Shifts In Clinical Attention And Focus:

Exploring The Boundaries Of Reverie

In The Therapeutic Process

by

Monique S. Bowen

A dissertation submitted to the Graduate Faculty in Clinical Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy,
The City University of New York

2012

This manuscript has been read and accepted for the
Graduate Faculty in Clinical Psychology in satisfaction of the
dissertation requirement for the degree of Doctor of Philosophy

_____	_____
Date	Paul L. Wachtel, Ph.D. Chair of Examining Committee
_____	_____
Date	Maureen O'Connor, Ph.D., J.D. Executive Officer

Paul L. Wachtel, Ph.D.

Steven J. Tuber, Ph.D.

Lissa Weinstein, Ph.D.
Supervision Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

SHIFTS IN CLINICAL ATTENTION AND FOCUS:

EXPLORING THE BOUNDARIES OF REVERIE IN THE THERAPEUTIC PROCESS

by

Monique S. Bowen

Advisor: Professor Paul L. Wachtel, PhD

Therapists have times of greater attention and of less, and each therapist may have the experience of noticing that her attention has shifted from what the patient is saying toward those thoughts that have been stirred. This qualitative study examined psychotherapists' perspectives on shifts in clinical attention and focus in their treatment of their patients, and the ways in which their particular approach to psychotherapeutic work influence how therapists understand and negotiate these potentially complex clinical moments. The study (a) captures how senior psychotherapists view such experiences, (b) surveys the conditions under which clinicians share their responses, thoughts and processes with patients, and (c) examines how therapists negotiate what may be conflicting considerations or principles in arriving at how they handle the experience.

Participants were recruited via several training institutes and professional psychological associations, and participated in a semi-structured qualitative interview that both documented and illuminated how senior therapists across theoretical orientations understand and explore shifts in clinical focus toward their own daydreams, fantasy, and interior monologues. This qualitative research study sought to provide an evidence and reference base for research scholars and for diverse groups of psychotherapy students,

training therapists, and other practicing clinicians from one corner of psychotherapeutic practice to another. Categories that emerged from the data were then grouped into four domains:

1) Therapists' descriptions of unbidden experiences.
2) How therapists understand these phenomenological shifts in theory and in practice.
3) Therapeutic uses of this particular clinical data.
4) The felt sense that helps therapists identify shifts in attention and clinical focus.

Trends in participants' responses to interview questions were identified with particular attention to departures from the clinicians' own standard technical practice or that of their theoretical orientation. The use of the verbatim quotations has enriched this narrative-constructivist approach, as the clinicians' own descriptions of their own unbidden experiences has provided uncommon access to the experiences of participants in this study.

Dedication

In loving memory of my mother, Helen;

her parents, Wesley & Lucille Memeger; and their parents,

Arthur & Essie Memeger and Roberta Reddick—

All put forth a desire so strong to succeed that the only work that remained

was to develop the means to reach the set goal.

Thank you for setting a high bar, and for willing me to meet and surpass it.

Acknowledgements

There are too many people to list here to whom I owe enormous thanks and gratitude for their love, respect, support, and other resources that have sustained me throughout my childhood and adult life.

I thank my parents for being neurotic, over-protective, and generally over-zealous in their desire to keep their good girl out of harm's way. They managed to do that, while also teaching me to assert myself and not to compromise my dreams for anyone, including them both. To my uncle, Wesley, Jr.: you have long been my mentor and a surrogate parent, reminding me that I have the tools to succeed at my disposal. I thank you and Aunt Harriet for being steady and present throughout my life. To Frances, I want you to know that I have always had you in mind in many of the things I chose to do because I knew you would be watching me and I wanted to make you proud.

I thank Esther Papell and Edward Sacher for teaching a precocious kid how to stand up and deliver under pressure in front of one's teachers and peers. To Krishna Winston, the first woman to provide me a living example of an academic's life: thank you for being a beacon and helping me to navigate the marriage of my personal and professional beings into one authentic person.

To my steady cohort throughout our time at City/CUNY—Aaryn, Alex, Melissa, Rebecca, and Ellen—your honesty, unselfishness, integrity, and acceptance has served as constant inspiration for me. To Aaryn, thank you for calling me your friend and meaning it. I am so glad we caught glimpse of each other that first day in 2002, and that we have kept an eye on one another since then. I could not have made it through '05, '07, or '10 without your humor and gusto.

I proudly acknowledge the doctoral faculty at City/CUNY who have taught me, and continue to serve as models for me, especially my committee members and readers, each of whom has greatly influenced my work as a scholar and clinician: Diana Diamond, Elliot Jurist, Jeffrey Rosen, Steven Tuber, and Lissa Weinstein. To my gifted dissertation advisor, Paul Wachtel, you helped me to make sense of feelings that I could not yet put into words, and you talked with me about the words we uncovered as we made sense of these un/usual experiences. Thank you for lending me so much of your time and yourself the last several years. I hope to return your generosity by paying it forward someday.

Deep and heartfelt thanks to the eighteen brave psychotherapists who willingly answered my questions and agreed to trust me with their clinical and personal experiences. I also thank my supervisors and clinicians who shared their talents and sometimes lent me their voices as I made my way through graduate study: Fred Busch, Linda Carter, Lila Coleburn, Peter Fraenkel, Daniel Grady, Jenny Kaufmann, Vera Paster, Lisa Robin, and Barbara Thacher.

To my partner and husband, Rod, I share this accomplishment most with you. Thank you for sharing my vision of completing this milestone, and for supporting me in every way that is important. Finally, Layla and Brock: I love and need you, too, and I am so glad I get to be needed and loved by you. I look forward to being fully present in the lives of two of the most beautiful, loving, and talented people I know.

Table of Contents

Introduction

In psychotherapeutic treatment, the therapist works in tandem with her patient to acknowledge internal struggles, to recognize unresolved conflicts, to respect self-doubts, and to accept ambiguities, including that which extends to the therapeutic relationship. To be effective in the tasks of psychotherapy practice, the therapist needs also to perceive both the shared and the private tensions that converge with and diverge from those of their patient(s). However, even with the best therapeutic technique and with reliable outcomes from close supervision, Aron reminds new and experienced therapists alike that their own experiences with the most common of tensions though separate is not all together dissimilar from those in their care: "Our own psychologies are as complicated as our patients' and our unconsciouses no less deep" (1996, p. 88).

An academic and a practicing relational psychoanalyst, Aron (1996) places an unmistakable emphasis on the reciprocal contributions both the patient and the therapist bring to the therapeutic relationship, and that inform their own internal monologues as well as their conscious and unconscious communications with one another. Typically, it is the patient's emotional responses, perceptions, conscious awareness and unconscious processes that are the ready material for observation, analysis and interpretation by the therapist. In contrast, the therapist's own experiences of the clinical milieu as it may seem to relate—or even appear unrelated—to the relationship with the patient have been largely written about as countertransferential reactions that should be limited, or to be understood as indicative of some unexplored pathology in the patient or with the therapist herself.

Aron (1996) presents a simple challenge to these perspectives inasmuch as he challenges a false dichotomy between the patient and the therapist. Surely, dichotomies exist in the relationship between patient and therapist; however, the notion that there are basic processes occurring within the patient that are not also occurring within the therapist is a myth—one that Aron dispels by speaking to a mutuality that exists within the dyad. With this empathic connection, based in a shared humanity and in the hope of the patient that the therapist can be of help to him, comes the possibility of being understood by another.

In making optimal clinical use of the conditions of psychotherapy, a therapist practicing "the talking cure"—the art, the science, and the discipline of self-understanding and understanding others—is also largely engaged in a "listening cure." The therapist and her patient plumb together the influences of reality and of the unconscious mind—both engaged as participants in an interdependent investigation of the subject's (patient's) real experiences in the world vis-à-vis the real therapeutic relationship. Often, in order to connect with the mental processes of the patient, the therapist relies on her own internal experience of the patient. She seeks to maintain her objectivity toward the patient and his experience of his inner world, but she cannot divorce herself from a level of introspection that provides clues to how others view the patient. Here, the spoken words and the not-conscious thoughts both have the potential for expression by each member of the dyad.

None would argue that a therapist should disregard her practiced, technical response to clinical material from the patient. However, there is a debate as to the value of the therapist's use of her own subjective experience of the clinical situation when those experiences are beyond that which is classified as observational data. The marriage of

scientific practice with intuition and its place within the field is not at question as much as whether attending to the therapist's internal experience of the patient provides useful information that otherwise might be missed in the general practice.

Hoffman (1994, 1998) observes that clinical work "requires an underlying tolerance of uncertainty and with it a radical, yet critical kind of openness that is conveyed over time in various ways, including a readiness to soul-search, to negotiate, and to change" (1994, p. 215). In the theoretical tradition from which both Aron and Hoffman operate, within the therapeutic interplay of each psychotherapy session the patient and the therapist co-create the language and communication of the treatment. Here, the transference and countertransference relationship serve as the source material for exploring the patient's experience of self and others. The therapist is ideally able to hold her patient's past experiences in mind while making space available for images formed from their mutually imagined hopes for what is possible for the patient.

My interest in the patient's subjective experience and the therapist's interpretations of that experience is born of an interest in this attempt on both their parts to co-create a space for this exploration of the self—through words and associations, but also in the form of unconscious, un-metabolized material, which will also be referred to in this paper as "unbidden" experiences (Wilner 1999). That which informs the therapist's ability to make an intervention (or an interpretation) is not her objectivism or attempts to maintain a clinically neutral stance. Our patients seek treatment with the hope that we will listen with an open mind, that we will have educated thoughts and opinions about what is going on with them, and that we will at moments disclose a point of view to them. Being "impartial" neither reflects the interest the therapist has for her patients, nor does it recognize the

personal bias she develops as she becomes engaged and interested in the outcomes of patients who have come to treatment seeking help.

Psychotherapists and psychoanalysts have argued about the uniqueness of the therapeutic relationship, with some advocating that clinicians should limit their own responses to their patients' words, actions, and belief systems when the therapist's own thoughts and feelings branch beyond the boundaries of what is observed as relevant and germane to what the patient offers as clinical material. In fact, therapists self-disclose to their patients both intentionally—for example, by answering direct questions about their age, marital and parental status, years in psychotherapeutic practice, etc.—and unintentionally—smelling of cigarette smoke, style of dress, appointment of the treatment room, et cetera (Balint and Balint 1939; Frank 1997; Wachtel 2008). But different therapists assign different meanings and respond to them in different ways. This study aims to understand what impacts one's ability to simultaneously acknowledge the experience while also engaging with and reflecting upon it. The results of this study will 1) document therapists' descriptions of their levels of awareness of shifts in clinical attention, away from what is being discussed by the patient and toward some seemingly unrelated material (which may turn out to be quite related, in fact) and 2) survey the range of intentional or unintentional disclosures of countertransference experiences to patients.

This exploratory study seeks to further investigate the area defined as the therapist's reactions to the transference relationship and any resistances of the patient, while considering the potential space for expression of the therapist's and patient's unconscious thoughts. In asking therapists from diverse theoretical orientations to articulate their thinking about and the meaning and importance of such experiences, there

is an opportunity to consider their rationales for disclosing or not disclosing these experiences on particular occasions. Although many theorists who have written about countertransference acknowledge the interrelationship of several phenomena that comprise this important aspect of the treatment, relatively few theorists have explored the therapist's willingness to self-disclose certain countertransferential reactions to their patients during therapy sessions. This study offers a different take on a large body of literature on countertransference and on therapist self-disclosures in that this review includes additional consideration of the impact of these phenomena on technique.

Literature Review

Views on Countertransference Phenomena, Intuition, and Unconscious Processes

> To put it in a formula: [T]he [doctor] must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. Just as the receiver converts back into sound-waves the electric oscillations in the telephone line which were set up by sound-waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free association. (Freud 1912, pp. 115-116)

These early theoretical formulations on clinicians' experiences of and reactions to their patients expose an unfolding perspective and understanding of this particular aspect of the therapeutic relationship. In 1910, at the Second Annual Psychoanalytic Congress, Freud (1910) reported a number of innovations in technique, including:

> [Those that] relate to the physician himself. We have begun to consider the 'counter-transference', which arises in the physician as a result of the patient's influence on his unconscious feelings, and have nearly come to the point of requiring the physician to recognize and overcome this counter-transference in himself. (p. 289)

Working from a medical-disease model, Freud maintains that the responsibility mainly lies with the patient for having this particular influence on the physician. Later writings seemed to suggest that some weakness had been exposed in the clinician that needed to be surmounted (Stern 1924; Glover 1927; W. Reich 1933; Berman 1949; Little 1951; A. Reich

1951; Fleiss 1953; Alexander 1956). We may note, however, that Freud too contemplated the role of the analyst's own thoughts and their function in connection with understanding the patient's unconscious (Freud 1910).

Ferenczi and Rank (1923) introduce a somewhat different perspective on this topic. With regard to the patient's transference to the analyst and the analytic situation, they write that this emergence can be viewed as an important opportunity for more intense focus. For Ferenczi and Rank (1923), the task becomes a kind of clarification of long-ago events, which have been repressed by the patient, in a manner that makes it possible for the patient to relive certain events with the analyst, who explains the very expressions that the patient finds it difficult to fully experience. They suggest that the analyst is able to perform this function without a preoccupation with the patient's past experiences, and instead with a more useful inclination toward recognizing and revealing that which has remained outside of the patient's awareness (Ferenczi and Rank, 1923).

Balint and Balint (1939) state that anything other than an interpretation is an error. In contrast, Sullivan (1940, 1949) discusses the therapeutic method as that of participant observation, highlighting the actual, mutual interaction between the patient and the therapist. For Sullivan, the analyst's role as co-participant is essential to the treatment, and for his part he must remain in step with his own affects as an important contribution to the therapeutic relationship. Rather than focus on what can be learned about the patient from the point of view of an outsider looking in, Sullivan's description of countertransference is in direct relationship to the patient's transference. In his shift to an interpersonal (two-person) model—away from the classical analytic perspective of listening (free association, one person model), —he sharpens his focus in on the *real* interactions between the dyadic

pair and on what the therapist can learn from his patient. So when, for example, due to some pre/unconscious process, the patient experiences the therapist as someone from his life, the analyst's own view of how the patient sees him influences the view the patient has of the relationship with the analyst.

Theodore Reik (1949) describes working with a patient who had been grieving a separation from her married lover she had left behind in Germany during Hitler's Third Reich. During a particular session filled with silences on the part of the patient— silences that Reik recognizes he begins to mirror—she associates to a dental appointment earlier in the day for a tooth extraction. Reik responds without hesitation or prior thought that he does not understand why the patient did not tell him she had had an abortion. Unsure of where this question has come from, his patient shoots him a look of incredulity and finally admits to keeping secret the fact that she had indeed had an abortion and that her former lover was the doctor who had performed the surgery. In addition to tracking the progress of the session—including the pauses by him and the patient—and his trust of his psychological training rather a simple judgment call, Reik (1949)—and, many years later, Rogers (1980)—ponders what it was that happened in him that brought him to this knowledge of his patient. He surmises in this instance, and in others he recounts in the paper, that he had an association that defied common sense and rather than turn away from it, "I just said what had spoken in me despite and against all logic, and I was correct." (Page 57)

Is this what we mean by "following your gut?" Reik would say no; in fact, instinctual feelings in this regard are not blindly followed. Instead, he states that both reason and logic may simultaneously overwhelm the therapist and make errors more common than if the

therapist simply yielded to his psychological training. Reik also refers to the "unconscious transferring" of what occurred in one realm of perceived conflict for the patient into an area of difficulty that the therapist has identified via his own understanding of unconscious processes and a burgeoning awareness of an unconscious withholding on the part of the patient. Reik calls this phenomenon a "secret communication" between therapist and patient; the psychological foundation is based in part on the analyst's instincts but a great deal more in an "understanding of the whole person to guess more quickly and adequately the unconscious meaning of the symptom or to find the motives and mechanisms behind its production." (Reik 1949) The basic theoretical aim seems to suggest that therapists rely on their intuition as an informed response to their training and their understanding of their patient's psychology.

In an important departure from the general view of the time, Paula Heimann (1950) offered a perspective that the therapist's countertransference reaction "is an instrument for research into the patient's unconscious" (p. 81, 1950). In her paper, Heimann conceives of the countertransference as encompassing a multitude of feelings and reactions on the part of therapist toward the patient. Unlike Freud and others, she does not limit countertransferences to include only the negative reactions. In contrast, Reich (1951) views countertransference as an example of the therapist acting out an unconscious need with the patient and argues that the therapist is defending against the same unconscious need. She also regards countertransference as evidence of a neurotic character problem in the analyst.

Little (1951) posited that unanalyzed aspects of the therapist's object relationships become connected to the patient. She concludes that the countertransference is invaluable

information about the total transference relationship—no more to be feared or avoided than the patient's transferences to the therapist. However, like Winnicott (1949; 1961), Little focuses mainly on her work with severely ill patients, noting that, for her, the countertransferences are most prominent with those patients. She went considerably beyond the consensus of her time to say the beginning therapist would have the most success if she 1) allowed her unconscious mind to roam freely and without impingements, 2) admitted errors to the patient, and 3) explained the possible origins of the countertransference response.

Cohen (1952) suggests that the commonality that exists among these descriptions of countertransference phenomena is an underlying anxiety on the part of the therapist. She states that "the presence of anxiety," whether recognized or out of awareness, is a product of the interconnectedness and influence of the patient-therapist relationship. Cohen (1952) speculates that if countertransference reactions were understood to have their origins in the therapist's anxiety, the therapist might have less difficulty embracing this experience of the patient. Cohen's (1952) definition of countertransference, which she suggests might be an equally good explanation for transference responses, is:

> When, in the patient-analyst relationship, anxiety is aroused in the analyst with the effect that communication between the two is interfered with by some alteration in the analyst's behavior (verbal or otherwise), then countertransference is present. (Page 235)

Cohen (1952) classifies three areas of anxiety in the therapist that, once aroused, lead to a countertransference reaction. First, situational factors (real-life events) occurring in the therapist's life, as well as social factors that may lead the therapist to seek recognition and approval from her patient; second, unanalyzed neurotic responses that are activated in the patient-therapist dyad, such that the analyst is stuck in a particular role or

mode of behavior and is thus unable to recognize distortions in the therapeutic relationship with the patient; and finally, the notion that the patient's communication of aroused anxiety to the therapist is experienced by the therapist as an empathetic response. The anxiety may represent a defensive operation by the patient, results in the therapist being identified by the patient with someone from the patient's past from whom the patient had hoped to elicit a certain behavior, and from whom she now tries to elicit a similar behavior on the part of the therapist. The difficulty with Cohen's (1952) rationale is that she regards countertransferences as largely anxiety-laden and, as a result, these experiences are regarded as solely a hindrance or interference with the treatment.

Heinrich Racker wrote three papers on countertransference in the mid-20th century all of which reflected and helped shape the discourse on this topic. He first described countertransference as "a danger to analytic work" due to the patient's many and varied conflicts, and the likely impact on the therapist's ability to maintain his role as interpreter of the patient's re-experience of his life vis-à-vis the therapeutic relationship (Racker, 1948). Next, he revised his position on the meaning of the countertransference and discussed how its use for the recognition of and the diagnosis of mental health issues could be of great help to clinicians. Further, he posits that the countertransferential experience of the analyst is an identification with the patient's internal object relationships and, thus, could have extrapolative value in assessing the psychological make-up of the patient (Racker, 1953).

In his third written examination of this phenomenon, Racker similarly (1957) explores the technical uses, in particular an articulation of the therapist's countertransference as a process for understanding the patient's transference reactions

and as a valuable guide to the therapeutic action and timing of interpretations. Most insightful among the contributions of Racker (1957) was his consideration of the analyst's behavior toward his patient via "identifying his ego with the patient's ego…or by identifying each part of his personality with the corresponding psychological part in the patient—his id with patient's id, his ego with the [patient's] ego, his superego with the [patient's] superego, accepting these identifications into his consciousness (page 319)", as well as the analyst's associative experience with the patient's internalized objects. Furthermore, Racker set himself apart in his research into these phenomena by exploring the inevitability of countertransference reactions in sharing clinical examples and insights into the therapist's responses in a variety of circumstances.

Racker (1957) also suggests that the then current usage of countertransference only held one aspect of the two meanings, that of a complementary identification, whereby the analyst partly identifies with the patient's internal object, such that the patient then becomes a projected object of the analyst. Instead, Racker (1957) advises that a *total* countertransference perspective be adopted, with concordant—or empathic— and complementary identifications included in the conception of this phenomenon.

Lucia Tower's work came to represent a new voice in the mid-20th century conversation on the technical and theoretical understanding of countertransference reactions. Tower added immeasurably to the conversation about the meanings and uses of countertransference reactions, and has written thoughtfully about using normalizing language, even suggesting that that which has seemed taboo is actually a common experience among analysts. Though analyst and therapist have been used interchangeably at times in this paper, this choice has been made on the grounds of the broad applicability

of these concepts to all therapists. However, every theorist cited thus far has written for psychoanalytically oriented audiences. When Tower (1956) speaks about the analyst's experience of countertransference, she refers to those men and women in the medical profession who (a) have undergone their own analytic treatment; (b) had been indoctrinated in a tradition of healing patients via a method that, at the time, privileged certain feelings as significant and others as to be excised; and (c) had aspirations to be that kind of analyst who is able to set aside for further self-analysis any of those fantasies or feelings about her patient that are not recognizable as having to do directly with what the patient is saying. Tower (1956) recognizes that branding the clinician's feelings as insignificant has hampered the necessary mining of the analyst's reactions to her patients, and she is one of the early theorists-practitioners to explore these experiences with an ear for the complementarities of the countertransference to the patient's transference to the analyst.

