THERAPISTS' USE OF THEIR VISUAL IMAGES IN THERAPY

by

DAFNA FUCHS

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	Elliot Jurist, Ph.D., Ph.D. Chair of Examining Committee
_____	_____
Date	Maureen O'Connor, Ph.D., J.D. Executive Officer

Paul Wachtel, Ph.D.

Steven Tuber, Ph.D.

Peter Fraenkel, Ph.D.

Vaia Tsolas, Ph.D.
Supervision Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

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Dafna Fuchs

Advisor: Professor Elliot Jurist

Therapists frequently experience a spontaneous appearance of a picture or sequence of pictures in their minds, while listening to their patients; in this research project I refer to these experiences as Therapists' Visual Images. The roles that these visual images play in the process of therapy may vary between different therapists, patients, and contexts. The goal of this study is to expand the theoretical understanding of this phenomenon that is common among therapists, but had not yet been studied using a controlled research. This study will examine the scope of the use of visual images that therapists experience during sessions and the processes that lead to these various uses of the image.

15 therapists were interviewed about their experience of having spontaneous visual images in sessions. They were asked about their thoughts and feelings about the experience as well as their use of their images in sessions. The data was coded and distributed to four domains representing the process of the appearance of the image: 1. Before the Image; 2. The Image; 3. After the image; and, 4. Therapists' Theories of the Functions of Visual Images.

In further analysis of the results, several processes of visual images were found, resulting in different types of images: Associative Images, Symbolic Images, and Defensive Images. These processes were found to be related to different uses of the image. These finding as well as the limitations of this study are discussed.

Acknowledgements

This project marks the end of a long process in which I learned about myself and others, through the immersion into the subtleties of human experience. This process of growth would not have been possible without many friends, colleagues, and mentors who accompanied my journey for the past eight years.

I would like to first thank my committee, who supported me through this process. To Dr. Elliot Jurist, in your subtle ways, you managed to make sure that I voice my thoughts and create my own way of being both a therapist and a thinker. To Dr. Steve Tuber, you were always there, giving warm words of advice and encouragement exactly when I needed them most. To Dr. Paul Wachtel, you offered both support and intellectual challenge, which provided me with a fertile groundwork for my growth. To Dr. Peter Frankel, your input and advice were well timed and invaluable. And, to Dr. Vaia Tsolas, thank you for joining this project, supporting me in this effort and offering your thoughtful insights.

This study would not have been possible without the therapists who were willing to invest their time and discuss their experiences genuinely and thoughtfully. It was fascinating to conduct the interviews and to interact with such creative minds.

This study was inspired by my own clinical experiences, which have not been possible without my patients. You gave me your trust and time, and invited me into your worlds with generosity and faith in the process. My experiences with you shaped my views and are continuously integrated into my work.

Lastly, to my husband, Ohad, thank you for your everlasting support and patience with me during this long process. You provided me with the space to grow and create myself. And to my kids, Tal and Rona, you are the reason for my continuous strive to push the limits of my consciousness, to expand, and change. I couldn't have done this without you.

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Chapter I: Introduction

It was the first session of the day. Listening repeatedly to details about my patient's petty arguments with her co-workers, yet again, I felt mainly impatient. This frustration was so familiar to me. As much as I tried to understand what was going on in moments such as this, I was blind to how deeply sad and scared Sara really was.

During these 26 months of therapy that led to this session I did not understand why Sara came back to therapy each week. Sara, who was a kidney transplant patient, came to therapy to deal with the psychological ramifications of being diagnosed with a Chronic Kidney Disease, including depression and anxiety symptoms mainly related to her fear of death. Shortly after the beginning of therapy, she was told that she needed a kidney transplant. Her father volunteered to be the kidney donor, and a few months into treatment she went through a kidney transplant surgery, which was successful.

In sessions with Sara, I felt that I could not possibly understand what she was going through, and all my efforts to try to do so were unsuccessful. I remember many conversations with my supervisor on this case; about how much she probably suffers, how it was like for her to have her father's kidney, and what it was like to be so close to death. But I never really felt like I "got it", that I was any closer to her experience. When this didn't help, I turned to intellectualization; I read books about kidney transplant patients to understand it theoretically, but I ended up feeling the same: I did not know what it was like to be a transplant patient, to be afraid of death, and I started to doubt my wish to really know.

In the beginning of my third year of working with Sara, a feeling crystallized in my supervision, a feeling that I had had for many months but did not name - I was not

empathic to my patient. I was frequently annoyed at her for not coming on time to the session, since she lived close to the clinic, and although I knew that she was tired on many occasions because of health related issues, it did not change my feelings - I felt tired too, I woke up at 6am to be there on time every Tuesday morning. Worst of all - whenever she cried in sessions I felt mostly surprised, not sad or worried. Shortly after, I felt guilty for being so cold. I experienced her cry repeatedly as a shallow cry, like a response to a feeling that was not present in the room any longer.

At times, I felt that there was nothing I could do for her, and even though I understood the potential meaning of it - the reflection of her own helplessness that there is nothing anyone could do for her - I still felt that this understanding got us nowhere. I talked about this in my supervision, my feeling that there is a central experience that I have no access to, and how it made me feel. Gradually, this feeling changed from guilt resulting from the difference between what I felt and "what I suppose to feel" to a painful realization that I cannot truly be there for her during these moments. She was alone.

Along with the feeling of being "unempathic" to her experience, I realized that I was not myself in the room with her, I felt restricted, put in a box, cast in a role. It was difficult for me to move freely between images, thoughts and feelings in her presence. In sessions, I could only respond to what she concretely said, and any thoughts of symbolic meanings were either experienced by me as not relevant or, were quickly dismissed by her. This experience, of showing me only one concrete dimension of her experience made me feel like a prisoner of her need to strip any content from deeper meaning, and keep me "under control".

And so, I was sitting in front of her, listening to her without understanding what she was really saying. For a few weeks now we have been talking about her difficulty to work, to study and to take care of her health all at the same time. After long discussions, Sara decided to leave her job and concentrate on school. She told me that she had talked to her supervisor about leaving her job the day before, and she now felt relieved. Although she stated that she felt relived, she seemed anxious to me. After exploration, it was revealed that Sara felt guilty about leaving her job, because her supervisor was "such a nice man", and generally her experience in this place was positive. Sara started to talk about her feelings regarding her leaving her job - she felt that she needed more time to study, so she had to quit, at the same time, she felt that everyone else around her is studying and working, so why can't she do it?

Sara talked many times before about this experience, but during this time, I suddenly heard two very different voices coming from her. I think it was when she talked in that manner, jumping from one state of self to the other, that I had the image - it was an abstract image of a tall figure, looking down on a less formulated shape, as if telling it what to do. The shapes did not touch, nor did they have any type of dialogue. I was very surprised. I tried to "catch my image" and focus on it; my efforts to do so reminded me of trying to remember a dream after waking up. Sara kept talking about her experience in the same manner, this time these two voices coming from her were clearer. It did not sound like a conflict, but more like two different people, each making his own argument, without acknowledging each other's existence. It took me a few minutes of listening to her talk in this manner to formulate an understanding of the image. I thought at that time, that the image was of a split.

When I had a formulated thought in my mind, I told Sara: “I have an image of what you are describing now. It is an image of you looking from the outside at yourself, observing and telling yourself what to do. At the same time there is another you, an “inside you”, who experiences the tremendous pain that comes with your struggle to keep everything together without understanding what is going on”. When I explained to her the image of her “inside self” and what I thought it represented, I suddenly felt extremely sad. The depth of the sadness hit me, like the image of the split. I was silent. Sara said: “yes, this is what happens” and started to cry. She added “and now I feel like crying”, in the efforts to catch the tears and stop them.

This session felt much closer, more intimate. I felt that, at last, I could take in a different part of her which I did not until then experience, and formulated it in my mind. I could both see her internal struggle and be in touch with my own feelings for her, which felt much more connected to her.

As much as I tried in the past to understand this enactment, it was only when I had this image that change occurred, which made me curious about this experience. My “unempathic” attitude toward parts of her experience was probably a reflection of the part of her who did not give room to the vulnerable, “inside part”. This collaboration between me and her “outside self” was probably the basis for this enactment. One could also argue that it was only when I had access to my own feelings of pain regarding my inability to be there for her - I could access the same qualitative parts in her. All these realizations came after experiencing the image. It was then when I became curious about the image, and what enabled it to happen.

I then started to notice that I experience visual images with patients quite often. Usually, it is a picture in my mind which turns into a thought eventually, a thought that I am not aware of prior to this image. I have noticed that my images are not only interpretive efforts; they can simply be clarifications, a visualization of the content presented in the session. For example, when a patient tells me about a dream, I very often visualize it.

I also found that some images are much more available to consciousness, or, closer to awareness, than others. In a session with a patient who came to therapy after 15 years of substance abuse, he was talking about how he thought that others perceived him. This patient was very often overwhelmed by his undifferentiated emotions, which in the past were self medicated through his abuse of alcohol and other substances. While he was talking, I had an image of pointing a flashlight at him, while he was walking in the dark. This image was of what I felt whenever I said something about his feelings that he could relate to. My understanding of his preoccupation with others' perception of him was related to his need for others to illuminate parts of himself. It helped him to see more clearly these parts of himself that were otherwise lost in his emotional turmoil.

When I talked about the phenomenon of visual images with some colleagues, I realized that many therapists experienced visual images during sessions, but very often do not pay close attention to their potential meanings and their own reactions to them. In addition, some therapists became aware of their past experience of having visual images only when I asked them about it. In other words, it seems that the experience of spontaneous visual images is a frequent experience that is often not recognized.

Nevertheless, when it is recognized, there is a sense of familiarity attached to it, as if it was there all along, but was not acknowledged.

Lastly, I learned from these conversations that these experiences are usually accompanied with a sense of a riddle; its meaning is not readily available to consciousness. This is why the image could be at times uncomfortable to share, since the image seems to reveal something that is not yet known or understood.

These observations, coupled with my own experiences of having visual images, led to my interest to look closely into the process and meaning of this phenomenon. I was curious to know more about the variables that play a role in the process of having visual images. My goal is, therefore, to map the variables that affect the appearance of the image, how therapists use it, and how it affects the treatment.

When I became interested in this phenomenon, I found that there is not much literature written on the experience of therapist's visual images; in addition, there is no former controlled research on the subject. I therefore chose to examine this phenomenon through a controlled qualitative research. 15 therapists were interviewed about their experiences of spontaneous visual images. They were asked to describe an image, followed by different questions about this experience including: the context of the session in which the visual appeared, feelings and responses to the image, their relationship with their patient, their own style as therapists, and their thoughts regarding their experiences. The therapists' answers were coded and attributed to four domains: Before the Image, The Image, After the Image, and Thoughts about Visual Images. The attribution of codes to these domains assisted in the examination of this experience as a continuous process.

In the following chapters I summarize the relevant literature review, describe the method used for this research and the various findings. In the last chapter, I pull together the results with the relevant literature, and bring my theoretic formulation of the processes that lead to therapists' visual images and their uses.

Chapter II: Literature Review

In this chapter I summarize the available literature on the emergence of therapists' visual images during sessions and their use of these images in the course of therapy. In the examination of the literature available, I had three main questions in mind. The first question was: what are visual images? are they fantasies? daydreams? reveries? How is this experience conceptualized in theory? Secondly, I wanted to look at the different potential roles that visual images can play in therapy, and finally, I was interested in the ways in which therapists actually respond to their visual images during sessions. In the review of the literature I quickly discovered that the process and use of therapists' visual image in therapy is rarely discussed as a separate theme in the literature. Therefore, in the efforts to answer these questions I will review the literature that is available on related issues, while pointing out the existing lacunas.

I will start this review with an overview of the concept of visual images, and how they interface with the literature on fantasies, daydreams, and reveries. Then, I will look at the history of the roles that visual images played in the course of therapy from various perspectives including: classical, object relations and relational points of view. Finally, I will discuss the therapists' responses to their visual images. Here, I will look at four different responses of the therapist: interpretation, rejection of the image, self disclosure, and self analysis. Since this research project will be focused on the appearance of spontaneous visual images in therapy, I will not focus on literature on the use of active imagination in cognitive therapeutic techniques.

I. The Concept of Visual Images

What are visual images? Norman's definition of therapists' visual images captures the phenomena as I experience it; in Norman's words: "visual image means a spontaneous appearance of a picture or sequence of pictures in the analyst's mind while listening to the analysand" (Norman, 1989, p. 118). Norman gives an example of this phenomenon, in which he experienced a visual image during a session with a patient. The patient was building a house on his maternal uncle's land; his mother originally received this piece of land to build on. The patient was worried that his brother would raise a claim to some part of this land, he therefore tried to get the house and the land registered in just his name. While he was talking about it, Norman became aware of a visual image: "a landscape which is markedly hilly with two great ridges covered with a forest; down to the right there is a glimpse of a lake and the road leading up to the house where it is lying in the valley between the ridges. The image has a title: mother's body" (Norman, 1989, p. 121). Norman understood his visual image as an interpretive image of what his patient was trying to achieve in his efforts to get the house and the land registered under his name; he explained: "through my image of the landscape I perceived a level of the material of which I might otherwise not have become aware - that the house in the country was remnant of a good, preoedipal relation to the mother which he (the patient-D.F) had managed to rescue from his hatred" (Norman, 1989, p. 121).

Are Visual Images Unformulated Experiences?

In the state of experiencing the above visual image as a response to the patient, Norman's image was not yet a formulated verbal thought, but a picture in his mind (with

a name attached to it). Stern, in the book Unformulated Experience, argues that when a patient is finally able to talk about unacceptable parts of his life, his thoughts and experiences are not fully formulated thoughts waiting to be discovered. On these moments, the patient is in a kind of a confusing state of not-knowing. This state of confusion is the state of "unformulated experience", in Stern's words, it is "the label to refer to mentation characterized by lack of clarity and differentiation… it is the unformulated form of those raw materials of conscious, reflective experience that may eventually be assigned verbal interpretations and thereby brought into articulate form" (Stern, 2003, p. 37). Stern's idea of the "unformulated experience" was influenced by the classical concept of the pre-logical experience which was developed by Tauber and Green (1959). Stern believes that usually there is no "unconscious clarity underlies defense" (Stern, 2003, p. 37), and therefore the therapeutic action is in the reconstruction of the unformulated experience rather than a discovery of an unconscious "truth". This process, of the creation of meaning includes the consideration of various possibilities through imagination. Stern expands his idea of the unformulated experience into a discussion on dissociation and argues that "dissociation is the deletion of imagination" (Stern, 2003, p. 98). He explains that dissociation is the inability to let the imagination play freely and thereby allow the freedom of thought.

Stern's definition of the unformulated experience and of dissociation as the deletion of imagination brings up the question of the role of visual images in his theory of the unformulated experience, and specifically, are visual images unformulated experiences? Do therapists' visual images point at dissociated experiences of the therapist? Stern says that "prior to being put into words, then, the analyst's experience of

the patient is unformulated" (Stern, 2003, p. 187). On one hand, it seems that from his point of view, the experience of visual images is an unformulated experience since it is an experience that is not yet put into words. At the same time, what marks the end of dissociation from Stern's point of view is the process of "imagination", or, the creation and experience of possibilities. Therefore, it seems to me that from Stern's point of view, therapist's visual images as a response to the patient's material are not necessarily unformulated experiences, but can mark the end of dissociation because of their imaginative quality. In other words, although visual images are not formulated verbally, they can nevertheless be visual formulations. In Norman's example of his visual image, as well as in the example that I gave in the Introduction chapter, both visual images were interpretive efforts that were available visually. In that sense, these images were the first step toward clarity, and although they were not yet verbally formulated and communicated, they nevertheless assisted in the formulation of the "unformulated experience" of the therapist.

Are Visual Images Fantasies or Daydreams? Are they Symbolic Equations or Symbolic Representations?

Stern's idea about the relationship between dissociation and imagination is related to Winnicott's distinction between fantasy and daydream. In "fantasy and imagination" (Winnicott, 1971), Winnicott demonstrates the difference between fantasy and daydreaming in his patient. He says that: "dreams fits into object- relating in ways that are quite familiar, especially to psycho-analysts. By contrast, however, fantasying remains an isolated phenomenon, absorbing energy but not contributing either to

dreaming or to living" (Winnicott, 1971, p. 26). From Winnicott's point of view, fantasy has a rigid quality, since it is isolated, while daydreaming is a phenomenon of imagination and interaction. Fantasy is a concrete image about a certain object; it is one-dimensional with no opening for additional meanings. Winnicott contrasts the fantasy of his patient with poetry and says: "fantasy was about a certain subject and it was a dead end. It had no poetic value. The corresponding dream, however, had poetry in it, that is to say, layer upon layer of meaning related to past, present and future, and to inner and outer, and always fundamentally about herself" (Winnicott, 1971, p. 35).

In addition, Winnicott's distinction seems to be related to Hanna Segal's distinction between symbolic equation and symbolic representation (Segal, 1957). In symbolic equation, the patient cannot use the symbol, but experiences it as the thing itself. There is no metaphoric use of the symbol as representing a wider range of meanings. Symbolic equation seems to be Winnicott's intention in his definition of the experience of fantasy. On the other hand, the experience of daydreaming or imagination opens a space for playing with various meanings that potentially live within the symbol, and therefore fits the term of symbolic representation.

From a classical point of view, both fantasy and daydreaming represent an attempt at wish fulfillment. Nevertheless, fantasies come under the domination of the primary process while daydreams operate more according to the secondary process. Modell, a contemporary Freudian, further expands on the meaning of fantasy as a symbolic equation and says: "a certain class of fantasies does not expand or transform the imagination but constricts it. When present, such fantasies can exert an organizing effect on the individual's life by contributing to a belief system that seriously limits his options

and choices. These fantasies can justifiably be described as malignant; they appear to be intractable, whether or not they are conscious or unconscious" (Modell, 2003, p. 123-124). Modell's distinction is between different types of fantasies, some of which seems to function as "symbolic equations" and some as "symbolic representations".

With this distinction in mind, the inevitable question is whether visual images are symbolic equations or representations? Do they belong to the realm of fantasy or to imagination? In his discussion on the therapist's reverie, Ogden tries to answer this question by arguing that the therapist's reveries are not simply inattentive, narcissistic self involvement images, but represents "symbolic and protosymbolic (sensationbased) forms given to the inarticulate experience of the analysand" (Ogden, 1994, p. 82). From Ogden's point of view, visual images as a part of the therapist's reveries belong to imagination, and therefore belong to the group of symbolic representations.

Although, at times, our visual images reflect an openness of a creative space, in which meanings are contained and generated, it seems possible that on other times the therapist may regress into his own world of concrete, narcissistic fantasy. The question, therefore, goes back to the concept of visual images - are they reveries?

Visual Images as Reveries

The concept of reverie was first introduced by Bion (1962), followed by Ogden. Ogden's definition of reverie is inclusive: "reveries are the ruminations, daydreams, bodily sensations, fleeting perceptions, images emerging from states of half sleep (Frayn, 1987), tunes (Boyer, 1992) and phrases (Flannery, 1979) that run through our mind, and

so on" (Ogden, 1997, p. 158). Therefore, spontaneous visual images which are experienced in the session are viewed by Ogden as reveries.

Bion's concept of reverie is somewhat narrower than Ogden's, he argues that reverie has a metabolic function in the therapeutic relationship: "reverie is that state of mind which is open to the reception of any 'objects' from the loved object and is therefore capable of reception of the infant's projective identifications, whether they are felt by the infant to be good or bad" (Bion, 1962, p. 36). Bion emphasizes the crucial role of the mother's capacity for reverie in the child's development. Bion argues that "the mother's capacity for reverie is here considered as inseparable from the content for clearly one depends on the other. If the feeding mother cannot allow reverie or if the reverie is allowed but is not associated with love for the child or its father this fact will be communicated to the infant even though incomprehensible to the infant. Psychical quality will be impaired to the channels of communication, the links with the child. What happens will depend on the nature of these maternal psychical qualities and their impact on the psychical qualities of the infant" (Bion, 1962, p. 36).

In addition, Bion emphasized the importance of the mother's reverie for the development of thinking: "a capacity for tolerating frustration thus enables the psyche to develop thought as a means by which the frustration that is tolerated (by the mother- D.F) is itself made more tolerable" (Bion, 1962, p. 307). This is done through what Bion named "alpha function" which is the function of digestion of information. The mother digests the material that is projected to her by the child through her reveries, the child then introjects them after these emotions were digested and detoxified by her. Undigested feelings have been digested by the mother's alpha function and thus made available for

thought (Bion, 1962, p. 309). The “undigested feelings” of the child is called by Bion “beta elements”.

Bion explains what happens when the mother does not detoxify the child’s “beta elements” through an example of an infant who feels fear of death. In normal development, the mother would tolerate that projection and the infant would introject the fear of death as tolerable. If, on the other hand, the projection is not accepted by the mother the infant feels that his feeling that he is dying is stripped of such meaning. The consequence is that the feeling reintrojects, not as fear of dying made tolerable, but as a “nameless dread”” (Bion, 1962, p. 309).

Ferro (2002) expands on Bion’s definition of reverie. Ferro thinks that this “dreaming in the waking state” is the most important conceptualization contributed by Bion. He applies this concept to the analytic relationship and says that “if we know how to listen to it, it becomes a valuable indicator of how the analytic couple is functioning” (Ferro, 2002, p. 480). Ferro thinks that there is a constant baseline activity of reverie in therapy “which is the way the analyst constantly receives, metabolizes, and transforms whatever reaches him or her from the patient in the form of verbal, paraverbal, or nonverbal stimuli” (Ferro, 2006, p. 1053).

