A STUDY OF THE WAYS THAT PSYCHOANALYTIC PSYCHOTHERAPISTS HOLD A SENSE OF THEIR PATIENTS' FUTURES, AND HOW THIS IMPACTS THERAPEUTIC ACTION

Penny Schreiber

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By

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ABSTRACT

A STUDY OF THE WAYS THAT PSYCHOANALYTIC PSYCHOTHERAPISTS HOLD A SENSE OF THEIR PATIENTS FUTURES, AND HOW THIS IMPACTS THERAPEUTIC ACTION

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This qualitative study explores how psychotherapists think about and hold a sense of their patients' futures, about what may be possible or desirable for an individual that may have been foreclosed. All of the participants knew something about the topic, although they approached it from different theoretical points of view and with different language. Their knowledge of these phenomena came from long experience as psychotherapists. From their responses it would seem that holding a sense of the patient's future, though not often addressed, is an essential psychotherapeutic function, forming a generally unspoken and often unconscious frame of reference for psychotherapy.

Data was collected in one hour semi-structured interviews with ten experienced psychoanalytic psychotherapists from different professional fields and theoretical orientations. Each was recorded on audiotape and transcribed. Data analysis followed the Grounded Theory approach described by Strauss and Corbin (1998).

Findings of the study reveal that although the participants all hold and actively work with a sense of the patient's future, most of them described this in terms of holding hope and possibility. The findings include: holding hope and possibility, therapeutic action, the issues of therapist influence, patient hope and hopelessness, affect regulation, future.

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I want to thank the Institute community, both faculty and students, for their support, and all the stimulating conversation over the years. I've enjoyed my association with this group so much. I am particularly grateful to the students, past and present, whose support and camaraderie has been so valuable.

I also am grateful to the ten participants in my study. They were willing to open up their minds and hearts in a way that amazed me. I felt blessed to have such a group of volunteers.

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CHAPTER I: INTRODUCTION

This qualitative research explores how psychoanalytically oriented psychotherapists think about and hold the notion of the client's future, and how the held future impacts therapeutic action.

Statement of the Problem and Background

Although the client's future is implicit in every psychotherapeutic treatment, it is not often discussed. The concept of future here includes a sense of what might be possible for the person, including shifts and changes in internal or external directions. Often this sense of possibility is not something that the patient knows or desires consciously; rather, it is something that will begin to emerge in the course of a treatment. This research explores how psychoanalytically oriented psychotherapists think about and hold the client's future; how—and if—the therapist thinks about this and how it may or may not be manifest in therapeutic action.

Traditionally and primarily, psychoanalytic psychotherapy has been concerned with how the past is being expressed in the present whereas the future is not often directly addressed. However, a dilemma for therapists has been that understanding the past does not always suggest a new way of living nor, necessarily, how to improve things.

Traditional constructions of transference assume that the past is being repeated in the present relationship, where it can be observed and interpreted. Powerful as this method is, understanding the underpinnings of a particular symptom, behavior, or way of life does not necessarily produce change and emotional healing in the patient. It is not an unusual experience in therapy for the patient to understand why he does what he does,

and how past paradigms repeat themselves in the present, particularly in the transference, yet to remain stuck in the same patterns.

In the preface to his book, *Self Creation: Psychoanalytic Therapy and the Art of the Possible* (2005) Summers makes the assertion that psychoanalytic theory and practice has been too much focused on insight, with not enough focus on how insight might lead to change in the individual. He outlines a method for attending to the patient's future based on a Winnicottian concept of transitional space.

Cooper (2000) states that Freud and his followers avoided considerations of the future in psychoanalysis, and he believes there needs to be more balance between how therapists understand and use the past and the future. (p. 14) The purpose of this study is to examine whether psychoanalytically oriented psychotherapists hold a sense of their patients' futures, and how this holding or not holding impacts their work.

A desire for change and an improved future is an inherent part of treatment. People usually come to therapy with the hope or wish for a better future. They may be in pain or conflict, and know they want the pain or conflict to go away, yet they may not know what a good outcome might be. They may come with a sense of not knowing what is possible, and yet underlying that are very deeply buried wishes and potential. They come wanting something better. Their symptoms may be a sign of a foreclosed future. Summers says, "when the future looks dim the present becomes empty" (2005 p. 32).

It was a consultant who first turned my attention towards thinking about my cases in the context of the patient's future, to what might be possible and how individuals limit themselves and their sense of their own futures. I found this to be an enormously helpful idea. It involved keeping in mind a sense of the best the person was capable of, and who

they might become. Though the future is a part of every treatment, it is not often acknowledged; and when it is spoken of or thought about, it is rarely approached directly. After working with this concept of the future as a focus in my therapy practice for some time, I started asking other therapists if they incorporated the future into their treatment, and quickly found out this was not something to which they had given much thought. Feeling isolated with this knowledge, I pursued this phenomenon through reading, and eventually through this study.

With some exceptions, we do not often see the future discussed in the psychoanalytic literature. The most famous article that incorporates a reference to the importance of a sense of the patient's future is Hans Loewald's "On the Therapeutic Action of Psychoanalysis," (1960). According to Loewald, the therapist needs to find the glimpses of what is possible for patients, and hold those glimpses, chipping away at the patient's distortions to find something more genuine. Loewald states:

> In analysis, a mature object relationship is maintained with a given patient if the analyst relates to the patient in tune with the shifting levels of development manifested by the patient at different times, but always from the viewpoint of potential growth, that is, from the viewpoint of the future. It seems to be the fear of molding the patient in one's own image that has prevented analysts from coming to terms with the dimension of the future in analytic theory and practice, a strange omission considering the fact that growth and development are at the center of all psychoanalytic concern. (p. 27)

And, in the same article, Loewald's words resonate with the way I had been taught by my consultant:

> In sculpturing, the figure to be created comes into being by taking away from the material: in painting, by adding something to the canvas. In analysis, we bring out the true form by taking away the neurotic distortions. However, as in sculpture, we must have, if only in rudiments, an image of that which needs to be brought into its own. The patient, by revealing himself to the analyst, provides rudiments of such an image through all the distortions—an image that the analyst has to focus in his mind, thus holding it in safe keeping for the patient, to whom it is mainly lost. It is this tenuous reciprocal tie that represents the germ of a new object-relationship. (p. 21)

One of the problems in writing about the therapist's sense of the patient's future is that when it has been written about, the language varies, often neglecting the term future altogether, using words like wish and hope instead. Stephen Mitchell (1993), for example, addresses hope and acknowledges how rarely it appears in the literature: "If discussions of the patient's hopes are rare in the psychoanalytic literature, discussions of the analyst's hopes have been virtually nonexistent until recently" (p. 207). Cooper, (2000), also writes about how the therapist has hope for the patient's future. He puts it strongly:

> Psychoanalysis has moved from attempting to be a science of the retrospective (how wishes and compromise formations were forged in development and mediate experience) to being a way of understanding and making meaning of how wish and hope are influenced in the present. (p. xvii)

Buechler, in *Clinical Values: Emotions That Guide Psychoanalytic Treatment* (2004), also speaks of hope, noting that is has an interpersonal aspect, that it needs to be realistic,

and that it requires self knowledge on the part of the therapist, about his desire to accomplish something. (p. 39)

It is my experience that in a psychodynamic psychotherapy, a sense of the patient's potential future is an ongoing and always present parallel track to understanding the past and transference configurations that reflect patterns from the past. For me, how the therapist thinks about "what is possible" does matter, and is an important part of a therapist's attitude toward the patient. For me, this sense of potential arises from a strongly attuned and specific sense of who this patient might become, based on his own capabilities and wishes. It is my belief that this is a track of clinical thinking that needs to be developed alongside historic, transferential interpretive functions.

The future is a part of every treatment, whether acknowledged and worked with or not, I am arguing that an awareness of the future is a valuable addition to the practice of psychotherapy, that the issue of the future needs to be more conscious for the therapist throughout treatment, and that the future can be a problem if it remains unacknowledged.

One reason why the issue of the future has largely been neglected is fear of influence. Therapists are rightfully concerned that they not impose values and agendas on patients. Related to this is the concern that the patient may be absorbing the therapist's agenda, or that the patient's progress may be the result of compliance. A clarification of this concern has been offered by Jonathan Lear, an associate of Loewald's and confidante of his later years. Clarifying Loewald, he says: "For Loewald, it is *the patient* [italics in original] who provides the rudiments, the image, of what needs to be brought into its own. That is, the patient provides his own rudiments of what he is to become" (2003, p. 109).

A sense of hope and of the future does not necessarily imply patient compliance. Friedman (1988) says:

> It is not necessary for the therapist to know exactly what he is encouraging. It is sufficient that he treats the patient as though he were roughly the person he is about to become. . . . The patient will explore being treated in that way. He will fill in the personal details himself. (p. 130)

The emphasis here is that in order to effectively focus on the future, the therapist must be aware of the client's emerging sense of self and of possibility. The new directions the patient finds have to come from within himself, and not be imposed by the therapist. Summers adds a caution about the perils of avoiding thoughts about the future: "To conduct therapy without a vision of the patient is more perilous still, because lack of awareness of the therapist's image of the patient will most likely result in unexamined influence" (2005, p. 144). In other words, consciousness of one's own attitude toward the patient's future, and what is possible would be an important part of the therapist's thinking.

The Research Question and Approach

My intention in this study was to explore how psychoanalytically oriented psychotherapists think about the dimension of the future. Do they hold a sense of the patient's future? Does the therapist think about the client's emerging self? Another aspect of this study is the question of how therapists think about what might be possible or desirable for an individual patient, ideas that she or he may have foreclosed for any number of reasons. What does the therapist do when the client has foreclosed the sense of his own future? I was also interested in how therapists experience hope—their own and

the client's. How does hope stay alive? What about hopelessness, and invitations to join in hopelessness? How does the therapist perceive the impact of the held future on the way that therapy is conducted?

The Grounded Theory approach informed the design of this study of subjective experience. Data was collected through in-depth semi-structured interviews with experienced psychoanalytically-oriented psychotherapists. The interviews were conversational, using Mishler's (1986) notion of the research interview as discourse. Data was analyzed using the "constant comparative method" as described by Strauss and Corbin (1998)

As used in this study, psychoanalytic psychotherapy is defined as therapy that is less frequent than psychoanalysis, but has a focus on unconscious processes, and in which transferences are understood and encouraged. Nancy McWilliams, in her book *Psychoanalytic Psychotherapy: A Practitioner's Guide* (2004), says that psychoanalytic treatments are defined by underlying belief systems rather than technique. This includes a belief that self-knowledge is a good thing, and that honesty with oneself leads to better mental health. (p. 4) Although many of the sources I use in this study focus on psychoanalysis, the ideas and principles are also applicable to psychoanalytic psychotherapy.

Having trained as a social worker, I learned to refer to the recipients of my services as clients. I have been exposed to a more medical orientation through reading and from colleagues, I have come also to refer to them as patients. In this research the two terms are used interchangeably to mean the same thing.

In this research, I use the concept of therapeutic action to mean the

> set of assumptions therapists make about how people get better in therapy, what it is in their experience that produces change, what kinds of changes are possible, and what the therapist does, says, and thinks that facilitates therapeutic growth and change. (Schreiber, 2005, p. 1)

Significance

I have chosen this subject for investigation, because I have had some beneficial, useful experiences that have involved holding a sense of the patient's future, and of what might be possible. In this study I investigated how this issue has been explored in the literature, and note the lack of a strong body of work related to the subject. I also investigate how other psychoanalytic psychotherapists discuss issues related to the patient's future.

I hope, through this research, to illuminate the notion of the holding of the client's future. Specifically, I would like to contribute to our understanding of how the patient's future is understood by practicing therapists, and how this impacts the treatment. I would like this research to add to therapists' consciousness of the held future.

CHAPTER 2: LITERATURE REVIEW

The subject of this study is how the psychoanalytically oriented psychotherapist holds the sense of the patient's future. The general focus of this literature review is on writers who discuss the ways in which the therapist thinks about the patient's future from the point of view of psychoanalytic psychotherapy or psychoanalysis. In addition, the literature review covers clinical writers' descriptions of how they perceive and engage the notion of the patient's future in therapy.

This review has been organized by topic areas that represent aspects of operationalizing the ways in which the future may be held, elaborated by the views of different authors. There are nine topic areas: (a) discussions of the future in psychoanalytic literature; (b) hope; (c) challenges to the therapist when what is possible is not clear: (d) dealing with the patient's anxiety about new ways of being; (e) fear of influence; (f) affect regulation, symptoms and defense; (g) possibility, change, and therapeutic action as related to a sense of the patient's future; (h) cultural influences on expectations about the future; and (i) the impact of theory on the therapist's view of the patient's future.

Discussions of the Future in Psychoanalytic Literature

The body of literature that addresses how the psychoanalytically oriented therapist holds and considers the patient's future is scant. A recent study by Frank Summers, published in 2005 and entitled *Self Creation: Psychoanalytic Therapy and the Art of the Possible*, is notable because it directly addresses the therapist's work with the patient's future. Because Summers engages with the topic more thoroughly than most authors, I rely on his work in various sections throughout this literature review.

The earliest significant work on this topic was written by Hans Loewald in 1960, "On the Therapeutic Action of Psychoanalysis." This article has become a common starting point for any discussion of how the therapist thinks about and holds the idea of the patient's future. Because it is a seminal work, and because it contains the ideas that became the basis of the subsequent psychoanalytic literature about the future, I feel it is helpful to repeat here two important quotations from that article that were already cited in the introductory chapter of this study. It is interesting to note that although Loewald's language was of the traditional, conservative psychoanalytic discourse of his day, his ideas were not. He provided an alternative to the psychoanalytic thinking about the therapeutic relationship as it was understood in the mid-twentieth century— that is, as a purely a transference phenomenon.

> In analysis, a mature object relationship is maintained with a given patient if the analyst relates to the patient in tune with the shifting levels of development manifested by the patient at different times, but always from the viewpoint of potential growth, that is, from the viewpoint of the future. It seems to be the fear of molding the patient in one's own image that has prevented analysts from coming to grips with the dimension of the future in analytic theory and practice, a strange omission considering the fact that growth and development are at the center of all psychoanalytic concern. (p. 27)

In a similar vein, he states:

> In sculpturing, the figure to be created comes into being by taking away from the material: in painting, by adding something to the canvas. In analysis, we bring out the true form by taking away the neurotic distortions. However, as in sculpture,

> we must have, if only in rudiments, an image of that which needs to be brought into its own. The patient, by revealing himself to the analyst, provides rudiments of such an image through all the distortions—an image that the analyst has to focus in his mind, thus holding it in safe keeping for the patient, to whom it is mainly lost. It is this tenuous reciprocal tie that represents the germ of a new object-relationship. (p. 21)

He asserts in this article that he is not prescribing a new psychoanalytic technique, but rather an alternative point of view.

Loewald also discusses the periods of regression and reorganization that take place in an analysis, pointing out the importance of the analyst's role in holding the client's future: He states:

> The patient can dare to take the plunge into the regressive crisis of the transference neurosis that brings him face to face again with his childhood anxieties and conflicts, *if* he can hold on to the potentiality of a new object-relationship represented by the analyst. (1960, pp. 19-20.)

What is possible becomes evident in the periods of reorganization. Loewald clarifies that what is "new" is not in fact new, but re-discovered; ways of being, relating to objects and oneself that were there in earlier times but not developed. Thus he makes the important point, later developed by many others, that the therapist or analyst becomes a new object. What is possible in the future is developed in the relationship with the therapist. The experience of transference is more than a re-experiencing of the past; it also can contain a new experience of future possibility.

Summers, (2005) says that, with the exception of Loewald, no major psychoanalytic writer has described the creation of a vision of the patient's future as a psychoanalytic function. This is a fairly new area of formal inquiry, although, perhaps, not a new idea in the field, as illustrated by my experience of being taught by a consultant to actively consider the patient's possible future, beginning in 1988, before much had been written on the subject. Summers, in both his works (1999, 2005) says that the future is implicit in every treatment. People come to therapy hoping for a better future, hoping that the troubles of the past do not repeat themselves.

One traditional method of impacting the future has been to make meaning out of the past. When this works well, an individual understands his distortions and the reasons for his feelings, thoughts, and behavior, and is able to modify these through this understanding. This point of view has limitations. Summers (2005) notes that although a therapist may view understanding the past as a road to a better future, sometimes this does not have enough therapeutic impact, and the patient considers understanding the past to be a confirmation of hopelessness. He may feel stuck with the only way he knows how to be. It is not unusual for a patient to understand a significant amount about his past, his thinking and relational patterns, yet still feel unable to do anything that is different. It is a common occurrence for the patient to have foreclosed his own future—to believe nothing more is possible. If, however, the patient feels that a better, different future is possible, the present will be experienced in a different way. The therapist can contribute to that possibility by holding a sense of future possibilities, both by internal attitude and by what is interpreted. Thus, a sense of the future is jointly created by the therapist and patient.

Holding a sense of the patient's possible future also requires a different kind of self-awareness by the therapist. Since the future is a significant factor in every treatment, it makes sense for the therapist to be conscious of it. There is value in increased self-knowledge on the part of the therapist regarding this aspect of the work, specifically, what the therapist thinks is possible for this particular patient, and a vision of what the patient would be like at his best.

To be unaware of one's attitude toward the patient's future may create a risk of unconscious or unexamined influence, a topic that will be discussed more fully later in this literature review. Summers stresses the import of the therapist's role in holding the patient's future.

> Given the inevitability of the future dimension, more harm can be done by the therapist's suppressing her image of the future than by recognizing it and consciously formulating it in response to the evolution of the patient's material. (2005, p. 59)

Cooper (2000) echoes Summers' concern with the importance of and lack of attention to this subject. He has developed a way of thinking about the patient's future, as an aspect of the therapist's subjectivity. According to Cooper :

> Our view of our patients' future is an essential and underemphasized aspect of formulation and interpretation and is most visible in our theories of change and how we conceptualize our various modes of influence. The view of the future as contained in the analyst's formulations is still another aspect of the analyst's subjectivity. (pp. 26-27)

Cooper is saying that a view of the future is implicit in what the therapist says and does, even when the future is not being specifically addressed. Cooper's main theme is hope, which is implicit in dealing with the future.

Hope

One of the important and most frequent ways the future is discussed in psychoanalytic literature is in terms of hope. In particular there are discussions about how the psychoanalyst or psychotherapist has hope for the patient, how he joins with the patient's hopes, how he deals with hopelessness, and how hope can evolve when a patient has lost track of what to desire.

Hope can be a difficult concept; it implies the development of a sense of what might be possible and the capability of generating the energy to assist in making that happen. There are many nuances of hope. It can be an attitude or a stance one assumes in uncertain circumstances. It can be a personal quality. It can be an activity. It is related to, though not the same as, visualizing outcome or setting goals

There has also been some work on hope within non-psychoanalytic psychological theories although this work is not the focus of this study. Snyder, for example, is the author of a number of books, including *The Psychology of Hope,* written in 1994. He includes in this book a hope test, and practical suggestions about how hope can be fostered in children and adults. In his 2004 book *The Anatomy of Hope: How People Prevail in the Face of Illness,* Groopman, writing from a medical point of view, describes a conversation he had with experimental psychologist Richard Davidson, who was studying the biology of positive emotions. Davidson describes hope as having both a

cognitive part, i.e. how we think, and an affective part, i.e. a feeling of hopefulness (as cited in Groopman, p.193).