Tower (1956) points out the violation of standard scientific premises inherent in the suggestion that one has control of the unconscious mind. She also highlights many references to "pressures" on the analyst's unconscious and conceptions of the emotional reactions of the analyst to the patient's transferences that are viewed as forbidden. From requirements that the analyst's countertransference reactions be healthy (Sharpe 1947) to statements that countertransferences are similarly undesirable as transferences from the patient (Fleiss 1953), the perspective of psychoanalysts was largely a dismissive one toward these phenomena. Tower (1956) remarks presciently that the potential sharing of countertransferences with a patient would have likely fallen under the heading of *wild analysis* (Kohut 1977).

Tower offers a sophisticated understanding of the phenomena her peers have struggled with, including those who seem to consider countertransference reactions as having some value yet simultaneously admonish their peers and trainees for having their particular responses. She writes with great clarity about the lack of clinical material exploring these reactions, and about the resistance of clinicians to presenting this topic for discussion for fear that their colleagues will meet them defensively and derisively. She notes that, of course, clinicians are trained to focus on that which is going on with their patient, and to check their own feelings and fantasies, especially if they do not appear to have direct relevance to what is going on with the patient. She describes these countertransference occurrences as natural, albeit mostly based in the analyst's discomfort, and she opines that in-group resistances (e.g. by practicing analysts) have developed from the anxiety brought on by the trepidation of exploring one's own reactions to one's patients, especially those on the prohibited end of the spectrum (i.e. dislike for the patient, erotic feelings and impulses, sexual fantasies). Furthermore, pressured by notions of perfection, Tower (1956) suggests, clinicians miss the opportunities that result from going deep into the analytic work with patients by refusing to apply the same techniques to their own conscious and unconscious processes as they do to their patients' ego functions.

Writing specifically about the long-term nature of psychoanalytic treatments, Tower (1956) hypothesizes that an important feature of the analytic work is the emergence of not only the patient's transferences but also the analyst's countertransferences. Rather than question the impact of the countertransference reactions, she considers the extent of their significance for the overall outcome of the treatment:

> I believe they function somewhat in the manner of a catalytic agent in the treatment process. Their understanding by the analyst may be as important to the final working through of the transference neurosis as is the analyst's understanding of the transference neurosis itself, perhaps because they are, so to speak, the vehicle for the analyst's emotional understanding of the transference neurosis (p. 232).

Tower makes an unequivocal statement about the value of countertransference affects and responses as they relate to the analyst's ability to understand the patient's transference communications. She views the use of the countertransference phenomena as a change agent in the therapeutic process and as essential to good clinical work:

> Ultimately…it would appear that even under the most ideal circumstances there are bound to be certain drifts, so to speak, from the utterly straight direction of the analyst's performance and understanding of a case, and it is these very slow almost imperceptible drifts which develop in him in which unconscious response to hidden pressures and motivations from his patient, I think constitute the essence of the development of a countertransference structure in and of itself (p. 234).

Shortly after Racker's and Tower's contributions on the subject, Tauber and Green (1959) offered an important look at the lack of attention to the matter of the *real* feelings of the therapist for the patient and the patient for the therapist. Tauber and Green (1959), like Tower (1956) suggest that clinicians have dismissed their own experiences as irrelevant and worthless, and this perspective has cast a shadow over these most common of experiences. In addition to making it difficult for the patient and therapist to engage each other in meaningful exchanges about themselves and the therapeutic relationship, it has also created a deep divide in the patient-therapist interaction in which an important part of

the examination of the patient's difficulties goes unexplored. They provide examples in which the patients are so isolated from their own real feelings and experiences that they in turn distance themselves from the clinician, making any emotional contact unlikely.

> An examination of the counter-transference reactions in the analytic setting must not be construed as sponsoring acting-out in the patient, but rather as a serious attempt to expand the developmental areas in the therapeutic situation (p. 129).

Tauber and Green (1959) surmise that the problem for the therapist arises from imposed restrictions on what is possible and appropriate in terms of relating to the patient and with regard to the potential that analytic space provides the pair. Thus, it is the contact between the patient and the therapist that allows that which is imagined and dreamed of to occupy the potential space of the treatment.

Tauber and Green's (1959) other significant contribution to the discourse on total transference and countertransference was their observation of vague, seemingly insignificant affective reactions that they noticed while conducting clinical work. Referring to "marginal reveries accompanied by a vague feeling of urgency," "unsought-for experiences," and "hunch[es] (page 121)" that conveyed that a form of communication was taking place between patient and therapist, Tauber and Green (1959) posit that these important experiences receive little to no attention as a result of a form of selective inattention by the analytic dyad. Nearly 50 years ago, Tauber and Green (1959) called for a scientific study that mines from the therapist's emotional spontaneity possible information in the hopes of understanding this therapeutic interaction as a form of countertransference communication. At a time when there was beginning to be a broad acknowledgement of the

possible usefulness of countertransference data, Tauber and Green boldly offer examples from their own clinical work of times when they shared dream material and preconscious thoughts with their patients. These clinical examples expose more about the intrinsic value of the therapist's shifts in attention and actual dream material than they do about the choice to involve the patient in a mutual exploration. What seems truly noteworthy is how much information about the patient and, of equal importance, about the dyad is contained in the barely conscious or seemingly incidental thoughts by the analyst. Even without the additional step of introducing the patient into the analysis of the countertransference, the recognition of the information treasure trove of the therapist's unbidden reactions to the patient must not be lost because of the additional technical consideration of whether or not to include the patient in an exploration of the meaning. The idea of attending to a shift in attention or a private reflection with a patient has taken several decades to influence the mainstream of psychoanalytic thought and technique, and even so has remained an area of intense inquiry and skepticism.

In the interim, others have continued to offer accounts and perspectives on countertransferences, much along the lines of earlier prohibitions regarding the analyst maintaining his therapeutic stance in the treatment. Winnicott (1961) writes that it is the job of the analyst to maintain a professional approach toward his patients, which requires objectivity and consistency on the part of the clinician. "The professional attitude is rather like symbolism, in that it assumes a distance between analyst and patient. The symbol is in a gap between subjective object and the object that is perceived objectively" (Winnicott 1961, p. 161). For Winnicott, however, countertransference does not include the use of one's own conscious and unconscious responses to his patients (mainly his severely

mentally ill patients, as he does not refer to how this phenomenon impacts his work with more neurotic patients). He believes that this term has become over-used and misunderstood, and taken to encompass all reactions by the analyst; instead, he is in favor of using some other title to speak to the broader area of analyst's reactions.

In an earlier paper, Winnicott (1949) does indicate that the countertransference can provide useful information regarding the patient and the ongoing treatment; and yet, there remains an element of "toxicity" in his descriptions of how the analyst still needs to rid himself of certain feelings in order to function in the treatment. Winnicott's (1961) later definition of countertransference refers to the neurotic characteristics of the analyst that destroy his ability to maintain his professional role and that have the potential to derail the treatment. Winnicott makes a remark to this point in his paper on countertransference that is almost humorous—which may or may not have been his intent. He states that "what the patient meets is surely the professional attitude of the analyst, not the unreliable men and women we happen to be in private life" (Winnicott 1961). In humor or in seriousness, Winnicott makes an interesting point about how the needs of the patient match up with the frame that the analyst sets up around the treatment relationship.

However, what Winnicott misses in making his point about the patient's needs (speaking here not so much about severely ill patients) in relation to the attitude of the analyst, is the difficulty and general inadvisability of maintaining a neutralized stance with one's patients when part of the analytic endeavor is also to represent a realistic figure with whom the patient is able to connect (Tower 1956; Stone 1962). Furthermore, the transferences arising from similarities between the patient's other significant relationships and the one between patient and therapist, as well as the countertransferences, which may

represent a communication from the patient to the therapist about some previous or current experience with others, provide the therapist with an occasion to understand the patient more fully (Tansey and Burke 1989).

In *The Matrix of the Mind* (1986), Ogden outlines his concept of the transference/countertransference interplay as an interpersonal manifestation of an internal object relationship. The event, as Ogden describes the moment, is an intrapersonal, transferential phenomenon whereby the patient experiences the other (in this case, the therapist) in a way similar to the internalized object; meanwhile, the analyst has an unconscious identification with the patient's projection that spurs him or her to act in a manner un-synonymous with his or her therapeutic function. Not unlike Racker's understanding of these two phenomena, Ogden (1986) suggests that there is a "becoming" of the object rather than an "experiencing" of the feelings that the object has. Others of Ogden's contemporaries have also wrote extensively about these phenomena, also taking two-person psychologies into account: rather than 'experiencing' and 'becoming', Bollas (1987) introduces the concept of the *unthought known*, while Stern (1997) refers to 'unformulated experiences'. Both Bollas' and Stern's conceptions are viewed, in part, as products of the dyadic communication that the therapist not only seeks to know consciously but that also is experienced outside of conscious awareness. That the therapist becomes the recipient of the patient's unconscious is not too far afield from Freud's (1912) recommendation that the therapist adjust himself so as to enter into the same condition he asks of his patient. Thus, the analyst who is freed from her own resistances becomes receptive to the patient's free associations:

> To put it in a formula: he must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. Just as the receiver converts back into sound-waves the electric oscillations in the telephone line which were set up by sound-waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free association. (Freud 1912, p. 360)

Matte Blanco delineates the different forms of the unconscious based partly in Freud's (1912) theories and partly on concepts steeped in mathematical logic. He is well known for positing a bi-logical structure—or two modes of logic—that operates in the mind (Matte Blanco 1988). The symmetrical mode operates at the level of the unconscious with a lack of differentiation or limitation, while the asymmetrical mode is represented in consciousness, where there is clear thought function and a capacity for differentiation. Furthermore, he (Matte Blanco 1988) proposes a link between these two structures, not unlike the corpus callosum, which serves as the link between the two cerebral hemispheres of the human brain. This link, or the unfolding function, "allows pieces of symmetry to be glimpsed asymmetrically by reflecting the symmetrical material in an asymmetric mode" (p. 179). He believes that the unfolding process means that a connection between internal and external experiences was established and re-established, allowing the conscious (asymmetric) mind to glimpse the multi-dimensional, infinitesimal world of the unconscious, symmetrical world of the mind.

Going an additional step, Matte Blanco's (1988) theory of bi-logical structures elucidates two types of unconscious experience. First, he recognizes the *repressed* unconscious of Freud that shelters our psychic experiences and allows for the re-integration of those past experiences. Second, he (Matte Blanco 1988) describes the unrepressed in the unconscious as that which is vastly unknown and which one glimpses only briefly. Matte Blanco elegantly offers that the moment for the dual thought processes to dwell together (in perpetual balance) is the play space of human experience. Experience then becomes the potential space between analytical, logical, and aware mind and the modes of unconscious thought. In the deepest interstices of the brain, he (Matte Blanco 1988) suggests that the bi-modal structure can exist simultaneously, though "incompatible, separate, and solitary, yet always together" (p. 79).

These works support the notion that the clinician holds in dynamic tension the un-remembered, unformulated past experiences of the patient while also practicing with the direct relationship with the patient—in the present moment—in mind, and as important to the therapist's function as a transferential object, as well as an object of the patient's possible (or potentially inevitable) negative reaction to the treatment.

Renik (1996) writes that it is on the basis of our own personal histories and emotional involvement with the realities of our patients that we are able to contribute to and to impact the self-investigative process they have undertaken with us. The therapist maintains an awareness of communicating her own values, beliefs and judgments as a way of engaging her patient based on her particular identifications with him, with his struggles, and with the people in his life (Renik 1996, 2006). He asserts that neutrality does little to help the patient because it fails to capture the value of what terms an uncommon dialectic

(Renik 1996) inherent in the therapeutic relationship. Rather, it is in the ability of the therapist to understand the patient empathically and then to engage him about those issues that challenge him most in the here and now that one stands to make the greatest contribution.

Green (1997) discusses the metaphorical journeys that patients describe in their processes of getting to therapy/analysis and in the course of a given treatment. The site of this 'creating' and 'playing' with metaphor can be envisioned as one where the therapist and the patient can engage the real work with a space available to communicate in whatever ways bring about connectedness. Green (1998) offers a formulation of Bion's theory that I have found helpful in thinking about the theoretical implications of this two-person model for contemporary clinical technique in psychodynamic psychotherapies. He writes that empathy and the ability to associate to clinical material on the part of the therapist help one's patients' access that part of their psychic experiences that is the basis for the histories they (we) construct about themselves (ourselves) and others. Green (1998) writes about the primitive, or the 'primordial', mind, which holds the bases for the formation of the self—from raw and unformulated thoughts that become either transformed or discharged—and relates to the ability to think abstractly and to create an idea of the self and the other. Green's discussion of the primitive mind seemingly proceeds from Ferenczi and Rank's (1923) earlier work on aspects of the here and now in the clinical work. Furthermore, Green's work incorporates ideas from Klein (1946) and Tansey and Burke (1989) on projective identification heretofore unmentioned in this discussion because of the in-depth exploration of the total transference situation (Racker 1958; Joseph

1985) that better accounts for the analytic therapist's unconscious understanding of her patient's experiences.

Drawing together these formulations in a discussion of the total therapeutic relationship, Summers (2005) states that in order for an optimally created potential space to be available for use by the analytic pair, the relationship must go through a transformative process. He proposes that since the analysis is used primarily for the repetition of the early transference relationships, initially there is little room left for the articulation of new patterns of being by the patient. Sometime after the analysis of these transference repetitions—to the point where the patient's defenses have been worked through via interpretation— the therapeutic relationship can evolve to hold new possibilities for relating between therapist and patient (Summers, 2005). Thus, "the purpose of the analytic process is no longer understanding what is, but creating something that has never been before" (p. 347), and for the therapist the work comes to focus on facilitating the development of the patient through the use of this new, less structured void of possibility and creativity, rather than maintaining the role as interpreter of the patient's existing problems in relating to others (Summers, 2005). Here the analyst's work shifts to include the identification of new expressions on the part of the patient and to encouraging the emergence of the new affects or interests in the service of supporting new, authentic ways of being that may be experienced as passing or insignificant (Summers, 2005).

Disclosures of Countertransference and of Newly Perceived Unbidden Experiences

Many of the prohibitions to therapist disclosures could be viewed as taking shape as early as Freud's writings in the early 1900s. The conflicts inherent in the psychoanalytic, psychodynamic, and existential and humanistic psychological theories sprung from Freud's belief that unlocking unconscious processes was essential to therapeutic communication:

> But if the doctor is to be in the position to use his unconscious in this way as an instrument in the analysis, he must fulfill one psychological condition to a high degree. He may not tolerate any resistances in himself which hold back from his consciousness what has been perceived by his unconscious; otherwise, he would introduce into the analysis a new species of selection and distortion which would be far more detrimental than that resulting from concentration of conscious attention (Freud 1912, p.115).

On the one hand, he admonishes clinicians to go through their own self-analysis so as to limit the burdens placed on their patients; meanwhile, on the other, he suggests that freeing oneself of resistances that limit one's conscious mind from perceiving his own unconscious mind is essential for good analytic work. This simultaneous presentation of both notions has often been misunderstood by students of psychology and psychoanalysis, and has made an explanation of technique in this regard a thorny and beleaguering task.

So, there remains a dilemma about therapist self-disclosure and its value to the treatment and to the therapeutic relationship. Often viewed as a self-gratifying act on the part of the therapist, there is also an overwhelming sense that self-disclosure to a patient is a declaration of the therapist's own humanity—a potential acknowledgement of the vulnerability that also gets stirred for the therapist when faced with the transactional

burdens of reciprocity in the clinical situation (Jacobs 1991). Some clinicians are able to comfortably use themselves and certain of their experiences consistent with the needs of their patients at a given moment in the treatment (Hirsch 1995; Jacobs 1991; Knafo and Feiner 2006; Ogden 1986, 1994, 1997; Tansey & Burke 1989; Wachtel 1993, 2008). However, whether to disclose one's private thoughts remains a complex decision even for the most-experienced therapists, including those who find value in its clinical application (Bromberg 2006; Davies 2004; Ehrenberg 1992; Hirsch 1995, 2008; Maroda 1991, 2005; Renik 2006; Searles 1979; Wachtel 2008). Despite the desire to share something with a patient, we often struggle along with our patients to make ourselves understood, even as we endeavor to understand them.

The prevailing clinical wisdom regarding technique is that self-disclosures, like interpretations, be offered with regard to their usefulness for the patient first and foremost (Maroda 1991; Ogden 1986). Whether the context be a dream, the therapist's reverie, or some other manner of "intersubjective analytic event" (Ogden 1997), it is the exploration of the patient's associations to the material that remains at the core of understanding the patient's unconscious anxiety, defense or resistance. Not unlike Freud, for Ogden (1990, 1992, 1994, 1997), to analyze the unconscious processes—or better-termed 'preconscious' formulations (Freud 1925; Tauber and Green 1959) of the therapist and his patient, it is essential to look at the reveries of the patient and the analyst.

In *Reverie and Interpretation*, Ogden describes his use of transference-countertransference during analytic sessions, and he acknowledges that his descriptions of unbidden experiences (Wilner 1999) will seem unusual to those unfamiliar with sharing these kinds of ruminations. Rather than leaving him concerned or feeling guilty, Ogden

(1994, 1997) describes the shift in his attention as an opportunity to reflect on the feelings that get stirred, so that he might better understand what his patient might be experiencing but also has not yet been able to grasp. Furthermore, he also points to the use of reverie as a countertransferential experience that is part of the process of what is created in the interplay between analyst and patient (Bion 1962; Ogden 1997).

In terms of contemporary theorists writing on the use of countertransference, Maroda stands apart as one of the rare few to write about therapists' disclosures of countertransference as an important aspect of analytic technique. Maroda (1991, 2003) offers the student and the experienced therapist basic reasons for revealing countertransferences to patients; moreover, she provides her readers with tools toward the incorporation of some of their own experiences into the treatment milieu without delegitimizing the analytic process. The power of the well-timed countertransference intervention comes when the disclosure is done to support the patient and the treatment, not to relieve the therapist of her reactions to the patient. As an advocate for the expression and disclosure of countertransferential experiences, she delineates disclosures of information at the request of the patient from disclosures of what gets stirred in the therapist when the patient requests information. Despite their demands, few patients are ready for the latter early on in treatment (Maroda 1991).

Maroda (1991) provides several recommendations to help guide psychoanalysts and psychotherapists alike through the myriad of questions from patients that may require one to respond. As the therapeutic relationship matures, the patient develops a greater curiosity about the layered communication with the analyst and a particular awareness of the analyst as a separate person (Maroda 1991). She writes that most patients will inform

their analysts when they are ready to explore the therapist's thoughts or feelings. Typically, patients will begin with the standard questions about the therapist and will take note of the therapist's reactions, looking for ease or discomfort and, when ready, move toward questions that plumb for understanding of the analyst. It is important to recognize that the patient is querying the therapist so as to know whether she has made an impact—to feel she is important to the therapist.

Maroda (1991, 2003) deftly offers clear signposts for the disclosure of countertransference. If a direct answer to their question is what is required, the patient will return to the question until an answer is given. If the therapist senses the request for a disclosure is coming from a deeply genuine place, then a disclosure in acknowledgement of the relationship with the patient is appropriate. If the therapist feels uncomfortable about not answering—as though she is doing it to protect her own feelings—then a disclosure rather than a withholding of information is indicated. However, Maroda is clear that if the discomfort is significant and not related to the therapist's own acknowledged fears, the therapist should wait because if it is important to the patient an opportunity will present itself again (Maroda 1991).

In Therapeutic Communication, Wachtel (1993) writes about varied attempts on the part of the therapist to understand and to be understood by his patients. He is most interested in the ways to improve the communication between therapist and patient. Wachtel (1993) reflects on which disclosures by the therapist meet the requirement of what is most helpful to a particular patient at a given moment in the treatment. He writes that much can be understood about the patient's experience and the treatment relationship through the therapist's decision to self-disclose. However, the therapist must keep the

power dynamics in mind, as well as his role as participant-observer, and must recognize that both disclosing and not disclosing will have meaning for the patient (Wachtel 1993). The decision depends as well on the therapist's comfort and discomfort with self-disclosure at that point.

Wachtel (2008) strikes an important note about the ordinariness and even inevitability of therapist disclosure, and questions the viewpoint of self-disclosures as an infringement on the therapeutic frame. "Rather, self-disclosure is a feature of *all* therapeutic work (p. 246, Wachtel 2008)." Wachtel discusses the inevitable trade-offs clinicians make as they treat their patients, and the impact therapist disclosures have on the therapy and on the therapeutic relationship. The therapist is simultaneously observing and experiencing something with the patient throughout any given treatment. But it is in the continuing choices the therapist makes to do one thing or another—or not to do it—that Wachtel (2008) sees the real challenge. For him, there may be positive or negative implications regardless of the choice that is made, and certainly consequences that lie in either direction.

In the chapter "Confusions about Self-Disclosure" in *Relational Theory and the Practice of Psychotherapy*, Wachtel (2008) introduces a theme that deserves further exploration as it is at the heart of the theoretical and technical considerations that simultaneously guide and inhibit therapist self-disclosures. Whether one employs terms like defensiveness, inhibition, or resistance to contextualize certain patterns of relating to others or the self-appraisals one may cling to, Wachtel (2008) urges therapists to attend to their patients' and their own levels of comfort and discomfort with unexplored feelings, difficult topics, and the transference and countertransference, in general. He details how

even ‘errors’ of self-disclosure can become opportunities for repairing ruptures. The therapist needs to appreciate his own participation in therapeutic misattunements and to acknowledge that there may be costs and benefits in the choice to withhold or to disclose information, advice, feelings, et cetera (Wachtel 2008).

Wachtel (1993, 2008) stops short of providing therapists with clear signposts for how to work with their own particular subjective reactions. The discourse on therapist disclosures as possible therapeutic interventions is directly related to the intersubjectivity that Wachtel (2008) distinguishes as the hallmark of the relational perspective. However, his discussion of the preparation of psychotherapists within a two-person approach neither takes on the issue of the therapist’s comfort and discomfort as a training question nor does it provide the beginning or experienced therapist with a much-needed decision tree on whether, when and how to know that self-disclosure is indicated or best held in reserve.