Ogden has written extensively on reverie and its importance in therapy (Ogden, 1995, 1996, 1997, 1999). He emphasizes the intersubjective aspect of reveries: “reverie is a process in which metaphors are created that give shape to the analyst’s experience of the unconscious dimensions of the analytic relationship. Unconscious experience can only be ‘seen’ (reflected upon) when re-presented to oneself metaphorically” (Ogden, 1997b, p. 726). Ogden stresses the metaphoric quality of reverie, that reverie is a re-

presentation of the unconscious, not a glimpse into the unconscious itself. To Ogden, reverie is “an emotional compass” (Ogden, 1997a, p. 571) to get a sense of his unconscious experience of the relationship with the patient.

Heather Weir agrees with Ogden in his intersubjective quality of reverie and adds that the analytic reverie is a dramatic example of what happens in therapy: “analytic reverie is a more easily examined manifestation of the intersubjective unconscious aspect of the analytic relationship. It also more clearly illustrates the transitional, the symbolic, and creative function of the analytic work” (Weir, 1996, p. 331).

To conclude this section, there is no shared understanding of the experience of Therapists’ Visual Images in therapy. This experience can be viewed as an unformulated experience, fantasy or daydream, symbolic equation or symbolic representation, and as a part of reverie. As a part of reverie, it could function as a digestive function for the patient, or as a metaphor to the analytic process. I will now add a historical lens to this discussion and review the understandings of this experience through various theoretical perspectives throughout history.

II. The Use of the Concept of Visual Images throughout History

Since the experience of therapists’ visual images was rarely discussed in the literature, and especially in the classical perspectives, I will examine not only the ideas about therapists’ visual images, but also the theories that developed on the patients’ visual images in therapy and apply them to the present discussion.

Historical Perspectives on Patients' Visual Images in Therapy

Freud changed his position regarding the role of the patient's visual images in therapy. In Studies on Hysteria, Freud made a statement about the basic rule of therapy: "I inform the patient that, a moment later, I shall apply pressure to his forehead, and I assure him that, all the time the pressure lasts, he will see before him a recollection in the form of a picture or will have it in his thoughts in the form of an idea occurring to him; and I pledge him to communicate this picture or idea to me, whatever it may be… having said this, I press for a few seconds on the forehead of the patient as he lies in front of me; I then let go and ask quietly, as though there were no question of a disappointment: 'what did you see?', or, 'what occurred to you?'" (Freud, 1895, p. 270). Freud eventually abandoned the concentration technique in the favor of free association, in which he emphasized the role of the dreams. Warren argues, that it was at that time, in the change of technique from concentration to free association that also marked the shift from visual to verbal, and from primary process to secondary process in psychoanalysis (Warren, 1961).

In addition, Freud changed his view on visual memories, from the theory of trauma to his paper on "screen memories". In this article, Freud wrote about vivid pictures of early experiences that were not presentations of the past (as he thought before) but rather synthesized combinations of fact, defense, instinctual wish, and traumatic experience whose "true nature" was maintained under repression (Freud, 1899).

Nevertheless, as much as Freud emphasized verbal communication and interpretation, in the Ego and the Id (1923) he stressed the differences between patients in using visual images in the process of turning unconscious to conscious experience: "we

must not be led away, in the interests of simplification perhaps, into forgetting the importance of optical memory- residues- those of things (as opposed to words)- or to deny that it is possible for thought processes to become conscious through a reversion to visual residues, and that in many people this seems to be a favorite method" (Freud, 1923).

Shapiro, in a useful article named "the significance of the visual image in psychotherapy" (1970) summarized two main schools of thought about patients' visual images at that time; one labels visual images as an expression of an impulse and the direct representation of an unconscious process, and the other views them as compromise formations between impulse and defense. The latter school of thought is represented by Kanzer (1958) who speaks of the visual image as being the end product of the transformation of an undesired idea. He argues that censorship blocks the entrance of disturbing thoughts into consciousness and forces the transformation, through regression, into their perceptual components. From this point of view, visual images are pre-verbal, more primitive representations of psychic content than verbal representations, and therefore, their appearance marks the process of regression. Shapiro argues that from this point of view the image remains "an island of resistance" which looks like a psychoanalytic process but is not accompanied by any insight: "in that sense, images are like symptoms, they are defenses, in the sense that they both move away from, and gratify indirectly the underlying impulse" (Shapiro, 1970, p. 209). This point of view on the patient's visual images seems closely related to Winnicott's definition of fantasy.

Shapiro presents another school of thought which views the visual image as the direct voice of the unconscious, an expression of the impulse itself, rather than a defense

against the impulse (Shapiro, 1970). Within this school of thought is Hammer (1967). According to Hammer (1967), whatever is psychically unresolved will, in the description of the scene, manifest itself, through visual forms, and resolve itself at the visual level, independently of conscious control. In the former case, the image is treated much as a screen memory, while in the latter approach, the image itself can reveal many of the unconscious conflicts since it considered to be the direct expression of them (Shapiro, 1970).

Shapiro, in the effort to summarize the above approaches to the patient's visual images, made a distinction between approaches that emphasize "what images conceal" versus "what they reveal" in the patient, as dependant on their structural differences (Shapiro, 1970). I believe that this distinction is relevant to the discussion on the therapists' visual images as well as the patients'; the therapist's visual images can either conceal or reveal information about the therapeutic relationship.

Warren (1961) also wrote about the significance of the patient's visual images during an analytic session. He seems to agree with the school of thought that views visual images as screen memories "in which a relatively innocuous picture is projected which screens the displaced affect" (Warren, 1961, p. 510). Warren views the visual image as a way to withdrawal from the analytic content, "a resting place from the conflict", that could follow a patient's silence in the session: "if, when there is a pause in the patient's verbalization, one asks the patient to describe what he sees, one may see how the visual image functions as a transient, uneasy resting place for the conflict-laden instinctual impulses. The patient temporarily withdrawals from the analytic fact by not verbalizing

his psychic processes, especially as they touch upon the analyst as the object of libidinal or aggressive drives in the transference" (Warren, 1961, p. 508).

In addition, Warren believes that "verbalization is more object directed that visual imagery. Regression to visual imagery is a more narcissistically cathected representation satisfying id and superego drives" (Warren, 1961, p. 518). Warren argues that, at times, visual images can appear as a result of the patient's anxiety. Here, their function is to discharge impulses which the patient fears might disturb the relationship with the analyst. Warren's solution to the patient's withdrawal is to ask the patient about it, and teach the patient to verbally communicate the visual image whenever he experiences one. Warren argues that the communication of the image verbally would block the efforts of the patient "to keep the analyst 'out of the picture'" (Warren, 1961, p. 508).

Lester joins the argument that the appearance of imagery is directly linked to anxiety, which threatens the transference relationship. The anxiety interrupts the flow of words in free association and causes a shift from verbal secondary processes to imagistic process, which, he sees as a primary process form. The role of the emerging image is to "bind, conceal and dissipate the anxiety in highly symbolic forms, very similar to that of the dream" (Lester, 1980, p. 412).

Finally, Shapiro concludes his discussion with the important idea that "what is defined as resistance has a great deal to do with what is defined as the task of communication" (Shapiro, 1970, p. 211). It seems to me that this idea can be applied to the therapist's visual images as well, and specifically to the relationship between the therapist's ideas about his own conscious and unconscious ways of communication during sessions and his responses to his own visual images.

The Analyst's State of Mind in Therapy – from Evenly Suspended Attention to Reverie

Freud (1893–95) wrote about the visual images of the analysand as helpful in the therapeutic work, especially with hysterical patients, but he never devoted any special study to the analyst's visual images appearing in psychoanalytic practice. Nevertheless, he did believe that the fundamental rule of free association has its counterpart in the analyst's effort to "surrender himself to his own unconscious mental activity, in a state of evenly suspended attention" (Freud, 1923, p. 239).

Fliess also talked about the state of 'free floating attention' and termed it "conditioned association". The word "conditioned" is used here in contradistinction to "free association". He stressed that the analyst does not indulge in ordinary 'free' daydreaming, like the patient does, where the stimuli come largely from within. The analyst's daydreaming is almost entirely stimulated from without, as a response to the patient's reactions (Fliess, 1942, p. 219-220). Fliess explains this phenomenon in classical terms: "the predominant characteristics of the analyst's work-ego (Arbeitsich) consists of a special temporary displacement of cathexis (Besetzungswandel), at present not fully describable, between ego and superego, whereby the latter's function of critical self-observation is utilized for the recognition of instinctual material which has transiently been acquired by identification with the patient" (Fliess, 1942, p. 226).

Ogden does not see eye to eye with Freud and Fliess regarding the idea of "free association" (Ogden, 1997). Ogden believes that it is antithetical to the effort to generate an analytic process to ask the patient to say "everything that comes to mind". Ogden

argues that it is as important for the patient to know that he is free to be silent as it is for him to know that he is free to speak: “to privilege speaking over silence, disclosure over privacy, communication over not communicating, seems as unanalytic as it would be to privilege the positive transference over the negative transference, gratitude over envy, love over hate, the depressive mode of generating experience over the paranoid- schizoid and autistic- contiguous modes of generating experience” (Ogden, 1997, p. 123).

In the state of reverie, Ogden says, the role of language is to capture and create the experience of the analytic relationship. From Ogden’s point of view “the language of both patient and analyst is dead (and thinking and communicating cease) when their use of language conveys certainty as opposed to tendency, knowledge as oppose to tentative, ever- sliding sense of things, fixity as oppose to movement and transition” (Ogden, 1997, p. 230). Ogden believes that the language should capture the idea that there is no still point of meaning at any specific time during psychotherapy.

The importance of the state of mind of reverie, to Ogden, reflects a role of therapy that is different from the classical point of view on therapy. In the classical perspective, the task was making the unconscious conscious or of transforming id into ego. In contrast, Ogden adopted Winnicott’s point of view about the role of analysis and said that “analysis is about the expansion of the capacity of the analyst and the analysand to create ‘a place to live’ in an area of experiencing that lies between reality and fantasy” (Ogden, 1997, p. 121).

Modell explains that this state of mind is essential when one is trying to solve a problem, which often what happens in therapy. He talks about the use of images as a non-linear process to solve a problem. Modell explains that we should not try to solve the

problem “head-on”. While we are not trying to solve it consciously, he argues, we proceed indirectly in the solution to the problem. He adds: “if you think too directly about a problem, you fairly quickly exhaust the usefulness of the tools accumulated in the course of the first phase, and are apt to become discouraged. Thought needs to be liberated in such a way that subconscious work can take place” (Modell, 2003, p. 31).

Bollas agrees and emphasizes the role of the “dreamier state of mind” for the therapist “the wish for knowledge must not interfere with a method that defers heightened consciousness in favor of a dreamier frame of mind, encouraging the free movement of images, ideas, pregnant words, slips of the tongue, emotional states and developing relational positions” (Bollas, 1999, p. 35).

Finally, Edgar Levenson presented with another point of view on the state of mind of the therapist and the appearance of visual images. Levenson, who practices the “detailed inquiry” technique, as a part of the interpersonal school of thought, thinks about himself in therapy as a “director perusing a script that I must transform into visual images” (Levenson, 2003, p. 234). Levenson is consciously trying to understand the patient through his visual images of the patients’ verbal communications. He uses images to understand what is missing in the patient’s communication, and inquires about it. This perspective on the generation of visual images and its use is vastly different from the theories above, since it emphasizes the conscious, guided pursuit after visual images, versus the spontaneous emergence of visual images in the state of reverie.

The History of the Relationship between Words and Images

What is the relationship between words and images in therapy? Gardner, who wrote about his experience with visual images in his book "self inquiry" thinks that "the visual ranges far ahead, scouting what is to come, and to be come upon, while the main body of verbal thinking plods along until, when possible, word catches up with, challenges, corrects, distorts, and augments vision" (Gardner, 1983, p. 72). In contrast to what Freud believed, Gardner argues that visual images are the initial reaction to internal experience, while verbal thinking is the effort to understand it.

As a part of Ogden's theory of reverie, Ogden also thinks that language is a metaphor, and therefore, an indirect method of communication between the patient and the analyst: "in attempting to use words in this way, the patient is not so much telling the analyst what he feels as showing him and telling him through his use of language what he feels *like* and what he imagines the analyst feels *like"* (Ogden, 1997b, p. 722). This is a very different approach to language than the classical point of view in which non verbal symbols are the indirect method of communication, and not verbal ones.

Similarly to Ogden, Modell emphasizes the role of metaphor over the role of language and argues that language is merely one form of metaphor and that metaphor exists apart from language "as evident in gestures, visual images, feelings, and bodily sensations, which can all function as metaphors" (Modell, 2003).

Fosshage points out that imagistic processing begins to develop before language, and argues that they contribute to early development of implicit relational knowing in therapy. Fosshage argues that the implicit relational knowledge of the patient is where

change in therapy occurs, in contrast to the classical position in which change happens mainly through interpretation and insight (Fosshage, 2005).

Bucci's ideas about therapeutic action are different from Fosshage's ideas. For Bucci, visual images are a part of "non verbal symbolic thinking". Symbolic processing for Bucci, involves organization of symbolic entities (images and words). Bucci (1997) suggests that subsymbolic processing occurs at the implicit level and that nonverbal and verbal symbolic processing follows processing rules that are explicit or can be made so (Bucci, 1997). Therapeutic action, in her view, is connecting nonverbal representations, in subsymbolic and symbolic formats, to language, which is the verbal symbolic processing. For Fosshage, the therapeutic action lies in the implicit level of communication and does not have to be translated into verbal language. Fosshage explains that: "while Bucci fills out from a cognitive psychology perspective the complexity, difficulty, and even limitation of connecting different cognitive processes in treatment, her emphasis on connecting through language supports the traditional psychoanalytic emphasis on the use of words, articulation, and exploration and interpretation" (Fosshage, 2005, p. 532). Bucci and Fosshage can represent the running battle throughout the history of psychoanalysis between interpretation or insight and relational experience as focal points of the therapeutic action.

Levenson thinks about imagery as a separate type of representation altogether, apart from verbal representations and parallel to it: "imagery should be thought of on its own terms, rather than as a cryptic version of verbal mediation or symbolic manipulation. Perhaps there are two separate and equally valid forms of mental representations" (Levenson, 2003, p. 235). Levenson talks about the historic context of privileging the

verbal representation over the visual one in psychotherapy "this ultimate privileging of the verbal over the visual is virtually ubiquitous in the history of psychoanalysis... the underlying premise (of the classical view) remains consistent however: to arrive at deep unconscious fantasy, drive derivatives, which are then contained or mastered by verbal interpretation" (Levenson, 2003, p. 234). Interestingly, Levenson, who is one of the pioneers of the "detailed inquiry" technique in psychotherapy, realized that this technique was visual in essence and not, as he thought before, verbal: "I had an epiphany about a year ago, when it occurred to me that the detailed inquiry, particularly the deconstructed detailed inquiry, is really visual, not, as one might reasonably expect, verbal, and that, indeed, the entire psychoanalytic praxis, although annotated in words, actually takes place in a visual spatial modality" (Levenson, 2003, p. 233). Levenson explains that in order to understand a patient's story, he needs to be able to create a visual narrative for it, and what is missing from that picture is the content of his detailed inquiry (Levenson, 2003).

Finally, Stern acknowledges the metaphoric role of language while he argues that language not only represents an internal experience but participates in the actual construction of the unformulated experience. He argues that "prior to being put into words, then, the analyst's experience of the patient is unformulated" (Stern, 2003, p. 187). This unformulated experience exists before putting it into words: "language must connect with something in the patient's mind that is already there: a nonverbal representation" (Stern, 2003, p. 166).

In conclusion, the history of the focus on visual images and their understanding changed dramatically over the years. The focus on the patients' visual images by Freud

changed into a focus on verbal communication. In turn, the role of these images changed from expression of impulses into the understanding of them as defenses. Since the focus in the classical views was mainly on the patient, there was no extensive discussion about the therapists' visual images in the course of the treatment. Along with the changes of roles of the therapist in the room, from a more classical and neutral role to a participant role, came the discussion of the therapists' state of mind in therapy and her countertransference reactions to the patient. Nevertheless, as a part of these countertransference reactions, visual images of the therapist have been rarely discussed. In the next section I will summarize the little literature available on the various roles that visual images can play in therapy from different theoretical perspectives.

III. The Potential Roles of Visual Images in Therapy

In Robert Gardner's Self Inquiry (1983), in which Gardner explores his own process of doing therapy, he poetically describes how he is always searching for visual images and how they emerge when it seems to him that his thinking is best: when he slowly oscillates between waking and the more dreamlike state. He said: "I seem always to look for visual images. I prize them. I count on them to set me straight. I think I see visual images when I am at what I think my best. I see them when I am in a tolerable turmoil: enough but not too much. I see them when complexity seems more challenging than oppressive… I see my images when I am troubled but not too troubled, puzzled but not too puzzled, startled but not too startled, vexed but not too vexed. I see them most often and most easily when I fall into or can put myself into a slow and steady bobbing from the more awake to the more dreamlike to the more awake to the more dreamlike.

Visual images appear, if they appear, when I cross from one to the other- either way" (Gardner, 1983, p. 70).

Visual Image as an Empathic Reaction

Visual images, as a part of the concept of reverie, are facilitators of empathy. For Bion, reverie is a necessary component in the mother's receptive function (Bion, 1962). The mother needs to be able to use her reveries to contain the child's negative feelings and digest them. Without a capacity for reverie and containment, Bion thought that the child's undigested feelings would have negative ramifications on his development.

Visual images can be seen as an empathic reaction. In Garder's Self Inquiry he demonstrated this point with a case in which he experienced a visual image as a response to his patient: "one day, on rising to show my patient out, I saw in my mind's eye a small black dog sitting in and looking out through a tall arched doorway, the center entrance of a large white house. I realized that early in the hour, when my patient had told of visiting friends "to help to build a dog-house," I had seen this same image. I realized, too, that on the first seeing, I had taken this to be an illustration of something my patient had said, an illustration without modification, and I had paid it no particular attention. Now, however, after the hour, I felt sure that what I had seen earlier was what I had again seen now, not a dog in a dog-house at all, but a dog in a two-story white Colonial, large enough to be a house for humans. I had seen, that is, a dog in a man-house" (Gardner, 1983, p. 50-51). When Gardner thought about this image, he realized that it had a meaning: "at edge of awareness I seemed to have told in visual image what I could not yet tell myself in words: he was like a dog who must do tricks to be admitted to a man-house" (Gardner,

1983, p. 54). Gardner's image allowed him to see what he was not aware of prior to the image and better formulate the case. In addition to this understanding, Gardner found in this image that he was empathizing with the patient: "whenever and wherever I approach the dog in the man-house, I find the same thing. I find he is two- faced. I find my patient; I find myself" (Gardner, 1983, p. 58).

In contrast to the perspective that the analyst's empathic reaction is closely connected to the appearance of imagery, Ross and Kapp wrote about imagery as an "interruption of empathy". They explained that because the analyst is not free to verbalize his associations as is the patient, he is acting out his unconscious mental activity, which may include "involuntary ideas into visual and acoustic images as a phase to the analyst response to the patient" (Ross & Kapp, 1962, p. 646). Ross and Kapp suggested that the appearance of visual images as a result of the therapist's (unconscious) efforts the get rid of an impulse through its direct expression.

Kern, who also studied his own visual images in therapy, concluded that visual images can reflect "untitherapeutic forces" within the analyst. These, are represented through what he once believed to be related to empathy, which was the content of his free floating attention (Kern, 1978). In his self study of his own visual images, Kern learned that what he thought was a result of pure empathy to the patient, he now understood as a process that contained both empathy and "antitherapeutic processes" or-countertransference. Interestingly, Kern separates between the content of the image and the background of the image in terms of their psychological meanings and says that the manifest form of the image reflects the attempts to empathize with the patient while the background of the image reflects the analyst's struggles with his own

countertransference: “backdrops aspects of the overall visual content, unremarkable in their manifest form, apparently carries when analyzed, important information about the presence and nature of an ongoing countertransference. While evidence of active attempts to empathize with the patient is reflected in the general theme and content of the visual imagery noted, the backdrops provide access to previously unknown struggles against a wish to act out certain (countertransference) fantasies with the patient” (Kern, 1978, p. 36). Kern integrates two possible roles of the visual image - empathy and countertransference, into one picture that comes to his mind.

The Roles of Images as Analytic Objects

Ogden thinks about reveries not as our own personal creations, but as a joint creation between the patient and the analyst. Ogden argues, that the patient and the analyst create an unconscious intersubjective space he named “the intersubjective analytic third” (Ogden, 1994, 1995, 1996). Both participants contribute to this creation. Following Winnicott, Ogden struggles with the dialectic of individuality and intersubjectivity. Paraphrasing Winnicott’s words about the mother and her infant (1960), Ogden said: “we must live with the paradox (without attempting to resolve it) that there is no such thing as an analysand apart from the relationship with the analyst and no such thing as an analyst apart from the relationship with the analysand” (Ogden, 1997b, p. 720). Nevertheless, Ogden emphasized that, of course, every participant in the analytic setting has his own contexts and separate personality that he brings with him to the session, but that reverie mainly reflect the intersubjective space between them (Ogden, 1994).