Mitchell, in his 1993 book *Hope and Dread in Psychoanalysis,* asserts that although discussions of the patient's hopes are rare in the psychoanalytic literature, "discussions of the analyst's hopes have been virtually nonexistent until recently" (p. 207). Mitchell also cautions that the analyst and patient may well have very different hopes, particularly at the beginning of treatment (pp. 208-209).

Embedding the concept of hope securely within psychoanalytic theory, Steven Cooper, in his introduction to *Objects of Hope* (2000), states:

> I have come to the conclusion that the concept of hope is among the most important . . . elements of all our sources of influence across psychoanalytic theory. In fact, I refer to the body of psychoanalytic theory as our logic of hope. (p. x)

He makes hope a central aspect of psychoanalytic thought and practice. He continues:

> Psychoanalysis has moved from attempting to be a science of the retrospective (how wishes and compromise formations were forged in development and mediate experience) to being a way of understanding and making meaning of how wish and hope are influenced in the present. (p. xvii).

In addition, I would suggest that wish and hope also impact the future.

Hope may imply action. Both Cooper (2000, p. 17) and Buechler, (2004, p. 44) say that there needs to be a kind of psychological push involved with hope. This implies a level of energy coming from the therapist. Cooper takes it a step further, saying that the therapist or analyst is "hellbent" (p. 22) on seeing if something can be different. This is

strong language, and implies a lot of motivation on the part of the therapist. Summers (2005) expresses a similar idea, saying that the therapist must not just discover the patient's potential, but must also believe in it. He states, "To a considerable extent, the success of the project relies on the tenacity of the therapist's spirit" (p. 149). He continues, emphasizing the active role of the therapist in imagining the patient's potential:

> The outcome of the therapeutic endeavor so depends on the evolution of the therapist's belief in the patient that it is hard to imagine a positive result with a therapist who cannot see the potential for a new self. (p. 149)

Hope for the patient's future on the part of the therapist means, among other things, a confidence in the patient, and being able to envision—and perhaps even inspire—what may be possible.

Cooper introduces the notion of hoping fruitfully. He describes the process in the following way: "the analyst is trying to learn as much as possible about what the patient wants, what the patient is afraid of, how the patient protects himself, and the like." (2000, pp. 32-33). He credits Freud with an attitude of challenging unreasonable hopes. "Freud's power, for me and probably for many analysts, resides in his unbending capacity to combat intellectually our predilections for naïve hope and unreasoned belief." (p. 130)

The literature confirms what I have long experienced: for the therapist to hope in a constructive, useful way is extremely important. It requires paying careful attention to what is said, and also to what is between the lines, for example, the hopes that the patient dare not speak for fear of having them dismissed or torn down. The patient's dearest hopes may be very fragile. The patient may be terribly afraid of something that cannot be

mentioned. The therapist needs to hold a sense of what the patient is capable of at his best, and, to get a sense of that, he or she needs to know the patient very well. It does no good to hope for things that lie outside the patient's capabilities; discernment is extremely important.

In no way does the therapist decide what is best for the patient, or who the patient really is, and impose this on the patient. There is complete agreement among all of the authors I have read on this point; what is possible comes from the patient, not the therapist. However, they stress that the therapist needs to be able to take on the task of seeing what the patient will not let himself see. Sometimes what a therapist needs to be able to do is to help the patient "connect the dots," to make meaning of his experience and his desires.

> Stern (1997) speaking from a relational framework, expresses this point of view:
>
> We work in psychoanalysis toward an authentic, unforced consideration of what we fear, and what we most deeply desire, and the consequences of these things. We want to know what our lives mean, and what meanings are alive for us. (p. 25)

Stern, I believe, is here addressing a mutual endeavor that includes both therapist and patient. Hope is expressed in terms of the patient's desires. He also addresses the need to go beyond what is conscious in our everyday thinking.

Buechler (2004) notes that sometimes it is easier for her, in doing psychotherapy, to identify the wrong thing to hope for than to identify the right thing. In a similar vein, Stephen Mitchell says in his book *Hope and Dread in Psychoanalysis* (1993) that it is much easier to tell when we are being untrue to ourselves or betraying ourselves than

when we are being true. (p. 133). I think that they are speaking of a common human experience that applies to both therapist and patient. Buechler and Mitchell both make the point that an individual patient may get a sense of something being wrong—and may not know why, only that something does not seem quite right, or is missing. I think this is another common human experience: experiencing "red flags" in a situation—but not knowing why. Often people talk themselves out of respecting their own "red flags," especially if they don't seem logical. What is being stressed here is that one job of the therapist is to pay attention to the patient's "red flags" and to make more of them, not less. People do and feel and think things for good reasons, which they may be inclined to disregard.

Buechler (2004) feels that hope has an interpersonal aspect—it can be, in part, a gift one person gives another, a poetic idea of the concept that matches my own experience. A therapist who challenges self-limiting assumptions on the part of the patient can be experienced as providing much needed emotional "oxygen" to the patient. This does not mean that the patient's despair is minimized by the therapist, but rather that the therapist can both stay close to the patient's despair, help make meaning of it, and begin to see other possibilities. Buechler also notes that hope is stronger and more useful when it is attached to realistic outcomes, not to some unreal sense of control over life. She differentiates hope from an expectant state of mind, in that emotional hope contains a push forward, which is more action-oriented.

It is important to consider limitations on hope—what is reasonably possible for the patient. Cooper (2000) elaborates this position by reminding us that it is important to consider the limits on hope, that part of the task of the therapy or analysis is to help the

individual come to terms with personal limitations. According to Cooper: "The tension between psychic possibility and limitation is a framework that constantly informs the analytic process" (p. 1). He cites Kirkegaard who wrote that hope is a "passion for the possible," and goes on to say that psychoanalysis can be described as having such a "passion for the possible" (p. 10). Again, there is a focus on the issue of discernment: what is possible, what might never be possible, what is worth trying for. Without some kind of limit on hope, treatments may go on too long, pursuing goals that are not likely, creating a kind of bubble environment where one does not have to consider limitations.

Cooper confronts what he calls a "selective, institutionalized incuriosity about some of the tensions between our hopes and the nature of limits in doing psychoanalytic work" (p. 219. He is concerned about a situation in which a therapist may avoid a patient's upset by making it seem like all things are possible, and not helping the person to deal with real limitations. He states:

> Limitations of analysis are actually part of what we have to offer—something about helping people both to bear increased psychic possibility (when it is defensively averted) as well as to grieve and mourn limitation. In this sense this involves a kind of optimal disillusionment, one that is borne of authentic rather than compliant or false acceptance of the loss of aspects of omnipotence. (p. 227)

It is important that the therapist's hopes are realistic, based on genuine potential in the patient. Cooper uses the phrase "objects of hope," to describe the relationship between patient and therapist, and sees the therapist as being a new object for the patient. He says: "What I call hoped-for objects refers to . . . a level of longing and hope within a patient's developmental and representational world" (p. 21).

Shechter (1999) researched hope in social workers from a psychodynamic point of view. She based her research on the idea that "hope is essential to doing psychotherapy" (p. 371). She conducted telephone interviews with ten therapists who answered questions about how they maintained hope in difficult clinical situations, described their work with situations in which hope was difficult, and evaluated the impact of colleagues, theory, and work experience on maintaining hope. Her conclusions indicated that being hopeful is a feeling state that is difficult to sustain. Transference reactions were often seen as a problem. Theory was important to her participants, especially psychodynamic theory that helped with self-reflection. (Theory was not elaborated in much detail.) Professional colleagues were important. Hope, she found, was more likely to be sustainable if a clinician could accept her own limitations and failures.

Challenges to the Therapist When What Is Possible Is Not Clear: Dealing With the Patient's Anxiety About New Ways of Being

A phenomenon that is a challenge to a therapist in working with a patient's future is this: the person may have an understanding of patterns from the past, and may want and be working for change, but may not know how to change, or may be frightened of change. This usually happens well into a treatment and can make a patient feel very vulnerable. Patterns from the past may be experienced as a problem, but also as an organizing principle. The person may feel he has a sense of how the world works, and giving that up may feel too disorganizing and confusing. A person needs to have some sense of what else is possible and have some experience living it before it is safe to think about altering old patterns. It is especially during this time that the therapist needs to have a sense about where things are going.

Summers (2005) writes that a patient may feel caught in that he may wish to change, but may see no alternatives. He states: "Between the relinquishing of the old and the failure to find the new is a void in which the patient has no anchoring points for navigating the interpersonal world"(p. 92). One way Summers suggests for the therapist to work with this situation is to recognize the patient's "spontaneous gesture"(p. 94). There are things that the therapist may see that the patient misses. A spontaneous gesture may include such things as an emerging interest, an unbalancing of the status quo. It can be a big upheaval, or something relatively subtle.

My own sense of a patient's spontaneous gesture is that it is a beginning of sorts, something that can be developed, or that points in a particular direction. The meaning of it may be unclear in the beginning, and it may create more confusion than resolution. The therapist needs to know the patient very well to be able to discern nuances of meaning. As I consider spontaneous gestures, a number of examples come to mind: the emergence of feelings that were previously cut off, such as the realization of affection for another person in someone who previously has felt cut off from relationships; a new ambition, such as returning to school or choosing another line of work; tolerating conflict or disappointment when one previously would have felt devastated; a smile when entering the therapist's office; an altered relationship to bodily symptoms; different sexual fantasies; more detail in reported dream material.

Summers (1999) agrees with Winnicott that there is a "true self," and that such a true self can be identified and understood. He writes that one of the dangers inherent in the uncertainty about where a person is going and what is possible is that the anxiety of the situation may lead a person to go back to old patterns as a default position, either for

lack of anything else to do, or because the anxiety of uncertainty becomes too strong. He poses two types of intervention as valuable in reducing anxiety—internally holding, and seeing possibilities (pp. 109-110). He observes that sometimes people who are trying to make a change try out an extreme opposite behavior. Pathological character traits are defensive, and letting go of the trait unleashes the anxiety the trait was designed to solve. A new self must be viable before old self-organizations can be released (2005, p. 239).

Stern, (1997) talks in a different way about the experience of not knowing what is possible. He says:

> Most not knowing that occurs under circumstances in which knowing is at least possible is best described as dissociation . . . . Dissociation should be defined as the unconscious decision not to interpret experience, to leave it in it's unformulated state for defensive reasons. (pp. 30-31)

Stern goes on to discuss the phenomenon of dissociation as an individual keeping himself ignorant:

> If one remains ignorant of the conclusions one might draw, or the observations one might make, or the feelings one might have, one sometimes can pursue aims one prefers not to acknowledge while bypassing certain conflictual, anxiety provoking interactions. (p. 51)

That an individual can and often does dissociate his sense of what is possible matches my experience.There may be an inability to "think outside the box." The person may long to have things be different, and not realize how invested he is in protecting himself by thinking in familiar patterns. Schore (2006) describes the mechanics of dissociation, and says that it represents "detachment from an unbearable situation, the

escape where there is no escape, a last resort defensive strategy" (p. 20). Thus one way a patient may lose track of what is possible in his future is through dissociation, a defense against unbearable anxiety.

Sometimes the person pursues unacknowledged goals. It is my experience that one of the tasks of the therapist in this situation is to recognize that this is happening, and to identify it in a way that the patient can handle. Sometimes the therapist needs to be the one who quietly remembers what is going on, until the patient can claim it. Stern talks of the power and pull of the familiar, which he feels can swallow up anything indefinitely—gains, possibilities, new ways of thinking and being.

Stern's solution for this sounds a lot like Summers—in that Stern (1997) encourages feelings of "tendency" in patients, and Summers (2005) looks for the "spontaneous gesture." Both are referring to a sense of something new arising from the patient, something that may be subtle and needs attention from the therapist in order to become evident.

Fear of Influence

A serious concern that arises as part of a consideration of the therapist's holding of the patient's future is the fear of influence, of imposing the therapist's agenda on the patient. This concern is one of the primary reasons the therapist's notion of the future has not been addressed more extensively. People have feared that if the therapist has a sense of the patient's possible future, this would mean having an agenda for the patient, or trying to make the client compliant with the therapist. There are several concerns. The first is whether the idea of the future comes from the therapist or the patient. As already noted, the idea of a therapist pushing an agenda on a patient is objectionable. The second

is how the therapist deals with inevitable ideas about the patient's future. To deny such a vision may create a situation where a therapist is not clear about his own point of view, and may create a situation of influence of which the therapist is unaware. These are important issues and they have been addressed by theorists in different ways.

Summers, (2005) stresses attention to clues from the patient and from therapist self-reflection:

> If the future is to enter the patient's world, the therapist must have a vision of the patient as possessing interests and talents that can be formulated into a projected future. The therapist's vision is necessary for the future to take form in the patient's mind, and the sense of the future is essential to the self. Nonetheless, it would be an unfortunate oversimplification of the process to say that self-formation is set in motion by the therapist's vision. It must be remembered that the therapist's vision is constructed from raw materials provided by the patient's behavior, interests, talents, and passions. (p. 73)

He goes on to say:

> The best antidote to imposing an agenda on the therapeutic outcome . . . is rooting the analyst's image in the patient's free associations and interactions as they emerge . . . . To conduct therapy without a vision of the patient is more perilous still, because lack of awareness of the therapist's image of the patient will most likely result in unexamined influence. (p. 144)

Other authors express different worries about the inhibiting impact produced by too much fear of influence. Cooper (2000) is concerned that too much fear of influence can turn into passivity. He like Summers, makes the point that it is impossible not to

influence. Cooper says that analysts have been afraid to take more responsibility for their wish to influence (2000, p. 30). Buechler (2004) says: "The analyst who is afraid of his impact or who feels guilty about it cannot fight passionately for life. Carefulness pulls him to pass up chances to elicit hope" (p. 43).

Summers (2005) is concerned that "change that does not correspond to the patient's experience can only be compliance, a further alienation from the self, rather than a contributor to its development." (p. 14). He interprets Loewald, saying that Loewald sees the therapist's vision of the patient's future as creating an

> . . . object relationship in which the therapist both follows and is ahead of the patient. If the therapist gets too far ahead, he runs the danger of molding the patient to an imposed image, but without a vision of the patient's future, he cannot help the patient realize possibilities of which he may not be aware. (p.55)

Summers differentiates himself from classical theorists, who, in his view, assume that any changes a patient makes are the result of somehow taking in what the analyst has to offer (2005, p. 9). Summers describes a way of thinking about this issue, his own way of addressing fear of influence which involves keeping the focus on the patient's emerging material.

> This emergence of the self in the process of analytic inquiry renders unnecessary identification with the therapist's vision. If we carry it to its logical conclusion, Loewald's contention that the therapist's vision is formed from the patient's material, the therapeutic action lies not in identification, but in the dialectical interplay between the therapist's vision and the patient's spontaneous gesture. The result of this process is the emergence of the true self. (2005, p. 59)

Strenger, (1998), shares the concern about influence, saying that since patients become dependent on their therapists' image of them and often have a desire to please, there is a danger that they are less likely to become who they need to be if they believe the therapist has different ideas for them. On the other hand, a patient with a therapist who believes in him and sees possibilities can go in directions he never dreamed.

Lear (2003) also expresses concern about influence. As an associate and confidante of Loewald's, Lear is concerned that Loewald's concept of "sculpturing" be interpreted in a way that fits the original intention behind the use of the artistic metaphor. He considers the possibility the sculpture passage could be misinterpreted by a therapist to justify a stance of knowing what the patient needs better than the patient does (p. 106). For Lear, the significance of this metaphor is that it directs the analyst's attention to the patient's "emerging core" (p. 116). He defines this core as "the elementary capacity of the psyche to hold itself together" (p. 118).

Another, rather different point of view that also addresses the importance of a state of not knowing, is offered by Ogden, in his book *This Art of Psychoanalysis: Dreaming Undreamt Dreams and Interrupted Cries* (2005). Ogden believes that psychoanalysis has come to value the capacity of the analyst and patient to not know, citing the influence of Bion. He relates this to the patient's future: "When an analyst is incapable of sustaining a state of 'not knowing,' the past eclipses the present, and the present is projected into the future." (p. 25) Bion (1967) writes that a psychoanalyst should approach each session without memory or desire (p. 17). He says: "Psychoanalytic 'observation' is concerned neither with what has happened nor with what is going to

happen but with what *is* happening" (p. 17). If a therapist assumes too much, he may join with the patient in eliminating possibilities for the future.

Affects, Affect Regulation, Symptoms and Their Impact on the Future

Affects

Another challenge to a therapist working with a patient's sense of the future has to do with how the patient experiences affects. Patients often foreclose what could be considered with respect to the future by staying with affects that are safe and familiar. People do this without realization or awareness; it becomes a part of their vision of how the world works. This is important in a number of ways. The therapist may begin to get a sense of what may be foreclosed in the future through what affects are missing or inhibited. Affects—or the lack thereof—thus can be a source of information about what might be possible. As individuals develop more affective possibilities in treatment, different future possibilities may start to open up. Spezzano (1993) describes how this might occur:

> Patients know (or do not know) that they have been doing, and will continue to do, everything they can to protect their characterological arrangements with the world through which, they are convinced, they have as much security, pleasure, happiness, and self-esteem as they can have without taking more risk than they can tolerate, We suspect that they can have more—they can have a more satisfying life, more good feeling, and a greater sense of well being. Toward this end, they must—and can—feel and use affects they now inhibit and abolish. They can elaborate these warded off and truncated affective states into thoughts that are

> now unthinkable. They can do much more in the world, by themselves and with others, than they now venture to try. Patients are terrified that this is so, and terrified of its implications. (p. 184)

What kind of guidance and direction can a therapist get from a patient's affects? Attending to affects provides good information about what is really important to the patient, and what is possible. Spezzano's theory includes the notion that "*affects* are the closest thing we have to *facts* in psychoanalysis" (p. ix). He agrees with Summers that psychopathology is an attempt at affect regulation.

Summers, (2005) believes that for an individual's self to develop and potential to be realized, affects must be used to further the cause of the developing self (p. 162). Basing his perspective on a developmental arrest model, he views psychopathology as being reflective of arrested affective states. Depression may be the result of the falling apart of a lifelong interpersonal pattern. (p. 193) Summers cites a case of a depressed patient; in this example, it was not that an improvement in the patient's depression allowed him to re-invent his life, rather it was his ability to create his life that resolved his depression (p. 211). Summers says that not developing an authentic self is a common reason for depression. If an individual is to develop, aggression must be available in order for the person to be ambitious and affection must be possible if a person is to have close relationships. Summers looks for "the full expression of self-affirming affective experiences, especially interest, enjoyment, and excitement, without invoking a negative introject" (p. 227).

