Institute for Clinical Social Work

CLINICAL SOCIAL WORKERS, PSYCHOANALYTIC THEORY, & DEEPENING THE TREATMENT

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ABSTRACT

This research used a case study methodology and sought to identify core beliefs and techniques related to deepening treatment by clinical social workers who are psychoanalytic psychotherapists. The main proposition was that clinicians have significant responsibility for establishing depth in treatment. Five seasoned practitioners were interviewed multiple times. Data analysis occurred in two phases: the development of individual case reports which included participants' idiosyncratic definitions of depth and cross-case analysis resulting in shared themes that are considered the therapist's contributions toward depth.

Participants' definitions of depth, core beliefs and techniques led to an understanding that depth is a subjective phenomenon. In general, deep therapeutic processes result in the patient gaining knowledge about self and having new interpersonal experiences. The study's main proposition was supported by the findings. The therapist's contributions toward depth include use of self-awareness, especially in internal dialogues, in day-to-day work, comfort with emotional intimacy, an understanding that patients' expressive freedom is both indication and goal of depth, strong abilities to tolerate intense affect, and practice wisdom grounded in self-acceptance and acceptance of limitations. The personal treatment of the therapist is considered indispensable in developing these capacities. For participants, depth is a guiding value over other considerations such as money or status and new therapists will benefit from support to embody this stance.

For my parents, Donald and Elizabeth Servatius
You both found your way to work you loved doing

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CHAPTER I

INTRODUCTION

Study Objectives

This study explored the experience of deepening therapeutic treatment as described by the study's participants. Specifically, it articulates the attitudes and techniques of psychoanalytic therapists that facilitate deepening of the treatment process. It focused on how participants think about depth and how they deepen treatment with their patients. The central objective was to identify components of reliable psychotherapeutic functioning that promote depth-oriented treatment as reflected on by seasoned practitioners. Participants are clinical social workers who practice psychoanalytic therapy. The research design is a case study methodology.

General Statement of Purpose

Interest in this topic stems from the researcher's understanding that inviting deepening in treatment is a primary goal of psychoanalytic therapy and the acknowledgment that doing so is a conscious decision. For many therapist/patient dyads, superficial treatment can occur as a result of resistance to psychic pain and a desire to keep the interpersonal arena free from conflict and ambiguity. Superficiality often becomes the default quality of treatment unless both patient and therapist make

unconscious and conscious decisions to move toward depth. There are some patients who dive into the depths and need their therapist to make room and keep up. However, many patients need their therapists to contribute to movement into deeper, partly known, or unknown aspects of themselves or their experiences. Movement into deeper exploration of these aspects is a primary goal of treatment as it provides new information, potentially unconscious knowledge, along with the therapist's belief in a process that offers ways to acknowledge and move through psychic pain and come to terms with the inherent ambiguity in life. There is much to learn about deepening treatment from listening to experienced voices of clinical social workers who use psychoanalytic theory in day-to-day practice. This study aimed to learn about the psychoanalytic therapist's thoughts and actions toward that deeper end.

Significance for Clinical Social Work

Psychoanalytic therapy uses psychoanalytic theories as guides for attitudes and techniques to establish depth in treatment. There are many theoretical traditions within psychoanalytic theory and, therefore, variable emphases in definitions of psychoanalytic therapy. The researcher defined it as inclusive of a type of process, goal and therapeutic stance. The process prioritizes and makes use of patient-guided content in a freely associated technique; transference as data about the patient's object relationships, wishes, and needs; and countertransference as data about the intersubjective arena between patient and therapist in order to gain insight into aspects of the patient's and therapist's unconscious worlds. The goal of psychoanalytic therapy is enhanced access to unconscious psychic life, which is considered to be the patient's unique truths. The

therapeutic stance includes curiosity, appreciation of complexity, affective attunement, and truth-seeking despite pain and discomfort.

Studying aspects of deepening treatment with clinical social workers was a good way to learn about their psychoanalytic practice as it allowed exploration of participants' professional experiences and analysis of the work of deepening in a way that moved beyond the jargon of theoretical preferences and allegiances to psychoanalytic schools of thought. Clinical social workers who practice psychoanalytic therapy generally see patients one to three times per week. This is one way to distinguish psychoanalytic therapy from psychoanalysis which generally occurs at a frequency of three to five times per week. Clinical social worker therapists often work with difficult cases, historically, cases that were deemed "un-analyzable" in traditional definitions of psychoanalysis, such as patients with personality disorders and severe trauma histories (Sanville, 1996).

The researcher's interest in the topic also comes, in part, from her observation that real-life clinical processes often do not seem as deep as descriptions of treatments that are studied in the course of psychoanalytic therapy training. This observation can lead to feelings of demoralization, making therapists more vulnerable to blaming patients when processes feel superficial. The researcher was curious about what is required of the therapist to do depth-oriented work using psychoanalytic theory without necessarily having the benefits of greater frequency. Studying what seasoned clinical social workers think about how they deepen treatment provides information for the field about its practice of psychoanalytic therapy. This study contributes to clinical process theory.

CHAPTER II

LITERATURE REVIEW

For brevity's sake, where gendered pronouns are needed, the therapist will be referred to as she and the patient as he in discussion of these roles in the therapeutic dyad. Additionally, therapist is the primary term used to refer to the psychotherapeutic practitioner and analyst is used in a quote and when it is the most descriptive choice to convey the theory or theorist. This review is written from the perspective of work with individual adults.

Psychoanalysis, Psychoanalytic Therapy and Clinical Social Work

There are various definitions of psychoanalytic therapy in relation to psychoanalysis.

> It may thus be said that the theory of psycho-analysis is an attempt to account for two striking and unexpected facts of observation which emerge whenever an attempt is made to trace the symptoms of a neurotic back to their source in his past life: the facts of transference and of resistance. Any line of investigation which recognizes these two facts and takes them as the starting-point of its work has a right to call itself psychoanalysis even though it arrives at results other than my own (Freud, 1914, p. 16).

> Psychoanalytic psychotherapy is here defined as those therapies based exclusively on psychoanalytic theory, but using modifications in the analytic situation, such as reduced frequency or sitting up, and/or deviations from psychoanalytic technique, such as suggestion and various supportive or "ego-building"

> techniques. Within the framework of psychoanalytic psychotherapy, there is some variation in approach or emphasis (ego psychology, object relations theory, conflict theory, deficit theory, etc.) just as there is in psychoanalysis (Fancher, 1990, p. 41).
> Regarding the objectives of the treatment, these treatment modalities vary: the objective of psychoanalysis is fundamental structural change, the integration of repressed or dissociated unconscious conflict in the conscious ego. In expressive or psychoanalytic psychotherapy, the objective is a partial reorganization of psychic structure in the context of significant symptomatic change (Kernberg, 1999, p. 1078).

Definitions of psychoanalytic therapy have changed over the years as debate over what makes a therapeutic process analytic has occurred. Historically, debate centered on the features that distinguished psychoanalysis from psychoanalytically-informed psychotherapy. Relevant to the study topic is the ways in which psychoanalytic psychotherapy have been conceived.

Sigmund Freud (1919) began the debate with an analogy to metals. He wrote, “the large-scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion” (p. 168). Thus began the identification of technique as the way to distinguish psychoanalysis. The pure gold refers to interpretation and is placed at a pinnacle above the use of suggestion in psychotherapy. There has been an underlying view that psychotherapy is often the treatment of choice by default due to the cost and time needed for psychoanalysis (Gill, 1954; Kernberg, 1999).

Other distinctions followed. Psychoanalysis was distinct by its use of transference interpretation rather than extra-transference interpretation (Strachey, 1934), by the development of a transference neurosis in the patient rather than less cohesive transference elements in psychotherapy (Ornstein, et al., 1977), and in its analytic stance of neutrality in relation to an analyzable patient rather than a therapeutic stance of necessary interventions such as suggestion, prohibitions, contracts and advice-giving with

more disturbed patients (Kernberg, 1999). Otto Kernberg adds that the goal of psychoanalysis, psychic structure change, is distinct from psychotherapy which seeks to partially reorganize psyche to the extent needed for problem-solving. Kernberg recommends that psychoanalytic psychotherapy be the treatment of choice for "the severest cases" including "severe life-threatening self-destructive behavior, such as chronic suicidal behavior, severe eating disorders, drug dependence and alcoholism and severely anti-social behavior" (p. 1085). Kernberg asserts that the regressive quality of the process and the neutral analyst in psychoanalysis is contraindicated in such cases.

Merton Gill may be considered a bridge between eras of debate in defining psychoanalysis and psychotherapy as he dramatically altered his definition over a thirty-year period. Initially, Gill defines psychoanalysis as, "that technique which, employed by a neutral analyst, results in the development of regressive transference neurosis and the ultimate resolution of this neurosis by techniques of interpretation alone" (1954, p. 775). Of the extrinsic elements such as frequency and use of the couch, Gill notes them as important but not essential to defining technique. Elaborating on the meaning of neutrality, Gill acknowledges that one cannot be a mirror and that neutrality exists as an ideal. Regular self-analysis of countertransference, the analyst's predominant use of her observing ego, and behaving in a reasonably stable way combine to approach a neutral stance that highlights the patient's transference reactions. He discusses the regressive transference neurosis noting that the psychoanalytic situation "itself exerts a nonspecific, steady, unremitting regressive pressure" and that the analyst "should not try to influence it in a specific direction" (p. 778). The regressive transference neurosis is to be resolved

by interpretation alone. Gill speaks to the importance of interpretation as opposed to effects of the relationship between analyst and patient. He states:

> This does not deny that unceasing processes of affective nonverbal communication go on between analyst and patient but that the goal of analysis is not to rest until these affective nonverbal interchanges have been converted into explicit verbalizations and have been encompassed by interpretation (p. 786).

Gill defines psychotherapy by its lack of use of these intrinsic techniques in a systematic way. He writes,

> The goals of psychotherapy extend over a very wide range. To take first the goals in psychotherapy with a relatively strong ego; the goal may be a resolution of a crisis, assistance through a troubled period, or symptom amelioration. The more limited the goal and the more acute the situation, the more likely is the therapy to veer toward the supportive rather than the exploratory end of the continuum and the more active is the therapist likely to be. But goals may range up to much more ambitious aims in cases where there is no pressing problem, but where psychoanalysis is impossible or not used for external reasons (1954, p. 793).

Thirty years later, Gill revises several aspects of his thinking, including the nature and analysis of transference, neutrality, and the regressive transference neurosis in such a way as to expand the extrinsic criteria of analytic work to include less frequent sessions, face-to-face arrangements, and work with more disturbed patients. He frames his revisions in the context of understanding technique in light of the developing two-person view of the analytic relationship (1984).

Gill reconsiders the nature of transference and its analysis in light of the therapist's influence on its development. Such influence is seen in the choices of focus the therapist makes in interpretations, which are then interacted with by the patient via his past. In other words, the therapist provides particular triggers to patient experiences (albeit unknown in advance), and that is what gets called up in transference manifestations. To simply wait for direct references to the transference from the patient's

free association implies that the patient does not accurately perceive real, present-day intentions of the therapist and that transference springs only from the patient. Rather, Gill recommends the therapist seek out clarification of what in the therapist or process led the patient to a particular stance so that both the present of therapist and patient and the past of the patient can become clearer. This view of transference allows the patient to warm up to the acknowledgment of his particular contributions to transference dramas.

Of technical neutrality, Gill acknowledges that the therapist does not have control over how her intentions are perceived or interpreted by patients and that there are times when the therapist's intentions are unconscious and therefore, unknown in the moment. In trying to meet the requirements of neutrality, Gill states, "It is as though we try to prevent the patient from mistaking our intent by having no intent" (1984, p. 168). This is, of course, impossible. Therapists' subjective interactions with patients are inevitable. Gill recommends reframing neutrality as willingness to explore patients' experience of the therapist's intentions and the plausibility of such interpretations.

Finally Gill takes up the definition of the regressive transference neurosis and similar to his view in 1954, he asserts the wisdom of not actively working to induce such a regression. He points to the influences of the therapist and the therapeutic setting on the development of transference and suggests that the term neurosis applies only if we imagine that an intense regressive transference situation just appears. He credits the seemingly spontaneous intensity to the fact that in classic technique the transference has been ignored until the patient does not allow it to be ignored any longer. Until this point transference neurosis had been defined as "regression has taken place in the transference to the time at which symptom formation first began, that is, an infantile neurosis" (1984,

p. 169). Gill questions the accuracy of such a definition by stating that what appears to be regression may actually be "increased awareness of previously disavowed mental content" (p. 170). He continues, "I will consider that well conducted analysis is marked by a transference, not necessarily by a regressive transference" (p. 170). Gill gives more value to the role of new experiences in the analytic relationship than he had previously done. For Gill, this experience is not deliberately created; rather it is naturally occurring and assists the patient. He redefines what is distinct about analysis,

> My reconceptualizations of these intrinsic criteria of analysis, namely transference and its analysis, the neutral analyst, the regressive transference neurosis, free association, and the role of experience in addition to interpretation lead me to the conclusion that the centrality of the analysis of transference, as I have defined transference, the refusal to manipulate it, and the searching out and making explicit whatever one can discern of inadvertent manipulation of the transference is alone the distinguishing characteristic of analytic technique (p. 172).

Gill understands a process to be analytic if it focuses on the analysis of transference and the analysis of resistance to the acknowledgment of transference. He states the consequences to his revised definition,

> The analytic technique should be employed as much as possible even if the patient comes less frequently than in usual psychoanalysis, uses the chair rather than the couch, is not necessarily committed to a treatment of relatively long duration, is sicker than the usually considered analysable patient and even if the therapist is relatively inexperienced (p. 163).

For many practitioners, this description highlights the importance of the use of analytic understanding as an important contribution from the therapist regardless of the name given to the endeavor.