Ogden argues that the therapist's reveries as well as the patient's dreams belong to the analytic third, and therefore one should not privilege either the patient's or the therapist's associations, dreams, and reveries. Ogden found that "spontaneity and generative thought in the analytic dialogue is significantly enhanced when analyst and analysand are released from (or more accurately, release themselves from and release one another from) the practice of privileging the patient's associations to his dreams, and instead treat the dream as a psychological event that is being generated in the intersubjective analytic dream space, analyst and analysand have the freedom to be receptive to the unconscious drift of the analytic third as reflected in their reveries, their experiences of "simply listening"" (Ogden, 1997, p. 152). Ogden gives an example of a therapist's response to a patient's dream and says that "we must not insist on an answer to the question "is the dream the analysand's dream, the analyst's dream or the dream of the analytic third?" the three must be held in an unresolved tension with one another" (Ogden, 1997, p. 142).

The idea that the therapist's reveries belong to both the patient and the therapist, goes against the classical idea of countertransference. Ogden emphasizes that reveries are not simply reflections of the therapist's difficulties: "an important event in the analyst's life, such as the chronic illness of a child, is differently contextualized by the analyst's experience with each patient, and as a result becomes a different "analytic object" in each analysis" (Ogden, 1997a, p. 570). Visual images, as a part of reverie, are considered by Ogden to be analytic objects that should be treated as belonging to the intersubjective field.

In a paper discussing Ogden's work, Grotstein explains that the concept of the third makes subjectivity a property of the analytic relationship: "the relationship, in other words, is itself a subject" (Grotstein, 2000, p. 630). This idea, that the therapeutic relationship is an analytic object, is most radical and useful concept from Grotstein point of view.

The Role of Visual Images as Creative Solutions

In the literature on creativity, visual images are frequently addressed as a solution to a problem that takes place in the unconscious. One frequently quoted example was given by the chemist Friederich August von Kekule which illustrated that the creative imagination of scientists can be both involuntary and unconscious. Modell brings Kekule's description of his discovery of the closed-carbon-ring. On one afternoon in 1865 he fell asleep: "again the atoms were gamboling before my eyes. This time the smaller groups kept modestly in the background. My mental eye, rendered more acute by repeated visions of this kind, could now distinguish larger structures, of manifold confirmation; long rows, sometimes more fitted together; all twinning and twisting in snakelike motion. But look! What is that? One of the snakes had seized hold of its own tail and the form whirled mockingly before my eyes" (Modell, 2003, p. 27-8).

In addition, Modell discusses the example of Einstein and his ideas about mathematical thought. Einstein talked about the play of visual images in his mind, and the play of muscular (kinesthetic) sensations, which we can infer are the products of an unconscious metaphoric process (Modell, 2003, p. 29-30). Visual images, in this case, can assist and sometimes even represent a solution to a mathematical problem, in contrast

to being a result of a well thought argument. Einstein explained that he uses verbalization to communicate the finding to others, not in the actual process of solving the problem.

Lester explains the qualitative differences between visual images and language, using Paivio's understandings about imagery. Lester argues that the quality of imagery makes for simultaneous availability of a large amount of visual information and thus contributes to the flexibility and the speed of thinking in images. In contrast, in verbal memory, multiple units of information are available successively, linearly, but not simultaneously (Lester, 1980, p. 413). Imagery is organized in a synchronous manner in contrast to the sequential organization of linguistic items. This synchronous organization permits the integration of complex information into a visual image.

Norman also talks about reverie and his use of it in therapy as a creative process, and specifically, about his efforts as an analyst to find a solution to contradictions presented by the analysand during therapy: "as analysts we are constantly trying to find a solution to the contradictions which we are confronted with by the analysand. Sometimes the analyst must really strain himself intellectually, alternating with periods of free-floating attention and so closer to the hypnagogic hallucinations. It may seem somewhat odd that the analyst should be half asleep and hallucinating, and I must then underline that I have not even been near to falling asleep on any of the occasions I present as examples. I have been wide awake but not occupied by anything other than the ongoing analytic work, a feeling of restful concentration, and an absence of any definite intentions" (Norman, 1989).

Heather Weir in "analytic reverie and poetic reverie" discussed the role of reverie as a "problem solver" through insight. She believes that the analytic insight is a result of

a creative process that connects between the conscious creative mind and the unconscious: “it is the conjunction of the creative conscious mind with the true expression of the unconscious, or the inner self, that together make the poem or the analytic insight” (Weir, 1996, p. 319). In addition, Weir argues that the analyst’s reverie is closely related to a work of art, and says that reverie “seems to stand as a surrogate or transitional creative ordering through a state of mind similar to the creation of or experience of a poem or work of art” (Weir, 1996, p. 317). Weir is using Winnicott’s ideas about creativity as being a product of the space between the mother and the infant, the transitional space where they play and create each other. Weir’s hypothesis is that this creative space is where poetic reverie can be linked to analytic reverie in the sense that they are both manifestations of the original attunement (Weir, 1996).

The discussion on therapy as a creative space is closely related to the theoretical concept of constructivism in therapy, which was discussed by various theorists, among them: Wachtel (1993), Aron (1996), Mitchell (1988, 1993), Hoffman (1983), and Stern (2003). As was discussed above, Ogden thinks about reverie as a part of an “analytic third” that is co-created by both the analyst and the patient. The past, in this sense, is being “created anew” in the present of the analytic session (Ogden, 1994, p. 9). Ogden explains: “I do not conceive of the analytic interaction in terms of the analyst's bringing pre-existing sensitivities to the analytic relationship that are “called into play” (like keys on a piano being struck) by the patient's projections or projective identifications. Rather, I conceive of the analytic process as involving the creation of unconscious intersubjective events that have never previously existed in the affective life of either analyst or analysand” (Ogden, 1997a, p. 589).

Lastly, visual images can point at what is novel in the therapeutic relationship. Thomson discussed the role of metaphors, to be the first perception of a new quality in the session (Thomson, 1980). He brings Sharpe (1935, 1940) and Milner (1952) as examples of supporters to the notion that the first perception of what is novel in science arrives in the forms of metaphors. In that sense, visual images, in their representative role, can capture a change in the relationship between the patient and the analyst, something "new", although not yet conscious.

IV. Therapists' Responses to Visual Images in Therapy

The question of the therapists' responses to their visual images is closely connected to the previous section on how therapists believe that visual images are generated, and what their potential roles are in therapy. Following the discussion on the potential roles of visual images in therapy, I will now summarize the available literature on the actual reported use of visual images by the theorists discussed above.

Norman wrote about the differences between analysts in their reaction to visual images: "we are more or less different as analysts. Some unquestionably accept that the analyst creates visual images and sometimes use them. But just as often, I have received answers which really fail to grasp my thoughts along these lines" (Norman, 1989, p. 1).

In the review of the literature, I found four main groups of discussions on potential responses to visual images: using of the image in an interpretation, staying with the image and not interpreting it (which is sometimes accompanied by free associating to the image), self disclosure of the image to the patient, and self analysis using the image as a countertransference reaction to the patient.

Interpretation

In the example given in the Introduction Chapter, Gardner first uses free associations after experiencing a visual image in the efforts to understand it. Gardner first tries to "move the images from edge-of-awareness to center" and then follows the lead of his associations to create a verbal interpretation to the image (Gardner, 1983, p. 76). Ogden brings Bion to explain his point of view on interpretation: "the answer is the misfortune or disease of curiosity- it kills it… answers are really space stoppers… putting an end to curiosity" (Ogden, 1997b). Interpretation as an answer is therefore, not therapeutic from Bion's point of view. One should not look for an answer but to keep the space open to different possibilities. Ogden emphasizes the importance of not imposing meaning on the reverie. He explains that reveries are not "'royal roads' to the unconscious transference- countertransference anxiety" (Ogden, 1997a, 570). They are metaphors, and therefore, therapist should allow accruing meaning rather than feeling pressured to find a meaning.

In addition, Ogden argues that reveries are rarely if ever "translatable" in a linear fashion to the therapeutic relationship dynamics. Ogden warns us that "the attempt to make immediate interpretive use of the affective or ideational content of our reveries usually leads to superficial interpretations in which manifest content is treated as interchangeable with latent content" (Ogden, 1997a, p.569). Therefore, the goal in using language to explain reverie is not to arrive at an insight but to "create possibilities" (Ogden, 1997b, p.219).

Along the same lines of thought, Thomson argues that the analyst should not be in haste to impose meaning on his subjective experience: “In his very inchoate nature or ‘unmeaning’ lies its truth. Or to put it differently the truth lies in it, but it can speak to the analyst only when he is ready to hear it, rather than result from his officious strivings to bring meaning. The analyst allowing himself to be swept along by the current, awaits the synthesis which he is confident will sooner or later occur” (Thomson, 1980, p. 184-5).

Norman agrees with not imposing meaning on an image and explains his technique in dealing with the visual image. He suggests directing attention to the visual image, which then is connected with affects and words and becomes conscious (Norman, 1989).

Weir answers the question of interpretation of a visual image through a comparison to explaining the feeling of reading a poem. She believes that: “The trick is to hang on to that feeling which is done by maintaining the poetic reverie state and putting the words to paper in the best expression of the emotional tension. This is done by keeping open the connection to the inner state that has been in some cases serendipitously revealed” (Weir, 1996, p. 319). Weir maintains the state of reverie along with her search for words to match the experience.

It seems that the use of language and interpretation in the perspectives presented above are different from the classical use of interpretation. In the classical view, the task was making the unconscious conscious (in the language of the topographic model) or of transforming id into ego (in the language of the structural model). In contrast, in contemporary views the goal of therapy is not to find a “truth” that lies beneath consciousness but to create a holding space for self examination and co create various

possibilities rather than to search for one “truth”. This difference, in turn, affects the use of the image in an interpretation.

Rejecting the Image

Gardner describes how he often ignores the images that emerge because they seem to be direct translations of what the analysand is saying. Gardner regards these images as defenses, expressions of the analyst's wish to blunt his own vigilance.

In addition, Gardner gives another reason to reject a visual image by the therapist- when the image operates as a defense against the experience of mutuality. He says: “they are moments of choice to accept or to reject the almost recognized similarities of myself and the other, and to try or to flee the adventure of fuller mutualities” (Gardner, 1983, p. 76).

Self Disclosure

Ogden, as a part of his thoughts about reverie and its metaphoric role, argues against self disclosure of the reverie. His rationale is that a statement about his own metaphors “is likely to rob the patient of an opportunity to create his own metaphors” (Ogden, 1997b. p. 729). This is no small matter for Ogden since, he thinks that the creation of metaphor, of a verbal symbol to one’s emotions, gives shape and emotional substance by representing one’s own experience to oneself: “The process of the creation of self-consciousness through the making of symbols and metaphors with which to represent oneself and one's experience to oneself is a very great achievement and a gift of immeasurable importance to the analysand: self-consciousness developed and elaborated

in this way comprises a good deal of what it is to be human" (Ogden 1997b, p. 727). Nevertheless, Ogden thinks that it is important to speak from his own experience when talking to a patient. He makes the distinction between talking "from his experience" and of his experience as oppose to "talking about" his experience, which is to self disclose (Ogden, 1997b, p. 729).

Arlow also thinks that the therapist's role is to encourage the patient's own "pictures" rather than provide him with his own images. He believes that the analyst role is to help the analysand create his own narratives: "in a sense, we dream along with our patients, supplying at first data from our own store of images in order to objectify the patient's memory into some sort of picture. We then furnish the picture to the analysand who responds with further memories and fantasies… we stimulate him to respond with a picture of his own" (Arlow, 1969, p. 49).

In his book on imagery in psychotherapy, Singer objects to self disclosure. He asks: "can we, as clinicians, ever share our images or fantasies with our clients?" his answer supports the classical position on countertransference and self disclosure. He says: "I believe that one must be circumspect about such efforts lest we inflict our countertransference and personal quirkiness on people seeking our help for their dilemmas and relationship difficulties" (Singer, 2006, p. 183).

The issue of self disclosure has been an ongoing debate in the relational school of thought. Wachtel (1993) wrote extensively about self disclosure in the therapeutic session. To clarify this issue, Wachtel makes several distinctions regarding self disclosure; the most relevant to visual images is his distinction between disclosures about what is transpiring in the session and those about the therapist's life outside of the

session. He explains that “revelations about the therapist that are not about what is transpiring at the moment between patient and therapist are much more likely to be regarded as inappropriate” (Wachtel, 1993, p. 211). Wachtel gives many additional contexts in which self disclosure would be the appropriate and therapeutic thing to do, and stresses the inability of the therapist to be a “blank screen” (Wachtel, 1993, p. 208).

Self Analysis - the Response to Visual Images as Countertransference

As was discussed above, there are theorists that believe that the appearance of visual images for the therapist reflect their own countertransference in the therapy. Ross and Kapp said that “the visual images of the analyst in response to his patient’s description of dreams are used by the analyst as the starting point for the uncovering of previously unconscious countertransference” (Ross & Kapp, 1962, p. 656). They suggested to use such images for self analysis, following Freud’s suggestion for the therapists to “overcome” their countertransference reactions: “we have become aware of the counter- transference”, which arises in him (the physician) as a result of the patient’s influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize his counter- transference in himself and overcome it” (Freud, 1910, p. 144).

Doucet argued that any imagery distracts the therapist, and therefore may have an adverse effect on him. Like Ross and Kapp, Doucet thinks that proper analysis of the therapist “should yield material which may be of value in arriving at a better understanding of the exchanges between the two partners, thus making the treatment more effective” (Doucet, 1992, p. 654).

Schore, suggests that from a biological point of view, “countertransferencial processes are currently understood to be manifest in the capacity to recognize and utilize the sensory (visual, auditory, tactile, kinesthetic, and olfactory) and affective qualities of imagery which the patient generates in the psychotherapist” (Schore, 2003, p. 73).

Contemporary thoughts about countertransference view it not as a weakness in the therapist, but as an inevitable process and a valuable tool in the therapeutic situation. Bady, in the article on “Countertransference, Sensory Images, and The Therapeutic Cure” summarizes the positive aspects of visual images as countertransference: “it provides cues to valuable information about the patient. It helps achieve empathic bonds. More important, the patient sees unconsciously the therapist’s response to countertransference-whether rigid and avoiding or genuinely accepting of various emotional responses” (Bady, 1984, p. 539).

Finally, Ogden believes that the use of the term countertransference to refer to everything that the analyst experiences obscures the simultaneity of the dialectic of “oneness” and “twoness”, of individual subjectivity and intersubjectivity. The problem with the concept countertransference is that it can be used as a self-evident statement that we are each trapped in our own subjectivity. Ogden thinks that for the concept of countertransference to have more meaning than this, we must continually re-ground the concept in the dialectic of the analyst as a separate entity and the analyst as a creation of the analytic intersubjectivity: “neither of these 'poles' of the dialectic exists in pure form and our task is to make increasingly full statements about the specific nature of the relationship between the experience of subject and object, between countertransference and transference at any given moment” (Ogden, 1994, p. 8).

In conclusion, there is no extensive literature written explicitly on the therapists' responses to their own visual images in therapy. The existing literature that was written specifically on this subject mainly includes self inquiries of analysts who wrote about their own experiences of the spontaneous appearance of visual images during therapy. Additional literature is written on related concepts which can be applied to therapist's visual images including: patients' imagery, reverie, countertransference, intersubjectivity, symbolization, and creativity. From the literature available it is clear that the therapists' visual images in therapy can play various roles in therapy; they can function as a daydream, as representations for a therapeutic process, as a defense or as a narcissistic fantasy. In other words, visual images can be facilitators of the therapeutic process or abstractive to it. Nevertheless, the ideas presented in this review are mostly applied theoretical constructs and reports of personal experiences; there is no literature available on controlled research about the therapists' responses to their visual images in therapy. Therefore, in this research project, I wish to further explore the phenomenon of spontaneous visual images during sessions through a qualitative research. With the above theoretical knowledge in mind, I wish to examine therapists' experiences as well as their conceptualizations on their own visual images, and how these perspectives may be related to their responses to and use of these visual images in therapy.

Chapter III: Method

Research Question

This is a qualitative research on therapists' responses to their own visual images in the course of therapy. Therapists frequently experience a spontaneous appearance of visual images in their minds, while listening to their patients. The roles that these experiences play in the process of therapy may vary. The purpose of this study is to explore the scope of the use of visual images that therapists experience during sessions as well as the process that leads to their use. The research question is therefore, how do therapists use their own visual images in therapy and what are the processes that lead to these uses? In order to address these questions, I will conduct interviews with therapists which would include questions about specific examples of spontaneous appearances of visual images during sessions, how the therapist responded to these images, how they used these images in therapy, and their reflections on that process.

Overview of the Study Design

The data for this study were collected via in-depth semi-structured interviews with therapists who had the experience of spontaneous visual images in their minds during sessions. The aim of this study was to elucidate themes in these interviews which would lead to a theoretic conceptualization of the process and use of visual images in treatment. To support this goal, a qualitative research was chosen to allow such theoretic conceptualization to emerge. An open ended questionnaire was designed to allow for generation of unexpected themes related to visual images. The participants were asked about their experience of having a visual image, including their feelings and thoughts

before and after their experience, how they responded to it, and how they used it in treatment. These questions were designed to get an overview on the process of having a visual image in treatment, as well as to allow therapists to process their experience and reflect on it as a part of the research data.

Subjects

Subjects were recruited to participate in this project through an email sent to the following list serves: NYU Postdoctoral program in Psychotherapy and Psychoanalysis, Society for Psychotherapy Research, NYU Postdoctoral Externship program, CUNY Clinical Psychology Doctoral Students list serve (psychocommunity), and Columbia Psychoanalytic list serve. 15 therapists and psychoanalysts responded, and all of them were interviewed for this project. Therapists mentioned all together 42 visual images in the process of the interview, and discussed at least one image in depth.

Out of the 15 therapists who were interviewed for this study, ten therapists had 16 to 30 years of experience seeing patients after being licensed. Five therapists were advanced graduate students in clinical psychology programs, who had 4 to 7 years of clinical experience.

The frequency of experiencing visual images varied among therapists. Most therapists reported having visual images occasionally in sessions. Three therapists reported experiencing visual images daily; one of them reported having images every session. In contrast, one therapist reported having a single distinct and memorable image in his 30 years of being an analyst.

Therapists' theoretical orientations included: Relational, Intersubjective,

Interpersonal, Object Relations, Self Psychology, and Cognitive-Behavioral. All the therapists used psychodynamic methods; some used cognitive behavioral techniques in addition to psychodynamic methods. Nine therapists stated that their theoretical orientation was relational or interpersonal. Three therapists said that they were "eclectic" or integrative". One explicitly stated that she uses "basic Freud" theory in addition to being a relational oriented therapist.

Many therapists had additional associative experiences other than visual, including: somatic sensations (for example: muscle tension, difficulty breathing), and auditory reverie (such as hearing music).

Lastly, therapists were asked about diagnosis, or symptoms, of patients with whom they experienced the image. Patients' symptoms included: depressive symptoms (worthlessness, flat affect, and emptiness), anxiety symptoms (OCD, panic disorder), difficulties in relationships (attachment issues, anger bursts, masochistic traits, and narcissistic personality traits), substance abuse, eating disorder, borderline personality traits, difficulty in verbalizing feelings, and dissociation.

Research Materials

The primary research instrument for this study was a semi-structured open ended questionnaire (see: APPENDIX I). This questionnaire was developed specifically for the purpose of this study. The interview started with a request to describe the images experienced by the therapist. This allowed for the therapist to access the memory of these experiences. The therapist was then asked to concentrate on one image to answer the rest of the questions. The questions about the image were divided into three main groups:

questions about the image, questions about the relationship with the patient and the process of therapy, and questions about the therapist's style. These three domains cover three main variables that were thought to play an important role in the use of the image: variables related to the image, variables related to the process of therapy and the therapeutic relationship, and variables related to the therapist.

Procedures

The data collection process was divided into two phases: the recruitment phase, and the interviews phase. In the recruitment phase, a flyer was sent to a number of training programs and analytic institutes. All 15 therapists who answered this email, were contacted and found to be suited for this research; they all reported having an experience of a spontaneous appearance of a picture or sequence of pictures in their minds, while listening to their patients. They were then invited to participate in the interview, using the questionnaire developed for this study.

This interview was conducted as a semi-structured interview, starting with an exploratory interview about the experience of images as a response to the patient's communication in therapy, and proceeding to more specific questions about this experience that were not addressed spontaneously by the therapist. This method provides the interviewee with the space to shape her own views during the interview. This method supported the exploratory nature of this research, as well as respected its subjects. It was important in this study to be mindful of the possibility that the therapist may experience his image as a personal and private phenomenon, and it was therefore important to keep the interview semi-structured and open ended.

The data for this research includes the transcriptions of one hour long interviews with 15 psychotherapists who experienced spontaneous appearances of visual images during therapy sessions.

Data Analysis

The therapist's responses to the questions were analyzed through grounded theory, as was developed by Glaser and Strauss (1967). Since this is an exploratory research in a field that was scarcely discussed and was not yet adequately researched, the hope was that an analysis through grounded theory would contribute to a comprehensive description of the phenomenon of spontaneous visual images, and possibly provide a conceptual framework for the process of the visual images generation and use thereof in therapy. This method of analysis assists in identifying the central factors that play a role in this process, affecting therapist's responses to their own visual images in the course of therapy. The identification of the main variables in the process would, in turn, provide the field with the framework for future quantitative research on the effect of various factors on the therapist's use of their visual images.

The data was coded line by line. Over 400 codes were found and distributed to four domains according to the process of visual images. These domains are: 1. Before the Image 2. The Image. 3. After the Image. 4. Therapists' Theories of the Functions of Visual Images. Within each domain, codes were grouped together according to their content and attributed to families of codes (see: APPENDIX II). These findings are presented in the following chapter.

