. Members with Fellowship standing (any social worker who holds a California State License for the practice of clinical social work and who has had three years of professional experience as a social worker beyond licensure) in the Los Angeles Chapter of the Society for Clinical Social Work were recruited for the study. Nine advanced clinicians recruited from the above sources were viewed as expert subjects who met certain criteria:

1) At least five (5) years of experience and actively practicing as a licensed clinical social worker utilizing a psychoanalytically-oriented approach to treatment.

2) Must have had post-MSW 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) The participants were judged to have sufficient life-experience, professional experience, and a sufficient degree of personal and professional introspection, to be able to differentiate their own countertransferential views from the patient's transferential views of therapy.

The sampling method was what Polkinghorne (1983) referred to as "exemplar" rather than random cases. Respondents were selected for their ability to function as informants who provide 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 than in other types of studies. "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 (see Appendix A) inviting practitioners to participate in a research study exploring the intersubjective and subjective

experience of the psychotherapist and what contributes to optimal responsiveness during the therapy hour. The practitioner was asked to return a statement to the researcher indicating whether he or she was willing to participate in the study. A return self-addressed envelope was included in the Letter of Introduction. The participants were assured of confidentiality. The sample was determined to be "not at risk" according to the guidelines of the Department of Health, Education and Welfare Policy on Protection of Human Subjects, as adopted by the California Institute for Clinical Social Work.

DATA COLLECTION

Data for this study were collected through individual, semi-structured, open-ended, in-depth interviews with clinical social workers. As Polkinghorne (1983) suggested, the "face-to-face encounter provides the richest data source for the human science researcher seeking to understand human structures of experience" (p.267). An interrogatory stance was utilized to elicit descriptions of interviewees' subjective and intersubjective experiences of optimal responsiveness. Lofland (1971) suggested that an interview, when used to collect qualitative data, provides a "guided conversation to enlist rich, detailed material that can be used in qualitative analysis" (p. 76). Polkinghorne (1991) expanded further, "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" (p.185), "the qualitative interview is conceived of as a discourse or conversation" (p.187).

OPTIMAL RESPONSIVENESS SURVEY

Prior to participation in the interview, an "Optimal Responsiveness Survey" (Appendix B) was completed by each respondent. This was a fill-in and sentence completion survey. The survey took approximately twenty minutes to complete. The subjects were asked to complete and return the survey within two weeks, in a pre-addressed, stamped envelope. The survey was devised by the researcher to accomplish the following:

1. To identify those respondents who have been in practice at least five years and who were currently in clinical practice, utilizing a psychodynamic approach to

clinical treatment; who have been in or are engaged in psychoanalytically-oriented psychotherapy or analysis; and who have had post-MSW level training through clinical consultation, supervision, and/or advanced formal training (section I).

2. To assess respondents' conceptual and operational understanding of optimal responsiveness (question 1, 2, 3).

3. To allow respondents an opportunity for introspection, reflection, and identification of clinical experiences of optimal responsiveness with their clients (intersubjectivity) and within themselves (subjectivity) (questions 1, 2, 3).

DATA ANALYSIS

The data collected from the interviews were analyzed according to what Glaser and Strauss (1967) describe as the constant comparative method. The four stages of this method are as follows:

1) comparing incidents applicable to each category
2) integrating categories and their properties
3) delimiting the theory
4) writing the theory (p.105)

Glaser and Strauss (1967) purported that the constant comparative method of joint coding and analysis is to generate theory more systematically by using explicit coding and analytic procedures (p. 102). The discovery of theory is

grounded in the actual data. According to Polkinghorne (1991) "the purpose of qualitative analysis is to develop a statement delineating a structure or pattern of relationships that organizes 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 like 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 (usually 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 audiotaped interviews were listened to by the researcher and notes were taken. The interviews were listened to for a second time to insure the thoroughness and accuracy of the notes. Major themes were highlighted, and categories were identified within these themes. Where meaningful further

subcategorization occured, the themes, categories and subcategories were constantly compared and checked until "best fit" descriptions were reached in each case. Evidence of contradictory data (i.e. variations within categories), was also explored. Finally, categories were analyzed to explore their relevance to theory and to generate hypotheses about what subjective and intersubjective experiences contributed to the optimal responsiveness of the nine research informants.

THE INTERVIEW GUIDE

Open-ended questions were utilized in order to avoid pre-determined categories of response, to maximize the range of possible responses, and to discover new phenomena that may have been 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 the researcher's experience rather than the experience of the interviewees. It was anticipated that each participant would have unique experiences, thoughts, feelings and beliefs about his or her experience.

The Interview Guide provided topics or 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 an interchange focusing on the research topic. Topics and probe questions were not covered in a specific order.

CHAPTER IV

FINDINGS

Data Collection

This was an exploratory study of the subjective and intersubjective experiences of psychotherapists that contribute to their optimal responsiveness with their patients. The major questions addressed in this study were:

> Question 1: What subjective and intersubjective experiences contribute to psychotherapists being optimally responsive?
>
> Question 2: How does the psychotherapist know that he or she has been optimally responsive?

Prior to the interview, the psychotherapists were asked to complete an Optimal Responsiveness Survey (see Appendix B).

The face-to-face interview was open-ended, semi-structured, and in-depth, conducted with nine clinical social workers. Through the use of an interview guide (see Appendix E), the researcher embarked on an exploration of the following broad topics:

TOPIC I: How the psychotherapist identified that he or she was optimally responsive in a session or in a particular turning point of interaction in a session?

TOPIC II: What subjective experiences the psychotherapist identified as facilitating his/her optimal responsiveness?

TOPIC III: What personal experiences and/or professional training the psychotherapist identified that may have contributed to an intersubjective optimally responsive therapeutic approach with a particular client?

An interrogatory stance was utilized to elicit data descriptive of the interviewees' subjective and intersubjective experiences of optimal responsiveness. The researcher attempted to build a conversation and to word questions spontaneously, so as to establish a conversation focused on the research topic. The intent of the interview was not to generate the same information among the respondents, but to allow for variations and differences related to the topic (Polkinghorne, personal communication, 3/92).

Treatment of the Data

Initial open coding of each interview was accomplished with an analysis procedure outlined by Corbin and Strauss (1990); Barritt, Beekman, Bleeker, and Mulderij (1984); Patton (1990); Glaser and Strauss (1967); and Polkinghorne (1983, 1991).

Each interview was transcribed, and coded for general themes, concepts and variations. The broad themes were continuously reviewed, analyzed, collapsed, compared, contrasted, combined and integrated. Shared themes and common forms emerged from the broad themes. The shared themes and common forms were then organized under preliminary categories. Categories were checked for discretness of properties, and condensed whenever appropriate. The final condensation for Research Question #1 yielded five broad themes, twelve categories, and two subcategories. Lastly, the final condensation for Research Question #2 yielded three broad themes, and five categories.

The themes and categories listed are not intended to imply that there is a discrete order of experiences which psychotherapists believe they must have to be optimally responsive. Rather, there was an overlap of categories among the psychotherapists interviewed; clear-cut distinctions between themes were difficult to make, as categories were intertwined, and each psychotherapist emphasized more than one issue.

For example, Therapist 1, could identify with her patient, R. (Theme II - Identification with this Particular Patient), and empathically resonate with the mutual experience of profound emotional pain due to abuse. Concomitantly, she was affectively attuned to and exquisitely aware of the significant subjective and intersubjective experiences

engendered through the interplay with her patient (Theme III - The Psychotherapist's Affect Attunement with This Particular Patient, Category #3 - The Psychotherapist's Attunement to the Intersubjective State of Being). Additionally, she was also coming to terms with the tremendous commitment and emotional toll that her patient, R., would impose upon her personally, at this time in her life (Theme I - The Psychotherapist's Subjective Life Experiences, Category #2 - Current Life-Cycle Issues).

The themes are reflective of the varying degrees, dimensions, properties, conditions, contexts, similarities, and differences among the psychotherapists interviewed, as to what contributed to their being optimally responsive. As per Strauss and Corbin (1990), "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). Grouping of the data according to emerging patterns, that is, according to repeated relationships between properties (attributes or characteristics pertaining to a category) and dimensions (location of properties along a continuum) of categories, (p. 61; p. 130) was delineated as specifically as possible.

Additionally, the themes are reflective of the core issues reappearing throughout the interviews; the categories are the specific components mentioned by one or more psychotherapists, that comprise a portion of the major theme.

Before presenting the analysis of the findings, demographic information regarding the respondents is introduced. In order to protect the confidentiality of the subjects, there is no reference to specific identifying characteristics such as age, ethnicity and unique contributions to the field of social work. Circumstances in a history unique enough to threaten anonymity have been disguised.

The Respondents

The sample consisted of nine clinical social workers who had been identified as "exemplars" of the subject under study. All met the selection criteria described in Chapter III.

The nine clinical social workers who participated in this study all held Masters' degrees, and five also held doctoral degrees. Among those who did not have doctoral degrees, four have had, advanced training, or were currently participating in advanced training.

All informants have participated in psychoanalytically-oriented psychotherapy or psychoanalysis as patients. All were currently engaged in private practice, employing a psychoanalytic or psychodynamic orientation. Two informants had been in practice five to ten years; one informant had been in practice eleven to twenty years; four informants had been in practice between twenty-one to thirty years; one informant

had been in practice thirty-one to forty years; and one informant had been in practice over forty-one years (see Table 1).

TABLE 1

YEARS IN CLINICAL SOCIAL WORK PRACTICE

5 - 10 YEARS	2
11 - 20 YEARS	1
21 - 30 YEARS	4
31 - 40 YEARS	1
Over 41 YEARS	1

The informants were asked to identify their primary theoretical orientation for clinical practice. Two indicated ego psychology, four indicated self psychology, two indicated object relations, and one indicated classical Freudian analysis, ego psychology, object relations, and self psychology inclusively (see Table 2).

TABLE 2

THEORETICAL ORIENTATION

Ego Psychology	2
Object Relations	2
Self Psychology	4
Classical Freudian, Ego Psychology, Object Relations, Self Psychology	1

There was a total of 8 female and 1 male respondents. All nine respondents were Caucasian.

DATA ANALYSIS

The major findings of this study are grouped according to categories and dimensions which arose out of the topic areas in the interview guide, combined with indigenous categories which arose from the interviews (Patton, 1990).

The analysis of the data yielded five themes, twelve categories within those themes, and two subcategories for Research Question 1. Table 3 is a summary of these findings.

The following section is an analysis of the responses to Research Question #1: What Subjective and Intersubjective Experiences Contribute to Psychotherapists Being Optimally Responsive? The themes and related categories are understood as the preconditions and precursors that the psychotherapists believed to be contributory to their optimal responsiveness.

THEME I: THE PSYCHOTHERAPIST'S SUBJECTIVE LIFE EXPERIENCES, were manifested in three categories of related issues:

Category #1: Losses and Mourning

The psychotherapist's evolving subjectivity, that is, that which is within the psychotherapist's subjectively evolving world, draws the psychotherapist, via his or her own openness, to explore fantasies, associations, feelings, and emotions - actively and spontaneously.

It is through this process, that the psychotherapist allows himself or herself to acknowledge significant losses and mourning, which then contribute to the informants having

TABLE 3

Research Question #1: What Subjective and Intersubjective Experiences Contribute to Psychotherapists Being Optimally Responsive?

THEME I: THE PSYCHOTHERAPIST'S SUBJECTIVE LIFE EXPERIENCES

Category #1: Losses and Mourning
Category #2: Current Life-Cycle Issues
Category #3: Psychotherapist's Relationship to His/Her Analyst or Psychotherapist

THEME II: HIS/HER IDENTIFICATION WITH A PARTICULAR PATIENT

THEME III: THE PSYCHOTHERAPIST'S AFFECT ATTUNEMENT WITH THIS PARTICULAR PATIENT

Category #1: The Psychotherapist's Subjective State of Being

Subcategory #1a: The Psychotherapist's Use of Images and Internal Dialogue

Subcategory #1b: The Psychotherapist's Use of Metaphor and Internal Dialogue

Category #2: The Psychotherapist's View of the Patient's Subjective State of Being

Category #3: The Psychotherapist's Attunement to the Intersubjective State of Being

THEME IV: THE INTERACTION OF HOPING, HOLDING AND BEING HELD

Category #1: The Support of Consultant or Supervisor
Category #2: Maintaining Hope in the Face of the Intolerable
Category #3: Support of the Holding Environment
Category #4: The Psychotherapist's Commitment and Primary Responsibility to the Patient

THEME V: THE MOVE BEYOND CUSTOMARY PARAMETERS IN A MANNER WHICH WAS OPTIMALLY RESPONSIVE

Category #1: A Disciplined Responsible Fashion
Category #2: To Risk, Regardless of the Psychotherapist's Need for Support and Safety

empathic resonance and affective attunement to the patient's experience. Informants 1, 2, 5, 6, 7, 8, 9 identified a major loss of their own as relevant; these are elaborated on the following examples derived from the interviews.

Therapist 7 presented a patient who had lost his 23 year old son due to a plane crash. Although the death was five years prior to the initiation of treatment, the father and mother of the deceased son were having severe unresolved grief and they were unable to move forward in their lives. During the interview, Therapist 7 shared her own recent loss of her father that seemed to have an impact on how she understood and was attuned to this couple's grief. The following excerpt illustrates this:

> There's pathological mourning for five years going on with this couple, so that their inability to deal with this obviously has something to do with them. So, that's been there all along....it turns out, as these strange things in life often do, they came to me, and I started with them two weeks after my father died. When they first came I thought about it, and I thought is my loss too recent for me to be able to deal with this, and I, I thought no, and I thought it might even help me to be sensitive to what I assume are the normal process of mourning and dealing with the loss, and my awareness. Had I never lost anyone I still would think I could handle it, but I don't know if I would have been quite as emotionally responsive, so I, I don't know....I'm very much aware of my own mourning process, sort of how it comes in and out in waves, and that's not something I would have expected, or, or felt aware of, but that's what happened...then all of a sudden it just sort of the missing the person just hits you, and there is an intense reaction. But I also think it's helping me see that what their doing is very pathological, and that it has to have other meaning...I could feel

> the intensity of the sadness of not ever seeing the person again, and I think that related directly to the loss of my father, or my recent loss.

Therapist 2 shared a portion of the interview of a patient whom she experienced as a challenge, in that she had to deal with the patient's intense anger and barrage of attacks. This psychotherapist became aware of her own personal experience of loss, and how this was related to the current treatment of this particular patient. The psychotherapist's personal experience of loss was identified and acknowledged by the psychotherapist, and its impact on the treatment of the patient.

> I know we had a real upheaval after the month of analysis...because my mother died. And there were times with the patient that I just didn't want to be there, you know, I was mourning my mother and there were times when I could be very sensitive and be there, and I think there was something, you know, I was in the same feeling state...

Therapist 2 elaborated on the effects of the loss in her personal life as it interrelated with the treatment of her patient, "...I think it's the whole issue of separations and how it can feel, and the struggle with attachment is one that I can resonate with in terms of my own make-up. My patient is very interrelated in the whole thing because my mother died on a Tuesday night."

Therapist 2 reflected further on her subjective experience of loss: "...I had to rush to the hospital...and I thought in my mind it would be very traumatic for her to find

this note on the door canceling that [Tuesday] evening saying I would call her the next morning...and that was extremely traumatic for her..." Therapist 2 was sensitive to the potential effect that this would have on the patient, "...because we both had our traumas to go through." The patient was working on issues related to her own trauma of loss in the analysis. Therapist 2's own personal loss also occurred during the patient's analysis, and this may have contributed to her increased sensitivity and empathic resonance with this patient.

The theme of the impact of the psychotherapist's personal loss and mourning was echoed by Therapist 5. She spoke of the untimely death of her 20 year old son, which had a profound impact on her, to the point that she was "not really wanting to live." The experience of extreme personal pain allowed her to identify with the depth of her patient's pain. She conveyed this in her work with a 30 year old female patient, who was massively physically and sexually abused. She associated to her own experience of pain due to the loss of her young son. This personal loss propelled her to consciously choose to work with adults in their mid-20's to late 30's. She felt that there was "enough life experience, enough pain, enough awareness...the push of pain and the pull of hope" with this population. Therapist 5 believed that her loss and her life experience influenced her to be particularly responsive and attuned to the patient whom she presented.

Therapist 6 shared that he had lost his father suddenly when he was 20 years old, which was the age of the young patient he presented. This psychotherapist felt that he had "...never quite finished...his need to have a father." Because of that he felt that it made him more sensitive to the importance of the role of the father. Therefore with this young patient whom he presented, he "saw an opportunity, and felt he could do it within professional and appropriate boundary lines, that is, to be fatherly and take care of somebody who needs and wants that within the therapeutic context."

Therapist 6 reminisced about his father, who was "...an unusually loving person." He had died when this psychotherapist was just going into the Army, and he felt that he did not, at that time, grieve his death properly. He felt through his own personal therapy that he was able to work through his grieving, and become more aware of the significance of his own personal loss. In addition, he noted how the memory of his personal loss was rekindled during the interview, and was intertwined in his work with the client whom he presented.

The identified losses and subsequent feelings of mourning and grief seem to have spurred these psychotherapists toward further introspection related to the cases they presented. This included an exploration of their evolving subjectivity of personal loss, and how this affected their responses to their

patient's emotional pain. The psychotherapist's loss was not disclosed to the patient, but was profoundly present in the psychotherapist's awareness.

The identification of their loss and mourning experiences seemed to put the psychotherapists on a highly sensitive level of self-awareness that was integrated into their therapeutic interventions with their patients.

Category #2: Current Life-Cycle Issues

The psychotherapists' reflections on phase of life issues, as well as their present life situations, were prominent themes among Therapists 3, 6, 8, and 9. This was particularly exemplified during the interviews with Therapist 6 and Therapist 8.

Therapist 6 was reflective about his current phase of life, and was focusing on his priorities. He had taken early retirement from a teaching position, and shared that he was missing his family, his children and grandchildren. Because of the tremendous commitment and pull toward helping his clients, he was unclear as to whether he would take on additional clients, or only "nice, neat cases." This is reflected in the following excerpt:

> I think at a deep level I am trying to make some decisions about how active to be in my practice. When shall I stop. When should I slow down. Should I just see fewer clients. Should I only take nice, neat cases...there are not too many of those. So I decided to take on a client, the daughter of a family that I had worked with in the past...I have

> a loyalty to my former clients. I have a genuine liking for that family with all of their dysfunctional processes. That's probably part of my whole family thing I'm telling you about. I think there's that element that I probably bring into the therapy.

Therapist 8 shared her early history of "...a mother who was highly intellectualized, and a father that was extremely emotional, highly intelligent and successful...but with very little capacity to, to withstand his passions..." and who therefore kept emotions to himself. She shared that within her early family experience, there was never an allowance for expression of emotion, particularly conflict or anger.

Because of her early childhood experience, Therapist 8 felt that an openness to conflict and anger is one of the most important capacities a psychotherapist can bring to the therapeutic situation. In other words, "the ability to let someone be angry, to allow yourself to be angry, to expose it with all one's inadequacies and infantile reactions." Therapist 8 felt that sometimes, depending on the particular client, it is appropriate to let the client know that you are angry, and that the patient can stand the psychotherapist's anger, and survive that too.

Additionally, this psychotherapist felt that if she is involved in helping a client, then she will do whatever she can do to help that person, and follow-through. However, this

stance of commitment and openness to a patient's conflict and anger is not without a toll upon the psychotherapist. She elaborated on this:

> There's a strain on the therapist. That's a choice we make. There are stages, I think in everyone's life as a therapist where there are some people, that I could treat today, or I could have treated twelve years ago...that I will not be able to treat in 10 years, because of the necessary connection, the necessary energy...the necessary struggle, which I may not be able to put in.

This view was echoed by Therapist 1, who shared that prior to taking on a client she was very aware of the tremendous emotional toll, strain and commitment that is involved in helping difficult clients to get better. She often took the necessary time to evaluate whether she would choose to take on a client who required such necessary energy. Because she had recently had a baby, she felt that it was necessary to seriously evaluate whether she would have the personal energy to take on a particular client. Prior to having a baby she did not give as much intense thought to these decisions.

Therapist 9 conveyed a kind of internal decision-making process as to whether she would take on certain clients. She felt "at this time in my life I don't need to take on the client. I don't need the client." Therapist 9 was a widow and had recently retired. She continued to maintain a small private practice. This was a time in her life where other priorities were in the forefront. The patients whom she

decided to take on, however, were regarded with a strong commitment to helping them through their difficulties, and helping them to get better.

Category #3: Psychotherapist's Relationship With Her/His Analyst or Psychotherapist, elaborated as follows:

The subjective experience of the psychotherapist as a patient was significant among all nine respondents. The experience of the psychotherapist as patient, that is, "...what it was like to be on the other side," is elaborated in this category. The quality of the therapist/analyst relationship was reflected in the following examples.

Therapist 3 shared her experience as a patient, and her need to have her psychotherapist be active; she resonated that feeling in the interaction with her patient. This was of particular significance, in that her identified optimal response to the patient - asking the patient to sit up rather than lay on the couch - stirred up memories of her own experience as a patient. She elaborated, "...I think it really must have tapped on my own feelings...and perhaps my own analysis when I have more to say...or wanted the analyst to take an action."

The experience of the responsivity of the analyst to the psychotherapist was significant among Therapists 1, 3, 5, 6, and 8. This was reflected in these psychotherapists' responses to their particular patient. It is reflective of

the psychotherapist's need for the experience of the analyst as a holder/container of hope for the psychotherapist. This theme is further expanded upon under Theme IV.

This was exemplified in Therapist 5's own experience of hopelessness and helplessness after the loss of her son, and how that influenced her later responses to the patient she presented. She shared her experience as a patient with her analyst, which she describes as a truly significant personal and professional learning experience. This experience seemed to be integrated in her work with clients. The following is an excerpt that illustrates this psychotherapist's analytic experience:

> I have had the privilege of a very successful analysis, with an analyst who was optimally responsive to me...the awareness of that experience entered the treatment with my patient. When I loss my 20 year old son, I really didn't want to live. My own process of my own analysis was that it was always very much inside of me...the patience, compassion, the infinite kindness, and I always thought such wisdom, good fortune...the good luck I had in finding that particular analyst for myself. The changes from not wanting to live...and that's when I began my journey.

Therapist 5 explained how she went on to complete her M.S.W. degree, even when she felt she couldn't do it. She continued beyond her graduate degree with further advanced training from a psychoanalytic institute. She summarized her achievement with the following statements:

> It all stems from the belief that my own therapist always had in me. The ability to inspire hopefulness in me. The capacity that I knew that he believed that I could do it even when I doubted that I could do it. And so that is the way I will

> forever practice my own way of therapy, stemming from the way I myself, my own personal experience. It's more, far more than just a matter of theory and technique.

Therapist 1 also indicated that in her decision to treat the presented patient, she reflected on her own past experience, both negative and positive. She felt that what the patient needed was a responsive psychoanalyst. During the period of time she was treating this client, this psychotherapist was also addressing very difficult personal issues of her own. Therapist 1 felt that she had a multitude of problems that impacted her work with her own client; she said that she was "...feeling very, very depressed, and I was not getting better, and it was just horrible. I was going five, sometimes six times a week, to an M.D. psychoanalyst ...I was going through torrents of hell every single day."

Her present analyst helped her to understand and work through powerful emotions which were stirred up through her work with the client she presented. Although the analyst was extremely helpful and attuned to this psychotherapist's needs, Therapist 1 recalled that this was not always the case in the past with other analysts. "I've had a lot of very bad experiences with different analysts and psychiatrists personally...and because of those negative experiences, I wasn't going to let my patient not get better."

An important part of this theme, is the impact of the negative therapeutic encounter, which further illustrates the

impact of the psychotherapist's experience with his or her own analyst upon his or her ability to be optimally responsive. That is, the psychotherapist learns what it might take to be optimally responsive as a consequence of the failure of such response in her own analysis. The following description of Therapist 8's experience with her analyst illustrates this point.

Therapist 8 conveyed the highly significant impact that her analyst had upon her. She recalled a earlier time in her therapy, which led to her belief that in order for her to be truly available and to "go to the line" for her own patient, she needed to have that experience via her own therapy. She recalled:

> In June I had a birthday party, and I said to him you didn't come. And he gave me a cock-and-bull story as to why, I knew it was a cock-and-bull story. I said your not even being honest with me. Which I would never do to a patient. He couldn't handle it. And I said ... you could have helped me a lot, but I guess the rest of my growth I'm gonna have to do on my own. I said because you didn't come through for me. For me it was very concrete. Put your money where your mouth is...you say I'm terrific, I'm a wonderful therapist, that you love knowing me, well, I want to see it. Come to my party. You don't have to marry me you don't have to go to bed with me...And I said I'm gonna do my work on my own now.

Therapist 8 needed her analyst to be responsive to where she was at that time, and to understand the significance of his being honest about the party. What was significant was the symbolic representation of the analyst being able to come to her birthday party; to her, it would mean that she was

accepted by him. The analyst had let her down, leaving her disappointed and frustrated. As the interview evolved, this psychotherapist reflected on the impact of this memory, and was affirmed as to how she would incorporate this experience into treatment with her own patients. First of all, she resolved that she would never lie to her patient, but be honest, and that she would "go the line to where the patient needed her to go" if that was in the best interest of the patient.

THEME II: HIS/HER IDENTIFICATION WITH THIS PARTICULAR PATIENT

The psychotherapists identified with their patients, in a kind of mutuality of subjective experience, that resulted in a positive conjunction with the patients. However, there were variations in how the individual psychotherapist incorporated their parallel experiences in the treatment. Some felt that there was no other way but to go through a kind of shared subjective experience in tandem (Therapists 1, 3, 4, 6, and 8). Others felt that their own personal experience of emotional pain needed to be put aside in the best interests of the treatment of the patient (Therapists 2, 4, 7, and 9).