Cooper (2000) speaks of the analyst's containment and holding of the patient's affects. He thinks this is a useful concept, but not sufficient in itself.

> The holding metaphor has been useful in focusing on the aspect of interpretation which involves the analyst's containment of the patient's affect. However, the holding metaphor is limited as a dynamic explanation in that it fails to address the analyst's aim or push intrinsic to any interpretation. (p. 17)

Internal Working Model

The assumptions made by a patient about how the world works and how this determines future possibility are addressed in Attachment Theory in the concept of the internal working model. The internal working model is the way of understanding one's place in the world, based on the types of attachments one made as a child. It consists of a network of cognitive and emotional representations, as well as behavioral representations. (Sable, 2000, pp. 21-22). This network gives a shape to what the patient believes he might reasonably expect in the future. John Bowlby, the originator of attachment theory, said that the person's world-view, or internal working model, is based on the perceived availability and responsiveness of attachment figures in childhood (1973, p. 203). Addressing the issue of the patient's perceived future, Bowlby writes, "each individual builds working models of the world and of himself in it, with the aid of which he perceives events, forecasts the future, and constructs his plans" (1973, p. 203). According to Bowlby, working models of attachment come from actual experiences, not fantasies, drives, or defenses. Bowlby writes:

> Children absorb impressions and messages from the people around them, and are affected not only by how they are treated, but by what they see and are told. Initially, their representations are quite rudimentary, but gradually become more elaborate and abstract with development . . . . Once constructed, these inner

> models tend to be so taken for granted that they operate almost automatically and unconsciously, enabling individuals to function more efficiently by interpreting and generalizing thought from the available data of previous experience. (as cited in Sable, 2000, p. 22).

An implication of this idea is that, with actual relational experiences in psychotherapy, the patient's internal working model evolves in ways that can potentially impact his sense of future possibility.

Agreeing with Bowlby, contemporary attachment theorist Schore writes: "at the psychobiological core of the intersubjective field is the attachment bond of emotional communication and interactive regulation" (2005, p. 843). He also writes: "It is accepted that internal working models that encode strategies of affect regulation act at levels beneath conscious awareness" (2003, p. 67). In discussing regulation and dysregulation of affect, Schore describes the dysregulation of affects not as producing the wrong affect, but rather as causing a problem with the intensity of affects. The inability to manage and regulate the intensity of feelings is a common outcome of early trauma and is present in all psychiatric disorders. He sees psychological deficit as "failure to recover following termination of a relational stressor"(2006, p. 28). The attachment of the patient to the therapist influences at a very deep and often non-verbal level the patient's perception of future possibility.

Symptoms

Symptoms are viewed as evidence of something not expressed: affect, potential, and true self. This means that symptoms are related to what is possible or not possible in the future. It makes sense that as the meaning of a particular symptom is considered, more possibilities may emerge. There are reasons behind what a patient does and the symptoms he has, and these reasons can be understood. A lot of the work of psychotherapy lies in making sense of what is going on, finding the underlying order implicit in phenomena that do not appear to make sense. It is troublesome for patients to be caught in a web of symptoms and defenses, which they do not understand and cannot explain to themselves. There is a great deal of relief and hope to be had in making sense of what is going on. This creates new possibilities for the patient. Summers (2005) says, "Arrested aspects of the self will seek disguised expression in the form of symptoms" (p. 31) and further, that pathological character traits usually have something valuable embedded in them. Thus symptoms carry within them a disguised, buried aspect of the self. He also asserts that somatic symptoms are the result of strangulated parts of the self, and they can be addressed by the development of new ways of being (p.172).

Possibility, Change, and Therapeutic Action as Related to a Sense of the Patient's Future

Possibilities

Another important aspect in considering how the therapist can get a sense of the patient's future is how possibilities are recognized. How do the therapist and the therapist and patient as a team begin to recognize what might be missing, what might be possible. The therapist's task is to help the patient find possibilities that have been closed off, and to start to find a way to examine whether it is possible to develop and live those

possibilities. Summers (2005) sees the task as one of creation of new possibilities or of helping the patient get back to possibilities that have been foreclosed. The therapist needs to get a sense of what the patient's potential might be, and help him to express it. He writes:

> The analyst must have a vision of the patient that fits into who the patient is, but that goes beyond the reality of who the patient has been in order to have a vision of who the person can be. (1999, pp. 93-94)

He goes on to discuss the role of interpretation in identifying possibilities:

> When interpretation conveys the analyst's recognition of desires buried under the veneer of anxiety-driven external behavior the patient feels "seen," often for the first time. Furthermore, if pathological behavior is understood as the patient's effort to communicate blocked potential, the patient feels "heard" in a way he never has before. The experience of being seen and heard is the first step toward realizing previously dormant potential and accounts for the relief that so frequently accompanies interpretations even when they are not immediately mutative. (p. 98)

When possibility starts to become apparent, the combination of the patient's relief—and anxiety about disorientation—can be powerful. There is a sense on the part of the patient that something that is needed might actually be possible. This realization calls into question current and familiar ways of functioning, which may be uncomfortable. These new perceptions about possibility lead to anxiety about change, as discussed earlier.

Change

Considerations of possibility also relate to how one conceptualizes change. Often change in psychotherapy is small but meaningful. Cooper says, "a seemingly small change is big stuff" (2000, p. 23). A paradoxical aspect of change is that if a therapist or patient pushes too hard for change, it may not be possible, because one runs into the defensive obstacles in the form of symptom or attitude. Often change occurs through understanding, sometimes understanding of something different from what is changing.

Change in psychotherapy may also be seen as change in how one thinks, freedom to think and feel in new ways, possibilities recognized, actions taken, symptoms that are less troublesome. Summers says that deep understanding of one's self is necessary but not sufficient for change to occur (2005, p. 15).

Carlo Strenger (2005) writes about a different notion of change—of being able to shape oneself to one's desire. This is different in that it does not involve a deeper "true self" but rather a choice to become what you want to be, which involves denial of aspects of true self that do not suit what the person would like to be. This speaks to a different phenomenon than discussed above—that of individuals desiring a designed, perfected persona that denies difficulties and puts an emphasis on perfection and image. He sees this phenomenon in many of his young clients. It appears to me that while other writers put an emphasis on the patient finding a future that is somehow more genuine and true to one's deeper nature, Strenger emphasizes his clients' wishes to fashion a desirable, perfected image. He neither judges nor applauds this.

Therapeutic Action

Therapeutic action may be defined as what it is about psychotherapy that produces change in a patient. "Every theory of psychotherapy has some set of assumptions about how people get better, what it is in their experience that produces change, what kinds of changes are possible, and what the therapist does, says, and thinks that facilitates therapeutic growth and change." (Schreiber, 2005, p. 1)

My long- term consultant, Richard Laude, M.D. with whom I have worked for many years believes that within the patient there is a powerful force of wanting to get better (personal communication, December 1, 2004). In his view it is important to keep in mind the optimal capabilities of people; it is important not to trivialize patients, even if they trivialize themselves and invite it from other people. He emphasizes taking people seriously, even if they do not take themselves seriously. Another point he makes is that people cannot overcome their problems by themselves. They need the help and presence of another person, a therapist. Both relationship and interpretations are important. An effective psychotherapy gives the patient the experience of stepping into a new world, an alternative reality, and experience he likens to "oxygenation." People consume their own oxygen, bleed away their life force. The therapist needs to align with and strengthen the healthy part of the patient. The patient needs to be taken seriously, even, and maybe especially, the things that don't make sense, even to himself.

Summers (1999) spells out what he considers to be the central dilemma of therapeutic action—"to overcome the threat to the self while changing the object relational patterns that define the very sense of self" (p. 108). This relates to anxiety about change, as discussed earlier. The patient has a sense of who he is, and this sense

involves some pathological character traits. This makes change difficult, because change makes the person feel disoriented, as if he is no longer himself. The patient might say that as long as he holds onto his belief system, he knows how the world works, and without it, anything goes. Possibilities may be interesting, but also extremely threatening.

Summers takes a stand against what he calls "passive absorption" of the ideas of the therapist by the patient (2005, p. 9), which he says is a part of both a classic as well as some contemporary relational points of view. He thinks therapists of psychoanalytic orientations other than his object relations point of view favor passive absorption. He says, "The minimization of the creative role of the patient in much psychoanalytic theory conflicts with the shift in the goal of analysis from the resolution of intra-psychic conflict to self-realization, the growth of the self (2005, p. 11).

Summers has a view of therapeutic action that involves the patient's role in its creation, based on Winnicott's concept of potential space.

> Once a psychological configuration is understood, the therapist suspends interpretation as well as any other techniques or interventions for the purpose of facilitating the creation of new meaning by the patient. In other words, the space is given over to the free play of the patient's imagination. Whatever associations, memories, or sensations now appear are viewed not as a source of understanding the patient's current patterns, but as incipient indications of the shape a new self might assume. (2005, pp. 22-23)

The therapist in such a situation would need to pay close attention to what the patient's thoughts say about what is possible. Summers introduces a major shift in the conduct of the analysis, once he begins to work within the concept of potential space. This shift

occurs at a particular point in time when he no longer makes genetic or transferential interpretations and instead lets the patient begin to create a different kind of experience.

> We may conclude that once potential space is introduced into the analytic process, the therapeutic relationship is fundamentally transformed. When the analytic process shifts to the need for creation, the therapeutic relationship shifts from an interpretive modality to potential space. Both the patient's and the analyst's roles are restructured: the patient is a creator, and the analyst, a facilitator. The field is no longer filled with the patient's material that must be understood but is open for yet-to-be determined meaning. At this point, the future takes on new prominence. (2005, p. 23)

With this method, Summers is attempting to break out of a particular kind of analytic stalemate. When he finds that transference interpretations do not produce change, he believes the therapeutic relationship needs to change from one based on interpretation to one based on potential space. He states:

> For the therapist's belief in a different future to resonate with the patient, there must be an unarticulated, latent sense of futurity in the patient. Because only possibilities that preexist in the patient will be meaningful, what the therapist finds must already be in the patient. (2005, p. 36)

With this change in the stance of the analyst from interpretation to co-creating potential space, the patient experiences much more uncertainty and ambiguity, and the therapist is active in a much different way. The therapist does not impose meaning in this system, and the patient feels confused and stuck, which the therapist allows as part of the process. The therapist, in Summer's system, looks out for spontaneous gestures that

emerge from the confusion. The therapist has to identify it first, because the patient might be too confused at that point to see it. According to Summers: "By continually illuminating dimly seen aspects of authentic experience, the analyst not only welcomes and promotes the explication of these previously undeveloped states, but in so doing imparts a sense of reality to them"(2005, p. 95).

Summers describes what such a spontaneous experience might look and feel like:

> The association that launches this movement may be as benign as a dormant interest never before linguistically encoded, or it may erupt as a disturbance of the patient's psychic equilibrium. This emergence may take intense, even destructive forms, but the analyst's job is to identify the glimmerings of the buried self rather than react to its distorted expressions and the patient's task is to find ways to develop these incipient interests and affects into modes of engaging the world. (2005, pp. 95-96).

Other therapists disagree with Summers' idea about therapeutic action and instead include a sense of the future even while they are working in an interpretive way. Many writers who share a psychoanalytic point of view and discuss where new experience comes from, say that the content of the future has to come from the patient, though there is disagreement about how that actually happens.

Also, one might define all of a psychotherapy, including interpretive parts, as potential space. Cooper (2000) adds this caution: "I think it is worth thinking about whether analysts have become so oriented toward maintaining potential space that we have lost a disciplined way of thinking about and talking about limits" (p. 227). Cooper seems worried about the sense of too much potential, and addresses the importance of

limits. It is necessary to consider what may not be possible, as well as what might be, and how one helps patients deal with limitations.

In exploring the question of creativity in psychotherapy, Summers draws from the work of Mihaly Csikszentmihalyi, from his book *Creativity: Flow and the Psychology of Discovery and Invention* (1996). Csikszentmihalyi describes five steps in the creative process, which Summers likens to the process that goes on in psychotherapy. The five steps are: preparation, incubation, insight, evaluation, and elaboration (Csikszentmihalyi, pp. 79-80). Summers applies this model and says that the creation of new psychological ways of being out of the insights of psychotherapy can come from a period of unconscious incubation, which may produce a new insight, which then has to be developed within the therapy. Summers says, "Placing the patient's innovation at the heart of therapeutic action contrasts with the notion of internalization and its counterpart working through, concepts that provide little room for the patient's creative use of insight" (Summers, 2005, p. 77). Summers emphasizes the emergence of spontaneous ideas of the patient rather than the patient taking in and processing the ideas of the therapist as the basis for therapeutic action.

Lear (2003) has a different take on therapeutic action. He is not inclined to seek an objective image of what the patient might become. Instead, he sees the psyche itself, as a psychological achievement. This is a part of his commentary on the Loewald article—what needs to be developed is not a specific trait or image, but "a subjective image of this person becoming a person" (p. 108). The result of this point of view is not that the analyst and patient discover an independently existing reality, rather that they

find a process whereby the psyche comes into its own. This addresses an important issue, that of preserving client autonomy and allowing freedom to develop.

Schore writes extensively on what makes therapeutic change possible. With a focus on neurobiology and attachment, he investigates how therapy impacts people. He says: "Empirical research suggests that one common process factor, the therapeutic alliance, is among the most robust predictors of treatment outcomes" (2006, p. 29). He also writes: "Contemporary psychoanalysis, which for many years has overemphasized explicit verbal mechanisms, is now focusing intensely upon implicit nonverbal communications, bodily based affective states, and interactive regulation as essential change mechanisms within the therapeutic relationship" (2005, p. 846).

Schore emphasizes something different from the other authors discussed in this study, that much of what is healing in psychotherapy, and forms a base for therapeutic action, occurs on a non-verbal level. The attunement between therapist and patient has a large non-verbal component. He emphasizes the value of the therapeutic relationship in producing change, as do many authors, but elaborates on the unspoken elements of the relationship (2005).

Cultural Influences on Expectations About the Future

It is important to examine the cultural context of the sense of what is possible in the future. There has always been a peculiarly American attitude toward the future. In 1835, Alexis de Tocqueville, writing in *Democracy in America*, Part I, said:

> They [the Americans] have all a lively faith in the perfectibility of man; they are of opinion that the effects of the diffusion of knowledge must necessarily be advantageous, and the consequences of ignorance fatal; they all consider society

> as a body in a state of improvement, humanity as a changing scene, in which nothing is, or ought to be, permanent; and they admit that what appears to them to be good to-day may be superseded by something better to-morrow. (pp. 455-456)

Though it was written many years ago, this observation reflects a way of thinking that has persisted. American culture traditionally has valued progress, individualism, and the sense of a better future—a belief in moving forward, moving ahead, and in the perfectibility of human beings.

Another tenet of mainstream American culture is that individuals are responsible for themselves. Levine (1993) writes:

> Americans have always been comfortable with the idea of progress. The belief that inevitable change brought with it inevitable advancement and betterment fitted easily with, and was reinforced by, the stress on the individual, the belief in human perfectibility, the relative rootlessness and lack of tradition, the unparalleled mobility, the indefatigable optimism, the sense of uniqueness and destiny that has characterized so much of America's history. (p. 190)

Americans are supposed to have a vision of a better future, and know how to get there. If they do not or cannot, they may feel they have no one but themselves to blame. This particularly American attitude makes it more difficult for those who despair due to poverty and oppression. There is not a sense of individuals having a right to the basics needs of life—food, clothing, housing, and medical care---but rather that these must be earned. People then tend to blame themselves for difficulties, and the culture tends to support this view. Many groups in the culture find doors closed to them. While they

experience the paradox that the better future is not available to them, it is perceived as their fault.

There exists a paradox in high-tech culture, in which the sense of limitless possibilities can be strong. There is freedom and little constraint, but there is little social support for the individual, coupled with enormous expectations. These circumstances can exacerbate anxiety about the future.

Putnam (2000) asserts that modern American culture puts more focus on personal independence and control and less focus on community. This point of view can lead to the expectation that we can achieve all we need through personal ambition and drive, and leaves us unready to deal with difficulties and failures. Individual identity becomes more important, as there is less support from the larger culture. This phenomenon can contribute to individuals arriving for psychotherapy with a sense of foreclosed future. Adams (2003), in his work of contrasting United States culture with Canadian culture, talks about the American Dream, which "suggests that anyone with a little vision and a lot of hard work can achieve material success"(p. 53). White (2003) elaborates on the American Dream. He says it contains three elements: an emphasis on freedom, a celebration of the individual, and a belief in the equality of opportunity. "At the heart of the American creed is a belief that the individual can shape the future" (p. 53).

I believe that one impact of this particularly American attitude is that sometimes people who arrive for psychotherapy with a sense of foreclosed future feel as though they have failed in their pursuit of the American dream. The culture demands optimism about a better future, as well as a strong sense of individualism.

The Impact of Theory on the Therapist's View of the Patient's Future

As a part of this study, I intend to consider how a therapist's theoretical orientation influences the way in which the future is considered and held. Different psychoanalytic approaches might have different things to say about considerations of the future. Some of these have been described in this literature review. Summers holds a Winnicottian, object relations point of view, while Cooper, Buechler, Mitchell, and Stern hold a more relational point of view.

My own theoretical approach is most aligned with that of relational psychoanalysis, a complex, multi-faceted set of theories. I will describe the aspects of this point of view that I believe impact the attitude toward hope and the future in the therapist. Relational psychoanalytic psychotherapy involves a dyadic therapeutic encounter, and views transference as a joint creation of the patient and therapist rather than the patient's projections onto the therapist. The therapist under this paradigm engages with the patient to transform old interaction patterns and forms of relatedness. Thus, in a relational model the future has a lot to do with what is possible in relationships that had not been a part of the person's relational pattern before.

The therapist becomes an active co-creator of what might be possible in the person's life. Change occurs in the relational field between therapist and patient. The relationship is seen as curative. Lewis Aron and Adrienne Harris, editors of *Relational Analysis Volume II: Innovation and Expansion* (2005), describe relational analysis in their introduction. They talk about the work of Stephen Mitchell, who developed two lines of thought regarding relational psychoanalysis. One was a framework, a structure to

contain relational theories. This structure contained three dimensions—self, other, and interaction. The second was his own relational conflict theory. They say:

> Our key point is that what is often called relational theory can be thought of as two independent projects: one is a relational theory that can house numerous relational theories; the second refers to the multiple, specific relational theories constructed by different theorists. (p. xvii)

For example, Mitchell (1988) describes a "relational conflict model":

> From a relational conflict perspective, disturbances in early relationships with caretakers seriously distort subsequent relatedness, not by freezing or fixing infantile needs, but by setting in motion a complex process through which the child creates an interpersonal world (or world of object relations) out of what is available. The child cannot do without relationships, without ties to others, both in terms of real interactions and in terms of a sense of connection, belonging. To be human means to be in relation to others, to be embedded in a relational matrix. The central process in psychoanalytic treatment is the relinquishment of ties to these relational patterns, thereby allowing an openness to new and richer interpersonal relations. (p.170)

This implies that the future has to do with making a new kind of relationship, which makes new ways of being possible. Mitchell (1988) goes on to say:

> I suggest that the basic ingredients of mind are self-organization, attachments to others and transactional patterns, all of which constitute a complex relational matrix. Where does the content of this subjective world come from? It is neither invented out of thin air nor simply provided by the external world. The creation of

> a subjective world of meanings is an interactive process. Pieces of experience are selected, refashioned, and organized into patterns. (p. 255)

This suggests how a new sense of the future might be created in a relational model. New ideas about what is possible in the future come from an experience with another person that helps create meaning, and a sense of what might be possible.