Chapter IV: Results

A detailed analysis of the 15 transcripts of the interviews was performed. The analysis generated over 400 codes, across various domains, which were hierarchically grouped into families of codes. In order to simplify the presentation of these findings, the detailed results and images are presented in the appendix. The findings, including the codes and the families of codes are presented in APPENDIX II, and the images discussed by the therapists are summarized in APPENDIX III for reference. Below I will present the main findings of the study.

In the examination of the data, the process of experiencing a visual image was tracked: from the moments before its emergence, through the experience of having the image, and finally, its use in the session and reflections on that process.

Below I will present the findings, focusing on four domains: Before the Image, The Image, After the Image, and Thoughts about Visual Images.

Domain I: Before the Image

Therapists were asked to choose one or more images which they were willing to discuss in length. Then, they were asked about the events that led to the experience of having a spontaneous visual image.

I. Content of the Session

One of the events therapists were asked about was the content of the session prior to the appearance of the visual image in their minds, including: what happened in the

session before they experienced this image, and what were the content and the process of the session?

Interestingly, in all the images except one, which the therapists chose to discuss in length, the content of the sessions prior to the experience of visual images was about conflicted relationships. The relationships discussed were mainly relationships with parents and other family members, romantic relationships, or explicitly about the relationship between the patient and the therapist.

Discussion on Relational Difficulties with Family Members

Many therapists reported that the discussion that triggered the image was about relationships within their families. One child patient talked about anticipating an unpleasant Christmas break with his family. Another patient talked about her conflicted relationship with her mother, and described a dream she had on the evening before her mother's visit. She dreamt about an egg, wrapped in cotton, with a fetus inside it.

> "She had the dream at the night when her mother arrived, and actually during the session she reported the dream, but she wouldn't work with the dream, but instead talked about her mother, it was rare, because the major concerns for her are the father. And she talked about a pattern, this was interesting, that whenever she is with her mother, she had this irritation, even when she tells something that is good for her, she doesn't know where it comes from. It became clear that it comes when the mother wants to mother her." (subject #8, 016).

In another example, the patient talked about a specific fight between her parents when she was approximately 6 years old:

> "Her parents were divorced, her father came over to give her some money, her mother and him were fighting and the mother was shoving the metal bed against the wall and screaming back at the father, she was afraid of the yelling and of the unpredictability, what each parent is going to do or react. Her mom is schizophrenic, so she was afraid of her mother's unpredictability and her father's rage, her father was really angry all the time, and just feeling that she had no protection." (subject #1, 011).

Another patient talked about her fight with her father, during which he pulled her shirt off out of rage:

> "she had to deal with her drug addicted father who needed some money and came to her, she said "you can't exploit me anymore", he came over and pulled her sweatshirt, she wasn't wearing a bra, her sweatshirt came off over her head, she was naked from the waist up, I could see her in the hallway fighting him off, and the shock of her nakedness in front of her father." (subject #14, 074)

Discussion about Difficulties with Intimate Relationships

In addition, some patients reported difficulties in intimate relationships, prior to the therapist's experience of visual image such as: difficulties in date situations, and

separations. One patient talked about how relationships take up internal space without nourishment:

> "She was imagining that she had this psychic internal space that had a limited capacity. Only so much can come in. she talked about a man that she opened herself too. Here, I also thought of a pie, you know, when there is certain space. For this guy to take residence within her, it was a presence of an absence. When he took up the room, he precluded other people from coming in to the space and other positive life form coming in, but his presence is a negative thing. He doesn't love her, is not nourishing her, just there and taking up all these things." (subject #5, 010).

Discussion about the Therapeutic Relationship

Some patients discussed their relationships with the therapist before the therapist had an image. In all three examples there was a conflict in the therapeutic relationship that led to the image. In one example, the therapist lowered the fees following the patient's request. Another patient told the therapist that "he is not her type" when the therapist had the image.

One therapist reported having an image in her last session with a patient, who decided to leave the treatment following the therapist's announcement of her pregnancy:

> "It was the last time we met, and it's funny, I didn't write it down. She called it

something, not termination, I don't remember the language she used, and at that point, when she is sitting there with black shirt, black pants, leather gloves, I had this images…" (subject #6, 025).

No Explicit Content – Image Experienced in the Beginning of the Session

On one occasion, therapist discussed a visual image that he experienced in the beginning of the session, before there was any conversation with the patient. The image was of a dead man floating in a pool.

"Well, what was a puzzle to me was that nothing happened before, because one of the thoughts that I had was "wait a minute, I just started a session, I'm suppose to be in an emotionally-ok space, so the first thing that came to my mind was "am I having a psychotic experience?", I said "oh, I may be in trouble here" (subject #14, 014).

II. Therapist's State of Mind before Experiencing an Image

Therapists were asked to describe their state of mind when experiencing a visual image versus their state of mind in sessions in general.

A Different Level of Consciousness

Some therapists talked about this experience as experiencing themselves in a different level of consciousness than usual. One therapist said:

"Usually I'm pretty focused, but it is focusing in a different way, another level of

consciousness, I'm picking up other things and I'm much more attuned to it. Hope it doesn't sound too crazy." (subject #7, 008)

One therapist said that she is "going to a different zone" when she has visual images, and another therapist said that the experience is "loosely dissociative", and explained:

"I was about to use the word dissociative, I mean it in its loosest sense. To me, there is an associative process happening, in that I am less aware that I am sitting in a chair in the room, it is as if I am riding through a landscape painted by the words of my patient. I know that there is a bit of a dissociative sense to it." (subject #4, 067)

Later in the interview, this subject described this experience as passively "letting go".

"You know how they say that we're not supposed to work? the patient supposed to work, we're not suppose to work, you know (laughing)? So, it is like a (signs of relief) take a break, you know, letting go of any kind of, maybe a kind of scanning of.., how there is a constant scanning of so much. When I started to learn how to drive, it like scanning all the time, so this is like letting go of that and relaxing into a picture." (subject #4, 071)

Another therapist, who is also a writer, described this experience as her writing experience, allowing the images to "go through" her.

> "It feels like that when I am writing too. I don't write easily but, sometimes it almost feels like I am going to a different zone. It feels like it's coming through me almost, so it's easy. Other times it feels it's difficult." (subject #7, 074)

Efforts to Understand the Patient

Yet other therapists thought that they had a more active role in the appearance of visual images. Specifically, they felt they were trying to connect to the patient or to understand the patient better when they had an image. In one case, the therapist felt that she was trying to understand the patient's feelings when that patient had difficulty talking about them.

Another therapist said that she was trying to put herself in the patient's position right before she had an image. A third therapist stated that usually before she can see something in her mind, she is actively thinking about the clinical situation.

> "It usually occurs to me when I am actively thinking in the transference, so it's an action on my part, but it is semi-spontaneous. I trust these images because of their spontaneity. It seems that when I form an intention to think about the clinical situation in its totality and all its complexity, when I start to move towards a verbalization that I want to deliver to the patient". (subject #15, 004)

III. Therapists' and Patients' Feelings in the Session Prior to the Image

Therapists were asked to describe not only the concrete content of the session, but also the affective content of the session as they remember it before having a visual image.

Patient's Feelings

Fear

Some therapists talked about their patients' fear before they had the image. On one example, a patient talked about her fear of being crazy, followed by an image of the patient's terrified expression:

> "For example, today my client described something that is kind of schizoid, her fears of being out of control. She believes (these – D.F) are bad thoughts, thoughts that are not ok to have, that she feels that these thoughts mean that she is crazy. So, she is daunting her own mental faculties. It made me start to realize, that maybe there are fears that are related to her own thought structures, she's been holding back for a long time." (subject #13, 067).

Disconnection from Feelings

Some therapists talked about their patients feeling guilty, or angry. At the same time, some therapists talked about having an image of feelings that their patients were disconnected from, a sense that their patients did not know what they felt. For example, one therapist had an image of her adolescent patients' anger, which the patient was not aware of at the time:

> "Perhaps what I saw that he didn't talk about was the intense feelings that he was having that he was not giving voice to, and I don't think are evident to the people around him. he comes across as someone with flat affect and yet the emotions that he is dealing with are so powerful, he destroyed his room out of anger. Part of my image was, he talked about how he needed to wait to his teacher, go back to talk to her, and walking back and forth in the hallway, and I was imagining the true emotions on his face going back and forth like that." (subject #11, 034).

Therapists' Feelings in the Session Prior to the Image

Therapists reported having a range of feelings prior to the experience of visual image including: angry, controlled, anxious, incompetent, as well as happy.

Frustration

The most common feeling that therapists reported experiencing before having an image was anger. Therapists were often frustrated about their efforts to understand the patient.

> "I was trying to get further in my understanding, it was not on purpose, but I was thinking about the alienation, disconnection, in the session. It's like, I feel a little frustrated. I want to go further with that to somewhere we've never been before. I think that the image came when I was trying to see something that I couldn't see." (subject #3, 020).

Another therapist talked about feeling frustrated about feeling out of control over the treatment:

> "Yea. I'm not sure, but this was maybe a period in the treatment when I was frustrated with her. With my feelings that she was being controlling in the sessions, over the treatment. Taking advantage, trying to pull me, like a puppet. I think that was probably a part of it. (You felt controlled). Yes, so she was also showing me what she felt like. But, I felt it very much. There is also the whole way of being, in and out, that is frustrating, because I wanted to help so much and I was like 'you are not letting me help you, you know', you're not talking and you're not coming. So there is that with a real desire to help her." (subject#1, 074-076).

Therapist's anger was not only directed at the patient. In one example, the therapist was angry at the patient's stepfather:

> "I have a patient, a step father of my patient, he is a man that I have, in behalf of my patient, a lot of anger towards him and I don't see him as a whole man. I see him chopped off." (subject #4, 033).

Anxiety

This therapist, who saw an image of the father being "chopped off", reported

being at times anxious as well when experiencing that image:

> "I felt some anxiety about feeling out of control a little bit. The feeling that his life is going to continue as it was, expecting retirement and pension, and everything was threatens, his world was coming to an end, or the future that he imagined." (subject #4, 059)

Other therapists felt anxious before having an image as well. In one case, the therapist feared for his patient, when she told him about her recent fight with her father, which he could see in his mind:

> "I feared for her. she was describing how upset she was, shaken, I remember feeling anxious for her and scared." (subject #14, 086).

In another case, a therapist had an image of a patient's dream, in which the patient had to cautiously carry an egg with a fetus in it:

> "When I visualize her carrying this egg with caution, I felt this anxiety, because it was as if she couldn't focus on, it was like a burden to her daily stuff. As I was listening to her, there was conflict about whether she should take care of her mother or do her daily things, like go to therapy and do her things, should she take care of her or not…. (The anxiety about that conflict you think?) Yes, that every moment of wanting something to herself would break the egg. I sensed the terror

about anything that she does in her daily life would bring a terrible thing". (subject #8, 024-027).

Another therapist felt anxiety about being incompetent before having an image of the therapy terminating:

> "it was a mix, I felt incompetent, confused, I had hard time feeling centered in myself in what was going on, I had a supervisor that was enormously helpful and non judgmental of my incompetence here, but my feelings of being confused and scared and somewhat like a child myself, I was in a new territory and she was so nasty, she really was very attacking, so I was scared." (subject6, 051).

Happy

Lastly, one therapist reported that she felt happy for the patient before she had an image of a trapeze artists, before making a jump:

> "I do recall feeling happy for the patient, that I really did feel that she is moving forward, a deepened in genuine strength and that she was ready to take this step and that I had every, full confidence that she will succeed. And that she just needed me to interpret her state at the moment to allow her to consolidate her strengths sufficiently to go on and let go." (subject #15, 036).

Domain II: The Image

Therapists were asked to describe the images. The types of images reported ranged widely from images of a picture in the therapist's mind, a movie or a play, a caricature of a person, an abstract image, and even pure color. The content of these images also ranged widely, below is a summary of the different contents reported:

Type of the Image Content

Images that Follow a Report of a Dream

The most common experience of a visual image was the experience of therapists seeing in their minds a picture of their patients' dream after they report it. In one case, a therapist described an image of her patient's dream:

> "In the dream she had her team, she said that her team crosses the finish line without her, she is there alone. I could imagine her standing there, when her team crossed the line, and she can't do it herself and I remember in the dream that all of the female member of her team disappeared, only men there. I could really picture that, all the women left, it was helpful to me to access this material to talk about it and elicit more." (subject #5, 102)

One therapist discussed her imagery followed by a dream report:

> "There is a patient, she has a sparse way of relating to her dream, which is why I don't have rich imagery. But with other patients, the dreams are very rich and I

have very rich colorful, detailed imagery and that's really, helps me to understand dreams, relate to them, talk about them. To stay with the visual imagery is an attempt to try to stay close to the dream language, not go to interpretation, not get away from the material." (subject #5, 055)

Images of the Therapist's History

Therapists often had images of their own history. One therapist reported having images of being a parent and a married woman. Other therapists talked about images of different scenarios from their life. One therapist talked about having images of his own childhood in sessions:

"I have images, mental visual images of being with my father when I was a little boy. And my father had very strong hands. He was an accountant. He had the hands of a carpenter. What I picture is walking with him and holding his hand, maybe 4 years old, it's a weekend, we are talking a long walk, it's not in the street of Manhattan, but in a city environment but not concentrated with buildings, like Inwood, or park slope if you know that area. And that's a very warm feeling, connected feeling, there are no words in it, it's not like we are talking in it." (subject #9, 016)

Images of the Patient's Feelings

Some therapists reported having images of their patient's emotional expressions. For example, one therapist saw in his mind his patient's emotional reaction to her

description of her fight with her father:

> "They were in the hallway, outside the apartment door, I see the hallway. And her face, in spite of the embarrassment, I saw in her face a sense of liberation at the same time." (subject #14, 080).

Images of the Patient as a Child

Many therapists reported having images of their patients as children when they talked about their childhood.

Surprising Images

Lastly, therapists talked about images that surprised them. These were usually emotionally charged images, which were followed by a sense of anxiety. One of the images discussed above, the image of the dead man in the beginning of a session, was followed by an overwhelming level of anxiety by the therapist. These images will be further discussed in the next section on Therapist's Feelings and Attitudes right after Experiencing the Image.

In addition, therapists were asked about a specific experience of having an image that feels disconnected from their immediate experience, an image that felt like it "came out of nowhere". Some therapists had examples of this experience in their choice of image. Interestingly, many therapists replied that they had a sense that they did have this experience but could not recall it:

"I close my eyes (laughs). I know I do, I struggle with it. I was saying before that I (have a) kind of (an) inhibition to seeing." (subject #9, 053)

"It is probably difficult for me to think about it right now, it would have been helpful if you could put these questions ahead of time, cause I know that there are times that images "from left field" come in, that they come out of nowhere but feels related, I just have hard time thinking about them right now." (subject #10, 053).

"I think I do, I can't remember any right now, but usually they are my personal stuff, you know, but I can't think of any right at this minute. And I'm sure that if I would reflect on it, it would have to do with something that is going on, our relationship, mine with the patient, or the content possibly. There are times when I just drift, and have an image, yes." (subject #12, 075).

Domain III: After the Image

Therapists were asked about their experience after having the visual image. They were asked about their thoughts and feelings, the effect of that experience on them and the patient, and eventually how they used this experience in the session, if at all.

I. Therapist's Feelings and Attitudes right after Experiencing the Image

Therapists experienced a range of feelings immediately after having the image including: curiosity, fear, surprise, and anger.

Fear

Interestingly, the most common feeling that therapists experienced right after having an image was fear. Therapists reported different levels of fears ranging from being "scared", to being "terrified" or "horrified", and finally, fear of "having a psychotic experience".

One therapist described her feelings of being scared and surprised after seeing and image of her patient as a "thief" in the context of reducing her fees:

> "It made me feel scared in the moment I guess, because I didn't see it coming. It's that I didn't know that she has the capacity; I know that she is taking advantage of certain things, you know, so... But the degree of devaluing me that sort of, came out. She can do that with other people. Well, she is not really a sociopath because she does feel guilt when she is using people, but to me that was scary, more like kind of, surprise." (subject #12, 45).

Another therapist saw an image of the girl from the movie "The Exorcist" in her mind. When asked about her feelings after seeing the image, she said:

> "Terrified. (Terrifed?) Yes, really afraid. It's interesting because I remember that as a kid I was really scared of this movie. So this image is associated with me being really scared in general, but then seeing that in the room with the patient… (So, do you remember why you felt so terrified, was it related to the movie or the moment? Or both?) Well, both but not so much the movie as much as this

particular piece of this scary girl, who was possessed, who had no control over her feelings, her head was spinning. The image itself was scary. I felt like the girl, like her I had no control it was just, popped up." (subject #1, 021-025)

One therapist thought that he may had a psychotic experience after he saw in his mind an image of a man in a swimming pool, being smashed to death by a track, in the very beginning of a session with his child patient. He stated:

"Well, what was a puzzle to me was that nothing happened before, because one of the thoughts that I had was "wait a minute, I just started a session, I'm suppose to be in an emotionally-ok space, so the first thing that came to my mind was "am I having a psychotic experience?" , I said "oh, I may be in trouble here". (That's really scary). Yes, I was very frightened." (subject #14, 014-016)

Rage

That therapist, with another patient, felt rage after seeing in his mind a fight that the patient had with her father. He said:

"I remember that I wanted to kick the shit out of him. It provoked fantasies of rescue, I wanted to beat the shit out of her father. And I knew that if I had been around I would have beaten the shit out of him. (So, you remember feeling angry). Oh, yes. (You know, it is interesting). More enraged than angry." (subject #14, 092-096)

II. Therapists' Use of the Image – Technique

Therapists were asked about their responses to the images, whether they used the image in the session, and if so, how. Therapists' responses to the images ranged from not utilizing the image in the therapy at all, to self disclosure of the image and discussion on its meaning.

Therapists Did Not Use the Image in the Session

Some therapists said that they did not use the image in the session at all. When the therapist reported not using the image, it was either a passive reaction to the image, a sense that the image is an integral way of doing therapy, or an intentional dismissal of the image.

An example for a passive reaction was given by a therapist who talked about visual images as a frequent experience she has during sessions. When asked about the use of the image after she experiences, she said:

> "Nothing, it's just part of the thought, part of the experience, involuntary reflexive visualization" (subject #3, 018).

> "Well, I think I always have visual images in sessions, I don't think about them much, we talked about them once before briefly and before that I haven't really thought about it much. So, every time I think about a session, I can remember. So,

I think I experience it every session but I don't reflect on its presence. You know?" (subject #3, 004)

Other therapists that chose not to use the image talked about it as an active dismissal of the image, rather than a passive submission to it. In these instances, therapists chose not to use the image because they felt that it was either not relevant to the session, or even interrupts the session. In one case, a therapist was asked whether the image changes when she finds out that the image is different from what the patient said. She replied:

"No, no, I disregard the picture. Push the picture away knowing that it's my picture and not the reality, and that I need to allow myself to hear him and his description, narrative as his symbols, and his verbal meaning, more than my visualization." (subject #4, 010)

One therapist talked about the experience of having a disturbing image, and her instinctive reaction to "get rid of it":

"Yea, like "I'm not seeing you!". You know, like those thoughts that you push away in a session, and those are the ones you should be listening to, like it just arrived fully formed." (subject #6, 045)

Therapists' Use of the Image

Therapists were asked about examples of concrete uses of their images, as well as their reflections of the functions that visual images play in therapy.

Self Disclosure of the Image to the Patient

The largest group of findings in this section was regarding the choice of self disclosure of the image to the patient.

Disclosure of the Image to the Patient

Many therapists reported using self disclosure when they felt that it was appropriate to the therapeutic process. Therapists, who reported disclosing the images, were asked about their motivation to do so.

A few therapists explained that disclosing the image allows the therapist to be more playful in the session, and in turn, allows the patient to be playful as well. One therapist stated:

> "It helped to give her permission to talk about things in a more playful way, just this is a space where we can do these things, share in the moment, say what comes to mind, see if my image makes sense to her." (subject #5, 030).

The same therapist also suggested that the image offered a non judgmental way to communicate with the patient.

> "I think it can introduce a different way of talking about your experience and that also the therapist's disclosure of the image is non judgmental. It is interpretive of course but not judgmental. There is such a danger I think to say directly: "you are pissing me off right now", you know? It has such a critical aspect to it. But if I say I have an image of an angry wolf, it speaks of something symbolic, it's symbolizes the emotion. Safe way to disclose, talk, share experience with other person without the danger." (subject #5, 098).

Some therapists talked about disclosing the image in order to explore its meaning with the patient. One therapist had an image of the patient's home after he asked her to accompany him to his home:

> "I know that it's a strange request, it has a history. I then realized, I have a detailed picture in my mind. I wondered about my picture and about the reality. With him in particular I disclosed not only that I had an image of it, but also talked about this image with him. I like to view it with meaning. But I also know that there are details that he talked about that I know that I can't picture. Then I need to let the words suffice." (subject #4, 006).

Lastly, some therapists argued that disclosure of the image may help the patient verbally symbolize her experience.

> "She never heard about the word gnomon before, but when I explained, she

seemed to identify with that and then brought it up again and again, that she was thinking about it and it made sense to her. I think it did help to give her little bit of language to talk about her experience." (subject #5, 032).