The internal conflicts about therapist self-disclosures are natural ones and not easily resolved by a simple, consistent strategy of choosing to disclose or choosing not to disclose. Is it the case that if the therapist feels comfortable with a line of inquiry from the patient, or an issue or a feeling that comes to the fore in the therapy, is he more likely to answer a direct question from, interpret the mutual meanings with, or disclose something intentional or unintentional (Frank 1997, 1999) to his patient? Conversely, if the therapist feels uncomfortable (or self-indulgent, or wrong in his understanding of his reaction to the patient or the material) will he be more inclined to ignore his reactions so as to avoid exploring the thoughts and feelings that have been stirred in him? Thus, if the therapist feels uncomfortable disclosing his reactions to his patient, is it because he fears exposure,

and if the therapist is comfortable with self-disclosure are the feelings evoked more likely to have a positive valence and the intervention viewed as having therapeutic value?

The extent to which a therapist can effectively and ethically use oneself is one of many thorny questions in this arena that relational theorists seem well positioned to tackle. To push therapeutic practice into an optimal zone, therapists must work to understand what makes them comfortable and uncomfortable clinically, as it is the scientific practice coupled with an instinctual know-how that light the path toward therapeutic action (Maroda, 1991, 2003). This does require that therapists attend more to their own experiences along with those of their patients. The therapist, in paying greater attention to that which seems irrelevant or not pertinent to the patient's own reflections, may be able to glean so much more data from the dyad. Therefore, it stands to reason that in paying attention to the therapist's own explorations of the seemingly unimportant and random that one might learn something about his patient and their mutual therapeutic interactions. The theoretical implications for using therapists' disclosures are explored by Wachtel (1993, 2008) and other relational theorists (Bromberg 2006; Davies 2004; Ehrenberg 1992; Frank 1997, 1999; Hirsch 1995, 2008; Maroda 1991, 2005; Jacobs 1991; Knafo and Feiner 2006; Ogden 1986, 1994, 1997; Renik 2006; Searles 1979; Tansey & Burke 1989), but the impact of the relational theories on technique is lean in comparison to the hundred years of prohibition on therapist reactions and self-disclosures from the more traditional end of the spectrum of psychoanalytic thought.

In the past twenty years, there have been several empirical studies that have explored aspects of self-disclosure. Hill, Mahalik and Thompson (1989) examined self-disclosure in eight cases of brief psychotherapy. The results show that reassuring,

supportive disclosures helped patients feel more comfortable. Therapists helped patients experience aspects of their own narratives with depth, and patients reported feeling less vulnerable, and felt safer exploring certain aspects of their experiences. The researchers hypothesized that self-involving disclosures—of therapists' personal reactions to clients and to occurrences that take place during sessions—would be more helpful than self-disclosing disclosures—of information by therapists about themselves; however, these results were not supported in this study. Self-disclosing statements included, "I understand because I have two children myself," or "I enjoyed the last session, too," or "this last session carries for me a sense of loss." (Hill, Mahalik, Thompson, 1989, p. 294) Interestingly, therapists rated their own disclosures as less helpful than their patients perceived them to be.

Barrett and Berman (2001) interviewed therapists at a large university-wide counseling center, where therapists were told to increase the number of self-disclosing statements they made with one patient, and refrain completely from making self-disclosing statements with another patient. Clients who received heightened therapist self-disclosure reported lower levels of symptom distress and reported liking their therapist more than the patients who received no self-disclosing statements from their therapists (Barrett & Berman 2001). The researchers found that when therapists disclosed information that was not in direct response to their clients' queries, the clients' viewed the effects of the disclosures less positively. Interestingly, results also showed that the total number of patient self-disclosures to therapists was the same in patients whose therapists self-disclosed, as those whose therapists did not self-disclose (Barrett & Berman 2001).

Generally speaking, using one's feelings to understand a situation with a patient should be the basis for inquiry, not necessarily cause for an immediate response (Ehrenberg 1992). The reactivity on the part of the therapist refers to over-identification with the patient that brings about a response that moves the therapist away from the use of her clinical sense and intuition, and toward a more gratifying stance for the therapist or the patient. Rather, the therapist's attunement to her own experiences of the therapeutic relationship should help her to maintain a simultaneous clinical curiosity and a constructive engagement with the patient without feeling the bind to resist, or suppress, her countertransferential feelings. As the field of vision has shifted to include a two-person model, making room for the therapist is not at all unusual. From this viewpoint, if we are to value, or at minimum entertain, all that comes to mind for our patients, we owe it to our practice to leave ample room for what comes to our own mind as well, even it if seems to have no clear or obvious relevance.

The particular contribution of this exploratory study will be to give attention to the subject of the unconscious derivatives of the therapist. This phenomenon of unbidden experiences in the therapy situation that lead the therapist to notice a shift in attention has been discussed in the literature mainly in narrative form as part of case presentations and articles on particular experiences, such as errors and mistakes in clinical practice. The aim of this study is to complement these case reports with a broader exploration of the views and practice of a range of senior clinicians.

Research Methods

Purpose of Study

This study examined psychotherapists' perspectives on shifts in clinical attention and focus in their treatment of their patients, and the ways in which their particular approach to psychotherapeutic work—based in experience and in theory—influences how therapists understand and negotiate these potentially complex clinical moments. This qualitative research study centered on a semi-structured interview, which allowed for data to be collected that both documents and reveals how senior therapists across a range of theoretical orientations understand and explore the patient's experience and dynamics via attending to unbidden shifts in clinical focus toward their own daydreams, fantasies, and interior monologues. This data will contribute to the current reference base for research scholars, diverse groups of psychotherapy students, training therapists, and other practicing clinicians from one corner of psychotherapeutic practice to another.

Study Aims

This qualitative research study provides a comprehensive and systematic account of the current state of thinking in the field, of the conflicts—and uncertainties experienced by—practitioners in their daily work, and of the moments when their practice may seem to contradict their general theoretical position. The aim is to explore convergences, understand divergences, and identify the difficult challenges that may point to fresh, differentiated modes of practice and new developments in clinical theory. In considering the ways that clinical reveries have a bearing on the therapeutic process, therapists have an opportunity to further our understanding of how to explore our patients' self and object relationships using a different and more distinct lens. Attention to one's reveries and

unbidden experiences, and facing the question of whether to disclose those experiences to the patient, may confront therapists of almost every theoretical orientation with particularly strong challenges to their familiar and comfortable ways of thinking and working. As a consequence, exploring this phenomenon and these questions allowed the therapists to explore ambiguities and undeveloped aspects of their theoretical positions. Thus, the therapists across orientations were able to revisit their points of view and contemplate new ideas or consider the clarification of old ones.

Unlike previous attempts to explore these phenomena, this study did not rely on the single narrative case study and thus is not limited in its interpretative value to an n=1. The research approach is inductive and interpretive, and offers a qualitative research method for the investigation of large numbers of narratives, using primary data made up of interviews, and including observations and the review of clinical vignettes (Skhedi 2004).

Sample

Participants in the study were recruited via several training institutes and via professional psychological associations, such as the Society for the Exploration of Psychotherapy Integration, the William Alanson White Institute, the Postdoctoral Program in Psychotherapy and Psychoanalysis (New York University), and the City University of New York (CUNY) Doctoral Program in Clinical Psychology alumni list-serve at The City College of New York (CCNY). Participants are all licensed senior psychologists with at least seven years experience since receiving the doctorate and are currently practicing psychotherapy. The sample size is 18. Subjects represent four major theoretical orientations in psychotherapy: 1) cognitive-behavioral ; 2) dynamic; 3) psychoanalytic; and 4) integrative—a dynamic base theory intermixed with developmental theory, family

therapy, or systems-related orientations, to name a few. Here are some the racial and ethno-cultural demographics, along with the gender and educational training breakdown of the sample:

- Four men and 14 women
- 12 people of European or Caucasian descent
- One person of African descent from the West Indies
- Five people from the US of mixed race ancestry
- Eight people of Jewish ancestry
- Three people of Caucasian descent described as Anglo-Saxon Protestants
- One person from South America of mixed race ancestry
- 16 people with Doctorates in Philosophy in Clinical Psychology
- Two people with Doctorates in Psychology
- One person with a Doctorate in Education in Human Development/Psychology
- Years in clinical practice: Four, 10-19 years; Seven, 20-29 years; and Seven, 30+
- Four cognitive behavioral therapists (CBT)
- Four psychoanalysts (PSY)
- Five psychodynamic therapists (DYN)
- Five integrative therapists using developmental and systems theories (INT)

Setting

Each audio-taped interview took place in either the therapist's private home or professional office, or in a small conference room in the Department of Psychology at The Graduate Center (CUNY). A digital recording device was used with an in-stereo microphone

situated between the interviewer and the participant. A quiet office environment was used for interviews, as it is essential to the overall quality of the recordings.

Procedures

IRB approval was obtained from CCNY. This exploratory study used an original, semi-structured qualitative interview to explore how therapists recognize aspects of their patients' subjective experiences via their own interior monologues, ruminations, daydreams, and other forms of reverie. From these recollections, data was gathered about therapists' experiences with unbidden experiences in therapy with their patients, and how these experiences may or may not have informed both their conscious and unconscious clinical choices and therapeutic actions.

This study was grounded in a constructivist approach to qualitative research and of data collection, which acknowledges the interviewer's role as both an observer of and a participant in this inquiry. The data are considered co-constructions, representing the mutual interpretation of the interviewer and of the interviewee as the interview proceeds. This model also allows for the recognition of the therapeutic relationship (co-constructed by the clinician and the patient and which it is constantly evolving) to be included as a subject of inquiry.

The interviews began with the participants' descriptions of times when they have noticed that their attention has shifted from what their patients are saying toward the thoughts or feelings that have been stirred in the therapist. Participants were then asked to consider whether these shifts have a possible predictive value—to inform diagnostic evaluation, to track therapeutic change over the course of treatment, or in the termination process where treatment outcomes are discussed. Each question had a selection of ready

prompts, with room for additional probes based on the participant's responses. In the final portion of the interview, study participants were asked to share vignettes from their clinical work that embody these shifts, or reveries. This method provided a context for the therapists' narratives of their experiences in the treatment room, and clarified similarities and differences in their therapeutic actions across the various theoretical orientations (See Appendix A for a detailed protocol of the interview).

Participants were also asked to complete a one-page demographic form (see Appendix B) within one week of the face-to-face interview. The ten (10) item form, which identified the participant by the same alphanumeric codename assigned to the subject for the recorded interview, was used to describe and to group the sample by common characteristics, such as age range, number of years in practice post-licensure, highest degree attained, to name a few. Subjects were given a stamped-addressed envelope with the form to expedite its return.

Data Analysis

The interviews were examined closely using a narrative-constructivist analysis. Categories were created based on the researcher's interpretation of the data collected rather than working from pre-set categorizations established by a person or persons unfamiliar with the particular study participants or the established line of inquiry. This process of classification is performed in an effort to create and adapt hypotheses relevant to the data instead of following a predetermined mode of analyzing the interviews (Charmaz 1995, 2000; Shkedi 2004; Strauss & Corbin 1990, 1994). This process also sheds light on the characteristics that emerge from the comparative analysis of multiple interview narratives (Shkedi 2004). Furthermore,

> While every single participant in collective case study is investigated in as much depth as possible and every single narrative preserves its context and identity, the multiple participants of the narrative survey provide the sought-after conclusions on the basis of a broad span of participants…. Since the narrative survey is based on multiple participants, it can argue more persuasively for some extent of qualitative generalization to population (Firestone 1993; Stake 1995), which collective case study obviously cannot (Shkedi 2004, p. 108).

The data were open-coded, using a line-by-line analysis of sections of each interview. Second, trends in participants' responses to the various interview questions were identified, with particular attention to departures from the clinicians' own standard technical practice or that of their theoretical orientation. The use of the verbatim quotations from the interviewees is consistent with the narrative-constructivist approach. Using the clinicians' own descriptions of shifts in attention to their own unbidden experiences will provide a genuine presentation of the experience of participants in this study.

Next, it was important to explore positive and negative attributions made by the clinicians regarding these shifts in clinical attention. In determining how the unconscious shift in attention comes into the therapist's awareness, and in acknowledging the valence with which the shift is experienced by the therapist (e.g. positive as relevant versus negative as inconsequential), the therapist's decision-making process as to whether and how to disclose a countertransference reaction to her patient is made available for exploration. Finally, the interviewer was able to observe and track her own specific impressions before, during, and after the interviews with thoughts, follow-up questions,

and burgeoning ideas spurred by the process. These data were also used to reflect on the interview proper and served as an additional source of information for post-analysis after the primary analysis of verbatim interview transcripts.

Results

A careful analysis of the 18 interviews was conducted that generated an extensive yet judicious code list. Using the methodology described in the previous chapter, the 139 codes that emerged from the narratives were then organized into 'families', or categorical groupings, based on the most salient themes (see Appendix B for the full list). These categories surfaced from the data and settled into four specific domains: (a) therapists' descriptions of unbidden experiences; (b) how therapists understand these phenomenological shifts in theory and in practice; (c) therapeutic uses of this particular clinical data; and (d) the felt sense of shifts in attention and clinical focus that are preverbal and largely outside of conscious awareness. Each grouping is summarized in this chapter with participant quotes used to emphasize the rich data set of experiences that provide an in-depth, in vivo look at therapeutic action.

Domain I: Descriptions of unbidden experiences

To open the interviews for this narrative study, therapists were asked to describe their notions about shifts in clinical attention and focus and to consider their full reactions to the nature of these experiences. All 18 participants discussed aspects of their theoretical understanding when in training and their actual experience of these clinical moments with their patients over the years and across practice settings.

Words and phrases to name unbidden experiences. By and large, all participants offered language common to their theoretical orientation to describe their experience as a shift from what their patient/client had been saying and toward thoughts that had been stirred in them: "Allow myself to check out"; "moving away" or drift away"; attention or

thought “wanders” or “is wandering”; “dream-like”; interior monologue; and useful data were the most common responses and were often the first descriptions participants gave.

> And sometimes, I guess, the p[atient] has had experiences where it’s not necessarily an issue I’ve had, but I’ve had similar experiences and I might be off for awhile thinking about those experiences. And just kind of get caught up and then realize that I’m not quite there anymore, because it sent me off some place where I haven’t thought about for a long time (P4: DS300020.doc - 4:3 (51:51)). [CBT]

Less common initial responses included “list-making” (4) and “not ‘Ogden’s reverie’” (1)—here a reference to Thomas Ogden and his well-known, personal vignettes from his own clinical work on this subject. In their initial responses, only two interviewees referred to the unbidden experience as reverie: “I always reflect on reverie when I find myself in the midst of it and try to step back and see how it might apply to the drift of the session, the material, [and] the patient” (P15: DS300075.doc - 15:1 (71:71)) [INT]. However, during the course of the interview nearly every participant referred to reverie(s) as an aspect of this phenomenon.

Emotional valence to therapists’ descriptions. Generally speaking, participants were able to engage the inherent tension that a shift in attention or awareness brought to the work, counterbalancing their positive and negative experiences. Positive words and associations were assigned to shifts and reveries, describing these experiences as providing useful information about the therapeutic relationship, about the patient in a way that should be approached with initial circumspection but tracked along with further observations, and in the following example, about serving as a superego support:

> [A] meta-therapist that regulates what I do and really observes what's going on and tells me, "Hey, is there where you want to go?" that kind of thing, kind of a mentor/supervisor for myself, [an] internalized supervisor (P5: DS300023.doc - 5:18 (319:319)) [DYN].

Other positive attributions included having conscious associations to reverie that confirmed the choice to allow one's self to follow the shift away from the direct clinical material. Additionally, several participants noted that these particular shifts into reverie helped them maintain an empathic connection to the patient and that they provide a guidepost to the therapist about where she is in the treatment relationship vis-à-vis the transference/countertransference milieu. A number of these positively valenced examples included references to visual, musical, and other aesthetic forms that were key in distilling the message these participants believed was uncovered from the communication with the patient. In most cases, therapists connected to an underlying feeling, or sense, about the unbidden experience that was described as "welcomed", "positive", "an incredible experience", "is always going to lead to something interesting", and as "so-called mistake [which] can become extraordinary moments of work".

> How do we know what something [is] which is just touching the memory for me, the clinician, and really [seemingly has] nothing to do with the patients.... obviously, there's a lot of grays out here where one never knows whe[n] this is actually a meaningful association that has personal meanings, but is, or can become, grounded in this patient-therapist relationship in a manner that's going to help me and us (P16: DS300006.doc - 16:14 (51:51)) [DYN].

Although there was a belief shared by all participants that there is value to these experiences, there were also therapists who remained skeptical about assigning too much value to this kind of clinical material—material from which they believed the true meaning could scarcely be fully known. The bulk of the negative perceptions of daydreams, interior monologues, and reveries were described as being "unproductive", "challenging", and spurred by angry or masked sexual feelings in the therapist. The few references made to the patients' contributions to this were viewed as part of transference/countertransference impasses or suggested undiagnosed character pathology in the patient.

Other common disapproving responses to shifts included guilt feelings evoked in the therapist, largely negative attributions to boredom that lead these experiences to be described as "distractions", an inability "to concentrate on this client", feeling "de-skilled" and "so impaired right now that I shouldn't be doing anything professionally", "unbalanced", and feeling "anxious and distressed by it and I feel I've been self-indulgent". In addition, there were prevalent admissions of guilt feelings by eight of the 12 participants whose descriptions of these experiences had a negative valence. Two of them also reported feeling "embarrassed" and left one participant questioning her clinical judgment:

> I mean, I never thought about it this way until right now, but I guess I have a certain notion about what my mental state should be to a responsible (pause) clinician and I'm in a compromised state. …I'm agitated. I'm not happy with myself (P16: DS300006.doc - 16:25 (235:235)) [DYN].

Less common responses were of two different categories: boredom and sleepiness, and atypical descriptions of reverie. First, boredom was described as producing guilt feelings and anxiety in the therapist, and yet was also believed to be something that could

be understood. Two participants described 'tiredness' as a sign of boredom but only one believed that signal was a further communication from the patient to the therapist. More common among the sampling was to see the therapist's clinical attention shift from engaged (i.e. described as active listening, 'evenly hovering attention', and comfortably present while also available to associations that might come) to "at sea" and, thus, no longer proximal to their patient.

Domain II. Practical and theoretical understanding of phenomena

Theoretical understanding. When asked about the theory, or theories, that influence their understanding of unbidden experiences and the like, all 18 participants discussed these phenomena as moments that occurred in each therapeutic encounter, regardless of whether the experience was welcomed or ever entered the therapist's consciousness. For example,

> It's more like that's happening all the time so it's ordinary and there are thousands of things about a shift that could be interesting in any given moment: a shift in the process, a shift in my level of engagement, some interesting contents that occur to me, some concordance with things that I'm thinking and then things that the patient starts to talk about that I couldn't have anticipated at least consciously (P 7: DS300025.doc - 7:17 (245:245)) [PSY].

Furthermore, the theoretical models that have been used to assign meaning to what therapists observe and experience were varied; yet, the categories of these concepts fell into clusters around themes that cut across the orientations of the participants. It was viewed as "commonplace", "par for the course", and "the usual state of affairs" for some of the psychoanalytic therapists, while one humanistic therapist had a decidedly different

perspective: “You know, it’s very intimate. It scares me a little bit.” Overall, these shifts, or reveries, were understood by most to be part of a complex network of assumptions related to “the transference-countertransference interplay”, “evenly hovering attention”, “associations”, “communication (self and self/other)”, “metaphors”, “product[s] of the therapeutic dyad”, and “encapsulating a patient’s struggle”. One example of this interlinked notion of unbidden experience captures these experiences and more:

> I could pay attention to see what this could be teaching me or telling me—one way, or the other. I don’t think unconscious communication is very linear, very cause and effect. … They just pop into your mind. And in therapy, that’s probably right now. And you can take that as being part of the unconscious communication of your own unconscious; all of the unconscious that [are] being shared in that particular time with the patient; or straight from the patient to your [the therapist’s] unconscious (P5: DS300023.doc - 5:8 (187:187)) [DYN].

The other, unusual descriptions of unbidden experience verge into dimensions that will be explored later on in this chapter; in the meantime, a small group of the clinicians provided distinct examples from their own histories with these phenomena that appear infrequently in the literature and yet are not completely novel either.

> I’ve also had experiences at times that have seemed almost telepathic, which is kind of weird. I mean I can have a reverie that seems just absolutely out of the blue, almost [a] kind of hypnagogic experience involving the patient, and then the patient will produce a dream that has imagery in it that is so similar to the reverie, that it’s really quite dramatic (P15: DS300075.doc - 15:8 (89:89)) [PSY].

> I mean, you know when there is like synchronicity (pause) energetically, and when there is not (P14: DS300034.doc - 14:19 (403:403)) [INT].

Observing and understanding "uncanny" clinical material, that which is not readily received in the field as data to be explored, has presented its own challenges (Taylor 2006). This experience has been described by psychoanalysts and philosophers as the unrepressed, unconscious thoughts become transmitted unconsciously between the dyadic pair. These two members of the sample group had clear influences for their perspectives of these experiences, while a few others were on the cusp of describing these phenomena but with less clear links to past research or theory.

Understanding of experience tied to feelings/emotions. It was common in this sample for the participants to identify shifts in clinical attention and focus via their changing feeling states. Some had positive associations while others maintained a view of experiences that took them away from the patient were negative, despite having a theoretical rationale for observing these moments. Many of the words and phrases used to describe unbidden experiences—reverie and wandering thoughts, in particular—evoked good and bad feelings in the therapists. The emotions varied a great deal, and included both expected and unexpected feeling (see Appendix D for a diverse list):

> I say great. It's more like data. It's like a dream. It's like my own, sort of, you know, my own preconscious thoughts (P17: DS300007.doc - 17:5 (119:119)) [INT].