This is elaborated on in an example described by Therapist 1. Therapist 1 was uncertain whether she would treat the patient presented. She realized that she would have to get in touch with many early childhood feelings of her own personal pain. During the interview this psychotherapist

shared her hesitations in embarking on such an intense therapeutic relationship. Through this patient she was, simultaneously, also beginning to get in touch with her own history of sexual abuse. This awareness was spurred by the initial work with this particular patient. There was a kind of mutuality of experience that this psychotherapist could identify with and her patient's pain. The patient she presented had suffered severe physical, sexual, and emotional abuse. This psychotherapist believed that in order to help this patient, she would have to get in touch with unresolved issues and painful memories from her own childhood abuse. She felt affirmed, however, that by working through her own personal feelings and memories, this would enable her to provide the needed treatment for her patient. She reflected:

> I got in touch with my own history of sexual abuse in working with R. ...Her childlike quality reminding me of my own inner child...I realized I was going to have to be a very precocious little girl once again in my life...so it was like little [Therapist 1] who was so precocious to both, and so because of that I knew what I was doing.

Therapist 2 however, related that although she could identify and resonate with her patient's struggle with attachments and separations, she also felt that there was also a part of her that was too wrapped up in her own turmoil for her to be helpful to her patient. Although she could identify, empathize and feel from her own experience the pain

of the patient's struggles, she felt that she needed distance from her own issues to be most helpful. The following excerpt describes her position:

> I can't really put my finger on what contributed to my being able to do that...I think there was something else, the whole issue of separations and how it can feel and kind of be, the struggle with attachment and separation is one I can resonate with in terms of my own makeup. So I think there are at times when if I get caught up in something myself, it's harder for me to get into it. But when I'm not caught up in it myself, which is most of the time, I think I tend to be able to zero in on it, because of my own makeup.

Therapist 3 however, was able to identify her own personal feelings as a patient, and to integrate this into her treatment of the patient whom she presented. Her response to her patient, suggesting that she sit up instead of lie on the couch, seemed to be a turning point in the therapy. What went on within this psychotherapist's own subjective experience was reflected in the following statements:

> You know, I remember those times of feeling so helpless to do something and wishing someone would do, do something. Now, I don't know why I said sit up. It just came to me...that that was what I should say.

With further probing she recalled:

> It was really her sense of isolation and terror that I must have identified with on some level, from my own world having experienced some of these feelings and being able to risk mine with hers, although not the same certainly. The inability of her to articulate in words some of these feelings that came from a time where I think the contact between mother and child needed to be in existence. I think it sort of must of tapped something. I wasn't really consciously thinking of myself at the time, you know...but I think it really must have tapped on my own feelings when I have had these feelings, and perhaps my own analysis when I have

> more to say...or wanted the analyst to take an action. You know I remember there being those times of feeling so helpless to do something and wishing someone would do, do something...to provide something for me that I was unable to provide for myself...whether it was containment, whether it was a suggestion...something active, an interpretation it could have been.

Therapist 9 acknowledged her identification with her particular patient, that contributed to a sensed correctness of fit. She provided some background data on the patient, a young man in his 20's, "...who was the head of a small agency." He was in a great deal of danger in being sued by the board of the agency that he worked for. He was in a crisis situation that prompted him to seek treatment.

Therapist 9 reflected on her experience with this patient, and questioned, "How in the world did he accomplish that? I felt here was somebody who really did accomplish a great deal. He really had a lot of capabilities and talents..." She felt, "...quite, warm and trusting of him. I don't usually pick-up a crisis situation on a pro bono basis because somebody asks me to." Additionally, there was something very significant that she resonated to with this patient, "...I felt very, empathetic with this guy and the spot he found himself in...that he must be a person who did function at a fairly high level to attain what he had at his age. I felt that he must be somebody who had a certain amount of integrity, because of what I knew of the agency from which he came."

Therapist 9 recognized that her own identification with this particular patient may have contributed to a sensed correctness of fit, in that she "...recognize[d] a lot of, [myself] in this kind of case situation, in which I think much of my modus operandi has always been, well, gee, now here's a problem, I gotta handle it. And I would empathize with that in this young man. Unrealistic as I think it was, and is for him at this point...so I think I saw some of myself in this person...or at least his story. Also, I started with an assumption that if my friend thought well of him, I would think well of him...that the referrer was somebody whose judgment I would value...I think it was a very positive..."

Therapist 9 wondered whether the patient would "...either give up now, and go hide, or will continue to struggle..." with the horrendous crisis. She reflected on her own subjective feelings and beliefs, "And I'm very much admiring of people who continue to struggle. So I think that confirmed that he was somebody that I would want to work with. As far as my personal situation here, I'm not sure that...that it's a lifestyle, that I tend to feel. I believe you have a terrible experience, you do what you can to make it in the most beneficial or profitable or fulfilling for you that you can...so, I think there's that parallel..." with this particular patient.

Therapist 9 reflected further on her own personal struggles, that contributed to her identification with this patient, "...about my own life experience...not that there haven't been hardships and difficulties and traumas and all kinds of things, but that somehow there is a message someplace, or a conviction someplace that you deal with it the best you can. And that doesn't deny having to be scared or frightened or overwhelmed, or whatever at times."

Therapist 9 felt that she admired and resonated with those who could "...be brave enough to want to ...struggle, enduring the pain, going through whatever it is, is possible, can be beneficial." She felt that she had "...a certain amount of connectedness with..." a person who is willing to struggle and "...with this patient it was right there...he captures me!...no question about it."

THEME III: THE PSYCHOTHERAPIST'S AFFECT ATTUNEMENT WITH THIS PARTICULAR PATIENT

All of the respondents utilized affect attunenment as the principal mode of apprehending and understanding the patient's subjective experience. Affect attunement, in this context, is described as a way of perceiving or sharing internal states. Stern (1985) held that the experience of attunement shifts attention away from simple external behavior to "what is behind the behavior, to the quality of feeling that is being shared" (p. 142).

Affect attunement can be understood as the psychotherapist resonating with the patient's thoughts, feelings, and experiences. The psychotherapist's affect attunement to his or her patient was empathic, that is, the psychotherapist conveyed an understanding and accurate responsivity to the patient, in a manner which resulted in the patient feeling understood. This was aptly described by Therapist 5, "...attunement is one of the most important components in therapy. It's when you can resonate with the other and know that they feel it. It is far beyond any words or any other interpretation..."

For the psychotherapists in this study, affect attunement contributed to their being optimally responsive with their patients. Theme III - The Psychotherapist's Affect Attunement - is elaborated in three categories.

Category #1: The Psychotherapist's Subjective State of Being

All nine respondents were reflective of their own subjective state of being in relation to the patient each presented. The psychotherapist's subjectivity is described in this context as the totality of the psychotherapist's own experiences, memories, associations, thoughts, recollections, fantasies, images, and reactions that the psychotherapist contributes and brings to the therapeutic relationship. It is not limited, however, to only those responses and reactions. By becoming aware of their own subjectivity, they were then

able to be affectively attuned to their patients. The affect attunement took place through the psychotherapist's (5, 6, and 7) recognition, identification, and communication of the patient's affect. That is, the psychotherapist was able to identify and recognize for the patient - verbally or nonverbally - the feeling state and experiences that were behind the behavior and/or words of the patient. This was reflected in the following examples.

Therapist 7 recalled her own subjective process of becoming aware of "...this man's tremendous prolonged grief." She starts by "...trying to be very, very sensitive, to their loss. His eyes often filled-up with tears." In observing and resonating with this patient, the psychotherapist shared from her subjective vantage point; "...I am trying to be very conscious of his mood, his posture...there is a sense of his falling apart." This was very critical for this psychotherapist. That is, to be very carefully attuned to his experience, otherwise "he becomes very defensive, particularly if his wife jumps in too quickly." He will often decide "...not to talk about it anymore." The psychotherapist's subjective experience, a precondition, facilitated the patient's growing awareness of his underlying feelings of letting go. The patient then moved forward and was able to identify his feelings.

In addition to the above, and as noted earlier, this psychotherapist lost her father two weeks prior to beginning treatment with this couple. Throughout the interview she was able to acknowledge to herself the personal loss she had experienced. She utilized her subjective experience of personal grief, which was interwoven into the treatment, and her subjective experience facilitated the therapeutic work with this couple.

Therapist 5 shared her subjective, spontaneous responses which were drawn forth through her interaction with the patient she presented. She expressed sheer delight, pleasure, and joy with her patient. She was quite reflective regarding her view of herself as a psychotherapist:

> I'm very warm, outgoing, and responsive, and I am expressive. It's just my personality. I would find that I would non-verbally express my pleasure and my excitement in where she was going, and non-verbally be able to lead, help her get, almost by my facial expressions and bodily expressions, to where she was going, with little verbal help on my part. There is something that I find that I do at times, and especially that I have done with her. What is...is that mother-child interaction, and which she would say something and I would applaud (clapping in the background)...isn't that wonderful! You know that kind of a feeling, like you're wonderful. I could do that, and have done that with her.

Therapist 5's own subjective experience and reflections enabled her to reach this client at the client's earliest developmental level. She believed that it was absolutely critical to attune to her client at the deepest level possible, and in a manner that would be optimal. To do that,

she reflected upon and acknowledged her subjective use of self as a psychotherapist. She felt the most appropriate and beneficial response to this client was based on building the relationship and providing a new reference point of experience that this patient had never had before. What she was describing was her attunement to the patient. She explained, "...attunement is one of the most important components in therapy. It's when you can resonate with the other and know that they feel it. It is far beyond any words or any other interpretation. I guess when I am telling you the things that I am doing with my patient, I am telling you about attunement."

Therapist 3 shared her views on her subjective state of being. Her internal subjective process seemed to enhance her attunement with the patient. She shared that being aware of a particular feeling, or specifically, "...when I've had that feeling myself" would determine whether she would provide something - "...anything for the patient - such as an interpretation, or asking a patient to sit up, or covering a patient with a blanket."

She described the subjective experience that proceeded her response to her patient as follows:

> It was the terror that I experienced within myself that made me suggest to her that we try sitting up...it was very interesting because it was like a turning point...a real movement into a new phase of treatment...this was a woman that never really could connect and form a relationship.

Subcategory 1a: The Psychotherapist's Use of Images and Internal Dialogue

The psychotherapist's subjectivity is manifested via an evolving internal dialogue and through the use of images. The psychotherapist's evolving internal dialogue is defined in this context as the psychotherapist's introspective narrative - of feelings and thoughts - in relation to the patient. The experience (portrayal) of the patient was described via the psychotherapist's introspective narrative, or evolving internal dialogue. The psychotherapist's use of images/imagery, associations, symbolic pictures, fantasy, as well as feelings, and thoughts, facilitated the psychotherapist's ability to be affectively attuned and attending to the patient's emotional state.

Therapist 2 discussed a session with her patient, in which she was "...barraged and verbally attacked" by her patient. The psychotherapist described this encounter as "...like a baby having a tantrum." This was a client being seen in psychoanalysis four times per week on the couch. The patient had canceled her sessions due to "being sick" and it was "...unclear on the answering machine message" whether the patient wanted the psychotherapist to telephone her back.

In the next session, following the patient's cancellation due to illness, and during the patient's barrage and attack, the psychotherapist's evolving internal dialogue - anxiety and confusion - seemed to facilitate movement in treatment, during

the very difficult encounter of that moment:

> So she came in on Tuesday night and just barraged me with hopelessness that she was not getting better. It was this barrage of I'm never going to get any better. There were some things that she had been thinking about that were very despairing to her and in terms of being a gauge as to how little progress she had made. So she went on and on about that at the beginning of the session, and I was totally confused. I thought, where in the hell is this coming from, and I just sort of sat there with it, which I think was very empathic of me...that I didn't sort of blurt anything out, or I contained my anxiety. She also was mildly attacking me [indirectly] as to 'Why aren't you doing more for me?'

Therapist 2 reflected further on her thoughts and actions:

> I didn't react in any way, I just thought I'm going to wait and see. I contained it and felt calm in my ability to wait and see what might come of it. Another thing that was going through my mind were the phone calls, and me not calling her back. I just sort of kept that in my mind - why is this coming up right now? - in the midst of this barrage.

This evolving internal dialogue with herself enabled Therapist 2 to become aware of certain transference themes which helped her to make sense of the barrage of attacks. Through her evolving internal dialogue, she was able to reflect on the lack of clarity - to return the patient's calls - in the midst of the barrage. She allowed herself to maintain a position of calmness and did not immediately react to the patient's attacks. Therapist 2 was thus able to begin to make sense of the attacks. She asked the patient whether she had "...wished that she would have called her back" and

"...did she feel hurt that she did not return the calls." The patient responded, "No," she didn't want her to call, in fact she "...dreaded that I [therapist] would call back." The psychotherapist identified this as the point in which "the patient's affect became apparent." At this point the patient shared that she was "...fearful that I [therapist] would chastise her for being sick, for playing hooky."

This psychotherapist's internal dialogue was initially one of confusion and anxiety. The psychotherapist's internal dialogue then evolved toward greater empathy, understanding, and attunement to the patient's affect and behavior. Therapist 2's associations, thoughts, and feelings enabled her to understand the patient's barrage of attacking as a way for this patient to verify her utter dread of whether the psychotherapist was going to agree with the patient, that "...she is hopeless and that she is worthless." The fantasy of the patient was that Therapist 2 would agree that her situation was hopeless. The patient expressed her fear that Therapist 2 was angry at her, would give up and "...throw in the towel." Therapist 2 recalled, "...she sighed, which always is a confirmation for me, and I think she was quiet for a minute or two. And things were just calm..." Therapist 2 recalled the feeling at that point in the session, and reflected on the corresponding image, "...it just sort of felt like you know there was this baby having a tantrum. And she just calmed down. That's how the session ended."

Therapist 3 she described vivid images regarding the patient she presented. One of the images that came to mind for her was that of an infant, "a flailing infant." She described further, "as an infant who was unable, whom no one would pick up." At this point Therapist 3 acknowledged that perhaps this was significant, "...I think that was probably my association, as I'm thinking about it." The psychotherapist's response, as a result of the association to the vivid image, "...was to ask the patient to sit up." The image for the psychotherapist was that of "a flailing infant, who seemed unable to connect, or have any attention, or any focus."

She continued further with the images, and described the patient's recurring dream. In the dream, the patient described herself as "...being on her back, like an infant, flailing her arms, trying to ward people off." Therapist 3 reflected, "...that brought my own associations of being an infant you know, perhaps left, unresponded to and not being picked up. She continued further, "...her dream also involved being unable to see, and I thought it was interesting because she wasn't able to see [lying on her back]." These associations, images and pictures seemed to prompt the therapist to ask the patient if she would sit up. This was a turning point in the therapeutic process.

Therapist 5 described the image of her patient in the initial stages of therapy as, "...in the beginning she was a little teency, weency, baby." She was "...unable to do the intellectual, cognitive the mental work in treatment." Therapist 5 felt that what was optimal in this case was to be affectively attuned and attending to the developmental needs of the patient. That is, she sought to be attuned to the patient's affect, which meant "starting where this patient is at, and being responsive to where the patient is at developmentally." Therapist 5 felt a verbal interpretation would have been inappropriate for this patient. The psychotherapist's association to the image of an infant, facilitated the psychotherapist to be exquisitely attuned and responsive to the patient's affect. The psychotherapist's use of images of "a teency, weency, baby," as well as "a terrified little rabbit...a weak kitten" contributed to the psychotherapist's attunement to this particular patient's situation. She elaborated, "All of a sudden she was now able and knew, that she had now taken on my function, and was now able to do it for herself. This was so very vivid and clear."

In subsequent sessions, the patient shared a dream with the psychotherapist. The dream was significant, because additional new material was brought into the session. This confirmed for the psychotherapist that the relationship was

becoming increasingly central and significant to the patient. The dream was "...symbolic of progress" in the treatment, and confirming for both patient and psychotherapist.

The psychotherapists' subjective use of images, associations, and pictures was a stepping stone toward increased understanding and attunement to their respective patients, at that particular point in the treatment. This was reflected in interviews with Therapists 1, 2, 3, 4, 5, and 7. It is first the psychotherapist's ability to subjectively identify and/or articulate the patient's affect, and secondly the psychotherapist's evolving internal dialogue, described through the use of images, and/or dreams of both psychotherapist and patient. The use of these images seemed to bring about a mutual shift reflective of progress, insight, or growth for the patient. This seemed to be mutually relieving to both psychotherapist and patient.

Subcategory #1b: The Psychotherapist's Use of Metaphor and Internal Dialogue

In addition to the use of imagery, the psychotherapists utilized metaphors which further expanded the psychotherapist's evolving internal dialogue. This was particularly evident in Therapist 1's account of a portion of a session.

Therapist 1, through her evolving internal dialogue, became aware of her own "...metaphor of Dorothy's ruby slippers." It was a kind of "...visual imagery." The

patient whom she presented, was "...severely abused physically, sexually, and emotionally." This psychotherapist felt it was absolutely critical for the patient, as well as herself, "...to have something to hold on to that would provide some special meaning." Ruby slippers meant to this patient a sign of "...hope and home." That is, "...to start building a new home, for someone who had been left out."

The significant aspect here is that the psychotherapist apprehended the critical need for hope with this severely abused patient. There was the initial subjective experience of the psychotherapist that inspired her to acknowledge the imagery of the ruby slippers, "...and somehow being so in touch with what R. had lived with, lived through, inspired me. There was more of a quality in my voice, and I communicated to her...that really made her feel inspired. That I really believed her, and that I really felt that she could do it, and I was right there to help her with this thing...that we were together."

Her association of the metaphor of the ruby slippers facilitated the psychotherapist's affect attunement to this particular patient. What unfolded during the interview was the patient's increasing ability to hold on to the hope that was associated with the meaning of the ruby slippers. This facilitated forward movement of the therapeutic process. Therapist 1 summed it up as follows, "First there was the

visual imagery, metaphor of the ruby slippers, which was symbolic of hope and home, and then the words came...we both felt relief."

The significant difference in this subcategory was that this particular psychotherapist conevetized the metaphor by giving her patient a tiny pair of ruby slippers. In subcategory 1a, the other psychotherapists utilized imagery themselves, but did not necessarily share these with the patient either metaphorically or literally.

Category #2: The Psychotherapist's View of the Patient's Subjective State of Being

In presenting the findings of this category, it is useful to recall that this study is concerned with the psychotherapist's subjective and intersubjective experiences which, from the psychotherapist's perspective, contribute to the psychotherapist' ability to be optimally responsive to their patients. For the purposes of this study, the patient's subjective state of being is reported from the psychotherapist's perspective. That is, the data reflects the psychotherapist's (observer's) subjective experience, of the patient's (observed) subjective experience.

Natterson's (1991) views provide a frame of reference for the presentation of the findings for this category. Natterson posited that "...the therapist can be regarded as the spokesperson for the unitary consciousness shared by the patient and therapist" (p. 212). He explained further,

"...the therapist's turning his or her attention to either person's subjectivity does not constitute neglect of the other, since the unified concept (intersubjectivity) implies continuing presence and importance of the sector that is not momentarily in focus" (p. 212). The psychotherapist may fluctuate in a state of reverie with the patient, "...or the therapist may be focusing intently and exclusively on the patient's verbal and nonverbal behavior, with a minimum of conscious self-absorption" (p. 214). The following data on the patient's subjective state of being, reflects the vantage point of the psychotherapist's affect attunement.

Therapist 1 shared her thoughts regarding her patient's subjective state of being. She prefaced this however, by describing how her work with children developed her belief that psychotherapists must tune in to all of the patient's needs. She explained, if she "...had a child patient who was just exhausted after school and wasn't feeling good...or maybe they're conked out with the flu, or maybe hungry, so nothing is going to work in that session..." unless the need is addressed and taken care of. Therapist 1 felt that her work with children helped her to be attuned to the patient she presented during the interview.

Therapist 1 viewed attunement and sensitivity to the patient's subjective state of being as a precondition to determining the optimal response to the patient. Therapist 1 conveyed that she had been to many "...analysts and M.D.

psychoanalysts" and that the experience was not always good. Because of her own subjective experience of her patient R., and her belief "...that therapist's must tune-in to all of the patient's needs," she determined how she needed to respond to her patient.

Therapist 1 described her patient R.'s subjective state of being in the following excerpt:

> ...from a flat affect...this young woman sat up, a strain lifted from her face...there began to be some expression in her eyes...in a way showing her that the things that she had been so upset about, in terms of herself, that her strength, of what strength she had, getting through it...that her not feeling and that numb feeling, had been...really the way she'd saved her life.

She elaborated further on the patient's subjective state of being by being sensitive to and respecting the meaning of the patient's achievement of an advanced degree. Therapist 1 resonated to the internal strength that her patient had regarding that accomplishment. By empathizing with the patient's subjective meaning of this achievement, this further enhanced her attunement to her patient's experience, "...and what that meant, how that would live through all of the rest of the degradation of the whole family." Therapist 1 viewed this accomplishment "...sort of like an inner resource that I think she had forgotten she had had, and that strengthened her..."

Therapist 1's sensitivity and attunement to her patient's subjectivity was significant, "...because of that, it was easier for me to work with her...and I try to draw her out, to understand that in a way, these were her feelings, and that she needed in some way to be able to understand those [feelings] overwhelmed her. Just really trying to help her to see who she was now, that she wasn't in that [old] situation..."

Therapist 8 described her work with a couple that conveyed her attunement to the couple's subjective state of being. She provided background information and history, "...a premarital couple, it's their second marriage, they have been living together for a year and a half, and this woman is learning how to be autonomous, deal with anger, deal with her feelings of limits. The man she lives with is learning, how they both come from backgrounds where hope was very limited for both their parents. She compensated for her feeling hopeless about ever having a life of her own by staying in a very unrewarding, emotionally unresponsive marriage because it was extreme wealth that she got in...that marriage. And he [current partner] lived in a marriage that was totally deprived of any emotional connection. Where he became the total caretaker, total organizer, and the professional position in the family. So, he was the father and mother to his wife, who is borderline, very angry woman, the mother and father to the sons, which you can't really do, and the doctor

to the community. And that's his role, and he was that as a child. Always taking care of his family." Therapist 8 shared her attunement to this couple's subjective state in the following excerpts. She listened to him talk about "...how he likes his bikes, cameras, and guitars, and all of his interests in the home." The woman patient, however, "...feels that she'll never have anything beautiful again in the home. The home won't be representative of her." Therapist 8 was sensitive to their subjective experience of one another, and reflected to herself, "What is it about this dialogue that is keeping these people from feeling, knowing themselves and feeling their own by the other?" She was sensitive to the woman's "...sadness that came over her." Therapist 8 described her atttunement and understanding of their situation, "...he sounded very very depressed to me." Therapist 8 reflected further, that it was as though "...he's going to give up on any dialogue [with his current partner], which is the same thing that he went through in his [previous] marriage." She verbalized her attunement to his subjective experience of putting his needs and desires in the background, and described it as though "...he has always relegated his interest to the porch...and he allows that."

Therapist 8 further described her attunement to their subjective state of being, in reference to issues regarding his children: "...he tries to compensate by telling [his son] to clean up for her. But she doesn't feel taken care of."

Therapist 8 shared that the subjective state of the patient at that moment was that she had difficulty verbalizing her needs, and felt that her needs would not be attended to by her partner. Therapist 8 described the patient's profound feelings of sadness, hopelessness, and belief that she would not ever be attended to when she would make a request. Although her partner was interested and willing to understand, there was still the feeling of hopelessness in each of their subjectivities. Therapist 8 reflected, "So I had to go to her inner world, and say to her..that I saw this sadness come over her..I looked at her and [said] that she was really feeling sad...that there was something on her mind that made her really angry..." Therapist 8 by being aware of the patient's subjective state of being at that moment, was sensitive to this patient's experience of wanting to make a beautiful home for the couple; but the patient feared that "...he would not see that as vital to his existence, that thereby she was not vital to his existence."

Therapist 8's affect attunement to this couple's subjectivities was summarized via her description of interactions and experiences of one another, "...as though they've given up...like it's pointless...so that it is now two people feeling pointless and hopeless." The response to one another in the session made the patient see that her partner

wanted to make it better for her. "And then they were opened again, and they left feeling hope. And they're able to have their dialogue."

This psychotherapist's exquisite attunement to each partner's subjective experience, individually, as well as their intersubjective interaction as a couple, facilitated "...the couple's therapy...to help, help them to come to know one another in a new way."

Category #3: The Psychotherapist's Attunement to the Intersubjective State of Being

The theme of attunement to the intersubjective state of being of both parties, that of the patient (the observed), and of the psychotherapist (the observer), was evident among all the informants. The **intersubjective** state of being is defined in this context as the interplay between two subjectivities, that of the patient (the observed), and of the psychotherapist (the observer). This category examines intersubjectivity from the experience and perspective of the psychotherapist. That is, those responses and/or reactions evoked within the psychotherapist, as a result of the interaction and interplay with the patient. The psychotherapist's range of reactions are evoked, initiated, and spontaneously drawn forth through the interplay between patient and psychotherapist.

In approaching the findings of this category, the views of Stolorow, Brandchaft, and Atwood (1987) are useful in providing a frame of reference. They posited a fundamental assumption, "All that can be known psychoanalytically is subjective reality - the patient's, the analyst's and the evolving, ever-shifting intersubjective (psychological) field created by the interplay between them" (p. 6). They expanded further on their conceptualization of psychoanalytic understanding:

> The development of psychoanalytic understanding may be conceptualized as an intersubjective process involving a dialogue between two personal universes...The actual conduct of a psychoanalytic case study comprises a series of empathic inferences into the structure of an individual's subjective life, alternating and interacting with the analyst's acts of reflection upon the involvement of his own personal reality in the ongoing investigation. (pgs. 6-7)

Within this category what seemed particularly apparent and significant was the psychotherapist's awareness and sensitivity to the patient's subjectivity, and to the interplay of their subjectivities. This was noted by the psychotherapists' observations of the patient's experience, mood, affect, and the evolving subjective meaning of the patient's life experiences. The intersubjective state of being - of both parties - effected and contributed to the psychotherapist's optimal timing of response, intervention, and provision of experience.

The psychotherapists' provision of a meaningful, symbolic, therapeutic experience via the relationship offered a new and different reference point for the patient. This can be facilitated and enacted by a variety and range of provisions. It may be gratification via the psychotherapist's acts, or providing of objects. This was enacted in varying ways by Therapists 1, 5, 7, and 8.