Non Disclosure of the Image

Some therapists said that they usually don't disclose their visual images. Therapists where asked about their rationale for their decision not to disclose the image. One therapist explained that she does not disclose the image if she does not understand how her image is related to the session. Another therapist argued that disclosing the image to the patient may burden the patient unnecessarily:

> "With most of these patients I would not disclose. I come from an interpersonal institute, but I did not experience it as working clinically very well, I mean, under certain circumstances, so I would say that I will never share these images.
> I would say nine times out of ten I wouldn't tell them. I don't want them to be burdened. Most of the time what I do with the image is I shelve it, I notice, I pay attention and put it away." (subject #2, 040)

Disclosure of the Therapist's Feelings

Some therapists made a distinction between disclosing the image and disclosing their feelings which were brought up by the image. One therapist gave an example of her choice of intervention after having an image:

> "When she told me that she didn't have a husband and kids and all that, I had a visualization of her in high school, having panic attacks, alone in her room, and I had a visualization of something she told me about before, but visualization of how I visualize it, and then I will say "you talking about this remind me of feeling unloved in high school". (subject #12, 077)

Articulate How the Patient Felt

Another therapist who chose not to disclose the image argued that it was easier for her to articulate how the patient felt after having an image. She was asked whether she discussed the image during supervision:

> "Oh, yea, immediately. We explored everything, then I was able to use it. I never shared it with my patient, but I was able to use it, to be more empathic in the session, be able to articulate with words how I understand how she felt". (subject #1, 037).

Ask Questions about the Image

Like this therapist, who decided to explore the image in supervision, other therapists reported that after having the image, they started asking themselves and their patients explanatory questions in order to better understand their experience, the patient's experience, and how the image is related to the session. For example, this therapist talked about her ideas about an effort to understand the meaning of the image in the therapeutic context:

> "(So, when you have a visual image, how do you use it? Do you disclose it, use it in an interpretation?) I would today, can disclose, but the disclosure would be about me trying to understand what is going on there instead of me putting it on the patient and make him responsible for it. Imagination might have something to do with something that is going on in the session". (subject #14, 117-118)

Interpretation

Some therapists used their images in an interpretation. For example, one therapist saw an image of a taxi meter when the patient made a comment about paying fees while he is on a vacation, stating that the "meter will be running" when he is on the beach:

> "It's like you are sitting in the back of a taxi, and I was watching the numbers pass. (In this instance, did you use it differently, did you talk about it?) Well, I just said "that's an interesting way for us to stay in touch, stay connected while you were away." (So, you used it as an interpretation, but you didn't share the image) Yea." (subject #6, 63-67).

Domain IV: Therapists' Theories of the Functions of Visual Images

The various uses of the visual image were informed by the therapists' thoughts about the functions of visual images in therapy in general. Therapists' ideas about the place of the image in the therapeutic process are summarized below.

I. The Functions of Visual Images

Visual Images as a Projective Identification

Many therapists thought that some of their images are visual projective identifications. They felt that their images are of the patient's feelings rather than their own reaction to the patient's struggles.

For example, one therapist answered the question about the function of visual images as follows:

> "I think that as organisms we are so receptive. If you think about feelings, and surface area of a human being is enormous. (So, the communication you are describing here, do you think it's a communication to yourself?) I think that part of it is picked up from patients (projective identification?) Well, empathic projective. I believe that, well people that deal with all kinds of, well we are all connected. What we call the space between two people there is a shared intersubjectivity. I believe that info is in different ways carried in net. It's how I imagine it, it's not scientific. I don't want to sound too spiritual about this. I do believe that in this space that info is carried, and I don't know how, in what form, I just know that what people enact is a felt experience. (so it can be a communication from the pt to you). Yes." (subject #4, 095-101)

Another therapist described her patient as not being able to verbalize her feelings, and have less awareness of them, and understood that as the reason for her visual projective identification. She had an image of a eulogy given by her patient at a funeral:

> "my patient never cries, I mean rarely, it happens sometimes, and when she says something my eyes get filled with tears and I get emotional for her. And those situations, I do visualize what she is telling me. Like to read a eulogy in her grandfather's funeral and not crying or breaking down, I feel that, a lot of projective identification here" (subject #12, 059).

Lastly, one therapist reported a visual image that he experienced 30 years ago, and did not forget since. This was the image discussed above of a dead man in a pool after being smashed to death by a truck. As discussed, the therapist saw the image in the very beginning of the session with his child patient, who shortly after told him that he saw a dead man in a pond on his way to the session. I asked the therapist what he did with his patient's report.

> "So, I asked him about his reaction to it and he said that it was his fault, I tried to normalize it and say that most people would be frightened to see something like that although it is not their fault. It was my way of thinking, projective identification, I picked it up from him, and not knowing, not having a cue, I thought I was going out of my god damn mind. and that's the way I worked with it, so I didn't revisit that until I saw your email." (subject #14, 022).

Visual Images Attached the Therapist to Their Emotional Reaction to Their Patient

Many therapists talked about the experience of having an emotional understanding of the patient versus an intellectual one prior to the experience of the

image. This group of therapists talked about this experience as their own emotional reaction to their image, and their understanding that this response was related to the patient's experience. In contrast to the therapists who experienced their images as projective identifications, these therapists recognized their emotions as responses and not as direct projections.

One therapist talked about the meaning of seeing an image of a possessed girl when listening to the patient talk about her psychotic mother:

> "Yea, I think that it was really showing me her terror. She was telling me how she felt afraid as a little girl, the patient, how terrified she was, felt out of control, and the image made me feel how she felt there, it was a way for me to really have her experience, understand how she felt out of control, possessed too by her mother. She was very controlling emotionally; it made very clear to me what was going on. (Do you had any understanding of what was going on with her before having this image or only after?) I think that cognitively I understood it before the image, like logically, but I don't think I was feeling it until the image, the image made me actually feel it". (subject #1, 027-029)

Another therapist discussed her visual image of a gnomon as a representative of the patient's feeling that relationships take space in her, instead of nurturing her. She described this image as an empathic experience:

> "I think I thought that I was getting close to relating to it someway, and I think it was

so, it was almost in, more understanding and less empathizing, it was more of a cognitive understanding and intellectual understanding, but less feeling of what that means. She was so disconnected from her own feelings, that I had a trouble understanding her too, so I was going after that, you know." (subject #5, 020)

Visual Image is a Symbol of Information that Is Not Verbalized

Many therapists thought that their visual image was a symbol of information that was not explicitly explored in the session. Some talked about their images as representations of information and feelings that were not explored, while others talked about images as capturing feelings that cannot be verbalized, or expressed otherwise.

For example, one therapist talked about her visual images as capturing information outside of awareness:

"In a way I think of them as a sort of a waking dream, like a picture is worth a thousand words, they have the capacity to capture and reflect and express so much that is going on that is outside of awareness, mine and the shared awareness, that they can do that in a kind of a concentrated form." (subject #6, 065)

Another therapist talked about images as capturing thoughts that cannot be out into words:

"I think my images tend to capture around the area that I am explicitly thinking, and there is probably a lot more, that is close to consciousness that an image could

potentially capture but I tend to capture around what I'm thinking, more than my thought. But, part of that, as far as conceptual there is only so much you can have. I am a writer, I write narrative, there would be a moment, I am visualizing it, and to explain it, to put it into words, would be, you couldn't put the whole thing into words. So much happens in a moment. But the image capture more than the explicit thought." (subject #3, 066).

Another therapist thought about visual images as mirroring the psyche:

"It's like mirroring; I don't think it's exhaustive. Just as being mirrored is so satisfying to a patient, the visual imagery mirrors a broader expanse of the psyche, than words alone can say." (subject #15, 087).

Other therapists talked specifically about visual images as representations of feelings that are not explicit in the session. For example, a therapist who treated a patient who had a difficulty expressing her emotions:

"So, the visual stuff I think is more associative than cognition, right? so it's much looser, imaginative, like not bound to language, but it's not quite like emotion which is very difficult to capture in language, visual image can capture emotion better than language." (subject #5, 020)

Lastly, most therapists thought about visual images as symbols. Nevertheless, some therapists thought about visual images as concrete representations of the reality.

The use of the interpretation for these therapists was different from those who thought about images as symbols. For example, one therapist reported seeing an image of her patient's dream:

> "I do have a patient who reported a dream, "being up in the clouds" or something, I pictured the clouds and then it occurred to me to ask her if she smoked marijuana, and she was actually smoking very heavily and hadn't told me about it." (subject #11, 010)

Visual Images as Carrying Many Aspects of the Therapy in a Condensed Way

Some therapists thought about visual images as carrying many aspects of the therapy. For example, one therapist had an image of a hemorrhaged embryonic sac, in the last session with her patient, who decided to leave the treatment when discovering that the therapist was pregnant:

> "Yes. It was the last time we met, and it's funny, I didn't write it down. She called it something, not termination, I don't remember the language she used, and at that point, when she is sitting there with black shirt, black pants, leather gloves, I had this images, did you ever seen the picture of an embryo? It was like that, a fuzzy embryonic sac, all the blood vessels that come off the placenta, sort of that kind of orange, blood vessel, but kind of dripping image. So, an amniotic sac lit up in an orange light with all these blood vessels, and in the bottom it was sort of like

hemorrhaged, blood. What I thought profoundly is “this is an abortion”.”(subject #6, 025)

When asked about the function of the image, the therapist explained:

“I think the image was the visual representation of what happened between us, that this is an abortive therapy. That I think what I could not acknowledge myself is my experience of her aggressiveness, and murderousness. And the other thing that I was thinking about, is that for training experience to count you need to have a certain amount of hours, so there was a piece of self interest too, would what happened here count? I think that, about the image, that I had difficulty, and dissociated around how sadistic she was and how much aggression was coming at me, so my understanding of the image was that it was a representation of the miscarriage of the therapy, that there was something that was being undone, and particularly in an aggressive way and that it all spoke about my vulnerability in the face of her aggressivity (aggression – D.F) around my pregnancy and somehow that the image was carried through maternity, that the image carried also her own image about her mother, and her feeling of her own body, femininity, and her capacity to be a mother given her issues with intimacy with her mother, it kind of captured in a very condensed way all of these aspects.” (subject #6, 039).

Visual Images as Visual Case Conceptualizations

One therapist thought about her images as case conceptualizations. She described her image and understanding of it:

> "I have this patient, how his interiority feels separate than anyone else's, nobody else would accept him, that others won't understand. so, during the session when he talked about the attitude, not feeling involved, I pictured some kind of outer shell, cross section, then inside a core, and then there would be various things out here that the person would related to, have relationship with, protected from the outside and separated form it. Sort of a biological image. (How did the core look like?) I'm seeing it in cross section. It's off white or greenish light, the outside section, and the inner section is more lit yellow, it's small, now when I think of it, it's sort of '"eggy", like an egg. Disconnection, an interiority that he feels that he can't have in the world for all the different reasons. An alienation." (subject #3, 008-010)

Later on in the interview she explained:

> "Well, in the core, it is my image of my understanding. Not what he talked about exactly, my visual case conceptualization." (subject #3, 052)

Some Images May Distract the Therapist and Interrupt the Session

Lastly, one therapist talked explicitly about how images can interrupt the session, by blocking information. She discussed a situation when she sees images that are

stereotypic and therefore block information from the patient:

> "For example, I have a patient who is a cross dresser. Immediately I am thinking how he looks like in women's clothing, you know. Unfortunately, it eclipses the whole spectrum of who he is. But that happens, I can't help it. I know now, that over time, I will get a more integrated image, but I also know that the stereotypic image is going to block me." (subject #2, 067)

II. How are the Images Created in the Process of Therapy?

In the end of the interview, therapists were asked about their thoughts on the process of the creation of visual images, as they experience it. Many therapists never thought about the origin and creation of their images. Some could not identify this process initially, but were able to generate hypotheses as to the creation of their images by the end of the interview.

Visual Images are the Result of an Unconscious Process of Information

Some therapists thought about visual images as the result of a process of information that was created in the unconscious. When discussing the use of the image, one therapist talked about the quality of visual images as representing unconscious information:

> "If we can access to our visual imagery, it is closer to something more pure, right? I mean it's closer to unconscious, unfiltered, uncensored, unintellectualized stuff."

(subject #5, 098)

Another therapist, talked about the co-creation of the image as an unconscious process:

> "Co-creation, exactly, but it's an unconscious, spontaneous co-creation. It's a creation of a different order of mentation, it's a combination of the induced countertransference in Racker's sense and a generative creative engagement on my part, that was induced in me that spontaneously generates these images, so that's one line of thought."(subject #15, 010)

This therapist discussed the process of visual image creation as a creation of both the patient and the therapist together, and therefore a representation of the interpersonal process.

Visual Images are Results of Cross Sensory Integration

This therapist, talked about visual images as not only a result of an unconscious process, but described this process as an unconscious cross sensory integration, in which the image is a representation of information from different senses.

> "Now Dan Stern, much later on, like in the 90's or the 80's studied cross sensory modalities in infants and he concluded that cross sensory integration was a possibility from the earliest days of life. He reported research that shows for

example that an infant who was fed with a certain kind of nipple, nipple of a certain shape but couldn't see the nipple, could later on identify visually the same shape. So there, the tactile sensory modality on their lips crossed to visual perception and they could identify visually what they physically just felt. So, I've always assumed that visuals created in me are some kind of a reliable integration by my unconscious of input from many different sensory modalities including --- and that they were really valid." (subject #15, 014)

The Connection between Feelings and Images in the Process of the Experience of Visual Images

Interestingly, all therapists talked about visual images as being attached to feelings. Many of the therapists could not identify if the feeling preceded the experience of the image, or came after the image. Some therapists could not separate between their images and the feelings attached to them. Therapists thought about these feelings, as either their own responses or their patient's projections; as responses to an image or as provoking an image. All therapists agreed that visual images are connected to feelings.

Many therapists could not identify whether the feeling or the image came first. Some therapists had a better picture in their minds of their own process during the interview. For example, one therapist had an image of her patient giving a eulogy:

"I think like with the eulogy with the podium. I started to visualize the pieces of it, I visualized a catholic funeral, although she is Jewish. As I visualize her talking I am starting to feel sad. But may be the feeling come first, I don't know as I told

you. Then, I see that she is not looking sad, and then I understand that I am feeling her sadness and then I am telling her this." (subject #12, 122)

Feelings Come After the Image

Later on in the interview, this therapist had a clearer picture of her process when discussing another image, an image of a thief, after feeling devalued by the patient:

"Yea, I think it's how it works for me, that the image comes before my sense of logic and understanding. So I think that feelings produced the image of the thief, you know my feeling that I wasn't aware of in the moment." (subject #12, 047)

Strong Feelings Precede the Image

Some therapists thought that visual images came when there was a strong emotional content in the session.

"The visual images mostly come up when my pts are talking about some kind of a conflict. Something that is emotionally charged, affect driven. You know, when they go on "and then I did this, and then I did that" you know, it's just of kind of like, I'm not visualizing that. When that becomes affect laden or emotionally driven then I start to." (subject #13, 029)

To conclude, this study yielded many finding, including conflicting ones, regarding therapists' experiences of their images, their feelings and thoughts about their processes,

as well as their use of their images. The amount of codes generated from the interviews as well as the range of these findings as were illustrated above, point at the complexity of this phenomenon. In the next chapter I will further examine the results in the context of the available literature and create a theory of Visual Images Typology.

Chapter V: Discussion

The overall goal of this research is to understand the experience of spontaneous visual images, and how therapists use them in therapy. This experience was examined through the process of the images first appearance in the therapists' mind, through the therapists' feelings and responses to them, and finally their reflections about possible meanings of the experience.

The assumption of this study was that spontaneous visual images are one phenomenon, which follows an identifiable process leading to therapists' various responses. The goal of this research was to track this process and to identify therapists' responses to it. Nevertheless, the results of this study, presented in the last chapter, suggest that the experience of having visual images serves multiple purposes. The results suggest that therapists have different types of visual images; each is led by a different process.

Below, I will walk the reader through the process that led me to this conclusion. I will first present the main results and identify the conflicts inherent in them, using the appropriate literature. This discussion will be followed by my conceptual formulation of the processes and uses of different types of visual images.

My formulation of the data is focused on three main types of visual images, which I will call: Associative Images, Symbolic Images, and Defensive Images. Associative Images are images that are close to the content discussed and are often a response to visual content in the session (for example, description of dreams). On the other hand, Symbolic Images are representations of the interpersonal process in the session. They are not simply associations to the content presented, but are related to the content

metaphorically. Lastly, Defensive Images are images whose function is to move away from the therapeutic process rather than further engage in it.

These theoretical formulations will emerge from the discussion on the interplay between the results and the current literature on visual images. This analysis will be divided into the four main domains, which were presented in the Results chapter: Before the Image, The Image, After the Image, and Therapist's Theories of the Functions of Visual Images. The second part of the discussion will be dedicated to my theoretical formulations of types of images. Finally, the limitations of this study and suggestions for future research will be addressed.

Part I: an Examination of the Results in light of the Literature on Visual Images

Domain I: Before the Image

I. Therapist's State of Mind before Experiencing an Image

There are two groups of findings regarding the therapist's state of mind prior to the appearance of the image. The first was a passive state of mind that focused on the therapists' lack of control over the experience. The second group of therapists focused on their active effort to understand the patient before they had the image.

Many therapists talked about their state of mind before the experience of an image as a "different level of consciousness" including: "going to a different zone", "letting go", and letting the image "go through" the therapist.

This state of mind of the therapist in therapy was discussed by Freud. Freud believed that the fundamental rule of free association for the patient has its counterpart in the analyst's effort to "surrender himself to his own unconscious mental activity, in a

state of evenly suspended attention" (Freud, 1923, p. 239). Fliess agreed that the attention of the therapist should be evenly suspended, with a special temporary displacement of cathexis, and named this state "conditioned association".

This point of view, that stresses the therapist's surrender attitude in therapy, was further discussed by Modell, a contemporary Freudian psychoanalyst. Modell argued that the image in therapy can be used as a non-linear process to solve a problem. He explained: "thought needs to be liberated in such a way that subconscious work can take place" (Modell, 2003, p. 31).

On the other hand, some therapists talked about their efforts to better understand the patient, right before they had the image. This effort included: trying to put oneself in the patient's position, to understand a patient who was not communicating her feelings verbally, or a general effort to understand the clinical situation. This is a more active description of the therapists' role in the appearance of spontaneous visual images; as one therapist described: "it usually occurs to me when I am actively thinking in the transference, so it's an action on my part". (subject #15, 004)

Robert Gardner is a psychoanalyst who has explored visual images as a process. He describes his state of mind before having the image, as an active search: "I seem always to look for visual images. I prize them. I count on them to set me straight. I think that I see visual images when I am at what I think my best. I see them when I am in a tolerable turmoil: enough but not too much. I see them when complexity seems more challenging then oppressive" (Gardner, 1983, p. 70).

Norman also talked about the active effort to understand the patient, along with the willingness to surrender oneself to the analytic process. A "restful concentration":

Norman talked about his efforts as an analyst to find a solution to a contradiction presented by the analysand during therapy: "as analysts we are constantly trying to find a solution to the contradictions which we are confronted with by the analysand. Sometimes the analyst must really strain himself intellectually, alternating with periods of free-floating attention and so closer to the hypnagogic hallucinations. It may seem somewhat odd that the analyst should be half asleep and hallucinating, and I must then underline that I have not even been near to falling asleep on any of the occasions I present as examples. I have been wide awake but not occupied by anything other than the ongoing analytic work, a feeling of restful concentration, and an absence of any definite intentions" (Norman, 1989).

The passive and active states of mind reported by therapists may represent different processes which precede visual images. The first process is a result of a passive state of mind, while the other is a result of an active effort to understand something that is not yet known. In the results, these processes were connected to different types of visual images, which will be further discussed below.

II. Therapists' and Patients' Feelings in the Session Prior to the Image

Patients' Feelings

Out of fifteen therapists, seven therapists talked about their sense that their patients were unable to experience their feelings, and therefore, to communicate them. These therapists thought that the main experience of the patient before they had the image

was disconnection from their emotions. Two therapists reported that their patients felt fear.

The appearance of the image as a response to an inability of the patient to access difficult feelings and verbalize them is interesting. It suggests that the therapist's images contribute to her understanding of the patient when the patient is unable to verbalize her emotions.

It seems that the patient, who cannot communicate verbally, uses a different channel of communication to communicate with the therapist. Fosshage (2005), a self-psychologist, points out that imagistic processing begins to develop before language and is a separate way of communication. Fosshage does not argue that the image is compensation for an inability to verbalize, but that it is an additional and separate channel of communication. He argues that images contribute to early development of implicit relational knowing in therapy. Also, Fosshage argues that the implicit relational knowledge of the patient is where change in therapy occurs, in contrast to the classical position in which change happens mainly through interpretation and insight. Moreover, from Fosshage's point of view, the image promotes implicit relational knowing, and is another tool to communicate information, rather than a less sophisticated tool.

Therapists' Feelings

The most common feeling that therapists reported before experiencing the image was anger or frustration, reported by five therapists. This frustration was related to the therapist's inability to see something in the session, a sense of being out of control over the session, or a possibly displaced anger on a third party discussed by the patient.

The frustration reported by the therapists was connected to their feeling that there is something that they do not understand or something that is not yet known. A few therapists who did not feel frustrated also reported this sense that there was something that they did not know before having the image. This data leads to the possible conclusion that the role of the image is to fill in a gap in the therapist's understanding of the therapeutic interaction. The appearance of the image as a response to therapists' frustration about lack of information, points at an existence of an unconscious processing of information. This processing takes place between the therapist's frustration and the appearance of the image. The image, from this point of view, could be a creative solution to a problem. This idea adds another dimension to the process of visual images; the image is not only a response to the patient's inability to verbalize feelings, but also a response to the therapist's frustration.