> And then over time, the more intolerable it got for me, the more I actually allowed myself to go and in a way felt like it was self-protective, like it made me able to endure the session with her to just allow myself to check out, because it was so difficult (P14: DS300034.doc - 14:3 (79:79)) [INT].

The shared emotions and experiences of containing one's own experience along with the patient's were discussed as material available to the therapist and the patient. Each participant offered his or her perspectives on the potential for value in exploring how these feelings might be understood and how one could use these experiences in support of treatment goals. That potential will be discussed later in this chapter.

Reveries/shifts assigned corresponding affective responses. Another theme that emerged when participants described their affective responses to shifts in attention and reverie was their reaction to their feelings regarding these experiences. In short, psychologists in the sample described having an awareness of attending to themselves, meanwhile simultaneously reflecting on the content and process of their shifts and on conducting the treatment proper. The fact of these multiple, reflexive processes is not in and of itself noteworthy; what is worth noting is the extent to which these experiences were viewed as elemental or as superfluous or even antithetical to the aims of the therapy as they emerged. Participants regarded the treatment alliance as the deciding factor between accessing one's own experience constructively—" I didn't feel like it took me away from her. I felt like it helped me in a sense be with her" (P6: DS300024.doc - 6:2 (77:77)) [DYN]—and accepting that going further could induce unexpected reactions in the patient—"I should not have because what happened was the patient used it against me and used it destructively to harm the treatment" (P15: DS300075.doc - 15:38 (335:335)) [PSY].

A few therapists described strong affective responses to unbidden experiences, and they noted when their responses became more noteworthy than the shift in attention itself:

> I remember one patient that I used to get very bored with because she was very masochistic… she really did some terrible things to herself for lack of judgment. She

> inflicted pain on herself. When she would get off on some of the very masochistic verbiage, I would really feel repelled and I had difficulty to focus on her and I would just go away. [T]hat [wa]s so overwhelming that my mind would just go somewhere else because I couldn't tolerate that sense of hopelessness, the lack of desire or respect. It's a very basic affective kind of an experience. With her, I used to digress into things that I enjoyed or things that I wanted to do. And I think I came to understand that I didn't want to be sucked into that hopelessness. I can do things. I like things. Have you ever been with a patient that's so narcissistic that they have no interests? Empty. You don't know what you're going to find inside them to hook up with, that you can't help that thing -- help build them up. Those patients are very difficult for me and it drives me crazy (P5: DS300023.doc-5:15 (291:291)) [DYN].

Several therapists remarked on their experiences with shifts as igniting in them both a desire to harvest whatever meaning these moments might offer them and yet not privilege the experiences above other communication from their patients. Some described "tracking" their own fantasies and reveries so as to discern patterns related to what is known about patients.

> If I can somehow get to a comfortable place with it, understand more about its meaning, come to accept the experience within myself, I may go back to it and either we count it in retrospect and say to the patient, 'You know when you were speaking about such and so I had a thought about this or that' (P15: DS300075.doc - 15:36 (313:313)) [PSY].

Shifts and reverie bring about an exchange of information. As mentioned, nearly every participant used the word reverie during the course of the interview at one point or

another. The unidirectional communication occurring within the therapist alone was described by many as "a retreat inward", shifts into reverie informing the therapeutic use of self, and as information—by content or by process—about the treatment proper or in response to diagnostic questions. Two unexpected reflections on the impact of shifts on the therapist were offered: First, one therapist described particular reveries as an 'internalized supervisor' that helped guide the therapist into and through periods of reflection on the patient(s); and second, reverie as clinical material of potential use that needs to be balanced with one's theoretical stance and possibly clinical and professional values. Though uses of these experiences will be discussed in greater detail in a later section, here therapists shared occasions when their theoretical and also professional values converged and diverged to inform their understanding of mostly unconscious processes.

> I would say that if I feel alert and that I have energy but my thoughts are going into different directions, then that's better than if I feel tired or less alert, and struggling to get through the time which sometimes happens. Because then the feeling of my mind wandering seems a little bit more like a symptom of a problem than it does the more engaged, free associative process that's going on inside me. [Or] a symptom of a problem that I'm experiencing that may have to do with me and the patient, presumably it does, but it could have something to do with me that is set off by the patient or it could be some form of projective identification that I would give even more responsibility to the patient for than I would give to myself. Usually I would think about it as involving both of us (P7: DS300025.doc - 7:16 (229:229)) [PSY].

A personal dimension to reverie for therapist. Any inquiry into the theory and the practice that undergirds these phenomena will undoubtedly elicit the personal points

of view of therapists about how they experience these clinical moments with patients. The descriptions of the therapists' experiences intersect on two distinct, though interrelated, axes: 1) disapproval of, and negativity toward, focal shifts into reverie or movement 'inward', and 2) the impact that shifts in clinical attention have on the therapist's professional sense of self as being of therapeutic use to their patients. In many instances, participants described feeling self-indulgent, as though the therapist should be more present after a shift in attention, and as if they could not move beyond their countertransference reactions to regain focus on their patients.

> I think that I am not welcoming necessarily of those moments when I go into myself, when I go into my own reverie. It feels like I'm leaving the patient (P15: DS300075. doc - 15:21 (181:181)) [PSY].
>
> Sometimes somebody will be talking about something that is similar to an issue I have had in my own life. So, I'll think about my own experience of that issue, wonder if that makes me competent to treat this person (P4: DS300020.doc - 4:1 (45:45)) [CBT].

Clinicians also contrasted their work with 'difficult' people whom they and their colleagues might be inclined to charge as the reason for any lack in their focal apparatus, or evenly hovering attention, with their later experiences of these phenomena which seemed to mute their capacity to listen, to find meaning in the material presented, or, more generally, to perform effectively as a therapist. For example,

> I immediately know that there is something either I'm avoiding or the patient is avoiding. They are just going on and on and on and I can't find a place for myself in the conversation, and that's usually when I am drifting off—when there is no place

for me. And the reasons are many why there is no place for me (P12: DS300031+32.doc - 12:3 (59:59)) [INT].

Others reflected some of this participant's observations; specifically that reveries and shifts in focus could not be adequately described as coming mostly from the patient (e.g. projection, normal or pathological projective identification). This same participant offered to deconstruct further the experience of a particular shift in focus from a supervisory session with an advanced doctoral-level trainee:

> I am listening to clinical material. It had to do with a mother who is acting very bizarrely and splitting all over the place with [the] clinicians involved with her children. … The supervisee was going on and on about how the mother was being manipulative and so forth, and I wasn't going into a reverie. [Instead] I was becoming irritable, which is precisely how the mother must feel. But it was my kind of transference to the trainee, because she was being highly judgmental and describing something. I agree with her, the mother was acting "crazy". The mother was splitting, the mother was being manipulative, all those words that we [use] amongst one another and we all laugh or cackle or tsk tsk about patients, which serve their own purpose.
>
> But she was doing it and it wasn't allowing her to come up with any solutions, because once you box someone into a corner like that, then you now have them nicely labeled and you can shove them off to the side and then we can dismiss them. So I was becoming—my reverie was—I didn't go anywhere, I just became irritable and [feeling stuck], again (P12: DS300031+32.doc - 12:4 (71:71)) [INT].

Domain III. Unbidden experiences as clinical data—the uses and the "how-to"

The responses to the utility of reverie, of shifts in attention, and of unbidden experiences in the treatment scenario were varied in this sample, as much as in the literature on the impact of therapist use of self-disclosure on clinical practice and in the countless case vignettes on the topic. For this section, participants were asked not only to examine their perspectives on the role and meaning of these phenomena, but also to explore how they have come to have these points of views at all and to what use have they put these notions and assumptions. Having asked therapists from diverse theoretical orientations to articulate their perspectives on the meaning and importance of such experiences, this opportunity was presented so as to consider their rationales for disclosing or not disclosing these experiences. Thus, this section does not represent an inquiry into the ethics of using one's self as a therapeutic barometer, but instead will disclose what the barometer is able to gauge and based on those measurements what activities reasonably follow.

Of the 18 participants interviewed, unbidden experiences were described as "data" or "information", "of value", or "useful" by 16 clinicians. The alignment across their disciplines and demographic differences is noteworthy. The two outliers—both of whom made no use of these words across their 43-minute and 60-minute interviews, respectively—were both trained as psychoanalysts. One had not practiced psychoanalysis since completion of analytic training, and the other is the participant most steeped in analytic theory and was also the sole subject not to give more than a one-word description with regard to clinical orientation ("psychoanalyst"). Like the other participants, however, these two participants described experiencing shifts in clinical focus into reverie and

interior monologues, and discussed their respective decision trees in deciding whether and how to apply meaning to their private thoughts. Thus, all the subjects in this study, regardless of theoretical orientation, experienced this class of unbidden experiences in some form with their patients.

As phenomenological data to be used directly. With regard to direct use of reverie, 17 of 18 participants have made unambiguous use of shifts in attention, reverie, or interior monologues. These include using one's associations to shifts in clinical focus to understand (a) patient conflicts; (b) clinical impasses; (c) progression of an ongoing treatment; (d) diagnostic issues that may be burgeoning or ongoing; (e) complementary and concordant identifications with patients or supervisees; (f) loss of empathic connection with a patient; and (g) in reflecting on patient resistances. A small subset of participants used their associations to content from their reveries to reflect on the therapy as a whole rather than assigning specific meaning to a particular issue or theme from the current or a recent session. Primarily, therapists gave examples where this data was used directly to track the therapeutic communication:

> It's more like [shifts are] happening all the time so it's ordinary and there are thousands of things about a shift that could be interesting in any given moment: a shift in the process, a shift in my level of engagement, some interesting contents that occur to me, some concordance with things that I'm thinking and then things that the patient starts to talk about that I couldn't have anticipated at least consciously before that. So it's some kind of convergence between my unconscious process and theirs (P7: DS300025.doc - 7:17 (245:245)) [PSY].

Direct use of reverie and other unbidden experiences was also represented in these therapists' disclosures to their patients. For some, worries about being judged by their patients or feeling shamed for sharing aspects of their personal experience of their therapeutic work were weighed against the clinical utility and with the possibility of making some meaningful discovery with a patient. Despite this, the endeavor to find clinical utility through exploring the therapist's experience of the content or the process of the shift in attention spanned theoretical orientations. Here are two examples—one from a psychodynamic psychotherapist and the other from a trained psychoanalyst who identifies as integrative with strong preferences toward family systems and developmental theory:

> [T]he experience of being in a storm was a real memory for me and being scared in a sailboat, but never at the level of fear that I was experiencing in these fantasies. In these fantasies—in a way that it never been true in real life—I felt absolutely alone and scared out of my mind. It was extraordinary…. How do we know that something which is just touching the memory, for me the clinician, may have really nothing to do with what's [happening with] the patients? And, obviously, there are a lot of grays out here, where one never knows when 'this is actually a meaningful association that has personal meanings,' or can become grounded in this patient-therapist relationship in a manner that's going to help me and, well, us [P16: DS300006.doc - 16:14 (51:51)) [DYN].

> Um, the—I do pause, certainly, enough to see—is this something not just informing me about the patient, but could it also be about me, too? You know, "is there something I'm really sad about, or angry about, or anxious about? So, it's like "you know, I'm going to stop on the way by just to sort of check [this] out. Hmm, maybe

that's something you ought to think about later!" Um, so I don't have any trouble sort of saying, "Okay, I took three seconds for myself in this"; but then [there is] the feeling and where to go with it. Now, if I think, "oh, this is just me", if I do, it's becomes a preoccupation…. I need to figure it out. And I'll [work to] figure it out later, and I come back and say, "is it relevant to the patient?" … Is it useful to this patient? (P3: DS300017 and 18.doc - 3:3 (249:249)) [INT]

Full disclosure of reverie/shifts linked to active therapeutic use of self. Unlike the previous section, which explored the use of shifts into reverie and other like phenomena as data that help the therapist to understand, then conceptualize and formulate, and then implement interventions, this section covers the active therapeutic use of full disclosures of these unbidden thoughts and ideas by the therapist directly with their patients. In many cases—some of which were prefaced by apologies and feelings of embarrassment—there was unanimity across orientations that well-timed disclosures were potent tools to access for therapists. Meanwhile, two participants found that disclosing their own interior monologues served as a way to model self-reflection in vivo for their patients, but also to grant patients who are ready to do the work an opportunity to mine the therapeutic relationship as a product of the dyadic communication. Here are two examples from those interviews:

I was thinking in the moment, as she was talking about what he was doing, just how that would drive me nuts and how that would be -- even if it was my kid.... And I was able to share this with him in a very concrete way, like "I was trying to imagine what that would be like if you were just calling me." I think I was even literally hitting the chair that I was sitting on to kind of give it meaning for him.

"… If you were just calling me, calling me, calling me, calling me, that would drive me nuts." Eventually he said, 'you know, stop, like that's enough. I don't want you to do that anymore.' And from there we were able to say, well, let's set some rules about what phone time with mom would look like. If you get her voicemail, leave a message and let's decide how much time on the clock until you can call her again. We were able to plan… in a way that he could understand. And he is very much rule bound, so we were able to extinguish that behavior pretty easily. So that's an example where I feel like I can share how it makes me feel or what happened to me in that moment in a way that can benefit the problem that we are trying to solve (P8: DS300026.doc - 8:21 (303:312)) [CBT]

[B]y attending to the space, the therapy space, keeping it safe, staying attuned, processing your own feelings, you can kind of create a therapeutic space where you can actually go there with somebody. So there would be a moment where I could say, "you know what, last time I had such a reaction to this, because I felt that I wasn't protecting you and I was worried that you wouldn't protect yourself. We have to talk about that."

I really, in my mind, see this as a journey that we take together. So I really believe that everybody is trying as hard as they can. I really give everybody the benefit of doubt. So I will frame it as, "this happened, and there must be some very good reason that this is so difficult for you or that you haven't been able to take care of yourself." So I try to go from that. I try to really start expanding the context of that. So there is - I really try to help the person and share that [I think] there is some reason that they are responsive like that. Okay? And that we're going to find it

together, and that we'll go there and the goal is not to stay there, but to get out of there. But it is still kind of a journey (P10: DS300028.doc - 10:16 (201:201)) [DYN].

Though frequency and their own awareness of using their inner experiences varied widely, many participants spoke about the unexpectedness of their own responses to this uncommon material. Slightly more than half of the participants were surprised to find themselves disclosing their reverie experiences so as to connect an interpretation to their patient's life experiences. Others regarded the potential pitfalls of using this data as enough to make them think for long periods about whether or not it was safe to disclose at all, but even those therapists settled on the view that the potential benefits outweighed their fears of risk, specifically for patients with whom they had longer therapeutic relationships.

…[T]here was no conscious thought. I was just like in some kind of like weird **state**. Again, though, this is somebody I probably worked with for five or six years, multiple times a week and so there was um, a…a context of I think a deeper relationship there, where it felt…I don't think I would allow myself to have that happen with somebody who I didn't know so well or—if I didn't feel kind of, in a sense, safe with her that would be all right. I mean, to do something useful with it…. It was really weird. I was freaked (P1: DS300008.doc - 1:25 (258:258)) [PSY]

Phenomenological data supports therapy goals (not specifically direct use). As with prior points of inquiry, participants' responses spanned from one boundary pole to the next—from associations to reverie that helped to access their patients' unconscious processes to powerful, countertransference reactions that bring the therapist to "check out" as a way to marshal the focus to maintain a connection with their patient—"Over time, the more intolerable it got for me, the more I actually allowed myself to go and in a way felt

like it was self-protective, like it made me able to endure the session with her to just allow myself to check out, because it was so difficult" (P14: DS300034.doc - 14:4 (83:83)) [INT]. Half of the participants remarked that having a chance to discuss these moments in individual and peer supervision was another way to uncover aspects of the patient-therapist communication.

Primarily, therapists cited examples of times when their unbidden experiences served as an adjunct used to aid the therapist in his capacity to perceive patient conflicts, identifications, and shifts in affective intensity, as well as presenting the therapist with an opportunity to reflect on, or monitor the progression of, the treatment as a whole. For instance, two participants responded that it was the inauthentic discourse of their patients that beckoned the shift in attention. One of the psychologists was trained as a psychodynamic therapist and described her modality as *eclectic*, while the other was trained in psychoanalytic psychotherapy methods but was mutually influenced by pragmatism, Milton Erickson, solution-focused brief therapy, and thirty years of work experience in a hospital setting with CBT as the chief modality. In both cases, the therapist's inner self-dialogue was of noting something atypical that changed the quality of the communication or was experienced as infringing on the framework of the treatment.

> Most of the time, in our experiences, it's not because of something they have said, but it seems to be quality of their discourse, that something seems less authentic than typical. And it just doesn't have that immediate presence of the important or real, and so when I start to drift, after telling myself, you can't drift because you are going to drift. Then I try to take a step back to try to see what's going on and try to get to the affect behind the words, instead of just listening to the words and figuring

them out. A lot of times that will give me some information that is clinically useful, and if it doesn't, then I switch back and forth between trying to tune in and then to sort of stepping back to see which stance I will finally get some meat from (P11: DS300029+30.doc - 11:2 (51:51)) [DYN]

When I find myself either irritable or bored, that's my reverie. I don't usually go like—I should move my car, or I should get a quart of milk—I mean, those things do come to mind. I am not sure I am particularly conscious of why I am having a particular association. I do know the minute I am having it. It doesn't take me very long to realize it. I immediately know that there is something either I am avoiding or the patient is avoiding. They are just going on and on and on and I can't find a place for myself in the conversation, and that's usually when I am drifting off—when there is no place for me. And the reasons are many why there is no place for me (P12: DS300031+32.doc - 12:3 (59:59)) [INT]

Indirect disclosures and impacts on therapeutic action. Fourteen participants reported that they in some way disguised active use of their unbidden experiences with their patients. Even the participants that decidedly used self-disclosure of these phenomena, with little to no reservation, reported sharing reveries and the like without disclosing it as anything other than an idea, a thought, or interpretation. One therapist said that though he liked to consider his unbidden experiences as an integral part of any treatment, he also felt bound to his patients and wanted to honor the therapeutic relationship by not straying too far afield: "Although I will take time to consider and then examine it, I feel that really what my duty is to get with the patient" (P15: DS300075.doc - 15:22 (181:181)) [PSY].

Nearly all participants agreed that they used themselves and their private thoughts at one point or another if only to conceptualize and later explore patient resistances. Another means by which indirect disclosures of reveries and shifts in attention seemed to have an impact on the treatment was as a part of supervisions and consultations. A third of participants across each orientation sought assistance when the reverie or shift happened repeatedly with the same patient(s). In a couple of cases, therapists were able to revisit what they experienced as a way of reestablishing an empathic tie to the patient. Here is an example from the therapist in the sample who drew a lot from experiences using mindfulness-based stress reduction both personally and in conducting therapy:

> [A]fter I noticed that [this was] happening for a couple of sessions—where it was really like an obvious escape on my part—, I brought it to my peer supervision group because I know I needed help. I was obviously not serving the patient. And after that conversation, I became (pause), I kind of shifted my tactic a little bit. I became more active with her and with that I was more honest actually with her about my experience of her. And that opened something up and we've really been able to move. It has just gotten so much more engaged, I think for both of us since then and more positive. I think both of us left each of those sessions feeling really depleted and really disconnected from each other and that has changed since I've been sort of less—I've allowed myself to circle off less (P14: DS300034.doc - 14:4 (83:83)) [INT]

"How to" disclose shifts/reveries (directly). The most consistent statements from participants about whether or not to disclose about one's inner experiences fall under the heading of "whatever helps the patient," which includes disclosures that serve as a model

to patients, encouraging them to reflect on a number of things, such as on their own affective responses, to following a hunch elicited by a reverie because it too is a product (e.g. an association, affective shifts) of the relationship that can be meaningful for the patient, the therapist, and the dyad. Yet, in terms of 'how to" use one's self in this way, participants responses varied but overlapped across reflections.

First, many of the therapists interviewed reported that reverie and similar experiences probably offered them information about their patients and the treatment relationship, and advocated its use. Four participants, who represented the spectrum of orientations described in the sample, reported that the value of these experiences was best mined with their patients and when used to test hypotheses based in working theories one has but for which the data need to be tested.

> What kinds of risks can you take with your patients? Can you be brave enough to say, "You know what, my mind just wandered there? I wonder if what you're saying is just too painful to—for even me to hold?" I don't know that I work in that kind of way too often, but I think I could be very brave and it could be a potentially powerful way to work with [patients], if you have the right kind of relationship (P14: DS300034.doc - 14:14 (265:265)) [INT].

Second, while several therapists felt that their own disclosures of these experiences could make a genuine difference for their patients, one third of participants specifically noted that if reverie could be explored in the moment it was happening for the therapist, it could serve two significant purposes: first, to learn more about the patient's willingness to use what comes from the therapist as material of some unassigned value and, second, to model for the patient that self-reflection and curiosity about one's own mental processes is

a meaningful endeavor.

> I will often say to a patient, 'you know it's interesting that when you said such and so, what occurred to me was such and so. What do you make of that?' So I will present it to the patient often to see if it can be of value to the patient and I think the patient understands that it's being presented as something that I think can potentially be a value to them in terms of advancing their self-understanding advancing the work (P15: DS300075.doc - 15:24 (235:235)) [PSY].

Third, in this instance, four participants spoke extensively about directly sharing these phenomena with their patients, expressing reservations but also concern for doing a disservice to their patients by not disclosing particular interior thoughts. In the first example, the therapist cautiously proceeded out of concern about how to disclose, but used his clinical judgment to guide him through what was deemed to be an important and appropriate disclosure. In the second, the participant revisited a disclosure made where the therapist questioned the impact of the disclosure despite the intent to support the patient and within a context of a healthy therapeutic relationship.