Therapist 5 was exquisitely attuned to her particular patient's subjective state of being, as well as her own subjectivity. This is described in the following interview excerpt:

> ...she had a mother who had abandoned her and a father [who was abusive]...her mother abandoned her and never protected her children from this brutal father...and I felt that that was the most important thing that I could do. Now in addition to this, with her being so fragile and so on the edge, she also had a serious eating disorder. She was bulimic and anoretic at the same time. When she went into the hospital, we had seen each other for about once a week, for about 6 weeks, and I decided that the most...that it was very important for me to see this young woman every day that I was there.

Therapist 5 was acutely aware and sensitive to the patient's subjective experience of terror and the antecedents of that terror. Additionally, she reflected on her own self-observations and experience of herself as a psychotherapist, in the treatment of this particular patient, in the following:

> I'm very warm, outgoing, and responsive, and I am expressive...and it's just, that is my personality. And I would find that I would express my pleasure and excitement in where she was going, and

> non-verbally to be able to lead, help her get almost, by my facial expressions and bodily expressions to where it was she was going, with little verbal help on my part. There is something that I find, that I do, at times...and especially that I had done with her, of what it is...is that mother-child interaction, and which she would say something and I would applaud [clapping in the background]. Isn't it wonderful?! You know, that kind of a feeling [clap]...like you're wonderful...and I could do that, and have done that with her.

Therapist 5 maintained attunement, understanding, and apprehending of the patient's subjective experience, transference issues, and organizing principles. This was reflected through the psychotherapist's resonance with the patient, as well as in her own subjective experience as the psychotherapist. There was an exquisite attunement to the intersubjective state of being.

This was particularly apparent as she apprehended the patient's terror of the prospect of Therapist 5 being away on vacation. Therapist 5 shared that prior to the one-week vacation, her patient was "terrified of my being away." The patient was hospitalized for psychiatric in-patient treatment at that time. The psychotherapist's attunement and empathic resonance to the patient's subjective state of being, as well as her own (psychotherapist) subjective state of being - the intersubjective state of being - prompted Therapist 5 to promise the patient that she would telephone her.

Therapist 5 maintained an attunement to the patient's subjective experience of her being on vacation, and subsequently promised that she would call, and did. She "...called the patient twice during the week." Additionally, her therapeutic enactment of attunement included bringing back for the patient something she had made while on vacation at a ranch, to give to the patient. Therapist 5 shared, "...I made it in the colors that I knew that she would so enjoy and meant something to her. So when I came back I could tangibly give her something that she would know that I had thought about her while I was gone, and that she was very special and very precious."

Therapist 5 apprehended the meaning of the patient's experience, and also intertwined her own personal experience as the psychotherapist. She saw herself as facilitating a new experience for the patient via her affect attunement. This was apparent in that when the psychotherapist returned from vacation, and her patient was released from the psychiatric hospital. This was a patient who "...had an eating disorder, and could never eat in front of anybody." Typically she would "...gather very little food, and go hide in a corner and eat." So on the day that she was discharged from the hospital, the therapist told her that "this was a very special day, a new beginning for her." This psychotherapist felt that it was responsive to this client to celebrate and "...took her out to lunch near the hospital.

The patient "...ordered her favorite food that she loved - Italian food" - and they had lunch together. Therapist 5 added that she knew this was something that the patient's "...mother had never done." Additionally, the patient's "...mother never came to visit or telephone the patient while she was hospitalized."

Therapist 5 was very sensitive and attuned to the patient's early experience of having a non-responsive mother. She was sensitive to the fact that the patient needed someone who would be responsive to her internal needs. That is, she was sensitive to the patient's subjective experience of never feeling special or precious enough to be responded to in a manner that was truly helpful. Concomitantly, Therapist 5 was attuned to her own personal subjective experience as a psychotherapist. It was evident that this psychotherapist's attunement and awareness of her own subjectivity in response to this patient contributed to this psychotherapist being optimally responsive to her patient.

The psychotherapist's affect attunement and apprehending of the patient's subjective experience, coupled with the psychotherapist's oneness to her own subjective experience of self, in tandem - as a precondition - facilitated an optimally responsive therapeutic experience for her patient.

This theme was further verified by Therapist 1. In the treatment of her patient, R., this psychotherapist became very aware of the depth and profundity of R's history of emotional,

physical, and sexual abuse. By being attuned to her patient's subjective experience, and descriptions of her pain, Therapist 1 became increasingly aware of the tremendous commitment that would be required for her to provide the proper and effective treatment for this particular patient. She knew that if she decided to work with R., "...that she was going to get better." Therapist 1 shared her own subjective experience that was spontaneously drawn forth via the relationship with her patient, "I'd had a lot of very bad experiences with different analysts and psychiatrists personally...I was just loaded with unresolved problems, what was happening in me, was exactly what I was not going to permit to happen with R."

A significant development occurred for Therapist 1 as the treatment with her patient unfolded. Her self-reflections and attunement to her patient's subjective experience of abuse, caused her to become increasingly aware of her own history of abuse. That is, Therapist 1's attunement to the intersubjective experience, stimulated via the treatment process with this particular patient, was described as follows:

> I got in touch with my own history of sexual abuse in working with R. ... Her childlike quality reminding me of my own inner-child...I realized I was going to have to be a very precocious little girl once again in my life...so it was like little [Therapist 1] who was so precocious to both, and so because of that I knew what I was doing...so it dovetailed into my work with R.

Therapist 1 described R's subjective state of being, her own subjective state of being, and the intersubjective state of being as follows:

> Well I think I always felt different, and different than my whole family, and I never could understand, um, I never could understand it or describe it. And as I got to know R., there was no question that she also felt different, and that because of that, both of us had felt isolated.

Therapist 1 spoke further on her subjective picture of her patient, "...the picture I had of a very innocent, good child, with these raving lunatics...At first you know [she had] this dull kind of intonation to her voice, and a trance like quality..." Therapist 1 reflected on her own subjective state at that moment, "...and it was just at that time that I began to realize that's what I had been, all of that, and yet I was able to function professionally." Therapist 1 summarized the intersubjective state of being of the psychotherapist and the patient: "So it was hard for me not to put it together, but it was a huge relief when I finally realized that this, trance, or whatever, daze...that daze from childhood...I didn't know that until later, but I was able to see it for me [through] R."

This psychotherapist utilized her analysis to deal with her own personal issues related to abuse, which was influenced by the work with her patient, R. Participation in her own analysis, as well as use of a consultant, helped the psychotherapist to maintain her attunement and reflective

self-awareness of the intersubjective state of being in the treatment of her patient. Therapist 1 believed that this stance contributed to her being optimally responsive with R. The psychotherapist's analyst and consultant assisted the psychotherapist to be affectively attuned to her own subjectivity and that of her patient.

Therapist 1 described her patient R. as often "...being exhausted, as she had been on-call for 24 hours." This psychotherapist felt that acknowledging the patient's physical situation - exhaustion and hunger - was "...acceptance all the way." Therapist 1 believed strongly that by tending to the patient's hunger (i.e. offering tea, providing cookies and milk and symbolic gifts as metaphors, etc.) was in effect saying to the patient, "I love you, I respect what you're doing...here, this will make you feel stronger and better."

Therapist 1 continued further, "...it says that I was thinking about her...I think it had to do a lot with accepting her, only accepting her physical hunger, and all the terrors she had, the emotions were all really okay. And of course, I don't think she's ever had anybody in her life make her a cup of tea."

Therapist 1 was attuned to her own subjective experience of her early life. She too, like R., had felt a sense of hopelessness, a feeling of being left out. She continued as she reflected on the intersubjective process:

> That this was a frozen individual [R.] who was very scared. Like a really good little girl, who just, who I'd had many times, and that I, I saw myself through that, I knew when I looked at her, to a certain extent, as I mentioned earlier, that, we had both, what I call the inner child.

Therapist 1 elaborated further on her intersubjective experience in the work with her patient: "...part of me is still currently experiencing [this]...I really did experience with R. that I had to rescue her...and I did, you know there was no question...I wasn't going to let something happen, I wasn't going to let her...not get the best care she could possibly get regardless."

The intersubjective state of being, that is, the psychotherapist's (observer) subjective response, based on the patient's (observed) subjective needs, was illustrated in the interviews with Therapist's 6, 7, 8, and 9. It was particularly evident in a portion of the interview with Therapist 7. Therapist 7 recalled an interaction with her patient that seemed to illustrate the attunement, apprehending, and accepting of her patient's subjective experience of traumatic events in her life. Therapist 7 was attuned to the importance of the critical timing of her responses to this particular patient. Therapist 7's patient had been carrying a tremendous sense of "...failure and shame" regarding the death of his son five years earlier. Therapist 7 was attuned to the affect behind his words; he said, "...that everyone told him he needs to let go." This

psychotherapist was attuned to the meaning of the words, "letting go" for the patient. She elaborated, "...something about the letting go idea that, that struck me that he, he sort of almost choked on the words every time he said them." The loss of his son, the intensity of his despair, and "...the feelings of failure and inadequacy were all interrelated for this patient."

According to Therapist 7, knowing this material was not enough. She felt that to be truly responsive she "had to be really sensitive and careful, and not sort of go at it head on, because he would have walked out the door. He just would have said, I'm not coming back...it was a very delicate sensitivity..." to the trauma and to his intense pain. The psychotherapist was acutely aware that his wife would often interrupt or intrude upon his subjective experience of the loss. However, Therapist 7's response was to allow the patient to experience the intensity of his pain, rather than to respond with an interpretation. This psychotherapist's attunement to the affect and subjective interactive meaning of the traumatic event (for both patient and psychotherapist), allowed for the necessary experience of mourning, within a safe therapeutic environment. The psychotherapist's attunement to the intersubjective state of being, enabled the unfolding of the patient's emotional pain, which then facilitated his previously thwarted bereavement process.

Therapist 7 had lost her father just two weeks prior to seeing this client and his wife. She described her own subjective experience in response to their pain, "...I started with them two weeks after my father died. So I certainly was sensitive to loss and the mourning process in myself, as we're going along for these three months." In reference to her personal loss, "...no it was not a child that I lost...I don't think I could have handled actually [the loss of a child] because it would have been too [painful]..." Therapist 7 shared that she too has children, and reflecting upon her subjective experience, felt that it would have been too difficult for her to work with the couple, if for example, she had just lost her son. However, in the work with this couple, "...in this particular situation, I think I could feel the intensity of the sadness of the not ever seeing the person again, and I think that related directly to the loss of my father, or my recent loss."

She elaborated further on her intersubjective thoughts and feelings related to her work with this couple, particularly with the father. She shared, "I was also clearly aware that he took a left turn, where I would take a right turn, that there was a difference in that I would not blame myself, and that his need to go back over the whole 23 years of his son's life and, and blame himself for, pick out every time that he overreacted or underreacted, or did something that he thought was wrong, and blaming himself..."

She shared her strong feelings in response to his reaction, "...[it] was clearly pathological to me...I was very clear that I couldn't identify with any of that...I was aware of that."

Therapist 7 reflected further regarding the patient's subjectivity in relation to the loss of his son. "...He brought up an example that, actually it was, it was the next week when he did this, when his son was about one, and it was Christmas and he hardly had any money, he spent five dollars on some little plastic toy, and, he is beating himself up for this terribly ...how could he have been so insensitive, and how could he have failed to provide for [his son]." Therapist 7 reflected on her own responses to this: "So, he's beating himself over and over and over again. And that, I don't have any identification with that at all, but I can understand that he's doing something to himself." From an intersubjective perspective, this psychotherapist's attunement, empathy and resonance with the pain of his loss - through her own recent subjective experience of loss - allowed her to recognize that his self-blame and severe self-punishment were intruding on his progress.

An important aspect which arose within this theme further illustrated the importance of the psychotherapist's attunement to the intersubjective state of being. This is in the negative therapeutic encounter, or when disjunction occurs in treatment. That is, the psychotherapist becomes aware of

what it might take to be optimally responsive as a consequence of the failure of such response in the course of treatment.

An example of this arose as Therapist 8 became aware of an error she had made during an interaction with her patient. Therapist 8 acknowledged that she had made a therapeutic blunder "...a frightening mistake and countertransferential disaster..." with a patient and subsequently acted it out on the patient. This psychotherapist acknowledged that she was "...filled with guilt, shame, and humiliation...and I did it because I lost it with this patient's narcissistic...intense, provocative narcissistic needs."

Much to the psychotherapist's surprise, the acting out of her reactions to the patient "...seemed to be positive overall...the effect worked." This was due to the psychotherapist's subsequent response to the patient, via "...an acknowledgement of the grave mistake" and error she had made. This was shared directly with the patient.

Therapist 8 was aware of her subjective experience in relation to this particular patient's subjective experience. The interplay of the two subjectivities then prompted the psychotherapist to telephone the patient, "...because I was willing to come to her, to call her and say, come back here, I really screwed up." The psychotherapist was able to apprehend the subjective state of being and significance of this act for this patient, in that "...she had never had

anyone apologize, recognize, or take responsibility for their mistakes." For this patient, "...she never heard that in her life."

Therapist 8 seemed able to identify what might have contributed to her initial negative response to this patient, via an openness to her own subjective experience. She identified a corresponding issue in her own early family life that prompted her initial negative response to the patient. During the interview she shared, "So, I too had never gotten that growing up." The psychotherapist's affective attunement and apprehending of her patient's subjective experience of unmet needs could then be addressed, as a result of this psychotherapist's unfolding awareness of her own subjective experience of unmet and thwarted needs.

She reflected further on her thoughts and feelings that arose in the work with her patient, "I believe that conflict and anger are one of the most important things that a psychotherapist has to bring to the therapeutic situation. The ability to let someone be angry, to allow yourself to be angry, to expose it with all one's inadequacies and infantile reactions so that the patient then feels they have a right..." She replied emphatically however, "...you don't act it out on the patient, you may experience it...it can be destructive to the other [patient]. Because we're there for the patient. But in order for them to feel that they have a right to be angry with us - and survive - that we will

survive their anger." She reflected that her initial negative responses to the patient had led to her greater awareness and openness, "...we have to let them know that we get angry and they survive ours. I will say something that will often infuriate a patient, but if I can stand with that, and have them elaborate and elaborate, till they see no one's been destroyed and they're not losing anything. Fear in so many people are punishment for expression of themselves."

Therapist 8 recollected her early childhood experience: "...as a child, my own hurt, shame and humiliation. The fact that I had a mother that was highly intellectualized, and a father that was extremely emotional, highly intelligent and successful but extremely, very little capacity to, to withstand his passions and keep them to himself. He would just blow up, and [my] mother who lived in such a state of denial about any of her feelings, that I, standing in that family...had to carry, to carry my own legs about, to be on the earth. That has taken me...to know, to find the balance, because, you know, I as a therap-, as a person, am an extremely passionate person."

Therapist 8's attunement to the intersubjectivity and the interplay of the two subjectivities - the psychotherapist and the patient - was facilitated through her reflective self awareness of her subjective experience, which was evoked in the treatment with her patient. She poignantly summarized her enhanced insight to her subjective experience as follows:

> When you live with a mother with denial...my need to have things really straightforward and direct comes from my background. So, that's the way I know I'm on this earth. This is what happened, isn't it? I had to learn..to know...yes, this is what happened.

THEME IV: THE INTERACTION OF HOPING, HOLDING, AND BEING HELD

The psychotherapists in this study maintained a holding environment for the patient, which contributed to their ability to be optimally responsive. This concept of a holding environment, however, also extended to the psychotherapist's experiences of being held, which enabled them to continue the on going treatment, often under extremely difficult conditions. The psychotherapists' experience of being held was often provided through the use of a consultant or supervisor. Most importantly, the interaction of holding and being held helped the psychotherapist to remain hopeful in the work with patients who reported experiences of profound emotional pain and/or physical abuse. Through this interaction, the psychotherapists affirmed their commitment to a strong sense of responsibility to their patients. Theme IV, The Interaction of Hoping, Holding, and Being Held, is reported from the data in four categories.

Category 1: The Support of Consultant or Supervisor

The psychotherapists underwent a process of evaluating

whether to work with the patient. This decision did not always occur immediately, and was usually made with careful forethought, as described by Therapists 1, 2, 4, 6, 7, and 8. Additionally, Therapists 1, 2, 4, and 9 made use of consultation or supervision to assist in the decision-making process. The consultant or supervisor also assisted in holding/containing the anxiety of the psychotherapist, which may have in some cases allowed the psychotherapist to believe that he or she could continue treatment with the patient.

Therapist 2, who was pursuing advanced analytic training in a psychoanalytic institute, explained how her supervisor was extremely helpful with her analytic case. She felt that her analytic treatment with the patient posed tremendous challenges. Throughout her work with this patient, however, this psychotherapist felt a strong and consistent source of support from her analytic supervisor. The supervisor was knowledgeable and "very comfortable and knowledgeable with primitive patients," which seemed to sustain her and allow her to continue the treatment. During the analytic treatment, Therapist 2 had suffered the loss of her mother, and during that time the supervisor was extremely supportive. Therapist 2 felt that the supervisor helped her to hold on to the patient. She felt that during her own grief related to the loss of her mother, she was not always as present and

attentive to the patient as she should have been. Because of the very positive support from this supervisor, this psychotherapist felt supported, contained, and held.

During that particular period, this psychotherapist saw the patient as very fragile, and felt that they were both fragile. She described that period as "both the patient and I were getting through the difficult time ... we both had our traumas to go through." Without the unfailing consistent support of the supervisor, Therapist 2 did not feel that she could truly be there for the patient.

The consultant played a key role for some of the psychotherapists. The consultant assisted the psychotherapist by providing a holding environment, while acting as a container for psychotherapist as well. This was particularly helpful for Therapist 1.

Therapist 1's relationship with a consultant was critical in sustaining and maintaining treatment with the patient she presented. As mentioned earlier, this psychotherapist was not certain whether she would take on the treatment of this patient. She often felt overwhelmed the first few times she saw the patient, because of the severity of the physical, emotional and sexual abuse that the patient had experienced, and that the patient was "telling me all these wild things." She saw the patient for three or four sessions prior to deciding whether she would continue. She made use of a consultant, whom she felt assisted her in deciding whether to

continue to treat the patient. The decision to take on this patient would mean "...a commitment to help her to get better. My consultant was very much interrelated in the treatment of the patient."

Therapist 1 was very aware of her own personal dynamics that were stirred up and would continue to be intertwined in the treatment with her patient. However, she recalled that when she "fell into her consultant's office, all of a sudden the precocious little [therapist] was fine." Through ongoing consultation, she was able to continue in the very successful treatment of the patient.

Conversely, another psychotherapist, Therapist 4, shared that while she was preparing to have supervision on her particular patient, she encountered a differing view from her supervisor. When she presented the case to her supervisor, the supervisor felt "...the patient would be a handful and very difficult, and that she would anticipate things getting very difficult with the patient in very long treatments." The psychotherapist felt differently. She disagreed with "his gloom and doom forecast." The psychotherapist felt that "...she [patient] had started the session upbeat and the patient felt connected, they both felt connected." Therapist 4 had mostly positive feelings about the relationship with her patient and about their work. She expressed further:

> Well, I kind of thought that he was overreacting to the symptomatology. I can remember my response to what he was saying. Somehow what my gut was saying...yes, it was not going to be easy, but I

> wanted to try it if it can be done. I didn't really feel discouraged about it. I realized that there was a possibility that she would go to once a week and really opt to stay with once a week, but still felt there was a lot we could do at once a week visits. He wasn't really judgmental about that. We both had the same idea that it had to be dictated by the patient as to what she could tolerate. He wasn't really discouraging...he was a little bit discouraging.

Therapist 4 felt strongly that she wasn't going to let the patient go without the help even if she were to drop the session frequency to once per week. Therapist 4 was not going to let the patient go, but would continue with her "...in the manner to which she could tolerate the uncovering of childhood material, and the manner in which she could be held."

Category #2: Maintaining Hope in the Face of the Intolerable

This category refers to the psychotherapist's ability to affectively resonate with and to tolerate the patient's intolerable emotional pain with a degree of openness, optimism and hope. This is an important precursor to the development of the holding environment, discussed under Category 3, for the patient, and is relevant to the container/contained concept.

A significant finding was that Therapists 1, 2, 3, 4, 5, and 6 presented cases with histories of severe and massive physical and sexual abuse. The psychotherapists themselves were so profoundly moved by the depth of the abuse and its

corresponding emotional aftermath that they were then compelled, and committed to help their clients, in a manner that enabled the psychotherapists to tolerate their patients' intense and profound sense of shame, guilt, and remorse. The psychotherapists then were able to maintain a sense of hope for their patients, in being able to withstand and contain their pain.

Therapist 6 felt that in the case that he presented it was critical for him to maintain a degree of optimism when his client had none. That "...it is important to keep on trying [for his client], to continue to find the strengths. That is to use the blend of things that he knows about life and people and just to keep on trying up to a point as a therapist." It was important to this psychotherapist to "retain a certain kind of optimism, even in the face of what seems like frustrating obstacles that will never go away." In this way he was able to withstand his patient's sense of intolerable emotional pain - an important precursor to preserving an intersubjective environment of hope.

Therapist 2 felt that she needed to just be able to withstand the barrage of attacks from her client. Although it was at times very difficult to tolerate the attacks, she believed that it was what this particular patient needed. Although she didn't always clearly understand the meaning of the attacks, she opted to stay with it as follows:

> She just needed me to kind of tolerate her pain and confusion...I just let it be...I was totally confused...I just sort of sat there, which I think was very empathic of me. I contained it, and felt calm in my ability to wait and see what might come of it.

Therapist 2 continued further in describing the depth of the patient's profound pain:

> But in the beginning...there was a period when she was very depressed...I did not say that much. And it felt to me like she just needed for us to be there together...and have me tolerate it...I'm not quite sure what it depends on. Sometimes I just follow my intuition. I really felt like I was walking a fine line between, letting her know I was there and remaining hopeful about her but not wanting to intrude...in this, her need to feel her feelings...I needed help with that to make sure that I wasn't going over particularly on the side of not saying enough to her.

Therapist 7 shared her own acknowledgement of her patient's pain. She presented a case of a mother and father who lost their young son. The father of the dead 20 year old son had been unable to work through his profound grief five years since the death of his son. Therapist 7 felt that he really had an inability to acknowledge the boy's death as it was related to feelings about himself and his own inadequacy. She felt that it was really related to the intensity of this patient's despair about himself, and his own inadequacy, or failure as a father to have saved his son.

This psychotherapist stayed with the pain, even though at times it was unclear as to the meaning of the patient's holding on to his grief; she was then able to facilitate the

client's awareness of his underlying feelings. He described his feelings, "...like I"m standing on the edge of a cliff, holding on with both hands to my son, and that if I let go emotionally in any way, the boy will disappear forever." During this piece of interaction in the treatment, the patient surprised himself with the intensity of his fear to let go.

This psychotherapist was able to facilitate the patient's uncovering of his feelings, and was able to tolerate the intense emotional affect that uncovering produced. She described the couple's formidable grief, as well as her own grief reaction in the following:

> The pain of these people is so big you can touch it. It is so big it fills the room...and a couple of times my eyes have filled up with tears, and I have not worried about that...how could I not be responsive to that? My feeling was that I should not try too hard to close myself off from my own identification. If there is a particular intensity which there have been a couple of times, that's real...it's a real response, and I think they have appreciated that. It would cost a lot to maintain a neutral position in a situation like this one.

Therapist 8 felt strongly that as a psychotherapist she is in the service of her patients "...to provide hope." She felt that it is done either by "...providing it, or by extending oneself to those patients that don't feel the hope." This then eventually allows for the patient "...to take that function over for himself." She explained that "...maintaining the hope is through allowing the patient to

really feel," but it is not just limited to feelings and emotions. That is, to actually be able "...to experience the therapist's caring and hope."

However, Therapist 8 also believed that it was equally as important for the psychotherapist to experience the hope as well as the patient. That is, "...to really let another feel, and not just feel, but experience you, and the therapist, me, I experience myself knowing that."

This hope is manifested through "...the connection in the relationship." For Therapist 8, "...the match between patient and therapist must be established, or there is no connection. Without the connection there is no hope."

She continued further, "It is the true love of another human being, without envy, and I think it only comes from one's life experience." Therapist 8 quoted from a psychotherapist whom she respected highly, Robin Robert, as follows:

THE HEART AND THE SOUL

To know another.

It is to know another and find
hope for them, even when they
can't.

Until they can take over that
function, if at all possible,
themselves.

Therapist 8 felt that this poem was truly the real art and the science of psychotherapy. She asked, "Without that why are we doing this?"

Category #3: Support of the Holding Environment

This category refers to the psychotherapist's ability to facilitate a holding environment, through the ability to be affectively resonant and to tolerate the patient's intolerable emotional pain. This holding environment helped to maintain hope for the psychotherapist as well as the patient. What facilitates the holding environment is the psychotherapist's degree of openness, optimism, and subsequent hope. In addition, to the holding environment the psychotherapists also seemed to provide the container/contained function for the patient.

Therapists 1, 2, 5, 6, and 7 all seemed to employ and interweave the concept of the holding environment in the work with the clients whose cases they presented during the interview. The holding and containing function of the psychotherapist was a necessary experience that their patients required in the treatment.

Therapist 5 expressed her firm belief that "the foundation of treatment rests on the relationship." She explained, "the relationship should convey to the patient at all times I care about you, you are important to me, and your life is important to me."

For this psychotherapist, "the relationship is the mortar." She utilized the analogy of building a wall. She explained that if one is building a wall one needs the bricks and the mortar. "The foundation for the treatment is based on the relationship. If the relationship, or the mortar is missing, then you are building a wall in mud."

She explained further that the building of the therapeutic relationship requires the building of trust and safety through nonjudgemental acceptance. What she meant by this is "...the usual empathic kinds of things that we all hopefully do as therapists. And only after that, you very gradually can begin interpretations. So you know we build that holding environment."

Therapist 5 illustrated the building of the holding relationship with the patient she presented, by visiting that patient on a daily basis. This patient was in a psychiatric hospital for the first time, following a major trauma of abuse in a current relationship. This abuse seemed to be a reenactment of an earlier trauma related to her father. Treatment continued beyond hospitalization, in the psychotherapist's office on an out-patient basis. Therapist 5 reaffirmed her belief:

> It just had to be that holding, soothing, kind of an environment where she could come in and where she could feel safe, and talk about her feelings and the terrors that she had experienced, and there was no interpretation whatsoever. It had to come at a later time.