My own view of how the therapist holds the patient's future includes a number of elements that fit with relational theory. In relational terms, the future is part of the transference that is co-created in the relational field. How the therapist thinks about what is possible does matter, and it helps to co-create the transference. New patterns of thought, feeling, and behavior may first occur with the therapist, or may arise in the patient. Another of many possible variations is that the therapist may feel pulled in to the patient's self-limiting attitudes. In situations where the idea of positive change creates disorganization and intense anxiety, the therapist's ability to hold the patient emotionally and see more than the patient can bear makes an enormous difference. This is a part of an intense, relational, mutually-created transference and a mutually created future.

This review focuses on literature relevant to a discussion of how psychoanalytically-oriented psychotherapists think about and address the question of the patient's future. Various approaches to and ways of considering this future have been described. The influence of cultural attitudes and expectations regarding a person's future is seen to affect both patient and psychotherapist. In the present research I explore this topic further through in-depth interviews with a number of practicing therapists regarding how they think about and work with the patient's future.

CHAPTER 3: METHODS AND PROCEDURES

The purpose of this qualitative study is to understand how psychoanalytically oriented psychotherapists think about and hold a sense of their patient's futures. There are a number of areas of inquiry. These include: How do therapists think about and hold a sense of what is possible in their clients' futures? How do they think about hope in relation to the future, join in patients' hopes, know what to hope for, deal with hopelessness, and consider limitations on hope? How do they deal with situations in which the patient is challenged in discovering new ways of being, and experiences inhibiting anxiety as a result? How do therapists deal with the issues of influencing the patient's future and fear of influence? How do they understand the role of affects, affect regulation, symptoms, and defense in dealing with the future? What is their understanding of therapeutic action, and what interventions or aspects of the therapeutic relationship create possibility for future changes? What influence does culture have on how the future is regarded? What impact do a therapists' theoretical orientations have on how they regard what is possible in the patient's future?

Design

My approach to this research is qualitative. The focus of the study is therapists' subjective experiences, as described in open-ended interviews that invite their thoughts and feelings about doing psychotherapy. A qualitative approach to research works well for analyzing data that comes from participants' personal and subjective experiences, as it allows the quality of those experiences to be retained in the analysis and interpretation of data. A qualitative approach is also useful in trying to understand an area of thought or

theory about which not much has been written as is the case with my inquiry regarding how the therapist holds the patient's future.

Qualitative research does not rely on statistical or quantifiable procedures or hypothesis testing, but uses, instead, other systematic methods and procedures to collect, code, and analyze data and to generate theory from the data. The specific approach that guided the data analysis aspect of my research is Grounded Theory, developed by Barney Glaser and Anselm Strauss (1967) and further described by Anselm Strauss and Juliet Corbin (1998). A theory, according to Strauss and Corbin, is described thus: "For us, theory denotes a set of well-developed categories (e.g., themes, concepts) that are systematically interrelated through statements of relationship to form a theoretical framework that explains some relevant . . . phenomenon" (p. 22). A "grounded theory" is one "that was derived from data systematically gathered and analyzed through the research process" (p. 12.).

The grounded theory researcher begins with an area of inquiry or study, and allows the theory to emerge from the data. The project does not begin with a preconceived theory. This approach goes beyond description of phenomena through the organization and categorization of data into increasingly complex conceptualizations and levels of abstraction. The methods of grounded theory combine well with the discoursive approach to interviewing as described by Elliott Mishler (1986) to provide an overall approach where findings and theoretical conclusions stay close to phenomenological data from which they are derived.

The data was analyzed using the "constant comparative method" (Strauss & Corbin, 1998). In using this method, the researcher examines the data collected from

participants, to compare similarities and differences among participants. The data collected in early interviews are used to develop hypotheses, and may modify later interviews.

Reliability and Validity

Reliability and validity are commonly held standards by which research is evaluated. Reliability refers to the accuracy of the measuring instrument or procedure, including whether the findings can be reproduced in different trials by other researchers. Validity refers to whether the study measures what it intended to measure, including whether the findings are generalizable. Validity and reliability are judged differently in quantitative and qualitative research.

Strauss and Corbin (1998) assert that "the usual canons of good science have value but require redefinition to fit the realities of qualitative research" (p. 266). Regarding validity, this involves the fit between the emergent exploratory concepts and the data, which they refer to as "theory observation compatibility." In the present research, meaning was developed in conversation between the interviewer and the participant. In presenting the findings for this study, excerpts from the interviews are given as evidence for my interpretations. Mishler (1986) says that validity in qualitative research relates to the care and quality of the research process. In his approach to the interview, meaning is developed through the discourse between the researcher (interviewer) and the participant.

While in quantitative research, the carefully constructed instrument aims to ensure validity, Patton, (2002) points out that, "In qualitative inquiry, *the researcher is the instrument*" (p. 14). The skill of the researcher ensures validity. The effort is not to define

"truth" about a certain area of inquiry; but, instead, to accurately represent and understand the population being studied.

Participants

Nature of the Sample

The research involved a sample of 10 participants. I looked for and selected participants who are psychoanalytically oriented psychotherapists from various professional fields, including social work, marriage and family therapy, psychiatry, and psychology, thus creating a small sample that includes diversity. Qualitative research typically involves small samples, with the number of participants determined by whether sufficient information has been collected to do justice to the subject.

Criteria for Selection

I selected participants who are experienced psychotherapists, and consider themselves to be psychoanalytically oriented. I did not interview psychoanalysts. By experienced, I mean psychotherapists who have been in practice for at least ten years. I believe that this much time in practice should be ample time for an individual clinician to develop a personal style of practice, and to be able to reflect on his clinical work. I recruited among licensed psychotherapists—psychiatrists, psychologists, social workers, and marriage and family therapists. I maximized variation among participants by not controlling for demographic variables such as gender, age, ethnicity, disability, or sexual orientation.

Recruitment

I recruited participants for this study by contacting colleagues and other mental health professionals. I sent a letter (Appendix A) describing the project, and asked for recommendations of potential participants. I contacted potential participants whose names I received, or who contacted me directly, by writing a letter (Appendix B), describing the research project. Included in this letter was a consent form (Appendix C) for potential participants to review, and a screening questionnaire (Appendix D). I telephoned the selected participants, to set up a time and place for an interview

Data Collection: The Interview

The data for this study was collected in open-ended, semi-structured interviews guided by a set of topic areas and probe questions relevant to the research question or purpose (see Interview Guide, Appendix E). Mishler (1986) describes the research interview as a discourse involving two persons. Mishler argues for a research interview which empowers respondents to tell their stories and give their views, such that the respondent takes the lead while the researcher guides the process. The researcher initiates the interviews with a statement or question that invites the respondents to tell it their own ways rather than asking for specific answers to specific questions. This approach to data collection is appropriate when the topic being investigated involves subjective experience. Mishler stresses the import of meaning being established in the process of the interview. The goal is to generate information-rich narratives. This also establishes validity.

Procedure

I interviewed each of the participants once, for one hour, in their own offices and tape recorded the interviews. I developed an interview guide to help remind me of topics to be covered, but it was not given to the participants. Though the interview guide presents topics in a particular order, no attempt was made to follow this order. Before beginning this interview, I reviewed with the participant the purpose of the study and issues of confidentiality (see introduction to the Interview Guide, Appendix E).

Topics of the Interview Guide

How Do Therapists Think About Their Patients' Futures?

This topic area addresses how and whether therapists think about their patients' futures in the course of doing treatment. Does the therapist have a sense of what might be possible for the patient in the future? Does understanding the past impact the future? What else might be needed, other than understanding the past?

How Do Therapists Think About Hope?

This topic focuses on how/whether the therapist has hope for the patient, and how he thinks about hope. It also addresses how the therapist deals with a patient's hopelessness, and what happens when the patient loses track of what to hope for. Related to this is the question of how a therapist and patient decide what to hope for. Is there action involved in hope? Are there limitations on hope, and, if so, where do they originate?

Challenges to the Therapist Regarding the Patient's Anxiety About New Ways of Being

This area of inquiry addresses the management of patient anxiety about change. It also looks at the confusion that can result for the patient when what used to be does not

exist anymore, and what is possible in the future is not yet clear, or how to get there is not clear. I include a question about how a therapist recognizes what is possible in the future.

Fear of Influence

This area of questioning addresses one of the reasons therapists have been reluctant to address their vision of the patient's future—the fear of undue influence. Included in this area of inquiry is how therapists are aware of influence and how they refrain from exerting too much influence. I was also interested in their thoughts about when it is useful to want to influence. Included in this inquiry is whether it is possible not to influence, and how or whether therapists keep their wishes to influence conscious.

Affect Regulation, Symptoms, and Defense

This topic area is concerned with the challenges to the therapist working with a patient's sense of the future that is created by how the patient experiences affects. A patient may foreclose what is possible in the future by limiting their affects to what is safe and familiar. A therapist may get a sense of what is foreclosed by noting what affects are missing or inhibited. What information do therapists get from affects, and what do they do with this information? Similarly, symptoms are evidence of something not expressed. What do symptoms say about what is possible in the future? How can a therapist determine, from a patient's symptoms and defenses, what might be possible in the future?

Possibility, Change, and Therapeutic Action as Related to a Sense of the Patient's Future

This area of inquiry addressed how possibilities are recognized, and how change flows from a sense of possibility. I included questions about how therapists think about

therapeutic action, and how change happens, thus creating the possibility of a different future.

The Impact of Theory on the Therapist's View of the Patient's Future

As a part of this study, I looked at how therapists' theoretical orientation impacts how they think about what is possible in the patient's future. I asked participants to identify their theoretical orientation and consider how it impacts their thoughts about the patient's future.

Data Analysis

I used Strauss and Corbin's (1998) "constant comparative method" to analyze the information collected in the interviews. This method leads to the development of theory that is "grounded" in the data. Themes that emerge in the course of conversations with participants are analyzed from the beginning of the interviewing process, and include the subjectivity not only of the participants, but also of the researcher.

Procedures for Data Analysis

It was important for me to immerse myself in the participants' subjective experiences. I took notes after each interview, and listened to the recording of the interview, taking notes as I listened. Each interview was also transcribed for the purpose of more in-depth review. I collected data and conducted further interviews until no new themes turned up, meaning that the categories could be considered saturated.

Data was analyzed by carefully using the "open coding" method, going over transcripts, line by line, to identify themes and meanings. I went through each transcript, identifying themes, for the purpose of developing categories and subcategories. In

comparing participants' responses, I noted common themes along with their variations and differences.

The data thus obtained was then put back together using "axial coding" (Strauss & Corbin, 1998). Axial coding involves looking for specific connections between categories, thus creating subcategories that identify dimensions and properties of primary themes. The final part of the coding process, "selective coding," is a process of integration in which a core category or unifying concept is identified, around which the other thematic categories can be arranged. Through this process the findings were organized conceptually, thus revealing my initial interpretive analysis.

Presentation of Findings

The findings of this study are presented in a narrative overview, followed by a detailed description of each conceptual category, its properties, and dimensions. Data examples are presented as evidence. I safeguard the anonymity of participants by revealing only enough information to illustrate the categories and subcategories that have emerged from the data, deleting any identifying details.

The final chapter presents a discussion and interpretation of the findings of the study with respect to the research question. Emergent theoretical propositions are examined as well as variations and deviations in the data. The findings are then addressed in relation to the existing literature and theory on the subject. Suggestions for future research that have arisen from this study and limitations of the study complete the final chapter.

CHAPTER 4 FINDINGS

This research explores the ways in which psychoanalytically oriented psychotherapists think about and hold a sense of their patients' futures, and how this impacts their work. The language of the participants' responses about the future often had to do with hope—how a psychotherapist holds a sense of hope and possibility with a patient. Almost all of the participants saw the holding of hope and possibility as an important psychotherapeutic function and were pleased to be able to put some of their experiences into words for this study. One participant said, "I am very interested in the whole idea of hope because I don't actually see why anybody would be in this business who didn't have hope."

Description of Participants

I interviewed a total of ten psychotherapists for this study, nine in private practice, and one who had recently moved to the area and had been in practice elsewhere, but had not set up a practice here. In order to protect their confidentiality and anonymity, I will not describe them individually. They all are located in the mid-peninsula area of the San Francisco Bay Area. All are highly experienced therapists---their years of practice varied from 18 to 44, with the average being 28 years. They include five men and five women. Five are licensed psychologists. One, licensed as a social worker, also has a Ph.D. in psychology. One is a licensed marriage and family therapist with a Ph.D., and three are psychiatrists. No one who was practicing at the master's degree level volunteered for this study. Several of the psychologists told me their own experience writing a dissertation led them to volunteer for the study, because they wanted to help another student with that

process. All of the participants treat individual adults. Two also practice group psychotherapy. Nine see couples, one sees adolescents, and none sees young children.

All described themselves as psychoanalytically/psychodynamically oriented, and some were more specific. Three described themselves as developmental, two mentioned object relations theory, two mentioned intersubjectivity, and four said they used Jungian theory. Two included "existential" in their theoretical orientation, one mentioned interpersonal theory, one mentioned relational theory, and two talked about attachment theory. Two worked with patients in twelve-step programs, which influenced how they thought about the research question.

Most of the participants engaged with the research question enthusiastically and had a lot to say about it. There was a very lively quality about the conversations with most of the participants, even though their professional development was quite different. When they spoke of theoretical orientation, no one sounded dry and theoretical; rather, they referred to powerful ideas and attitudes that inform their work in a meaningful and personal way.

Attitude Toward the Question

The research question was considered very important by the participants and noted to be a topic not often talked about. Most expressed a great deal of interest in this study, and were grateful for the opportunity to have a conversation about how they hold the patient's future. There was a sense that this study was interesting and useful and that it was good for them to focus on it. There was a sense of much energy and enthusiasm in the interviews. One said that my recruitment letter had started him thinking about how he and his patients attend to issues about their futures:

> When you start attending to a subject like this, it shapes how you listen. I have been paying more attention to the subject of both what my patients tell me spontaneously about their dreams, wishes, hopes for the future, plans or fears of their own. I am also focusing on what might be my conceptions for them, for their future and how that relates to my own experience of the future in my life, my family's life, that sort of thing. It has been a kind of complementary process of reflection.

Different participants called the question intriguing, or crucial. It got them thinking about something they all seemed to know about at a deep level, but had not talked about or even thought about very much. One said, "hope is clearly an important issue, especially with depression." The research question provided a stimulus to put into words a powerful experience that was not often discussed in any meaningful way. One participant said, "I'm amazed that you're asking all these basic, most important questions."

Two of the participants seemed less enthusiastic, but they were the exception, and nevertheless provided useful insights. These two interviewees engaged fully with the interview topics, but did not appear to have the level of energy and enthusiasm for the conversation that the others did. The enthusiasm of the other eight participants was so obvious that this was a notable contrast.

Many of the participants spoke of their development as therapists. One of the participants described her reason for agreeing to participate:

> I began to think about the opportunity this would be for me to think about this question, and distill and constellate the different place I'm at today after many,

> many years of being a therapist. You travel the road, you go along and it's both conscious and unconscious. I thought this would be an opportunity to bring up for myself how I think about this today.

Jungian Participants

The participants who consistently cited their theoretical orientation as being significant to my research question tended to have some Jungian training. They were not Jungian psychoanalysts—I didn't interview psychoanalysts of any persuasion—but they had had some significant Jungian training. One participant described it this way:

> We are so focused on origins, and this really gets more of Jung's idea about destinations. There is so much of a tendency to focus on the roots that we forget the tree, leaves, fruits and branches, so this question really bears on the notion of where things go as opposed to where they come from.

He said that Jung focused on the individuation process, so that a conception of the future, and what is possible are part of the therapeutic process. Another of these participants used the words "individuation" and "separation," combining her Jungian ideas with attachment theory, feeling that attachments are necessary before individuation and separation can take place. Another participant has been a student of a Jungian teacher and connected that personal experience to the experience of finding something you didn't know you were looking for. A fourth participant said he held a point of view derived from the Jungian analytic tradition that when people come to therapy their development is arrested in some way, and it gets re-engaged in relationship. He thought that the therapist could then get a sense from their dreams what their developmental trajectory might be. He thought that a Jungian approach was oriented towards future development.

Overview

When asked about their attitude toward their patients' futures, the participants were eager to talk about how their experiences of holding hope and possibility influenced their sense of their patients' futures. Most of them saw this as being an important psychotherapeutic function, that is not often talked about. Most thought that the therapist's sense of hope for the patient is usually non-specific, although a few participants mentioned situations in which they had specific hopes for patients. Most of the participants felt that holding hope and possibility for patients involves the value system of the therapist, and elaborated on personal belief and value systems that influenced their work. There were some differences expressed regarding hope and being realistic. Some participants thought it was important that therapist hopes be realistic, and others thought it was too limiting, not wishing to decide for another person what is possible. Many thought that therapist hope is best expressed in action.

The interviewees, all of whom are experienced therapists, had a very good sense of how patient hope is evidenced and expressed in the therapy hour. Patient hope, they observed, may be expressed both in what kinds of things are said in the therapy hour and in reports of life changes outside therapy. They were aware of the dilemmas regarding therapist influence, and considered it to be inevitable and complicated. They have much experience with and understanding of patient hopelessness. They also were forthcoming about the kind of anxiety change brings up in patients, and all thought that emotional holding and containment on the part of the therapist was the most helpful intervention in dealing with the anxiety about change.

The participants talked about how affects and symptoms reveal what patients experience as possible or foreclosed in their futures. They saw part of their task as therapists to help make meaning out of affects and symptoms the patient doesn't understand. This activity is part of the larger task of expanding a sense of future possibility, resolving pain, and promoting personal growth. Therapists also learn from the patient's past what might be possible in the future.

Holding Hope and Possibility

In thinking about the future, I found that the participants felt strongly that an essential psychotherapeutic function is holding a sense of hope and possibility for the patient. This organizing core of hope and possibility for patients provides an often unspoken frame of reference for the work of psychotherapists. A participant said, "I think that a signal part of what a psychotherapist does is to functionally hold hope for the patient or client." He also said, "the nature of human beings is that we don't know the range of possibilities open to us." Other participants talked about lending patients our hope, and asserted that what is possible may not be conscious at the beginning of therapy.