This idea about visual images as unconscious processes of information is presented in the literature on creativity. Visual images are frequently addressed as creative solutions to a problem which takes place in the unconscious. Modell discussed the role of visual images as an "unconscious metaphoric process" (Modell, 2003, p. 29-30). He brings examples of chemists and mathematicians, who saw in their minds solutions to difficult problems. For example, Modell brings Kekule's description of his discovery of the closed-carbon-ring. On one afternoon in 1865 he fell asleep: "again the atoms were gamboling before my eyes. This time the smaller groups kept modestly in the background. My mental eye, rendered more acute by repeated visions of this kind, could now distinguish larger structures, of manifold confirmation; long rows, sometimes more fitted together; all twinning and twisting in snakelike motion. But look! What is that?

One of the snakes had seized hold of its own tail and the form whirled mockingly before my eyes" (Modell, 2003, p. 27-8).

Other therapists felt anxious before experiencing the image. Therapists explained this anxiety as either a fear for the patient, their own fear of incompetency to treat the patient, or thinking about their anxiety as identifying with the patient and experiencing their conflict.

The image as a response to anxiety could be interpreted as an effort to move away from the material. Ross and Kapp (1962) wrote about the therapist's imagery as countertransference reaction and an "interruption of empathy". They explained that because the analyst is not free to verbalize his associations as is the patient, he is acting out his unconscious mental activity, which may include "involuntary ideas into visual and acoustic images as a phase to the analyst response to the patient" (p. 646). Ross and Kapp suggested that the appearance of visual images as a result of the therapist's (unconscious) efforts to get rid of an impulse through its direct expression.

At the same time, therapists' anxiety prior to having an image can be explained by the therapists' own conflict about knowing the patient or knowing more about the therapeutic interaction. In that sense, the therapist's anxiety could be complementary to their frustration. The therapist wants to know more about the patient and the interpersonal interaction, but is anxious to know at the same time. The appearance of the image as a response to frustration and anxiety is a creative solution to the therapist's conflict. The therapist's anxiety, in that sense, is the anxiety connected to the fear of knowing, of getting closer to the material, rather than further away from it as was thought of by Ross and Kapp.

Lastly, the difference between anxiety and frustration prior to the image can point at two separate processes of visual images. One is a visual image that is a response to the therapists' anxiety, and the other, a response to her frustration.

Domain II: The Image

The content of the images discussed by the therapists ranged widely. The content was analyzed and assigned to types of images. Most images fell into the following categories: Images that follow a report of a dream, images of the therapists' own history, images of the patient's expression of their feelings, images of the patient as a child, and images that were surprising to the therapist.

Domain III: After the Image

I. Therapists' Feelings and Attitudes right after Experiencing the Image

The most common feeling that therapists experienced right after having an image was fear (reported by six therapists). Therapists reported different levels of fears ranging from being "scared", to being "terrified" or "horrified", and finally, fear of "having a psychotic break". Another reported feeling among therapists was anger. This was a much less common experience.

Of note, the most common experience before having an image was frustration, while the most common affect after having the image was anxiety. Out of the five therapists who were frustrated, only one explicitly talked about her feeling of being anxious after the image. Most therapists did not identify their feelings both before and after the image. Nevertheless, the data reveals that every image had a feeling attached to

it, and that the feelings reported before the image are different than the feelings reported after it.

It is not clear yet whether there is a transition of feelings before and after having the image, this would have to be examined in a future research on images. If there is such a transition of emotions, the question of the image as a regulatory agent becomes central.

It is important to note that therapists who felt anxiety after the image were surprised by the image, and did not understand its immediate connection to the process. Other therapists did not identify any specific feelings after having the image, possibly because it was not an overwhelming feeling. This fact again points at two separate processes that generate visual images.

II. Therapists' Use of the Image – Technique

Therapists' responses to their images ranged from not utilizing the images in therapy at all, to self disclosure of the image and discussion on its meaning.

Therapists Did Not Use the Image

Some therapists reported that they did not use the image at all. Some reported that they didn't intentionally use it because they felt that the image was an integral experience in the session, not an object for observation. Other therapists decided to actively dismiss the image. Those therapists gave examples of situations when they experienced their images as interruptive, because they thought that their images were personal and not related to the patient. Others felt that the images could block information, or lastly, some felt that the image was too disturbing to them.

These findings about therapist's reasons for not using their images speak not only to therapists' various theoretical orientations, but also to the variety of visual experiences. First, some images are a part of the session, like any other experience in the session. This idea puts the image as a part of the analytic process rather than an object that represents it. These images are experienced as associations, rather than an event in the session that needs special attention.

Others felt that the image interrupted the session. These images could be defensive images that keep the therapist away from the content of the session rather than staying close to it.

Some therapists felt that the image interrupted the session because it had a personal nature. This does not seem to represent a type of image but rather a therapist's perspective on her experience. The source for this point of view seems to be in the classical perspective on countertransference; the therapist's personal associations need to be kept away from the analytic dialogue and controlled for.

Kern (1978) discusses visual images as countertransference reactions. He did a self study of his visual images, and concluded that visual images are both empathic reactions and countertransference reactions. He named the countertransference "anti-therapeutic processes". Interestingly, Kern separates between the content of the image and the background of the image in terms of their psychological meanings and says that the manifest form of the image reflects the attempts to empathize with the patient while the background of the image reflects the analyst's struggles with his own countertransference.

On the other hand, Gardner (1983) thought about the personal nature of the image in a different way. Gardner wrote about his own experience of rejecting an image when the image operates as a "defense against the experience of mutuality" (p. 76). Gardner discussed the experience of having images that are motivated by identification with the patient. In contrast to therapists in the study who felt that this was a good cause for rejection of the image, Gardner argues for the opposite: "they are moments of choice to accept or to reject the almost recognized similarities of myself and the other, and to try or to flee the adventure of fuller mutualities" (p. 76).

The reasons for not using the images discussed above reflect two separate variables affecting the results. One variable is the therapist' theoretical orientation reflected in the above discussion on countertransference. The other variable reflected in the data is a reaction to different types of images. One type presented above is a visual association, which was treated by therapists like any other cognitive association in the session.

Self Disclosure

The largest group of findings related to the therapist's use of the image is related to self disclosure of the image to the patient. Many therapists reported that they disclosed the image to the patient. Those therapists who disclosed their images had various explanations for their choice to disclose. One therapist explained that disclosing the image allows the therapist and patient to be more playful in the session and that it offers a non judgmental way to deliver an interpretation. Another explanation was that the disclosure opens a space for the exploration of the image's meanings. Lastly, one

therapist raised the idea of disclosing as an effort to help the patient start a symbolization process in the lack of verbal abilities.

A few therapists said that they usually don't disclose their images. These therapists decided not to disclose because they did not understand yet how the image was related to the session, or they felt that the disclosure of the image would burden the patient.

Some therapists decided not to disclose the content of the image, but disclose their feelings about it. Lastly, some therapists were able to articulate to their patient how they thought that their patients felt, following their image about it. Disclosure of feelings is an interesting finding, since it points at the ability of these therapists to translate the feelings produced by the image into words.

Self Disclosure to Promote Symbolization

One therapist used her image to promote her patient's ability to symbolize. This therapist saw a gnomon in her mind, when the patient talked about her relationships with men. She discussed her use of disclosure of her image as an effort to give the patient words for her experience:

> "She never heard about the word gnomon before, but when I explained, she seemed to identify with that and then brought it up again and again, that she was thinking about it and it made sense to her. I think it did help to give her little bit of language to talk about her experience." (subject 5, 032).

This is an example of the use of the image not only as the therapist's representation of the therapeutic process, but the use of disclosure to create a playful space to promote symbolization.

The question of self disclosure has been an ongoing debate in the relational school of thought. Wachtel (1993) wrote extensively about self disclosure in the therapeutic session. To clarify this issue, Wachtel makes several distinctions regarding self disclosure; in one important distinction, Wachtel points at the difference between disclosures about what is transpiring in the session and those about the therapist's life outside of the session. He explains that "revelations about the therapist that are not about what is transpiring at the moment between patient and therapist are much more likely to be regarded as inappropriate" (Wachtel, 1993, p. 211). Wachtel gives many additional contexts in which self disclosure would be the appropriate and therapeutic thing to do, and stresses the inability of the therapist to be a "blank screen" (Wachtel, 1993, p. 208). The important idea presented in these distinctions between appropriate and inappropriate self disclosures, is that self disclosure is not in fact the center of the debate. Self disclosure can be either appropriate or inappropriate depending on the meaning attached to it in the therapeutic process.

Therefore, self disclosure is directly related to how the therapist perceives the image. Interestingly, some therapists thought about their images as representations of an interpersonal dialogue, and used their image to communicate to the patient something about their interaction. For example, a therapist who saw in her mind an abortion in the last session with a patient interpreted her image to the patient as related to the termination process. On the other hand, another therapist thought about going to the grocery store

when her patient rejected her. This therapist decided not to disclose her image to the patient, possibly because it was a defensive image or an image that could be hurtful to the patient.

I believe that this distinction between images is central when discussing visual images. This distinction is represented in the literature in Hanna Segal's discussion on "symbolic equations" versus "symbolic representations" (Segal, 1957), and in Winnicott's discussion on "fantasy" versus "daydreaming" (Winnicott, 1971). The application of these discussions on visual images reveals a central difference in representations. The first is a Symbolic Image, which symbolizes a process in treatment, such as the example of the abortive treatment. The second is a Defensive Image, such as in the example of the therapist who needed to get away from the session and go to the grocery store. This image is defensive because its essence is a retreat into fantasy versus engagement in the session through imagination, or "daydreaming" (Winnicott, 1971).

Interpretation versus Exploration of Meaning

Many therapists said that they ask many questions after having the image, in order to explore the various meanings of the image in the context of the therapy, while others used direct interpretations. This idea is supported by Ogden (1997), who emphasizes the importance of not imposing meaning on the reverie. Ogden thinks about reverie as metaphors, and as such, the therapists' role is to allow accruing meaning rather than feel pressure to find a meaning, or impose his own formulations on the patient. In addition, Ogden believes that reveries are rarely translatable in a linear fashion to one meaning, and therefore: "the attempt to make immediate interpretive use of the affective or

ideational content of our reveries usually leads to superficial interpretations in which manifest content is treated as interchangeable with latent content" (Ogden, 1997a, p. 569). Therefore, the goal in explaining reverie is not to arrive at an insight but to "create possibilities" (Ogden, 1997, p. 219) or to find multiple meanings rather than constrict the conversation. At the same time, interestingly, Ogden does not write about using self disclosure as promoting this process.

Weir also believes in postponing the question of meaning and interpretation in the favor of holding on to the feeling brought up by the image. She compared this process to reading a poem: "The trick is to hang on to that feeling which is done by maintaining the poetic reverie state and putting the words to paper in the best expression of the emotional tension. This is done by keeping open the connection to the inner state that has been in some cases serendipitously revealed" (Weir, 1996, p. 319).

Gardner (1983), in his book "self inquiry", writes about his own process after experiencing visual images. He described his process as first of having free associations to the image, and then follows the lead of his associations to form a verbal interpretation to the image (p. 76).

In conclusion, some differences in the use of visual images reflect different theoretical orientations while others reflect responses to different types of visual images. For example, the question of self disclosure is not only a theoretical preference, but also a clinical decision related to a specific clinical situation. In that sense, I believe that self disclosure would be less probable when the image is defensive and more probable when the image is symbolic.

Domain IV: Therapists' Theories of the Functions of Visual Images

The uses of the images by the therapists were informed by their ideas of the functions of visual images in therapy.

Projective Identifications

Many therapists thought that at least some of their images are projective identifications. As such, they described their feelings as a result of identification with the patient. They described it as their "patients' feelings" that they picked up rather than their reaction to the patient's emotional state. An example of this response was given by an analyst who saw an image of a dead man in a pool, in the beginning of a session, before any conscious interaction was made. After an exploration, he found that the patient had an actual experience of seeing a dead man in a pond on the way to the session that day.

This finding can be further understood through Bion's concept of reverie (Bion, 1962). Bion emphasized the crucial role of the mother's capacity for reverie as containment for projective identifications from the infant. He argued that through reverie the mother may digest the material projected to her by the infant, and detoxify it. This material is then available for thought. This function is called the alpha function. The undigested feelings of the child are called "beta elements" (p. 307). From this point of view, the therapist's role in the session is to use the image as a detoxifying function, and assist the patient to tolerate difficult feelings. More specifically to the example above, Bion gives an example of an infant who is afraid of death and projects in onto the mother. He explains that if all goes well, and the mother is able to tolerate this anxiety, the infant would eventually inroject the fear of death as tolerable (p. 309).

The same experience, of feeling a strong emotion following the experience of the image, was interpreted by other therapists as an experience of empathy.

Empathy

Many therapists said that the images assisted in helping the therapists understand the patients emotionally versus an intellectual understanding prior to the images. In contrast to those who felt that their images were projective identifications, these therapists recognized their emotions as responses and not direct projections from their patients.

This finding is an illustration of Ogden's point of view on reverie and its use in therapy. Ogden argued that reverie is a re-presentation of the unconscious, not a glimpse to the unconscious itself. He thought about reverie as an "emotional compass" (Ogden, 1997a, 571), and as such directs him to the emotional experience he has with the patient.

Many therapists talked about images as symbols of information that was not verbalized. Some thought that their images represented information that was not explicitly explored in the session, such as the patient's feelings. Others talked about images as capturing feelings that cannot be verbalized, or expressed otherwise. The theoretical question that differentiates between these views is whether visual images capture the subtlety of emotions that by definition cannot be captured by verbal communication.

Fosshage (2005) argues that visual images are another way to communicate in session, separate and complimentary to verbal communication. This is an important distinction to make, between visual images as a channel of information that becomes

available when verbal communication is unavailable, or alternatively, that visual images exist alongside with verbal communication and capture the subtlety of emotions that cannot be expressed otherwise.

The idea that there is unconscious information ready to be revealed by the therapist was discussed by Norman (Norman, 1989, p. 121). Norman saw in his mind an image of landscape with the title "mother's body" as a response to his patient's discussion on family dynamics. He then expands on its meaning: "through the image of the landscape I perceived a level of the material of which I might otherwise not have become aware – that the house in the country was remnant of a good, preoedipal relation to the mother which he had managed to rescue from his hatred" (Norman, 1989, p. 121).

On the other hand, Stern argues that there is no "unconscious clarity underlies defense" (Stern, 2003, p. 37). Stern's point of view on the process of therapy is that underneath the defense there is unformulated experience that needs to be co-constructed in the process of therapy. Norman's experience from Stern's point of view will therefore be unformulated experience, and will become a dynamic formulation only when Norman assigns meaning to it, through the reconstruction of the unformulated experience. As discussed above, this experience could also be understood as a step towards the creation of meaning through the use of imagination.

Some therapists in the study thought about visual images as carrying many aspects of the therapy in a condensed way. This idea is consistent with Lester's (1980) ideas about the differences between visual images and language. Lester argues that the quality of imagery makes for simultaneous availability of a large amount of visual information and thus contributes to the flexibility and the speed of thinking in images. In

contrast, in verbal memory, multiple units of information are available successively, linearly, but not simultaneously. This simultaneous quality of the image permits an integration of complex information into one image (p. 413).

To conclude, these points of view on images represent very different responses to the image. The first is the therapists who believed that their images are direct projections from the patient, as "not belonging" to the therapist but to the patient. Other therapists talked about the image as connecting them to their feelings, rather than a cognitive understanding of the patient that they had prior to the image. These therapists thought about the images as connecting them to their own dissociated feelings about the interaction rather than directly to the patient's feelings. Lastly, some therapists thought about their images as carrying layers of information that cannot be carried by language.

Part II: Conceptual Formulation of the Process and Use of Therapists' Visual Images

In putting together all of the above findings and reflections, I came up with the following conceptualization of the process of visual images and their use.

The main finding of this study is that there is more than one experience of visual images; there are several types of images which are results of separate psychological processes. This important distinction between types of images emerges from the above discussion. The discussion points at three different types of images.

The first is a spontaneous image that does not reflect directly the content of the session, but is a representation of the interpersonal process in the session. These images

are often experienced as surprising since their connection to the session is usually not readily available to the therapist. I named this images Symbolic Images.

The second type of images, are images that directly reflect the content of the session, and usually come up as a response to visual material. For example, these are frequent when a patient talks about a dream, which is visual in nature. These images are not surprising to the therapist, they are experienced as a part of the session and their connection to the explicit content of the session is readily available to the therapist, at least in part. This does not mean that these images cannot be further interpreted and explored, but that these images are more readily available to consciousness than symbolic images. I named these images Associative Images.

The third type of image, are Defensive Images. Their role is to distance the therapist from the content discussed. Since most therapists did not mention images that are defensive in nature, there isn't enough information in this study to be able to track the visual defensive process. Therefore I will not focus on these images.

The different types of images are results of separate processes, and they have consequences to the use of images in therapy. I will use this initial distinction to discuss the different processes that lead to different uses of images in sessions.

I. Symbolic Images - Spontaneous images that are representations of the session's process

These images do not simply represent the content, but seem to be pregnant with layers of meaning that are not readily available to consciousness. The fact that they are not readily available to conscious understanding points at their unconscious source.

These images are usually surprising to the therapist. For example, subject #1, saw a scene from the Exorcist in her mind while her patient talked about a conflict with her mother when she was a child. This image was surprising and terrifying to the therapist. Many other therapists talked about their surprise after having a symbolic image. Nevertheless, therapists who are comfortable working with their images in general feel less surprised by them even when they are not readily connected to the session. For example, subject #5, who had an image of a gnomon when her patient talked about her relationship with men, was not alarmed by this experience, but took it in and processed it. Robert Gardner also reports images that are representations of the interaction, but is not usually surprised by them (Gardner, 1983).

Interestingly, these images seem to come up when something is not communicated verbally in the session. The findings point at two central reasons for this miscommunication of information to occur:

1. Often (reported by seven therapists), the patients are disconnected from their feelings when the image appears. The reason for the miscommunication is the patient's inability to verbalize their feelings, since they are not consciously available to them. At the same time, there seem to be another channel of communication that the therapist is able to perceive, which results in the visual image.
2. Other times, the therapists may have difficulty in hearing the material. Most therapists did not talk openly talk about their conflict about knowing. One therapist, talked about her image of her patient's

> boyfriend dating someone else. She said that she did not want to see this in her mind, and after she had this image it became a conscious thought that she needed to grapple with. Although most therapists did not talk about this conflict, the finding that therapists were mostly anxious after the appearance of the image may point to that direction.

Therapists' feeling before experiencing a Symbolic Image is often frustration. Many therapists felt frustration before the image, which may be an indicator for their motivation to know more or understand what is not yet known. Some were explicit about their wish to further understand the patient, and others talked about their cognitive understanding of the patient accompanied by the lack of an emotional understanding.

The most common feeling after experiencing the image was anxiety. This anxiety seems to be related to both the way in which they received the information (through visual images) and to a possible conflict related to that information.

Some therapists talked about the fact that they do not share these experiences with their colleagues because they felt that it was not an acceptable experience. For example, subject #14, who saw a dead man in a pool in his mind, reported that he did not discuss it with anyone since it happened 30 years ago. Another therapist, subject #2 explained her feelings of being misunderstood by her colleagues whenever she talked about visual images:

> "Well, I don't know, I don't talk about it (visual images – D.F) with colleagues so much. You know, we may talk about other things.

Really?

Yes. I've heard it before, but some of the time if I talk about it, it's almost absurd, there almost spiritual, like new-age-horoscope, I see a vision, something like that, and I mean, that's not what I'm talking about. This is not about "out there". So it's hard to talk about that." (subject #2, 006-008)

Visual images seem to be still considered an out of the ordinary experience and therefore, images are mostly not a part of the analytic conversation. As such, having this experience may be uncomfortable and anxiety provoking to the analyst. Symbolic Images seem to be especially surprising, which may feel intrusive to the therapist.

At the same time, as mentioned above, the therapists may have been anxious after the appearance of the image because of their conflicted feelings about being exposed vividly to the information they wished to avoid. In that case, this could have been the reason for the difficulty in communicating the information in session. In other words, the patient may have told the therapist something that the therapist could not process consciously. The anxiety points at the therapist's conflict between "knowing" and "not knowing", the wish to know the patient along with the fear of knowing.

Often, the information that is presented through the image needs to be decoded or co-constructed. Usually, there is one level of information that is available consciously, and other levels of meaning that need to be decoded. For example, the therapist who saw in her mind an abortion as a response for her patient's decision to terminate the treatment had the immediate thought that "this is an abortive therapy" (subject #6, 039). It is later on that she realized the different additional layers of meanings of the image:

> "I think the image was the visual representation of what happened between us, that this is an abortive therapy. That I think what I could not acknowledge myself is my experience of her aggressiveness, and murderousness. And the other thing that I was thinking about, is that for training experience to count you need to have a certain amount of hours, so there was a piece of self interest too, would what happen here would count? I think that, about the image, that I had difficulty, and dissociated around how sadistic she was and how much aggression was coming at me, so my understanding of the image was that it was a representation of the miscarriage of the therapy, that there was something that was being undone, and particularly in an aggressive way and that it all spoke about my vulnerability in the face of her aggressivity around my pregnancy and somehow that the image was carried through maternity, that the image carried also her own image about her mother, and her feeling of her own body, femininity, and her capacity to be a mother given her issues with intimacy with her mother, it kind of captured in a very condensed way all of these aspects". (subject #6, 039)

This process of decoding the image and understanding its many layers of meaning is the question of the use of the image in therapy. The first clue to disentangle the riddle that the image carries with it is to look into the feeling attached to the image. In other words, understanding the image is only possible through experiencing the feeling that is attached to it.