Transference as uncontaminated by the therapist's contributions is an unacceptable view of transference in contemporary analytic practice (Aron, 1992b; Gill, 1984; Hoffman, 1992; Stolorow, 1990). It is generally accepted that transference is at

least partly influenced by the therapist (Gabbard, 2007). Several contemporary authors have further contributed to Gill's deconstruction of the myths of the neutral analyst, pure interpretation without suggestion, insight versus support, and the analyzable patient. Robert Stolorow (1990) discusses technical neutrality as an illusion. He prefers to position the therapist in a stance of sustained empathic inquiry—a stance that seeks to understand the patient from within his frame of reference. He writes,

> Sustained empathic inquiry by the analyst contributes to the creation of a therapeutic situation in which the patient increasingly comes to believe that his most profound emotional states and needs can be understood in depth. This, in turn, encourages the patient to develop and expand his own capacity for self-reflection and to persist in articulating ever more vulnerable and sequestered regions of his subjective life (p. 121).

Stolorow also furthers Gill's acknowledgment of the therapeutic relationship as an important aspect of treatment. He refers to drawing a sharp distinction between relationship and suggestion on one side and analysis and interpretation on the other as a false dichotomy which mirrors the "long-standing debate over the centrality of affective bonding versus cognitive insight in bringing about change in psychoanalysis" (1990, p. 122). For Stolorow, transference interpretations are not insights from outside the context of the relationship. Interpretations occur from within the "affective bond" which by their very nature are rooted in theoretical frameworks of the therapist and therefore, they are suggestions (p. 122). What is important for Stolorow is that the therapist explore whether this creates a demand for the patient to adopt the analyst's view of things in order to keep the relationship.

Bertram Karon (2002) discusses the analyzable patient from the perspective of what the therapist might do to create an analytic process. Patients with borderline and psychotic structures are only un-analyzable if one conceives of the therapeutic role as

unchangeable. In his clinical examples of analytic work with patients who have borderline and psychotic structures, Karon notes that the therapist must be willing to shift between roles that include emergency responses, advice-giving, and interpretation. Karon writes,

> The important thing is to do what is necessary to deal with the crisis, whether it is suicide, homicide, or some other serious issue. But political considerations have clouded the issues. In the early days of psychoanalysis, Freud and the other psychoanalysts did whatever they thought was necessary for their patients' good. When the phrase “psychoanalytic therapy” was used, it referred to psychoanalysis as therapy (p. 127).

Howard Gorman (2002) provides a thought-provoking view of the consequences of conflating classical techniques of neutrality and abstinence with psychoanalytic attitude and intentionality. Doing so eliminates the supportive, problem-solving aspects of analysis and creates nonproductive schisms between analysis and therapy and within analytic communities. He proposes reframing definitions in terms of psychoanalytic attitude. He writes,

> A psychoanalytic attitude encompasses intention to maintain, overall and as far as possible, an uncompromising but flexible focus on the unconscious and conscious psychoanalytic meaning of the both the patient’s and therapist’s communications; consistent with the goals of psychotherapy, the therapist communicates with the patient for the primary and ultimate purpose of conveying psychoanalytic meaning in order to provide the patient with an opportunity to increase emotional, cognitive, and conative understanding. The patient has an intentional role to play. The psychoanalytic attitude of the patient/client will be the at least verbally expressed intention by the patient/client to allow the psychotherapist’s psychoanalytic intention to govern the therapist’s role in the relationship (p. 58).

Essentially, the dyad must have some significant level of conscious intent to create psychoanalytic meaning of the patient’s life, past and present.

Currently, those who delineate between psychoanalysis and psychoanalytic therapy debate issues such as degree of cohesiveness of transference and its analysis,

depth of access to early experiences, object relationships, fantasies, and developmental needs, and the optimal frequency of sessions to facilitate such process (Fancher, 1990; Fosshage, 1997; Ornstein and Ornstein, 1977; Schwartz, 2003). There are differences between psychoanalysis and psychoanalytic psychotherapy, especially in regard to intensity and access to the patient's early life that can result from increased frequency of sessions and the agreement between patient and clinician for a primarily exploratory process in psychoanalysis. The following definition usefully describes a contemporary view of psychoanalytic therapy,

> Gradually, the term "psycho-therapy" came to refer to modified arrangements in which a transference neurosis is not cultivated but in which transference reactions are addressed, resistances are processed, and transforming insights are sought. The therapy client is not asked to lie down and say whatever comes to mind, but the therapist does invite the patient to speak as freely as possible about the problem areas that occasioned the treatment (McWilliams, 2004, p. 17).

This study did not seek to make any definitive statements regarding definitions of psychoanalytic therapy as compared to psychoanalysis. It does have an underlying assumption that it is the therapist's responsibility to have conscious intent to offer whatever depth might be possible. Review of what makes a process analytic confirms this assumption and the study explored such conscious intent. This study sought to learn how clinical social work therapists, in particular, work with psychoanalytic theories and deepening.

Clinical social work has a particular perspective that many social work therapists bring to their advanced training in psychoanalytic therapy. While, clinical social work borrows from many different theories including psychoanalysis, psychology, and sociology, social work is more accurately defined by its core values (Goldstein, 2007; Strean, 1996). Three core values of social work can be summarized. First, "person-in-

environment" which refers to a person, their environment (family, culture, neighborhood, et cetera) and their impact on each other is the context of understanding another person. Second, social work directs workers to "start where the person is" as a technique to respect the value of client self-determination. Third, the relationship is seen as the medium by which any intervention or change will take place and so, by implication, the person of the worker will have an important impact (Schmidt, 2007). These values along with borrowed theories give clinical social work flexibility that allows for a variety of ways to conceive of helping relationships. Clinical social workers do not seek to be purists. Rather, they seek to provide service based on where the patient is, what they are asking for, resources available, and a willingness to show up and try what is possible. Carolyn Saari (1986) sums up the clinical social work stance when she writes,

> The practice of clinical social work involves a process in which assessment, goal setting, planned intervention, and evaluation are prominent features. The effectiveness of the interventions is presumed to rely upon the strengthening and reordering of the organizational structures in the client's life, including those structures that have traditionally been seen as intrapsychic, interpersonal, institutional, and/or societal. Practice invariably takes place in the context of a purposeful relationship in which the tools selected for intervention may involve available and appropriate social resources as well as the professional self of the social worker. The practice…is neither an art nor a science, since such a division is artificial—it is both (p. 12).

This stance—assessing what is needed and being open to trying what might work—and social work's core values have contributed to the contemporary practice of psychoanalysis (Edward, 2007). In particular, the primacy of the relationship and use of the therapist's self are reflected in contemporary relational psychoanalysis.

There are several aspects of psychoanalytic clinical theory that are thought to facilitate depth in psychoanalytic therapy. Four process elements that contribute to deepening make up the remainder of this review; therapeutic frame, free association,

transference and countertransference. Several major schools of psychoanalytic clinical theory—classical, object relations, self psychology, intersubjective systems, and relational—place variable emphases on these elements. However, all agree that they are important components of getting to and working at the level of unconscious process, the hallmark of depth-oriented treatment. A major aspect of inquiry of this study regards the nature of depth in psychoanalytic therapy informed by psychoanalytic concepts and techniques. The researcher was curious about how participants understand and use process and technical elements in their work.

Therapeutic Frame

The therapeutic frame provides the opportunity for the patient to begin to trust in both the process and therapist. The ongoing emergence of the patient's trust via a consistent and reliable frame is essential to the process of deepening treatment (Hall, 1998; McWilliams, 2004). Establishing and maintaining the frame also provides a container for the anxiety inherent in the work for both patient and therapist (Ogden, 1989). Finally, frame is the structure from which transference and countertransference can emerge and be used to deepen understanding. There is debate over how fixed the frame must be to facilitate the deepest possible exploration with patients.

> Clinicians of the more classic or traditional mindset believe that a fixed and steady frame, consistently held, leads to deeper unconscious communication, less opportunity for both patient and therapist to act out, and more intensity—and therefore, depth—in the treatment. Then there are those clinicians of the more relational, intersubjective mindset, who feel that a rigid frame produces resistance, closes down unconscious communication, and creates a more distant, less intimate, and ultimately defensive process (Tolleson, 2008, personal communication).

Freud (1913) speaks to beginning psychoanalytic treatment and the recommended guidelines. They include a two-week frame (ten to twelve sessions) as experiment for diagnostic purposes, leased hours that are paid for regularly without exception, and meeting six days a week with a variable length of session depending on the patient's pace. He acknowledges that some patients take more time than a standard hour to allow deeper access to unconscious material in their communication. Nearly daily sessions are designed to limit the defensive overlay atop unconscious material and to keep the therapist up to date on the patient's everyday life. He refers to the joke about the "Monday crust" after Sunday's break (p. 140). He also allows for three times per week for less severe cases and treatments already well underway. Finally, Freud recommends the use of the couch so that visual cues such as facial expressions will not influence the patient's associative drifts and the transference. Freud's recommendations are designed to create the conditions that allow both patient and therapist the freedom to give themselves over to the sway of unconscious material. In general, psychoanalytic therapy uses all of Freud's recommendations except for the couch and daily sessions. Since Freud made his recommendations, various clinicians have put forth conceptions of the therapeutic frame that facilitate depth in treatment.

Robert Langs (1975) refers to the frame as ground rules and boundaries, and asserts that the clinician's delineation and management of the ground rules and boundaries reflect her identity as a therapist and the state of her intrapsychic conflicts and needs. For Langs, ground rules and boundaries are extensive and include fee, hours, length of sessions, the fundamental rule of free association, absence of physical contact, the therapist's relative anonymity and professional concern, the use of neutral

interventions geared primarily toward interpretations, and an exclusive relationship with total confidentiality (p. 469). These are the factors that will allow for resolution of neurotic difficulties through “constructive unconscious identification” with the therapist and the treatment setting (p. 470). “Constructive unconscious identification” allow patients to use interpretations to gain insight leading to structural change.

Consistent employment of the ground rules fosters the fullest expression possible of the patient’s conflicts, fantasies, and memories, especially as revealed in the relationship between patient and therapist; the transference. When therapists deviate from the frame, patient communications are disguised unconscious references, including and especially anxiety, in reaction to the therapist’s (mis-)management of the frame. Patient associations in the aftermath of frame deviations are often less transferential distortion and more valid commentary on the therapist’s unresolved unconscious conflicts and needs. Langs identifies the following common and troubling themes in these communications: loss of autonomy, seductiveness, exhibitionism, and loss of control to someone in authority (p. 484). The therapist who is alerted to examine her management of the ground rules and boundaries by these and other themes and works to repair, rectify, and adjust more toward the ideal frame is considered to be listening to the patient’s wise unconscious communication and working to limit the impact of her own pathology, thereby giving the patient the best possible chance for healthier resolution of unconscious conflicts. He advocates that the therapist’s consistent maintenance of the frame is the best way to hear unconscious transference communications. For Langs, when the frame is secure, the therapist can be sure that what is being communicated is transference material. On the other hand, when the frame is not secure as in the aftermath of frame

deviations, associative material is disguised reference to the therapist's neurotic behavior. Patients become anxiously adaptive to frame deviations (p. 475). Therefore, Langs is cautious about accepting arguments that rationalize frame deviations, such as the need to build a therapeutic alliance, especially when the unconscious negative consequences go unconsidered. He writes:

> The most meaningful expression of the therapist's or analyst's humanity in the treatment setting lies in his usual attitude of concern and in his capacity to offer the patient a correct interpretation, especially at a moment when he has not participated in a neurotic interaction with the patient (p. 486).

One begins to conceive of Langs' ideal frame and frame management as rigid and potentially impossible. Many contemporary psychoanalytic writers would say that the anonymity of the therapist is all but impossible due to what is implicitly communicated about the therapist via interpretations (Aron, 1992b; Ehrenberg, 1995). Additionally in psychoanalytic therapy, the face-to-face arrangement increases revelation of the therapist's subjective state via visual cues. However, Langs provides an important perspective about the ubiquitous nature of transference and alerts the psychotherapist to patients' reactions to frame deviations as an important source of unconscious knowledge and an opportunity to adjust frame to re-establish the safety and reliability needed for depth in the clinical process.

Jane Hall (1998) identifies both the physical arrangements and the therapist's stance of benevolent curiosity as the primary ingredients in a reliable therapeutic frame. The physical arrangements include the consulting room, schedule, timeliness, fee, and consistency regarding these arrangements. The therapeutic stance or functioning that creates and sustains the frame includes respect for the patient's pace, undivided attention, nondisclosure and benevolent curiosity. Both the consistency of physical arrangements

and the therapeutic stance, especially not taking sides or giving advice, are primary ingredients in developing the trust required for patients to reveal their depths. She quotes Ella Sharpe.

> A deep-seated interest in people's lives and thoughts must in a psycho-analyst have been transformed into an insatiable curiosity which, while having its recognizable unconscious roots, is free in consciousness to range over every field of human experience and activity, free to recognize every unconscious impulse, with only one urgency, namely, a desire to know more and still more about the psychical mechanism involved…When we come to a habit of thought, a type of experience, to which we reply: "I cannot understand how a person can think like that or behave like this," then we cease to be technicians. Curiosity has ceased to be benevolent (p. 13).

While patients may come to treatment hoping for a prescribed course of action, for advice or censure, or a shortcut, Sharpe makes a clear statement that psychoanalytic therapy seeks understanding and deeper revelation rather than reformation and that the therapist's functioning of benevolent curiosity has a good deal to do with establishing such depth of inquiry. Hall summarizes her understanding of the importance of this stance and the ability to hold a consistent frame.

> The therapist's attitude of respect, patience, and benevolent curiosity combined with her confidence in the analytic process is what impresses the patient and permits her to stay in treatment. The persistent durability and constancy of the therapist and her functions presents the patient with a new reality, one that holds the potential for reviewing and experiencing the calamities of life in a new way. Differentiation becomes safe. Separations become bearable. Competition becomes acceptable. Feelings of effectiveness become more rewarding than feelings of omnipotence and grandiosity. Experiences of success and failure can exist side by side and do not cancel each other out. Closeness and intimacy become possible (p. 11).