Participants described seeing possibilities that they felt patients were not seeing in themselves. One said, "There are more possibilities for this person than they can think or imagine." The hope that therapists hold is an active and practical attitude that forms part of the container that makes psychological growth possible. Another said, "I think that one of the jobs for the therapist is to hold the hope, even if the patient doesn't have it." Some participants expressed the view that sometimes they could see patients in ways that the patients couldn't see themselves. One said, "I can hope beyond what patients can hope for in themselves, because I think they are so wounded that they don't have the

capacity for hope." Along the same lines, another said, " I can usually see the patient in a way that they don't see themselves. Very often people who have come to me have been traumatized and they consider themselves to be bad, stupid, or unlovable, and in interacting with them clearly they are none of those things."

Sometimes therapists have a sense of what "manifestations of improvement" might look like in a patient. One participant said, "I think just from having a sense of who they are, it gives me a ballpark about what's possible, what's appropriate, what's realistic." This person also added: "The therapist may realize that something is changing before the patient does." She sees "possibilities hidden in narratives." In the course of the patient's conversation, the therapist may note changes, evidences of growth, that the patient may not be fully aware of, or may not have recognized as meaningful.

Three aspects of holding hope emerged in the conversations. They are: the specificity of the hope, hoping realistically, and the impact of the therapist's personal values. Each will be considered separately below.

The Specificity or Non-Specificity of Hope

An important consideration is whether hope on the part of a psychotherapist for a patient is specific—oriented toward certain outcomes--or more general. Although some had specific hopes for patients, most considered the holding of hope to be non-specific, an active sense that more is possible. When hope is presented as specific, it represents the participant's vision of what a patient might accomplish or become. Hope is described as a way to imagine better things for a patient, to see them in ways they have not been able to see themselves, to provide a therapeutic container to help them create a vision of who they might become, and to grow in that direction. While it might seem related to hope,

and certainly to the future, none of the participants mentioned anything about any kind of specific goal setting with patients.

Responses from the participants indicated that usually hope was not specific, but more general. And they expressed a concern that it should not be too specific. One participant cited a few lines from a poem, which I later found were from "East Coker" written in 1940 by T.S. Eliot: "I said to my soul, be still, and wait without hope/ For hope would be hope for the wrong thing" (1963, p.186). These lines capture some of the feeling of the participants who try to avoid attachment to specific patient outcomes.

Another participant had an interesting way of describing the non-specificity of hope:

> I think that my first reaction was remembering, I can't tell you when, how I used to be afraid of thinking about patients' futures. Or that I would feel their fear of thinking about the future. "Am I going to leave my husband?" "What if I don't like my job?" "I'm going to have money problems, I can't think about it" And, getting free from their fear of what might happen if they did the work about what was going on in them now. So my first thought was about getting free of thinking about their future, after which . . . as the work continued, their future sort of took care of itself.

This participant found it very important to do the psychotherapeutic work, without an agenda for change. She might say to the patient something along the lines of, "Let's just think and feel together about what is going on, and see what we can understand and let that [the future] take care of itself." One of her ideas was that "when a person gets freer from what's making them unhappy, they start to have ideas about things that they wish."

She talked about the experience of a patient becoming less constrained, understanding inhibiting defenses, and thus becoming freer. The constraints she was referring to had to do with a paradox—that the fear of repeating a pattern is why the pattern gets repeated. She said, "I carry my hope in freedom."

A participant described as "quiet arrogance" any sense that a therapist could know what the patient's future holds. There are too many surprises in a person's life. He said that in a general sense, "possibility exists, hope exists, and it is part of my function to hold that." In the same vein, another participant saw hope as being oriented around potentials for growth, rather than specific outcomes. He thought that hope was more appropriately attached to interpersonal phenomena as opposed to things like career ambitions. Another participant said, "It's not my job to define what's realistic." Continuing with the theme, one person said that while she did not set specific goals for the future with clients, she did hold "the sense of the patient being happier, more effective, less anxious . . . that the presenting symptoms will resolve in one way or another." Another agreed with the idea of basic hopes rather than specific ones, "I have a fundamental belief that people have their own capacity to grow and sort of become themselves and that basically a therapist tries to get things out of the way so that they can do their own growing." Another said that he did not think about optimal outcomes—rather, he focused on "potentials for development that could continue to grow, so there is no end point."

There were, however, some stories about specific hopes that the participants had for patients, such as a better job, a new relationship, or stopping destructive behaviors. Several said that patients frequently surprised them with how much more they were

capable of than the therapist thought. One participant told the story of a patient whose marriage improved far more than he ever thought possible in the course of the treatment.

Hoping Realistically

Related to the concern about the specificity of hope is the question of hoping realistically. Some participants made the point that hope to be most effective, should be realistic while others expressed the idea that it is not always clear what is realistic for a particular patient who might be capable of more than the therapist imagines. One who particularly highlighted the need to be realistic put it this way:

> I think that if hope is not reality based, it is not useful to the patient, it's not useful to the therapist, and patients know it. They get it. They read it. At best, then, the therapy becomes unreal, not particularly useful---or at the worst, then, I think that the client and I share a delusional system. . . . So I think that hope has to be reality based because a working premise for me as a working therapist is about telling the truth, hopefully with some degree of sensitivity and empathy.

Another participant observed that his point of view had altered somewhat over time:

> I always, in my work, leave open the possibility for the unexpected. So I don't always know what is possible for them. I tend to have a pretty optimistic orientation in general and with my patients, although that has gotten over the years much more leavened with a kind of realism about really what might be possible for them.

Taking the other view, one participant said, "It's not my job to define what's realistic." Another clarified this point by suggesting that clients may surprise the therapist, pointing out that what could be realistic changes may be unknowable, because

the therapist might not experience all that a patient is capable of within the therapy hour. He says he is often surprised by changes they make in the outside world, such as better relationships. For instance, he refers to a particular patient: "He sort of muddled through therapy, but he really was capable of more than I anticipated for him." Another participant said that she keeps hope realistic by keeping it general, such as hoping that the patient is going to feel better, that he will "come to terms with [his limitations] and live a happy life anyway." One participant added that sometimes we need to help our patients accept their lot in life, as well as help them change. In the same vein the following participant expanded upon the notion of realistic and unrealistic hope:

> I work with really small increments of behavior and change and I don't think you can go far off when you're thinking that way. I'm not thinking in terms of the patient's future development. I can harbor a hope that a patient will develop the capacity to have relationships but I will not put that on him. I'll be working from moment to moment at the level of what is preventing the patient from being able to express feelings, to express love, to express hatred, to be engaged. So I'm not in the realm of having unrealistic hopes, or at least discussing them with the patient.

Therapist Attitudes and Values

Holding a sense of hope and possibility for the patient involves therapists' attitudes, and may reflect their personal value system. Many of them described themselves as hopeful or optimistic people. One participant pointed to attitudes on the part of the therapist that facilitate change:

> You can make up a list and slice and dice it a thousand ways. I will tell you the first three or four things that come across my mind. Patience, curiosity, empathy, and a sense of solidness to the client or patient. They can come, they can go, and you are still here.

This participant emphasizes how the stability of the therapeutic relationship over time becomes the bedrock for hope. Patients may leave therapy and come back, and be comforted by the therapist being there and available. Several participants also described patients who had left treatment and returned years later, having carried a sense of their therapists' solidity and consistency. These qualities came through as some of the most important therapist attitudes that may be unacknowledged or unspoken because they are so intrinsic to psychotherapeutic work.

One participant described hope itself as a moral and ethical value she holds. She was, in fact, not sure why anyone who didn't have hope would be a therapist. She said that hope has always been a part of her and is a human value, even a religious value. "We almost have a duty to hope for other people." Similar to holding hope as a value in itself, a participant described the attitudes that she found helpful and healing as the basis of hope: "The basis of my hope is . . . that there is something so alive in the human psyche . . . the desire for wellness, the desire for wholeness . . . is at work in us."

One participant described himself as having a "certain tenacity;" —he didn't like to give up on people. He associates this with his ability to stay hopeful:

> I like to keep trying and don't like to give up, and sometimes I think that may be a fault, because sometimes I don't know when it is time to give up. But it does keep

> me hopeful that something is going to change. You can't know what's going to happen.

One participant expressed an attitude of encouragement when he said:

> There are times when we become our patients' best cheerleaders. We lend them our hope and we, by believing in them, by hoping for the best for them, and that becomes a vital kind of ground for them to build some of that in themselves.

Another said, in a similar vein: "I think there are some things that might be basic. You want a person to be loved, you want a person to feel good about their work, you want a person not to have horrible symptoms."

A participant who described himself with a humorous paradox as a "hopeless optimist" offered a context in which the expression of hope would be held back. He deemed it necessary to change his normally optimistic stance in working with manic patients. He thought that while it is useful to be optimistic with depressed, gloomy patients, "with manic patients it would be the other way around, because the expectations and hopes they carry are beyond reason. So putting a damper on that becomes important."

Therapist Hope As Action

A psychotherapist's hope is often expressed in action. Certain psychotherapeutic activities express the psychotherapist's hope and help to establish hope and possibility in the patient. The therapists I interviewed talked about how the hope and possibility they hold internally is expressed in certain therapeutic activities. While some participants shared common ideas about how their hope becomes action, they sometimes also pointed to very different aspects of their therapeutic action as embodying and enacting their hope.

Creating Possibilities of Action

Therapists can act on their own hope by helping the patient create possibilities of action. One participant pointed out how the therapist's hope can help create possibilities:

> To the extent that hope is held as an option of possibility, then I think that . . . the frame of possibility enlarges for the client. If the frame of possibility enlarges for the client then there are options for action, for the evolvement or the evolution of competence, which is a critical factor phenomenon, at least in the theoretical constructs I hold about this kind of work.

I asked him what theoretical constructs he was referring to, and he cited a book by Michael Basch, called *Understanding Psychotherapy.* This participant stressed helping the client develop competence, which is an action-oriented approach. He expanded upon how he wants to create possibilities of action for the client:

> to offer the client a shame-free possibility to step into, to keep on offering these action based possibilities because if people are willing to step into these action based possibilities, then they find that there is a kind of competence that emerges from the successful follow-through with that.

Elaborating the active aspect of therapists' hope as well as its non-specific property, one participant said, "Therapists help people to clarify and define projects for living." I was interested in the notion of projects for living, and pursued this with him, asking him whether he thought people were aware of their projects for living. He said:"We help people to clarify and define and maybe even recognize what their projects for living are and it is not for us to impose that on them, but maybe to help realize it or discover it." His sense is that the action of the therapist consists not of imposing agendas

on patients, but rather helping them realize or discover their own agendas. He went on to say that "we are not only witnesses, we are actually participants in that process."

Relying on an understanding of the positive aspects of a client's life, two participants describe activating their hope through taking a supportive stance. One said she looks for what a person has done well in life, and actively points that out and supports it. She considers, also:

> How did they find a way to do what their self was saying they needed to do . . . I hear myself saying . . . look at what you did with this. This is possible, these are all the possibilities of what you did when you didn't even think about it, you were just trying to develop who you were.

She is describing a process of pointing out strengths and possibilities that the person is not aware of in a usable way. The other participant said that she looks for the positive in people and points it out to them.

> So when I see sort of glimmerings of something they've done well, or they just happen to fall into something . . . I can see that can become a part of their full reality if they want that. I'm always looking for positives.

She also said, "Building the patient's sense of agency is a really good way to promote hope."

Patient education is another therapist activity that is seen as creating hope and opening new possibilities for the patient. This same therapist described how she sometimes does psycho-education with her patients, about things such as the meaning of symptoms, and also about trauma. One participant spoke of the power of reframing self-limiting assumptions. He referred to a book by a 12th century Buddhist priest called

Instructions for the Cook wherein, washing a leaf of lettuce was revealed to be helpful to the practice of the whole comunity, thereby bringing out the deeper meaning of a mundane task.

Repairing Damage

Two participants, in the process of describing how the therapist's hope is expressed in action, included the idea of repairing damage. One of them explained this as meaning that he needs to model how to handle mistakes for his patients: that if he makes a mistake, he can and will clean it up. He said that he was a big believer in the process that people in 12-step programs call making amends. The idea is that the therapy context can be an arena for learning that messes can be made and cleaned up, and problems can be solved. He noted that this may go against a lot of archaic beliefs held by the patient. Repairing damage builds possibility. He asks, "How can you build hope if you can't clean up messes?"

Providing a Secure Attachment in Order To Establish a Secure Base for Exploration

One participant well versed in Attachment Theory used this theoretical point of view to describe how her hope is expressed in action. This participant said:

> I do have a sense of possibility, but it's slightly different than when I wasn't as attachment-based. What is missing needs to be taken care of, so they can be present with themselves, before they can go on to do what they . . . need to do."

Her idea was that people need to reorient themselves to feeling securely attached to her as a therapist and to themselves before they can look at their internal life. The future holds more possibilities for the patient after a secure attachment is established.

Providing a Witness or Container for the Patient's Healthier Self

One participant described a kind of action that she feels expresses and activates hope by using metaphors of the therapist as witness and container: "Part of what I think therapy is about is to provide a witness and container for the individual to align with their healthier self." The therapist is a witness—someone who can see and attest to the developing healthier self in a patient. The patient then may have the life-altering experience of being seen, which can help to define, solidify, and create the healthier self. The therapist may also function as a container, holding the healthier self, which the patient may experience as fragile.

Observation of Patient Hope

Therapists sense, often intuitively, how and when a patient becomes hopeful. This section describes what a therapist actually observes when hope and possibility begin to develop and become evident in patients. This includes both internal changes in the patient that are talked about in the therapy session, as well as external changes in the patient's life, particularly in relationships. Several participants said they thought that the greatest sign of hope in a patient is that they show up for psychotherapy. One person described evidence of a person's hope this way: "It's about how people talk about themselves, how they encourage themselves, how they behave with people in their lives, how they behave with me, start talking about hopes and dreams."

Observation of Internal States

One way a therapist can discern the presence of hope in a patient is through the patient's emotional and thinking states expressed in the therapy hour. One participant mentioned "animation, aliveness, enthusiasm, and engagement." He, along with other

participants, spoke of a "glimmer," which he described as a "taste of something that either feels insightful or seems to show a little shift." Another participant took it a step further. He said:

> I look for a widening of people, sort of a cognitive sense of their own possibility. They bring in more of a range of possibilities in their life. I look for slight elevations in mood. I like to pay attention to humor and the patient's capacity to use humor, to engage with humor. Oftentimes this speaks to me deeply of possibilities.

He continues with a discussion of internalization, and what these signs he observes can mean about the patient: "If clients can internalize hope, internalize possibility, then that becomes part of their own internal dynamic that quite frankly drives treatment forward massively." Another participant observed that as patients get freer from what is making them unhappy, they "start to have ideas about things that they wish." She thought that sometimes a therapist would hear these emotional glimmerings before the patient does, describing her occasional perception of "a little something that was changed that didn't have quite enough purchase to be there consciously." This was similar to another participant's comment that he looks for seeds or hints of possibilities, while others look for more emotional range in a patient, or any possibility of hope in the person, past or present.

Individual participants spoke about certain unique perspectives relating to the observation of hope. One such perspective was that emotional states are observable through facial expressions, something in a person's eyes, and facial flexibility, which indicates "room to move." Another sees indications of hope in patients through the

positive feelings they express about other people, signaling a capacity for positive feelings about themselves. Another unique observation was that the presence of low-level anxiety could be a sign of hope. The following quote describes what he means:

> Joy and looking forward to something, it might even be looking forward to the session, some apprehension coming in, might even go into something disturbing, you know in the sense of going a little bit over the pleasant end of excitement. I was thinking just now of patients sitting in the waiting room waiting for a session, and that is frequently with anxiety. And the anxiety, I think, if it is low enough, is kind of pleasurable and exciting. And if it tips into a higher range, it gets uncomfortable. But [that is] much more hopeful than if the patient is sitting out there despairing.

Only one person mentioned dreams as evidence of hope, saying, "Sometimes people have a dream . . . once in a while a vivid dream of the future. It's amazing."

Reports of Life Changes Outside Therapy

One of the more commonly described signs of hope in a patient is their reporting change in the outside world. Sometimes this parallels a sense of more internal hope expressed within the therapy situation, but sometimes it is the first evidence that the patient is more hopeful. One participant described case situations in which the therapist does not see much change in the hour yet the person's outside world seems to go better. Another participant focuses on the evolution of competence in a patient. Several participants treat alcoholics; one of these said that external evidence of change and hope is more dramatic in recovering alcoholics than in other patients, in whom they can be

more subtle and nuanced. One participant focused on evidences of individuation and separation.

Several participants see hope as evidenced by changes in important relationships. One described a patient being able to enter a love relationship, after being alone for many years. Another described improvement in a marriage that the therapist had thought was hopeless. Several participants who also practice group psychotherapy found relationships within the group to be enormously helpful in facilitating hope and change at an interpersonal level.

An interesting response was that hope in so many people revolves around "doing"—being active, working, being ambitious, and that this can create problems when it is the only way to feel hopeful; a lot of people don't know how to live in a way that isn't as action based. This participant particularly noted individuals who have retired, and are trying to make sense out of their lives. She thought that a client might say something like, "Well, I've done the hardest part of my life, now I'm supposed to sit in the backyard and play ping pong." She said it was hard for people to make a life that isn't organized by work, or at least by doing.

> Another participant said that she listens for small changes in a person's life:
>
> Sometimes I listen for something they are talking about that interests them, or they tell me they met this new person and they are very interested in some kind of music and . . . they discover they're interested too, but they are anxious about proceeding so we talk about how they might do that. So little things that come up in their lives, I try to listen for that and how that can work for them.

Sometimes changes in a person's life are small and easy to overlook, as noted by the participant who said that he looks for small increments of change rather than large ones.

Therapist Influence

Therapists have historically been very concerned about not exerting undue influence on patients. Today, the inevitability of influence is recognized and remains an area of concern. The participants all addressed this problem, but dealt with it in different ways. Relating therapist influence to hope, some of them felt it could be a problem when a therapist wants more for a patient than the patient wants for him or herself. The question of whether hope implies pushing the patient and about the inevitability of influence were also topics in the participants' responses.

When the Therapist Wants More for the Patient Than the Patient Envisions for Himself

Speaking of wanting more for patients than they wanted for themselves, one participant said:

> ...There are certain cases . . . of people I have seen for a while, and maybe they have made some improvement, but they feel ready to stop, but I have more in mind for them. So I may think that they need more work in certain areas or certain issues don't seem as resolved as I would like them to be.

If the therapist wants more for the patient than the patient wants, hope could become an imposition on the patient and not feel helpful. Addressing the same concern, a participant said that she worried about imposing an agenda on a patient because what she wants for the person can be so different from what they want. This becomes even more anxiety producing for the therapist when they perceive the patient's wants to be self-destructive. Another participant describes being careful not to get too attached to her own hopes for

outcomes. One said he tries to be influential without imposing his view on patients, by "helping them to either validate their own actions or reconsider them." Another was very aware of the potential risks of wanting more for patients than they want for themselves:

> It scares me when my idealization and my omnipotence and all that comes in because that might not be what they want. They may be perfectly happy at 60%, 80%, and I want them up there higher.