Therapist 1 shared her experience of creating a kind of holding environment that facilitated the maintenance of hope for her patient.

> R. was really sinking into despair, and I was catching it quicker. We were both sinking into despair at the whole situation...what she was, what she had lived through and was still living it...it was at that moment that I realized that, she needed something, I needed something to help us, to pick us up and sort of re-energize us, give us hope, and that's when it was that I became aware that as I use the metaphor of Dorothy's ruby slippers.

While the metaphor of the ruby slippers symbolized hope for the patient, concomitantly, it also supplied needed hope and reenergizing that Therapist 1 needed. This seemed to aid the psychotherapist in continuing with this very difficult case.

Therapist 2 shared her reflections on the sometimes challenging task of maintaining hope with her patient, who was being seen four times per week on the couch. She described often having to balance letting the patient know she was "...supportive and available," as well as "...remaining hopeful about her, but not wanting to intrude on her need for her feelings and experience." She expressed that it was "a delicate balance," and as the therapist she had to "keep it up." This was a particular challenge for Therapist 2, as she wanted to be certain that she wasn't being unresponsive to the patient, that is, by not verbalizing, or responding

optimally. Therapist 2 described this patient as someone who "...felt like she just needed for us to be there together, to have her feel that way, and have me tolerate it."

Therapist 2 said that for this particular patient, "...at times there is little direct interpretative work that can be tolerated." There are periods when the "...interpretative work is experienced by the patient with overwhelming humiliation and subsequent fear" that the psychotherapist will abandon or reject her. "The patient could not tolerate too much of that type of intervention."

Therapist 2 said that often the most important and significant part of the session for the patient was knowing that the psychotherapist was there for her, "...she lies down and we're here together....she just wants to lie there and be like a little kid, and have me read her a story. She doesn't want to work on anything, she wants to just sort of be here."

Through these examples, the psychotherapists illustrated their enactment and provision of a holding environment, through which they would attend to the needs of their particular patient at that particular point in the therapy. They felt that this stance was particularly responsive to their patient. The data indicates that the provision of a holding environment maintained a sense of hope for the patient, which in turn facilitated the therapeutic work. This dramatically illustrates the interactive quality of hope and

holding - both complexly interwoven variables which were precursors to the psychotherapist's ability to be optimally responsive.

Category #4: The Psychotherapist's Commitment and Primary Responsibility to the Patient

Therapists 1, 2, 5, 6, 7, and 8 expressed a profound commitment to the patients they presented. Their descriptions of their actions seemed reflective of their commitment, and their interventions were enacted with the best interests of the patient in mind. This was illustrated through their sense of caring, loving, and loyalty to the patient. This commitment is described in the following examples.

Therapist 1 shared that she had initially felt overwhelmed due to the severity of her patient's emotional trauma, physical, and sexual abuse. However, once she had decided to continue to treat the patient she was very committed. She confirmed this strong determination: "...that if I continued to see her she was going to get better...I think that inner resolve inside of me at least it always had to a certain extent, somehow put that extra whatever, whatever it is, if there is an artistry, I guess in therapy, that's when something like this happens. I knew, I just knew I wasn't going to let her go down so low, or let that happen."

Therapist 1 shared her belief that this commitment was akin to the obligation of a parent to a child. The adult makes the decision that "you are not going to let the child do

something that's bad for them." This psychotherapist felt that this was the necessary commitment and primary responsibility which she had for her client. Most importantly she believed that this stance was "in the best interests of the patient." She was, "...taking things into my own hands." Most importantly, she remarked, "You have to care with all your heart and soul."

Therapist 6 shared his views about his commitment and primary responsibility to the patient. He described the need to proceed as a social worker in a way that is in the best interests of the client; this may often mean "...risking oneself and possibly making a mistake, but that "...if one gets involved in the life of a client, then one will take risks." Therapist 6 asked himself, "What's my first responsibility? I am a social worker. The first responsibility is to try to help this client and not cover my ass."

Therapist 6 believed that it is "...necessary to be open and fluid to the process of psychotherapy and always with the best interest of the client as the guide." This psychotherapist felt that it was necessary "...to maintain a balance between being supportive and also providing the necessary challenge to growth." He elaborated further, "...if there is no support, there is no client, and if there is no challenge, there is not growth."

For this psychotherapist, the sense of commitment and primary responsibility to the patient provided a kind of maintenance of hope for the patient, as well as for the psychotherapist. This is reflected in the following statement, "Trying up to a point...to maintain a kind of optimism...even in the face of frustrating obstacles that will never go away."

THEME V: THE MOVE BEYOND CUSTOMARY PARAMETERS IN A MANNER WHICH WAS OPTIMALLY RESPONSIVE

Within this theme, the psychotherapist is moved to go beyond customary parameters, despite the fact that such a move may conflict with the professional community. The psychotherapists valued a professional stance of responding to the patient in a manner that was truly in the patient's best interest. Within this theme, the psychotherapists grappled with attending to the subjective experience and needs of the patient, while discerning their own subjective experience in a disciplined manner. Moreover, the psychotherapists reported the necessity of risking their colleagues' support as they proceeded to treat the patient in a fashion that they felt was optimally responsive.

Category #1: A Disciplined Responsible Fashion

Although they were convinced that their stance of interventions were optimally responsive, all of the informants cautioned that optimal responsiveness should not involve "wild

analysis." A firm belief among the psychotherapists was that one must respond to the patient in a manner that truly fits the subjective experience of the patient, rather than gratifying some experimental need of the psychotherapist. This, the psychotherapists universally felt required a disciplined and responsible approach to their interventions.

Therapist 6 believed that utilizing an intersubjective approach that is truly optimally responsive personally meant "to be human." This included being very disciplined as a psychotherapist. He believed that there are certain guidelines such as "...being ethical and maintaining a professional stance that is in the best interest of the patient." However, it also meant to Therapist 6 "...to be able to risk" with therapeutic interventions, rather than relying only on what theory professes in terms of technique. This was illustrated in the case that he presented. He felt that if he had relied only on "...what the textbooks recommended" he would have missed an optimal "...opportunity with his patient." That is, he would have missed an opportunity that allowed for mutually experienced understanding and insight between patient and psychotherapist. Therapist 6 felt that he must risk at times with interventions, explore them, reflect upon his subjective feelings, and proceed if appropriate. He felt that he needed to distinguish "...how best to meet the patient's needs, and to make sure that if it's just a matter of meeting my own

need, as some therapists do when they disclose or tell stories - then I do nothing - I just let the thought pass over me. It's called discipline. Then if I find something useful in that, that I can use, something useful that is going to help the client, I tend to listen to it and don't let it just pass over me. It's hard for me to describe."

As part of the "disciplined approach" Therapist 1 felt that in order to be truly in the service of the patient, the psychotherapist must be very focused on the patient. That is, "to put everything else out of your mind. When you close the door and it is time for the session, you know, put yourself in the place of the patient or whatever. But, regardless of, and no matter what's going on...there's no way you can allow any intrusive thoughts coming in, unless you analyze them, and realize what's going on. I don't know if this is really spelled out enough in therapists' training..."

Therapist 8 seemed to validate this view by emphasizing the necessity of psychotherapists to maintain the connection with clients in a very disciplined manner. She elaborated that it is the psychotherapist's skill that maintains the connection with patients, and to try to find out what might have contributed to a lost connection. She felt it is the psychotherapist's skill, as well as the desire, to explore and uncover the reasons for a missed or lost connection with

the patient. She expressed emphatically, "If you aren't really there with your patient every second, you're not going to figure that out...fast enough to hold on to the patient."

Therapist 7 shared her views on the importance of being disciplined with patients. She conveyed her experience in her role as a psychotherapist, as a teacher to social work students, and as a clinical consultant. She maintained a stance she described as a "disciplined use of self." She believed this was a necessary, but complex concept to describe. She explained that it is often "...just too easy to identify and not be able to use it effectively." For Therapist 7 this was "...not attunement." It is not, "Oh, I can identify and get in there with them. It has a discipline to it."

She shared her belief that many psychotherapists do have a natural talent that contributes to their being attuned and intuitive to their patients. But, in addition to their natural talent, she felt strongly that it must be blended with discipline, knowledge, and skills.

Overall, Therapists 1, 2, 3, 5, 6, 7, and 8 all conveyed the importance of maintaining a "disciplined approach" to their patients. Therapists 1, 2, and 7 also verbalized the importance of being open to a kind of "free-floating process." This "free-floating process" can best be described as akin to Freud's (1912) concept of the analyst's maintenance of "evenly hovering attention," as well as Stolorow, Atwood, and

Brandchaft's (1987) recommendation that the psychotherapist's analytic stance take the form of "sustained empathic inquiry."

These psychotherapists maintained that a therapeutic stance of general openness combined with discipline was optimal. The importance of staying where the client is at, and responding in a manner that is in the "best interests of the client," and not the psychotherapist, was emphasized. The psychotherapists interviewed identified a sense of heightened self-awareness, openness to self-reflection, analysis of countertransference, use of clinical consultation, and personal psychotherapy/psychoanalysis as assisting them to maintain a disciplined approach. This disciplined approach, for these psychotherapists, contributed to their being optimally responsive to their clients.

Category #2: To Risk, Regardless of the Psychotherapist's Need for Support and Safety

The psychotherapists reported a strong willingness to risk, and to pursue interventions that they believed were optimally responsive to their patients. In several situations, Therapists 1, 4, and 5 - despite their colleagues' differing views - proceeded with interventions which they believed would differ from those of more traditional psychoanalytic parameters.

Therapist 8 felt that it takes a great deal of "...courage to be a real therapist." That is, to be one who is willing "...to be genuine, and to have the courage to allow oneself to risk being the kind of therapist that can allow the patient to experience the hope." She shared that at times it was difficult to share her innermost beliefs and perspectives with her colleagues, because she feared their criticisms when they did not share her views. She shared that it is often "...frightening to risk one's colleagues' criticism." By this she meant that the professional community often held opposing views on psychotherapists' interventions and responses. Traditional psychoanalytic views make it very difficult to be genuinely open, self-disclosing, and candid in making interventions with patients that truly work and result in positive changes within the patient.

Therapist 8 emphasized that she "...doesn't follow the rules for rules' sake." That is, she will not be bound by what the textbook, prevailing and/or traditional professional community views are regarding treatment. Instead, she utilizes an approach that she refers to as "intersubjective," that allows for the relationship and the connection to determine her response to the client. Concomitantly, she expressed that "...if one breaks the rules, one had better be ready to take the risks involved in breaking the rules." One

must be ready to handle the response from the patient, and "...to go the line...right to the line," where the patient needs the psychotherapist to go.

Additionally, Therapist 8 felt strongly that her patients must "...flourish and improve." The fact that the patient improves is confirming and validating. This validation is reaffirming for Therapist 8 to continue to treat and regard clients in the manner and framework that she believes is truly optimally responsive.

Therapist 1 shared many personal responses that arose through her work with the client she presented. She found herself offering provision, and gratifying a need for the patient (i.e. offering the patient something to eat - cookies and milk, tea, giving of symbolic gifts) actions that she would not ordinarily discuss in a professional group. These provisions and gratifications were offered with an attunement to the patient's subjective experience and objective (i.e. physical exhaustion and hunger) state of being. The psychotherapist's response of a provision was also an attunement to the intersubjective state of being of both patient and psychotherapist.

Despite this approach she was concerned about the criticism, judgment, and negative reactions received from her colleagues. Significantly however, despite apparent disagreement from some of her colleagues, Therapist 1 proceeded in providing for her client, and in responding in

a manner that she felt was optimally responsive. She did not adhere to the prevailing views of standard psychoanalytically oriented practice. Instead, she stood firm in her belief, and acted in a manner that was congruent with her beliefs. This, she believed, was truly "...healing and beneficial for the client." The concept of "what is in the best interest of the client" allowed her to proceed on the path that she believed was optimal. Therapist 1 explained, "I can share all this with you, but I wouldn't in a large professional group."

Therapist 4 shared an example of major differences of opinion with her supervisor, at the psychoanalytic institute where she was pursuing advanced training. Despite that fact that the supervisor felt that her patient "...would be very difficult to treat in long-term therapy," Therapist 4 went ahead and continued treatment with the patient. She did not allow her supervisor's discouraging comments and parameters to sway her from her belief in and commitment to the work with the patient.

Therapist 5 shared an experience she had in a clinical consultation group, that required her to make a major decision whether to continue with the group after she had disclosed an intervention which another group member challenged. She shared the following scenario from the consultation group:

> In this small consultation group I was presenting a case and I said it was very relevant that this patient had come into therapy. I was waiting for her to tell me something, which she absolutely somehow was avoiding. I finally asked her, which was the appropriate thing to do. And one of the persons in my small consultation group said to me, "You did what? You asked her a question?" So I said you mean you wouldn't have asked her? You'd let her sit like an elephant in the room and not respond to that? She answered, of course. This other therapist comes from a very traditional, classical analysis. She is very bright, mature, and very rigid, and would never be able to be responsive in the way that I and others would respond. Also, the supervising analyst heard the discussion and did not in any way intervene.

This experience posed serious concerns for this psychotherapist. She "...no longer felt safe to be in that group. I realized that I could no longer develop or grow within that group." She experienced this group as not being able to meet her needs; the group's approach was incongruent with the way she believed that a group should help her to feel safe enough to risk and grow as a psychotherapist. "So I called and informed the group leader that I would no longer be able to continue in the group. It's a matter of being safe, not judged, and not criticized."

Therapist 6 shared his views about the application of theories in practice. Although Therapist 6 had been a professor for many years, as well as a clinician, he felt strongly that theories need only be used as guides, not as absolute dogma. For Therapist 6, "...you just have to maintain a openness and use theories within reason." He felt that knowing the theories was helpful, but that it was more

important to use his gut feelings, coupled with years of experience, supervision, and learning, as the real determinants to his response to his clients. Although "...a supervisor would probably disagree..." with the interventions he made with the patient he presented, Therapist 6 felt affirmed that his responsivity to his patient was optimal. He felt affirmed that through risking and "breaking the rules" of theories, that he was able to facilitate an exceptional intimacy in the therapeutic relationship, that would have been missed if he had followed the textbooks.

The next section is a presentation of the data analysis relative to Research Question #2: How Does the Psychotherapist Know He or She Has Been Optimally Responsive? An analysis of the data yielded three themes, and five categories within those themes. Table 4 summarizes these findings. The themes and related categories are the effects and results that confirmed for the psychotherapists in this study that they had been optimally responsive.

As noted earlier in this chapter, the themes and categories listed are not intended to imply that there is a discrete order of effects or results. Rather, the themes outlined are reflective of core issues reappearing throughout the interviews. The categories are the specific components mentioned by one or more psychotherapist that comprise a portion of the major theme. The following is a compilation of

the psychotherapists' observations that indicated how they understand that they have been optimally responsive with the patient they presented during their interviews.

TABLE 4

Research Question #2: How Does the Psychotherapist Know He or She Has Been Optimally Responsive?

THEME I: APPARENT SHIFTS IN PATIENT'S AFFECT

Category #1: A Reduction in Anxiety
Category #2: An Increased Sense of Vitality/Well Being Emanating From the Patient Due to the Decrease in Anxiety

THEME II: EXTERNAL OBSERVABLE SIGNS

THEME III: ACCESS TO AND DEVELOPMENT OF NEW MATERIAL

Category #1: New and/or Improved Behaviors
Category #2: There is Increased Self-Disclosure of New Material Evoked From Within the Patient
Category #3: A Powerful Exceptional Intimacy in the Relationship

THEME I: APPARENT SHIFTS IN PATIENT'S AFFECT, was manifested in two categories of psychotherapists' observations, as follows:

Category #1: A Reduction of Anxiety

In this category a reduction of anxiety was reported by Therapists 1, 2, 3, 4, 6, 7, and 9. Through the psychotherapist's attunement to the patient's affect, what unfolded was a shift in the patient's anxiety. Oftentimes there was mutual relief associated with the reduction of the patient's anxiety.

This category will be understood utilizing Stern's (1985) view on affect and attunement. Stern (1985) posited that "Tracking and attuning with vitality affects permit one human to be with another in the sense of sharing likely inner experiences on an almost continuous basis" (p. 157). Stern explained further, "This is exactly our experience of feeling-connectedness, of being in attunement with another. It feels like an unbroken line. It seeks out the activation contour that is momentarily going on in any and every behavior and uses that contour to keep the thread of communion unbroken" (p. 157).

The psychotherapists in this study seemed to utilize this approach in responding to their patients. That is, "tracking and attuning" and to "being with" their patient. The psychotherapists felt that their response were optimal when they facilitated a decrease of anxiety. Interestingly, the psychotherapist's as well as the patient's anxiety was relieved. This is illustrated in the following examples.

Therapist 1 shared that her attunement to her patient's depression in the form of "...flat affect and emotional paralysis," was lifted when the psychotherapist offered a provision of a pair of tiny ruby slippers. Therapist 1 "...just knew" that the ruby slippers were exactly what the patient needed. The symbolic meaning of "...the slippers meant to this patient inner strength and hope." This contributed to a reduction of "...affect of depression, fear

and anxiety" and mutual relief for both patient and therapist. This was believed to be significant for Therapist 1, because she observed that "...there was a lifting [of anxiety]...[and] it was a relief to both of us."

Therapist 3 conveyed that the patient experienced a sense of relief as a result of her asking the patient to sit up rather than lie on the couch. She described a change in the patient's affect as the hour ended. "There was just more spontaneity after she sat up...definitely more affect. There seemed to be less fear." She felt that the patient was then emotionally able to "...tolerate a bigger variety of affect."

This psychotherapist had previously identified her own subjective feeling of terror, that prompted her to ask the patient if she would like to sit up. The psychotherapist's own terror, as well as the patient's terror, was relieved. The patient "...experienced it as my telling her she was getting better...now I never said this but she saw it as progress." That somehow she felt "...it was a progression in the analysis...she saw this as real progress for herself and felt very good about it."

Therapist 7 felt that "...if there is a connection with a patient and the therapist is attuned to that, there results a regulating effect - an affect regulating effect - and the person's affect will change." Moreover, according to this psychotherapist, "...it is in the tone, pitch, [and] the manner in which the feeling is conveyed to the patient." She

felt that it is the psychotherapist's "...attunement that effects the patient's affect." She applied this to her patient. As she became increasingly attuned to "...his not letting go of his dead son," and by conveying this to him, this moved him from tears into a deeper grief reaction.

Through the psychotherapist's attunement to the patient's intersubjective state, the patient experienced the depth and meaning of his loss, and finally felt his pain was being profoundly understood. Although still in emotional pain, there was a shift that took place. That is, there was a sense of relief and reduction in anxiety.

This was also conveyed in an interaction observed by Therapist 2. After an intense episode, the patient was fearing rejection and "...throw[ing] in the towel" by the psychotherapist. The patient was fearful that the psychotherapist was "giving up hope" on the patient. As this explanation was given to the patient, and was understood, Therapist 2 observed that the end result was that the patient sighed. The patient's anxiety was relieved through the explanation and empathic understanding of the psychotherapist. "...she sighed which always is a confirmation for me...I think she was quiet for a minute or two. And things were just calm, it just sort of felt like you know there was this baby having a tantrum. And she just calmed down."

Category #2: An Increased Sense of Vitality/Well-Being Emanating From the Patient Due to the Decrease of Anxiety

Therapists 1, 2, 3, 4, 5, and 6 observed an increased sense of vitality and overall well being among their respective patients. Vitality and well being in this context is viewed as a restoration of "...optimal cohesion, vigor, and harmony" (Wolf, 1988. p. 44). Lichtenberg (1992) expanded further, "Therapists influence the vitality present in any categoric affect, pleasurable or dystonic, as well as the therapeutic ambience as a whole...developmentally, the core feature of the experience lies in the attunement of caregivers to the infant's motivational needs and the vitality of the intimacy this affords". The dimensions of vitality affects are inextricably involved with all of the essential processes of life (Lichtenberg, 1992; Stern, 1985). The attunement of caregivers to the infant's motivational needs is applicable in this study; that is, it is analogous to the psychotherapists' attunement with their patients.

A dimension contained within this category was the mutual joy and pleasure that was experienced between the patient and the psychotherapist (Therapists 1, 3, 4, and 5). There were outward expressions of pride, joy, clapping, excitement, respect, pleasure, admiration, approval felt and experienced by the psychotherapist and conveyed to the patient (Therapist 1, 4, 5, 6, 7, 8 and 9).

The findings for this category are explained and understood within this framework. Vitality affects will be expanded upon further in Chapter V.

An example of this was evident in the interaction between Therapist 4 and her patient. Therapist 4 observed that her patient was "...particularly cheerful, starting the session talking about very positive things in which she was pleased about, sort of excited about little things." She continued to discuss a very important meeting she had with a Worker's Compensation psychologist. She reported that the meeting was very positive, "...overall the patient felt good about the meeting." At this point Therapist 4 sensed and was attuned to the patients affect state, and verbally responded, "I think that you are happy to see me today." The patient's positive and pleased response was, "How did you know?"

The psychotherapist shared that "...seeing the patient's facial expression gave me a clue." Tuning in to the patient's affective and subjective experience facilitated this psychotherapist to enact her optimal response - the verbalization of attunement - via the therapist's comment, "I think you are happy to see me today."

"After that point...," the patient started to "...generalize about her anxiety regarding the appointment with the psychologist." She experienced the familiar anxiety and worry about being "...assaulted verbally or being

misunderstood." In other words, "...the patient was anticipating the reenactment of childhood traumatic scenes from authoritative figures," in addition to "...traumatic abandonments and misunderstandings."

The patient made the connection of her earlier childhood traumas and associated them with the anticipated trauma of the meeting. However, the fact that the meeting was successful was in many ways a working-through of the earlier pain of previous traumas. The patient was "...proud, relieved, and her anxiety was lifted." She felt a sense of "...competency that she was able to handle the meeting" in a very forthright and assertive manner, despite her tremendous anticipation of abuse, and the concomitant anxiety.

This psychotherapist's ability to be exquisitely attuned to the patient's experience and affect facilitated a decrease in anxiety, and "...there was a marked increased overall sense of vitality and aliveness within her..."

Another example is cited with Therapist 5. After a series of sessions focusing on her patient's difficulty dealing with a work associate, this psychotherapist provided a holding, soothing, environment for her patient. Rather than an interpretation, this stance provided a therapeutic ambience within which this patient could then have access to greater understanding of the antecedents that contributed to the difficulties she was experiencing in relation to this work associate.

Therapist 5 described observations of her patient, who "...literally bounced in, radiant, full of energy and vitality, pleasure and excitement, just glowing. Life is good...she was alive, there was vitality and there was juice...There was oooh...we knew it!" This description of the patient occurred after a series of sessions in which the patient worked through significant issues that were interfering with her feelings of self-esteem and vitality.

THEME II- EXTERNAL OBSERVABLE SIGNS

There were significant external signs reflective of a shift in the treatment. The external signs occurred at turning points, special moments in the therapy encounter, as well as at other phases in the treatment process. The external observable signs were manifested in a variety of forms (i. e. tears; physical manifestations such as shifts in posture; facial expressions reflective of a change in affect - smiles, reddened faces, an evident expression in the patient's eyes; and overall visible shifts reflecting calmness, soothing, relaxation). The following are examples from the data that describe this theme.

Therapist 7 shared significant external observations of her patient. The father of the young boy who died had difficulty "letting go" of his son. Apparently, people around him would all tell him that he had to "let go of his son" in order to go forward. Therapist 7 shared that she had to

"...tune in to his mood, his posture, his affect, and the meaning of the letting go." At a particular point in the session Therapist 7 offered an explanation to her patient, "...that if he let go of his son that in a sense it would be like he never had him, and that is why he can't let go." At this point, Therapist 7 observed that "...his posture changed, his face got red, he got teary, which were all signs that I touched something in what I said." These external observations verified for the psychotherapist that she was attuned to the symbolic meaning and subjective experience of this patient.

Therapist 2 shared that she had focused on her patient's fears of being regarded as "a hopeless case" by the psychotherapist. As described in the findings for Research Question #1, this patient was terrified that the psychotherapist would throw her out of therapy because she had missed her previous appointment. This psychotherapist's evolving internal dialogue enabled her to understand the patient's initial barrage of attacking as a way for this patient to verify her utter dread of whether the psychotherapist would agree "that she is hopeless and that she is worthless." The patient expressed fear that Therapist 2 would "...throw in the towel." After that interaction, Therapist 2 observed that the patient, "...sighed which is always a confirmation for me...the sigh was confirming that I was right on with her..." Therapist 2 described the effect

of this interaction, as "it just sort of felt like...this baby having a tantrum. And she just calmed down." For Therapist 2 the external observable sign which signaled a shift in the patient's affect was an overall outward calming and soothing of the patient who just quieted down.

Therapist 8 discussed an optimally responsive interaction that resulted in an external observable sign of tears. She shared that she was able to be affectively attuned to her patient's sense of hopelessness and emotional pain. It was described as though "...she would never get the sense of love from her husband." This was reminiscent of the patient's early family experience with her parents. Therapist 8 verbally responded by sharing her perceptions of the patient's dilemma. The patient's response was that "...she looked at me and she got tears in her eyes, and she was able to then speak about her fears." Therapist 8 felt she had "...hit home because the tears began and she began to express her wishes."

Therapist 1 shared her observations of external signs that verified that she had been on target, and optimally responsive with her patient. She described that initially the patient presented with "...dull affect, and with a dull intonation in her voice." Through the therapist's optimal provision of the ruby slippers, which "...symbolized hope and home," there were significant observable signs that signaled a shift in the patient's affect. Therapist 1 reported that

she could see "...the shining in her eyes...her chin lifted up...it was fresh air in every fiber of her body." She continued further and described "...she was like a paralyzed little girl, it was like a little robot...then this woman sat up, a strain up-lifted [from] her face...there began to be some expression in her eyes."

THEME III: "ACCESS TO AND DEVELOPMENT OF NEW MATERIAL", had three aspects, as follows:

Category #1: New and/or Improved Behaviors:

In this category, the psychotherapists reported that their patients shared experiences of new understanding and insight. Subsequently, the psychotherapists observed that their patients had a different approach to familiar situations. This was reported among Therapists 1, 3, 4, 5, 6, and 8.