Tracking this process was difficult for the subjects. Most therapists had difficulties remembering subtle details of their experience, and very often the image was not understood completely.

One therapist could track her feelings before and after having the image and how it affected her. This example illustrates the process of the Symbolic Image. Subject #12 saw an image of a thief in her mind when her patient left the room in the end of the session. The session was about the therapist lowering the fees for the patient. The therapist was able to identify her initial surprise of having the image, which was followed by a strong feeling of "being used", a feeling she was not aware of prior to the image. The therapist started to disentangle her image by paying attention to her feeling of "being used". She was then aware of this side of her relationship with her patient, that she was not aware of before. Interestingly, this image was of a thief from an old novel (rather than an image of a stereotypic one), who was a man (unlike the patient, who is a woman) and from a different ethnicity than her patient:

> "So, when I saw her I had this visual of a thief from like an old novel, like that, like the three musketeers, like someone that just ripped you off." (subject #12, 029)
>
> "I only remember that he was different than her, thinner, she had weight issue, and different ethnicity, she is Hispanic. For some reason, like either English or northern African, like Moroccan or something, I don't know why." (subject #12, 035)

The differences between the image of the patient and the patient point at the fact that the image is pact with additional information and meanings that was not yet explored in the therapeutic relationship.

To conclude, in my view, the symbolic visual image is a creative solution, a product of unconscious processing of interpersonal information. The image is a picture illustrated by this unconscious process. It is decoded into explicit information first through experiencing the feeling attached to it.

II. Associative Images - Images that are associative reactions to the material

These images come up naturally as a part of the session. For example, visualizing a dream told by the patient. The therapist is usually not surprised by these images, because they are an integral part of her natural responses to the material. The content that results in these images is usually visual, and therefore the visual response is natural. This image results from a natural, empathic stance of the therapist.

Examples of these images include: an image of a suffering look on the patient's face when the patient talked about her fear of being crazy, an image of the patient as a child when the patient talked about his childhood, or an image of the patient in a blind date situation following a description by the patient. These are all examples of therapists' visual efforts to better understand their patients' experiences.

Interestingly, the image in the therapist's mind is never an exact picture of the patient's description. These differences are results of the therapist's own variables including their personal associations, and the transference-countertransference relationship. These are interesting to understand in the context of the therapeutic

relationship. Nevertheless, it seems like these images are closer to consciousness than the symbolic images, and their symbolic value is therefore limited.

Therefore, Associative Images are images of visual content in the session that triggers natural imagery to occur. This imagery has an empathic flavor and is not conflictual in nature. These images are personal visual translations of the information presented and as such contain countertransference information.

III. Defensive Images - images that are results of an effort to get away from the material

Lastly, both examples of symbolic and associative images discussed above are images that are results of an effort to understand the patient (although some are results of a conflict between getting closer to the material with the wish to stay away from it). A third type of images is Defensive Images. These are images that are results of an effort to get away from the material and the relationship through fantasy. They are naturally less discussed or openly acknowledged by therapists. As mentioned above, there was only one image in this study that seemed to me to be of a defensive nature. This was the image of a therapist going to the grocery store when she felt that her patient was “hateable” (subject #15). In this example, the motivation that led to that image was an effort to get away from the patient rather than an effort to get closer to the patient at that time. These images stand between the therapist and her feelings, rather than allowing to stay with the clinical moment.

Images as defensive processes were discussed in the literature on patients’ visual images as explored in the chapter on Literature Review. Shapiro (1970) discussed the role

of visual images as resistance: “images are like symptoms, they are defenses, in the sense that they both move away from, and gratify indirectly the underlying impulse” (p. 209).

Therefore, I believe that Defensive images are in essence fantasies. They are results of the motivation to move away from the therapeutic moment into an isolated private space. These visual images are not imaginative spaces: they are not playful, nor are they interpersonal in nature. Therefore, these images have no interpersonal metaphoric value, and should not be interpreted as such.

I believe that the data reveals a few types of images that are results of different psychological processes. The types identified in this research are: symbolic images, associative images, and defensive images. These conceptualizations about types of images and their processes have implications on the use of visual images. It is crucial to identify the type of image experienced before making an informed decision on how to use it in treatment. Symbolic Images contain a lot of unconscious information that therapists can start to disentangle through the experience of the feeling attached to them. In addition to the therapist’s use of his own subjectivity, these images may carry many layers of meanings which can be explored mutually in the session. At the same time, associative images do not contain the same depth of material. Associative images contain countertransference information that can be explored in treatment. Lastly, it is important to identify defensive images as such. The effort to move away from the material presented is important for the therapist to address. In addition, the therapist should identify defensive images to avoid an assignment of meaning to fantasy.

This theory of visual images types changes the discussion from a discussion on the use of visual images to a discussion on the process of visual images and how the process informs its use. The different types of images may inform the therapist of its potential meaning and in turn, change its use. Therefore, the concrete question of interpretation versus exploration of meaning, self disclosure or self analysis becomes secondary to the type of the image experienced.

Finally, this study enabled me to form hypotheses as to the process of visual images and its affect on its use. Since this is a preliminary study on this subject, there are many questions that remained unanswered, and could be further examined through a future research.

Limitations of the Study

This study has a sample size of 15 clinicians, who discussed altogether 42 images. This sample size provided with the opportunity to examine the phenomena of therapist's visual images in depth. At the same time, the limitation of this small sample size is that its results cannot be generalized.

In addition, the subjects for this study were recruited through emails to psychologists' list serves, and are therefore were not randomly selected. First, this is a self selected group of therapists. Secondly, these therapists volunteered to share their images, which raise the question of the types of images that were shared and those who were left out of this study. These facts put another limitation on the generalization of these findings.

This group of therapists is defined by the fact that they have thoughts about visual images. This research was not performed on therapists who did not report having images,

and therefore no conclusions can be made about the nature of images in the general population of therapists.

Many of the subjects were either from a relational or an interpersonal school of thought. Some could not identify with any specific school of though. There was only one therapist who reported using Freudian theory in her work, and therefore the classical point of view is under represented in this research.

Lastly, all the data was coded by the primary researcher. Coding the data by one person carries the risk of affecting the data. In order to add another perspective on the data interpretation, every step of the analysis was shared and approved by the chair of this dissertation. Nevertheless, the possible affect of the researcher's personal perspective on the data remains.

This is a qualitative research on a phenomena rather than a controlled research. No hypothesis was examined in this research, but rather hypotheses were generated through the data as groundwork for future study.

Future Research

The main goal of this study was to begin mapping the variables participating in the process and use of therapist's visual images. Two main variables affecting this process were found: type of visual images and the therapists' understanding of the image. A few hypotheses were generated regarding the role of the type of visual images in this process. These hypotheses should be examined in a future research:

- There are different types of visual images that are results of different processes, among them: symbolic images, associative images, and defensive images

- The process of symbolic images involves an unconscious processing of information
- The decoding of symbolic visual images is done first through the experience of the feeling attached to the image
- Associative images contain countertransference information
- Defensive images are used to move away from the material rather than getting closer to it

In addition, it would be important to disentangle the variable of the therapists' ideas about their images, from the type of visual images in order to examine the hypothesis of types of visual images, their processes and affects on the use of images.

Another question that was raised in the discussion was regarding the difference between the therapists' feelings before and after the experience of the image. A detailed questionnaire should be created in order to track the subtleties of this process and find whether indeed therapists experience different feelings before and after having an image. This is central in understanding the regulatory role of the image.

Another interesting avenue to pursue is the connection between the patients' diagnosis and types of visual images. Since many images were responses to the patient's inability to verbalize their emotions, the experience of visual images can be connected to specific diagnoses such as dissociative disorders.

In addition, it would be interesting to interview therapists from various perspectives, including classical perspective and cognitive behavioral, and compare their process of visual images. This would provide with a wider perspective on this process

and would provide with more information about how theoretical perspectives may affect the use of visual images in therapy.

This is a study on therapists' images only. Since the experience of spontaneous images is a wide phenomenon, it would be interesting to look at images in the general population and examine the types of spontaneous images that occur daily. This phenomenon can also be further understood through a research focused on brain function and imagery in the general population.

Finally, it could be beneficial to compare therapists' and patients' visual images in one specific session. If indeed visual communication is separate and complementary to verbal communication, it would be important to look into all visual communications in one therapeutic setting to disentangle the role of the image in therapeutic communications.

APPENDIX I: QUESTIONNAIRE

I. You have said that you have experienced visual images in the course of your work with patients.
1. Describe the images.
2. How often this has occurred?

II. Choose one incident in which you experienced such an image in your mind as a response to your patient's verbal communication.

1. What do you see? Describe the image in detail
2. Do you see it clearly? Was it one picture (a still image) or series of pictures (a moving image)?
3. What did you feel when you experienced this image?
4. Think about the context in which this image appeared: what happened in the session before you experienced this image? What was the content and process of the session?
5. How do you think this image was related to the session, if at all?
6. What happened after you experienced the image in your mind? How did you respond to it? What did you think about it? What did you do with it? (did you share it with the patient?)
7. Reflecting back on this experience: what do you think about this experience now? How did it affect the treatment? How did it affect the relationship?
8. Thinking about this experience now, would you have done anything differently? (Would you have used the image in a different way?)

III. Think about the therapy with this patient.

1. How long have you been seeing this patient? How often?
2. How old is the patient? Gender?
3. How do you think about this patient diagnostically?
4. How would you describe your relationship with this patient?
5. Do you often experience visual images during sessions with this patient?
6. Do you experience visual images related to this patient outside of sessions?
7. Do you have repeated visual images in sessions?

IV. Think about your "style" as a therapist.

1. Can you describe your state of mind when experiencing a visual image versus your state of mind in sessions in general?
2. How would you describe your theoretical orientation or perspective?
3. To what extent you feel that you are trying to follow your theoretical orientation or your training while sitting with a patient? (thinking outside of the box)
4. Would you describe yourself as a "visual person"? (Do you remember faces and places easily?) Would you describe yourself as a "verbal person"?
5. Do you use visualization outside of therapy? Do you enjoy visual art?
6. Are you left handed or right handed?
7. How often do you experience visual images?

8. Do you experience visual images with all your patients or only with some? How do you understand it?
9. How many years have you been seeing patients? Approximately, how many patients did you have over the years?
10. What do you think about visual images in therapy? What are their roles? How can you use them? (Interpretation? Self disclosure?)
11. Can you recall any experiences of reverie that were not visual? (An auditory reverie, a fleeting thought, a physical sensation)? Tell me about this experience.
12. Do you have anything else to add that you feel is relevant and did not have an opportunity to talk about?

APPENDIX II - RESULTS

Families

Before Image (BI)

- **Content of the session**
- **Therapist's attitude**
- **The relationship between the therapist and the pt**
- **Pt's feelings**
- **Pt's behavior**
- **Therapist's feelings**

After Image (AI)

- **Therapist's feelings and attitudes right after experiencing the image**
- **Use of the image – what did the therapist do with the image?**
- **How did the experience of having an image affect the pt, the therapist, and the relationship?**

Image (I)

- **Type of image**
- **Content of the image**

Thoughts about visual images

- **What is the function of the image in the therapy?**
- **How the image is created?**
- **Therapist's feelings toward the image**
- **Frequency of visual images**
- **Discrepancy between visual images and pt's description**

Demographics (D)

- **Pt's diagnosis**
- **Therapist's experience**
- **Therapist's theoretical orientation**
- **Length of therapy before the emergence of the image**
- **Other experiences of reverie (somatic, auditory)**
- **Therapist's experience with expressive art**

Codes by Families

Before Image (BI)

- ### Content of the session (BI)

    - **Discussion on relational difficulties with family members**

BI: child pt talked about anticipating having an unpleasant Christmas break with family
BI: pt talked about his living situation
BI: pt talked about not having a husband and children
BI: pt was telling the dream about the egg with the fetus inside, wrapped in a cotton, which was the night before her mother's visit
BI: before the image pt talked about a specific fight between her parents when she was 6/7, when she was afraid of her mother's unpredictability and her father's rage
BI: pt told the therapist about her fight with her father, in which he pulled her shirt off

    - **Discussion difficulties with intimate relationships**

BI: pt talked about how specific relationships take up internal space without nourishment
BI: pt talked about the feeling of "breakdown" because of her break up from her boyfriend
BI: pt talked about going to a blind date

    - **Discussion on the therapeutic relationship**

BI: context of the image: therapist lowered the fees
BI: pt talked about leaving therapy, led by her therapist's pregnancy
BI: pt told the therapist that he was not her type

    - **Other relationships**

BI: pt talked about not caring about what other people thought
BI: pt described pushing people to their limits

    - **No explicit content – image experienced in the beginning of the session**

BI: the pt told the therapist about an experience that morning of seeing a dead man pulled out of a pod

- ### Therapist's attitude (BI)

    - **Another level of consciousness**

BI: "going to a different zone"
BI: state of mind - focused, on target, "another level of consciousness"
BI: therapist's state of mind was "loosely dissociative"

    - **Letting go (passive)**

BI: state of mind of "letting go"
BI: therapist's state of mind was "as if I am riding through a landscape painted by the words of my pt"
BI: therapist feels that she cannot force herself to see visual images, but allows it to happen
BI: therapist allows the image to "come to her", passive
BI: therapist thinks about visual images as "coming through" her

    - **Effort to understand the pt (active)**

BI: therapist tried to understand what the pt feels since the pt had difficulty to talk about her feelings
BI: therapist was trying to attend to the pt and disregard her emotional experience
BI: therapist was trying to find something within herself to connect
BI: therapist was trying to understand and connect with the pt
BI: therapist is putting herself in the pt's shoes in the visual image
BI: state of mind before the image: trying hard to understand the pt

BI: therapist's state of mind before the image: trying to put herself in the pt's position
BI: visual images occur when the therapist is actively thinking in the transference
BI: therapist tries to intensify her feelings

- **The relationship between the therapist and the pt (BI)**

    - **Strong emotional connection**

BI: a sense of connectedness with the pt, the effect of a powerful emotion of the pt
BI: relationship: "a constant push and pull"
BI: "pt was hateable"

- **Pt's feelings**
    - **Anxiety**

BI: anxiety about mortality
BI: pt talked about being afraid that she is crazy

    - **Guilt**

BI: pt felt guilty

    - **Anger**

BI: pt was angry at the therapist, felt deprived

    - **Pt was disconnected from her feelings**

BI: pt had difficulty to name and talk about feelings
BI: pt was disconnected from her feelings

- **Pt's behavior**

BI: pt talked in a high voice, which reminded the therapist of a "dumb blond"
BI: pt was attacking towards the therapist

- **Therapist's feelings**

    - **Frustration/ Anger**

BI: the therapist felt frustration, pain, anger
BI: the therapist was frustrated, trying to get further in her understanding
BI: therapist felt frustrated with the pt right before the image came into her mind
I: therapist's feelings at the time of the image – anger
BI: therapist was frustrated and angry with the pt
BI: therapist was angry and frustrated with the pt

    - **Anxiety**

BI: therapist felt anxious when she had the image
BI: therapist feared for the pt, was anxious

    - **Controlled**

BI: therapist felt forced out of the room, that the pt wanted her father to sit there, not the therapist

    - **Happy**

BI: therapist felt happy for the pt, and was confident of the pt's strength to move on (termination)

    - **Desire to help**

BI: therapist felt a desire to link the pt to the outside world

- **Offended**

BI: Therapist felt offended by the pt, who forced her out of the room

- **Incompetent**

BI: therapist felt incompetent, confused, not centered, scared

After Image (AI)

- **Therapist's feelings and attitudes right after experiencing the image**

  - **Curious**

AI: curiosity about the image
AI: questioning herself why she had the image

  - **Fear**

AI: the therapist felt terrified following the image
AI: therapist felt scared
AI: therapist remembered that she was scared of that image as a child - possessed girl who has no control over her feelings
AI: therapist was scared of his own image
AI: the image was horrifying to the therapist
AI :the therapist felt terrified after the image
AI: the therapist felt terrified following the image
AI: therapist was horrified when she had the image
AI: therapist thought that he is having a psychotic break

  - **Surprise/ No control over the image**

AI: therapist's feeling that the image "came out of nowhere"
AI: therapist felt like the person in her image - having no control over the appearance of the image
AI:therapist's feeling that the image "came out of nowhere"

  - **Anger**

AI: therapist felt rage
AI: therapist was enraged: "I wanted to kick the shit out of him"
AI: therapist felt used, as if the pt stole something from her

  - **Cannot identify a specific feeling**

AI: therapist felt extremely uncomfortable
AI: in the moment of the image, therapist feels like a "fly on the wall", an observer

- **Use of the image – what did the therapist do with the image?**

  - **Did not utilize it the therapy (let it be, passive)**

AI: "I leave it alone"
AI: I leave it. Leave it alone.
AI: therapist is not doing anything with the image "involuntary reflexive visualization"
AI: therapist didn't do anything about the image in that session
AI: therapist usually does not reflect on the visual image's presence

  - **Dismiss it (active)**

AI: therapist pays attention to the image and then puts it away
AI: therapist tried to push the image away before looking at it
AI: when the image and pt's reality are different, therapist disregards the image

- **Disclosure of the image to the patient**

AI :self disclosure of the image
AI: therapist disclosed the image
AI: therapist discloses the image
AI: therapist is using self disclosure a lot
AI: therapist might disclose the image
AI: therapist often discloses the image
AI: therapist use of the visual image: discloses, mirror an affect, interpretation, explanatory question
AI: therapist uses self disclosure with images

- **Why the therapist discloses the image?**

- **Allows the pt to be more playful**

AI: disclosing the image helped the pt talk about things in a more playful way
AI: self disclosure of the image helped the pt to be more playful, "share in the moment"
AI: self disclosure of the visual image as a playful way to connect to the pt

- **Non judgmental way to communicate**

AI: disclosing a visual image is a non judgmental way to communicate

- **Helps the pt to symbolize his experience**

AI: disclosure of visual images helps the pt symbolize their own experiences
AI: therapist used self disclosure to establish a common language

- **Modeling empathy**

AI: sharing an empathic image as modeling empathy for the pt

- **Non disclosure of the image**

AI: therapist did not share the image
AI: therapist did not disclose the image
AI: therapist would not disclose the image in most cases
AI: therapist does not disclose the images usually
AI: therapist did not disclose the image
AI: therapist usually doesn't disclose the image, but discloses the feeling
AI: therapist mostly does not disclose her images
AI: therapist never shared the image with the patient
AI: therapist is not necessarily disclosing the image

- **Why the therapist does not disclose the image?**

- **Because the therapist does not know whether/ how it is relevant**

AI: therapist is more reluctant to share the image when she cannot see how her image is related to the subject

- **Disclosing the image may burden the pt**

AI: therapist feels that disclosing the image would burden the pt.