W. W. Meissner (1996) adds an interesting note by identifying the patient's empathy with the therapist's task of maintaining the frame as an important element that facilitates a reliable frame and therapeutic alliance which "opens illusory transitional space, within which transference and countertransference variants can find expression,

and provides the framework within which these elements can be explored and understood" (p. 110). Frame facilitates the possibility of such work which remains difficult. Without a reliable frame it is thought to be impossible. Therefore, Meissner, like Langs, asserts that the therapist's attention should always include the state of the frame.

Arnold Modell (1998) further explicates the role of the frame in establishing the paradoxical nature, necessary to allow depth and change, within the therapeutic relationship. While the therapist's and patient's complex emotional reactions to each other and their work are very real, they occur within the frame making the relationship different and separate from ordinary life and offering an unreal or illusory space. Modell identifies the therapist as primarily responsible for holding this tension between the real and the illusory by not gratifying patients' transference wishes in relation to the frame. He quotes Freud's recommendations.

> It is, therefore, just as disastrous for the analysis if the patient's craving for love is gratified as if it is suppressed. The course the analyst must pursue is neither of these; it is one for which there is no model in real life. He must take care not to steer away from the transference-love, or to repulse it…but he must just as resolutely withhold any response to it. He must keep firm hold of the transference-love, but treat it as something unreal, as a situation which has to be gone through in the treatment and traced back to its unconscious origins (Freud, 1915, quoted in Modell, p. 166).

This paradox of real and illusory allows patient and therapist to play, to experience each other as both real and as transformed by fantasy, and to shift between different levels of reality while moving amongst different forms of self-observation and immersion. The frame plays a primary role in creating the needed "as if" experience to allow for such fluidity.

Thomas Ogden (1990) also discusses the need for analytic space that can be one of playing, imagining, symbol formation, and meaning making. From an object-relations perspective, Ogden writes:

> A patient's use of projective identification can be thought of as a collapsing of analytic space in a way that threatens the therapist's capacity to maintain a state of mind in which his own feelings and thoughts can be understood as symbolic constructions as opposed to registrations of fact…When the therapist is serving as the object of a patient's projective identification, the therapist often feels impelled to "do something" about what is happening instead of attempting to understand what he is experiencing. When the therapist feels compelled to take action in this way, he is very often exacerbating the collapse of the therapeutic space, the space in which meanings can be understood instead of dispelled (p. 239-40).

It is the therapist's responsibility to manage being used in this projective way by working to understand the potential communications within the projection while at the same time holding the framework of possibility and meaning making rather than settling on statements of fact. Choices related to positioning interpretations as statements of the patient's subjective meaning-making of life events rather than static facts of history are considered to be part of the therapist's responsibility in managing the frame of analytic space. This stance assists patients to actively create new, deep and complex understanding and meaning rather than remain in the fantasy of being a passive victim to one's past. Ogden's focus on analytic neutrality vis-à-vis non-action does lend itself to therapeutic space that expands and deepens meaning. However, psychoanalytic therapy with extremely self-destructive patients sometimes requires the therapist to firmly establish limits and make clear when action will be the intervention of choice for patient safety (Kernberg, 1999). Ideally, exploration and meaning making will follow such action and intervention.

Nancy McWilliams and Anthony Bass discuss frame as less fixed and more idiosyncratic to therapeutic dyads. They assert that the qualities of the frame can vary from dyad to dyad. McWilliams (2004) calls attention to aspects of the frame that evolve from personal requirements for the therapist. Therefore, frame delineations can vary from therapist to therapist and are geared toward managing anxiety in both therapist and patient. However, she also advocates that one not be lulled into thinking that as long as ground rules are authentic, anything goes. Neither end of a rigid-flexible frame continuum is advocated. There is a focus on minimal frame requirements for effective psychotherapeutic work. She uses Gabbard's (1998) distinction between "boundary crossings" which may further the work and "boundary violations" which may injure the patient and damage the potential for the work. Examples of boundary crossings might be lending a book to a patient, scheduling a phone session during vacations, and not charging for missed sessions if they are rescheduled. Examples of boundary violations are sexual overtures, drinking alcohol with a patient, and borrowing money from a patient (McWilliams, 2004, p. 101). The frame may also vary depending on whether the goals of therapy are more supportive or more exploratory although she doesn't delineate these differences. This reader presumes that the more exploratory, the more anxiety—conscious and unconscious—and so boundary crossings should be less frequent.

Anthony Bass (2007) provides examples of flexible frames geared to the particular nature and negotiations of each therapeutic pair and advocates for such flexibility. He quotes Marion Milner and her conception of the frame as the establishment of a special kind of space and reality, making possible "the development of that creative illusion that analysts call transference" (p. 8). He adds a perspective that patient and

therapist are co-creators of the frame, each dyad creating their own unique space and reality. He agrees with Langs that the patient is consciously and unconsciously reading the therapist via the therapist's relation to the setting and its ground rules but disagrees that this is in any way avoidable and that it always relates to the therapist's pathology. For Bass, the frame is both structure and movement.

> The 'frame' remains an essential reference point throughout any analysis. Although in one sense it is meant to create and stand for, both practically and symbolically, a therapeutic structure with clear and safe boundaries in which the process of therapy unfolds, the establishment of a frame is, at the same time, paradoxically an integral part of the process itself. That is, the establishment of the frame serves both as a relatively fixed, clearly delineated, clearly defined container for the therapeutic work and as a point of departure for the negotiation of transference-countertransference elements, and enactments, and the working through of such enactments in an intersubjective field. Aspects of the patient's and analyst's psychic lives, and the way their relationship is taking shape, are expressed and negotiated through the establishment of a frame for their work together (p. 6).

Irwin Hoffman (1992) discusses the therapist's moment-to-moment choices in a clinical process. He relates the therapist's decision to respond with spontaneity and creativity, including personal expressions such as encouraging a patient to stay until the end of the hour rather than leave early, as a way to open dialogues that would otherwise be closed off for exploration (p. 2). Bass identifies these examples as the need to "toss out the rule book from time to time" (2007, p. 7). These descriptions imply that one ought to know the rule book in order to be able to toss it out occasionally. There is a basic frame that is implied in critiques of the more fixed frame. Part of the current debate centers around the difficulty inherent in defining that basic frame.

Most psychoanalytic writers agree that consistency of frame, as agreed upon by patient and therapist, is part of the development of trust needed to create a reliable working alliance, to contribute to an atmosphere that allows for the expansion of

transference and increased intensity of the therapeutic relationship, and to tolerate the anxiety that comes with such treatment. Establishment and maintenance of the therapeutic frame is considered an integral part of reaching goals in psychoanalytic work. Despite theoretical preferences related to the therapeutic frame, the bulk of the responsibility for this aspect of deepening the treatment lies with the therapist, especially through use of consultation (Freud, 1915; Gabbard, 1996).

There are disagreements and debate regarding optimal flexibility of frame for increased depth in the therapeutic process. One of the difficult aspects of analytic work and frame-setting is that psychoanalytic therapy seeks to welcome and contain powerful, regressive aspects of personality (McWilliams, 2004). Debate centers on dimensions of frame as well as how therapists relate to such dimensions. For many, fixed frame dimensions with a therapist who does not easily yield to patient requests for deviations provide the best possible containment for intense participation in therapy. For others, general frames with therapists who conceive of patient requests for deviations as potential needs for intense involvement will better facilitate an intimate process of understanding and exploration. Gabbard summarizes the importance of thoughtfulness regarding changes to the frame in the context of unconscious motivations.

> For most patients most of the time, they would prefer to do something other than analyze. We analysts may frequently join them in that preference. Analysis takes us to the darkest corners of the psyche where we may not wish to go, and resistance often finds the best hiding places. Only with a collaborative effort of analyst and patient over time can we usefully determine the value of shifting frame in one direction or another (2007, p. 928).

Free Association

Free association is a crucial aspect of an analytic process. It is the construct that encompasses one primary goal of treatment—the patient's expressive freedom. Freud and Bollas define free association as the primary source of data for therapist interpretations of unconscious material. Winnicott adds an understanding of free association as the process by which patients introduce their complex selves to both their therapist and to themselves, a way to creatively articulate and find self. Finally, Ogden postulates that both patient and therapist's free associative, internal processes join to create something new.

What is known as the fundamental rule of free association began with the following instructions to the patient from Freud (1913),

> One more thing before you begin. Your talk with me must differ in one respect from an ordinary conversation. Whereas usually you rightly try to keep the threads of your story together and to exclude all intruding associations and side-issues, so as not to wander too far from the point, here you must proceed differently. You will notice that as you relate things various ideas will occur to you which you will feel inclined to put aside with certain criticisms and objections. You will be tempted to say to yourself, "This or that has no connections here, or it is quite unimportant, or it is nonsensical, so it cannot be necessary to mention it." Never give in to these objections, but mention it even if you feel a disinclination against it, or indeed just because of this. Later on you will perceive and learn to understand the reason for this injunction, which is really the only one you have to follow. So say whatever goes through your mind (p. 147).

Freud came to these instructions in process of his articulation of the unconscious and his experimentation regarding how best to access it. He imagines free association as though one is traveling on a train and describing what one sees outside the window. This puts one in the frame of mind of a reverie and allows the focus to be less on any one thing and more on the space between things described—the associative links that can be heard as

unconscious derivatives. Freud asserts that the mundane is probably more important than the dramatic, that unconscious communication relies on the transfer of thoughts and feelings onto everyday ideas in the realm of the preconscious. He instructs the therapist to be unfocused,

> To surrender himself to his own unconscious mental activity, in a state of evenly suspended attention, to avoid so far as possible reflection and the construction of conscious expectations, not to try to fix anything he heard particularly in his memory, and by these means to catch the drift of the patient's unconscious with his own unconscious (1923, quoted in Bollas, 2002, p. 78).

Freud (1913) also offers his instructions as recommendations and uses the analogy of a game of chess as a way to understand that any recommendations for beginning psychoanalytic treatment have limited applicability and cannot claim an unconditional nature once the process is underway. Here is a flexibility that many theorists following Freud lost, perhaps in their zeal to do and promote psychoanalysis.

Christopher Bollas (2002) draws attention in particular to the role of the therapist in accessing unconscious messages from the patient's free association. He reminds us that the patient's free association is incomplete without the concomitant free-floating listening by the therapist, resulting in the "Freudian pair" (p. 7). The Freudian pair is communicating on deeper levels—unconscious to unconscious. The therapist's internal, and sometimes verbalized, free association is a crucial part of the product of contemporary analytic therapy—the patient's own connection to a deeper understanding of self (Bollas, 1983). It is not easy to sustain free-floating attention in general and perhaps especially in once weekly face to face psychotherapy.

Sandor Ferenczi (1985) relates the difficulties patients and therapists can have with free association. Patients may feel offended and neglected by the seeming lack of

attention and may not tell the therapist about these feelings in order to protect the therapist from their negative feelings. Therapists may feel guilt for their moments of boredom, inattention, and fatigue. Both parties can feel lost and scared. Reactions to the method may go unspoken unless the therapist inquires. One can conceive that reactions of this kind—the demand from either or both parties for conclusions and for the therapist to be more immediately useful—may be more intense in just one hour of weekly contact. And yet listening in this way is crucial to the capacity to hear unconscious communication. Bollas (2002) writes, "If the psychoanalyst does not listen in the Freudian manner, then we would have to say that the patient's unconscious does not perceive a counterpart and will not find its desire in the course of analysis" (p. 33). If one does not listen for it, the unconscious may not be expressed in interpretable form. The psychoanalytic therapist must have faith in the process of unconscious communication. Freudian faith is "a belief that if one gets rid of oneself (and all one's theories) and surrenders to one's own emotional experiences, then eventually the patient's unconscious thought will reveal itself" (p. 37).

Winnicott (1958) highlights an important contribution to therapeutic space that facilitates expressive freedom. When the therapist can hold space via non-interpretation she allows the patient freedom to find himself while alone in the presence of the therapist. He conceived of the value to the patient when the therapist can refrain from the need to make sense, be clever, or do anything.

> In the relaxation that belongs to trust and to acceptance of the professional reliability of the therapeutic setting, there is room for the idea of unrelated thought sequences which the analyst will do well to accept as such, not assuming the existence of a significant thread (1971a, p. 55).

This watchful, quiet stance which tolerates nonsense and chaos allows for the emergence of play, dreaming, and creativity, all factors that enhance person and life (1971a, p. 51). Winnicott expanded the notion of free association as the freedom not to speak in the service of discovery and development of the self. This is a shift from understanding the patient's nonverbal activity predominantly as resistance to the analytic process.

Like Winnicott, Thomas Ogden (1997) emphasizes the need for the patient as well as the therapist to have private space for reverie. He asserts that asking patients to say everything that comes to mind has too much potential to deprive the patient of much needed silent reverie, the kind that evokes unconscious expression. It is important for the patient to know he is free to be silent as well as free to talk. Ogden proposes altering the fundamental rule to include freedom to reveal and keep private, and freedom to communicate with each other, both in forms and words thereby creating the "analytic third" (Ogden, 1994, p. 463). The analytic third is the overlap between patient and therapist's unconscious and emerging conscious reveries, asymmetrically created, individually experienced and jointly analyzed. Mutual reveries between patient and therapist in the analytic process reveal aspects of the nature of transference and countertransference, thus facilitating deeper understanding by the dyad.

Free association encompasses a variety of aspects of therapeutic functioning creating the potential for listening to and interpreting unconscious material, for the patient to locate aspects of himself, and for the therapist to hear her own voice in a nonjudgmental, receptive way as part of learning about the patient. Adler and Bachant (1996) provide a cogent summary of the importance of free association to analytic work.