Therapist 5 shared a vivid example of how her patient applied new understanding and insight via new behaviors. This was a session that was particularly significant, as the patient was able to gain increased insight into her fears. The patient was "...feeling fragmented and a little bit paranoid" regarding a woman at the bank with whom she worked. She felt that this work associate was "...somehow out to get her, and didn't like her, and caused her all kinds of difficulty and unfortunately that woman's desk was right

behind the patient's. She could literally feel that the woman was watching her, judging, and looking over her shoulder." Therapist 5 continued:

> I began to help her to free associate about what that meant and who this woman reminded her of...who this woman really represented to her, and take it back to early childhood, and to realize that it was an aunt that she had never talked about. It was the cruelty and abuse that V. felt from this aunt. That pointing a finger accusingly, and demeaning to V. This aunt had an only daughter, and V. often felt treated like Cinderella (in the ashes), and her cousin like the bad stepsister. V. realized that that was the root of her bad feelings with this woman at work.

Therapist 5 felt that V. was able to take this insight to another step, that is, to associate those early experiences with the difficulties that she was having at work. "This was the 'ah ha' experience of realizing who the woman [associate] represented to her...[it] was a re-creation of an earlier experience."

> What made the session so memorable was that [in] that particular session she learned...really truly learned to be able to do the work for herself without needing me to do it for her. She had internalized enough of the process, that she could now do it for herself. All of a sudden she was now able and knew - that she had now taken on my function - and was now able to do it for herself. This was so very vivid and so clear and time has proved me absolutely right.

Through this increased understanding, her patient was then able to approach the work situation with greater internal strength and less vulnerability. Essentially, here

was a woman who was now able to understand her reactions to her co-worker, and she began to feel differently and subsequently act differently with her.

Therapist 1 reported that her patient began to "...think of herself differently." That is, "...different from the horror, abuse, and terrors that she experienced within her early family life." This was also evident in the patient "...making her advanced degree work for her." The advanced degree was a symbol of her strength and representative of her having a different kind of life. "Showing that she was different, [different from] battering father, and the alcohol. That she was now different...that she lived in a clean apartment, she was clean, as compared to her before." This was a patient who had a severely abusive [physical and sexual] family history. Through the psychotherapist's "intersubjective optimal responsivity" (Bacal, 1992), this patient was able to embark on the process of new understanding and insight into her early traumatic life. Part of that process was evident as the patient began to "...think of herself differently" and approach old situations with greater understanding and new behaviors. This psychotherapist reported that the patient continued to flourish in her professional and personal life.

Therapist 3 shared the following impressions that indicated was a significant turning point in the treatment with her patient. She provided some background information

on an analysis she had with "...a young woman who came in and immediately wanted to [begin analysis] and she thought she would have no trouble doing [analysis]...so for about a year and a half I saw her four times a week, and she was on the couch...I was sitting behind her." Therapist 3 shared, that a great deal of the analysis focused on "...her issues revolve[ing] around an abusive family, intrusiveness, not being understood, longings that seemed that she could never have met."

Therapist 3 recalled, "....there came a point when, it was her dreams, [that was reflective] of searching for a connection." Therapist 3 reflected on their intersubjective state of being and recalled vividly, that there was "...one dream in particular, [and] it was - the way that she looked at me - when she came into the session, when she sat down on the couch and when she left." Therapist 3 reflected on her own subjective experience at that moment, "...it was the terror that I experienced in myself, that made me suggest to her that we try sitting up...and it was very interesting because it was like a turning point, it was really a movement into a new phase of treatment."

Therapist 3 suggested that the patient sit up rather than lie on the couch, "...[because] this was a woman that never really could connect and form a relationship. It was representative of her being able to involve [with] another person... and the eye contact and the interaction gave her

support." Therapist 3 shared that her patient's behavior "...was enacted outside the session in her work, in her relationships, she was able to include another, which she was not able to do before this, and it was somehow, it was just really intuitive in me...that this was the moment it was going to happen."

Therapist 3 continued further :

> I mean we had had things that led up to it, and we, she knows she can lay on the couch any time she wants, but this has really enabled her to develop the capacity for empathy and make space in which to play with things that occur, and it's been very fruitful. I mean those are more dramatic experiences.

In this example Therapist 3 acknowledged that the patient now had the ability to form a significant connection. The psychotherapist's suggestion "to sit up" was experienced by the patient as progress in her treatment. Most significantly, as noted by Therapist 3, "...it was enacted outside the session..." which was a new behavior for this patient.

Category #2: There is Increased Self-Disclosure of New Material Evoked From Within Patient

Within this category, the psychotherapists observed an increase in the patient's self-disclosure of new material. The therapeutic interaction and dialogue seemed to stimulate the patient's sharing of new material.

An example of this was described by Therapist 2. She shared how her patient provided new material in the form of a dream. Therapist 2 felt confirmed in her response to the patient and explanation about the patient's anticipated fear and guilt about missing the sessions. She was attuned to the patient's worry and anxiety, and ultimate fear that the therapist would "...throw her out and give up on her..." This then prompted the patient to disclose dreams in the next session.

Therapist 2 related, "...she reported a dream that she had had this night, the night after the session in which the therapist felt barraged...on a Tuesday night, after the session. She actually had three dreams...but this one seemed to really sort of express what her anxiety had been about, and I felt like [she was] able to come in and talk about it..." Therapist 2 felt that it was significant that the patient brought in the new material in the form of her dreams. Therapist 2 verbally responded to the patient's dream "...so that I was able - we were able - to make sense of it..." Therapist 2 saw her patient as now "...open and sensitive."

The dream that the patient disclosed was about someone who was "...a body snatcher wanting to take her body and take her away and get rid of her...and snatch her body." There were some "...other dreams about being killed, but there was a woman who wanted to help her and gave her a place to hide

out, and saved her basically, because she went back to her apartment the next day and saw the body snatcher had been there and had missed her."

Therapist 2 reported that she responded to the patient's dream by illustrating "...this dilemma of hers of coming in and being worried that I'm gonna be this body snatcher. Sort of take her away, and she can lose herself or she [will] just vanish..." The patient's recurring theme was verbalized, "...things are hopeless, worthless, she is nothing, versus, seeing me and hoping to be able to have me as a helpful person who is going to save her from her despair and her feelings of nothingness inside."

Therapist 2 summarized, "...she confirmed when I said that and she said, it's so hard to come here sometimes, and that you know, to kind of balance out what, what she wants and what she hopes for and what she feels she gets sometimes, versus her fears, [and] dreads about what could happen...so I think that, you know, though she probably was sick those days, there was unconsciously this other battle going on - that we got to - I think through my addressing the phone calls and the dreams, and being open to looking." It was Therapist 2's addressing the patient's phone calls that seemed to prompt this patient to have access to new material and subsequently to disclose the material via her dreams.

Therapist 5 observed marked positive results that indicated that the patient had progressed in treatment, "...all of a sudden she was now able, and [I] knew, that she had now taken on my function, and was now able to do it for herself. This was so very vivid and so clear, and time has proved me absolutely right!" Therapist 5 explained, "She now can come in here and tell me a dream...she could dream about me - but it was not me - it was her mother who was really [who] the dream was about!...that's why I remember it because it was such a significant session."

She summarized how the dream produced new material for the patient. She tells me about a dream, she could interpret the dream herself! She knew what it was about. She knew what it meant. That again I knew she was strengthened and she was empowered. There was that core, that strong person in there where my functions have all been internalized...well not all...but should we say, optimally internalized?! [laughs].

Therapist 9 shared reflections on her work with a 27 year old man, who "...was the head of an agency and had gotten into financial difficulties and was about to be sued by the Board...which created for him a great deal of anxiety." This crisis prompted him to seek treatment.

Therapist 9, through her affect attunement, was able to facilitate the patient's awareness of the antecedents that contributed to his behaviors. He began to make new associations and insights into the previous behaviors that had resulted in a major crisis in his life.

As Therapist 9 maintained an attunement to his subjective state of being, and responded to the patient, "...is this the way you always handle things?...taking all the responsibility, or reassuring other people, when [you have your own] anxiety." This psychotherapist responded to his theme of taking care of everything, and being reassuring to everyone, even in the face of serious problems.

Therapist 9 shared that at this point the patient then associated to new material that was never before recognized or identified. "And he immediately flashed back to his alcoholic mother. In his early childhood, when he was the caretaker, he was the person who would come home, find her [intoxicated] and feel that it was his responsibility to get the house organized and get everything fixed up before father came home, because father would [be extremely upset]. After father left, that pattern continued with the [patient] having to reassure the grandparents. So he was constantly the guy who was supposed to make it all right."

Therapist 9 observed that it was the "...simple question - Is this how you always handle things? - that led [him] to a whole path...[recognition of a] coping style that he had adapted to, adopted. And how that [coping style] got him into trouble in this situation."

Therapist 9 shared that at this point the therapy moved forward, and they further explored the new material evoked from within the patient. By this third session, she felt that "...he was much more with me. Making more eye contact, showing a certain amount of...[increased self-awareness]... And for a therapist that is always rewarding...and that you're on target."

Therapist 4 was attuned to the patient's mood and affect. She was particularly attuned to the patient's "...expression on her face..." She recognized, and then verbalized this to the patient, "I told her that I thought she was happy to see me today..." She continued further, "...and that maybe your having trouble sleeping was almost sort of a mixed thing, like really looking forward to coming, having missed [the appointment] since Wednesday, and having a lot of things to tell me."

Therapist 4 shared how the patient disclosed new and additional material, "...later it seemed after that point she started talking about...or started generalizing from her anxiety on Tuesday...Monday night having trouble sleeping also anticipating the Tuesday appointment...and then she was

generalizing what happens to her when she gets anxious and looking back, she felt that it was, that she got more anxious than she had to, and that she in the anxiety and the worry about possibly, her worry had to do with being assaulted verbally or being misunderstood, it having to be traumatic. She was also anticipating a reenactment of childhood traumatic scenes from authoritative figures."

As Therapist 4 identified and verbalized the patient's emotional state, the patient then associated to new material. The patient was increasingly reflective of her underlying feelings of anxiety and worry. This then assisted the patient to associate to her original trauma, of "...being verbally assaulted and the trauma of being misunderstood." This was new material for the patient, which led her to become increasingly aware of her early childhood feelings of trauma and abuse. That is, the "...anticipating the reenactment of childhood traumatic scenes from authoritative figures...and traumatic abandonments and misunderstandings." This was particularly significant for this patient, as a turning point, in that she had been "...massively, physically, and sexually abused as a child."

Category 3: A Powerful Exceptional Intimacy in the Relationship

In the aforementioned interaction between Therapist 4 and her patient, a powerful exceptional intimacy evolved within the relationship. This was exemplified in the following

description from Therapist 4, who saw the patient's "...eagerness to reestablish her contact with me..." was perceived by the psychotherapist as "...the tie...I want to say reproduce."

This psychotherapist understood the patient's subjective experience of disruptions in relationships as indicative of the depth of that patient's longing for connection and intimacy in a significant relationship. That is, the psychotherapist understood this patient's need to connect via a tie, and reproduce a connected relationship, that she had never before experienced. Therapist 4 felt this was valid in that "...she had some pretty disappointing ties in relationships with her parents." She seemed to understand the profundity of the patient's subjective experience, which contributed to the powerful exceptional intimacy that evolved in the therapeutic relationship. This need was so great that the patient would create disruptions.

Therapist 4 shared pertinent background information regarding her patient, "...she's made a lot with her life, and has had a lot of success and strength. So there was somebody that she was able to identify with and get emotional supplies with as a child. I don't think that it was her parents, but maybe her grandmother...there were a lot of interferences and disruptions with it..." Reflecting upon the relationship, she felt that "...her eagerness and her intent to reestablish the ties [with the psychotherapist] as soon as possible" was

significant and contributed toward the patient's increasing ability to allow for greater trust and safety within the relationship, which brought about this exceptional intimacy. She expanded further, "...she could reproduce that occasional disrupted relationship with the one person that she could sort of count on" - the psychotherapist.

In recounting this part of the session, Therapist 4 felt that the work with this particular client was moved to a deeper, more intense level. The powerful exceptional intimacy that evolved was evident in that she observed the important meaning of this patient's need and "...more obvious experience of her trying to connect..." with Therapist 4, after the initial disruption which took place when the patient canceled the previous appointment. The psychotherapist's attunement to the patient's subjective experience assisted the psychotherapist to further the treatment of patient.

Therapist 4 observed that the patient was very willing to reconnect from the initial disrupted tie of the missed session. That is, the patient was able to risk and trust with the psychotherapist, and allow again for the reconnection. With the reconnection came the evoking of new material and associations for the patient, which contributed to a an exceptional intimacy in the therapeutic relationship.

Therapist 6 shared his work with a woman who was "...prone to psychotic episodes." This is a woman whom Therapist 6 had also seen when she was just a teenager. "She is now however a young woman in her 30's, married, and very much wanting to have a baby." She was in Los Angeles for a brief period of time, visiting family.

He recognized that the patient was "...investing me with this great trust..." Therapist 6 offered her an empathic explanation of the rage which was recreated in the relationship with her husband, with its origin related to rage with her mother. "That when her husband abandoned her, because of his work, and made a certain promise to her about how much time he would spend away from home but for reasons beyond his control, he could not keep the promise...she was reexperiencing, I thought, that same rage..." so similar to the subjective experience with her mother. The patient's response was, "..ahhh, is that what it is. Yes, that makes sense. So, I am angry at my mother, and I never really expressed that, and I am angry at my husband...and I am talking a little about that." Although Therapist 6 was cautious in presenting the empathic explanation to his patient, what resulted was the development of a powerful exceptional intimacy in the relationship.

Therapist 6 shared that he was not absolutely sure whether he should continue further uncovering of material with his client. He was concerned about her limited available

support system if additional material was uncovered. However, the patient was interested in continuing. At this point Therapist 6 engaged her in their mutual task of uncovering her underlying pain, which was manifested through acute psychotic episodes. He continued,

> ...you seem to want me to help you unravel a puzzle. It is as if something is in your head that is not coming together. She said, exactly. So, I said, well, let's try another, provided you tell me exactly how you feel, and if it's upsetting, you tell me, and if it makes you feel relieved, you tell me that, if it doesn't make any sense, you tell me that. She says okay.

Therapist 6 provided additional empathic explanations about her subjective experience and the meaning of her menstrual cramps, "...the [menstrual] cramps are very, very painful, and the self-reproach that accompanies them are even more painful, and you don't process them directly so you displace them on to these bad people outside of - who you really know - and not your enemies, and you start hearing voices and people are making accusations against you."

At this point Therapist 6 awaited her response. She was relieved. This was verified by her appearance of "relaxation, a smile, and tears, you know, a mixture of emotions. A healthy response. So, I felt, insofar as I could, you know...it was a kind of optimal response...I was sort of taking care of her...It was sort of an intense emotional experience...It was quite exciting."

Therapist 6 provided an empathic explanation for his patient. This response helped her to experience an increased sense of understanding and awareness of the feelings behind her behavior. The psychotherapist's optimal response seemed to deepen the exchange, and allowed an exceptional intimacy to unfold. This intimacy seemed to strengthen the patient's ability to take in the new information, as well as experience the concomitant emotional relief.

What occurred in this category was the psychotherapists' observations of an intense therapeutic relationship and the unfolding of an exceptional intimacy between patient and psychotherapist. Therapists 1, 4, 5, 6, 7, 8, and 9 observed that the patient was then better able to discuss further their subjective experiences of traumas, conflicts, fears, and hopes.

CHAPTER V

DISCUSSION AND IMPLICATIONS

Overview of Dissertation

The purpose of this exploratory, qualitative research study was to gather specific data about what subjective conditions the psychotherapist experiences which contribute to effecting optimal responsiveness in the therapeutic encounter.

The selected informants demonstrated an operationalized understanding of the concept of optimal responsiveness, as illustrated through their completion of the Optimal Responsiveness Survey (see Appendix B).

Data from the interviews were analyzed according to Glaser and Strauss' (1967) method of constant comparative analysis. Additionally, procedures for qualitative phenomenological research outlined by Corbin and Strauss (1990), Barritt, Beekman, Bleeker, and Mulderij (1984); Patton (1990) and Polkinghorne (1983) were utilized. Results of this analysis are discussed below in light of the literature regarding the psychotherapist's subjective and intersubjective experiences, and a framework for conceptualizing optimal responsiveness. Theoretical perspectives are described that contribute to an

understanding of optimal responsiveness, starting with Freud and progressing to self psychology and other contemporary theoretical views. Also included are developmental perspectives that illuminate those factors that contribute to the psychotherapist's maintenance of an intersubjective optimally responsive stance (see Chapter II, Review of the Literature).

The two main questions of this study are:

Question #1: What subjective and intersubjective experiences contribute to psychotherapists being optimally responsive?

Question #2: How does the therapist know he or she has been optimally responsive?

PRESENTATION OF FINDINGS

A total of five themes, twelve categories, and two subcategories constitute the findings for research question #1. A total of three themes and five categories constitute the findings for research question #2. They are outlined in Tables 3 and 4 of Chapter IV.

This chapter is a discussion of the findings presented in Chapter IV with respect to these themes. The discussion of the findings will address how the present study has illuminated the research questions, and contributed to an understanding of areas not anticipated prior to the study.

Lastly, this chapter contains a discussion of the problems and limitations of the study, as well as its implications for clinical practice and further research.

Using a format which parallels the presentation of the findings in Chapter IV, the themes and categories discussed and interpreted as they correspond to the research questions.

Review of Findings - Research Question #1

Research Question #1: WHAT SUBJECTIVE AND INTERSUBJECTIVE EXPERIENCES CONTRIBUTES TO PSYCHOTHERAPISTS BEING OPTIMALLY RESPONSIVE?

The data from the informants indicated that there is a progression of ways of thinking and being that allowed the psychotherapists to take a stance towards their patients that contributed to their ability to be optimally responsive with their patients. The Thematic Schema of Optimal Responsiveness (see Diagram I) suggests a means of conceptualizing the overall process and course of experiences that emerged for these psychotherapists - as preconditions - that contributed to their being optimally responsive. However, this schema does not imply that a distinct and sequential order of the themes was requisite for optimal responsiveness to occur. Rather, this schema suggests that what emerged from the findings was a flow of intersubjective experiences that

resulted in a thematic schema. The themes will be discussed in light of this schematic process. This schema is expanded in the Summary portion of this chapter.

THEME I: THE PSYCHOTHERAPIST'S SUBJECTIVE LIFE EXPERIENCES
Category #1: Losses and Mourning

Seven of the nine respondents reported that they experienced a major loss during their lives. This category was pervasive in contributing to psychotherapists' optimal responsiveness. During the interviews it seemed significant that each of the seven psychotherapists' poignantly reflected upon their own losses in relation to the patients they presented. The seven psychotherapists interweaved their own personal losses - grief and mourning - into their responses to their patients. During the interviews with Therapist 5, 6, and 7, each openly mourned the personal loss with tears and concomitant emotional pain. Although the psychotherapists were sensitively in touch with their losses and pain, they did not share this with their particular patients. The identification of loss and mourning experiences seemed to put the psychotherapists on a highly sensitive level of self-awareness, that was integrated into their therapeutic interventions with their particular patients.

The identification, recognition, and emotional awareness of their losses and mourning was seen by the psychotherapists as having contributed to their affect attunement and empathy towards their patient's traumas, and corresponding emotional

pain. There was a mutuality of subjective experience that contributed to their attunement and empathic resonance. That is, the psychotherapist's attunement to his or her own subjective pain, and corresponding resonance to their particular patient's pain, may have contributed significantly to their being optimally responsive.

Simos (1979) reflected on the delicate role of the psychotherapist in dealing with issues related to loss:

> In the course of socialization into the helping professions, we learn that in areas where we are blind to our own problems, we cannot see clearly into those of our patients. Where we hurt, we cannot listen to the hurt of another. Only by having problems and overcoming them, suffering and finding healthy relief from suffering, struggling and finding socially and personally acceptable solutions to our dilemmas, can we hope to help others find healthy solutions to their problems in living.
>
> Thus, the helper must have both knowledge and personal experience in having lived through the cycles from loss to restitution in his own life. This means recognition of the loss, appropriate grieving, and healthy restitution completing the cycle from loss to restorative living. There is a further demand on psychotherapists to recognize and help the patient become aware of loss and grief or the absence of grief as underlying dynamics in some of the problems that come to their attention. Loss cannot be escaped. It is an ongoing and essential part of the human condition. By helping people deal more effectively with loss and grief we can be instrumental in enabling them to move on to more creative living. (p. 8)

Because loss is a universal human experience, this may explain how seven of nine psychotherapists openly shared their sensitivity to their personal loss, its effect upon their subjective life experiences, and the interplay of these

experiences in the treatment of their patients. Although Simos (1979) emphasized the importance of the psychotherapist identifying his or her particular loss and grief experiences, it is also important to add that the psychotherapist's life experience of past and current losses can contribute significantly toward facilitating the psychotherapist's attunement to his or her particular patient. By allowing the subjective experience of loss and subsequent mourning to emerge, the psychotherapists in this study seemed to have an increased sensitivity, attunement, and empathic resonance to their patient's struggles. Consequently, this may have contributed to their being optimally responsive to their particular patients.

Category #2: Current Life-Cycle Issues:

The psychotherapists' awareness of the impact of their phase of life issues as they related to the treatment of their particular patient and of patients in general was significant. During the interviews, the psychotherapists acknowledged that phase of life issues brought about significant differences in their decisions to treat a particular client, in comparison to what they might have done during a previous time in their careers.

Therapist 8 articulated:

> There's a strain on the therapist. That's a choice we make. There are stages, I think in everyone's life as a therapist where there are some people, that I could treat today, or I could have treated

> twelve years ago...that I will not be able to treat in 10 years, because of the necessary connection, the necessary energy...the necessary struggle, which I may not be able to put in.

The psychotherapists reflected on the intense energy and availability that often is required of the psychotherapist. This energy, commitment, and availability was more of a prominent issue at certain times in the psychotherapist's life.

For example, Therapist 1 made use of sessions with a clinical consultant that assisted her in making a decision whether she would take on her client. She was very aware of the strain, commitment and necessary energy that would be needed to help her client to get better. She was reflective of the changes that were occurring in her personal life - having a baby - that would influence her decision whether to take on the client.

Therapist 6 had taken early retirement from a teaching position. At this time in his life he was reflective of his degree of involvement in his practice, and balancing his feelings of "missing his family, his children and grandchildren." At the same time he acknowledged "...the tremendous commitment and pull and [energy] required to help clients." At this time in his life his choices were focused around "...at a deep level I am trying to make some decisions about how active to be in my practice. When should I stop. When should I slow down..."

According to Guy (1987), significant events in the life of the psychotherapist, as well as the corresponding life-cycle issues, affect the therapeutic relationship:

> As the therapist journeys through the life cycle, the developmental changes and challenges associated with adult living will present a variety of issues and concerns which may disrupt the stability and predictability of their life and relationships. Many significant events in the life of the therapist have been shown to have an impact on the practice of psychotherapy. They influence the inner world of the therapist in a manner that frequently becomes apparent to patients during the course of treatment. (p.195)

Guy (1987) also posited that the psychotherapist's personal and professional life are "impacted as he or she passes through the life cycle and eras of adult development...In addition to the developmental issues and concerns common to most individuals, therapists seem to experience several others which are uniquely related to the role of psychotherapist and the practice of psychotherapy." Some of the major life events that impact both the private inner life of the psychotherapist, and his or her professional encounters are: marriage, pregnancy, parenthood, moving to a new location, death of a loved one, personal illness or accident, aging, and retirement may profoundly affect the psychotherapist.

Among the psychotherapists interviewed, some of these major life events were identified. This was one aspect of the psychotherapist's subjective life experience. These life-events, coupled with the psychotherapists current

life-cycle issues, impacted the psychotherapist's interaction with their patients, which sometimes contributed to their being optimally responsive.

A related issue was the kind of choices that the psychotherapists were making at this time in their lives. Their decision about whether to take on a particular client was influenced by their degree of energy, commitment and availability to take on this intense therapeutic relationship. The consideration of the personal life of the psychotherapist was a major influence in the selection of the client, as it impacted the psychotherapist's overall client load.

Category #3: Psychotherapist's Relationship With His or Her Analyst

The psychotherapist's experience as a patient, and the quality of the relationship between the psychotherapist and the analyst, was extremely influential in contributing to the psychotherapist's optimal responsiveness to their particular patient.

As reported by Therapist 3, her experience as a patient prompted her to respond to her own patient in the manner that she did. She was attuned to her own subjective experience of "...what it was like to be on the other side," and the feeling of wanting her analyst "...to do, do something." Her subjective experience as a patient, and the attunement to her own patient's subjective experience, prompted her to "...ask her [patient] to sit up." This response was apparently

optimally responsive to the patient, as the patient saw herself as "...getting better." The patient experienced this suggestion as "...progress in the therapy."

There was unanimous agreement among all nine respondents that the quality of the experience of responsiveness of their own analyst or psychotherapist was absolutely critical in terms of how the psychotherapist would respond to their patients.

For instance, Therapist 1 shared that she had spent years with numerous analysts, but that these were often negative experiences. This validated her feeling that she did not want the treatment with her patient to be a negative experience. Therapist 1's subjective experience as a patient and the quality of the relationship with her analyst as well as her previous negative experiences influenced her commitment and the quality of her relations with her patient, R. In Therapist 1's words, "I've had a lot of experiences with different analysts and psychiatrists personally...and because of those negative experiences, I wasn't going to let my patient not get better."

Therapist 8 added a different dimension to this category. She experienced a negative therapeutic encounter with her analyst. She acknowledged that her analyst had lied, and had given her "...a cock-and-bull story" response. Because of this significant experience, she felt affirmed in her belief that it is critical for psychotherapists to be honest, direct,

authentic, and acknowledge limitations or a mistake with their patient. For Therapist 8, this was absolutely necessary for the affirmation of her subjective experience. This negative experience contributed to her sensitive attunement and response to her patient. This was clearly very critical for Therapist 8, and therefore was a value which she maintained with her clients.