> I ultimately decided that I would bring it up when it seemed appropriate, but I didn't know exactly what I would do with it when it did come up. And I'm really glad I was cautious in how I brought it up because they were talking about the difficulty of being vulnerable with each other, to being scared to be vulnerable to each other (P4: DS300020.doc - 4:14 (217:217)) [CBT].

> I thought I should not have shared and when I opened it up with the patient and we discussed my reaction, I told her that I thought I should have not shared and then I felt that I have really done her a disservice. She was very clear with me that I was

> dead wrong, that I was not giving her enough credit and that she was glad that I shared and said to me, 'I will never want you to hold back on anything. I want to know whatever, wherever, I want to know where you're coming from,' which is interesting (P15: DS300075.doc - 15:39 (337:337)) [PSY].

Fourth, though participants unanimously agreed that clinical errors were fodder for the therapy, only one participant spoke made a direct reference to the literature about using mistakes both as content for use in the treatment, but also to create an opportunity for the patient to discuss the therapist's perceived error and use it toward a positive outcome:

> Certainly the more secure I become over the years clinically, the more transparent I am about that in a way that I know is always going to lead to something interesting and as you know, in the interpersonal literature, there has actually been more and more discussion explicitly about that how our so-called mistakes or our lapses—where there is an empathic break between the patient and the therapist—can become extraordinary moments of work P16: DS300006.doc - 16:35 (347:347)) [DYN].

Finally, about one-third of participants endorsed using their unbidden experiences to implement a decision tree to guide their direct use of disclosures. The notion of a disclosure as an intervention is largely antithetical to how most analytic psychologists work with these phenomena because of its negative connotation about and possible implications for the therapeutic communication within the dyad. However, therapists interviewed from other orientations stated that in the treatment scenario there are multiple, choice points upon which to act. And yet, they were of two minds about reveries

and their role in the treatment process—unwelcomed and intrusive, at times, and interesting and useful in other moments.

Of the five therapists who put forth their conceptions for the use of disclosures as interventions, one psychodynamically-trained therapist who actively integrated cognitive- and dialectical-behavior therapies into her repertoire, described the impact as at its most profound when used to examine a patient's level of functioning and relatedness:

> You'd think perhaps that I'd be more likely to disclose in psychodynamic work because so much of it is about transference and countertransference. But, actually, interestingly, Linehan and some of the cognitive therapists talk about self-disclosure as part of the work. Um, and again, sometimes using self-disclosure to help the patient reality test—normalize, um, by being a role model. There are all kinds of ways to use self-disclosure in CBT and DBT (P2: DS300009&DS00010.doc - 2:28 (400:402)) [INT]

In this example, the therapist welcomed the perspectives from other orientations when attempting to model disclosures for the patient, but also joined with the patient 1) by identifying automatic thoughts and 2) in partnering to restructure problematic cognitions by substituting more life-affirming thoughts and beliefs.

"How to" use shifts/reverie as data to make indirect disclosures. Three main themes emerged from the data on indirect therapist disclosures. First, four participants revealed that they would share only an experience or a feeling they have had in direct response to the patient, but will stop short of disclosure of their reveries, choosing neither to unpack those experiences nor to admit to shifts in clinical attention and focus.

> I would say it's rare, but I do disclose my feelings. Rarely a disconnect because I think if I've really gone off elsewhere, I feel that what I may have gained is not worth what I lost, losing the client and I feel guilty about that and I guess I don't want to -- I don't want my clients to wonder whether I'm with them. I do use only my feelings in sessions (P4: DS300020.doc - 4:22 (287:289)) [CBT]

Next, slightly less than one-quarter of the participants described giving special consideration to their reverie experiences but consider it essential, in discussing it, to maintain a close relationship to the patient's own experiences. Thus, instead of negotiating the intricacies of their own, equally difficult psychologies, "I want it [to be] benign, but like in a way that shares thoughts that aren't too complicated, or ugly or, like, messy" (P14: DS300034.doc - 14:16 (275:275)) [INT]. And lastly, nearly two-thirds of therapists hoped to help patients connect to aspects of experience that had not been processed into conscious awareness, including work that could be initiated within dyadic communication—"I use my [self-] experience to think, well, 'this is something that this person needs personally', and then I try to find a way to convert my [own] experience into language in the sessions in some way" (P10: DS300028.doc - 10:8 (52:52)) [DYN].

Challenges with use of reveries but have bearing on therapeutic practice. One-third of participants described shifts into reverie and other similar phenomena as unconscious communication where the therapists queried themselves about the unconscious processes of their patients' so as to access their experiences. "You know that kind of typical, 'how am I feeling right now about the patient, how much of that is me, or how much of that is the patient?' 'What's going on here, developmentally?'… You know, that

back and forth, [the] very quick shifts that really are almost like multiple levels of consciousness" (P2: DS300009& DS00010.doc - 2:2 (83:83)) [INT].

Furthermore, five therapists described how their therapeutic focus was disrupted due to their countertransference reactions. Three of these therapists reported that they were able to regain focus on the patients and the material at hand, while two participants reported that their functionality was negatively impacted. Half of the sample described the challenges associated with their unbidden experiences but they still felt it had a bearing on their therapeutic practice. For example, one participant offered this summary for the difficulty inherent not only in attending to one's own uncommon experience and corresponding affective response but simultaneously trying to remain present to patients' conflicts and resistances: "The things that are fraught with conflict or tension or anxiety or discomfort are often defining what needs to be discussed and that's become a working assumption of mine" (P15: DS300075.doc - 15:45 (399:399)) [PSY].

Domain IV. Engaging unconscious processes: Putting a felt sense into words

As communication, on multiple levels. Participants used terms that encompassed a broad area of therapeutic communication to describe the role of these experiences in the treatment scenario. Furthermore, as has already been mentioned indirectly, questions about appropriate and unusual uses of unbidden experiences surfaced early in a number of interviews, ahead of the question being posed directly. Yet, before recommendations impacting practice were discussed, many psychologists expressed their thoughts about the back/foreground in which this kind of therapeutic communication occurs, as well as the multitude of ways one could describe these experiences as unfolding phenomenologically. Some of the conceptions include

1. Reverie as a coalescence of brain functions within therapist-patient dyad
2. Telepathic experience
3. Hypnagogic imagery
4. Reverie of the therapist will eventually manifest in the patient
5. Unbidden experiences potentially hold value that cannot be fully accessed
6. Being on the cusp of something emergent

Intuitive experiences bring about unique clinical opportunities. Participants' responses clustered around three areas of intuitive experience. This section illustrates some of the uncommon experiences these therapists' noticed, felt, and recognized as unique signifiers about therapeutic communication and relationships with the patient. Though some were more comfortable than others with these burgeoning insights, all but two therapists were able to entertain and sustain a level of curiosity about how these phenomena might be explored and examined.

1. An element of uncanniness about the experience.

> "It's irrelevant. It's as if time doesn't exist. It's not to say it's faster or slower, it's just irrelevant. The office is irrelevant, the color of walls is irrelevant, it is just the experience. I am sounding psychotic, aren't I? Oh boy!" (P11: DS300029+30.doc - 11:23 (381:381)) [DYN]
>
> "I had this experience once a long time going. I was sitting with somebody and I thought, if I could understand -- and I don't know if I'll be able to put this into words. But it's almost like the air, like the negative space around the person…. Like if I could understand that then I would understand the person,

like meaning, sort of the milieu, the context in which this being came into themselves in this moment“ (P14: DS300034.doc - 14:20 (403:403)) [INT]

2. Therapists have experience of their functionality becoming constricted when struggling with a felt sense that cannot be put into words.

“Well, I mean, when I’m bored, I feel very sleepy. So I stopped feeling, I stopped thinking, you know, um, and it is with highly intellectual its patients” (P 2: DS300009&DS00010.doc - 2:26 (310:310) [INT].

“There are some patients who have no interest in your mental process. I think it’s their deficiency. I think it’s a limitation. But nevertheless at that particular—at some particular moment in time, they’re not interested in your process. And if that is the case I’m not inclined to share my process” (P15: DS300075.doc - 15:29 (283:283)) [PSY].

“Without much emotion and I am holding some aspect of her experience, that’s not said, but it’s - and those are the days that you come home from work and you are like, what am I doing? What am I holding?” (P10: DS300028.doc - 10:3 (17:17)) [DYN]

3. Provides an entry point to a conversation about what the therapist notes about other levels of communication that are possible in the therapeutic dyad.

“I believe that the past exists in the present, it exists in our imagination. The past is taken up into our interpersonal relationships in the here and now” (P10: DS300028.doc - 10:22 (345:345)) [DYN].

“And I think sometimes that attunement doesn’t come, it’s not necessarily always accompanied with like “Oh, I get this. I understand this.” It’s like --

something is understood. I couldn't necessarily say what it is, but something is understood, something is happening" (P14: DS300034.doc - 14:23 (463:465)) [INT].

Description of shift/reverie 'burgeoning'. To describe being on the cusp of something occurring on a level that is part of the brain's unconscious process proved to be a difficult thing to do. In this section, more than in those before, it was essential to let the participants' descriptions exist on their own, without too much alteration or translation so that, as much as possible, reflecting on these observations of past therapeutic experiences could take on multiple meanings and existences at once. Interestingly, only one of the cognitive-behaviorally oriented therapists gave an example that fit this particular theme.

P1: "I think there is often almost like amnesia for that moment of transition…. There are some things that happened that are sooo, kind of, vivid (trails off). That you can sort of (pause), note them, but often (long pause), often I, often I don't." [PSY]

P3: "The shift…. There are times when the sheer shift, [is] um—wham. What just happened? Okay… what just happened?" [INT]

P5: "And you can take that as being part of the unconscious communication of your own unconscious, all of the unconscious that's being shared in that particular time with the patient, or straight from the patient to your unconscious. People do that. They even give you bellyaches." [DYN]

P6: "Sometimes, it's kind of an 'aha' moment." [DYN]

P8: "I think there is almost like amnesia for that moment of transition. …[T]here are some things that happened that are so, kind of, vivid that you can, sort of, note them, but often…often I…often I don't." "There was no conscious thought. I was just in

some kind of weird state." "I also feel like, you know, they would start talking about tension and relief and sort of what I find is what I'm doing is I'm trying to access and it sounds so like new age, but like this place in myself that I know I can go where I'm open to what going on and it…it can make some kind of sense and me and the other person can go somewhere together." [CBT]

P11: "So it was this kind of listening,…almost as if a TV is on in the background and if a couple of words come up that might spark your attention, then you fully focus. Otherwise, you are just aware of, not quite always, but you are not taking in every detail. It's like pieces are just sort of coming together in the back of my head." [DYN]

P14: "It just paralyzed me and it sent me away until I realized how far away I was going. And, in fact, that I was like allowing myself to leave, really, the room and sort of said, 'No, no, no, you have to come back here.'" "I think I'm aware in the moment that it's happening, I think I can make a conscious choice, whether or not allow it to continue to happen." "There are times when you know when you're locked in with your patient and you're in, you're coming to something and an awareness is building and you feel it, both of you feel it. And then there are times where you don't. It's like where every cell of your body is engaged and it's a feeling in the room." [INT]

P15: "I've also had experiences at times that have seemed almost telepathic which is kind of weird. I mean I can have a reverie that seems just absolutely out of the blue, almost this kind of hypnagogic experience involving the patient and then the patient will produce a dream that has imagery in it that is so similar to the reverie that it's really quite dramatic." "When there's a shift or a coming together, when somehow

there's a Gestalt shift, you see it different—I see it differently. I grasp an understanding of it in a different way." [PSY]

P16: "So it wasn't just pleasurable memories associated with it. But there was a level of aloneness, of upset-ness that was new and really shook me. " [DYN]

P17: "It's like a dream. It's like my own, sort of, you know, preconscious thoughts. … I greet it with pleasure. Like if you could remember a dream in the morning and say, "Hey, that's great." [INT]

Generalizations about impact on practice and/or teaching. Eleven of the 18 participants sought to explore the potential for these experiences beyond their use with specific patients to considering implications of shifts into reverie and their direct and indirect use on overall practice and the teaching of clinical technique. Here are the most salient recommendations from these participants regarding the impact of these phenomena:

- Unbidden experiences in therapists occur most when the patient is disconnected from material; may appear as boredom, sleepiness, anger, or emptiness in the therapist
- New information or uncommon content of reverie are more likely to focus therapist's attention rather than less.
- Feelings of both tension and relief are necessary and linked aspects of accessing and being available to unbidden experience.
- Therapeutic action occurs when therapist can help the patient integrate warded off material. One's capacity to do this is impacted by the therapist's training and orientation because to use one's self in this way and to regard associations from

patients as possibly meaningful to a treatment situation must be integrated into the theoretical and practical training at multiple points.

- Supervisors more than theoreticians will affect whether trainees are encouraged to mind and mine these experiences, report them, put them in a context relevant to the orientation, and then potentially make use of them.

There have been more than 100 hundred years of references to the communication between patient and clinician as the (dynamically) *repressed unconscious* (Freud 1912) experience and the *unrepressed unconscious* process (Mancia 2006). The approbation of the use this material has gained growing support given the increased emphasis in the last fifty years on two-person psychologies, as well as the sense among therapists that the examination and exploration of the relationship between the patient and the clinician's unconscious processes might have value. Relational psychoanalysis and psychotherapy practice has in fact helped spur a language for these experiences on the part of the therapist. The results for this study will now be added to the language of that practice and will be unpacked more in the following chapter.

Discussion

This qualitative research study provides a small, yet comprehensive and systematic account of the current state of thinking about psychotherapy—exploring the conflicts and uncertainties experienced by practitioners in their daily work and the moments when their practice may seem to contradict their general theoretical position. The interviews were examined closely using a narrative-constructivist analysis; thus, categories were created based on the researcher's interpretation of the data collected rather than working from pre-set categorizations established by persons unfamiliar with the established line of inquiry. This process of classification guided the creation and adaptation of thoughtful assumptions closely linked to the data rather than providing a purely descriptive account of individual interviews.

Numerous categories emerged from the data, which were then grouped into four domains: Therapists' descriptions of unbidden experiences, how therapists understand these phenomenological shifts in theory and in practice, therapeutic uses of this particular clinical data, and the intuitive experience that accompanies some shifts in attention and clinical focus. Next, trends in participants' responses to interview questions were identified with particular attention to departures from the clinicians' own standard technical practice or that of their theoretical orientation. The use of the verbatim quotations has enriched this narrative-constructivist approach, as the clinicians' own descriptions of their own unbidden experiences has provided uncommon access to the experiences of participants in this study.

As discussed in the previous chapters, there are numerous points of departure when considering the landscape of unbidden experiences, conscious and unconscious

communication, and the occasionally thorny topic of therapist self-disclosures. What has emerged from the scores of articles, monographs, and vignettes about the breadth of these experiences is not at all dissimilar from what was perceived by the 18 clinical practitioners who were interviewed for this project over the course of three years (2008-2011).

Naming and 'norming' unbidden experiences

Across theoretical orientations, the participants assigned similar words and phrases to their descriptions of unbidden experiences. Regardless of either the expressed opinions about the origin of these occurrences or the underlying feelings therapists have toward them, all spoke directly or indirectly about the curiosity evoked by these clinical moments and their corresponding responses to this material. Over the course of all 18 interviews, the therapists eventually described their 'reveries' and some opined about the lack of openness on the subject within the field, even among those psychoanalytic clinicians who seem naturally inclined to look upon this topic favorably. As outlined here and elsewhere, the theoretical literature is filled with an impressive amount of thoughtful and evocative notions about the source(s) of these intra-therapy events. The written work on technique is replete with examples from Freud forward about all manner of uncommon experiences visited upon practitioners.

Some of the study participants eagerly held in dynamic tension a positivity toward this counterbalancing act of remaining open to multiple inputs from the sources of this subtle communication: first, in having noticed a change in their listening to patient material; second, toward the thoughts, emotions, and even physical manifestations of their affective responses that had been stirred; third, of containing all the possible self-other exchanges of information embodied in just becoming aware of these experiences; and

next—though far from last—of registering into consciousness what has emerged and of welcoming the numerous points of departure that signal and summon the therapist to make, at least initially, a choice. For those with less than positive reactions to shifts in their clinical attention, the curiosity was described with greater circumspection and was acknowledged as disquieting to the expected flow of typical client sessions. Despite themselves, several participants reported disclosing to their patients with doubt and reservation and yet with self-assurance based 1) on their clinical and/or theoretical orientation, 2) on trust, that it would be safe to do so with particular patients, 3) in response to affective shifts within themselves or their patients, and 4) on their belief that even if a disclosure seemed to be in error, there is much to be gained for the therapist and patient by reflecting on therapeutic mis-attunements.

The four therapists who met these experiences with the most skepticism seemed bothered by the realization that their attention was not primarily with the patient's concerns. Furthermore, the admissions in the interview evoked feelings of distress, questions about their level of professionalism, and concerns about possible character flaws, such as self-indulgence. Interestingly though not surprisingly, three of the four therapists who experienced shifts in attention this way were trained primarily as cognitive-behavioral therapists, which accounts for three-quarters of the psychotherapists for whom CBT was their theoretical orientation. Each regarded unbidden experiences as compelling and worth exploring; however, not knowing how to adequately use themselves and their experiences in this way coupled with fears about making a mistake with a given patient, greatly restricted these therapists' willingness to trust their own intuitive sense. Though it was more common for therapists (eight participants, in this case) to share some guilt feelings or

slight sense of embarrassment in having had these experiences, a segment of this sample felt that to waver in their conviction with the tenets of their training would too greatly compromise what they believed their therapeutic stance should be.

With respect to the concerns echoed by therapists in this study about assigning too much value to their internal experiences, an intended outcome of this research was to create (and, with some participants, to model) a systematic method for chronicling and examining this process as it has unfolded in therapies but also as it occurred in each individual interview between the subject and the interviewer as a participant observer. The interview itself provided the interviewees the opportunity to listen to the interviewer not only reflect on her perspectives and understanding of these phenomena, but also transform the space between interviewer and participant into a place where non-hierarchical engagement about this topic became possible. The hope was that despite ongoing taboos about the occurrences of use of these experiences, all participants could share aspects of their positivity, negativity, or neutrality to unbidden experiences.

As a result, conscious communication ensued about how these moments strike the therapist, what one decides to call the experiences—for themselves, with their patients, and in consultation with peers and supervisors—, and where they go, both within themselves and with regard to direct or indirect communication with their patients in the moments, sessions, and treatments that follow.

How to understand unbidden phenomena: Will the theory inform practice?

> There are folks who say, well, [reverie] is always telling me something about the patient. I don't really believe that. I think it's often telling you something about

yourself that you can use, and then [later] you [might] find it to be more useful with the patient. (P1: DS300008.doc - 1:8 (58:58)) [PSY]

Among study participants, there was unanimous agreement that reverie, interior monologues, daydreams and fantasies, list making, and numerous other mental activities not involved directly with patient material occur all the time in and around the practice of psychotherapy and psychoanalysis. That it happens was of interest to all the participants to varying degrees, and so were its origins. It was surprising to uncover from the data that, without exception, therapists found their experiences of these phenomena to be ultimately interlinked with the patients' experiences. Across theoretical orientations, and in spite of concerns about the timing or appropriateness of these inner experiences, many participants referenced feeling a pull toward subjectivity, which provided the therapist with an opportunity to use her self as a vehicle for relating directly to some aspect of the patient's experience.

For the psychodynamic therapists and psychoanalysts, the direct or indirect use of one's self would already be in line with their theoretical stance(s). In these instances, what might have come to the fore in practice, as part of a reverie about the treatment, would be a personal interpretation of that inner moment such that it has bearing on the therapeutic relationship. As an example of this, one participant chimed in with a well-accepted perspective, though relatively contained to psychoanalytic psychology, on its function in therapy: "I think that the analyst[s] strives to listen in such a way that they're both highly focused and attentive on the one hand, but also ruminative, distracted, and engaged in reverie on the other hand, simultaneously" (P 7: DS300025 - 7:1 (40:40)) [PSY]. However, the apparatus connecting the reverie/unbidden experience to its eventual interpretation or

self-disclosing gesture remains largely unknowable within the vastness of therapeutic communication. The topic of how to move these unusual (or usual depending on the therapist) associations from a felt sense to a reasonable and ethical offering to the patient remained precious fodder for the entirety of the data collection process.

> I am careful about what I say, but I will use my own experiences. I will use what's happening in the clinic, it's very fluid. It's possible, as we are taking about this, that maybe I am much more relaxed as a supervisor. I might be even more creative as a supervisor than I am as a therapist, because the association seems to come much quicker and over a wider cultural and psychological range than with my patients. (P12: DS300031+32.doc - 12:10 (318:320)) [INT]

The theories and private examples from close to 60 vignettes shared by the participants in this exploratory study light the stage for any training or supervisory experience on what therapists notice, what they miss along with what they capture, and how they feel about both the connectedness and the inevitable mis-attunements that are a part of the therapy process. With the stage prepared for a broadened conception of unbidden experiences, there is now an opportunity to pull back the curtain and see how these therapeutic endeavors take shape and how they can continue to inform thoughtful, researched practice.

As described in the previous chapters, the affective responses to these phenomena were reported in extremes—from “pleasing” and “joyful” to “bizarre” and “repelling”. Two therapists described “being scared” of whatever was to emerge from these feelings, relaying that they were very unsettled by affects that had no immediate associations. Another therapist’s description of feeling “at sea”, however, seemed to fit with his

conceptualization of his patient's conflicts, such that although the affect was discomforting (as it came on suddenly) he could relate it to what had to that point remained unsaid. In fact, this therapist opined that his ability to track this murky communication allowed him to pass a test put forth unconsciously by the patient, forcing him to simultaneously experience and make sense of the patient's months-long silence.