> Free association is unparalleled in it ability to deepen analytic exploration. The potency of free association derives primarily from its ability to provide access to

> the fantasies, fears, wishes, and powerful affect laden derivatives of the unconscious. Facilitated by the analyst's general restraint and personal comfort with primary process modes of communication, free association enables previously unconscious contents to emerge and take center stage. Because of this access, the processes engendered by free association are very different from those generated by a more interactive model of therapeutic engagement where the patient's attention is repeatedly captured by the therapist's responses (p. 1026).

Transference

So often it happens that the route to truth is through the intensity of illusion. Is not analysis a veritable playpen for transference and countertransference, and what are those if not vehicles for finding truth by knocking on the walls of illusion? Are not dreams the quintessential illusions, fictions? Are not most art forms—lines on a flat plane or ambiguous words in blank verse or people playing roles on stage—are not these all built on illusion, to encounter a level of truth and reality that is otherwise inaccessible?

—Emmauel Ghent, *Paradox and Process*

Transference, resistance to transference, and its interpretation and analysis have been emphasized as a primary route toward identifying and understanding patients' intrapsychic and interpersonal patterns and worlds. There have been several trends in thinking about transference. Such movement has been a part of the shift in theorizing about the therapeutic process as based on a one-person psychology to a two-person psychology. The first major trend comes from the Freudian and Kleinian theories and defines transference as the projection and repetition of the patient's infantile experience onto the therapist and therapeutic setting. The second major shift in thinking is represented by an understanding of transference material as communication about developmental needs. This trend is represented by some object relations and self-psychology theories. The third and most current trend considers changes in the therapeutic relationship and conceptions of transference based on intersubjectivity (two-person psychology) and social construction theory and are part and parcel of

intersubjective systems theory and relational theories. These theories expand the role of the therapist related to patient transferences in understanding the nature of the therapeutic relationship. Therapists are involved with interpreting projected material and providing environments that facilitate healing and development; they also have a responsibility to be available for patients as they seek to find their most authentic versions of self and perhaps, to perceive the subjectivity of the other (therapist) as well.

Freud (1912a) describes transference as a stereotype plate holding the idiosyncratic preconditions, instincts, and aims for the course of love for each individual, developed out of innate disposition and influences in the early years of life. The process of transference in therapy involves the patient's repressed and forgotten wishes, fears, and longings, related to his original objects, becoming revived in the present with the therapist as object. Freud identifies remembering what one has repressed as the goal of analytic treatment. Transference was understood as the patient's primary resistance to overcome if the patient was to remember infantile experience. Over time, he realized that it could not be overcome; rather, it is the primary field of action in analysis and must be interpreted, engaged and worked through. He still conceives of transference as the primary resistance when he notes:

> When anything in the complexive material (in the subject-matter of the complex) is suitable for being transferred on to the figure of the doctor, that transference is carried out; it produces the next association, and announces itself by indications of a resistance—by a stoppage, for instance (1912a, p. 31).

Now, however, he understood its inevitability and its value. The unconscious material was made available by the analysis of resistance to the analytic process, by the very dynamics that have attempted to keep it hidden. Identifying (interpreting) and working through the transference is described as the "struggle between the doctor and

patient, between intellect and instinctual life, between understanding and seeking to act" (1912a, p. 35). Freud describes analytic abstinence as the avoidance of acting from the position of projected object and sees it as the best way to be available for such projections.

Freud's recommends that transference be interpreted primarily when it manifests as resistance. Built into this method is the analyst's listening and nonverbal functioning, "So long as the patient continues to utter without obstruction the thoughts and ideas rising to his mind, the theme of the transference should be left untouched" (1913, p. 152). Here, Freud's unobjectionable positive transference is considered to provide fuel to the process.

James Strachey (1934) adds significant detail to the struggle between therapist and patient played out in the transference. He notes that for an interpretation to be part of the analytic cure of reconstructing the patient's past, it must be mutative. Mutative interpretations must be emotionally immediate in the process and are always transference interpretations. Genetic transference interpretations provide opportunity for the patient to consider whether the thought or impulse now directed toward the therapist is still as scary, as bad, as worthy of punishment as originally believed. He acknowledges that not every comment made by the therapist is a transference interpretation but makes clear that commentary outside of transference—infantile instinctual life directed toward the therapist—should be limited as interpretations about other people in the patient's life can collude with the patient's strong resistances to transference acknowledgment. He also implies that mutative transference interpretations occupy a small portion of the treatment. They are limited and difficult to make. He refers to this difficulty and highlights the

importance of the therapist's ability to manage her own fears of instinctual energy or primitive processes in order to deepen the patient's awareness of his own primitive process,

> It may be rationalized into the difficulty of deciding whether or not the particular moment has come for making an interpretation. But behind this there is sometimes a lurking difficulty in the actual giving of the interpretation, for there seems to be a constant temptation for the analyst to do something else instead. He may ask questions, or he may give reassurances or advice or discourses upon theory, or he may give interpretations—but interpretations that are not mutative, extra-transference interpretations, interpretations that are non-immediate, or ambiguous, or inexact…All this strongly suggests that the giving of a mutative interpretation is a crucial act for the analyst as well as the patient, and that he is exposing himself to some great danger in doing so. And this in turn will become intelligible when we reflect that at the moment of interpretation the analyst is in fact deliberately evoking a quantity of the patient's id-energy while it is alive and actual and unambiguous and aimed directly at himself. Such a moment must put to the test his relations with his own unconscious impulses (p. 77).

Strachey delineates the importance of genetic transference interpretations that are emotionally immediate (mutative) as the primary work of psychoanalytic cure and acknowledges the difficult aspects of this primary analytic function. It is of note that this difficulty remains constant from treatment to treatment and within any given treatment, transference interpretation by transference interpretation. This researcher wonders whether and how once or twice weekly treatment impacts the therapist's anxiety around and avoidance of transference interpretations.

Melanie Klein (1952) holds that object relationships exist from the beginning of life and so transference is not isolated to specific impulses and superego prohibitions but encompasses all of one's early life experience, fantasized and actual, along with the relationships in which intrapsychic and interpersonal experiences occur. Klein writes,

> For many years transference was understood in terms of direct references to the analyst in the patient's material. My conception of transference as rooted in the earliest stages of development and in deep layers of the unconscious is much

> wider and entails a technique by which from the whole material presented the *unconscious elements* of the transference are deduced. For instance, reports of patients about their everyday life, relations and activities, not only give an insight into the functioning of the ego, but also reveal—if we explore their unconscious intent—the defences against the anxieties stirred up in the transference situation. For the patient is bound to deal with conflicts and anxieties re-experienced towards the analyst by the same methods he used in the past (p. 209, original emphasis).

Her understanding of transference also indicates that the therapist cannot interpret negative and positive as mutually exclusive. For Klein, just as infantile emotional life vacillates rapidly between love and hate, so does transference. It is not a question of whether to interpret transference but rather, to listen for it in an expanded way and to link it to the persecutory and depressive anxieties inherent in relationships between people. Because transference does not necessarily get conveyed in direct references, Klein recommends listening for the patient's extra-transference references to other people and activities in his life as transference proper. This is consistent with Strachey's (1934) recommendations regarding extra-transference interpretations.

Betty Joseph (1985) shows the movement to deeper understanding when one listens for the valence of object relational experience and its defenses in the transference. There is a difference between saying to a patient, "You want me to understand how you feel without having to tell me anything about it" and saying, "I think you are letting me know what it is like to be a child of a mother who could not help you make sense of your feelings. You might be telling me that and trying to stay away from your feelings at the same time." The second interpretation is less accusatory and connects to the patient on a deeper emotional level. Here is Klein's encouragement for the therapist to listen not only to the words but also to the emotional experience of the interaction itself in order to gain access to the larger context of unconscious aspects in the transference.

Paula Heimann (1956) provides two important points in the development of the nature and manifestations of transference and its interpretation. While she disallows conscious therapist self-disclosure and reinforces the primary role of the therapist as screen for projections of the patient's ego expressions, she also alerts us that no matter how much one tries to control expression of one's personality, the patient perceives and reacts to its existence and what is revealed implicitly. Merton Gill (1984) makes important use of this point in his understanding of the plausibility of the patient's reactions to the actual situation between patient and therapist. Contemporary relational theorists take this insight further by theorizing within the philosophical view that individual treatment happens in the context of a two-person relationship (Aron, 1992b; Hoffman, 1992). This shift implies a less authoritarian environment for treatment by acknowledging what the therapist can learn from the patient but does not necessarily change the primary focus of analysis—that is, the person of the patient.

Heimann contributes to the beginning of understanding the multiplicity of transference phenomena. It is not just infantile impulses of the patient directed at the therapist—that is only one version of the transference. She tells us to be mindful of the question, "Why is the patient now doing what to whom?" (1956, p. 311). Thus vast possibilities are opened. Like Klein and Joseph, Heimann relates to transference as capable of carrying any and all parts of object relationships; instincts, defenses, anxieties, the patient, the object, the need, the expected response, the fantasy creating the interaction, and on and on. She brought pluralism, so vital to contemporary theorizing, to transference data.

Ronald Fairbairn (1958) was among the first analysts to question the neutrality of many aspects of technique, including the couch and the therapist, stating that every interpretation is an intervention (p. 92). His theory of ego development is based on splitting needed to protect one's internal world from seduction and profound and devastating disappointment of objects and environment. A primary goal of treatment is to integrate the ego in general and to re-orient the patient to the opportunities in the outside world, to help him move from turning away to turning toward the outer world. Fairbairn came to see the use of the couch as less than neutral and probably something that reinforces the isolation and lack of connectedness that patients living in closed internal systems cling to (p. 80). The strongest resistance to treatment is the patient's desire to keep the status quo of his closed internal system. In light of this, transference can be seen as the refusal to see the therapist as a real person. Fairbairn notes that he abandoned the use of the couch with beneficial results for patients. He posits the patient's need for the therapist to successfully breach the patient's closed internal world system of split objects and ego. He states clearly that transference interpretation and the making conscious of unconscious instincts will not alone effect the desired change. Rather, he asserts treatment ought to be a developmental trajectory of a therapeutic relationship based on transference to a therapeutic relationship based on the nature of two real people in connection. For Fairbairn, the personal relationship is both tool and product of analytic therapy. Here is movement away from the onus of correct interpretations as the single task of the therapist in deepening treatment.

Merton Gill (1979) picks up on the dyad's resistance to transference awareness and posits use of the present-day relationship between therapist and patient as a tool to

decrease resistance. He focuses on the existence of resistance, in patient and therapist, to both the awareness of transference and the resolution of transference. Due to this strong resistance regarding the awareness of transference, Gill asserts that an important way through is to interpret the allusions to the transference in the here and now rather than rely on the more distant genetic interpretations that may increase the patient's resistance of awareness of transference. Here and now transference interpretations allow the patient the experience that his feelings are plausible and connected to the actual analytic situation which allows for further elaboration and exploration of the aspects of the patient's experience that are not so plausible and connected to the actual analytic situation, the genetic transferences. This leads to awareness and expansion of transference, the work of analytic therapy. And in the process of that work, the patient has a new experience; he is treated by the therapist in an unexpected way.

Here is evidence of the growth in psychoanalytic goals since Freud's goal of making unconscious elements conscious. Among the additional uses of analytic treatment are the actual relationship and its role in allowing an expanded understanding of self in relation with others in the present and of self in relation to early caregivers. Transference has become plural and multiple. The new experience of the analytic relationship has potential to heal and to contribute to renewed self-development via understanding of and attunement to needs (Kohut, 1968). According to Gill, interpretation in the here and now is what gives insight its emotional immediacy as required by Strachey (1934). Gill does not advocate replacing genetic transference interpretations with here and now transference interpretations. He makes an argument that both are valid and challenges the classical idea that transference manifestations be interpreted only when there is a

stoppage in free association (1979, p. 282). Again, this points to the acceptance of the idea that transference not only stories the past but also provides insight into present day needs for relationship and development.

Several theorists further developed concepts of transference material as communication of unmet developmental needs and arrested development in addition to, and sometimes replacing, understanding transference material as expression of conflict between id, ego, and superego. These are the object relations and developmental components of transference work and represent the shift in understanding from infants as seeking instinctual gratification to infants as object-seeking (Fairbairn, 1979).

These shifts bring the therapeutic relationship to center stage, less as the vehicle for projection and repetition of the past and more as the vehicle to hear and explicate unmet developmental needs and arrests. D.W. Winnicott, Michael Balint, and Heinz Kohut are three primary voices that bring the analytic relationship and its role in development into focus. Winnicott and Balint in particular question the wisdom of interpretation as the only route to self-growth and understanding.

Winnicott (1956) conceived of a type of transference work that he placed before the work of ordinary psychoanalytic work, or the analysis of neuroses. This is the work of providing an environment that will allow for the emergence of a stable, differentiated ego. That is, for some patients there is not yet a reliable, intact ego to be analyzed. For some people, the failure of the adaptive environment at the stage of emergence from primary identification with the caregiving environment (including the mother) causes the development of a pseudo or false self defined as a “collection of innumerable reactions to

a succession of failures of adaptation" (1956, p. 386). What is of primary importance here is the setting, not interpretation.

The setting is considered to be all the aspects and details of management of treatment, including the therapist's behavior. Therapeutic behavior as "good enough" adaptations to patient needs create an environment where the patient can express early developmental dependency needs that have not been resolved, only hidden (1956, p. 387). The risks and failures of the stage of ego emergence from primary identification begin to be acknowledged especially by making use of the therapist's failures. Winnicott offers a different view of resistance in this type of transference work. Resistance is seen not as the avoidance of awareness of transference but as the clue to the existence of the therapist's mistake in adaptation to needs. Resistance is a signal for the therapist to examine her behavior and countertransference for a mistake in receptivity, thereby giving the patient the opportunity to elaborate on early environmental failures and the chance to become angry and connect with the emerging ego. This can lead to freedom from unresolved needs and from dependence on the therapist (Winnicott, 1956, 1971). This represents dramatic movement away from therapist as interpreter to therapist as provider of milieu.