- **Disclosure of therapist's feelings brought up by the image**

AI: therapist talks about the feeling that the image brought up for her, the pt being "unloved" in high school
therapist usually doesn't discloses the image, but discloses the feeling

- **Articulate how the pt felt**

AI: Therapist was able to articulate in words how the pt felt
AI: therapist was able to articulate in words how the pt felt
AI: therapist use of the visual image: discloses, mirror an affect, interpretation, explanatory question

- **Ask the pt questions**

AI: therapist asks a lot of questions
AI: therapist use of the visual image: discloses, mirror an affect, interpretation, explanatory question
AI: therapist uses images to understand the pt's experience

- **Examine if image is related to pt or therapist**

AI: therapist checks if it is related to her or to her pt

- **Questions herself about the image**

AI: therapist is questioning the image if the image is disturbing to her
AI: therapist question himself about the image, curious
AI: therapist examines how the image makes her feel

- **Talk about the image in supervision**

AI: therapist understood the meaning of the image in supervision
AI: therapist understood the meaning of the image in supervision

- **Use it in an interpretation**

AI: therapist used the image as an interpretation of the situation
AI: therapist used this image as interpretation that the pt is smoking Marijuana, which turned out to be true
AI: therapist use of the visual image: discloses, mirror an affect, interpretation, explanatory question
AI: visual image as a safer and lighter way to introduce interpretation
AI: use of visual image: interpretation

- **How did the experience of having an image affect the pt, the therapist, and the relationship?**

  - Pt's feelings and behavior
    - **Pt was more open about her feelings and experiences (no disclosure of image)**

AI: image changed the pt's ability to open up about her fears and fantasy (led by the therapist's deeper understanding of the pt after having the image)

    - **Pt felt safer (no disclosure)**

AI: pt felt much safer
AI: pt trusted the therapist more
AI: dynamics: pt was afraid to lose the therapist by scaring her, after the image she felt safer because the
AI: therapist was able to enter that experience and they both survived it

    - **Pt had a language to discuss her experiences (after disclosure)**

AI: the image gave the pt a language to talk about her experience

  - Relationship between the pt and the therapist
    - **Relationship felt closer**

AI: pt and therapist created a celebration together of the "ball dropping"
AI: therapist and pt's relationship got closer

    - **Therapist felt more empathic towards the pt after the image**

AI: therapist felt more empathic to the patient after this image
AI: therapist felt that her empathy to the pt was extended to a "bodily empathy" as someone is impinging on her
AI: therapist and pt talked about her loss, therapist was able to connect to her loss and pain

Image (I)

- **Type of image**
    - **Image of the therapist's history**

I: from the therapist's life experiences (as a parent, married woman)
I: therapist sees an image of his own childhood
I: type of image: a scenario from the therapist's life
I: therapist has a number of visual images in his mind from his history, that he retrieves often during sessions
I: types of images: therapist's own memories, people or scenes
I: type of image: image that is related to the "therapist's own thoughts"
I: type of image: image of what the pt is saying versus "countertransference" - images that are experienced as the therapist's

    - **Image of the pt's feelings**

I: in the image, the pt had an intense feeling that is usually not evident to others
I: therapist saw pt's feelings in her expression: embarrassment and liberation
I: visualize an affect on the pt's face

    - **Image of what the pt was saying (close to content)**

I: type of image: close to content
I: type of image: image of what the pt is saying versus "countertransference" - not immediately useful material, the therapist's

    - **Image of the pt when he was a child**

I: type of image: imagining how a pt look like younger or older
I: types: visualizing something that the pt described about her childhood
I: therapist tends to have visual images when pts talk about their childhood

    - **Image that follows a description of people in the pt's life**

I: therapist has images when a pt tells her about an interaction with other people outside of therapy
I: therapist is visualizing when pt is talking about people in their lives
I: types of image: seeing the pt's tall mom from the therapist's point of view

    - **Images followed by the pt's dream**

I: therapist is visualizing a lot when the pt is talking about dreams
I: therapist has visual images when pts talk about dreams
I: therapist has visual images when she is picturing pt's dreams

    - **Pure Color**

I: type of image: "color flash before me"

    - **Caricature**

I: type of image: caricature

    - **Images that surprised the therapist**

I: type of image: therapist feels like he has experiences of images that "come out of nowhere" but cannot capture it
I: type of image: therapist knows that she has an experience of an image that "comes out of no where" but cannot give an example
I: type: unrelated image that "sails into my field"
I: the image was an "out of the blue" experience
I: therapist has a feeling that she had visual images that "came out of no where" but cannot remember them
I: type of image: therapist feels like she had the experience of a visual image that "came out of nowhere"

but cannot grab it

- **Movie/ play (moving picture)**

I: the image was a movie
I: type of visual image: movie, a person in a situation
I: type: a character from a play
I: type: movie
I: type: movie like
I: type of image: two dimensional, cartoon, black and white
I: types of visual images: moving picture (numbers pass on a txi meter)
I: the image was a movie
I: type of images: picture, movie

- **Picture**

I: type: caricature
I: type: picture
I: type of image: "quick snap shots"
I: type of images: picture, movie

- **Abstract**

I: type of image: abstract (not real)

- **Brief fleeting images**

I: type: "brief fleeting images in my mind"
therapist feels like there are images that she cannot capture

- **Images from the media**

I: media affects the images when something is out of the therapist's experience

- **Flexible images**

I: the therapist's image contains details that were not a part of the pt's description
I: therapist's images of pt's dreams are flexible, they change with the pt's content
I: therapist changes her image if the pt talks about her dream in a way that shows that her image was not accurate
I: the color of the original image changed when the therapist talked about it

- **Content of the image (42 images)**

I: a detailed picture of an abortion "hemorrhaged embryonic sac"
I: a mouse and an elephant
I: a play box
I: a suffering look on the pt's face
I: a trapeze artist who lets go of one bar and trusts that the other will catch him
I: a white man in a swimming pool, swimming, and a track smashes him, blood comes out
I: how it would be like to have the person as a priest (context: an interview)
I: image of a mud, not being able to get out of it, both physical sensation and a visual image
I: image of combat situations
I: image of Marilyn Monroe after pt talks in a high voice
I: image of the girl from the movie "Exorcist", her head was spinning and she was vomiting
I: image of the pt's body, muscular
I: image of the pt as a child, how their parents look like, the colors and atmosphere around
I: image of the pt as a thief from an old novel, who just "ripped you off"
I: image of the pt fighting with her father, naked from the waist up
I: image of the pt having a panic attack in her room, alone
I: image of what the therapist will buy in the grocery store

I: pt at her job, in front of the computer, not doing anything
I: pt being "up in the clouds", after pt reported that as a dream
I: pt is checking off things from a list
I: pt is talking with people at a restaurant
I: subway train going faster than the one close to it
I: taxi meter
I: the pt's apartment building and the outside area
I: the pt's boyfriend has a relationship with his classmate, both have no faces
I: therapist and pt on a date
I: therapist had an image of having sex with the pt
I: therapist had an image of her patient with another patient, who is in charge of the ball dropping in time square
I: therapist has images of him and his father walking together, a connected feeling to the image
I: therapist imagined a gnomon as a representation of absence
I: therapist imagined how the pt approached his teacher about not getting his work back from her and how she responded
I: therapist visualized an egg with a fetus, which was in the pt's dream
I: visual image: a man "chopped off" (upper body only)
I: visual image: a pt's father with a big black mustache
I: visual image: paper falling from a high floor
I: visual image: therapist breast feed too many puppies
I: visualize the pt in a blind date situation
I: with a pt with OCD, pulling the pt out of a shower
I: visual image: how people would look like after a cosmetic surgery
I: visual image: pt with a posture of "not caring" from a 50's movie
I: visual image: triangular brown netting - "cord", with areas that are glowing
I: like an egg, green and yellow inside, cross section

Thoughts about visual images

- **What is the function of the image in the therapy?**
    - **A visual case conceptualization**

the visual image is a visual "case conceptualization
the visual image is the therapist's understanding of what the pt is saying
the visual image symbolized a disconnection
the image is a concrete extentiation (extension - D.F) of what the pt was saying
The images flashes out my understanding

    - **Visual images mirror the pts' thoughts and feelings (projective identification)**

therapist thinks about visual images as "to get into my clients heads"
therapist thinks that her visual images carry her pt's emotion, projective identification
therapist thinks that she has certain images that are "completely the pt's"
type: projective identification
an image can be a type of communication from the patient to the therapist
visual images are visual projective identifications
visual images are visual projective identifications
the therapist felt that his feeling of frustration mirrored his pt's feelings

    - **Therapist understood the pt's experience emotionally (vs. cognitively) – empathy**

the image helped to understand an experience emotionally versus the cognitive understanding prior to the image
the image made the therapist feel how the pt felt, to have her experience
the image showed the therapist the pt's terror

therapist and pt talked about her loss, therapist was able to connect to her loss and pain
therapist thought that the anxiety she felt during having the image was the pt's anxiety
therapist thinks about visual images as an empathic experience
therapist thinks that visual images is a quicker way to get in touch with her feelings
visual image helps to create a deeper understanding of what the pt is going through
visual images are more tangible, more approachable, attainable, than describing emotions
visual images are ways to understand the pt's experience, to be more empathic
visual images gives the therapist more information, and the therapist is able to put herself more in the situation
therapist connects to the pt emotionally through the image
When I have an image in my mind, I am processing in a deeper level, connected empathically to my client.
more empathic to the pt after the image
before the image, therapist did not acknowledge her experience of the pt's aggressiveness
"more of a cognitive understanding and an intellectual understanding, but less feeling of what that meant"
function of visual images: "attach me to my feelings"
visual images is another way for the therapist to "immerse herself in the experience"

- **Visual image is a symbol of info that is not verbalized**

visual image is a symbol of something that is not said (feeling, info)
visual images captures the pt's subjective experience that cannot be captured with words
The visual imagery mirrors a broader expanse of the psyche, than words alone can say.
visual images are things that we cannot verbalize
visual images show what was not verbalized
image is helpful in connecting an emotion that the pt is not verbalizing but might be present
the visual image helped with the things that are not verbalized
in the lack of language, therapist was creating a symbolization process using the visual image in the session

  - **visual image captures emotions better than language**

visual image can capture emotion better than language.
to stay with the visual image is an attempt to stay close to the dream language versus interpretation

- **Allows a space for the therapist to process an affect**

visual image allows the therapist to process the affect, understand the meaning of it

- **Countertransference - Some visual images are related to the therapist**

therapist thinks that some images are about herself, not the pt
the image did not feel like a co-creation but a personal image of what was happening
AI: therapist thought that the image could have been affected by her history of early labor with her first child

  - **Image may interrupt the session**

the image can interrupt the therapist in allowing herself to hear the pt's reality
visual images can block information - stereotypic images

- **Therapist understood what should be articulated to the pt**

therapist was more "on target" about what she should articulate to the pt
therapist understood the repetition of the pt's feeling of competition

- **The image was about the relationship with the pt**

therapist thought that the image was about the relationship with the pt, "maternal toxicity"
the therapist thinks that the image was about the abortion of the therapy, the pt's aggression, and murderousness
AI: therapist thought that her image of going to the grocery store was not defensive, but an act "of desperation" to preserve her relationship with the pt

- **Image summarizes information from different senses**

It seems to summarize a lot of information from many different regions into a new creation that repositions

and advances both the treatment and the patient
Visual images are psychic organizers. Maybe visual images organize us all the time, who knows.

- **Image carry many aspects of the therapy in a condensed way**

the image carried many aspects of the therapy in a condensed way: pt's aggressiveness, miscarriage of therapy, therapist's vulnerability, pt's issues with maternity
visual images mirror the pt's and the therapist's psyche, co-creation

- **Images show information/ feelings that were not conscious**

the therapist is trying "to put in what is missing" via a visual image, this is why she has more images with pts who disclose less
the image "paints out what is missing in the picture"
therapist's idea of the use of visual images is threefold: to deepen her listening, filling the blanks of what they are telling or feeling, to understand what she experiences with the pt as a diagnostic tool
visual images emerges from the unconscious
visual images communicate what is in the preconscious
visual images capture more than what we are aware of (unconscious)
type: the image is like a narrative over a movie
visual images have more details than what the therapist conceptually knows about the pt
visual images have the capacity to capture and reflect what is outside of awareness (therapist's and the shared awareness) in a concentrated form
visual images make explicit what was implicitly there before
there is something in me that doesn't know something and image is telling me something.
I think my images tend to capture around the area that I am explicitly thinking
I think that the image came when I was trying to see something that I couldn't see.

- **Use of visual images to inform the intervention**

therapist can use images in interpretation, or disclosure and mutually formulate an interpretation
therapist uses the image to inform her intervention

- **visual image as a relational bridge**

visual image as a bridge to the pt, a transition to a safe space

• How the image is created? (process of visual image)

- **not a logical process**

image comes before the sense of logic and understanding
therapist think that the reason she imagines pt's dreams is that because it is a "not logical and linear" process
visual image is a "waking dream"

- **Visual images are the result of an unconscious process of info**

there is a lot of information that is registered but not processed consciously
visual image captures the area around the conscious thought
therapist thinks that there are ways of knowing things that people pick on, which is not scientific, images and dreams are a part of that
visual images are closer to unconscious, unfiltered, uncensored, unintellectualized stuff

- **Visual images are results of cross sensory integration**

visual images are cross sensory integration
I've always assumed that visuals created in me are some kind of a reliable integration by my unconscious of input from many different sensory modalities

- **Visual images are co-creations**

visual images are co-creations

therapist recognizes that his image is made of both his and his pt's feelings
visual images are the language of the therapist that connects with the language of the pt
visual images are always generated by the analytic process itself

- **therapist engaged with the feelings induced in her by the pt**

It's a meeting in me of something from the pt and the analyst in me engaged with what is induced in me by the pt.

- **When does the therapist have visual images? (context)**

  - **when the therapist is understimulated**

visual image to keep the therapist engaged when she is understimulated
visual images occur when the therapist tries to make something out of a "thin content"
visual images occur when there is over-stimulation or under-stimulation

  - **when the therapist tried to understand the pt**

the image came when the therapist was trying to see something that she couldn't see

  - **when the pt cannot express herself**

therapist has visual images with the pt who expresses herself less, she thinks that it may be a form of projective identification

  - **when the therapist feels connected to the pt**

therapist has visual images when she feels connected to the pt
I don't' know if it's just a good emotional connection, I think it's a powerful emotional reaction that I am more likely to have these images.
process of having visual images: feel connected to the pt with no boundaries

  - **image comes up when a pt talks about a conflict**

The visual images mostly come up when my pts are talking about some kind of a conflict.

- **The connection between feelings and images in the process of the experience of visual images**

  - **Visual images are connected to strong feelings**

the images have colors, which are associated with the affect
visual images are connected to strong feelings
every image has a feeling attached to it
feeling that the therapist was unaware of produced the image
sometimes the feeling comes first and then the image, and sometimes the other way around
there are thoughts and feelings associated with the image as the image comes up

    - **The feeling comes after the image**

the process of visual image: therapist had the image, then felt sad, then realized that the pt wasn't aware of that feeling, so she told her about the feeling of sadness
therapist thinks that the image comes first, and then she was trying to unpack the feeling that was attached to it

    - **Strong feelings precede the image**

visual image occur when there is a strong emotional content in the session
visual images are affect driven, they come up when the content is emotionally charged
Strong feelings evoke in me images while less strong feeling don't.
therapist thinks that the feeling comes before the image

    - **Different feelings come before versus after visual images**

therapist feels surprised to see her pt's devaluing look on her face, then had the image of a thief, and finally felt used

- **Therapist's feelings toward the image**

    - **Safer to experience a feeling through an image than experience it directly**

it is less threatening to see a feeling through a visual image than feel it directly

    - **Loves having images**

therapist loves having visual images, feels engaged in the work, fruitful, playful

    - **Does not talk about images with colleagues**

therapist did not talk about her visual images before this interview
difficult to talk about visual images with colleagues

    - **Trust the image**

I trust non verbal much more than what people say.
I trust these images because of their spontaneity.

- **Frequency of experiencing visual images**

    - **Daily/ every session**

therapist experiences visual images daily
therapist experiences visual images every session
therapist thinks that she is visual all the time, this is the way she thinks
I use visual imagery almost as a main state of my work

    - **Depends on the content**

therapist experiences visual images automatically with dreams, and with visual content

    - **Depends on the pt**

therapist has more images with certain pts than with others
therapist has more visual images to pts that she feels more connected to
therapist has more visual images with pts that disclose less
therapist feels that pt's concreteness limits her own space for imagination
therapist experiences less visual imagery with obsessional pts because he feels bored
therapist has more images with certain pts than with others
therapist thinks that she has more visual images with pts who are less concrete
when the therapist is bored with the pt, she has less visual images
when therapist's countertransference, she has more visual images

    - **One image/ Occasionally**

had one distinct and vivid visual image
It is the occasional magical moment

- **Discrepancy between the image and the pt's description**

    - **No recognized discrepancy**

therapist's image was confirmed in reality
therapist doesn't question the image unless it turns out to be "not correct"

    - **There is a discrepancy**

Contrast between what the therapist pictured in her mind and the reality
therapist doesn't view the discrepancy bt her image and the pt's dream as important
therapist recognized that there is a difference between her image and real life: in the image the pt was alone in school
therapist cannot imagine certain details

Demographics (D)

- **Pt's diagnosis**

    - **Depression symptoms**

D: diagnosis: depression, attachment disorder
D: diagnosis: elusive rage, depression
D: diagnosis: not worthy
D: pt's diagnosis: depression, difficulty with separations
D: pt's diagnosis: depression, dissociation, substance abuse, eating disorder
D: pt's diagnosis: OCD, depressive symptoms, social awkwardness, difficulty to connect
D: pt's diagnosis: eating disorder, depression, Borderline features
D: diagnosis - need to be in control, violence in the house, pt felt empty

    - **Anxiety symptoms**

D: diagnosis: OCD, panic disorder
D: diagnosis: terror of interpersonal relationships
D: diagnosis: OCD

    - **Anger bursts**

D: diagnosis: the pt comes across as having a flat affect (vs. anger bursts that he experiences)
D: pt's diagnosis: borderline tendencies, attachment issues, control issues
D: pt's diagnosis: violent outbursts, doing poorly in school, socially rejected
demographics: diagnosis - need to be in control, violence in the house, pt felt empty

    - **Relational Difficulties/ Attachment issues/ Narcissism**

D: diagnosis: relational difficties
D: diagnosis: pt rejects people before they can like her
D: pt's diagnosis: borderline tendencies, attachment issues, control issues
D: pt's diagnosis: interpersonal issues around men
diagnosis: pt cannot talk about feelings, bodily symptoms, fear of intimacy
diagnosis: narcissistic personality
D: pt's diagnosis: narcissism, intellectualized, detached
D: diagnosis: pt has no empathy at times
D: diagnosis: hystrionic, and Masochistic traits

    - **Difficulty to verbalize feelings**

D: pt's diagnosis: difficulty with verbalizing emotions
D: diagnosis: pt cannot talk about feelings, bodily symptoms, fear of intimacy
D: pt's diagnosis: drug abuse

    - **Dissociation**

D: diagnosis: dissociation

- **Therapist's experience**

D: Ex: 4 years
D: therapist's experience: 4-5 years
D: demographic: experience: 4-5 years
D: therapist's experience: 5 years
D: therapist's experience: 7 years
D: therapist's experience: 16 years
D: demographics: experience - 17 years
D: demographic: experience - 18 years
D: therapist's experience - 19 years

D: therapist's experience: 19 years
D: therapist's experience: 20 years
D: therapist's experience: 24 years
D: demographics: therapist's experience - 27 years
D: therapist's experience: 30 years

- **Therapist's theoretical orientation**

D: therapist's theoretical orientation: anti- Kleinian
D: theoretical orientation: eclectic
D: theoretical orientation: integrative
D: theoretical orientation: object relations
D: theoretical orientation: relational
D: theoretical orientation: relational, interpersonal
D: theoretical orientation: relational, some self psychology, also uses CBT
D: therapist's theoretical orientation is relational or interpersonal
D: therapist's theoretical orientation: interpersonal
D: therapist's theoretical orientation: psychodynamic, self psychology
D: therapist's theoretical orientation: relational, intersubjectivity, some basic Freud
D: demographics: theoretical orientation – relational
D: no theoretical orientation
D: theoretic orientation: interpersonal
D: theoretical orientation - eclectic - intersubjective
D: theoretical orientation: psychodynamic - relational

- **Length of therapy before the emergence of the image**

D: therapist has been working with the pt for 4 months
D: therapist have been working with the child for 3 years
D: therapist saw the pt 1.5 years, once weekly
D: therapist saw the pt 2.5 years started with twice and then 3 times weekly
D: therapist saw the pt 3 times pe rweek for over 12 years
D: therapist saw the pt for 3 years, twice weekily
D: therapist saw the pt for 4-5 months, twice weekly, when he saw the image
D: therapist saw the pt for 9 months. twice weekly, the image came up in the beginning of therapy
D: therapist saw the pt for about 2 years, 3 times per week
D: therapist sees the pt twice a week for 9 months
D: therapist worked with the patient 1 year, once weekly

- **Other experiences of reverie (somatic, auditory)**

D: therapist experiences physical sensations in sessions
D: therapist has physical sensations too in sessions
D: other reveries: physical sensations
D: other types of reverie: physical: tense in the body
D: other types of reverie: physical: tension in the thighs, hard to breath
D: other types of reverie: somatic "I felt contagious"
D: other types of reveries: songs, and physical reactions (stop breathing)
D: physical response to the image - tense in the muscles
D: therapist has somatic experiences often in sessions
D: types of reverie: physical too, always tied to affect
D: physical response to the image – tense in the muscles
D: therapist has other types of reverie such as auditory (hearing music)

- **Therapist’s experience with expressive art**

D: therapist was a photographer, and worked in advertizing before becoming a psychologist
D: demographics: therapist is an artist - computer graphics, clay, painting
D: demographics: therapist is printing on fabric, decorating baby's clothes
D: demographics: therapist studied visual art and is playing music

APPENDIX III: THE VISUAL IMAGES BY SUBJECTS

Subject #1
Image of the girl from the movie "Exorcist", her head was spinning and she was vomiting

Subject #2
Paper falling from a high floor
Therapist's breast feeding too many puppies
Being with a pt with OCD, pulling the pt out of a shower
How people would look like after a cosmetic surgery

Subject #3
The pt with a posture of "not caring" from a 50's movie
A triangular brown netting - "cord", with areas that are glowing
Like an egg, green and yellow inside, cross section

Subject #4
A man "chopped off" (image of the upper body only)
A pt's father with a big black mustache
A mouse and an elephant
The pt's apartment building and the outside area

Subject #5
A gnomon as a representation of absence

Subject #6
A detailed picture of an abortion "hemorrhaged embryonic sac"
A taxi meter

Subject #7
The pt's boyfriend has a relationship with his classmate, both have no faces

Subject #8
An egg with a fetus, which was in the pt's dream
Image of a mud, not being able to get out of it, both physical sensation and a visual image

Subject #9
Image of the pt's body, muscular
Therapist has images of him and his father walking together, a connected feeling to the image

Subject #10
An image of her patient with another patient, who is in charge of the ball dropping in time square
Therapist imagined how the pt approached his teacher about not getting his work back from her and how she responded

How it would be like to have the person as a priest (context: an interview)

Subject #11
Pt being "up in the clouds", after pt reported that as a dream
Image of Marilyn Monroe after pt talks in a high voice
A subway train going faster than the one close to it

Subject #12
A play box
An image of the pt as a thief from an old novel, who just "ripped you off"
Pt at her job, in front of the computer, not doing anything
Pt is checking off things from a list
Pt is talking with people at a restaurant
Image of the pt having a panic attack in her room, alone

Subject #13
A suffering look on the pt's face
Therapist and pt on a date
Therapist had an image of having sex with the pt
Visualize the pt in a blind date situation
Image of combat situations
Image of the pt as a child, how their parents look like, the colors and atmosphere around

Subject #14
A white man in a swimming pool, swimming, and a track smashes him, blood comes out
Image of the pt fighting with her father, naked from the waist up

Subject #15
A trapeze artist who lets go of one bar and trusts that the other will catch him
Image of what the therapist will buy in the grocery store

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