This was an issue she had struggled with, and, using very strong language, she said it is "unethical, immoral, whatever, for me to decide how my patients are going to turn out." And, "I'm somebody who wants a lot for everyone I meet and I have no business doing that as a therapist." She pointed out that this kind of problem could interfere with termination, with the therapist wanting a patient who feels finished to stay in therapy and accomplish more. Another therapist also brought up her caution about imposing her enthusiasm and excitement on people who weren't ready:

> I think it's easy for us to get caught up in our own view, our own point of view, our own vision for the person and not be aware of it. I know there are times when I put myself into it, and in a way I probably shouldn't, it isn't helpful.

Another participant talked about a client who dropped out of therapy at a point where the therapist saw more being possible, because things were going too fast, but returned years later to pick up the work.

Does Therapist Hope Imply a Push?

Does hope imply a push on the part of the therapist? The idea of "pushing" the client is troublesome to most therapists. All participants saw a push as being worrisome, but some saw it as occasionally necessary. Others felt that a push never has a place in

psychotherapy. This seems to be a topic around which there is not much agreement. No one likes to do much of it, some admit to it but are slightly embarrassed, and some say they do not do it at all. The following are various ways different participants talked about and equivocated about this: One admits he sometimes has pushed, although he is not crazy about doing so. Yet he wondered whether a push might show a patient something about what is possible. Another does not think therapy requires a push, but that it is helpful for the therapist to "create possibilities of action." This relates to pushing in that he might suggest things a patient might actually do in his life. Another, who works with a number of patients dealing with alcoholism, said she does not push but she may nudge: "Most of the time I think it is not useful to push because the patient is better at resisting than I am at pushing, and then it can feel intrusive and disrespectful." Yet she will never push someone to stop drinking, preferring to "help them see how drinking affects their lives." She adds that there is one exception she makes to this, which is when the patient is just about ready, she may "give a little nudge."

The following two participants were unequivocal, saying they do not push: one indicated that her hope for a patient never involves a push on her part. She said, "When I get attached to something I am thinking that they should do or that I think would be a great path, I know I should worry." The other said: "I don't think pushing is going to help. It's only going to take away hope." The balance she sought was to be encouraging without pushing.

On the other hand, some were more positive about the value of an occasional push, describing contexts in which they would do so. A participant who will occasionally push a patient explained that he might be "encouraging that they try out, that they take

certain risks, and/or they take a new direction--they feel something they haven't felt before, or that they are willing to go into a traumatic experience that they've sealed off." My sense of this response is that he will sometimes push a patient who is getting close to addressing something important. Another described a case in which a patient was refusing to go to work. The therapist pushed the patient to go because he was threatening his livelihood and identity. This was the only participant to address the problem of what happens when the patient is potentially self-destructive. Another participant declared that a push by a therapist is worrisome, and "sometimes absolutely necessary." Another said he would push the patient, tell the patient to try something—not because he wants them to comply, but because he wants to "push them into the world," implying an attempt to get them moving. Bringing up the notion of timing as a therapeutic context, one participant said she would be more likely to push earlier in therapy, as a way to engage with the patient. This was an uneasy topic for all the participants.

The Inevitability of Influence

Today, the inevitability of influence is recognized and remains an area of concern. Many of the participants expressed this and suggested that since influence is inevitable, it should be as conscious as possible. A particularly strong expression of this point of view comes from a participant who stated that, there is no getting away from it, the reality is that a therapist is going to influence a patient. He suggested that getting consultation is an important way to deal with this. Another participant emphasized the importance of getting consultation when dealing with problems related to influence. He said one way this gets complicated is that it is hard to tell if he is creating compliance

when he is influencing, or whether he is helping the patient hold in mind something they could not hold by themselves. He also emphasized that influence needs to be conscious:

> I know, I believe that I have influence . . . that sometimes it is conscious and sometimes is a lot less conscious. I think, given it can't be avoided, I like to do my best in making more of it conscious about what my inclinations for the patient might be.

Yet another participant was concerned about not being conscious of influence, pointing out that he may have more influence than he realizes, because it is hard to tell what effect a particular interaction has had.

Then there is the problem of what the patient may want and the question of the context for when influence might be called for. A participant described a situation in which a patient wanted more influence from the therapist, in the form of permission and reassurance. This was a young patient, and the participant thought this was possibly an age–related phenomenon, suggesting that more influence may be useful with younger patients. Also speaking of a purpose for influence, several participants agreed that there could be too little influence, as well as too much, and that it was important to maintain an engaged stance. One participant, emphasizing the delicate balance between too active and too passive, said:

> I've gone back and forth with this idea of the therapist's authority and intersubjectivity theories and dialectical constructivism, things like that, where you are always influencing, you can't get out of it. You can't not influence, so you are faced with: if that's inevitable how do you want to navigate that and how

> powerfully do you want to bring something in or back off. Even if you back off you're still influencing.

Being aware of their own influence was seen as a struggle for many. One participant said she wasn't sure that therapists generally were as aware of influence as they need to be.

Therapists Conceptualize Hopelessness in Patients

As the participants considered hope and possibility, they also spoke of their observations about hopelessness in patients. Often in the beginning of therapy, a patient presents with an attitude of hopelessness, with a sense of a foreclosed future. A patient may initially arrive at psychotherapy feeling and appearing hopeless, with no possibilities.

One participant made a particularly strong statement about how hope may be foreclosed at the beginning of therapy:

> There is a way in which the internal perspective of the client or the patient is foreclosed relative to how they show up in the therapist's office. Usually, I think, because there are constraints around internal belief systems, depression and anxiety for the most part, in the population that I see. In that context, hope is a foreclosed option.

Therapists describe how they experience patient hopelessness and some talk about possibility for the patient in the face of hopelessness.

The Therapist's Assessment of Patient Hopelessness

Working with hopelessness in patients is a challenge described by all of the participants. They described different aspects of hopelessness. One associates hopelessness with depression, saying she thinks that when there is a sense that the future

is closed off, it contributes to patient depression. She put it this way, "I think if you have a sense of hopelessness, which translated means no future, it influences the present because you get depressed and you don't try. You give up." Another participant noted that the patient's inability or lack of drive or motivation to invest himself in the therapy can be seen as evidence of a patient's hopelessness, another manifestation of a closed off future. Hopelessness is one of the symptoms of depression, and depression causes hopelessness.

However, one participant thought that the hopelessness a patient may present with is usually a part of depression, but this is not always so. He took it further:

> I think that sometimes when you're working with some very difficult people, like patients who have serious personality disorders, schizoid personality disorders, or negative symptoms of schizophrenia where there is prevailing gloominess and negativity . . . a sort of dreary sense of possibility for themselves in the future, whatever, that becomes very obvious in conversation—that quality of hopelessness which doesn't only mean depression.

I asked him to differentiate hopelessness and depression. I think he was the only participant who addressed this, bringing in context:

> The context of hopelessness in depression, I think, comes from a kind of narrowing of focus in terms of how they view themselves, their life, a real constriction of not only the energy in feeling but of their conceptual life, whereas the hopelessness that comes from a kind of schizoid or schizophrenic hopelessness seems to be a much more expansive kind of hopelessness. It is a hopelessness that comes from having tried and given up or despaired, or

something has broken in their capacity to relate to the world in terms of a more positive dimension. So I think there is a subtle difference, it may feel like the same kind of hopelessness, but the contexts of it are so different. This is how I have experienced it.

Addressing hopelessness with a combination of medication and psychotherapy was another way therapists described their experience. A participant said that she thought about medication when confronted with a patient's hopelessness. She described working in an inpatient unit for eating disorders: "I watched hopelessness turn into hope with a change in the seratonin." She thought that some people have a lifelong struggle with hopelessness, and that it helps to both be on medication and therapy all their lives. Another participant, a psychiatrist, described using medication with hopeless patients.

One unique description of patient hopelessness was more poetic. It was from a participant who said he worked with a patient whose hopelessness defeated every positive development in his life. He described hopelessness as "an active process something like tar that is dragging down elements of hope."

Hopelessness and Limitation

When asked about hopelessness, a number of participants thought it was important to remember, in the face of hopelessness from patients, that more is possible than the patient initially realizes. This is related to therapist hope, which was discussed earlier, but was described as a specific reaction to hopelessness.

The following quotes from several participants illustrate this. Speaking of interpreting to a hopeless patient one said: "The expression that we have come to use together is that she doesn't get not to know what she knows, but that doesn't mean that's

all there is to know." Another participant noted: "I think I have had enough experiences with being surprised—not only that I've had a lot of them, but enough to make me skeptical about being discouraged." A participant indicating that she never thinks anyone is hopeless, said, "I don't think anything is foreclosed. I've seen people who are just terribly, terribly disturbed, but I don't think anything is foreclosed I really don't." Several participants said they held hope for the patient until the patient was able to do so for himself.

Therapists' Reactions to Patient Hopelessness: The Mutual Arousal and Regulation of Affect

The loss of the ability to manage and regulate feelings is an outcome of early trauma, and is present in psychiatric disorders. Hopelessness is one result of unregulated negative arousal that can create negative arousal in others. Anxiety, hopelessness, and despair in a patient can arouse similar feelings in a therapist. One participant described this experience: "Very often I can become hopeless when a patient is hopeless. I can look at my own feelings sometimes and if I find myself feeling about a patient, 'oh my gawd, you are screwed . . .'that means to me that the patient is hopeless." Another talked about "catching the anxiety," and described what that experience might be like:

> I feel it in my body. My breathing changes and I think, Oh my God, I've got to do something to make something happen so that there is something good that happens. That's no good. I can feel it. I pull my arms in. I will make something good happen. Not good.

These therapists are very aware of when patient hopelessness starts to make them feel hopeless.

When the therapist is able to regulate his own affect, it helps the patient regulate theirs. One participant describes an experience of this kind:

> I try to be with them [patients] in their hopelessness. I find if I'm present in that place, that it's not so lonely for them. It's not so bleak. I see so many people who have been abused and had horrible lives. I've seen a lot of hopelessness, and suicidality. And what I found is that if I'm present with them as fully as I can be in their hopelessness that they become less suicidal. I found if I just sat with them in their despair and really, really explored it with them, that it lifted by the next day.

Another participant noted that "the therapist keeps on lending to the client what they cannot find for themselves." When a therapist is able to do that, she feels better herself, and the treatment progresses. Another said, "Sometimes I have to work to separate myself from the patient's hopelessness." One participant, in discussing her wish to help patients slow down and give themselves enough time to deal with big problems, will tell them "It's never too late," which has a calming and soothing effect and can help with patient anxiety and impatience. Another said, when talking about therapist hope: "It's not unlike courage in the sense that we encourage people, and maybe we 'enhope' people too." Another participant describes how he permits himself to experience emotional arousal with the patient, which helps regulate the experience for both:

> I have a sense of . . . a genuinely emotional affect of experience [in patients] that really reflects some core aspect of their beingness and I think at that point oftentimes I get very quiet and very respectful and will move metaphorically closer to the patient so there is a sense of connection with me in that they are not

alone in that experience and are understood in the experience. I think there is a general healing in that.

Anxiety About Change

Change, even when desired, can be anxiety producing and disorganizing. Psychotherapists have noted that often just when progress is being made in the therapy, the patient may do something to slow it down or even end the therapy. The patient's world view, relied upon for so long, may no longer make sense, but a sustaining new world view is not firmly in place. I inquired about how participants handled anxiety about change in patients, because much work on the patient's potential future occurs in dealing with this anxiety. As the participants considered the anxiety about change, the similarities in how they dealt with it were remarkable. This was the area of inquiry that produced the most agreement. Holding and containment by the therapist were felt to be helpful in addressing the anxiety about change.

Old Patterns Are Organizing; Change Can Be Disorganizing

Old patterns of thought, feeling, and behavior may be a problem, but because they may also be organizing for the individual, they can be extremely persistent. Participants spoke about this in the following ways. One participant, recognizing this phenomenon, said he would directly interpret to the patient that old patterns were organizing, but maladaptive. He said:

> I would want to be able to link the change to the anxiety and describe that—how they have been in the world, and how they now are, and how this may account for some of these kinds of feelings that they are not aware of. So, I would try to be

> able to notice the sequence of things and how the change may have contributed to whatever anxious feelings that they're having.

He said that a patient might feel "a little off center" when changing behavior. Another found interest in taking apart the belief systems that underlie old patterns. One participant humorously described the dilemma: "It may be hell, but we know the names of the streets." Another put it this way: "The gravitational pull back to the old thing; even when it doesn't work very well, it's so powerful." The following therapist raised some relevant questions regarding resistance to change:

> Why do people have resistance to change? Is it because change involves loss and grieving, and they are reluctant to deal with loss and grieving, and our role is to help with that? Or is it that there is something about the unknown that is threatening, the novel, the unknown, the risks that they will face, that they don't feel up to the task or adequate to it, so that their anxiety is a reflection of something about how they shape their future . . . or they might feel motivated but don't feel ready?

Describing this phase of treatment as liminal, an in-between stage, another said that the anxiety of this phase is horrendous. She was likely to use a peer consultation group during this phase of treatment, because she is likely to catch the anxiety. She feels the anxiety in her body, and feels pressured to make something good happen. One participant observed that sometimes it feels as though patients would rather go back where they were, because it is familiar. "I will spend a lot of time talking to people about what it's like to be in that kind of place and what it feels like to have hope and they can be better but how scary that is." Disorganization brought on by change was described as a big

problem by a participant who spoke of a patient who made enough progress in his therapy to start a love relationship, at which point he seriously regressed. He said:

> What happens is the fear associated with making ventures into the new area gradually declines from very high levels that might even be associated with terror initially, to panic, to less anxiety over time, as ventures are made into life and relationships. The patient needs to make the venture whether it's with the therapist or the world, to assert himself to remake over and over again this positive movement in order for the anxiety connected to it to decline.

Seeing it differently, another participant said that the anxiety about change is more disorganizing than the actual change would be, that people are more scared before change happens than when it happens. They fear losing their identity. The defense against anxiety is what is overwhelming. He said, "If they actually get to the point where change is happening, it's actually not really [scary]—it's too necessary." He didn't like the word "change," preferring to say that "something's moving" or "something's developing." He felt that the word "change" implied that the person was supposed to be different.

Holding and Containment

Emotional holding and containment is the therapeutic activity described as having the most useful impact on anxiety about change, helping the patient to go through this phase. There was agreement among the participants about the value of holding and containment in dealing with this type of anxiety.

One participant described how containment might be played out in the therapy hour, focusing on experiencing, naming, and understanding anxiety:

> I try to understand, interpret, describe what I think is going on and is driving the anxiety. I hope that would be containing for the patient. I try to monitor my own anxiety and see where that is, both as a way to understand the patient and also as a way to be available to the anxious feelings of the patient. So describing it, trying to name it, interpret it, like feeding back to the patient something they can resonate with makes the anxiety explainable, understandable. I try to notice the sequence of things and how the change may have contributed to whatever anxious feeling they were having.

Another participant had a different idea about containment, focusing on an attitude of trust, particularly trust in the therapist's knowledge and experience.

> I think in some ways the idea comes back to being a container. With clients in that place, some part of my function is to shift to a kind of quiet trustingness between us. The quiet trustingness nature of the therapy itself, the quiet implicit message is, I have been down this road before, I know that this road takes you to places that are important to go to and I trust that the outcome will resolve usefully in your service. Some are said out loud but it is a quiet tonal form of empathy with anxiety.

This participant highlighted the value to the patient of the therapist's self-confidence, and willingness to use expertise for the patient's benefit, which can create a trusting atmosphere. One participant talked about containment from the point of view of the patient, and was impressed when a patient described to her the experience of feeling contained, saying:

> Someone said to me recently, it is so amazing, this person explained containment to me, which was that I was able to react to what was going on for her and have feelings about it. However, she could see that more was going on inside me than that. That it was bigger. That I could hold what was happening to her but it was part of something bigger. It didn't overwhelm me, it wasn't everything, and that gave her hope.

One participant thought that the level of holding a patient depends on the level of disorganization and disintegration of the patient. Another participant said he doesn't back off when clients get scared of change, so as not to agree with the notion that change is too much for them. He felt that the fear of change was often worse than the change itself. Those who do group psychotherapy noted the importance of containment by groups, which can be an important part of a holding environment.

Other Thoughts on Anxiety About Change

Individual participants had a number of other interesting ideas regarding the anxiety about change. Two participants spoke of the situation in which a person is not ready to change, even though there is genuine desire and motivation. One of these said it is necessary that a therapist be "respectful of unreadiness," emphasizing that the goal of therapy needs to include acceptance as well as change. One person who frequently works with alcoholic patients, noted that for many people, but especially alcoholics, social supports, such as 12-step programs, are important in change.

The Relation of Affects and Symptoms to the Patient's Sense of Future Possibility

The patient's affects and symptoms may provide a clue for the therapist about what is possible and what possibilities have been foreclosed. Patients may foreclose what

can be considered with respect to the future by staying with affects that are safe and familiar. Patients might not be aware of doing this—it is so much a part of their vision of how their world works. The therapist may start to get a sense of what the patient has foreclosed in the future by observing what affects are missing or inhibited. As individuals develop more affective possibilities in treatment, different future possibilities may open up. Symptoms may be viewed as evidence of something not yet expressed, and thus, as the meaning of a particular symptom is understood a different future may become possible. Although there was some disagreement on this, many of the participants thought that affects and symptoms provided important clues about what the patient experienced as possible. This was stated by one participant:

> Symptoms for me are signaling systems on how people are attempting to manage a current difficulty with tools, coping strategies, defenses that come out of some previously formed experience, that are probably not sufficient to the current situation and they tell me two things. They tell me both what the client has learned to do, and they also inform me about, okay, if they learned to do this, what have they not learned to do that may be more useful or functional to be addressed, that, if they did it, would begin to open up these constructs around hope and possibility, or incompetence.

Another participant said he thought "the symptom may be a reflection of how they're viewing and experiencing their future." He gave an example of this:

> I am thinking, for example of college students who come with a sense of they have gotten to a point where they are not really sure why they are doing what they

> are doing. They don't see this as either relevant for their future, what they planned or what they haven't, or they've lost a sense of the value of their future.

He went on to say that such a dilemma could bring on depression, confusion, and self-doubt. One participant said he thought that symptoms of character disorders, such as narcissistic disorders, in which a patient might be lacking in empathy, made him less optimistic and hopeful for the patient. One participant said she knew a patient was in trouble when he talked about feelings in an avoidant manner, talking *about* feelings rather than having feelings. She also encourages people to pay attention to bodily sensations—"to realize that the body is speaking to them."

Making Meaning out of Affects and Symptoms

The limitations of a patient's affects may indicate ways in which parts of his future are foreclosed. Symptoms may provide evidence of these limited affects, again linked to the future. The therapeutic task of helping patients understand the meaning of their affects and symptoms, in order to help them see the reasons for their fears, was described by one participant as "a lot of work." Others spoke about the way they approached achieving this understanding and about its import. One participant said:

> I start by asking the patient to make meaning. I very seldom start with my own meaning-making system. I believe that people can construct meaning-based systems out of their affective experiences. Quite frankly, intuitively more knowledgeable than whatever I might offer.