Winnicott (1956) speaks about very early developmental stages and the importance of the treatment situation as an object relationship where significant healing and developmental progress can take place. Michael Balint (1968) also discusses the importance of the object relationship in treatment to address difficulties in living resulting from problems during early development. Balint refers to damage at the pre-Oedipal level as the basic fault. He distinguishes it from Oedipal-level development asserting the two-

person nature of the earliest care-giving relationship, mother and infant. For patients whose primary difficulties are a legacy of pre-verbal damage, the language of transference interpretations can be meaningless. Balint writes,

> Often a proper interpretation, which makes a repressed conflict conscious and thereby resolves a resistance or undoes a split, gets the patient's free associations going again; at the level of the basic fault this does not necessarily happen. The interpretation is either experienced as interference, cruelty, unwarranted demand or unfair impingement, as a hostile act, or a sign of affection, or is felt so lifeless, in fact dead, that is has no effect at all (p. 175).

The basic fault refers to the patient's subjective experience of self as having a core that must be fixed, resulting from the failings of early environmental care, and the anxiety surrounding this area of the psyche (p. 21). Regression to the basic fault in the treatment process should be accepted, not encouraged or interpreted. The therapist should allow herself to be used to develop a particular type of object relationship, should not use technique that is suggestive of omnipotence, and should remain as "unobtrusive and ordinary" in the patient's eyes as possible (p. 167). Transferences in this instance are not characterized by intrapsychic conflict. Rather, transference consists of the whole pre-Oedipal relationship and emerges in treatment as a bid for recognition and healing. The therapist's presence, not her words, are crucial and the therapist functions as provider of time, milieu and a more understanding environment, not a more caring, loving or gratifying one.

Balint articulates the danger of seducing the patient by trying to be a more loving or gratifying object than the patient's original object. Seduction encourages the patient to view the therapist as omnipotent and omniscient, and thereby increases a potentially never-ending dependence on the therapist as primary object. Balint speaks to the aim in analytic work at the level of the basic fault,

> The aim is that the patient should be able to find himself, to accept himself, and to get on with himself, knowing all the time that there is a scar in himself, his basic fault, which cannot be "analysed" out of existence; moreover, he must be allowed to discover his way to the world of objects—not be shown the "right" way by some profound or correct interpretation (p. 180).

Balint offers an orienting framework when interpretation—words really—become useless in understanding the patient or the process because they do not match the developmental level the patient and therapist need to understand. Balint provides an important understanding of how the therapeutic relationship can exist as an opportunity for psychic healing along with revelation of psychic contents.

Heinz Kohut (1968) also explicates transferences based not on developmental conflict resulting from instinctual desires and superego prohibitions but on developmental needs for idealization, mirroring and twinship. These once normal needs become intensified and pathological when there has been a less-than-gradual, often traumatic, disappointment with early caregivers that has resulted in the lack of internalization of capabilities such as self-soothing, for example, and therefore a structural deficit in the psyche (p. 89). Self-psychological treatment seeks to make use of the relationship to allow the remobilization of archaic or early developmental, merger, idealizing and mirroring needs. Once remobilized, patient and therapist have the opportunity to build cohesion in the structure of the patient's psyche resulting in a reliably healthy, mature narcissism. Included in these important changes are a realistic, less grandiose view of self and a realistic, more reliable but not perfect experience of the other. Kohut (1968, 1971) formulated the human need for relationships that provide experiences for growth and development as the primary data in patient transferences and the responsiveness of the

therapist to understanding these needs as crucial components to facilitating the kind depth in treatment that may lead to enduring character changes for patients.

The most current shift in transference theorizing comes out of movement into a philosophy of a two-person psychology as the context for treatment. George Atwood and Robert Stolorow (1984) conceive of the psychoanalytic process as one of subjectivity itself. They write,

> Psychoanalysis is pictured here as a science of the intersubjective, focused on the interplay between the differently organized subjective worlds of the observer and the observed. The observational stance is always one within, rather than outside, the intersubjective field, a fact that guarantees the centrality of introspection and empathy as the methods of observation (p. 41).

Psychological development of personality occurs in the child-caregiver system of mutual interaction and results in recurring patterns of relating (Stolorow, 2008). Any subjectivity, that is, any person, is prereflectively organized by the resulting patterns of self and objects that become unconscious organizing principles. Of transference and its analysis, Atwood and Stolorow write:

> The concept of transference may be understood to refer to all the ways in which the patient's experience of the analytic relationship becomes organized according to the configurations of self and object that unconsciously structure his subjective universe. The transference is actually a microcosm of the patient's total psychological life, and the analysis of the transference provides a focal point around which the patterns dominating the patient's existence as a whole can be clarified, understood, and changed (1984, p. 47).

Countertransference is the way the unconscious organizing structures of the therapist shape the therapeutic relationship and the patient's transference. Whenever two subjectivities meet and interact in treatment, there are "intersubjective conjunctions and intersubjective disjunctions" (p. 47). In conjunctions, the therapist hears and makes meaning of patient's communications in a way that is close to the patient's meaning

because the unconscious principles and configurations are similar. In disjunctions, the therapist significantly alters the patient's meaning because the subjective configurations between patient and therapist are distant. Intersubjective conjunctions facilitate the therapeutic process of deep understanding while intersubjective disjunctions obstruct such depth of understanding. In order to make the most possible space for the patient's subjective meanings to enter into therapeutic awareness and understanding, the therapist must have reliable "reflective self-awareness and capacity to de-center from the organizing principles of her own subjective world and thereby grasp empathically the actual meaning of the patient's experiences," especially in intersubjective disjunctions (p. 47).

Stolorow (2008) delineates two broad dimensions of transference, non-traumatic developmental patterns and traumatic repetitive patterns. Developmental transference consists of the patient's longings for developmental experiences that were missing, insufficient or prematurely lost. Repetitive transference is seen in the patient's fear, expectations, or actual experience of re-traumatization by the therapist, evoked by something in the therapist that is enhancing the fear or experience. Treatment provides opportunity for "structural transformation" by the repeated experience of being understood by the therapist and the repeated acknowledgment and analysis of not being understood during disjunctions (Stolorow, 1984, p 60). These much-repeated experiences in the therapeutic relationship eventually become a capacity within the patient, a reliable ability to understand oneself.

Relational theorists also consider the role of intersubjectivity, albeit in different ways, in the formation, nature and analysis of transference. Jessica Benjamin (1995)

offers a critique of theory that views the therapeutic relationship as existing between subject (patient) and object (therapist). She defines intersubjectivity in a particular way. She asks how human beings move from experiencing others as object to acknowledging and recognizing others as subjects and considers the potential of the therapeutic relationship in assisting with the development of this ability. Benjamin takes Winnicott's (1971) theory of the developmental capacity to find a usable object in the aftermath of fantasized destruction of the object, which has survived, and develops these ideas further.

The object who has survived destructiveness is now placed outside of the subject's control and can be recognized as such. She postulates that Winnicott's ideas can be understood as a "basic tension between denial and affirmation of the other, between omnipotence and recognition of reality" (p. 39) Benjamin notes that just because there has not been much theorizing about the importance of the mother's subjectivity and the infant's early recognition of it does not mean it has not been there. She describes the ways in which mutual recognition can be seen in mother-infant interactions,

> It is certainly true that recognition begins with the other's confirming response, which tells us that we have created meaning, had an impact, revealed an intention. But very early on we find that recognition between persons—understanding and being understood, being in attunement—is becoming an end in itself. Recognition between persons is essentially mutual. By our very enjoyment of the other's confirming response, we recognize her in return. What the research on mother-infant interaction has uncovered about early reciprocity and mutual influence is best conceptualized as the development of the capacity for mutual recognition (p. 33).

This capacity, for Benjamin, is only unevenly realized. She underscores the ongoing movement between self-assertion that negates the other (intrapsychic fantasy) and the recognition of the persisting other (external reality, intersubjectivity) in human

relationships and in the therapeutic relationship. Of the therapeutic process Benjamin says,

> In the analytic process, the effort to share the productions of fantasy changes the status of fantasy itself, moving it from inner reality to intersubjective communication. The fantasy object who is being related to or destroyed and the usable other who is there to receive the communication and be loved complement each other. What we find in the good hour is a momentary balance between intrapsychic and intersubjective dimensions, a sustained tension or rapid movement between the patient's experience of us as inner material and as the recognizing other. Suspension of the conflict between the two experiences reflects the establishment of a transitional space in which the otherness of the analyst can be ignored as well as recognized. The experience of a space that allows both creative exploration within omnipotence and acknowledgment of an understanding other is, in part, what is therapeutic about the relationship (p. 47).

Benjamin provides an understanding that the existence of a therapeutic process itself may mean there is some capacity in the patient to view the therapist as outside his omnipotent control. The therapist does not have to insist on recognition. It is there, even if in the smallest way. Like Fairbairn (1958), Benjamin highlights that the process of identifying and working through transference may offer an opportunity for growth in this capacity to recognize the other, which contributes to authenticity in relationships.

Lewis Aron (1991) uses the context of intersubjectivity to expand the sources of data for transference interpretation to include aspects of the clinician's subjectivity as interpreted by the patient. He advocates inviting expression and exploration of what the patient comes to know about the therapist implicitly. He makes use of the generally accepted idea that unconscious communication, recognition and direction is occurring in the therapeutic dyad at all times. He also makes it clear that anonymity of the therapist is impossible and yet, that does not mean the end of discernable transference. There is much to learn about the patient's earliest relationships in the ways in which patients try to learn about the therapist, protect or do not protect the therapist from observations of the

therapist's character, and may be reading the therapist's feelings before the therapist is even aware of having them. Aron asserts that therapists who can be open to and curious about the plausibility of patients' observations have the opportunity to articulate with patients what is old reenactment and what is new development in the therapeutic relationship and process. These ideas tend to raise anxiety about giving too much permission for therapist self-disclosure and may increase the risk of therapists using their patients for narcissistic gratifications. Aron points out that he is advocating exploration of what patients learn implicitly about their therapists rather than more explicit self-disclosure by therapists (1991, 1992b).

The nature of knowledge in psychoanalytic clinical theory includes the proposition that anything can become defensive, especially those ideas that are rigidly conceived and employed. Christopher Bollas (2007) asserts this to be true about here and now transference interpretation. He identifies a disruption in the therapist's listening capacity if the therapist is listening, in particular, for a certain type of transference. Bollas juxtaposes listening for versions of transference such as here and now transference, with making oneself receptive in a general way to transference as Freud defined it; transference involving "the deployment of mental functions that facilitate the possibility of unconscious thinking, unconscious creativity, and unconscious communication between two participants" (p. 88). He urges analytic communities to return to this way of thinking about how unconscious ideas get transferred to consciousness via the free associative process, which Freud first labeled transference. This allows for more free-talking and thinking and less foreclosure on unconscious communication. Foreclosure on the time and process needed to hear associative links occurs when therapists are

selectively listening for material in order to make a certain type of transference interpretation. Strachey (1990) states that mutative interpretations are actually rare in any given treatment. The rest of the time, something else is happening. Winnicott (1971) emphasizes holding and non-interpretation. Bollas (2007) reasserts the importance of silence and listening on the therapist's part as the bulk of the therapist's work toward depth in understanding the patient's unique truth.

The nature of transference has undergone at least three conceptions of how it stories the therapeutic relationship, and provides avenues toward depth of understanding of the patient and his troubles. The first version of the transference relationship is one of projection of mental contents, specifically infantile experience, from the patient onto the therapist. Therapeutic action in this version is interpretation leading to insight about and resolution for the patient of his deepest intrapsychic conflicts. The second version of transference and its uses in treatment relate to developmental needs, deficits and arrests. In this version, it is crucial for the therapist to accept, understand, and validate as well as provide a safe environment in which the patient can acknowledge and grieve his past and find a way to a potentially different future via the therapeutic relationship. The depth considered to result from this understanding of transference is the accomplishment of psychic healing. The third version is one that conceives of transference as co-created by patient and therapist and the process by which that gets identified, understood and accepted. Depth is connected to existential struggle and understanding about the nature of life and relationships, a coming to the capacity to hold inherent tensions that may never get resolved. There are certainly debates over which version of transference is true and what techniques allow for the most depth, psychic change and healing. Study participants

in practice, reflecting on their work and what they think are the most useful ways to conceive of and work with transference to create depth in treatment are explicated in this study.

Countertransference

Like transference, countertransference has undergone significant changes via definition and technique. Countertransference has been expanded to include preconscious and conscious as well as unconscious responses to the patient and therapeutic situation. Some define it as all of the therapist's feelings and attitudes toward the patient rather than just the therapist's reactions to the patient's transferences (Heimann, 1950). Techniques for countertransference use have also been expanded due to an understanding of its ubiquitous nature. It can be used as an important source of information to increase and deepen understanding about the patient, the therapist, and the unique therapeutic process of each dyad (Renik and Tyson, 1986).

Freud conceived of the therapist's unconscious as both help and hindrance to the free associative process. His limited comments on countertransference proper are focused on the potential of the therapist's unconscious resistances to the analytic process to become interferences with the patient's freedom of expression. He notes,

> We have begun to consider the "counter-transference," which arises in the physician as a result of the patient's influence on his unconscious feelings, and have nearly come to the point of requiring the physician to recognize and overcome this counter-transference in himself…we have noticed that every analyst's achievement is limited by what his own complexes and resistances permit, and consequently we require that he should begin his practice with a self-analysis and should extend and deepen this constantly while making his observations on his patients (1910, p. 80—81).