Bacal's (1990) views on the patient's experience of frustration seem applicable to Therapist 8's experience with her analyst:

> ...there is no analyst whose responses are so "optimal" as to preclude the patient's recurrently experiencing frustrating and hurtful discrepancies between what he is after and what he gets from him. The establishment, and repeated reestablishment of the selfobject relationship following disruption associated with inevitable frustrations, strengthens the self and promotes a sense of entitlement to, and a confident expectation of, being reliably listened to and understood and of having one's essential psychological needs met. It is important that the analyst, in his responses, be able to avoid precipitating intolerable experiences of traumatization...The analyst's ability to remain steady in the face of the patient's reactions to his (the analyst's) selfobject failures as well as to acknowledge his mistakes and limitations, provides the patient with additional opportunities for apprehending him as significant and therapeutic selfobject. (p. 258)

Therapist 5 echoed a belief similar to that of Therapist 8. However, for Therapist 5, this belief came to her via a positive analytic experience. She experienced her analyst as attuned, hopeful, and attending to her subjective experience as a patient. She felt that her analysis was a success, which greatly contributed to how she practices her style of therapy.

This is reiterated in the following, "It all stems from the belief that my own therapist always had in me. The ability to inspire hopefulness in me. The capacity that I knew that he believed that I could do it even when I doubted that I could do it. And so that is the way I will forever practice my own way of therapy, stemming from the way I myself, my own personal experience. It's more, far more than just a matter of theory and technique."

Although the psychotherapists in this study had varied experiences with their analysts or psychotherapists, it was evident that the experience of personal psychotherapy for the psychotherapist was a significant factor in contributing to their optimal responsiveness. Casement (1991) was emphatic in his views on psychotherapists being analyzed, as follows:

> Because unconscious speaks to unconscious it is essential that a therapist should have maximal access to this deepest level of interactive communication via his own unconscious responses to the patient. It is for this reason that analysts and therapists have to be analyzed; and it is that experience, combined with a knowledge of theory, that helps most to make sense of a therapist's unconscious resonance to what is being communicated by the patient. Without personal analysis there is a limit to how much therapeutic use can be made of these elusive levels of unconscious communication. (pgs. 180-181)

The three categories of Losses and Mourning, Current Life-Cycle Issues, and Psychotherapist's Relationship to His/Her Analyst or Psychotherapist were identified under the broad theme of <u>The Psychotherapist's Subjective Life Experiences.</u> The psychotherapists' subjective life

experiences, as illustrated within the related categories, was a precursor that **allowed** for the psychotherapists progression to Theme II.

THEME II: HIS/HER IDENTIFICATION WITH THIS PARTICULAR PATIENT

It was apparent within this theme that the psychotherapists were profoundly affected by their patient's subjective experience and early history of emotional pain. The degree to which the psychotherapists responded to their patients varied according to their individual patient. Nevertheless, each psychotherapist was deeply affected through the interaction with their particular patient. For instance, Therapist 1 gradually became aware that if she was going to continue treatment with her patient, that she would need to get in touch with her own past history of abuse. Therapist 1's evolving awareness of this led her to seek clinical consultation and psychoanalysis, which assisted her to work through her personal issues related to abuse.

According to Bacal (1992), "The complexity of interactions between the patient and the therapist that comprise the experience of a selfobject relationship for the patient also results in the therapist experiencing a selfobject relationship with his patient. The therapist, too, brings unmet selfobject needs and prior selfobject experiences into the relationship with his or her patient..." The psychotherapists in this study were able to identify with

their respective patients in terms of the patients' subjective experience of their histories; that identification contributed to their being optimally responsive. The implications for this theme might include the suggestion that a precondition for psychotherapists to be optimally responsive with their patients involved the establishment of a selfobject relationship for the psychotherapist.

Bacal (1992) is emphatic in this view. "The therapist's experience of a selfobject relationship with his or her patient is not only pervasively operative in every therapeutic relationship, it constitutes in my view a precondition for the therapist to respond in ways that will enable the patient to experience a selfobject relationship with him."

Expanding further, Bacal (1992) stated, "It is likely that a good deal of what we call countertransference comprises the analyst's experience of the thwarting of his selfobject needs that are ordinarily met in a selfobject relationship with his analysand." The implication for the psychotherapists in this study was that their level and degree of identification was a precondition that enabled them to be exquisitely optimally responsive to their clients. Moreover, the emphasis is not necessarily to "...decenter from countertransferential selfobject relationships..." of the

psychotherapist, but to allow for an unfolding and understanding of these needs, in the service of facilitating the therapeutic work with the patient.

Goldberg (1991) stated:

> I view psychotherapy as the personal journey of two in order that each finds him/herself. A personal journey means a search to find something in oneself. It is a journey of two because one cannot find him/herself without the other in this endeavor. Nor can this quality, sentiment, or realization be found passively or simply in contemplative aloneness. It requires a trek together to find something externally that mirrors something inside. (p.227-228)

Perhaps the identification of these psychotherapists with their patients served the psychotherapist's selfobject needs via the "...relationship with the patient...there is a certain essential mutuality or reciprocity in the analytic selfobject relationship" (Bacal, 1992).

Winnicott (1960) emphasized the significance of identification in the mother/infant dyad as follows:

> The important thing, in my view, is that the mother through identification of herself with her infant knows what the infant feels like and so is able to provide almost exactly what the infant needs in the way of holding and in the provision of an environment generally. Without such identification I consider that she is not able to provide what the infant needs at the beginning which is a life adaptation to the infant's needs. (p.54)

Winnicott's views on the mother/infant dyad are also applicable to the psychotherapist/patient interaction and identification. The psychotherapist's identification with his or her particular patient, and the sensed correctness of fit,

seemed to **enhance** the psychotherapist's ability to be exquisitely affectively attuned to their patients, as well as to their own subjective experience. This is illuminated in the following discussion of Theme III.

THEME III: THE PSYCHOTHERAPIST'S AFFECT ATTUNEMENT WITH THIS PARTICULAR PATIENT

According to Stern (1985), "Attunement behaviors...recast the event and shift the focus of attention to what is behind the behavior, to the quality of feeling that is being shared...Attunement (is) the predominant way to commune with or indicate sharing of internal states" (p.142). It is the psychotherapist's affect attunement that translates and renders intelligible the patients' feelings. The findings contained within this theme correspond with Stern's framework of attunement.

Category #1: The Psychotherapist's Subjective State of Being

Within this category, the psychotherapists subjectivity is described as the totality of the psychotherapist's own experiences, memories, associations, thoughts, recollections, fantasies, images and reactions that the therapist brings to the therapeutic relationship.

The psychotherapist's attunement to his or her subjective state of being influenced their responses to their patients. The psychotherapist's subjectivity was spontaneously drawn forth via the interaction with the patient. By attending to

their own subjective state of being, the psychotherapists were able to be ever more attuned to the patient's experience.

Natterson (1992) is emphatic about the "therapist's subjective involvement as inevitable and indispensable" (p.5).

He postulated guidelines or "homilies" in reference to the psychotherapist's subjective involvement and interaction with his or her client:

> 1) Don't ask yourself whether you are having a fantasy involving the patient, Instead, ask yourself what fantasy you are having, and assume that it is related to the therapy.
>
> 2) When a patient reports a fantasy or dream, or has behavior or symptoms suggesting fantasy, don't assume that only the patient is fantasizing. Instead, accept that whether or not you realize it, you also are engaged in fantasy.
>
> 3) The customer is always right. That is, whenever the patient criticizes you, recognize that at least a tiny fraction of the patient's criticism is correct. Explore this, find the root meaning of this in your life. Only then should you interpret the meaning of the patient's criticism in terms of the patient's life.
>
> 4) Do not try to banish thoughts and feelings. These are clues to your fantasy contribution.
>
> 5) Do not confuse your subjectivity with countertransference. Don't try to eliminate it. It is your most accurate resource for tracking the emotional interplay.
>
> 6) Therapeutic intimacy arises when you permit your fantasy activity to develop in conjunction with the patient's.
>
> 7) Fantasy that distances or removed you from the patient indicates resistance to therapeutic involvement in either the patient or you.
>
> 8) Do not confuse self-awareness with self-disclosure. (p. 3-4)

Casement (1991) emphasized that, "Therapists can no longer claim to be the blank screen or unblemished mirror, first advocated by Freud, because they too are people and no person can be blank or unblemished. Every analyst and therapist communicates far more to the patient about himself than is usually realized. It is important to take this clinical fact into account" (p. 8).

Additionally, Lindon (1993) stated:

> Rules of abstinence and neutrality can in and of themselves not only obstruct the analysis, but further traumatize the patient by the absence of validating attunement, which seem to confirm the templates resulting from the original traumas...I believe what is called for is the analyst's careful sustained empathic exploration of the patient's subjective experiences, including the meanings of any provisions or lack thereof...psychoanalysis deserves to be freed from the shackles of the rule of abstinence. (pgs. 41-42)

Subcategory #1a: The Psychotherapist's Use of Images and Internal Dialogue

Therapist 5 described her patient through the use of the image of a "...teency, weency, baby...who was unable to do the intellectual, cognitive, the mental work in treatment" at that time. She felt the optimal response for this patient was to be affectively attuned and attending to the developmental needs of the patient, that is, "starting where this patient is at, and being responsive to where the patient is developmentally."

Relative to Therapist 5's stance, Bacal (1985) suggested that the analyst must first serve as a "transitional selfobject" for the patient during the "creative aspects of

the transference" before the archaic selfobject transference will take place and lend itself to interpretation. Therapist 5 felt that an interpretation would have been inappropriate, and not responsive to this patient's needs. She saw her patient developmentally as "a teency, weency, baby" as well as "a terrified little rabbit...a weak kitten." These images were helpful for this psychotherapist in facilitating an optimal response to this patient.

Bacal (1992) posited the "therapist's ability to respond optimally to his patient...is also significantly influenced by his capacity for creative imagination or fantasy." Perhaps in view of Bacal's perspective, these psychotherapists were allowing for their capacity for "creative imagination" and "fantasy" through the use of images in apprehending their patient's subjective state of being. The psychotherapists seemed to be open to utilizing their "creative imagination or fantasy" through the use of images, to enhance their attunement to their patient.

Therapists 1, 2, 3, and 5 in this category utilized imagery and their introspective narrative of thoughts and feelings to assist in their attunement to their patients' developmental needs and subjective experience. This contributed to their being optimal responsive with their particular patient.

Subcategory #1b: The Psychotherapist's Use of Metaphor and Internal Dialogue

There has been a long history of the use of metaphor in psychoanalysis, starting with Freud's (1900) earliest metaphor, in which he compared mental functioning to a system of lenses. Later, Freud (1912) utilized the metaphor of the psychoanalyst as similar to a surgeon, a mirror, a blank screen, and a telephone receiver. Metaphor in this context is referred to broadly. In psychotherapy, metaphor can be utilized to explain "how to construct and deliver long stories with metaphorical meanings in the course of psychotherapy." Additionally, "therapists sometimes use objects and activities that may have metaphorical meanings" (Barker, 1985, pgs. 6-7).

Therapist 1 initially associated to the visual imagery of a tiny pair of "Dorothy's ruby slippers." She then utilized the metaphor of the slippers to symbolize "...hope and home." That is, "...to start building a new home, for someone who had been left out." This psychotherapist apprehended the critical need for hope for her severely abused patient. Therapist 1's affect attunement to the patient's developmental needs facilitated her to offer a provision - a tiny pair of ruby slippers - to the patient. As the treatment ensued, this patient was able to hold on to the hope that was associated with the symbolic meaning of the ruby slippers.

Therapist 1 seemed to apprehend the patient's "need" and "mobilized developmental longing," and concretized the metaphor by providing her with a tiny pair of ruby slippers. Additionally, in respect to this particular patient, Therapist 1 also offered her other provisions (i.e., tea, cookies and milk) during the course of therapy. For Therapist 1 "she just knew" that this was exactly what her patient needed. She was attending to all of the patient's needs - physical and emotional. Therapist 1 felt affirmed that this response was optimal, because the patient continued to progress very successfully in her treatment.

Winnicott's (1960) view on environmental provision seems applicable to Therapist 1's affect attunement and subsequent response to her patient:

> I refer to the actual state of the infant-mother relationship at the beginning when the infant has not separated out a self from the maternal care on which there exists absolute dependence in a psychological sense. At this stage the infant needs and in fact usually gets an environmental provision which has certain characteristics:
>
> It meets physiological needs. Here physiology and psychology have not yet become distinct, or are only in the process of doing so; and It is reliable. But the environmental provision is not mechanically reliable. It is reliable in a way that implies the mother's empathy (p. 48).

Bacal's (1985) remarks regarding optimal responsiveness is applicable to Therapist 1's attunement, "...Other selfobject needs may require a responsiveness for which verbal interpretation will not do and we need to study the

significance of these optimal responses for the patient, for example, the warmth provided by the analyst's blanket, or the thirst or faintness that elicits a drink, as well as other needs that may be related to the 'psychological survival of the self'" (p. 215). Therapist 1 utilized the metaphor as a vehicle for attunement into her patient's subjective experience.

Category #2: The Psychotherapist's View of the Patient's Subjective State of Being

The psychotherapists observed and affectively attuned to their patients' subjective state of being, which influenced and effected their responsiveness to their patient.

Basch (1985) emphasized the importance of affective attunement in the following:

> Through affective attunement the mother is serving as the quintessential selfobject for her baby, sharing the infant's experience, confirming it in its activity, and building a sensorimotor model for what will become its self concept. Affect attunement leads to a shared world; without affect attunement one's activities are solitary, private, and idiosyncratic...if affect attunement is not present or is ineffective during those early years, the lack of shared experience may well create a sense of isolation and a belief that one's affective needs generally are somehow unacceptable and shameful. (p. 35)

The psychotherapists in this study employed affect attunement and apprehended their patients subjective experiences. This in effect constituted the optimal response for their patient. For example, Therapist 1's attunement with

her patient's subjective state of being allowed the patient to become aware of the symbolic meaning of achieving an advanced degree, and the subjective meaning of that accomplishment. Therapist 1 explained how that accomplishment helped the patient to see that her life was now different, "...and what that meant, how that would live through all of the rest of the degradation of the whole family." This led to the patient feeling understood by Therapist 1. Moreover, her subjective experience was now shared with another, rather than experienced in isolation, as it was in the past.

Stolorow, Atwood, and Brandchaft (1987) emphasized the significance of the caregiver's affect attunement to the child's subjective state of being, in the following excerpt:

> Throughout countless experiences throughout early development, the caregiver, by comprehending, interpreting, accepting, and responding empathically to the child's unique and constantly shifting feeling states, is at the same time enabling him to monitor, articulate, and understandingly respond to them on his own. When the caregiver is able to perform this important selfobject function by way of using her own affect-signaling capacity, a process of internalization occurs, culminating in the child's ability to use his own emotional reactions as self-signals. When affects are perceived as signals of a changing self-state rather than as indicators of impending psychological disorganization and fragmentation, the child is able to tolerate his emotional reactions without experiencing them as traumatic. (p. 72)

The importance of acknowledging the patient's subjective experience of being, via affect attunement, is significant because, "...the tendency for affective experiences to create

a disorganized (i.e. traumatic) self-state is seen to originate from early faulty affect attunement, with a lack of mutual sharing and acceptance of affect states, leading to impaired affect tolerance and an inability to use affects as self-signals" (Stolorow, et al, 1987, p. 72).

Bacal (1990) discussed the psychotherapist's attunement to the patient's subjective experience:

> From moment to moment, and often from hour to hour, the patient's sense of his analyst's understanding is not usually mediated by the analyst's words; rather it is predominantly associated with the patient's usage of the qualities of the analyst's receptive quietness into which he weaves his creative phantasy that the analyst is in empathic resonance with his subjective experience. (p. 256)

Category #3: The Psychotherapist's Attunement to the Intersubjective State of Being

Within this category, the psychotherapists' affect attunement, empathic understanding and apprehending of the patient's subjective experience, transference issues, and organizing principles was illustrated in the interviews. The psychotherapists resonated with their patients' subjective experience, while maintaining affect attunement to the interplay of both subjectivities.

According to Stern (1985), "For there to be an intersubjective exchange about affect, then, strict imitation alone won't do" (p. 139). He cited several processes that must take place. Although Stern described them in relation to infant-parent exchange, they are applicable to the patient-psychotherapist interaction:

> 1) The parent must be able to read the infant's feeling state from the infant's overt behavior.
>
> 2) The parent must perform some behavior that is not a strict imitation but nonetheless corresponds in some way to the infant's overt behavior.
>
> 3) The infant must be able to read this corresponding parental response as having to do with the infant's own original feeling experience and not just imitating the infant's behavior. (p. 139)

Stern continued, "It is only in the presence of these three conditions that feeling states within one person can be knowable to another and that they can both sense, without using language, that the transaction has occurred" (p.139).

Therapist 5 seemed to maintain in the forefront of her awareness an attunement to her patient's subjective, experience much in the way that Stern described above. She apprehended, without words, the patient's affect - she knew that the patient was "terrified of my being away" on a week's vacation. This prompted Therapist 5 to promise the patient that she would telephone and she "called the patient twice during the week." In addition, upon her return the psychotherapist provided the patient with a gift she had made during her vacation, and took the patient out to lunch, in which the patient ordered her favorite, Italian food. She read where the patient was - via affect attunement - and then performed a function which the patient was not able to perform. The patient subsequently felt responded to and

understood. Therapist 5 responded to the patient via affect attunement, and through the interplay of their intersubjective state of being.

In Stern's view, "Affect attunement is a particular form of intersubjectivity that requires some processes that are unique to it (p.144)." Stern's views seem to be illustrated in this study, via the psychotherapists' descriptions of the enactment of attunement to the intersubjective state of being.

Natterson (1992) emphasized, "Psychotherapy at its core and at its best, is an evolving relationship of exceptional intimacy...the achievement of this intimacy intensifies the power of the therapy and is a function of the therapist's skill and sophistication...intimacy breeds comfort and fluency in both parties, thereby stimulating therapeutic dialogue of remarkable effectiveness". Natterson (1992) continues, "...when the subjectivity of patient and therapist interact, a powerful intimacy is achieved...the underlying basis for the intimate relation of patient and therapist exists in the fantasy life of both. In any human dyadic relationship, the power that <u>is</u> the relationship arises equally from both parties."

Therapist 7 seems to illustrate Natterson's view on the intersubjective experience that occurred with her patient. She was attuned to her patient's profound pain from the loss of his son, which assisted her to respond to him with a

delicate sensitivity, that kept him in therapy. Concomitantly, she also acknowledged that "...I started with him two weeks after my father died." She supplied her own contributions and subjective experience of her own loss to the relationship. However, she was also was aware that "...he took a left turn, where I would take a right turn, that there was a difference in that I would not blame myself, and that his need to go back over the whole 23 years of his son's life and blame himself...was clearly pathological to me...I was very clear I could not identify with any of that...I was aware of that." Therapist 5 was able to facilitate movement in the therapy with this patient, after five years of postponed grief.

Natterson (1992) discussed his view of the intersubjective experience:

> Each person brings to any encounter his or her view of the universe, which he or she needs to express to, perhaps even impose upon, the other. The interaction of these two world views, beliefs or fantasies - whatever you wish to call them - results in a fluxing, unstable, shifting condition that constitutes the therapeutic process. I believe this is the same as the growth process that occurs in any interpersonal experience. A joint fantasy is generated in this interaction. And when the two parties - patient and therapist - separate, the world view or fundamental fantasy of each will have changed. These encounters are micro-moments of history and constitute the fundamental process of self-development and self-transformation going on continuously in all people. The agency of this unfolding is the intersubjective experience. (p.7)

The psychotherapists' affect attunement to the patient's subjective state of being and to their own subjective state of being furthered the exceptional intimacy of the therapeutic relationship. This exquisite attunement, as a precursor, seemed to **promote** the psychotherapists' progression toward Theme IV: The Interaction of Hoping, Holding, and Being Held. This is illuminated in the following discussion of Theme IV.

THEME IV: THE INTERACTION OF HOPING, HOLDING AND BEING HELD

Within this broad theme, the psychotherapists described their provision of a holding environment for the patient, in the face of the intolerable, while maintaining hope. The psychotherapists were able to maintain this balance by the use of several sources, as outlined in the related categories: #1 The Support of Consultant or Supervisor; #2 Maintaining Hope in the Face of the Intolerable; #3 Support of the Holding Environment; and #4 The Psychotherapist's Commitment and Primary Responsibility to the Patient.

It is helpful to view the findings in light of Winnicott's theoretical construct of holding. Winnicott originally referred to the holding environment as a way of conceptualizing the needed environmental provision by the mother to her infant. According to Winnicott (1960), "The holding environment has as its main function the reduction to a minimum of impingements to which the infant must react with resultant annihilation of personal being. Under favourable

conditions the infant establishes a continuity of existence and then begins to develop the sophistications which make it possible for impingements to be gathered into the area of omnipotence..." (p. 47). Winnicott (1963) further described the holding function in the following; "You will see that the analyst is holding the patient, and this often takes the form of conveying in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced, or that is waiting to be experienced" (p. 240).

The holding environment concept is applicable to these psychotherapists' ability to sustain a holding environment, in which hope could be maintained for their patients. The four categories within this theme will be discussed in light of Winnicott's theoretical construct.

Category #1: The Support of Consultant or Supervisor

The psychotherapists in this study were often able to continue in the treatment of their patient with the assistance of supervision or consultation. Therapists 1 and 2 both shared that they experienced relief, soothing, and holding from a consultant or supervisor in their meetings. The use of the consultant/supervisor reduced the psychotherapists' anxiety, apprehension, and feelings of being overwhelmed.

Additionally, it can be surmised that potential intersubjective disjunctions were avoided through these

psychotherapists use of consultations. Stolorow (1983) believed that the exacerbations and entrenchments of patients psychopathology severe enough to be termed "negative therapeutic reactions" are most often produced by prolonged, unrecognized intersubjective disjunctions, wherein the patient's selfobject transference needs are consistently misunderstood and thereby relentlessly rejected by their analysts. For Therapists 1, 2, 3, 4, 5, and 8, had a consultant/supervisor available to them as needed. Without hesitation, these psychotherapists made use of their consultants or supervisors to assist them in working through and/or avoiding potential intersubjective disjunction.

Casement (1991) affirms psychotherapists need to be held when treating patients:

> Student analysts and therapists have a particular need to be professionally held while they learn about the analytic holding that a patient needs in therapy. They should be able to draw upon the experience of their own analysis; they can also be held by their knowledge of theory and of technique, to have the security to continue to function analytically even under pressure. But, in addition, there needs to be a supervisory holding by an experienced person who believed in the student's potential to be in tune with the patient and to comment helpfully. (p. 25)

Category #2: Maintaining Hope in the Face of the Intolerable

The psychotherapists were confronted with their patients' histories, which often included severe abuse and corresponding emotional pain. Therapist 2, for example, felt she needed to be able to withstand the "...barrage of attacks..." from her

client. This was often very difficult for her to tolerate, and she acknowledged that she didn't always know the meaning of the verbal attacks. Therapist 2 shared, "...I did not say that much. And it felt to me like she just needed for us to be there together...and have me tolerate it...I'm not quite sure what it depends on...I really felt like I was walking a fine line between letting her know I was there and remaining hopeful about her but not wanting to intrude..."

Casement (1991) spoke to Therapist 2's experience in the following excerpt:

> I wish to stress that at no time is unconscious hope more vital than when a patient is putting an analyst through the roughest of times. Even though treatment may intermittently look totally hopeless, and the analyst may be made to feel entirely hopeless too, it is most important not to lose sight of the fact that such problems in treatment are often (in themselves) an expression of the patient's unconscious search for some help - never previously found - with serious emotional difficulties. What the patient needs is to find someone who can bear being really in touch with the patient's extremes of personal difficulty without having to give up, someone who (without being unrealistic or trying to be omnipotent) can find some way to see the patient through...But when an analyst is able to find the capacity to see a patient through such extremely difficult times, ultimately the unconscious hope is met. (p. 306-307)

Therapist 6 felt that he needed to "retain a certain kind of optimism, even in the face of what seems like frustrating obstacles that will never go away." By doing this he was able to tolerate, hold, and contain his patient's subjective

experience of pain. For Therapist 6, this stance was an important precursor to preserving an intersubjective environment of hope.

Bowlby (1979), in discussing the delicate and difficult role of psychotherapists in maintaining a sense of hope for patients, explained, "Clearly, to do this work well requires of the therapist not only a good grasp of principles but also a capacity for empathy and for tolerating intense and painful emotion. Those with a strongly organized tendency towards compulsive selfreliance are ill-suited to undertake it and are well advised not to" (p. 154).

What allows for maintaining the hope? According to Therapist 8, "It is the true love of another human being without envy, and I think it only comes from one's life experience."

Category #3: Support of the Holding Environment

The concept of the holding environment was interwoven into the work of Therapists 1, 2, 5, 6, and 7. Therapist 1 described her provision of a holding environment, which facilitated the maintenance of hope for her patient. She stated, "R. was really sinking into despair, and I was catching it quicker. We were both sinking into despair at the whole situation...at that moment I realized that she needed something, I needed something to help us, to pick us up and sort of re-energize us, give us hope..." Therapist 1

provided her patient with the metaphor of the ruby slippers, which symbolized hope. This metaphor was symbolic of mutual hope for patient and psychotherapist. This psychotherapist apprehended what was needed for her patient, and their intersubjective state of being. In this way Therapist 1 maintained a holding environment.

Casement's (1991) comment is relevant to Therapist 1's experience, "Patients have taught me that when I allow myself to feel (even to be invaded by) the patient's own unbearable feelings, and if I can experience this (paradoxically) as both unbearable and yet bearable, so that I am still able to find some way of going on, I can begin to 'defuse' the dread in a patient's most difficult feelings" (p. 128).

Therapist 2 also shared her experience of the challenge of maintaining a holding environment with her patient, while withstanding the "...barrage of her attack." She upheld the "...delicate balance" of "...remaining hopeful about her, but not wanting to intrude on her need for her feelings and experience." Bion's (1962) concept of the psychotherapist acting as a "container" for the patient's frustrations, anxiety, fears, and rage, seem applicable to Therapist 2's experience with her patient. Casement (1991) acknowledged, "A therapist's capacity to provide a patient with this analytic holding is discovered through the real (and recognized) survival of that which the patient experiences as

the worst in himself or herself" (p.128). He continued, "As always, it is when an analyst or therapist is under stress that analytic holding comes to be most tested" (p. 129).