Another participant said she thinks that symptoms give evidence of internal belief systems. She gave a humorous personal example:

> I had a dog one time, and we kept the dog out of the bedrooms, we didn't want the dog in the bedrooms, people were allergic. The boys kept their bedroom doors closed. Then we decided, okay we are going to leave the bedroom doors open, but the dogs still wouldn't go inside. And to me that is sort of the symbol of how the symptom prevents . . . anxiety prevents people from doing things. Depression prevents somebody from doing the things. And similarly these doors were closed, they were taught that they couldn't go into these rooms, and they developed anxiety about going into the rooms? Or they developed depression? But they couldn't go into the room, but in any case, it prevents them, the symptom, from opening the door or even going into the room when the doors are opened.

Although this example has to do with dogs rather than people, it illustrates her point that rigid internal belief systems can give rise to symptoms, and that symptoms then foreclose options for the future. She continued, in a more serious vein, to describe how symptoms might work in people, assuming they don't understand the meanings of their symptoms:

> And this is not something that people even say consciously to themselves. I think that as a therapist you can help somebody say, oh, this is what you do and this is what you don't do. This helps because it is so implicit, it's in the implicit memory, it is not in episodic memory.

Another participant used affects and symptoms to assess what is being left out. She said:

> I'm inclined to see what is presented to me in terms of how it's inhibiting, or what it is causing to be left out. I don't know if I get a sense of what's left out. I just get a sense of the inhibitions, so an affective state can make certain things off the

> table, as can symptoms. Just keeps things out of the universe. I just know there is an obstacle and if I focus on that and we modify that, then we get to see.

A participant spoke specifically about the way symptoms indicate what is possible and what is foreclosed. He noted that with schizophrenics, "the likelihood that they are going to shake their alienation and isolation is very low." He sees character change as a very slow process.

> I would say on a spectrum of development, if you have schizophrenia at one end and neurotic problems and higher order organization at the other end . . . if that were a three-foot line, you can hope to accomplish a few inches in many years of character change.

He also believes the age of the therapist matters in assessing the meaning of affects, that younger therapists might have trouble assessing things they have not seen before. One participant noted that she had recently read that "depression could be an important movement, an important phenomenon for a person who has had a false self." She saw depression as the "expression of years of suppressed pain."

Disagreements

Whereas the above-described participants spoke of affects and symptoms as signs which help them assess what is possible and what is foreclosed, several participants did not think this way. They mostly felt that they did not like to say that anything predicted what was possible in the future, not affect, nor symptoms, nor anything else. One participant said that people had surprised him enough that he did not want to make predictions based on affects or symptoms. He said that he has never liked the concept of analyzability, because it requires predictions and judgments. He said, however, that he

would hold questions in his mind about the meanings of affects and symptoms. Another participant said she did not like to make predictions based on affects, but that she was working with "a pretty normal population." Again she noted that many patients had been capable of much more than she would have thought, an idea to which I think most of the participants would have agreed. Another said, "I've seen people that are terribly disturbed, but I don't think anything is foreclosed." She thought, however, that people might be inhibited.

The Impact of the Past on the Future

The subject of how therapists use the past in their work is enormous, certainly greater than the scope of this study. One of the areas of inquiry had to do with a small aspect of that larger subject, namely, how therapists learn from a patient's past what he (the patient) might consider possible for the future. One participant put it this way: "I think our normal tendency is to both interpret reality as it fits with what we already know and have experienced which then creates a future, and react to the present as if it were the past." This participant had a question about this: "If all you know is what has happened, where would you get the dream of what could be?" This participant felt that memory and experience create expectations, and thus expectations are a form of memory. She thought that we take for granted that what we have experienced will be what happens in the future, and that belief colors current experience. One participant, suggesting the danger that the past can foreclose the future, put it this way: "The snags and traps and problems that a patient has run into are likely to be reproduced in the future unless some understanding of the past occurs—a lot of understanding." Another added that it is not

that understanding the past frees the person up. It is that the past is probably still happening in some way.

On the other hand, the patient's past may be used by the therapist to help him define a sense of what is possible, where his strengths lie, and to find the events and times in the patient's life that have made him proud and excited. One participant said that he pays attention to what events in patients' histories they are proud of, where they "come alive in their own biography." Another participant described how she helped patients look at "how do they use what they got stuck in, in their family of origin." Possibilities become apparent by observing how a patient managed with whatever situation he was dealt. Still another expressed a similar thought: "Understanding the past helps you to know what it is that you have that is ongoing, and that it can be helpful."

CHAPTER 5: DISCUSSION

This study looks at how psychoanalytically oriented psychotherapists think about and hold a sense of their patient's futures and how this impacts their work. The findings reveal that therapists do consider thinking about the patient's future as an important psychotherapeutic function. However, the participants conceptualized the topic in different ways. Though the term "future" was presented to them for consideration, they did not use it specifically, speaking instead of hope and possibility, words that operationalize how they think about the future. Though the research problem addressed the issue of hope, it was not my intent that this be the primary focus of the study; for the participants that is what it became.

The participants expressed a sense of hope for their patients as primarily non-specific, though examples of specific hopes arose. They were concerned about keeping their hope realistic, though some felt it was not up to them to decide what was realistic. Discussing the dangers of having an agenda for the client, they showed concern about how hope is held and expressed. This also came through as a dilemma regarding therapist influence. They agreed that therapist influence is inevitable, so it makes sense to be as aware of it as possible. They felt that therapist hope is often expressed in action, such as creating possibilities of action, repairing damage, and providing a witness or container for the patient's healthier self.

The participants also spoke about recognizing patients' sense of hope for themselves. The therapists had a good sense of how patient hope is evidenced and expressed, either spoken of in the therapy hour or reported as changes that occur outside the hour. Participants had much experience with patient hopelessness. The participants

considered what patient affects and symptoms indicate about what may be expressed as possible or about what may be foreclosed in their future. They thought it was important to help make meaning out of affects and symptoms the patient does not understand. This activity is part of the larger task of expanding a sense of future possibility, resolving pain, and promoting personal growth. They also said they learned from the patient's past what might be possible in the future. They also were familiar with the kind of anxiety that is stirred up in patients by change. The participants thought that holding and containment by the therapist was the most useful intervention in dealing with anxiety about change.

In this chapter, I shall discuss my conclusions about and interpretations of the findings, followed by a description of my own experience regarding holding the patient's future and a discussion of findings with respect to the literature. Finally I shall make some suggestions for future research, address limitations of the study and implications for the field.

Conclusions

Holding the Future Is an Essential Psychotherapeutic Function That Is Not Often Addressed

A sense of the patient's future is important for the therapist, not often talked about, and not often put into words. I believe, and my research has shown, that holding a sense of the patient's future is an essential psychotherapeutic function that tends to be taken for granted or assumed. It forms a generally unspoken and often unconscious frame of reference in psychotherapy. It is an attitude or an orientation that becomes operationalized as an active and practical part of the psychotherapeutic process. I think one reason it is assumed is that a sense of holding a patient's future exists at such a deep level for experienced therapists that it is rarely discussed. Many of the participants told

me they had not thought much about this topic, yet they realized they had a lot to say about it. The research interviews stimulated their thinking once they considered it for a while. I think the research questions put into words something they already knew but had not focused on, and their answers helped them define the subject for themselves. Since consideration of the patient's future is mostly absent from practice theory, much of what the participants thought about this topic appeared to result from knowledge accumulated through years of practice.

The Future Is Not Often Addressed Directly

While the research question was framed in terms of how the participants thought about and held a sense of their patients' futures, they started talking almost immediately about hope, meaning to them that holding a sense of the patient's future involves holding hope and possibility. There was concern by one participant that the word hope sounded too sentimental, but the concept existed for everyone, no matter what they called it and they all agreed that holding hope and possibility is an essential psychotherapeutic function. None of the participants spoke of goal setting, which might have been a way of addressing the future.

One reason that my question about holding the future may have been translated into the concept of hope by the participants is that "future" may not be a comfortable word for a lot of psychotherapists, and it is not often used in theory. A discussion of the future may create certain fears: of prediction, of having an agenda, or even of creating a self-fulfilling prophecy. Although I did find some references to the future in the literature, the participants did not talk about the future directly.

The phenomenon I refer to when I speak of holding the patient's future existed in the participants in a deep and unarticulated form. When I found a way to ask about it, I found that the participants did recognize and work with this phenomenon, using words like hope, possibility, destination, differentiation. Though psychoanalytic theory does not often directly address looking at and holding a patient's future, participants did use words drawn from their own theoretical orientation to describe this aspect of their work. They also described profound personal experiences. The responses of the participants confirmed my belief that the issue of the future is under-theorized but nonetheless lives strongly in therapists who do deep and life-changing work. I think the future is part of the relational, intersubjective field of the work, which includes the vicissitudes of hope, but of which hope is only part and not the whole story.

Dealing With Patient Hopelessness

The participants were a hopeful group and did not dwell much on frustrations of their hope. When asked, however, they talked about their experience of patient hopelessness, and how they dealt with it. They all had experience with patient hopelessness, knew what that felt like, and described the attitudes they held in the face of hopelessness. They spoke of getting caught up in patient hopelessness and how they deal with it and guard against it. In addressing and holding a sense of the patient's future, one of the most important things a therapist does is to engage in mutual regulation of affects – the patient's and their own—in order to provide a different and healing experience for a hopeless patient. They tended to point to interventions and verbal content rather than acknowledging that this regulation of affects is often non-verbal

It was interesting to me that no one spoke of getting overwhelmed with patient hopelessness, or about therapist burnout, or compassion fatigue, which certainly can be occupational hazards. I think this may be because the research question was framed in a more positive way. This may also have affected self-selection for involvement in the research, in that those who are burned out or overwhelmed would be less likely to volunteer for a study like this.

Awareness of Possibilities: The Paradox of Influence

Psychotherapists may see possibilities in patients that the patients cannot see in themselves. This knowledge is part of the container that makes psychological growth possible. Therapists need to hold this knowledge, without exerting undue influence or compromising patient autonomy. Inherent in the research question is a dilemma or paradox. It was generally agreed that it sometimes has value for therapists to want more for patients than the patients want for themselves but it is well known that there is a problem with therapists having an agenda for patients, which implies undue influence, or encouraging patient compliance with a therapist's goals and values. There is a question about whether therapists' hoping produces compliance in patients, and how psychotherapists manage that risk. How often does a patient who needs his/her therapist's approval try very hard to become the kind of person the therapist would approve? The participants were keenly aware of this dilemma, and worked within the tension it creates. Often this problem is handled by therapists holding a non-specific attitude of hope. Although the participants saw hope as non-specific, they agreed that it is an important function, as well as an important part of a psychotherapist's personality and character.

Anxiety About Change

A patient may cling to what is familiar, even if it is a problem. Change, even positive change, can be anxiety-producing and disorganizing for the patient, and can impact how future possibilities are experienced. It is a common experience among therapists that just when progress is being made in therapy, the patient may slow it down, or may even stop the therapy. Negative and destructive patterns of thinking and behavior can be quite organizing. The patient may have had a way of understanding how the world works that no longer seems valid. Even though this recognition may represent progress, it can be terribly disorganizing. A new, reliable worldview is not in place, and the patient has the experience of living in a world where he does not know the rules. I thought this was an important area of inquiry, because this dilemma impacts the work on the patient's future and it may lead to derailment or delay or even an outright retreat, as this phase of treatment can be very anxiety-producing for the patient.

One participant brought up an interesting point, which I think has some merit: the patient may know what needs to change, but might not be ready, and we also need to respect this unreadiness. One participant thought that anxiety about change, since it is rooted in the past and what has already happened, is more frightening than actual change would be. The participants agreed that therapist holding and containment have useful impact on anxiety about change. The therapist's ability to work with the patient by holding and containing some of this anxiety is part of what creates the future. This idea is consistent with Winnicott's idea of the holding environment. When everything else is changing, there is constancy for the patient with the therapist.

Winnicott likened the therapist's holding of the patient to the mother's emotional holding (distinct from physical holding) of the young child. Phillips (1988) said: "For Winnicott, and those who were influenced by his work, psychoanalytic treatment was not exclusively interpretive, but first and foremost the provision of a congenial milieu, a 'holding environment" analogous to maternal care" (p.11.) Winnicott describes the holding of an infant, in his essay "The Concept of a Healthy Individual," which is included in the book *Home Is Where We Start From* (1986):

> In an environment that holds the baby well enough, the baby is able to make *personal development according to the inherited tendencies.* The result is a continuity of existence that becomes a sense of existing, a sense of self, and eventually results in autonomy. (p. 28)

In a similar way, the therapist holds the patient emotionally, thus creating an environment in which personal development and a different future are possible. In his article "Psychiatric Disorder in Terms of Infantile Maturational Processes" included in the book *The Maturational Processes and the Facilitating Environment*, (1965), Winnicott describes what a therapist might do to hold a patient:

> 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. (1965, p. 240)

An Implicit Question

Throughout the interview process, one strong sense I had was that the participants were rather consistently answering a question that seemed to be implied but not stated. In

my analysis of the interviews, I have been trying to put this implicit question into words. It is something along the lines of "How do you understand psychotherapy to be a useful human endeavor, and how would you describe the kind of internal mindset on the part of the therapist that produces growth in the patient?" In observing the participants, I saw that their eyes lit up, and they talked with great enthusiasm about their development as therapists. They demonstrated their enthusiasm for the work, their identity as therapists, and their personal growth. Talking about the research question opened up another discussion about how therapists have faith in the whole endeavor of psychotherapy. I think this happened because I was asking questions that go to the core of the meaning of psychotherapy. I think, also, that people do not have much of an opportunity to talk about such things, which appear to be meaningful to therapists. This led to a discussion of therapists' values.

Therapist Attitudes and Values

In keeping with this implicit question, participants brought up specific attitudes and values they felt were inherent to their identity as therapists as well as an extremely important aspect of holding a sense of hope and future possibility. They addressed the question of why psychotherapy is important as a human endeavor, expressing their own philosophies regarding therapy.

I would add another value to those brought up by the participants: that is important that the therapist not give up on the patient, even if the patient is inclined to give up on himself. It is essential for the therapist to stay the course. This can be as simple as a comment like "See you next time" at the end of a session, which can be sustaining for both the therapist and patient. This kind of therapeutic constancy is an

important psychotherapeutic function, different from interpreting conflicts and compromises and other verbal interventions.

There are additional values that I would identify as consistent with themes in this study. Patience is important because it helps the therapist stay the course with the patient, building a strong foundation for the patient. Curiosity is important because it can lead to an open mind, a sense of possibility, or the consideration of new ways of thinking. Flexibility is important because it helps the therapist deal with the unexpected.

The practice of psychoanalytic psychotherapy is rooted deeply in personal values, and can become a belief system and a way of life for the individual. The participants had developed a deep set of beliefs and values about their work. The research question tapped into some of these deep values.

The Role of Experience

This study attracted experienced psychoanalytic psychotherapists. I have concluded that the sense of the patient's future and possibility is something that is best learned through long-term experience, by having been through the therapeutic change process with many people, as well as in the therapist's own therapy and life. Much of what the participants thought about the research topic seemed to be the result of knowledge accumulated through years of practice and years of interactions with patients. It may be that therapists who can hold a sense of the future are the ones who are comfortable practicing intensive psychotherapy for a long time. Perhaps this ability sustains therapists as well as patients. By this I mean it may enable therapists to be with the patient for a long time and through many difficulties.

It was interesting that the participants' language tended to vary—they took whatever theories they knew and found useful, and expressed their ideas in that language. The result is a kind of practice wisdom, that is good to put into words where it can be recognized by the speaker and shared with others, including at times with patients or with younger, less-experienced therapists.

Thinking about the role of experience made me wonder whether people who had not been in practice as long would know or think about this. I doubt that young, beginning therapists would have a sense of this in the same way. Or they might actually have hope for a patient, but not know as much about why, and how good psychotherapy is helpful. It could be useful to teach this concept in training programs that teach psychoanalytic psychotherapy. I think this point of view is most useful for psychotherapists doing long-term work, in which the relationship is key. It would doubtless take a different form in briefer types of psychotherapy where positive goals and a belief in the patient's ability to accomplish them focus more on the immediate future than on the future in a more global sense.

My Background in Holding the Patient's Future

This study was motivated, in part, by my own experience. Although I tried not to impose my experience on the collection and analysis of the data, I do feel it is important to describe that experience, since it varies in some ways from the findings of the study. This description should illuminate my conclusions as well as add to and inform my discussion of the implications of this study.

My view of this topic is a little different from some of the views held by the participants. While I don't think it is right to impose specific agendas on patients unless

the patient is self destructive (an important qualifier mentioned by only one participant), I do think it is useful to imagine good things for them, in line with their own wishes and desires. The therapist need not even tell the patient about this, but it may help create an atmosphere in which more is possible.

Years ago, as mentioned in an earlier chapter, I was taught by a consultant to keep in mind a vision of the patient's future, a sense of what they could become, of what was possible. The purpose of this was not to impose an agenda of my own on the person, or to use undue influence; rather it was a method of holding inside myself all the patient was capable of, who they could be at their best.

To help myself do this, one practice I started was to take some time outside sessions—maybe on the weekend—to think about each patient, and imagine what they would be like if their problems were more resolved. I would imagine one patient free of depression, another with a satisfying job, and another with an improved marriage and better relationship skills.

This practice was useful to me in a number of ways. It helped me not to take on some of the patients' negative self-images, and to see alternative possibilities that were not in their current experience. I think it is very easy for a therapist (or anyone else) to assume and internalize another person's opinion of themselves as the correct one or the only possible one, and this practice provided me a way not to get caught up in that.

It is also important to recognize the kinds of unspoken invitations to relatedness one's patient invites. Patients do this subtly, often unconsciously because it feels so normal. This is an important force in psychotherapy, and it defines a part of the intersubjective space, which is often not talked about directly. The practice I describe

also enables me to treat the person as the person they might become, which is helpful to me and, ultimately, I believe, to them.

I had also, at times, observed a disturbing trend among some therapists to speak of patients in a somewhat contemptuous way, no doubt responding to the burdens of projective identification or an intersubjective state of negative arousal in the therapeutic relationship, or burnout or compassion fatigue. I do not think this is unusual, though it is not, to my knowledge, discussed or written about in the literature. I needed an alternative to this kind of negative arousal and thinking. Visualizing future circumstances helps me to regulate my negative affect and ultimately to work more effectively, and enable my patients to progress in their lives. Heinz Kohut (1971) wrote of the "gleam in the mother's eye" (p. 116), which fosters her child's development, and he saw the analyst's participation as having a similar function.

I think that by holding a sense of the patient's future and what they might become the therapist can create more intersubjective room to maneuver. I definitely do not mean that the patient will then become everything that the therapist imagines. But if the therapist can clear a little psychological space so that more is possible, the patient's internal world may expand in ways he would never have considered. This does not imply that the therapist should have an agenda for the patient; it is not about creating what happens, but rather, making room for it in the intersubjective field. This is a relational phenomenon, not a recipe. It is similar to hope, but it is more. If I imagine people free of symptoms, at their best, it gives me a different resting place with them and makes me a different kind of container in a different kind of holding environment.