This conception of countertransference came to be known as the therapist's blind spots or unanalyzed neuroses. Freud also makes clear statements that the therapist's unconscious capacity and processes are crucial tools. He writes of the listening stance that supports unconscious communication when the therapist "turns his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the transmitting microphone" (1912b, p. 115). By doing so, Freud theorizes the therapist can listen for unconscious derivatives within herself as hints to reconstructing that which is being communicated from the patient's unconscious. In order to do so, the therapist must be open to communications that travel this route and must transform her subjective experience into thought. He relates both the help and hindrance of the therapist's unconscious responses to the patient,

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

Ongoing treatment of one's own is considered crucial in order to develop one's unconscious capacities and to come to know, and therefore listen for, one's idiosyncratic neuroses.

It may be that in order to promote psychoanalysis, his clearest statements about technique regarding countertransference were weighted toward management of blind spots and the danger of countertransference enactments (Jacobs, 1999). Further definition of countertransference would be developed by those that would follow Freud.

Ronald Fairbairn (1952) provided ideas that help to deepen understanding of transference via countertransference phenomena. Fairbairn's theory of ego-splitting and goals of therapy—ego integration and development of the ability to experience and use new object relationships—conveys his understanding that part of the therapists' role is to become drawn into the patient's world while simultaneously drawing the patient out of his internal world to find the therapist as separate and new object. To do this, one must be able to be experienced as an old, bad object and remain connected to one's separate subjectivity. Winnicott formulates (1971) this as the therapist's ability to receive and survive the other's aggressiveness. The implications for countertransference use include the ability to reflect on the feel of being the bad object and its specific qualities, which brings aspects of the patient's internal world to life along with the ability to be something else, something separate from the patient's internal world, to be one's self, a new object that offers good qualities. In order to be this separate subjectivity that offers good qualities one must feel something good about the patient. Here is a shift away from the prohibition of using one's specific feelings about the patient for one's functioning as therapist.

Sandor Ferenczi maintains that real events, rather than fantasies, of trauma and early caregiver failures can account for much of patients' symptoms and suffering. He began to work from a perspective that emotional understanding of such events is equally important as intellectual insight for therapeutic success and healing, that the therapeutic relationship, particularly the therapist's empathy, are primary curative factors (Ferenczi, 1985; Borden, 2009). In fact, Ferenczi understands that failures are not always connected

only to the patient's resistances and analyzability. Rather, failures of treatment are also contributed to by therapists' own inadequacies and limitations (Aron, 1992a).

Ferenczi (1985) was one of the first analysts to champion the idea that countertransference was inevitable and valuable in understanding the patient's actual traumatic experiences. Throughout the history of psychoanalysis and alongside the debate over countertransference and its manifestations as problematic or instructive are questions about therapist disclosure of countertransference feelings and thoughts.

For D. W. Winnicott (1949), it is sometimes necessary to cautiously disclose countertransference. Countertransference sometimes contains objective, not neurotic, responses to characteristics in the patient. Using a case example, he identifies a specific type of countertransference, "objective and justified hatred" (p. 71), that results from experience with a patient whereby hatred is the only reasonable response one could have and represents an identification with one of the patient's internal objects. For Winnicott, this leads to the understanding that to either deny the experience of hatred or to put it aside as an unresolved conflict represents a disservice to the patient, leaving the patient alone with his experience of hatred in the maternal relationship. The patient's cure depends on the therapist's ability to engage, understand, and contain this feeling of hatred. He also recommends that the therapist judiciously share something of her experience in the aftermath of such regressed experience. Winnicott raises technical questions regarding powerful countertransference reactions and the possibility that to share countertransference feelings in limited ways may be crucial to therapeutic success. These are ideas that get further developed in contemporary object relations theorizing.

Paula Heimann (1950) builds on the conception of countertransference as more than neurotic reactions of the therapist. She makes explicit the idea of countertransference as a tool for understanding patient's unconscious fantasies and defenses. For Heimann, the therapist's own treatment is crucial to developing the ability to use countertransference as a research tool as some elements of countertransference originate as projections from the patient's unconscious. She asserts,

> The aim of the analyst's own analysis, from this point of view, is not to turn him into a mechanical brain which can produce intellectual procedure, but to enable him, to sustain feelings which are stirred in him, as opposed to discharging them (as the patient does), in order to subordinate them to the analytic task in which he functions as the patient's mirror reflection (p. 82).

Heimann adds affective resonance to Freud's (1912b) description of the therapist's unconscious as a receptive organ by asserting the need for the therapist to have, in addition to freely working attention, a "freely roused emotional sensibility so as to follow the patient's emotional movements and unconscious phantasies" (p. 82). This allows the therapist to access the patient on a deep level and gives her a valuable means of understanding the patient's voice. She recommends that the therapist take a careful listening stance toward her feelings but does not advocate direct disclosure of those feelings. She writes,

> In my view Freud's demand that the analyst must 'recognize and master' his countertransference does not lead to the conclusion that the countertransference is a disturbing factor and that the analyst should become unfeeling and detached, but that he must use his emotional response as a key to the patient's unconscious. This will protect him from entering as a co-actor on the scene which the patient re-enacts in the analytic relationship and from exploiting it for his own needs. At the same time he will find ample stimulus for taking himself to task again and again and for continuing the analysis of his own problems. This, however, is a private affair, and I do not consider it right for the analyst to communicate his feelings to the patient (1950, p.83).

Heimann distinguishes between the idea of the therapist behaving in a more "human" way by sharing her subjective experience directly with the patient, considered to be burdensome to and potentially exploitive of the patient, and the therapist "becoming" human in the patient's perspective as part of the outcome of a successful treatment. That is, by using countertransference, sustaining rather than discharging feelings, as a source of insight into the patient's unconscious fantasies and defenses which then become accessible to interpretation and working through, the patient's ability to perceive reality will be increased so that the therapist will be perceived as human rather than god or monster.

Margaret Little (1951) also asserts that the therapist needs to allow for and learn from her intense feelings. She points to the potential for the therapist to develop a paranoid or phobic attitude towards one's own feelings in relation to the patient if it is believed that countertransference feelings are only problematic. She understands that in addition to the unconscious fantasies patients have about their therapists, patients also come to know a great deal of truth about their therapists, actual and psychic. She writes,

> Analysts often behave unconsciously exactly like the parents who put up a smoke-screen, and tantalize their children, tempting them to see the very things they forbid their seeing; and not to refer to the counter-transference is tantamount to denying its existence, or forbidding the patient to know or speak about it (p. 37).

A difficult resistance to overcome in the therapist is the willingness to hear about this knowledge from the patient. Little's thoughts are a forerunner to Aron's (1991) focus on the usefulness of the patient's interpretation of the therapist's subjectivity.

Wilfred Bion and Heinrich Racker also believe countertransference to be full of possibilities for insight into the patient's projections and introjections. Bion (1959, 1962) discusses, through the metaphor of the process between infant and mother, the

importance of the therapist's functioning as container of intense affective projections from the patient. He theorizes that the therapist's abilities to sit with, wonder about (reverie), and develop thoughts about her countertransference feelings before speaking or interpreting are crucial to a goal of analytic therapy; the patient is able to know and tolerate his more disturbing or frightening thoughts and feelings. Use of such reverie by the therapist helps the therapeutic dyad to access some of the deepest layers of psyche, the preverbal experiences (Vaslamatzis, 1999). Bion, like Winnicott (1958), expresses the value of the therapist's holding and containing functions rather than constant discharge via interpretation.

Racker (1968) makes several cogent points regarding countertransference. He frames the therapeutic relationship as one existing between two people, giving transference and countertransference equal status in the interaction. Transference and countertransference are always present and mutually influence each other. Therefore, the way to know transference is through analysis of countertransference. He also understands countertransference as both help and hindrance to the therapeutic process. Racker's perspective is that therapists are not so different from their patients, that the phenomena of countertransference are very similar to transference. Like Little, Racker asserts that the therapist is never completely free from neurosis,

> Just as the whole of the patient's personality, the healthy part and the neurotic part, his present and past, reality and fantasy, are brought into play in his relations with the analyst, so it is with the analyst, although with qualitative and quantitative differences, in his relation with the patient. These two relations differ, above all, through the different external and internal situations of patient and analyst in analytic treatment and through the fact of the latter's having already been analysed. Nevertheless the previous statement still holds. For neither is the analyst free of neurosis (p. 105—06).

Of countertransference, he makes several analogous comparisons to transference. Countertransference is always present, its pathological expression is countertransference neurosis, its sublimated positive expression is the therapist's motivation to do therapeutic work, and it becomes subject to investigation as a technical problem to be resolved when it becomes resistance, especially when it becomes primarily sexual or negative. Like transference, countertransference can be an indispensable tool, a threat to treatment, and a frame of observation for therapeutic work. Racker also delineates the mutual influence between transference and countertransference—transference affects the patient's behavior thus impacting countertransference just as countertransference affects the therapist's behavior, thus impacting the transference.

Racker writes about the lack of scientific investigation into countertransference in a discipline that was founded on and values, above all else, thorough investigation of its subjects. He presumes it is due to rejection of countertransference feelings, especially primitive anxiety and guilt. The rejection, he theorizes, represents an ongoing neurotic attachment to infantile ideals. Here Racker makes, what was at the time, a radical observation. He states,

> We must begin by revising our feelings about our own countertransference and try to overcome our own infantile ideals more thoroughly, accepting more fully the fact that we are still children and neurotics even when we are adults and analysts. Only in this way—by better overcoming our rejection of countertransference—can we achieve the same result in candidates (1968, p. 130).

He challenges the specific ideal of the therapist's objectivity as unrealistic and based on the myth that the therapeutic situation is an interaction between a sick person and a healthy person.

> The truth is that it is an interaction between two personalities, in both of which the ego is under pressure from the id, the superego, and the external world; each

> personality has its internal and external dependencies, anxieties, and pathological defenses; each is also a child with his internal parents; and each of these whole personalities…responds to every event of the analytic situation. Besides these similarities exist differences, and one of these is in "objectivity." The analyst's objectivity consists mainly in a certain attitude towards his own subjectivity and countertransference…True objectivity is based upon a form of internal division that enables the analyst to make himself an object of his continuous observation and analysis. This position also enables him to be relatively "objective" towards the analysand (p. 132).

For Racker, depth in understanding the patient's transferences is directly connected to the therapist's ability and success in analyzing her countertransference. The therapist should listen very carefully to the highly charged countertransference positions she finds herself in, as they can provide clues to what the patient is unconsciously acting out. If the therapist does not work to consciously perceive her reactions, she too will engage unconsciously in acting them out (1968, p. 141). Racker's ideas serve as prelude to highly debated views on enactment in contemporary theorizing.

Many of Racker's observations have been further developed by object relations theorists to underscore countertransference as a crucial tool for deeper understanding of the patient. Thomas Ogden (1994) conceives of the "analytic third" created by the analytic dyad: "This third subjectivity, the intersubjective analytic third is a product of a unique dialectic generated by (between) the separate subjectivities of analyst and analysand within the analytic setting" (p. 463). Intrinsic to this definition is the conception of layered influence. The individual subjectivities of patient and therapist are both creators of and influenced by the analytic third. Ogden anchors countertransference in this conception and understands it as a product of the ongoing interplay of subjectivity and intersubjectivity. He writes,

> I have attempted to describe something of the way in which my experience as an analyst (including the barely perceptible and often extremely mundane

> background workings of my mind) are contextualised by the intersubjective experience created by analyst and analysand. No thought, feeling, or sensation can be considered to be the same as it was or will be outside of the context of the specific (and continually shifting) intersubjectivity created by analyst and analysand (p. 470).

Countertransference is inextricably connected to the clinical moment and is an important part of understanding and deciphering the unconscious communication that is always occurring. Aspects of both the therapist's and patient's pasts become newly created in the experience generated in the therapeutic interaction. Creating and using the analytic third allows therapist and patient to speak from within and about unconscious experience, presently and retrospectively. Ogden describes a technique that does not directly disclose countertransference data. Instead it uses countertransference data by listening to one's trains of thought in a way that wonders "why now" and what this might mean in this particular therapeutic dyad and moment (1994, p. 471).

Christopher Bollas (1983) delineates ways in which the patient expresses himself through the therapist, describing the therapist as the other patient in the room and countertransference as a second source of free association. Patients create an environment in the analytic space that expresses their idiom. Therapists provide a kind of attentiveness that reflects countertransference readiness, a mental space receptive to the patient's transferences and preparedness to be affected by the patient through the countertransference. In this way, therapists "are invited to fill differing and changing object representations" (p. 4), primarily through affect which may represent "something of the patient's mother, or father, or some aspect of the patient's mind which he finds unbearable" (p. 6). Bollas posits that the effect of the patient on the therapist is always part illness (reflecting the patient's transferences). These are the aspects of the

countertransference that the therapist is able to articulate and make available to the analytic pair for consideration and analysis. He states,

> Because the analyst is the Other patient, sustaining in himself some intersubjective discourse with the analysand, it is essential to find some way to put forward for analytic investigation that which is occurring in the analyst as purely subjective and private experience. It is essential to do this because in many patients the truly free associative process takes place within the analyst, and the clinician must find some way to report his internal processes thereby linking the patient with something that he has lost in himself and enabling him to engage more authentically with the free associative process (1983, p. 6).

Drawing on Winnicott's clinical style, Bollas conceives of offering one's subjective internal process to the patient as a potential, not official, truth. For Bollas, ordinary countertransference is a state of not knowing how what one is feeling applies to the patient and the therapy. Deepened understanding of the patient's intrapsychic world requires the therapist to tolerate long periods of such not knowing (p. 4). Additionally, Bollas tunes into countertransference experience to listen for what feels most emotionally true in a given session in order to offer ideas to the patient about the patient's self working to be expressed in the moment.