Polanyi (1967) writes, "I shall reconsider human knowledge by starting from the fact that we can know more than we can tell. This fact seems obvious enough; but it is not easy to say exactly what it means" (pp. 3-4). The meaning(s) and mechanism(s) of unbidden experiences, reverie, or unrepressed unconscious processes cannot truly be known consciously. The usual patterns of brain activity continue outside of conscious awareness, leaving a host of early and complex experiences stored in implicit memory, from which only a very small tangle of language and images can emerge by way of a mediating environment (e.g. dreams, free associative processes, slips of the tongue, etc.) (Mancia 2006) This mental flotilla is not repressed; it, simply, **is**. Some have viewed this as an impingement upon therapeutic functionality, while for others it has been a necessary symmetrical extension of conscious therapeutic activity. Despite this, symbolic, pre-symbolic, and pre-verbal experiences are stirred as part of the transference-countertransference milieu of the patient and therapist, not at all unlike the manner in which these same memories were formed in the first communication between mother and infant (Beebe and Lachmann 1998). Here, one of the psychoanalytically trained participants provides a brief summary of the investigative process she employs to track both her reflections and actions in the treatment scenario.

> Look, a piece of the puzzle is [just] not fitting. Well, so, the reverie may not be so useful in that particular time. And yet, there's [this] piece that doesn't seem to fit in the puzzle and I said, "Oh, what's that about? Oh!" And I have to do a revision of things. I have to think about where it does fit. Now, why did I think it was going to be this way as opposed to that way? What does this [all] mean? I have to review the context and, after I do, it's a more conscious effort to integrate that piece [of new information], at least for a moment. If that doesn't work, then I have to say, "Okay. Let's go back to fishing." (P5: DS300023.doc - 5:35 (861:869)) [DYN]

Maurice — A clinical case

Maurice, one of my early patients, began treatment at the clinic where I worked shortly after an arrest for domestic assault of his former girlfriend, who was also the mother of his school-aged daughter. In his mid- twenties at the time, Maurice expressed his ambivalence toward the treatment with me from the beginning of the clinical intake process. He took great pains to inform me that therapy had been recommended by his judge, but he was primarily interested in working through his other issues. Deep concerns about authority (therapist-patient), power (dominant over subordinate), and expertise (skilled versus novice) were prominent themes that we struggled with together over the course of the therapy.

Maurice was consistent in his lack of confidence: In me, in the possibility that therapy could help him resolve his conflicts, and in general, he expressed concern that he was being victimized and persecuted by women who sought to belittle him at every turn. Since I was "just like the rest of them" in my attempts to "to take [his] power" from him, he often communicated his resentment of, and discomfort with, the imposed framework of the

treatment. He typically arrived late, the effect of which was shortened sessions, from 50 minutes to only twenty. He seemed to sense that I was greatly affected by his repeated lateness; however, he reported that my presumed irritation was 'of little concern' to him, and that 'there was no point in making a case out of it. '

As I waited for Maurice to arrive for one particular appointment—ten minutes of the session time had elapsed—I prepared myself for another 20-minute session, a circumstance that had become the norm rather than the exception, and a situation I was not adequately addressing with Maurice once he made it to the treatment room. We had spoken by phone after his last missed session and he said that he planned to come to this one. I half-expected him, but part of me guessed he would not come. Before the session time was complete, I began to consider the previous months of the treatment. Several sessions before, we had discussed at length what was then an upcoming month-long hiatus from clinic sessions, and he said he thought he might not return to the treatment after that long break. In that session, I felt myself trying to persuade him to stay in the treatment. As I lacked the power to will him into therapy, Maurice chose to attend only made one appointment since we recommenced the therapy.

As the clocked rolled past the 40-minute point, I left the therapy room and returned to the lounge across the hall, listening out in case he came before the end of the hour. I sat back heavily into the couch, and here was what emerged from my hypnagogic state:

> I walk through the apartment I share with my spouse, and I see a figure pass outside the window. I see that it is a man, and as he gestures and waves for me to come over. I approach and stop suddenly when I recognize him. Maurice is smiling, motioning for me to help him further open the window, a window that I had shut

earlier. I look around and then up the stairwell to check for movement before I walk quickly over to the window.

Maurice looks different than his usual appearance—he is casually dressed in a sweat suit, his hair is longer, and he wears it in a braided cornrow style, and he is not wearing his glasses. We both raise the window and he asks repeatedly if I will let him in. I am self-conscious and look over my shoulder, concerned that Kurt, who I know is upstairs, can hear Maurice and I speaking in hushed tones. I do not want them to meet, and so I tell Maurice I cannot let him in. "Oh come on, he won't know. I need to talk to you." He lifts one leg and puts it through the open window and as he does, I step back slightly, ask him to wait there, and I tell him I will come outside. Just as I turn to leave, I see someone above us on the fire escape leading to the second floor window. It is a disheveled woman in her 50s or 60s. She is light-skinned, possibly Caucasian, but there is a question about that. Her hair is wild and unkempt, and her clothes are stained and threadbare.

When she notices me, she smiles and shows that several of her teeth are rotten or missing. As she laughs, she seems familiar and I feel that I must know her. She does not seem to care that I see her entering my house. I do not want her to come in, a fact I think she knows. She looks down at Maurice and I as she proceeds to open the upstairs window and disappears into the house. Meanwhile, Maurice, whose leg is still in the window, resting on the inside pane, says that he will wait for me to come talk to him. As I turn to go upstairs, I hear Kurt's raised voice as he comes down the stairs. I cannot make sense of his words and the room begins to blur out of focus.

Having roused myself, my awareness shifted back to the present and to the couch on which I was seated.

I spoke to Maurice by phone once briefly after that missed session, and I left two messages about his absences for subsequent sessions. Due to the number of missed sessions, I followed up the calls with a personal letter regarding the status of the treatment. He called to say he would come back in, but never did and so I terminated the case. As the last "session" material I had to speak of, my supervisor and I spent several weeks revisiting this reverie moment, exploring its multiple, possible meanings. It had not been unlike me to have brief shifts in attention during the course of the eight-month treatment. I often reported them as incidental add-on comments to complement the actual session material; in truth, these experiences often shaped my observations and, on occasion, shaped particular interpretations I made to the patient.

My reverie about this patient contains themes of resistance and invincibility—shutting the windows to keep people out, if not by request then by force. In the daydream, the people being kept out perhaps want to have a place or position in the house, which, in the context of the therapy, could be viewed as the treatment room. In reality, I believe Maurice struggled with his wish to be in control of the treatment—deciding when to exit and yet hoping to remain in therapy and to engage in the therapeutic experience with me.

As a new therapist, I was intrigued by this additional 'data', wondering about the extent of its actual relevance to the treatment, or what might represent component parts of my own unresolved conflicts. Although the supervision helped bring focus to some of these moments, as products of my own anxiety about being new to this work, there were also occasions when my shifts in attention, and occasional daydreams, highlighted themes that

were being hinted at in the treatment but would also go unaddressed. For instance, during the first several intake sessions with this patient, I recognized that I had an unusual reaction to Maurice's height and physique. He was of above-average height; however, a rather tall woman myself, my sense was that he had to bend down to speak to me (he turned his head slightly to enter therapy rooms). I often felt he towered over me and used his height and girth to make an impact. In my mind, he might as well have been over a foot taller than me given my skewed sense of him. In reality, he was probably only five or six inches taller, so there was clearly something to the attention I gave to his physical presentation.

I noted several things about it: Focusing on his outer appearance highlighted how difficult it was to keep a sense of how he was actually doing outside the treatment. I had a difficult time capturing aspects of his inner emotional life, and, at times, I felt I had only a thin grasp on the quality of his interpersonal relationships. In session, he would often relate a number of bodily concerns about becoming weakened. These statements were quickly counterbalanced with intense wishes to be all-powerful. In sessions, he busily inflated his prowess with women and was consumed by a desire to be all-powerful, "crushing" people and things that annoyed him. I believe that Maurice's interest in larger-than-life characters (WWE wrestlers and numerous animated superheroes) and preoccupation with his own physical appearance stood in stark contrast to worries he had about his ability to ward off the mental and physical illnesses that befell his parents. Thus, if he could make himself larger than life then perhaps he could stave off reminders of his very humanness and of his mortality.

I think there were many ways I kept my patient and his history at bay because of my fears of engulfment, of not being sure how to help him accept the history of mental illness in his family, and of how to assuage his worries that he too might be institutionalized with "my parents' sick on me," as he would put it. I believe that the spouse out-of-view in my daydream represented my supervisor, who I tried to keep in the dark about my lack of confidence about treating the patient, and my worries that he was someone who could become dangerous. In part, I wanted to protect him from outsiders that did not know him, but because of our shared ethno-cultural background, I think I also sought to cover-up my fear of him so that it did not become the fodder for conversation about a threatening man with whom I feared being alone. I also think that the old woman might have represented his mother—long dead yet so alive in Maurice's life and his preoccupations about his own mental and physical health—who also needed to live more in the treatment. Here, I believe I colluded with Maurice to keep her out of the treatment because of our mutual concern about what her severe Axis I diagnosis might mean for him in the long term.

If I consider what came before this unbidden daydream, my association to his absence was that my patient was attempting to exit the treatment and that I was now the one to be alone. With several weeks to consider this part day-residue/part-fantasy, I had an opportunity to relate more empathically to the likely terror my patient experienced as part of coming to therapy. During and since this treatment, my hope for Maurice was that he might enjoy a full life with a realistic self-perception and with supportive and loving people around him whose caring he could count on and accept. But why would that be what he believed for himself given what his experiences had been heretofore? In allowing himself to trust me and the possibility that he was not destined to face his past and present alone, he

would have had to believe that what had happened before was not pre-programmed to happen again. The corrective experiences that might have come from an exploration of the themes and the corresponding emotions were interrupted far too soon for us both.

Therapeutic uses: How does it work?

> We started to talk a little bit about how therapists can work with this material with their patients, and you give them your sense of sort of what your process can be, or tends to be around processing your own experiences and even doing that with patients." (P11: DS300029+30.doc - 11:19 (244:244)) [DYN]

This interviewee was an outlier in this sample. Unlike most others, she reported that supervisors in her doctoral training program exhorted trainees to use more aspects of their own experience so as to expand the field on which to gather and process patient experiences. Not unlike that training program, study participants were asked not only to examine their perspectives on the role and meaning of these phenomena, but also to explore how they have come to have these points of views at all, and to report to what use have they put these notions and assumptions. Although this study was modest in size, the 18 participants were truly representative of key demographic trends among practicing doctoral level psychotherapists, including (a) similar proportion of males to females receiving PhDs in psychology (1:3 nationally versus 1:4 study) (Bailey 2004); (b) nearly identical percentages of PhD psychologists of African (5-6%), Latino (5-6%), Asian (4-5%), and Caucasian (>80%) descent (Bailey 2004) both in the US and in this sample; and (c) all seven major theoretical orientations—behavioral, cognitive-behavioral, existential-humanistic, interpersonal, psychodynamic, social learning, and systems—were represented among participants of the study; however, for proportion and comparison,

participants were grouped into the four categories that best represented the theoretical orientation that guided their current practice: cognitive-behavioral; dynamic; and integrative (a psychodynamic base with influences from most other orientations).

Therapists across orientations acknowledge unbidden experiences, and regard them as data to be used to understand patient conflicts, clinical impasses, progression of an ongoing treatment, complementary and concordant identifications with patients or supervisees, loss of empathic connection with a patient, and the state of patient resistances. Furthermore, there was agreement across orientations that a well-timed disclosure could be a powerful tool to have access to for therapists. Upon deliberation as to how these experiences have shaped therapeutic action in the treatment room, participants' direct use of unbidden experiences remained consistently high, with 17 of 18 subjects using these experiences to track communication with their patients; moreover, the therapists' perceived insights into shifts into unbidden experience became the basis for explicit disclosures based in the therapists' sense of the clinical utility for their patients, as well as the dyadic communication. A few therapists reported being surprised by their use of their own experiences directly with their patients; however, once again, clinical utility won out over concerns about impropriety or fears about being judged by or feeling vulnerable to patients.

This viewpoint prevailed, however, only when treatment relationships were viewed as secure. If these therapists felt that the stakes were high enough for their patients and for the therapeutic relationships, they were more likely to actively and directly disclose their reverie and unbidden experiences (and do so fully). Participants who reported concerns about negative appraisals from patients with whom they directly or indirectly used these

phenomena, eventually decided to risk possible pitfalls, especially if they had worked with a particular patient for extended periods.

One-quarter of participants felt compelled to seek help with these clinical moments from either contracted supervisors or in a peer supervision setting. The reasons were variable but centered around opportunities to shed one's self of guilt feelings and to have support from a fellow practicing therapist. In some instances, these supervisory experiences made it possible for the therapist to return the patient and discuss their own associative material, or keep on the look out for another moment to make a connection. More than half of the participants were very harsh with themselves even when they made a choice to use their shifts, and so it was difficult to always get an accurate read on whether any one of them was able to negotiate their ambivalence about disclosing to a productive end. Any choice in this matter continued to be significantly fraught for the bulk of the participants; that is, except for the two psychoanalysts discussed earlier. Neither seemed overly concerned with labeling their unbidden experiences or countertransferences as any more or less important than other occurrences in the total treatment situation and, thus, considered all material as up for exploration given their framework. Both analysts seemed most at ease with the contradictions and discomforts that arose in the therapy sessions they discussed, as well as managing any distress about the ambiguity of countertransference-type disclosures during the interview.

In sum, through the in-depth examination of these experiences, the majority of therapists made use of their reverie and other similar phenomena both out in the open and for their own personal and professional understanding. Uncovering the choices of words and phrases, and even the language of felt sense used to document and explain these

phenomena, represent potential guideposts to fellow clinicians on the 'roads' taken and not taken; well-worn and abandoned; and resurrected and knowingly departed from, all en route to a subtle yet distinct theoretical and practical sampling of therapeutic actions.

Engaging unconscious processes: Putting a felt sense into words

The limitlessness of our communications occurs without respect to time, at least as a linear measurement, both inside and out of the treatment room. Are we not still in conversation with our patients even after the hour has ended? We often think about them in the intervening days or week since our prior sessions, and we may occasionally choose to offer, in conversation, what happened that called them to mind. Engaging patients in this manner about an open line of communication from patient to therapist (outside of sessions) is in ambiguous territory, and each orientation offers its suggestions and prohibitions for its use. In this study, participant therapists were asked not only to reflect on their conscious communications with their patients—direct and indirect—but also to consider how they come to acknowledge and put words to a felt sense, or inkling, hovering outside the confines of consciously aware thoughts and stated interpretations. This was a difficult endeavor, as having such an unusual conversation with each participant did not always happen, due to certain limitations in this interviewer's manner of communicating on this topic. The times of greater success exploring the topic occurred when a genuine example was provided and explored, and a model for what could be discussed under this rubric was present and accessible to the participant-interviewer pair.

One participant—P 14, an integrative therapist who reported psychodynamic and mindfulness theories as working constructs in her therapeutic practice—described seeking help with a patient he had tremendous difficulty staying with during sessions and tried not

to think about once sessions were over. He reported that this fact was, in part, due to the patient's difficulties with movement and bodily pains but also because the patient's narrative had become repetitious and difficult to comprehend fully. From the outset, the therapist described an ominous sense that taking on the patient would require a lot of him and that "I needed to protect myself in some ways from the tremendous sort of need [there] because the patient was really very depressed and deeply isolated, and in physical pain." As he talked more about the patient, another aspect of the patient's life experience was that of sexual and racial traumas. Unlike with the past sexual abuse the patient endured, this participant had most trouble with the layered social quagmire of race in US culture and finding a place for the topic to reside in the treatment without the power of the systemic nature of race overpowering the other equally profound issues of the treatment. This was the only therapist to discuss race, the relevance of race to his patient and to their therapeutic relationship, and its commonality to the their dyad and between participant and this interviewer.

When P 14 realized he was taking mental leaves from his patient during sessions—"I felt justified like, 'God, I need a break,' so I'm giving it to myself"—he went to a peer supervisory group (a) to unpack the unsettled feelings ("one was self-reproach, but also thoughts like maybe she needs a different [therapist]") and (b) to grasp the meaning of the physical sickness that would overtake him during and after sessions.

> A cronopio receives his medical degree and opens a practice in the Calle Santiago de Estero. A patient arrives almost immediately and tells him how there are places that ache, and how he does not sleep at night and eats nothing during the day. 'Buy a large bouquet of roses', the cronopio tells him.

> The patient leaves, somewhat surprised, but he buys the bouquet and is instantly cured. Bursting with gratitude, he returns to the cronopio and not only pays him but—as a delicate testimonial—but he [also] presents him with a gift of a handsome bouquet of roses. He has hardly left the office when the cronopio falls ill, aches all over, cannot sleep at night and eats nothing during the day.
>
> (J. Cortazar, "Terapias" from *Historias de Cronopios y de Famas*, 1969)

Cortazar's story (see Appendix E for Spanish translation) humorously captures the symmetry and cyclical quality that is very much at the core of human experience as single beings and as a corpus. The impacts can be as expected or can come in forms unimagined, as in the case of the cronopio and his patient. One can imagine that this transfer of symptoms from the patient revealed to the doctor the extent of the patient's pain, while also providing the patient with relief and a belief that through this *transaction* he might be understood and even helped.

In the case of P 14 and his patient, the transactional quality to the upset the therapist experienced was partly what induced him to seek supervision.

> I owed her my attention, my full presence but [leaving] I think that it also helped me to be a little maybe to [get perspective]… Whenever I start thinking about CBT, like 'what worksheet I can hand to somebody?', I know that it's that I'm feeling at a loss and I want to do something. So I think on the one hand, there are those sort of little bit like self-castigating feelings, but on the other hand, I felt some kind of compassion for myself like this a tough situation and you're doing what you can do which is not necessarily the best way to handle it, but you're clearly, you need something too. And so how can you give yourself what you need. So this can be --

you can work this out. And that's also what part of what mindfulness is about, just sort of offering yourself some compassion in tough moments, instead of just adding insult to injury. (P 14: DS300034.doc – 14:4 (88:88)) [INT]

Having reversed course from "moving away" from the content and process of the shift in affective states to engaging with his patient around her physical and psychic torment, the therapist noted that he was able to access the needed empathic connection that allowed their work to extend beyond what the therapist had come to expect from their treatment relationship. Exploring the feelings associated with these depleting therapy sessions, helped the patient to feel that he (the therapist) understood (indeed, felt) her experience, and that she (the patient) had in fact reached him, even "gotten to him", as P 14 remarked.

To extend this theme, it is useful to consider all the actions that occur outside of awareness such that one's experience springs from one domain, passes through an unknown number of additional areas, before it arrives in the preconscious space where thought and language come to reside together. The theories about how the therapist acquires and later processes these formerly unconscious bits of data are many, but so are the ways that the therapist can translate and associate these experiences into something both he and the patient can connect to. If this all happens as it could, one cannot help but to recognize the amount of intricate work taking place inside, outside, and around these loci of representations, before actual words are even spoken. If true, this would mean that the participants' descriptions of "distractedness", "tiredness", "boredom", "uneven attention", and "go[ing] into myself… feels like I am leaving the patient" represent the derivatives of therapeutic communication. Of course, the uses are debatable; but that it signals us that

something is indeed bubbling up and becoming suddenly noticeable, as it emerges from some unknowable area of the unconscious, seems undeniable.

I propose that it is in the conveyance of affects and in the (co-) constructions of the therapist and patient together that each participant experiences aspects of their early, present, and (potentially) future selves in the presence of another. This 'experiencing' with the patient can release an untold number of boggling feelings in the therapist, some of which have been named herein, and discussed in the previous chapter under the emergence of unbidden experiences and therapists affective responses. The formulation of new points of departure in this area can be used to expand the frame(s) of clinical practice, supervision, and teaching, each of which were touched on at various points in these interviews and remained of particular interest and concern for this cohort of therapists. To use what the participants in this study offered as their own reasoned perspectives in this regard, "we" offer the following for all therapists' consideration when putting words to one's unbidden experiences, and later in choosing to use it to disclose directly to a patient, or in modeling for a patient how to use the therapist and the therapeutic relationship to its fullest extent:

1. Pay attention to what is not being said by your patient. Note what sounds to your ear as inauthentic, scripted, deadened. Often it is when the session material is in keeping with the therapist's expectations of what the patient has to offer that the therapist may notice their attention has shifted. Reveries, interior monologues, other unbidden experiences (some offered even sudden sleepiness) become more common during these moments and can be used as part of the corpus of session material.

2. Before making active use of any of these experiences, simply note what it is that has happened and when such that you are not able to keep with the flow of the patient's narrative (e.g. thoughts wander, list making, visual imagery). This is a normal aspect of healthy brain function and so it is not necessary to change anything. Be curious rather than being critical at this stage.
3. Depending on the emotional expression of the patient and the extent to which your current theoretical orientation privileges affective changes, track the typical emotional cadence and any alterations to it. Instead of relying mostly on words and observable behavior changes, try to connect with the rhythm of sessions and changes therein.
4. Rather than having as a goal to hold evenly hovering attention, instead develop a sliding back and forth motion. Though some will have better success with this, one's ability to maintain a healthy emotional distance while broadening the range of material therapists can attend to will allow clinicians to use themselves fully. To access the full range of possibility that reverie might allow, the therapist must be willing to drift along at times, to get side-tracked, and to become lost in order to also move toward feeling comfortable or feeling "on one's game" vis-à-vis the patient.
5. For advanced trainees, a key part of supervision will include working on experiencing more than listening. This will be particularly useful for all therapists who have been told to note, for instance, any breaks in continuity of session material as a sign of an area where patients may be experiencing conflict. Instead, from these interviews, comes the suggestion that where there is silence

or a paucity of language, the therapist performs best as the one who can help patient contain the unexplored experiences while slowing unpacking each one at a reasonable pace. By working through these life experiences within the transference, the therapist manages to stay reasonably close to the patient's own experiences, and thus runs a lower risk of feeling guilty (or at worse) being condemned by patients or colleagues for referencing their own experiences.