This reflection is not something I share with the patient directly. Rather, it is a stance that I take, an understanding that I have, that influences how I interact with the patient. It is almost like a reverie or meditation. The idea is to make conscious how the patient could look if not burdened by injuries or stressors—to have a dream for the person and his or her future.

A therapist's conscious attitude toward the patient's future was seen by many of the participants in this study as being useful for treatment. That matches my experience that having a view of a possible future on the part of the therapist helps to make things possible for the patient. It may be expressed in terms of holding or interpretation, but has a somewhat different quality, a kind of therapeutic stance or value system that impacts the intersubjective field.

The Relationship of Findings to Literature

Many of the themes reflected in the literature were also talked about by the participants. Loewald (1960) discussed fear of influence. I think perhaps this was a greater fear in Loewald's time than it is now because neutrality was considered the ideal therapeutic stance; instead, most of the participants in this study thought that influence was inevitable and that they needed to be conscious of it. Cooper (2000), Loewald (1960) and Summers (2005) all have indicated that the future is an underemphasized aspect of psychotherapy; I think most of the participants would agree with this.

I think the participants would also agree with Cooper about the importance of hope. Cooper states that hope needs to be realistic; my participants were divided about whether it was up to the therapist to decide what is realistic. Cooper talks about hope

being linked to what is possible, and sees discernment of realistic hope as being important. Most of the participants did not share this concern.

I would add to the notion of hoping realistically that the therapist needs to also factor in the patient's role in bringing hopes to fruition. One of the participants spoke of the need on the part of the therapist to respect unreadiness.

One participant characterized a psychotherapist as an object of hope, thus agreeing with Cooper. The patient may hold the therapist as a self-object that allows hopefulness in a way that might not otherwise be possible.

Cooper also emphasized that it is important that psychotherapy not create a kind of "bubble" environment in which one does not have to consider limitations. The participants did not, for the most part, share in this concern. Cooper asserts that part of the analytic task is to grieve and mourn limitation. None of the participants said this, although it would be an extension of their discussing anxiety about change.

All of the participants agreed with Summers that change is extremely anxiety producing. He and all the participants agreed that holding and containment are a good way to deal with the anxiety about change. Summers emphasizes what he calls a spontaneous gesture—an action on the part of a patient that indicates that change is happening. The participants don't exactly talk about this; there is, however, the problem that different people use different language to describe these phenomena. A similar idea emerged in the research—one participant talked about the possibilities heard in patients' narratives.

In the literature several of the major authors (Summers, Loewald, Cooper) spoke specifically about the patient's future using that exact language. Few of the participants

spoke about the future: they spoke, rather, of holding hope and possibility. I think the notion of the future may have made some of the participants uncomfortable, as though looking at the future required making predictions. There is a subtle difference. I think a sense of the possible future adds another dimension to hope—a vision of what might be possible.

A number of the participants noted that their conception of their patients' futures was informed by Jungian theory, particularly his ideas about individuation. In pursuing this idea, I used the book *The Handbook of Jungian Psychology: Theory, Practice and Applications,* edited by Renos K. Papadopoulos (2006). Chapter 9, by Murray Stein, is called "Individuation." Stein describes the importance of individuation:

> The theme of individuation sounds through Jung's writings, like a leitmotiv, from the time of his break with Freud and psychoanalysis onward without pause until his death. All things considered, it is perhaps his major psychological idea, a sort of backbone for the rest of the corpus. (p. 196)

He goes on to explain the concept. "Individuation is a term used to indicate a person's potential for full psychological development. . . . In its simplest formula, individuation is the capacity for wholeness and evolved consciousness" (p.197). He describes three stages of individuation: containment/nurturance, which refers to childhood; adapting/adjusting, which refers to early and middle adulthood; and centering/integrating, which refers to late adulthood and old age (p.199). Several participants used this framework in their thinking about their patients' futures.

Jungians have been trained, perhaps more than other therapists, to regard seriously where the patient is going as well as from where he has come. Jungian

therapists do not put as much emphasis on the past as on the next phase of development, which relates directly to a sense of the patient's future. The participants who had Jungian training were somewhat more comfortable than the others in talking about holding their patient's futures.

Ideas for Future Research

One possible avenue for future research would be to limit the focus to the future exclusively rather than incorporating the concept of hope. In this way it would be possible to see if the future per se is considered, and what participants' feelings about the use of the word might be. A way to approach the research question would be to ask people to talk specifically about how or if they hold a sense of the patient's future, without getting into ideas about hope; or how they use their imaginations in thinking about what might become of their patients.

The question could also be studied with other groups. Psychoanalysts, less experienced therapists, cognitive/behavioral therapists, or therapists specializing in short term crisis work would be likely to hold different points of view about the therapist's view of the patient's future.

It would be interesting to contrast the impact of theory versus practical experience. This study suggests that theory as it currently exists is less useful than practical experience in giving a therapist a way to hold the patient's future. However, a theory that stresses the importance of the held future could be helpful.

None of the participants mentioned concrete goal setting, which is an important part of some theoretical frameworks, particularly brief therapy models, and would be another way of addressing the future. The question of the therapist's sense of the patient's

future could be considered with participants who include goal setting as a part of treatment.

Another approach would be to consider the research question in light of more specific psychoanalytic theories, in order to figure out what assumptions are made about the future from different psychoanalytic points of view. Since in most theories this is not mentioned specifically, inferences would have to be made.

Another possible avenue for research about the role of the future in psychotherapy might be to compare therapists who have been supervised in a way that includes consideration of the future, and those who have not. My guess would be that the overt consideration of the future on the part of therapists is rare in training, consultation, or supervision. It may be, however, that it does get communicated but in the same unconscious, unspoken way it is held by therapists. How do supervisors or teachers hold their student/supervisees futures? It may also be that the profession of psychotherapy attracts people who are capable of doing this, as a part of a more general capacity for holding and containment, though this would be difficult to ascertain through current research techniques and instruments

This research topic is also part of the bigger topic of how therapists' assumptions and attitudes impact patient well-being, and how therapists become aware of their assumptions. Therapists, like anyone else, can get so accustomed to their own assumptions and values that they do not see them, and this can impact patients if they enter into a treatment where unspoken values are assumed. There are many kinds of assumptions and values that therapists might hold, such as the ways the therapist considers useful to deal with conflict, express and regulate emotions, or promote self-

interest. These vary among therapists and impact how the individual therapist regards the world of the patient.

To build upon the present research, the implicit question about therapists' faith in the whole endeavor of psychotherapy could be made explicit. Participants in this study spoke about this without being asked. I think further exploration of this topic could provide knowledge about therapists' experience of their role as well as their sense of the skills, personal qualities and values associated with success in the profession.

Limitations of Study

The study was limited by the choice of participants: psychoanalytic psychotherapists. Psychoanalysts, or psychotherapists of a different theoretical orientation might respond somewhat differently. The same is true of less-experienced therapists or trainees who were also not included in this study.

The greatest limitation in approaching therapists' views of their clients' futures was in the lack of common vocabulary to conceptualize the research questions and limited theory with which to address them. That was one of the interesting things about the study—that the topic was under-theorized—but it also created limitations on how to talk to participants. There was a lack of a common language. Perhaps defining and operationalizing a common vocabulary for the participants would help to focus the results more into looking specifically at the research question.

Because this study focused on therapists, the research question was not considered from the patient's point of view. Another limitation is that I did not ask about situations where all the therapist's good hopes for the patient have come to naught, and both the therapist and the patient are discouraged about the patient's future.

Any study is impacted by the culture of the area in which it is conducted. One such as this that focuses on a high-achieving, high-pressure area like the San Francisco Bay Area is likely to have different results from one conducted elsewhere. I think that high future expectations are assumed in the area, which adds pressure to the idea of future.

Implications for the Field

Holding a sense of the patient's possible future is an important and powerful psychotherapeutic attitude that has not been emphasized nearly enough. I believe that to hold consciously that sense is potentially helpful to patients, and could increase therapist effectiveness.

The held future is something that appears to be known and used by experienced therapists, although there is not a common language in which it is addressed, nor a common theory. This suggests a number of implications.

One implication is for training of psychoanalytic psychotherapists. I think it would be useful for therapists to be trained to observe how they hold their patients' futures and to work with this knowledge—to make this a conscious process. The participants learned to hold their patients' futures through long experience in practice, but I think it would be possible and beneficial to discuss this with and teach this to trainees. I think it would also be useful for more experienced therapists to be exposed to this way of thinking, to help them formulate their thinking about it, and to cultivate awareness of the phenomenon.

Another implication has to do with the development of theory. The participants did know about holding the patient's future, but for most it wasn't formulated

theoretically. I think it would well serve the various psychotherapy professions and their patients to have this entire process made conscious and theorized. It would be helpful for therapists to become more conscious of their awareness of the patient's future and make this a more useful working attitude. More solid theory on this topic would build a strong foundation and increase its usefulness. An awareness of the importance of the held future would be a valuable addition to theory, since the future is present in every treatment.

A third implication is that vocabulary about holding the patient's future needs to be more developed. An agreed-upon language with which to represent the phenomenon would be a powerful clinical asset. It makes sense to pay attention to the language by which holding the future is described, and to include this in commonly held knowledge about psychoanalytic psychotherapy. Language and theory development are parallel processes and need to happen together.

It is useful for psychoanalytically oriented psychotherapists to consciously hold a sense of their patients' futures. The purpose of this awareness is not to impose on or lead the patient; rather, it is to clear some interpersonal, relational space, where more is possible. It is my experience, which has been supported by this study, that a sense of the patient's potential future is an ongoing and always present parallel track to understanding the past and transference configurations that reflect the past.

APPENDIX A

RECRUITMENT LETTER TO COLLEAGUES

Penny Schreiber, MSW
Licensed Clinical Social Worker
License # LCS6244

885 Oak Grove Ave., Suite 304
Menlo Park, CA 94025
(650) 325-3065

Dear

I am about to begin the data collection phase of my doctoral dissertation at the Sanville Institute, and am writing to ask your help in recruiting participants.

My qualitative study is about how psychotherapists think about and hold a sense of their patients' futures, about what may be possible or desirable for an individual that may have been be foreclosed. Coming to a psychotherapist implies a modicum of hope, though what is possible may be unclear. I am interested in how therapists might hold that hope, and how it plays itself out in therapeutic action.

I am looking for a small number of experienced (10 years or more) psychotherapists from any of the mental health professions who identify themselves as psychoanalytically or psychodynamically oriented, but are not psychoanalysts. I will spend about an hour to an hour and a half with each participant in an unstructured interview that I will tape record.

Can you think of someone who might be interested and appropriate for this study? If so, you could either tell them about it and suggest they contact me, or give me their names and contact information and I will get in touch with them directly.

My address and phone number are at the top of this letter. Please let me know if you have any questions.

Sincerely,

Penny Schreiber, LCSW

APPENDIX B

LETTER TO PROSPECTIVE PARTICIPANTS

Penny Schreiber, MSW
Licensed Clinical Social Worker
License # LCS6244

885 Oak Grove Ave., Suite 304
Menlo Park, CA 94025
(650) 325-3065

Dear

[for individuals who have contacted me directly: I appreciate the interest you have expressed in participating in the research study I am conducting. For individuals whose names I have received from a colleague: I was given your name by
because s/he thought you might be interested in participating in a research study I am conducting] I am writing to give you some information about the study and to invite your participation.

I am a doctoral candidate at the Sanville Institute. The question I am exploring in my research study is how psychoanalytically oriented psychotherapists their about and hold their patient's futures, how this informs their clinical practice, and how theory influences this aspect of practice.

Participation in this study means that I will interview you for about an hour, at a time and place that is convenient for you. I will tape record the interview. I might also follow up with a brief phone call if I need clarification of something that we discussed. If you choose to participate, I hope you will find the process to be helpful in clarifying your thoughts about the aspect of practice being studied and your own theoretical assumptions. I will be happy to send you a summary of the study results if you wish.

I will treat the information you give me as confidential and will protect your anonymity, as well as that of any clients you discuss during the interview. I have enclosed a copy of the consent form for you to review and which I will ask you to sign at the time of the interview.

If you would like to participate in this research project, please complete the brief questionnaire and return it to me in the enclosed self-addressed envelope as soon as possible. I will then be in touch with you regarding the possibility of your participation.

I hope this project is of interest to you. Please feel free to contact me at the above phone number if you have any questions.

Sincerely,

Penny Schreiber, LCSW

APPENDIX C

CONSENT FORM

I, _____, hereby willingly consent to participate in the study on how psychoanalytically-oriented psychotherapists think about and hold the idea of their patients' futures. This doctoral research project will be conducted by Penny Schreiber, LCSW, under the direction of Sylvia Sussman, Ph.D., principal investigator and faculty member, under the auspices of the Sanville Institute.

I understand the procedure to be as follows:

A one to one and one-half hour audio-taped interview will occur in a confidential setting to be arranged between myself and the researcher. I will be talking about my experiences of thinking about and holding a sense of the patient's future, and how that impacts psychotherapy.

I am aware of the following potential risks involved in this study:

The risks of participating in this study are minimal, perhaps consisting of mild discomfort responding to interview questions or unintended disclosure of confidential information. I understand that I may refuse to answer any question that makes me feel uncomfortable or may involve the disclosure of confidential information. I also understand that I may terminate the interview at any time and that I may withdraw from participation in the study at any time. If I choose to withdraw from the study, I understand that any information provided by me will not be used in the study in any way, including any reports based on this research. Although unlikely, should I experience emotional distress as a result of participation, I understand that I may contact the researcher who will make provisions for me to receive professional help, at no cost to me for up to three sessions, to resolve this distress.

I understand that this study may be published, and that my anonymity and confidentiality will be protected—that is, any information I provide that is used in the study will not be associated with my name or identity. Information provided during the interview that might, alone or in combination identify me or another person will be deleted from the record as quickly in the data analysis process as possible. At the end of the research project, all records will be destroyed.

Signature

_____Date_____

If you would like a copy of the results of this study, please provide your name and address:

APPENDIX D

PERSONAL INFORMATION FORM

Name_____

Address_____

Telephone (day)_____(evening)_____

Email address_____

Profession and year of licensure:

Social worker_____

Marriage and Family Therapist_____

Psychologist_____

Psychiatrist_____

What is your theoretical orientation? _____

_____

Penny Schreiber

APPENDIX E

INTERVIEW GUIDE

Introduction

Thank you so much for agreeing to this interview, and for being a part of my research project. At this point, would you please sign the Informed Consent form which assures you that your anonymity and confidentiality will be protected.

As you know, I am interested in hearing about how you think about and hold a sense of your patients' futures, about what might be possible or desirable for them. Individuals usually are aware only of possibilities they have known, making the past a predictor of the future. Coming to a psychotherapist implies some level of hope in a patient, though what is possible may not be at all clear. I am asking you to help me understand some of the ways in which psychoanalytically oriented psychotherapists think about their patients' futures, and how this impacts their work. As we talk, I encourage you to bring up examples from your practice to illustrate our process and your thinking. I'd like to begin by asking you to share your initial thoughts and reactions about this question and what drew you to be a part of this research.

Thinking About the Patient's Future

How therapist has conceptualized my request to think about the patient's future.

Therapist's initial response to the question of the patient's future—do they think about this?

Does the therapist have a sense of what might be possible for the patient in the future?

Differentiate therapist's sense of what is possible for the patient from what patients want for themselves or see as possible.

How do possibilities become apparent?

What clues are used?

How do you get a sense of what the patient would be like at his best?

Regarding the creation of possibilities for the future: what do you think is the role of understanding the past?

How do you think a sense of the future impacts the present?

What else might be needed, other than understanding the past?

What is your sense of the impact of the therapist on the patient's future?

Hope and Hopelessness

How do you discern the presence of hope in a patient?

Therapist's own hope—its use and implementation; limitations.

Maintaining realistic hope.

Thoughts about the patient's hopelessness.

How do a patient and therapist decide what to hope for?

Does hope for a patient imply a push, or other action by the therapist?

How does the therapist challenge the patient's self-limiting assumptions?

Anxiety About Change

What about when the patient is in transition and the future outcome is not clear?

Possibility of change in such a transition.

Managing with anxiety and disorganization brought on by change when past patterns have had a powerful organizing force.

Confusion that can result for the patient when what used to be isn't anymore, and what is possible in the future is not yet clear, or how to get there is not yet clear.

How does the therapist discern the beginnings of new directions?

Do you point these out to the patient, hold them internally?

Influence

How does the therapist manage thinking about the patient's future, without imposing an agenda or undue influence?

How are therapists aware of influence?

Does the therapist think it possible to not have an agenda for the patient's future?

Usefulness of therapist influence—too much, too little.

Inhibition on the part of the therapist due to fear of influence, and limitations caused by their own assumptions.

How or whether therapists keep their wish to influence conscious.

Affects and Symptoms

The therapist's observation of the patient's affects and symptoms as an indicator of what is possible and what is foreclosed.

Sensing what is being inhibited or defended against, and usefulness of this information.

How do you help a patient make meaning out of things they don't understand?

Possibility, Change, and Therapeutic Action

Therapist recognition of possibilities in the patient.

Therapist's attitudes that facilitate change.

How therapist identifies potential changes, and aids in their evaluation, and implementation..

Participant's Current Practice and Theoretical Orientation

Type of practice, kinds of patients.

Theoretical orientation.

How do you think your theoretical orientation influences your sense of what is possible for the patient?

Closure

How was this interview for you?

Is there anything you would like to add?

APPENDIX F

THE SANVILLE INSTITUTE

PROTECTION OF RESEARCH PARTICIPANTS APPLICATION

(Submitted by candidate to the Institute Office if the Dissertation Committee has determined that the research proposal requires it. Most do.)

Title of Research Project A Study of the Ways that Psychoanalytic Psychotherapists Hold a Sense of Their Patients' Futures, and How This Impacts Therapeutic Action

Principal Investigator: Sylvia Sussman, Ph.D.
(print name and degree)

Investigator: Penny Schreiber
(print name)

I have read the *Guidelines, Ethics, & Standards Governing Participation & Protection of Research Participants* in research projects of this Institute (in Appendix D of the *Student and Faculty Handbook*), and I will comply with their letter and spirit in execution of the enclosed research proposal. In accordance with these standards and my best professional judgment, the participants in this study (check one)

_____ Are not "at risk."

__✓__ May be considered to be "at risk," and all proper and prudent precautions will be taken in accordance with the Institute protocols to protect their civil and human rights.

I further agree to report any changes in the procedure and to obtain written approval before making such procedural changes.

Sylvia Sussman, Ph.D. 11/17/06
signature of Principal Investigator/date

Penny Schreiber 11/18/06
signature of Investigator/date

Action by the Committee on the Protection of Research Participants:

Approved ✓ Approved with Modifications _____ Rejected _____

[signature], Ph.D. 12/28/2006
Signature of representative of the Committee on the Protection of Research Participants/date

Approved [signature] 1/11/07
(signature of Dean & date)

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