Category 4: The Psychotherapist's Commitment and Primary Responsibility to the Patient

The psychotherapists verbalized a strong sense of commitment and loyalty to their patients. Within this category each psychotherapist was determined to assist his or her patient, "in the best interests of the patient." They expressed a feeling of truly "...[caring] with all your heart and soul." Winnicott's (1963) view of holding further explains this psychotherapist's stance. "Holding includes especially the physical holding of the infant, which is a form of loving. It is perhaps the only way in which a mother can show the infant her love" (p. 49).

Winnicott's (1963) concept of "primary maternal preoccupation" is descriptive of the psychotherapists' stance in this category. Winnicott referred "...to the immense changes that occur in women who are having a baby, and it is my opinion that this phenomenon, whatever name it deserves, is essential for the well-being of the infant. It is essential because without it there is no one who is sufficiently identified with the infant to know what the infant needs, so that the basic ration of adaptation is missing" (p. 256).

Therapists 1 and 6 were primarily focused on providing the necessary interventions that would help their patients get better. Therapist 1 summed it up in the following, "...that if I continued to see [R.], she was going to get better...I think that inner resolve inside of me at least it always had to a certain extent, somehow put that extra whatever, whatever it is, if there is an artistry, I guess in therapy, that's when something like this happens. I knew, I just knew I wasn't going to let her go down so low, or let that happen."

The sense of commitment and primary responsibility to their respective patients **emboldened** the psychotherapists to Theme V: The Move Beyond Customary Parameters In A Manner Which Was Optimally Responsive. This is illustrated in the following discussion.

Theme V: THE MOVE BEYOND CUSTOMARY PARAMETERS IN A MANNER WHICH WAS OPTIMALLY RESPONSIVE

Within this theme, the psychotherapists conveyed a sense of confidence and affirmation in their stance with their patients. This was validated by their decision to often go against the prevailing traditional psychoanalytic community's views on therapeutic parameters. This is highlighted in the two categories outlined below.

Category #1: A Disciplined Responsible Fashion

Therapists 1, 2, 3, 4, 5, 6, 7, and 8 all conveyed a strong belief that in addition to responding in a manner that is truly in the best interests of the patient, they must also respond in a disciplined, responsible fashion. Therapist 6 shared that there are certainly ethical and professional guidelines he maintains, but effective treatment also meant "...to be able to risk."

Therapist 1 felt that the psychotherapist must be very focused on the patient, "to put everything else out of your mind." This was echoed by Therapist 8, who felt that the connection with the patient was of paramount importance. She shared, "if you aren't really there with your patient every second, you're not going to figure out fast enough [how] to hold on to the patient..." to maintain that connection. Therapist 7 also maintained a stance which she described as a "disciplined use of self."

Bacal (1985) comments on the "parameter" are helpful in conceptualizing this category:

> In my opinion, there is no such thing as a 'parameter,' an extraanalytic, or unanalytic, measure we adopt for a time in order ultimately to return to doing proper analysis in the traditional way. We must respond in ways that enable us to communicate understanding to the particular patient with whom we are working. That is analysis. (p. 215)

Bacal emphasized further however:

> While the analyst need not intentionally enact a part different than the significant parent ("corrective emotional experience"), he does have

> to consider what response will be optimal in relation to the current level of his patient's specific developmental capacity to utilize empathic understanding of his selfobject needs for human relatedness. This will be therapeutic. (p. 224)

Bacal (1990) further stated, "...there should be no rigid interdictions against, nor indeed, no categorical imperatives for, any particular responses. The analyst's guidelines must be that they are therapeutically usable and they do not interfere with his professional functioning of his personal tolerance" (p. 257).

The psychotherapists favored a broad "disciplined responsible fashion" in their approach to treatment, which fits in with Bacal's notions. The psychotherapists' "disciplined responsible fashion" of conducting treatment was tempered by Bacal's guidelines, which suggest that one's approach be "...therapeutically usable..." and "...they do not interfere with his professional functioning or his personal tolerance."

Category #2: To Risk, Regardless of the Psychotherapist's Need for Support and Safety

Within this category, the psychotherapists proceeded to take a stance which they believed was optimally responsive to their patient. Regardless of their colleagues' or professional community's actual or potentially differing points of view, they proceeded in the manner to which they believed was beneficial for their clients.

Therapist 6 explained that "...you just have to maintain an openness and use theories within reason." He felt strongly that if he had followed the textbooks, that he would have missed an opportunity to respond to his patient optimally. Perhaps his view of "breaking the rules" is related to Bacal's (1985) statement that "...there is no such thing as a parameter." What Therapist 6 was attempting to do was to respond to his patient in a way that communicated his understanding to his patient. For Therapist 6, being optimally responsive with his particular patient meant diverting from the rules of the textbooks or theories, if and when he thought it necessary. Casement (1991) supported this view:

> By listening too readily to accepted theories, and to what they lead the practitioner to expect, it is easy to become deaf to the unexpected. When a therapist thinks that he can see signs of what is familiar to him, he can become blind to what is different and strange. (p. 9)

Therapist 1 found herself responding and offering provisions, and gratifying the patient's needs (i.e. offering something to eat - cookies and milk, or tea; giving of symbolic gifts) actions which she would not ordinarily discuss in a professional group. She stood firm in her stance which she believed was truly "...healing and beneficial for the client." Perhaps Bacal's (1990) view, which advocated "...the analyst's overall provision of optimal responsiveness: the therapist's acts of communicating with his

patient in ways that that particular patient experiences as usable for the cohesion, strengthening, and growth of his self" (p.256), validates Therapist 1's responsiveness.

Therapist 8 shared that she "...doesn't follow the rules for rules' sake." She expressed however, that "...if one breaks the rules, one had better be ready to take the risks involved in breaking the rules." For this psychotherapist, this meant that she was ready "...to go the line...right to the line," to respond in the way which the patient needed her to respond. This approach involved some risk; there is a certain degree of not knowing, and uncertainty of the end result. Casement postulated on the value of psychotherapists "use of not knowing" and tolerating "...periods during which they may feel ignorant and helpless" rather than "...to strive to appear certain" (p. 8). Further, Casement believed "the experienced therapist or analyst has to make an effort to preserve an adequate state of not- knowing if he is to remain open to fresh understanding." (p. 8)

Bion (1975) encouraged analysts to hold together their knowing and not-knowing, in what he called "binocular vision." Analyst can learn to follow with one eye those aspects of a patient about which they know they do not know, while keeping the other eye on whatever they feel they do know. There is thus a creative tension between this knowing and not knowing (Casement, 1991, p. 10).

Berger (1987) postulated "a therapist's capacity to bear with the patient's narrative without imposing order too quickly requires the ability to tolerate puzzlement" (p. 85). Berger expanded further:

> Therapeutically useful puzzlement entails a knowledge of method and theory, keen powers of observation, heightened attention to data rather than to theoretical formulations...the capacity to resist needing to know...and a sense of hopefulness. (p. 87)

The psychotherapists in this category reacted against a rigid adherence to traditional psychoanalytic views. Additionally, they felt judged, criticized, and unsafe about airing their differing views among their colleagues (Therapist 1, 4, 5, and 8). Regardless of this, the psychotherapists proceeded with those interventions that they felt were most beneficial, and produced positive results with their patients.

The psychotherapists in this category were willing to risk their colleagues' support in taking a stance which they felt was optimally responsive to their patients. This was a significant move beyond customary parameters.

Research Question #2: HOW DOES THE PSYCHOTHERAPIST KNOW HE OR SHE HAS BEEN OPTIMALLY RESPONSIVE?

THEME I: APPARENT SHIFTS IN PATIENT'S AFFECT, were manifested in two categories of psychotherapists' observations:

Category #1: A Reduction of Anxiety

A significant reduction of anxiety occurred among the patients of Therapist 1, 2, 3, and 7. This reduction in anxiety was experienced by both the patients and the psychotherapists. Bacal (1992) posited "...there is an essential mutuality or reciprocity in the analytic selfobject relationship." This mutuality and reciprocity resulted in a lessening of anxiety, as reflected in the findings contained within this category.

Stern (1985) postulated that shared experiences are "...the capacities for identifying cross-modal equivalences that made for a perceptually unified world are the same capacities that permit the mother and infant to engage in affect attunement to achieve affective intersubjectivity" (p. 156). The psychotherapists utilized affect attunement, which engaged their patient, and together they moved toward the "achievement of affective intersubjectivity" (p. 156). The result was that the patient's anxiety was reduced, which was also felt by the psychotherapist. This was illustrated by Therapist 3's "tracking and attuning" to her patient's affect and subjective experience, which prompted her to ask the

patient to sit up rather than lie on the couch. The result was that the psychotherapist's own terror, as well as the patient's terror were both relieved.

Therapist 1 maintained a continued "tracking and attuning" of her patient's "vitality affects." She was aware of the patient's dull intonation, her depressed affect, and her sense of hopelessness. Through this process of attunement, she observed that the patient's "...flat affect and emotional paralysis" was lifted. They both felt "...there was a lifting [of anxiety]...[and] it was a relief to both of us." Therapist 1's intersubjective optimally responsive stance allowed for "the sense of sharing likely inner experiences on an almost continuous basis" (Stern, 1985, p. 157). Stern explained, "This is exactly our experience of feeling-connectedness, of being in attunement with another. It feels like an unbroken line" (1985, p. 157).

Category #2: An Increased Sense of Vitality/Well-Being Emanating From the Patient Due to the Decrease of Anxiety

According to Stern (1985), two "...forms of affects - discrete categorical affects such as sadness and joy as well as vitality affects such as explosions and fadings - are attuned to" within the mother-infant interaction (p. 156). He explained further, "We experience vitality affects as dynamic shifts or patterned changes within ourselves or others...[vitality affects] become essential to an

understanding of attunement" (p. 156). Vitality affects are those affect states that include qualities of feeling such as "surging, fading away, fleeting, explosive, crescendo, decrescendo, bursting, and drawn-out" (Lichtenberg, 1992). Psychotherapists observed an apparent shift in vitality and overall well-being among from their patient's as a result of their optimal responses.

For example, Therapist 4 reported that in addition to the patient's decrease in anxiety, "...there was a marked increased overall sense of vitality and aliveness within her..." Therapist 4 seemed to be exquisitely attuned to her patient's subjective experience and affective state, which she described as, "...particularly cheerful, starting the session talking about very positive things in which she was please about sort of excited about little things."

Therapist 5 observed that after a series of sessions in which the patient had worked through recurring issues that were interfering with feelings of self-esteem, there was a shift in the patient's affect. This was observed by Therapist 5 as she commented, "...[my patient] literally bounced in radiant, full of energy and vitality, pleasure and excitement, just glowing. Life is good...she was alive, there was vitality and there was juice...There was oooh...we knew it!"

Lichtenberg's (1992) views on the self-object experience as it relates to vitality states is applicable:

> In the rise and falls of the ordinary clinical situation, a selfobject experience implies the existence of mental contents comprising an intact or restored affectively invigorated sense of self, and affirming and/or like-minded, and/or idealized other, and whatever else a dominant motivation calls for. A selfobject experience...is a reference...to an affect laden symbolic representation, and the specific relationship between self and affirming, like-minded or idealized other, that of part self, part other, is itself a symbolic representation bearing the stamp of fantasy and metaphoric expression.

Lichtenberg (1992) explains further,

> How do we recognize empathically and introspectively a selfobject experience? A patient enters analysis in a state of distress. Gradually, she feels more intact, more herself. She feels understood, her good intentions appreciated, her failures sympathized with, her accomplishments affirmed and admired. She is having a selfobject experience. But from whose point of view? Hers. Her view may well be shared empathically by her analyst.

Through the selfobject experience, Therapist 5's patient experienced a "...restoration of cohesion and vitality of the self. Restoration in the clinical setting is relatively dramatic," whereas "...attunement in normal development occurs with relatively little notice" (Lichtenberg, 1992).

In summary, Lichtenberg offers a framework in which the psychotherapist can promote a restoration of "optimal cohesion, vigor, and harmony" (Wolf, 1988, p. 44) with their patients, in the following:

> Consequently, as therapists, when we consider our contribution to helping the patient create or restore a selfobject experience, we must think of ourselves not as the individuals we are, but as the metaphor - symbolic representation - the patient forms of us in his or her psyche. By doing the ordinary work that promotes restoration of self, self-righting, and the exploration of transferences and motivation, the optimally responsive therapist triggers pari-passu selfobject experiences. (Lichtenberg, 1992)

THEME II - EXTERNAL OBSERVABLE SIGNS

The psychotherapists, through affect attunement with their particular patient, were able to discern observable signs in their patient's behavior that informed them that they had been optimally responsive. These observations occurred at turning points, or optimal moments in the therapy encounter. These external observable signs (i.e. tears, changes in facial expressions, changes in body posture, etc.) were evidence for these psychotherapists that they had been optimally responsive. Furthermore, these external observable signs also contributed toward uncovering additional material.

For instance, Therapist 8 shared that the external observable sign in her patient was tears. She explained further, "...she looked at me and she got tears in her eyes, and she was able to then speak about her fears." This psychotherapist knew that she had been optimally responsive: "...[I] hit home because the tears began and she began to express her wishes." Wolf's (1981) perspective is helpful in understanding this interplay between Therapist 8 and her patient:

> Harmonious or reciprocal empathic resonance took place between analyst and patient, 'At the moment that I really understand what is going on in the analysand, I also know that he really understands what I am doing'. (p. 7)

Through maintaining a stance of sustained empathic inquiry, Therapist 7 was attuned to her patient's "...his mood, his posture, his affect, and the meaning of the letting go." The empathic explanation she made to her patient was, "...that if he let go of his son that in a sense it would be like he never had him, and that is why he can't let go." The observed external signs that indicated that she had been optimally responsive was that "...his posture changed, his face got red, he got teary, which were all signs that I had touched something in what I said." She was attuned to his subjective experience and meaning of the loss, and his response indicated that he felt understood.

Bacal's (1985) comments provides further verification of the occurrence of optimal responsiveness in the interplay between Therapist 7 and her patient:

> The accuracy of the analyst's empathic insights is confirmed by the patient's expression of his own empathic grasp of the analyst's psychological activity at that moment. A process of transmutation of the analyst's functions into the patient has begun. The interaction has been optimal from both the analyst's and patient's point of view and neither need question the appropriateness of the gratification he receives in this way. (p. 211)

THEME III: ACCESS TO AND DEVELOPMENT OF NEW MATERIAL

Category #1: New and/or Improved Behaviors

The psychotherapists reported a shift in behaviors among their patients that were either new or improved. Significantly, the patients became more aware of their own affect states that contributed to their new or improved behavior. For example, Therapist 5 shared, "...through [the patient's] increased understanding, the patient was then able to approach the work situation with greater internal strength and less vulnerability...[the patient] began to feel differently and subsequently act differently."

Therapist 1 reported that her patient began "...to think of herself differently" and approach old situations with greater understanding and new behaviors. The patient flourished in her personal life and professional endeavors. For Therapist 3, her patient was able to begin to connect with her in the analysis. "This was a woman who never really could connect and form a relationship. It was representative of her being able to involve [with] another person...[and it] was enacted outside the session in her work, in her relationships, she was able to include another..."

There are varying views in the literature as to what contributes to a mutative experience for the patient. Contemporary theorists have varying views. Tolpin (1988) suggested "optimal empathic engagement" as the indispensable ingredient and crucial determinant for the development of a

healthy self-organization, or for a successful analytic endeavor. Terman's (1988) concept of the "dialogue of construction" characterized the process of structure formation. That is, "the doing is the making. The dialogue is the structure. The repetition - not the absence or interruption - creates the enduring pattern. This is the essential stuff of which we are made - and remade" (p. 125). Stolorow and Socarides (1987) emphasized "the central curative element may be formed in the selfobject transference bond itself" (p. 66). They shifted the emphasis of the mechanism of change from optimum frustration to the centrality of affect attunement. Bacal (1985) suggested that the common curative element is "...the patient's experience of the analyst's optimal responsiveness; and the quality of the therapeutic relationship at that moment confirms, for the analyst, that his response is usable by the patient" (p. 211).

It is significant to note however, although the psychotherapists reported and observed new and/or improved behaviors among their patients, "...a single episode of understanding is clearly insufficient to alter the patient's experiential state or behavioral patterns. For the patient to change, the cycles of experiencing and understanding need to be repeated in the context of many different settings and stories" (Berger, 1987, p. 219). Furthermore, "...each discovery, and each repetition, adds a slightly new dimension of understanding to the pattern or experience under

examination. In the process of making these discoveries, the patient also experiences and contemplates the significance of the same pattern over and over again in the therapeutic relationship" (p. 219).

Although there are many forces involved regarding what is mutative, it was the psychotherapists' optimal responsiveness that effected the new and/or improved behaviors among their patients.

Category #2: There is Increased Self-Disclosure of New Material Evoked From Within the Patient

The psychotherapists maintained a stance of acceptance of their patients' subjective reality. This stance facilitated the patient's disclosure of new material via greater understanding, insights, or the production of dreams. Moreover, through the interplay between Therapists 2, 4, 5, and 9 and their respective patients, the patient experienced an optimally responsive selfobject relationship with their therapist. This contributed to the patients disclosure of new material in varying forms.

Bacal (1992) emphasized the selfobject relationship as a "continuous dynamic experience and multifaceted concept. It implies the experience of a relationship, that is at the very center of the therapeutic process." Further, it appears that the patients were able to utilize their psychotherapists in a

manner in which they felt empathically understood and optimally responded to; they were thus prompted to disclose new material:

> From moment to moment, and often from hour to hour, the patient's sense of his analyst's understanding is not usually mediated by the analyst's words; rather it is predominantly associated with the patient's usage of the qualities of the analyst's receptive quietness into which he weaves his creative phantasy that the analyst is in empathic resonance with his subjective experience. (p. 256)

It was the "alive, understanding presence" of optimal responsiveness that facilitated these psychotherapists to attune to and resonate with their patients subjective experience. This stance allowed for the patient's disclosure of new material.

Category #3: A Powerful Exceptional Intimacy in the Relationship

Within this category, were varying degrees and dimensions in which the psychotherapists observed and experienced a powerful exceptional intimacy in the interactive relationship with their patient. Therapist 4 explained that there was an "...eagerness to reestablish the tie..." despite the disruptive experience of the patient missing a session. This psychotherapist understood the patient's subjective experience of disruptions in relationships as indicative of the depth of which the patient's longing for a connection and intimacy in a significant relationship. She expanded, "...she could reproduce that occasional disrupted relationship with the one

person that she could sort of count on " - the psychotherapist. Therapist 4 was empathically attuned to the meaning of the disruptions. This stance facilitated the patient to be able to risk and trust, which prompted her to reconnect with the psychotherapist.

Wolf's (1988) views expanded on Therapist 4's approach with her patient. Wolf's framework provides an understanding as to what contributes to the development of an exceptional intimacy. He posited that "the analyst's empathic perceptions of the patient's experience will eventually be matched by the patient's increasing empathy for the analytic task performed by the analyst" (p.154). Wolf cited several ways in which the analyst can foster an exceptional intimacy in the therapeutic relationship, even when disruption has occurred. He suggested that a newly constructed analytic reality should have three components, as follows:

> 1) the analysand's reality, mainly private but to some extent accessible to the analyst by empathy;
>
> 2) the analyst's reality, mainly private, but to some extent accessible to the analysand by empathy; and
>
> 3) the shared mutual reality of the understood and explained discrepancy between the two. (p. 154)

Wolf explained:

> Appropriate mutual acceptance of all three constituents of analytic reality is equivalent to empathy at the highest level and strengthens the self cohesion of both parties...By gaining the strength to really see what they have been looking at, both participants benefit from new perceptions that become part of the construction of a new reality for each - the analytic reality. (p. 154)

Bacal (1992) emphasized the "basic sense of entitlement" to the analyst's selfobject responsiveness:

> If one has confident expectation that one is entitled to ongoing selfobject relationships with significant others, the self is stronger and feels more prepared to respond reciprocally to the comparable selfobject needs of others.
>
> I am suggesting that the experience of this basic sense of entitlement is a precondition for experiencing a selfobject relationship. A relationship in which the patient feels that he or she can count upon the selfobject responsiveness of his or her analyst, not the analyst, his or her analyst. I attempted to express this important sense of ownership of the other and the concomitant sense of specialness within the self when I said that the self is the self's object. I believe that this sense of ownership is also at the heart of what has been called "basic trust."

Therapist 6 acknowledged his initial hesitancy in providing an empathic explanation to his patient. Despite his subjective experience of caution and empathic concern, this psychotherapist engaged the patient in a mutual task of uncovering her underlying pain. His careful attunement to her subjective experience facilitated greater intimacy and an overall sense of relief. Her response was "relaxation, a smile, and tears...a mixture of emotions. A healthy response...it was a kind of optimal response...I was sort of taking care of her...It was sort of an intense emotional experience...It was quite exciting."

These psychotherapists responded to their patient's needs by taking "...cues that emanate[d] from [their] patient's unconscious search for what is necessary to meet unmet needs"

(Casement, 1991, p. 288). Attunement to these cues contributed to the development of a powerful exceptional intimacy in the relationship. Casement (1991) expanded on the powerful experience that can occur in the therapeutic relationship, in the following:

> The gains in analysis are by no means limited to insight or to those changes that follow from interpreting the transference. There are times when significant change takes place around an experience that can be regarded as 'profound' even if not specifically an experience of the transference. For instance, a patient can be profoundly affected by experiencing something quite new in the analysis, or by reexperiencing something that had been 'forgotten' and lost. Unlike other profound experiences, which may be encountered in solitude, this always involves both participants in the analytic relationship. (p. 353)

Casement (1991) summarized the exceptional intimacy that occurs in the ongoing analytic experience in the following passage:

> The analytic journey is often difficult and painful for analyst as well as patient, quite frequently bewildering, and at times awesome. Progress is slow and sometimes intermittent. Nevertheless, working with the analytic process can at the same time be extraordinarily enriching (to both participants) as true aliveness is rediscovered, as creativity is released from what had been blocking it, and as patients recover the capacity to be more fully themselves and to be playful. (p. 356)

SUMMARY

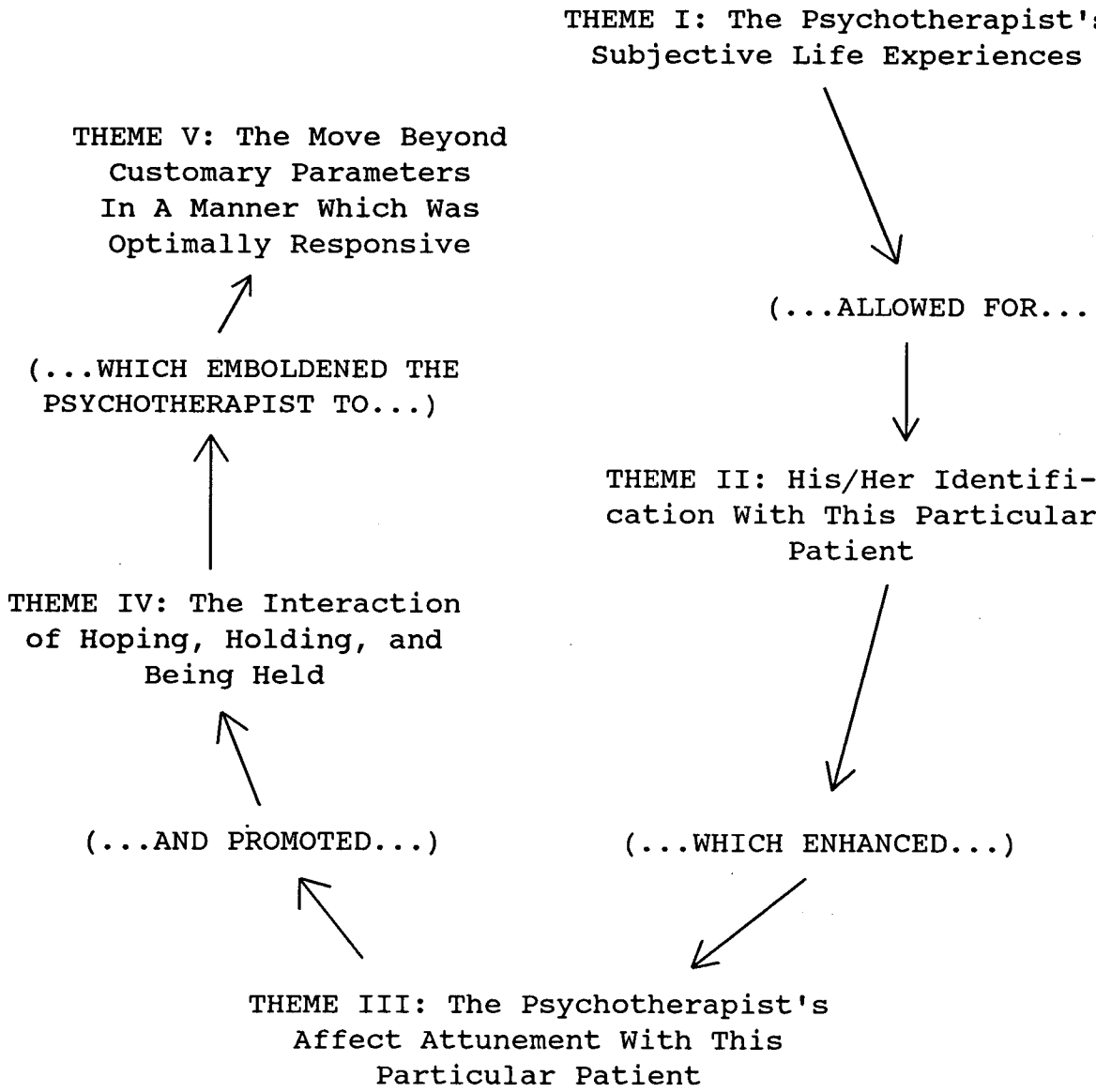
The nine respondents in this study were autonomously practicing psychotherapists whose years of post-graduate clinical practice ranged from five to 41+ years. They were purposefully, rather than randomly, selected. Because this study involved a small number of participants rather than a large sample, generalizations to the larger population of psychotherapists are not possible, nor were such generalizations the purpose of this study. The intent has been to explore the subject with the selected informants in order to provide information on the cumulative effects of the psychotherapist's experience that lead to optimal moments and turning points in the therapeutic encounter. Conclusions regarding the questions addressed in this study and their related findings are as follows.