6. A call for the therapist's stance to be more transparent to the patient, with unbidden experiences described as products of the therapeutic work (or working through) that the patients and therapists are doing together. For the one-quarter of the sample that chose to use shifts into reverie, etc. to make only indirect disclosures, they conveyed a desire to maintain space (likely unconscious) for the convergence of both their subjective experiences. The gains would then come from the mutuality inherent in this therapy relationship, rather than the focus resting mainly on the contents and processes generated solely by the patient in a uniform therapy. By alerting the patient early in a treatment that part of your therapeutic stance is to draw on all manner of experience (including one's own, as therapist), therapist disclosure of unbidden experiences can be viewed as instinctive and thus an integral component of the modeling the therapist exemplifies with her patient, thus, making it permissible, of interest, and of import to venture into these areas of their own and shared experiences.

For both junior and senior therapists concerned about errors of omission, commission, self-indulgence, or partiality, I think the mistakes come more when one is out of practice with any acquired skill. An ethical and conscientious lot, therapists are greatly

concerned about monitoring their own subjectivity and biases in an effort to be the best, good-enough parents to their patients. Though it could be discomforting to have patients tell us that what we have offered them is not right or that we do not understand them at all, there are worse things than being wrong. The important lesson for patients and therapists alike is that freely admitting that we are going to make mistakes will hopefully alleviate us from the grip silence can have on us, and that can prevent us from effectively using our own subjectivity for positive impact.

Limitations of the current study

The chief limitation of this study was the small sample size. At the same time, although the sample size was small, it did allow for a selective, in-depth exploration of unbidden phenomena. Furthermore, it revealed a great deal about the experiences of the participants. However, due to the limits in sample size, results from this study cannot, without further research, be generalized to a larger population of therapists vis-à-vis their relationships with their patients. Another limitation of the small sample size is that men and women representing diverse backgrounds, including people of color, and openly gay, lesbian, bi-sexual, and trans-gendered people were not well represented in the sample. For this study, the homogeneity of the sample was actually helpful in determining trends precisely because the sample size was so small.

Another limitation of this study is that all of the data was collected, coded, and interpreted by the interviewer. This choice was made in order to emphasize self-reflexivity during each step of the process. However, multiple coders would have helped to establish inter-rater reliability and might have added additional perspectives to the interpretation of this data.

Suggestions for Future Research

An exploratory study, using a qualitative approach with a narrative-constructivist analysis was a significant feature of this research in that it allowed for the hypotheses to be created in vivo, based on the research interviewer's interpretation of the data collected rather than working from pre-set categorizations established by others external to the process. For future research, a larger sample would certainly improve the ability to discern patterns and trends in the narrative data. Future research also would benefit from the inclusion of a rating scale, with some forced choice items so that the qualitative approach employed here could be complemented by a more quantitative approach.

Appendix A. Semi-structured Interview

Dimensions of Experience—Shifts in Clinical Attention and Focus (DE-SCAF) Interview

[Start: *Before the interview proper, can you describe, in your own words, you clinical and theoretical orientation? Are there any theorists or practitioners who have been particularly relevant to how you work with patients? Briefly, can you give me a demographic breakdown of your patient population*?]

>>>In everyday life and in the treatment situation, sometimes something someone says provokes a particular train of thoughts or impressions that sparks a reverie in the therapist. Most therapists have had the experience where they notice that their attention has shifted from what the patient is saying and toward the thoughts that have been stirred. These shifts in our attention can be brief ruminations, wandering thoughts, daydreams, or fantasies.

1) Think about some of the times that this has happened in your practice. Can you tell me about some of these experiences?

   (After initial response) Please tell me more about one of these experiences, and any details you can recall:

   - What sparked the shift in your attention;
   - Who/what was it about;
   - Do you remember if you continued to follow what the patient was talking about;
   - What brought your awareness back to the patient;
   - Did you attempt to process the shift in attention in the moment or at any point later on; and

- How did you think about the content or the process of (fact of) the shift?

2) Next, tell me about the feelings you have had when you realized you had a shift in your attention. (If interviewee describes one feeling, be sure to ask about others.) [What is therapist's affective response—guilty, intrigued, etc? If the subject acknowledges one or the other feeling, ask 'when do you feel one or the other feeling with regard to shifts in attention?' I want to be able to understand how they conceive of it. Also, if they describe a positive experience, be sure to ask for times where they felt the experience was not positive or vice versa.]
    - How do you usually feel when this happens?
    - What influences when you feel good (or okay) about it and when you do not?
    - Do you notice whether you become more interested in either the content of or the process of the drift as a result of this shift in attention?

*[Here, explore range of experiences. Compile a list of these kinds of experiences: for example, the times when therapist has this experience and what they note about when it happens, and then list what the corresponding feelings are about the shifts in attention?]

3) Some therapists are more inclined than others to share information like this with patients and others would be unlikely to share their thoughts or processes with patients.
    - Where do you stand on this spectrum?
    - What is the basis or origin of that stance/position for you?
    - What do you then think (theoretically or conceptually) about the(se) shifts in attention?

4) I am also interested in your views on how therapists can work with this material with their patients.

- How do you explore and/or process these experiences either on your own, or with the patient(s)?
- Have there been times when you resisted sharing something of this content, or process, with your patient and it felt 'right,' or times when you did share something and that felt right?
- Conversely, are there times when you felt you made the 'wrong' choice to share something and you later regretted it, or when you felt you should have shared something but did not?

For those who express reluctance to share shifts in attention or similar countertransferential material with patients, ask

- Are there ever any occasions when you think you might tell a patient about some aspect of your experience in this area?

If 'absolutely not', test the limits.

- Have there ever been occasions where against your better judgment you did in fact share the content of a shift with a patient (either directly or as part of an interpretation)?

If 'no,'

- Did you ever feel that that was a missed opportunity?

For everyone:

- Thinking about either those occasions when you have shared or when you have not, take a moment to go back and think about those instances. When

did what you decided to do work well with the particular patient/dyad, and when did it not. Please provide examples.

5) Tell me about your experience of listening to session material.
    - In general, in your sessions, are there things you are more likely to listen for, or to hear more prominently in the course of a session than other things?
    - Tell me about the occasions when you become aware of any shift in your felt sense of session material. Can you describe the feelings when your patient(s) has brought up some material that sparks a shift in your attention, or shifts your clinical stance or your listening. How do think about/understand this phenomenon?

Appendix B: Demographic Information Form DE-SCAF Subject _____

Today's Date:

Age Range: (please check one)

40 to 50 __ 50 to 60 __ 60 to 70 __ 70 to 80 __

Highest Degree Attained: Year Degree Conferred:

Advanced Training (please circle) YES NO

Name of Institution: _____

Certificate Year:

How many years were you working toward this certification?

How many years have you been a licensed practitioner?

List the professional organizations with which you are affiliated or have membership.

Name	No. of Years
1.	
2.	
3.	
4.	
5.	

If you attend professional conferences, please name them with your dates of attendance

1.
2.
3.
4.

Please name the e-mail groups and list-serves in which you participate.

1.
2.
3.

Appendix C. Themed Groupings with all related codes

"How to" disclose shifts/reveries (directly)

[q2: reverie disclosed so as to connect interpretation to pt life experience]

[q2: reverie informs therapeutic use of self]

[q2: therapist belief that disclosure of reverie/shift can make a therapeutic difference for a patient]

[q2: therapist discloses interior monologue, etc. as a way to model for patient]

[q2: therapist discloses reverie/shift to pt after oppty for self-reflection or consultation with a colleague(s)]

[q2: therapist disclosure of reverie allows dyad to play with metaphor and apply it in/directly to pt experience]

[q2: therapist explores shift in the moment because of own affective response to material]

[q2: therapist feels job is to reflect on reverie as part of treatment]

[q2: therapist implements decision tree(s) to guide interventions]

[q2: therapist is transparent with pt about when a disclosure feels like a mistake, as it can be positive experience for pt to discuss with therapist]

[q2: therapist sees value in using reverie to test a 'hunch' with pt if it seems it could help pt]

[q2: therapist shares reverie based on relationships with patient and knowledge of patient capacity to work with material coming from therapist]

[q2: therapist shares reveries with patients]

[q2: therapist tentatively shares reverie out of concern for doing a disservice to pt by not saying something]

[q2: understanding associations from own life or other patients can be meaningful]

"How to" use shifts/reverie as data to make indirect disclosures

[q2: therapist belief that clinical utility of reverie is determined by whether therapist can make sense of material and its applicability]

[q2: therapist belief that disclosure of reverie/shift can make a therapeutic difference for a patient]

[q2: therapist disclosure of reverie allows dyad to play with metaphor and apply it in/directly to pt experience]

[q2: therapist feels job is to reflect on reverie as part of treatment]

[q2: therapist implements decision tree(s) to guide interventions]

[q2: therapist orientation and therapist awareness of experience of reverie differ from feelings evoked by reverie]

[q2: therapist sees value in using reverie to test a 'hunch' with pt if it seems it could help pt]

[q2: therapist shares with patient a version of reverie without disclosing it as anything other than a thought]

[q2: therapist uses understanding of reverie to conceptualize and explore patient's resistances/unconscious processes]

[q2: therapist weighs/contrasts theoretical beliefs with clinical utility of reverie/shifts]

[q2: therapist willing to disclose a life experience or a feeling; RARELY willing to disclose reveries or shifts in attention]

[q2: therapist/pt mine therapist experience so as to understand therapeutic process at work in dyad]

A new idea or further clarification of an old one that impacts practice and/or teaching

[q3: 'new information'/uncommon content of reverie focuses therapist's attention]

[q3: less likely to have reverie if empathic tie is strong; more likely to drift toward internal experiences if pt is disconnected in some way]

[q3: less likely to reference on own internal experience and more likely to focus in on session content and pt experiences]

[q3: sensation of tension and relief related to accessing reveries and/or being available to have such experience]

[q3: therapist describes quality of communication when close to something emergent]

[q3: therapist experiences shift as a "coming together"-- a "Gestalt" shift]

[q3: therapist registers boredom as sleepiness]

[q3: understanding associations from own life or other patients can be meaningful] [q4: therapeutic action determined in part by therapist's orientation and by desire for pt to integrate warded off experiences]

[q4: therapist as supervisor encourages trainees to use shifts/reveries/drifts with pts]

A personal dimension to reverie for therapist

[q1: oddity noted as moving toward seemingly non-clinical material]

[q1: reverie described as a retreat inward]

[q1: shift CANNOT be characterized as mostly about the patient]

[q1: shift/reveries feels self-indulgent]

[q1: therapist feels she should be more present after shift in attention]

[q1: therapist quiets herself down during a session when she feels anxious]

[q2: therapist cannot move beyond CT reaction and is unable to refocus on patient] [q3: sense of fear/concern felt when considering sharing inner experience with patient]

[q3: understanding associations from own life or other patients can be meaningful]

<u>As communication, on multiple levels</u>

[q1: interior monologue]

[q1: Make a mental note of shift so that one can return to session material]

[q1: reverie as a coalescence of brain activities and functions within a dyad]

[q1: reverie as communication]

[q1: reverie described almost as (by) product of the dyad]

[q1: reverie described as a retreat inward]

[q1: reverie described as a telepathic experience]

[q1: reverie described as hypnagogic imagery]

[q1: shift described as therapist querying self about experience of pt]

[q1: therapist's shift into reverie will eventually manifest from patient]

[q2: 'mutuality of communication creates "symmetry"]

[q2: communication between therapist and pt occurs on multiple levels]

[q2: reverie is a communication that has value but cannot be fully accessed]

[q3: therapist describes quality of communication when close to something emergent]

As phenomenological data to be used directly with patient

[q2: associations help figure out what something means]

[q2: associations help when therapist allows self to "follow" the shift/reverie]

[q2: exploring move away from material with pt with whom it feels safe to do so] [q2: reverie disclosed so as to connect interpretation to pt life experience]

[q2: reveries inform therapist about progress of treatment]

[q2: reveries offer diagnostic information]

[q2: therapist's experience uncovers complementary identification]

[q2: therapist's experience uncovers concordant identification]

[q2: therapist's values conflict with patient and therapist loses empathic connection to pt]

[q2: therapist can sometimes move beyond CT reaction and refocus on patient]

[q2: therapist cannot move beyond CT reaction and is unable to refocus on patient] [q2: therapist discloses with trepidation because of pt's potential judgment of therapist and shame that might accompany it]

[q2: therapist disclosure of reverie allows dyad to play with metaphor and apply it in/directly to pt experience]

[q2: therapist uses understanding of reverie to conceptualize and explore patient's resistances/unconscious processes]

[q2: therapist/pt mine therapist experience so as to understand therapeutic process at work in dyad]

[q2: understanding associations from own life or other patients can be meaningful] [q3: 'new information'/uncommon content of reverie focuses therapist's attention] [q3:

therapist's association sometimes viewed as provocation from patient about session content or therapy proper]

As phenomenological data to be used in support of the treatment goals (not specifically direct pt intervention)

[q2: "checking out" and moving away from content is 'self-protective"]

[q2: associations help figure out what something means]

[q2: associations help when therapist allows self to "follow" the shift/reverie]

[q2: reveries inform therapist about progress of treatment]

[q2: reveries offer diagnostic information]

[q2: shift is due to inauthentic discourse from/with pt]

[q2: therapist's experience uncovers complementary identification]

[q2: therapist's experience uncovers concordant identification]

[q2: therapist belief that clinical utility of reverie is determined by whether therapist can make sense of material and its applicability]

[q2: therapist can sometimes move beyond CT reaction and refocus on patient]

[q2: therapist cannot move beyond CT reaction and is unable to refocus on patient] [q2: therapist experiences shift/reverie when she feels angry or pushed away]

[q2: Therapist takes content/process of shifts/reveries to supervision or seeks consultancy so as to get additional perspective]

[q2: therapist uses understanding of reverie to conceptualize and explore patient's resistances/unconscious processes]

[q2: understanding associations from own life or other patients can be meaningful] [q3: 'new information'/uncommon content of reverie focuses therapist's attention] [q3: sense of fear/concern felt when considering sharing inner experience with patient]

[q3: therapist's association sometimes viewed as provocation from patient about session content or therapy proper]

[q3: therapist registers boredom as sleepiness]

[q3: understanding associations from own life or other patients can be meaningful]

Description of shift/reverie burgeoning

[q1: ability to identify reverie/shift as it is happening]

[q1: description of shifts as making treatment 'more vivid']

[q1: oddity noted as moving toward seemingly non-clinical material]

[q1: reverie described as a telepathic experience]

[q1: reverie described as hypnagogic imagery]

[q1: the content and what it "stirs up" sparks shift in attention]

[q3: sensation of tension and relief related to accessing reveries and/or being available to have such experience]

[q3: therapist describes experience of reverie/shift where there is a change in visual field: therapist sees things differently]

[q3: therapist experiences shift as a "coming together"-- a "Gestalt" shift]

Full disclosure of reverie/shifts: Active, therapeutic use of self

[q2: exploring move away from material with pt with whom it feels safe to do so] [q2: reverie containing erotic material can be shared but with respect and needed contextualization]

[q2: reverie disclosed so as to connect interpretation to pt life experience]

[q2: reverie is explored in the moment as it unfolds so as to make use of it]

[q2: therapist determines disclosure of reverie based on patient's ego strength]

[q2: therapist discloses interior monologue, etc. as a way to model for patient]

[q2: therapist discloses judgment of pt based on therapist's own value system]

[q2: therapist discloses reverie/shift to pt after oppty for self-reflection or consultation with a colleague(s)]

[q2: therapist discloses with trepidation because of pt's potential judgment of therapist and shame that might accompany it]

[q2: therapist disclosure of reverie allows dyad to play with metaphor and apply it in/directly to pt experience]

[q2: therapist explores shift in the moment because of own affective response to material]

[q2: therapist feels must disclose shift/reverie even though feels uncomfortable] [q2: therapist implements decision tree(s) to guide interventions]

[q2: therapist is transparent with pt about when a disclosure feels like a mistake, as it can be positive experience for pt to discuss with therapist]

[q2: therapist sees value in using reverie to test a 'hunch' with pt if it seems it could help pt]

[q2: therapist shared reverie/shift with patient, felt later that shouldn't have shared it, and decided probably shouldn't have after all]

[q2: therapist shares reverie based on rels with patient and knowledge of patient capacity to work with material coming from therapist]

[q2: therapist shares reveries with patients]

[q2: therapist willing to disclose a life experience or a feeling]

[q2: therapist/pt mine therapist experience so as to understand therapeutic process at work in dyad]

Words and phrases to name unbidden experiences

[q1: "allow myself to check out"]

[q1: "went off"/" moving away"/"drift away" from clinical material]

[q1: attention 'wanders' or "is wandering"]

[q1: interior monologue]

[q1: list making]

[q1: not Ogden's reverie]

[q1: useful data]

Negative valence to description of reverie

[q1: concern that shifts in attention will spark even more]

[q1: description of shift in focus evoking guilt feelings]

[q1: negative association to shifts in focus]

[q1: shift/reveries feels self-indulgent]

[q2: therapist cannot move beyond CT reaction and is unable to refocus on patient] [q2: therapist feels bad about shift in attention when she gets stuck there]

[q2: therapist feels role is impacted negatively by certain CT reactions to pt/pt material]

Positive valence to descriptions of reveries

[q1: description of shifts as making treatment 'more vivid']

[q1: positive association to shift in attention]

[q2: associations help when therapist allows self to "follow" the shift/reverie]

[q2: therapist is transparent with pt about when a disclosure feels like a mistake, as it can be positive experience for pt to discuss with therapist]

[q2: therapist regards some reveries as superego supports: 'internalized supervisor' that helps guide therapist]

[q2: understanding associations from own life or other patients can be meaningful] [q4: therapist has remarkable reverie experience that mirrors patient's association or dream]

Felt sense of this phenomena offers therapist unique point of entry in uncovering dyadic communication

[q2: therapist functionality becomes constricted when certain CT gets evoked]

[q3: sense of fear/concern felt when considering sharing inner experience with patient]

[q3: therapist describes experience of reverie/shift where there is a change in visual field: therapist sees things differently]

[q3: therapist describes quality of communication when close to something emergent]

[q3: therapist experiences shift as a "coming together"-- a "Gestalt" shift]

[q3: therapist registers boredom as sleepiness]

[q4: therapist sees a continuum of affective experience that get staged across interpersonal rels]

Shifts/reverie as self or self:other exchange of information

[q1: reverie as communication]

[q1: reverie described almost as (by) product of the dyad]

[q1: reverie described as a retreat inward]

[q1: reverie described as a telepathic experience]

[q1: reveries with sexual material are information to be understood]

[q1: shift/reverie described as private thought made public]

[q1: therapist's shift into reverie will eventually manifest from patient]

[q2: communication between therapist and pt occurs on multiple levels]

[q2: exploring move away from material with pt with whom it feels safe to do so] [q2: reverie disclosed so as to connect interpretation to pt life experience]

[q2: reverie informs therapeutic use of self]

[q2: reverie is a communication that has value but cannot be fully accessed]

[q2: reveries inform therapist about progress of treatment]

[q2: reveries offer diagnostic information]

[q2: shift is due to inauthentic discourse from/with pt]

[q2: some shifts in attention for therapist use only]

[q2: therapist's experience uncovers complementary identification]

[q2: therapist's experience uncovers concordant identification]

[q2: therapist belief that disclosure of reverie/shift can make a therapeutic difference for a patient]

[q2: therapist can sometimes move beyond CT reaction and refocus on patient]

[q2: therapist cannot move beyond CT reaction and is unable to refocus on patient] [q2: therapist determines disclosure of reverie based on patient's ego strength]

[q2: therapist discloses interior monologue, etc. as a way to model for patient]

[q2: therapist discloses judgment of pt based on therapist's own value system]

[q2: therapist discloses reverie/shift to pt after oppty for self-reflection or consultation with a colleague(s)]

[q2: therapist discloses with trepidation because of pt's potential judgment of therapist and shame that might accompany it]

[q2: therapist disclosure of reverie allows dyad to play with metaphor and apply it in/directly to pt experience]

[q2: therapist explores shift in the moment because of own affective response to material]

[q2: therapist functionality becomes constricted when certain CT gets evoked]

[q2: therapist implements decision tree(s) to guide interventions]

[q2: therapist is concerned that revealing her reveries will restrict patient's freedom to use her]

[q2: therapist is distracted by material from previous sessions and listens for it]

[q2: therapist is helped by mindfulness practice as it leads to greater awareness in shifts in attention]

[q2: therapist is not inclined to share reverie with patients]

[q2: therapist is transparent with pt about when a disclosure feels like a mistake, as it can be positive experience for pt to discuss with therapist]

[q2: therapist limits use of shifts out of concern for making 'wrong' choice/ intervention]

[q2: therapist ponders the reverie yet feels his job is to stay close to pt's experience] [q2: therapist realizes she is thinking about another patient's parallel story]

[q2: therapist reflects on reverie after session as sometimes more mental room because sessions can be so full of material]

[q2: therapist regards some reveries as superego supports: 'internalized supervisor' that helps guide therapist]

[q2: therapist sees value in using reverie to test a 'hunch' with pt if it seems it could help pt]

[q2: therapist shared reverie/shift with patient, felt later that shouldn't have shared it, and decided probably shouldn't have after all]

[q2: therapist shares reverie based on rels with patient and knowledge of patient capacity to work with material coming from therapist]

[q2: therapist shares reveries with patients]

[q2: therapist shares with patient a version of reverie without disclosing it as anything other than a thought]