Self psychology perspectives on countertransference provide specificity to countertransference descriptions related to transferences. Ernest Wolf (1979) identifies probable countertransferential reactions to patients' selfobject needs for mirroring and idealized merger. Among reactions to the patient's mirror transferences are feeling sleepy, irritated, and erased, and an increased feeling of need to assert oneself. Idealizing transferences tend to make the therapist feel uncomfortable with the patient's expectations and can engender self-doubt and self-deprecation (pp. 581-582). Therapists can be alerted to such countertransference reactions by listening for patients' communications about their experience of the therapist and the setting as useful or not.

These are conceptions of countertransference as disruptive to the unfolding of the patient's archaic selfobject needs and therefore, should be analyzed and contained.

Wolf also explicates an understanding of countertransference that is necessary to the therapist's empathic functioning. In order to have a truly introspective understanding of patient communications, she must call upon her own affective experience of selfobject needs. Empathic immersion requires the therapist to allow a controlled regression within her own self in order to find the emotional experience the patient needs to convey (Kohut, 1977; Wolf, 1979). However, the benefits of regression in the countertransference to the level of selfobject needs and experiences should be accompanied by a great deal of monitoring while one's intimacy and mature selfobject needs are met in one's private and collegial lives (Wolf, 1979, p. 586). Wolf highlights the potentially fine line between countertransference use that enhances depth of understanding the patient and countertransference enactment that disallows the space in the therapeutic relationship necessary for the patient to reveal such needs. Countertransference disclosure is not endorsed. Rather, the therapist's attention to the therapeutic process should be scanning for indications that the fine line has been crossed and in such situations, should work to repair the balance.

Perspectives on disclosure of countertransference feelings are closely tied to conceptions of analytic neutrality. In the early years of psychoanalysis, neutrality was defined in the following way:

> Neutrality is the analyst's attempt to remain equidistant from the patient's conflicts without taking a moral position influenced by personal values. Neutrality relative to the patient's conflicts is rooted in Anna Freud's suggestion that the analyst remain equidistant from id, ego and superego (Bachant and Alder, 1996, p. 1034).

Along with this definition was the strong recommendation of analytic abstinence in relation to the patient's pressure to act or do or provide rather than interpret. Neutrality and abstinence seemed to merge in the caricature, and probably in practice for some, of the unyielding, inhumane, and coldly distant analyst. Bachant and Adler (1996) represent analytic neutrality in a contemporary way as the complement to the patient's free association. They highlight three dimensions of neutrality—neutrality with regard to conflict, sequence, and transference—that one strives for in the analytic therapist role. Working to not guide the patient in relation to which aspect of the patient is revealed and prioritized, what order or timing of issues unfolds in the patient's process, and what particular types of transference data emerge, allows the fullest and deepest free associative process for the patient. They write,

> Technical neutrality certainly does not imply the eradication of the analyst as a person from the interaction; to think in this way is to conflate the ordinary meaning of neutrality with the technical concept. Fundamentally, the attitude of neutrality embodies an acknowledgment of what is true in the patient's psychic experience. A patient's feelings, fantasies, beliefs, wishes, and intentions are what they are, and the neutrality of the analytic listener makes no demand that they be otherwise. We recognize in this an ideal which elevates the love of truth above personal comfort. It informs the analyst's functioning, in the same sense that free association does for the patient, as something to be striven for though not always fully attained (p. 1033).

For Bachant and Adler, countertransference disclosure to the patient is not indicated for a depth-oriented process. Countertransference disclosure would shift the therapist's position away from neutrality and toward directing the process and transference development. The focus should remain on understanding the patient and countertransference should be used as a tool to do so, to articulate such understanding. They identify the process of analytic treatment as a one-neurosis, two-person model (p. 1041).

Original prohibitions to making use of countertransference data in the therapeutic process focused on the ways in which countertransference inhibits the therapist's listening functionality. The still-valid warning includes the understanding that unanalyzed countertransference can become enactment at the level of boundary violations that threaten the viability of the therapeutic process (McWilliams, 2004). However, countertransference is no longer considered just an impediment to an analytic process. It is seen as a tool in deepening understanding of patients' internal worlds, patterns, needs and relationships (Hoffman 1998; Joseph, 1985; Wolf, 1979). Current debates center on the nature of enactment and disclosure of countertransference and whether and how they may open deeper exploration and understanding in the therapy relationship.

Relational psychoanalytic theorists question the therapist's ability to prevent enactments and posit the possibility of countertransference disclosure as potentially useful in finding ways out of impasses based on enactments. Relational conceptions of transference as a joint creation rather than "an endogenous process that unfolds from the mind of the patient" assert that "transference cannot be fully resolved or fully understood without reference to the countertransference" (Aron, 1992b, p. 184). In other words, for Aron and others (Benjamin, 2004; Davies, 2004), getting ahead of countertransference before it is part of enactment within the therapeutic relationship is an impossible ideal. These authors consider countertransference data, and sometimes countertransference disclosure, as part of understanding a current and inevitable enactment in the transference-countertransference field of interaction. According to Burke and Tansey (1997) relational psychoanalysis provides countertransference disclosure with a theoretical home asserting that debates within this school of thought focus not on whether

enactment and countertransference disclosure is helpful. Rather, they grapple with the following questions,

> Does disclosure facilitate or restrict the patient's capacity to experience and examine transference? How does the therapist's disclosure influence the type of information elicited from the patient? Does disclosure promote or detract from the therapist's ability to maintain a position of relative neutrality? What is the degree of understanding a therapist should have concerning a countertransference-transference paradigm before he engages in disclosure (p. 9)?

For relational theorists, one aspect of neutrality is conceived of as openness to offer and allow for exploration of the patient's observations of the therapist's behavior in the analytic relationship and process. During such exploration, the therapist may implicitly or explicitly confirm, disconfirm, or elaborate on the patient's observations.

Donnel Stern and Jody Messler Davies consider enactments to be inevitable and an important route to unconscious—often dissociated rather than repressed—mental contents. Stern (2008) wonders how a therapist is able to identify countertransference reactions that are unconscious. By definition, they are not in the therapist's awareness. He posits that therapists become aware of unconscious countertransference via enactment and questions the existence of a completely objective aspect of self that has been thought of as the therapist's observing ego.

Stern uses a theory of self that consists of multiple self-states, some well-known and some less-known or even unformulated. The process of therapy allows both therapist and patient to learn about each of their own self-states, especially those that exist outside awareness. Stern formulates a model of clinical process whereby the patient and therapist create internal conflict from unconscious enactment, thereby expanding awareness of self experience and expression. This is in contrast to clinical process that seeks to resolve internal conflict. Discomfort (countertransference) in the mind of the therapist is often a

first clue to the understanding of a current enactment of dissociated self-states and experience. This discomfort becomes felt as awareness of tension or conflict in the interpersonal field between patient and therapist. Resolution of the interpersonal tension comes as each party is able to recognize and tolerate the internal conflict that was being projected between them. Stern writes,

> It turns out that knowing the countertransference seems impossible only as long as we are thinking from the position of singlemindedness. When we are able to create only one state of mind, it seems and feels as if, to observe itself, that mind must somehow twist around and think itself from an impossible elsewhere—the bootstrapping problem. In the achievement of conflict, we create an alternative to the rigid perceptions that have locked us into the status quo; we create multiple consciousness. As singlemindedness is replaced by two or more internal positions, one part of us becomes capable of observing another part without having to perform metaphysical contortions; the mind can feel and reflect on what it could only live out blindly before (2008, p. 23, HTML copy).

In this formulation, transference, countertransference, and enactment are seen as intricately connected and as such, identifying and unraveling them are a vital part of the process of psychoanalytic therapy.

Davies (2004) proposes a new definition of analytic neutrality and dissociation as a normative capacity that frames enactment as a bulk of the work of analytic therapy. These ideas are also based on the relational psychoanalytic theory of multiple self-states. Analytic neutrality is conceived of as “the therapist’s capacity to move fluidly from one particular transference-countertransference paradigm to another without becoming mired in the repetitive reenactment of any one configuration” (p. 718); that is, the therapist should be able to participate in an enactment while understanding that this is just one way of being with this particular patient. She believes the therapist is met by some level of ability within the patient that she terms therapeutic dissociation and defines as “the patient’s capacity to appreciate the tension between one particularly heightened

transference-countertransference experience against a backdrop of multiple other potential interactions" (p. 718). The patient is able to let go of defining self and the particular clinical moment as the one and only version of self and clinical moments.

For Davies, these capacities allow therapist and patient to acknowledge, accept, and take responsibility for hard-to-tolerate aspects of self that are considered bad or shameful. She asserts that there are clinical sequences when the patient needs the therapist to acknowledge and take responsibility for such aspects in herself in order for the patient to do so. Like Stern (2008), Davies offers a view of enactment as a way to facilitate the emergence of previously unformulated self-states and to deepen the experience of intimacy in the therapeutic relationship. This view of enactment conceives of some enactment as containable and fluid for the dyad as opposed to a view of enactment that is only destructive to treatment. It also includes countertransference disclosure as a technique to contribute to movement out of repetitive enactments.

Jay Greenberg (2001) explicates a cautious appreciation of the relational focus on the new relationship and on exploration of the contributions of both patient and therapist to the therapeutic process. His critique brings to mind a pendulum. Classical technique has been interpreted to mean that the therapist should reveal nothing about her subjective experience to the patient. For Greenberg, relational technique could, in its attempts to address the fallacy of the blank screen therapist and perhaps unintentionally, instruct therapists to focus on the interplay of two subjectivities impacting each other at the cost of receptivity to the patient's uniquely private and personal experience that has little or nothing to do with the therapist. Like Bollas's critique of the here and now transference interpretation (2007), Greenberg cautions against subscribing to any technique as the only

route to anything in the therapeutic process arguing instead for an appreciation of multiplicity of techniques to help patients know themselves.

Countertransference analysis, use, and disclosure, along with ideas about the nature of enactment, are the topics of current, highly charged debates between schools of psychoanalytic theory. Classical, self psychology and intersubjective systems theories charge the therapist with responsibility to attain the fullest possible awareness of countertransference in order to use it toward understanding the patient and assisting with crucial empathic functioning that facilitates knowing the patient's experience and subjectivity as deeply as possible. These points of view also instruct the therapist to use countertransference awareness to prevent participation in enactments with patients that impinge on and disrupt the patient's revelation of self, conflict, or need. Object relations theories recommend some amount of countertransference disclosure that can bring into awareness an aspect of the patient that has been denied, disavowed, or projected. Countertransference disclosure, in this light, is thought to help the patient achieve deeper understanding, acceptance, and integration of his internal world, and therefore, less need to project in interpersonal relationships. For relational theorists, awareness and analysis of countertransference occurs in the midst of, not before, enactment is already taking place. Countertransference analysis sheds light on the particular enactment of the moment, either as it is done privately by the therapist or observed and expressed by the patient. Additionally, countertransference disclosure is considered a viable route out of toxic enactments toward deeper understanding of the patient's experiences, past and present.

Psychoanalytic therapy is extremely stirring work. It is frightening to connect and stay with primitive anxiety, guilt, shame, fear, and all other complex affective states and resulting defenses that patients and therapists bring to psychoanalytically oriented treatment. Crucial to practicing psychoanalytic therapy are the development and maintenance of reliable abilities to tolerate powerful affect and observe one's involvement in intense relationships.

CHAPTER III

THEORETICAL AND CONCEPTUAL FRAMEWORK

Theoretical Framework of the Study

Theory does not seem to me to be the major concern. It is a useful servant but a bad master.

~Harry Guntrip, *Psychoanalytic Theory, Therapy and the Self*

The goal of this study was to discover and explore participants' points of view about deepening their therapeutic work with patients. The theoretical framework is a general psychoanalytic approach or stance, one that helps to evoke and hear the unique, subjective, internal aspects of participants' reflections on themselves and their work. Freud's instructions to new analysts (1912b) capture the listening stance this researcher strove for during data collection and analysis. He writes of listening with evenly suspended attention in order to avoid the sort of focus that results in selecting familiar ideas, thereby potentially disregarding unfamiliar and unknown material and getting in the way of other perceptual capacities, e.g. unconscious reception of affect or thought. The researcher worked to limit any resistance to what she heard, thought, or felt in communication with participants. This form of listening by the researcher encouraged the participants' freedom of expression on the topic.

Christopher Bollas (2002) speaks to the probability that the listener to free associative material will distort or alter the speaker's communication, will select and create constellations of thought that are familiar to the listener. He provides an analogy that reminds us that we are gifted with processing abilities that occur simultaneously.

> The problem is one of form versus content. The analyst's unconscious life will alter the patient's communications, dream-working them into unconscious complexes of the analyst's own creation; but at the same time the ego's ability to follow the structure of the unconscious logic will continue, a procedural capability unimpeded by the work of the analyst's own unconscious, much like operating a car is ordinarily uninfluenced by the driver's passing thoughts (p. 18).

Free association and evenly hovering attention are not completely possible. Rather, they are ideals that the researcher and psychotherapist strive for while attempting to hear what must be listened for in these ways.

Free association was further limited due to the need to stay focused on the research topic. While the researcher created an interview situation where the participants were given space to think and verbalize in an associative way, she also participated in constructing the narrative by her questions and requests for elaboration. However, listening for the way participants' structured their associations—how they began, where they went from there, when the subject shifted or changed, and other linking elements—provided insight into meanings for participants, conscious and unconscious, related to the topic (Cartwright, 2004).

Other aspects of the researcher's listening stance included what Nancy McWilliams calls the psychoanalytic sensibility (2004). This includes curiosity, appreciation of complexity, capacities for identification and empathy, and respect for subjectivity and affect. The researcher's assessment of her role in the interview process was similar to McWilliams's discussion of assessment of therapeutic intervention, not

whether it followed a prescribed theoretical school of thought but whether it allowed the participant “to speak more freely, to disclose more genuine or troubling feelings, to deepen the work.” (p. 21).