Question #1: What Subjective and Intersubjective Experiences Contribute to Psychotherapists Being Optimally Responsive?

Five broad themes emerged in the data, which illustrated a progression, or a process of subjective and intersubjective experiences among these psychotherapists. A Thematic Schema of Optimal Responsiveness was constructed to conceptualize this process (see Diagram I). This schema is useful as an illustration, but the data might be organized,

DIAGRAM I

THEMATIC SCHEMA OF OPTIMAL RESPONSIVENESS*



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* This is not a universal schema of optimal responsiveness. This diagram illustrates the series of preconditions associated with the optimal responsiveness for most of the respondents in this study.

conceptualized, and interpreted within a different schema for another researcher. This Thematic Schema of Optimal Responsiveness is not postulated as a model in which optimal responsiveness occurs. Moreover, it is not intended to imply that there is a distinct order of experiences psychotherapists must have to be optimally responsive. Rather, it is intended to illustrate a conceptualization of the process, and a course of themes and categories of experiences that contribute to psychotherapists being optimally responsive. The findings are summarized in light of this thematic schema, as follows.

All of the nine psychotherapists identified subjective life experiences in the forms of losses and mourning, life-cycle issues, and their relationship with their psychoanalyst or psychotherapist as significantly contributing to the quality and nature of their responsiveness to their patients.

Losses were identified for seven of the nine psychotherapists. The psychotherapists' experiences of loss and mourning were interwoven in their interactions with their patients. There was a mutuality of subjective experience that contributed to their attunement and empathic resonance. By allowing their subjective experience to emerge, the psychotherapists seemed to have an increased sensitivity.

The psychotherapist's current life-cycle issues impacted their optimal responsiveness. The consideration of personal issues in the life of the psychotherapist was a major influence in the decision whether to take on a client. This was apparent in that the psychotherapists acknowledged the intense energy, commitment, and emotional availability that is required to do effective treatment. As one psychotherapist aptly stated,

> There's a strain on the therapist. That's a choice we make. There are stages, I think in everyone's life as a therapist where there are some people, that I could treat today, or I could have treated twelve years ago...that I will not be able to treat in 10 years, because of the necessary connection, the necessary energy...the necessary struggle, which I may not be able to put in.

The psychotherapists' experiences as patients and the quality of these relationships were extremely influential in contributing to the psychotherapists' optimal responsiveness with their particular patients. Several psychotherapists made reference to their experiences as a patient; they stated that these experiences whether they were positive or negative, facilitated the development of their therapeutic stance. The psychotherapist's selfobject needs seemed to be attended to via their relationship with their own psychoanalyst/psychotherapist; this was a precondition that affected the quality of their responsiveness to their patients.

The psychotherapists' subjective life experiences **allowed for** the psychotherapists to identify with their particular patients. For these psychotherapists, there was an identification and a sensed correctness of fit with the patient. Essentially the psychotherapists experienced a selfobject relationship with their patients that fostered an identification, and an essential mutuality; a reciprocity of selfobject experience was felt by the psychotherapist. This was a precondition that enabled the patients to have a selfobject relationship with their psychotherapists. Additionally, this selfobject experience was a precursor for these psychotherapists to be optimally responsive with their patient. The psychotherapists' identification and sensed correctness of fit **enhanced** their affect attunement with these particular patients.

Subjectivity in this study is described as the totality of the psychotherapist's own experiences, memories, associations, thoughts, recollections, fantasies, images, and reactions that are brought to the therapeutic relationship. The psychotherapists' attunement to their own subjectivity was indispensable, and was inextricably bound in the therapeutic work with their patient.

A related subcategory was the psychotherapists' use of images and internal dialogue. The psychotherapists awareness of their subjective state of being enhanced their capacity for creative imagination and fantasy through the use of

imagery. This served to assist the psychotherapist in apprehending their patient's subjective state of being. The use of images and internal dialogue of thoughts and feelings heightened these psychotherapists' attunement to their patient's experience.

A second related subcategory was the psychotherapists' use of metaphor. The metaphor in this context was understood as a means of attunement. That is, the metaphor had symbolic meaning and value to the patient. The psychotherapist's attunement to the patient's subjective experience and level of development facilitated the psychotherapist's response; the metaphor was a concretization of attunement.

The patient's subjective state of being was understood via the vantage point of the psychotherapists' affect attunement. The psychotherapists' receptiveness, empathic resonance, and affect attunement to the patient's subjective state of being facilitated a mutually shared experience between patient and psychotherapist. The result was the patient felt understood, and internalized the functions of the psychotherapist. This was sigificant, in that the "tendency for development of a disorganized self-state originates from early faulty affect attunement." (Stern, 1985) The psychotherapists exquisite attunement to the patient's experience, allowed the patient to internalize the qualities of the psychotherapist.

The intersubjective state of being was described as the interplay between two subjectivities, that of the patient (the observed), and of the psychotherapist (the observer). The psychotherapists resonated with their patients' subjective experience, while maintaining affect attunement to the interplay of both subjectivities. The psychotherapist's stance of affect attunement - to both subjectivities - contributed to the psychotherapist's optimal timing of response, intervention, and provision of experience. This provision of experience offered a new reference point for the patient, which facilitated change. The psychotherapist's affect attunement, as a precursor, **promoted** the creation of an environment in which the interaction of hoping, holding, and being held could occur.

The psychotherapists were able to promote a holding environment, while maintaining hope for their particular patient. One of the major factors which enabled the psychotherapists to provide a holding environment was their relationship with their clinical consultants or supervisors. These relationships served to contain, hold, soothe, and relieve the psychotherapists' anxiety related to the treatment of their patients. Additionally, potential intersubjective disjunctions were avoided through the use of a clinical consultant or supervisor. These psychotherapists did not hesitate to utilize the constructive support and maintenance of hope obtained via this special relationship.

The psychotherapists maintained a stance of hope for their patients, even in the most difficult times of the therapy encounter. This was particularly challenging for six of the nine psychotherapists, whose presented cases involved massive physical, sexual and emotional abuse. The psychotherapists were so profoundly moved by the depth of the abuse and its corresponding emotional aftermath that they became compelled and committed to help their patients improve. The psychotherapists were able to maintain a sense of hope for their patients, while tolerating, containing, and holding their patients' pain.

What seemed to facilitate the holding environment was the psychotherapists' degree of openness, optimism, and subsequent hope. The psychotherapists were affectively resonant with their patients, and were able to sustain and contain the patient's intense range of affects. The maintenance of the holding environment was a necessary optimal response that their patients needed to progress in therapy.

The psychotherapists expressed a primary preoccupation to take the necessary stance and provide interventions that would be in the best interests of their patients. The psychotherapists expressed their commitment and primary responsibility to their patients through their caring, loving, and unwavering "inner resolve" to help the patient improve. Their commitment and primary responsibility to

their respective patients **emboldened** the psychotherapists to move beyond professional parameters in order to respond to their patients optimally.

The psychotherapists were emphatic about maintaining a disciplined psychotherapeutic stance. Although they advocated a disciplined responsible approach, they were also open to a kind of "free-floating process." They believed that this combination of a disciplined approach and a "free-floating" process was a stance that was optimal with their patients. This approach was tempered with their belief in maintaining a focus that was in the best interest of the patient. Additionally, to insure that their response was "therapeutically usable," the psychotherapists attempted to respond to their patient at their current developmental level.

The psychotherapists reacted against feeling being rigidly confined to the traditional psychoanalytic views. They proceeded to take a stance which they believed was optimally responsive with their patients, often in spite of their need for support and safety to risk. In other words, regardless of the opinions of colleagues or customary parameters in the psychoanalytic community, they proceeded to work with their patients in a manner which they truly believed was most beneficial. For some psychotherapists, this meant withdrawing from nonsupportive settings. Additionally, some psychotherapists would withhold information from

colleagues regarding issues related to their therapeutic stances or interventions with their patients. This was a very significant finding, as these psychotherapists were able to move beyond customary parameters, despite the fact that support and safety to risk was also an important value for them.

Question #2: How Does The Psychotherapist Know He Or She Has Been Optimally Responsive?

The psychotherapists observed apparent shifts in their patient's affect which informed them that they had been optimally responsive. These shifts were manifested in two categories. The first shift was an observable reduction in the patient's anxiety. The psychotherapists were attuned to their patients' subjective experience, which facilitated a decrease in anxiety. They utilized affect attunement to engage their patient, and together they moved toward the achievement of affective intersubjectivity. The result of this was a reduction in anxiety, which was mutually felt by patient and psychotherapist.

The second type of shift in the patient's affect was an increased sense of vitality and well-being emanating from the patient, due to the decrease in anxiety. Several of the psychotherapists observed that their optimal responses brought about a restoration of the patient's sense of cohesion and a

vitality of the self. The psychotherapists maintained a stance that contributed to helping the patient create or restore a selfobject experience.

The psychotherapists observed significant external observable signs that were reflective of a shift in the treatment. These external observable signs occurred at turning points in the therapy encounter, as well as at different phases in the treatment process. The external signs were manifested in a variety of forms, such as tears, shifts in posture, and facial expressions reflective of a change in affect - smiles, reddened faces, or evident expressions in the patient's eyes. These external signs were viewed by the psychotherapists confirmation of their own empathic understanding, that was "confirmed by the patient's expression of his own empathic grasp" (Bacal, 1992) of the psychotherapist's optimal response at that moment. This process confirmed for the psychotherapists that they had been optimally responsive.

Another significant theme was the access to and development of new material contributed by the patient, which was manifested in three areas. One area was the psychotherapists' reports of observed shifts in behaviors among their patients that were either new or improved. The improved behaviors often took place in situations that had previously been difficult for the patient. The patients were observed to have greater selfawareness and less vulnerability;

as they began to feel differently, they subsequently acted differently. The implication is that the psychotherapists' responses to their patients - at that particular time in the treatment - were reflective of an optimal response, in that the patient began to evidence new and/or improved behaviors.

An additional manifestation of the disclosure of new material was the expression of new insights, greater understanding, and the production of dreams. The patients' production of new material resulted from the experience of a selfobject relationship with their psychotherapists. Further, the patients were able to utilize their psychotherapist in a manner in which they felt empathically understood and optimally responded to. Through this selfobject experience, the patient was able to utilize the qualities of the psychotherapist that prompted them to disclose new material.

Lastly, the psychotherapists observed and experienced a powerful, exceptional intimacy in the relationships with their patients. They responded to their patients' needs by taking "...cues that emanated from their patient's unconscious search for what is necessary to meet unmet needs" (Bacal, 1992). The psychotherapists allowed their patients to feel a sense of entitlement to their special relationship. In this way the patient was able to reciprocally respond to the psychotherapist, and thereby they engaged in a powerful exceptional intimate relationship.

LIMITATIONS OF THE STUDY

This study is exploratory, phenomenological, and descriptive, for the purposes of generating hypotheses and theory. As such, it describes the structure of an experience, but does not delineate the characteristics of a group or attempt to make generalizations about psychotherapists' subjective and intersubjective experiences that contribute to their being optimally responsive. But, as exploratory information, it does identify possible trends in what psychotherapists believe is optimally responsive.

Perhaps the most significant limitation is that what these psychotherapists defined as being optimally responsive was limited to their subjective appraisals of what was optimally responsive. This study did not correlate data from the patients of these psychotherapists, to determine whether what their psychotherapists were perceiving as optimally responsive, actually was.

Further, the Thematic Schema of Optimal Responsiveness (Diagram I) is limited to this researcher's conceptualization of these psychotherapists' experiences. Another researcher might conceptualize the data within a different schema.

This was not a random sample. Hypotheses or explanations that were generated must be accepted or rejected on the basis of comprehensiveness, closeness to the data, and the absence of a better explanation. The material is presented in such a

way that interpretations may be reviewed and critiqued. As in any such study, the findings remain open to reinterpretation in light of new evidence of understanding.

IMPLICATIONS FOR CLINICAL PRACTICE

Although the psychoanalytic literature has emphasized the significance of the personal life of the psychotherapist and its overall effect and impact on the progress of treatment, no research has been directed at studying the subjective and intersubjective experiences that contribute to psychotherapists' optimal responsiveness. Additionally, although there have been discussions in the literature, there has been no systematic study that provides a conceptual understanding that verifies for the psychotherapist that he or she was optimally responsive. The findings of this study can serve as a basis for further research, as well as guide graduate and professional training for those in the mental health professions.

There are several implications for this study. This study has provided knowledge as to the kinds of subjective and intersubjective experiences psychotherapists have that contribute to their being optimally responsive. This study can serve to heighten psychotherapists' self-awareness, and sensitivity to those subjective aspects of themselves that may contribute to, or limit, being optimally responsive.

This study suggests that there are certain precursors that contributed to psychotherapists' ability to be optimally responsive. Although certain experiences may predispose a psychotherapist to be optimally responsive with patients it appears that the impact of specific kinds of subjective and intersubjective experiences shape the capacity to respond optimally. The Thematic Schema of Optimal Responsiveness (Diagram I) was developed as a way of conceptualizing these experiences. Psychotherapists can assess, compare, and contrast their personal experiences of optimal responsiveness utilizing this schematic process.

This study identified several areas of subjective life experience that contributed to the psychotherapists' ability to be optimally responsive. The psychotherapists' personal losses and subsequent mourning was a very significant aspect of their subjective experience. Issues related to unresolved losses were rekindled and interwoven in their work with their patients. The current phase in the life-cycle of the psychotherapist was also pertinent to their decisions on whether to take on certain clients who might not have been taken at another phase in the psychotherapists' life. Also, the meaning of the current life-cycle phase for the psychotherapist influenced the psychotherapist's capacity to respond optimally. Additionally, the quality of the relationship with their psychotherapist/psychoanalyst was inextricably intertwined in the interaction with their

patients. Overall, the psychotherapist's subjective life experiences - personal psychotherapy/psychoanalysis, loss and mourning, and life-cycle issues - are seen as crucial factors that can contribute to, or limit, the psychotherapist's capacity to be optimally responsive with his or her patient.

Another implication of this study was the value of noninterpretative analytic work. That is, for some patients noninterpretative work allowed for the development of a selfobject relationship with their psychotherapist. This was a necessary precondition in order for the treatment to progress. The significance of the selfobject relationship was especially important in facilitating the psychotherapist's ability to apprehend and respond to the developmental needs of the patient. This is particularly applicable in the treatment of patients with early selfobject deficits. This study suggests that the range of responses should be broadened to include other noninterpretative work that is responsive to the patient's particular developmental level. Bacal's (1988) statement is applicable to this implication:

> ...a good interpretation is only one component of the analyst's optimal responsiveness...When interpretations persistently fail to provide this experience for the patient, then apart from the possibility that the interpretations may be wrong, the likelihood of traumatic frustration in the patient's early childhood must be considered. In these instances, the patient will require something out of the ordinary from the analyst in order to feel understood by him, something that the analyst may regard as out of order; a change of demeanor or attitude, perhaps some action, such as the

> acceptance of a gift, an alteration of fees or appointment time...It is as if the patient is now saying to the analyst, "Show me. Be who I need you to be, don't just interpret it." If the analyst cannot find a way to respond optimally to this appeal, the patient may continue and even intensify "acting-in" or may surface from the regression and accept the limitations of analysis for himself, at least with that analyst. (p. 130)

Further, this study has illustrated the significance of the selfobject relationship that is mutually and reciprocally experienced between patient and psychotherapist. This study suggests that optimal responsiveness is derived from the psychotherapist's affect attunement to the mutually reciprocal selfobject relationship. Perhaps, as Bacal stated, this process can be referred to as "intersubjective optimal responsivity." Bacal's (1992) explanation confirms this important implication:

> The essence of the analyst's contributions to the patient's experience of a selfobject relationship is his or her optimal responsiveness to those of the patient. As we know, the therapist's optimal responsiveness may take many forms. It preeminently includes the willingness to collaborate on the task of working-through disruptions in the selfobject relationship between the two participants. It may include the interpretation and/or the provision of a variety of verbal and nonverbal selfobject functions. It may entail an inquiring attitude, or a quiet noninquiring presence, a echoing confirmation, or a confrontational challenge. It's form will be determined not only by the issues that the patient and the analyst are working on, and by the strength of the patient's self, but also by the patient's operative level of developmental achievement...

The theme of hoping, holding, and being held has significant implications. The psychotherapists were able to tolerate their patients' overwhelming emotional pain when the psychotherapists themselves had experienced being held, contained, and soothed via their clinical consultant or supervisor. This allowed the psychotherapist to be able to contain, hold, and provide hope for the patient in the face of very difficult treatment situations. This interaction instilled and affirmed a powerful commitment and an intense primary responsibility to their patients.

The theme of the emboldened psychotherapist moving beyond customary parameters in a manner which was optimally responsive, was a finding with important implications. Also significant was the psychotherapist's need for safety to risk in psychoanalytic settings. Psychotherapists who do not feel support, safety to risk, and trust in psychoanalytic settings will tend to withdraw or withhold valuable information from colleagues that was beneficial for the treatment of their patients. Psychotherapists will risk disclosing those interventions in settings that promote, encourage, and value discussion on the intersubjective aspects of psychoanalytic work. This study suggests that the psychoanalytic community should remain open to progressive ideas and interventions that shed new light on prevailing views and expand psychoanalytic inquiry.

The findings for Research Question #2 had several important implications. There were a number of observations made by the psychotherapists that confirmed for them that they had been optimally responsive with their patients. The cumulative effects were reflected in three themes: 1) Shifts in the patient's affect; 2) External observable signs; and 3) Access to and development of new material. These findings suggest an initial framework by which the psychotherapist can verify whether their psychotherapeutic interventions were optimal and therapeutically usable.

DIRECTIONS FOR FURTHER RESEARCH

As an adjunct to the present study, it would be valuable to explore the patient's perspectives of what contributes to their feelings of being optimally responded to by their psychotherapists or psychoanalysts. It would be interesting to discern whether the experiences of patients are similar to the experiences of psychotherapists in terms of their views of what was optimally responsive in the therapeutic encounter.

In addition to descriptive studies, quantitative research might be undertaken to assess the differential effects of variables such as age, gender, ethnicity, geographic locations, treatment with specific patient populations, and brief psychotherapy versus long-term psychoanalytic psychotherapy on optimal responsiveness.

Future qualitative researchers could study additional subjective and intersubjective experiences which may contribute to psychotherapists' ability to be optimally responsive. The Thematic Schema of Optimal Responsiveness (Diagram I) could be reconceptualized, and adjustments could be made for the inclusion of additional significant subjective and intersubjective experiences of psychotherapists. Also, new insights and indicators could be generated via a study that expands on how the psychotherapist verifies whether he or she was optimally responsive.

Some questions for further research include the following:

1) What subjective and intersubjective experiences contribute to patient's feeling optimally responded to by his or her psychotherapist or psychoanalyst?

2) How do patients know that they have been optimally responded to by their psychotherapist or psychoanalyst?

3) Do the patient's and the psychotherapist's experiences of optimal responsiveness correlate with one another?

4) What are the complementary selfobject needs that contribute to a good match or fit between patient and psychotherapist?

APPENDIXES

APPENDIX A

INTRODUCTORY LETTER

Carmely Estrella, M.S.W., L.C.S.W.
Licensed Clinical Social Worker
16539 Chattanooga Place
Pacific Palisades, California 90272-2331
(310) 578-5916

Dear Colleague:

I am writing to ask for your participation in a research study. I am exploring the intersubjective experience of the psychotherapist and the patient, and attempting to discover within that framework, that which facilitates optimal responsiveness. My study uses an exploratory design and will attempt through individual interviews to identify from the therapist's perspective, common patterns of experience that contribute to optimal responsiveness. There is no better way to understand this than by talking 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 Philip A. Ringstrom, Ph.D. of the California Institute for Clinical Social Work.

The selection of my population will begin with the collection of data taken from an "Optimal Responsiveness Survey." If the results of your survey responses so indicate I will be contacting you to see if you would be willing to participate in an approximately 1 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 provided.

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

Sincerely,

_____
Carmely Estrella, MSW, LCSW

APPENDIX B

OPTIMAL RESPONSIVENESS SURVEY

Section I

1) Number of years in clinical practice_____

2) Which of the following best describes your primary job 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 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-MSW training (check all that apply):

a) clinical consultation_____
b) supervision _____
c) advanced formal training_____

Section II

DEFINITION:

Optimal responsiveness involves the therapist acting in a manner which conveys a sense of understanding, attunement, and empathy appropriate to the patient's experience. It may or may not include a verbal interpretation. The therapist's range of responses is therefore less constrained and more free to engage the patient in a variety of intervention styles (such as, but not limited to: modification of framework, appointment time, fees, confrontation, gratification, etc.). The determination of the therapist responding optimally is confirmed through both the patient and therapist experiences. This study is an exploration of both parties experience, from the therapist's perspective.

Please complete the following questions in a way that best describes your thoughts, feelings, and experiences. Use the reverse side if more space is needed. Thank you.

1. Please describe a session or a piece of interaction in a session, in which your clinical interventions could be identified as having been optimally responsive to a particular client:

_____
_____
_____
_____

2. In reference to the above session, please describe your experience as the therapist (i.e. thoughts, feelings, associations), that could be identified as having contributed to your being optimally responsive:

_____
_____
_____
_____

3. Please describe what your patient did, said, or revealed that confirmed your having been optimally responsive.

_____
_____
_____
_____

****

If you would be willing and available to participate in an in-depth, personal, and confidential interview, please fill-in below.

Name _____

Address _____

_____

_____

Telephone: Office ( )_____ Home ( )_____

Best times and days to call _____

Thank you for your time and interest!

****

APPENDIX C

INFORMED CONSENT FORM

California Institute for Clinical Social Work

I, _____, hereby willingly consent to participate in **Optimal Responsiveness: An Exploratory Study of the Intersubjective and Subjective Experiences of Psychotherapists** research project of Philip A. Ringstrom, Ph.D. (Dissertation Chairperson) and Carmely Estrella, L.C.S.W. (Investigator) of the California Institute for Clinical Social 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 time also without penalty.

2) I am aware that there is little 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 my anonymity will be protected unless I give written consent to such disclosure. The interview will be conducted by Carmely Estrella, L.C.S.W.

4) I have been informed that the interview will be taped for purposes of data analysis. I have also been advised that my name will not appear on the tape and that at the completion of the study, the tape will be erased. I realize that without my consent I will not be identified in any publication nor presentation of information gathered as part of this study.

Signature:_____ Date: _____

APPENDIX D

INTRODUCTION TO INTERVIEW SESSION

Thank you very much for taking the time to meet with me and assisting me in my research project. I also wish to thank you for giving me this opportunity to meet with you to discuss your subjective and intersubjective experience as a psychotherapist, and how this contributes toward facilitating optimal responsiveness in the therapeutic encounter.

Our meeting will last for approximately one hour. I will be audio-taping our conversation. The tapes will be for my use only, and will be erased after the study is completed. Before starting I would like you to complete this Informed Consent Form.

Do you have any questions before we start the interview?

APPENDIX E

PRELIMINARY TOPICS AND PROBE QUESTIONS

The subjective and intersubjective experience of the psychotherapist is an area that may contribute to optimal responsiveness in the therapeutic encounter. The following topics and corresponding probe questions will be explored during the course of the interview:

Topic I: The therapist identifies that s/he is optimally responsive in a session or interaction of a session:

What did you experience during the session that conveyed to you that you had been optimally responsive? What was it about the session(s) or interaction within the session that conveyed to you that there was a significant turning point? What were the indicators for you? What was known about the patient's developmental level that you feel is significant in this therapeutic encounter? What was so very therapeutic for the patient at that particular moment? What worked well, and what did you do about it? (Explore the range of responses that may not necessarily be verbal; may include gratification; provision of experience, etc.) How was it different at that hour (in comparison to other hours)? What do you think was occurring within the patient? Did you observe any visible changes with the patient at that moment? (This topic will explore how the therapist can identify the client's subjective experience and its relationship to the episode of optimal responsiveness)

Topic II: The therapist identifies his/her subjective experience(s) that facilitate optimal responsiveness:

Please describe any personal experience(s) you had either prior, during, or after a session that you feel may have contributed to being optimally responsive at that session. What was it like for you? How were you feeling at that particular hour? What might have contributed to you being so very attuned to the patient at that moment? (This topic will attempt to cull as much of the inner state of the therapist as possible)

a) Explore any of the following areas: feeling state of the therapist; the therapist's inner thoughts/processes; free associations; dreams; recollections and/or early personal memories as evoked by the client; early/recent relationships that have assisted you in being optimally responsive; evidence of past/recent relationships that you experienced as being misunderstood?; pictures/images that the therapist was aware

of; the kind of (feeling) tone of that session; current life-situation of the therapist at that time; verbal (interpretations) and non-verbal actions/responses; experience(s) of the therapist; the nature and quality of the ambience for the therapist.

Topic III: The therapist identifies personal experiences and/or professional training that may contribute to an intersubjective, optimally responsive therapeutic approach:

What (how) do you feel in your personal experience, and /or professional training has contributed to the maintenance of an optimally responsive analytic stance/ambience? Additionally, what factors do you personally believe/feel need to be improved that will help you to maintain an optimally responsive analytic ambience? What working-model, if any, does the therapist utilize to insure an intersubjective, optimally responsive stance? What evidence does the therapist have that facilities the interplay of two subjectivities, that of the patient and that of the therapist? What do you do when you feel you are no longer optimally responsive with your patient, to get you back on track? (i.e. intersubjective dysjunction/conjunction) What do you think would improve your overall ability to be optimally responsive with your patients? Do you feel there is a difference in your use of optimal responsiveness in your personal as opposed to your professional life? (This topic will attempt to identify those aspects of the analytic ambience that therapists identify as contributing to optimal responsiveness)

Closure

Do you have anything further that you would like to add? Do you have any questions or comments about the interview itself? Thank you very much for your willingness to share your time and discuss your experiences with me. Would you be interested in the results of this study?

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