[q2: Therapist takes content/process of shifts/reveries to supervision or seeks consultancy so as to get addl perspective]

[q2: therapist tentatively shares reverie out of concern for doing a disservice to pt by not saying something]

[q2: therapist uses understanding of reverie to conceptualize and explore patient's resistances/unconscious processes]

[q2: therapist weighs/contrasts theoretical beliefs with clinical utility of reverie/shifts]

[q2: therapist willing to disclose a life experience or a feeling]

[q2: therapist willing to disclose a life experience or a feeling; RARELY willing to disclose reveries or shifts in attention]

[q2: therapist/pt mine therapist experience so as to understand therapeutic process at work in dyad]

[q2: understanding associations from own life or other patients can be meaningful] [q3: 'new information'/uncommon content of reverie focuses therapist's attention] [q3: less likely to have reverie if empathic tie is strong; more likely to drift toward internal experiences if pt is disconnected in some way]

[q3: less likely to reference on own internal experience and more likely to focus in on session content and pt experiences]

[q3: sense of fear/concern felt when considering sharing inner experience with patient]

[q3: sensation of tension and relief related to accessing reveries and/or being available to have such experience]

[q3: therapist's association sometimes viewed as provocation from patient about session content or therapy proper]

[q3: therapist describes experience of reverie/shift where there is a change in visual field: therapist sees things differently]

[q3: therapist describes quality of communication when close to something emergent]

[q3: therapist experiences shift as a "coming together"-- a "Gestalt" shift]

[q3: therapist registers boredom as sleepiness]

[q3: understanding associations from own life or other patients can be meaningful] [q4: therapist's thoughts move away from pt because senses flow of session content] [q4: therapist as supervisor encourages trainees to use shifts/reveries/drifts with pts]

Theoretical understanding

[q1: describes reverie as 'an association"]

[q1: description of reverie as part of transference/countertransference interplay] [q1: description of reverie experience by stating what it is not]

[q1: interior monologues that allow therapist to move away from anger and aggression and toward humor]

[q1: reverie is experienced as occurring in semi-conscious state]

[q1: reverie as a coalescence of brain activities and functions within a dyad]

[q1: reverie as communication]

[q1: reverie described almost as (by) product of the dyad]

[q1: reverie described as a retreat inward]

[q1: reverie described as a telepathic experience]

[q1: reverie described as hypnagogic imagery]

[q1: reverie is commonplace; norm not the exception for analytic therapists]

[q1: reverie or shift described as a central metaphor or encapsulating a patient's struggle]

[q1: reveries with sexual material are information to be understood]

[q1: shift CANNOT be characterized as mostly about the patient]

[q1: shift described as therapist querying self about experience of pt]

[q1: shift/reverie described as private thought made public]

[q1: shifts in attention are NOT the same as drifts]

[q1: shifts in attention/focus toward diagnostic questions]

[q1: shifts in focus that move toward associations help maintain connection to patient]

[q1: some shifts in attention are about boredom]

[q1: the content and what it "stirs up" sparks shift in attention]

q1: therapist's shift into reverie will eventually manifest from patient]

[q1: therapist is "always listening" with "evenly hovering attention"]

[q2: 'mutuality of communication creates "symmetry"]

[q2: communication between therapist and pt occurs on multiple levels]

<u>Therapist attends to own reveries/shifts/associations and corresponding affective response to them</u>

[q1: therapist quiets herself down during a session when she feels anxious]

[q2: therapist can sometimes move beyond CT reaction and refocus on patient]

[q2: therapist cannot move beyond CT reaction and is unable to refocus on patient] [q2: therapist discloses with trepidation because of pt's potential judgment of therapist and shame that might accompany it]

[q2: therapist orientation and therapist awareness of experience of reverie differ from feelings evoked by reverie]

[q2: therapist reflects on reverie after session as sometimes more mental room because sessions can be so full of material]

[q2: therapist shared reverie/shift with patient, felt later that shouldn't have shared it, and decided probably shouldn't have after all]

[q3: less likely to have reverie if empathic tie is strong; more likely to drift toward internal experiences if pt is disconnected in some way]

[q3: less likely to reference on own internal experience and more likely to focus in on session content and pt experiences]

[q3: sense of fear/concern felt when considering sharing inner experience with patient]

[q3: sensation of tension and relief related to accessing reveries and/or being available to have such experience]

[q3: therapist describes experience of reverie/shift where there is a change in visual field: therapist sees things differently]

[q3: therapist describes quality of communication when close to something emergent]

[q3: therapist experiences shift as a "coming together"-- a "Gestalt" shift]

[q3: therapist registers boredom as sleepiness]

[q4: therapist has remarkable reverie experience that mirrors patient's association or dream]

<u>Therapist identifies challenges associated with reveries but that still have bearing on therapeutic practice</u>

[q1: interior monologues that allow therapist to move away from anger and aggression and toward humor]

[q1: shift CANNOT be characterized as mostly about the patient]

[q1: shift described as therapist querying self about experience of pt]

[q1: shift/reverie described as private thought made public]

[q1: therapist feels she should be more present after shift in attention]

[q2: attention is disrupted when therapist identifies with patient material]

[q2: therapist's values conflict with patient and therapist loses empathic connection to pt]

[q2: therapist can sometimes move beyond CT reaction and refocus on patient]

[q2: therapist cannot move beyond CT reaction and is unable to refocus on patient] [q2: therapist experiences shift/reverie when she feels angry or pushed away]

[q2: therapist feels bad about shift in attention when she gets stuck there]

[q2: therapist feels must disclose shift/reverie even though feels uncomfortable] [q2: therapist feels role is impacted negatively by certain CT reactions to pt/pt material]

[q2: therapist finds less 'space' for attention to reverie in acute care as compared to private practice]

[q2: therapist functionality becomes constricted when certain CT gets evoked]

[q2: therapist weighs/contrasts theoretical beliefs with clinical utility of reverie/shifts]

[q3: sense of fear/concern felt when considering sharing inner experience with patient]

[q3: therapist's association sometimes viewed as provocation from patient about session content or therapy proper]

Understanding of experience tied to feelings/emotions

[q1: concern that shifts in attention will spark even more]

[q1: description of reverie as part of transference/countertransference interplay] [q1: description of shift in focus evoking guilt feelings]

[q1: identify shift in attention via feeling states]

[q1: interior monologues that allow therapist to move away from anger and aggression and toward humor]

[q1: negative association to shifts in focus]

[q1: positive association to shift in attention]

[q1: reverie is experienced as occurring in semi-conscious state]

[q1: shift/reveries feels self-indulgent]

[q1: therapist feels she should be more present after shift in attention]

[q1: therapist is reminded of another patient whose story is "parallel"]

[q1: therapist quiets herself down during a session when she feels anxious]

[q2: "checking out" and moving away from content is 'self-protective"]

[q2: affective response can create shift in attention]

[q2: attention is disrupted when therapist identifies with patient material]

[q2: therapist feels bad about shift in attention when she gets stuck there]

[q2: therapist feels must disclose shift/reverie even though feels uncomfortable]

<u>Veiled disclosures of reverie/shifts: impacts interpretation, queries & remarks, overall therapeutic action</u>

[q2: therapist ponders the reverie yet feels his job is to stay close to pt's experience] [q2: therapist shares with patient a version of reverie without disclosing it as anything other than a thought]

[q2: Therapist takes content/process of shifts/reveries to supervision or seeks consultancy so as to get addl perspective]

[q2: therapist uses understanding of reverie to conceptualize and explore patient's resistances/unconscious processes]

[q2: therapist willing to disclose a life experience or a feeling; RARELY willing to disclose reveries or shifts in attention]

Appendix D. Compendium of words/phrases used to describe unbidden experiences

Checked out	Stuck	Hopeless
Good	Don't like it	Repelled
Discomfort	Sleepy	Unsafe
Compromised	Not good	Alert
Guilty	Bad	Mixed
Right	Bored	Fine
Different	Feels dead	Responsible
Scary	Intimate	Paralyzed
Unrelated	Confused	Not good enough
Attentive	Lost	Surprised
Can't tolerate it	Caught up	Interested
Overcome	Bizarre	Compelled
Sad	Agitated	Do not open this up
Angry	Uncomfortable	Full
Distressed	Not functioning	Lonely
Great	Engaged	Tired
Boiling up inside	Unbalanced	Isolated
Wrong	Triggering an affect in me	Embarrassed
Pleased	Overwhelmed	Self-indulgent
Anxious	Confused	Curious
Joy	Lost	Terribly distracted
Related	Distant	

Appendix E. Spanish language version of "Therapies"

Terapias

Un cronopio se recibe de médico y abre un consultorio en al calle Santiago del Estero. En seguida viene un enfermo y le cuenta cómo hay cosas que le duelen y cómo de noche no duerme y de día no come.

-'Compre un gran ramo de rosas'- dice el cronopio.

El enfermo se retira sorprendido, pero compra el ramo y se cura instantáneamente. Lleno de gratitud acude al cronopio, y además de pagarle le obsequia, fino testimonio, un hermoso ramo de rosas. Apenas se ha ido el cronopio cae enfermo, le duele por todos lados, de noche no duerme y de día no come.

Julio Cortázar, para "Historias de Cronopios y de Famas"

References

Alexander, F. (1956). *Psychoanalysis and psychotherapy.* New York, NY: Norton.

Arlow, J.A. (1980). The genesis of interpretation. In *Psychoanalytic Explorations of Technique: Discourse on the Theory of Therapy*. H.P. Blum, (Ed.). pp. 193-206. New York, NY: International Universities Press.

Arlow, J.A. (1986). Discussion of transference and countertransference with the difficult patient. In *Between analyst and patient: New dimensions in countertransference and transference*. H.C. Myers, (Ed.). pp. 75-86. Hillsdale, NJ: The Analytic Press.

Aron, L. (1990). One-person and two-person psychologies and the method of psychoanalysis. *Psychoanalytic. Psychology, 7*: 475-435.

Aron, L. (1991). The patient's experience of the analyst's subjectivity. *Psychoanalytic Dialogues, 1*:29-51.

Aron, L. (1996). *A meeting of minds: Mutuality in psychoanalysis*. Hillsdale, NJ: The Analytic Press.

Balint, A., and Balint, M. (1939). On transference and counter-transference. *International Journal Psychoanalysis 20*:223-230.

Barrett, M., & Berman, J. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology, 69*:597-603.

Beebe, B. & Lachmann, F.M. (1998). Co-constructing inner relational processes: Self- and mutual regulation in infant research and adult treatment. *Psychoanalytic Psychology* 15: 480-516.

Benjamin, J. (1988). *The bonds of love: psychoanalysis, feminism, and the problem of domination*. New York, NY: Pantheon Books.

Berman, L. (1949). Countertransference and attitudes of the analyst in the therapeutic process. *Psychiatry, 12*:159-66.

Bion, W.R. (1970). *Attention and Interpretation*. London, UK: Heinemann.

Bloomgarden, A. & Mennuti, R., Eds. (2009). *Therapists speak bout self-disclosure in psychotherapy*. New York, NY: Routledge.

Bollas, C. (1983). *Expressive uses of the countertransference*. New York, NY: William Alanson White Institute.

Bollas, C. (1987). *The shadow of the object. Psychoanalysis of the unthought known*. New York, NY: Cambridge University Press.

Bromberg, P. M. (1998). *Standing in the spaces: Essays on clinical process, trauma, and dissociation*. Hillsdale, NJ: The Analytic Press.

Cohen, M. (1952). Countertransference and anxiety. *Psychiatry 15*:231-243

Cortazar, J. (1969). *Historias de Cronopios y de Famas*. Translated from Spanish by Paul Blackburn. New York, NY: Pantheon Books.

Deutsch, H. (1942). Some forms of emotional disturbance and their relationship to schizophrenia. *Psychoanalytic Quarterly 11*:301-321

Ehrenberg, D. B. (1992). *The intimate edge*. New York, NY: Norton.

Ehrenberg, D.B. (1995). Self-disclosure: Therapeutic Tool Or Indulgence?—Countertransference Disclosure. *Contemporary Psychoanalysis 31*:213.

Fairbairn, W. R. D. (1952c). Schizoid factors in the personality. In R. W. D. Fairbairn, *Psycho-analytic studies of the personality* (pp. 3-27). London, UK: Routledge. (Original work

published 1940)

Ferenczi, S. & Rank, O. (1924). *The Development of Psychoanalysis*. Madison, CT: International University Press.

Ferenczi, S. (1950). On the Technique of Psychoanalysis In *Further contributions to the theory and technique of psychoanalysis*. London, UK: Hogarth Press.

Fliess, Robert. (1953). Countertransference and counteridentification. *Journal of the American Psychoanalytic Association*. *1*: 268-284.

Frank, K. A. (1997). The role of the analyst's inadvertent self-revelations. *Psychoanalytic Dialogues, 7*: 281–314.

Frank, K. A. (1999). *Psychoanalytic participation: Action, interaction, and integration*. New York, NY: Analytic Press.

Freud, S. (1910). *The future prospects of psycho-analytic therapy*. Standard Edition 11. London, UK: Hogarth Press.

Freud, S. (1912). *Recommendations to physicians practicing psychoanalysis*. Standard Edition 12. London, UK: Hogarth Press.

Gill, M.M. (1982). Analysis of Transference I: Theory and Technique. New York: International Universities Press.

Gill, M.M. (1983). The interpersonal paradigm and the degree of the therapist's involvement. *Contemporary Psychoanalysis 19*: 200-237.

Glover, E. (1927). Lectures on technique in psychoanalysis. *International* Journal *Psycho-Analysis 8*:311-38.

Green, A. (1997). The intuition of the negative in playing and reality. *International Journal of Psychoanalysis, 78*:1071-1084

Green, A. (1998). The primordial mind and the work of the negative. *International Journal of Psychoanalysis, 79*:649-665

Greenberg, J.R. & Mitchell, S.A. (1983). *Object relations in psychoanalytic theory*. Cambridge, MA: Harvard University Press.

Grotstein, J. (2000). *Who is the dreamer who dreams the dream? A study of psychic presences.* Hillsdale, NJ: The Analytic Press.

P. Heimann (l950). On countertransference. *International Journal of Psychoanalysis 31*:81-84.

Hill, C., Mahalik, J., & Thompson, B. (1989). Therapist Self-Disclosure. *Psychotherapy,* 26: 290-295.

Hirsch, I. (1987). Varying modes of analytic participation. *Journal American Academy of Psychoanalysis,* 15: 205-222.

Hoffman, I.Z. (1983). The patient as interpreter of the analyst's experience. *Contemporary Psychoanalysis, 19*: 389-422.

Jacobs, T.J. (1991). *The use of the self: Countertransference and communication in the analytic situation*. Madison, CT: International Universities Press, Inc.

Jacobs, T. (1995). On the question of self-disclosure by the analyst: error or advance in technique. *Psychoanalytic Quarterly, 68*: 159-183.

Joseph, B. (1989). Transference: the total situation. In *Psychic Equilibrium and Psychic Change: Selected Papers.* London, UK: Routledge.

Kohut, H. (1971). *The Analysis of the Self*. New York, NY: International Universities Press.

Little, M. (1951). Counter-transference and the patient's response to it. *International Journal Psycho-Analysis, 33*: 32-40.

Loewald, H.W. (1960). On the therapeutic action of psycho-analysis. *International Journal of Psychoanalysis, 41*:16-33

Loewald, H.W. (1986). Transference-countertransference. *Journal American Psychoanalytic Association, 34*:275-287.

Mancia, M. (2006). Implicit memory and early unrepressed unconscious: Their role in the therapeutic process. *International Journal Psychoanalysis, 87*:83–103

Matte Blanco, I. (1975). *The unconscious as infinite sets: An essay in bi-logic*. London, UK: Duckworth.

Matte Blanco, I. (1988). *Thinking, feeling, and being: Clinical reflections on the fundamental antinomy of human being and world*. New York, NY: Routledge.

Maroda, K. (1991). *The power of countertransference*. Chichester: Wiley. Reprinted in paperback (1995), Northvale, NJ: Jason Aronson.

Maroda, K. (1995). Projective identification and countertransference interventions: Since feeling is first. *Psychoanalytic Review, 82*:229–247.

McLaughlin, J.T. (1981). Transference, psychic reality, and countertransference. *Psychoanalytic Quarterly, 50*: 639-664.

Mitchell, S. (1988). *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press.

Ogden, T.H. (1979). On projective identification. *International Journal Psycho-Analysis, 60*:357-373.

Ogden, T.H. (1985). On potential space. *International Journal Psycho-Analysis, 66*:129-141.

Ogden, T.H. (1986). *The matrix of the mind: Object relations and the psychoanalytic dialogue*. Northvale, NJ & London, UK: Jason Aronson.

Ogden, T.H. (1989). *The primitive edge of experience*. Northvale, NJ: Aronson.

Ogden, T. (1994). *Subjects of analysis*. Northvale, NJ: Aronson.

Ogden, T.H. (1997). Reverie and interpretation: Sensing something human. Northvale, NJ: Aronson.

Polanyi, M. (1967). *The Tacit Dimension*. Garden City, NY: Doubleday & Co., Inc.

Racker, H. (1953). A contribution to the problem of counter-transference. *International Journal Psychoanalysis 34*:313-324.

Racker, H. (1957). The meanings and uses of countertransference. *Psychoanalytic Quarterly 26*:303-357.

Racker, H. (1968). *Transference and countertransference*. New York: International Universities Press.

Reich, A. (1951). On counter-transference. *International Journal Psychoanalysis 32*:25-31.

Reich, A. (1960). Further remarks on counter-transference. *International Journal Psycho-Analysis 41*:389-395.

Reik, T. (1948). *Listening with the third ear: The inner experience of a psychoanalyst*. New York, NY: Farrar, Straus.

Renik, O. (1993a). Analytic interaction: Conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly, 62*: 553-571.

Renik, O. (1993b). Countertransference enactments and the psychoanalytic process. In *Psychic structure and psychic change*. M. Horowitz, O. Kernberg & E. Weinshel (Eds.). pp. 135-158. New York, NY: International Universities Press.

Renik, O. (1996). The Perils Of Neutrality. *Psychoanalytic Quarterly, 65*:495-517

Renik, O. (1999). Playing one's cards face up in analysis: An approach to the problem of self-disclosure. *Psychoanalytic Quarterly, 68*: 521-539.

Renik, O. (2006). *Practical psychoanalysis for therapists and patients*. New York, NY: Other Press.

Sandler, J. (1976), Countertransference and role-responsiveness. *International Journal Psycho-Analysis, 3*: 43-47.

Searles, H. F. (1975). The patient as therapist to his analyst. In *Countertransference and related subjects*. pp. 380-459. New York, NY: International Universities Press.

Singer, E. (1977). The fiction of analytic anonymity. In The Human Dimension in Psychoanalytic Practice. K. Frank, (Ed). pp. 181-192. New York, NY: Grune & Stratton.

Stern, A. (1924). On countertransference in psychoanalysis. *Psychoanalytic Review, 2*:166-174

Stern, D.N. (1985). *The interpersonal world of the infant*. New York, NY: Basic Books.

Stern, D.B. (1997). Unformulated experience. In *Dissociation to imagination in psychoanalysis*. Hillsdale, NJ: The Analytic Press.

Summers, F. (2000). The analyst's vision of the patient and therapeutic action. *Psychoanalytic Psychology, 17*:547-564

Tansey, M. and Burke, W. (1989) *Understanding countertransference: From projective identification to empathy*. Hillsdale, NJ: Analytic Press.

Tauber, E. S. (1952). Observations on Counter-Transference Phenomena: The Supervisor-Therapist Relationship. Samiksa 6:220-228

Tauber, E. S. & Green, M. R. (1959). *Prelogical experience*. New York, NY: Basic Books.

Tower, L.E. (1956). Countertransference. *Journal American Psychoanalytic Association, 4:* 224-255.

Wachtel, P. L. (1981). Transference, schema, and assimilation: The relevance of Piaget to the psychoanalytic theory of transference. In P. L. Wachtel, (Ed.), *Action and insight*. New York, NY: Guilford.

Wachtel, P. L. (Ed.) (1982). *Resistance: Psychodynamic and behavioral approaches*. New York, NY: Plenum.

Wachtel, P. L. (1993). *Therapeutic communication: Knowing what to say when*. New York, NY: Guilford.

Wachtel, P. L. (1997). *Psychoanalysis, behavior therapy, and the relational world*. Washington, DC: American Psychological Association.

Wachtel, P. (2007), *Relational theory and the practice of psychotherapy*. New York, NY: Guilford Press.

Wile, D. B. (1984). Kohut, Kernberg, and accusatory interpretations. *Psychotherapy: Theory, Research and Practice, 21*: 353-364.

Wilner, W. (1996). Dreams and the holistic nature of interpersonal psychoanalytic experience. *Psychoanalytic Dialogues, 6(6)*:813-829.

Wilner, W. (1999). The un-consciousing of awareness in psychoanalytic therapy. *Contemporary Psychoanalysis, 35(4):* 617-628.

Winnicott, D. W. (1949). Hate in the counter-transference. *International Journal Psychoanalysis* 30:69-74.

Winnicott, D. W. (1960). Countertransference. *British Journal Medical Psychology, 33*:17-21.

Winnicott, D.W. (1969). The use of an object. *International Jour Psychoanalysis, 50*: 711-716.

Winnicott, D.W. (1971). *Playing and reality*. Middlesex, England: Penguin.

Winnicott, D.W. (1986). *Holding and interpretation: Fragments of an analysis*. London, UK: Hogarth Press.

Wolstein, B. (1983). The pluralism of perspectives on countertransference. *Contemporary Psychoanalysis, 19*: 506-521.

Wolstein, B. (Ed.). (1988). Introduction. In *Essential Papers on Countertransference*. pp. 1-15. New York, NY: New York University Press.