As in psychoanalytic therapy, this study sought to reach as deeply as possible into the participants’ subjective experiences. The researcher’s abilities to use these basic tenets of psychoanalytic listening were thought to provide the best frame to explore participants’ thoughts and feelings about their work. Using a general psychoanalytic listening stance allowed the researcher to bring a more open mind to receive participants and their ideas rather than over-privileging any particular psychoanalytic theory of deepening treatment. Those theories were presented in the literature review section and were also used in discussion following the study’s findings.

Statement of Assumptions

The following assumptions are a set of organizing ideas that have been developed through the study of theory and the experience of psychotherapeutic practice.

1. Part of psychoanalytic therapeutic functioning includes facilitating or inviting deepening of the process of treatment.
2. There is a great deal to learn about how psychoanalytic therapists who are clinical social workers think about this therapeutic function.
3. Psychoanalytic therapists think about issues of facilitating or inviting depth work with their patients in their day-to-day work and will honestly share these thoughts with the researcher.
4. Depth in psychoanalytic therapy is considered desirable.

CHAPTER IV

METHODOLOGY

Type of Study and Design

The focus of this study is the psychotherapist and how she contributes to establishing and facilitating depth-oriented treatment. The primary objective was to identify and explore the techniques and core attitudes of the participants through multiple interviews. According to Yin (2003), case studies are the preferred research strategy when three conditions are present. First, case study methodology contributes to answering “how” and “why” research questions, providing both explanatory and exploratory data. Second, in a situation where there is little researcher control over events, case study methodology focuses on the primary actor in the phenomenon to be studied. The interviews in each case provide subjective data from the person conducting the work. Finally, this methodology is useful in providing information about events occurring contemporarily within a real life context. The focus of this study—clinical social work practitioners of psychoanalytic therapy and their thoughts about deepening treatment—meet these three conditions.

Yin identifies five important components of a case study design: questions, propositions, unit(s) of analysis, logic linking the data to the propositions, and criteria for interpreting the findings (p. 21). This case study design includes all of these components.

The question is “how do clinical social workers who practice psychoanalytic therapy deepen treatment?”

The main proposition is that clinicians have significant responsibility for creating depth-oriented treatment. The study’s units of analysis are the participants’ thoughts, beliefs, attitudes, and techniques expressed during interviews. The logic linking interview data to propositions is descriptive and interpretive; what participants say and what the researcher observes. The philosophical foundation for this study is a phenomenological-hermeneutic one. Phenomenological descriptions focus on lived experience and are concerned with essential meanings in the experience for the experiencing person. Hermeneutic perspectives involve the study of uniqueness of persons rather than empirical perspectives that intend to study replaceable and repeatable phenomena. Hermeneutic perspectives also include interpretations of what is essentially unknowable in itself; “a philosophy of the personal, the individual, which we pursue against the backdrop of an understanding of the evasive character of the logos of others, the whole, the communal or the social” (Van Manen, 1990, p. 7). Participants’ reflections on their experiences as members of the group psychoanalytic therapists and the researcher’s interpretations provided diverse ideas, discovery of meanings and potential enhancement of former meanings regarding the research question (Greenwood and Loewenthal, 2005). The logic and value of the descriptive, interpretive findings include an invitation to the reader to make judgments in relation to the research question.

There were two steps in the analysis of findings. First is the presentation of individual case reports that provide information about how each participant deepens therapeutic treatment. The analysis is a psychoanalytic interpretive one based on that

used by Tolleson (1996) and will include circumstances, dimensions, and meanings for each participant related to the topic. The second step is to present a cross-case report providing comparative information between cases (Tolleson, 1996; Yin, 2003).

Sources and Nature of Data, Population, and Sampling, Setting, Scope of Study

The data for this study was collected in interviews with participants (psychoanalytic therapists who are clinical social workers and experienced enough to have significant insight into deepening the treatment process). Data was subjective, experience-based and narrative. The bias regarding experience reflects the researcher's belief that effectiveness at establishing depth-oriented treatment increases over time as experience lends itself to the learning that psychoanalytic therapy practice requires. Hubert Dreyfus (2005) speaks to the importance of experience in becoming an expert in one's field. Experience allows for the "switch from detached rule-following to a more involved and situation-specific way of coping," (p. 7). He discusses the situation-specific way as less detached rational analysis and more flexible responsiveness by staying involved and sees this shift as one from left brain to right brain processing. Experienced practitioners provided interview data rich in the interplay between technique and intuition.

Multiple interviews with a sample of five participants provided data that generated knowledge based on depth rather than breadth. Because the focus of this study is subjective experience of complex phenomena, depth is preferred as it provided more opportunity to know each case well, and understand their uniqueness, which then allowed for the emergence of similarities and differences between cases (Stake, 1995).

Participants were referred to the researcher by seasoned therapists who were not a part of the researcher's dissertation committee. Rationale for this type of sampling was reflective of the need to interview therapists who were likely to be self-aware and non-defensive in discussing their work as well as committed to being involved in depth-oriented treatment. Therapists known by the researcher to have these qualities led the researcher to participants. The researcher did not accept referrals of therapists who are already known to her. This constituted the first phase of screening for participants.

The second phase of screening participants was done with a brief telephone interview. The following parameters stipulated that five study participants:

1. Are clinical social workers
2. Identify as psychoanalytic or psychodynamic therapists, defined in a previous section
3. Have been in clinical practice for at least 20 years
4. Are currently in or previously have been in a psychoanalytically oriented treatment
5. Are currently in or have completed some form of extra-practice study (that is, post-masters clinical education certificate or academic program, or psychoanalytic study or consultation group led by or consisting of experienced psychoanalytic therapists)
6. Were willing to be interviewed three times and audio taped each time
7. Agreed to disguise and discuss case material during the interviews

In addition to verifying these requirements of participation in the study, the screening telephone interview provided a sense of whether the participant could teach the

field something about deepening treatment. This was the first instance of the researcher's use of her countertransference for interpretation. Upon acceptance into the study, each participant was assigned an identification number used to identify participants on all subsequent interview forms and audiotapes. Each participant was interviewed in his or her office. These measures insured privacy and confidentiality.

Data Collection Methods and Instruments

This study used two sources of data: interviews and researcher field notes. Primary data was narrative material about deepening treatment generated from three semi-structured and unstructured interviews with each of five participants. All interviews were conducted by the researcher and lasted approximately 60 to 90 minutes creating 18 hours of raw data in the form of audio recordings. Each interview was professionally transcribed.

Tolleson (1996) identifies several specific factors that come together as rationale for multiple interviews:

1. Multiple interviews increase familiarity and comfort with the researcher and may lead to more honest reflections;
2. There is more opportunity for clarification and elaboration of ideas and meanings;
3. Mental processes in participants are sparked as the process of being interviewed, then continuing their work while thinking about deepening will occur two times so that the data generated will be very connected to actual practice;
4. Given more time with participants, the researcher has an opportunity to have an experience of being with the participant that is less simplistic than a one-time

> view and will incorporate a variety of types of communication such as language, nonverbal behavior, and interactions.

Returning for further discussion allows for a hermeneutic process of inquiry in which participant and researcher collaborate to focus in on the preliminary themes by exploring questions such as “Is this what the experience is really like?” (Van Manen, 1990, p. 99). Validity of findings is increased by comparisons between the researcher’s interpretations and verbatim transcripts (Siegel, 2002).

This intensive, phenomenological approach to data collection aims to illuminate the subjective experience of its participants. Revealing and interpreting subjective experience lends itself well to clinical interviewing methods and rationales. The main parameter for participants was to reflect on their thoughts and experiences related to deepening treatment and the researcher began with questions about that process. Beyond that participants were free to elaborate on what is most meaningful and important to them on this topic (Tolleson, 1996).

Yin’s (2003) list of skills that make for a good case study investigator is strikingly similar to the skills that make a good psychotherapist.

> A good case study investigator should be able to ask good questions and interpret the answers; be a good listener and not be trapped by his or her own ideologies or preconceptions; be adaptive and flexible so that newly encountered situations can be seen as opportunities, not threats; must have a firm grasp of the issues being studied [thereby] reducing the relevant events and information to be sought to manageable proportions; and should be unbiased by preconceived notions, including those from theory [in order to be] sensitive and responsive to contradictory evidence (p. 59).

As the researcher is also a psychoanalytic therapist, these skills were used in data collection. It was the researcher’s responsibility to follow the narratives, ask for

clarifications, and invite and seek a focus on deeper, latent meanings in the discourse (Tolleson, 1996).

Interviews moved between semi-structured and unstructured, from surface to depth, from guided discourse to spontaneous elaboration. In the first interview, the researcher asked participants to share case examples that came to mind during interviews and to disguise identifying information. The researcher disguised a second time any case material used in case reports. Interviews were open-ended using a clinical interview method that allowed for mining of participants' thoughts on deepening treatment and operationalizing of participants' terms such as transference, relationship, interpretation, and depth. At the end of the final interview, a professional profile was taken, including participants' education and training, questions about caseloads (regarding frequency and longetivity of cases), and theoretical beliefs about development and psychopathology (meta-psychological theories) and treatment (clinical theories). This allowed for the collection of some demographic information about participants without misleading them into thinking the topic during the interviews should be about theory rather than reflection on their work.

The second source of data consisted of researcher field notes that included researcher observations and reactions to the participant interviews. Field notes assisted in identification of issues that needed clarification with participants during the remaining interviews and potential patterns in the data. Researcher interpretation of emerging data via field notes was crucial to the flexibility needed to deepening understanding of each case as questions were added or changed (Stake, 1995). Additionally, field notes that included detail about the "fluctuating feeling states and other nonverbal material

associated with particular segments of interviews," brought a fuller description of context and emotional impact of data to the findings (Cartwright, 2004, p. 220).

Finally, field notes helped to amplify researcher transferences and conceptual biases in order to identify their influence as much as is possible. However, case study methodology with a phenomenological-hermeneutic philosophical foundation makes no absolute claim that findings will be free from researcher influence. Greenwood and Loewenthal state, "Phenomenological research offers a representation of what was seen by the researcher who was engaged in looking at a specific object or issue" (p. 42). Again, findings are a product of the points of intersection between participants and researcher and readers are invited to interact with conclusions.

Data Analysis

Overall, the strategy for data analysis was the specific analytic technique of explanation building, making theoretical statements about behavior and process (Yin, 2003). This was done by employing a psychoanalytic interpretive analysis to create individual case reports, as developed by Tolleson (1996). Rival explanations or interpretations were considered by the researcher through feedback on her conclusions from participants and some committee members.

Psychoanalytic interpretive analysis of the interviews and field notes created a desired parallel process. Just as it is presumed that deepening treatment occurs, in part, by listening for latent as well as manifest meaning in the free associative process and interpreting internal motivation and content, listening for deeper latent meaning in the multiple interviews with participants resulted in subjective meaning worth considering.

This analytic strategy provided findings about the subjective experience of each individual participant. Interview data was kept intact and a case report for each participant was generated. It was important to stay close to the participants' reflections before broadening the focus of analysis to a comparative one because each of these very experienced participants have important things to say in their own right. It allowed participants' perspectives to be heard before breaking the data into parts. Each individual case report is a personal theory of what it takes to facilitate depth-oriented treatment. Analysis then looked at themes, across the five participant cases, which emerged as relevant to the topic of deepening treatment. Comparative analysis covers similarities and differences between participants.

With-In Case Analysis

Psychotherapeutic process is difficult to study, as each therapeutic dyad is idiosyncratic in its use of psychoanalytic aims and techniques. This study looked at one particular part of therapeutic process, the therapist's reflections on his or her own contributions to deepening treatment. This is subjective data and is best first analyzed as a whole in order to maximize glimpses into the work toward deepening treatment for each participant. The use of the case study method allows in-depth description of experience and interpretations by the researcher of that experience (Runyan, 1984). Each case report delineates, via the researcher's interpretive analysis, aspects of the participant's psychological process of deepening treatment. One major goal of this study was to bring to light aspects of the functioning of the psychoanalytic therapist. These aspects are presented as themes, or theoretical statements, in each of the five individual case reports.

Within each case study report, the researcher developed these themes as "categories of meaning," (Tolleson, 1996, p. 116) about the study topic that were most salient to each participant. "Categories of meaning" incorporate participants' interview content and researcher observations during the interview process, along with the researcher's clinical and theoretical knowledge about deepening treatment. Participant reviews of individual findings were part of the case report analysis. This contributed to construct validity in two ways. It decreased the likelihood of false reporting by the researcher and increased the researcher's ability to present multiple perspectives (that is, consider alternative explanations) and meanings (Yin, 2003).

Cross-Case Analysis

Upon completion of analysis of individual interview data, the researcher completed a comparative analysis of themes and observations of note across the five case studies. Categories of meanings between participants were compared for similarities and differences with some researcher generated hypotheses about those comparative observations. The researcher discusses the collective data in relation to traditional psychoanalytic ideas about deepening treatment to highlight what was expectable, and what was unexpected and possibly new. This is presented as a summary discussion of the data.

Statement on Protecting the Rights of Human Subjects

Informed consent was obtained from each of the participants. The written and signed consent included:

1. The purpose of the study
2. The names of the researcher's dissertation committee and readers
3. Participant agreement to complete three in-person interviews with the researcher, which would be taped and transcribed
4. The limited risk of the study which was feeling professionally exposed in relation to discussing the topic as participants are part of a relatively small professional group. While this was extremely unlikely as participants are mental health professionals who have developed strong professional identities over many years of practice and with a history of therapeutic support, the plan for responding to feeling exposed was a de-briefing session(s) with the researcher or another person identified by the participant.
5. Notice of the participants' right to withdraw from the study at any time without suffering any negative consequences
6. Procedures for insuring confidentiality which were as follows: Privacy was provided during interviews. The researcher did not share the identities of participants with anyone. No actual names were used in the dissertation and other identifying information was disguised as necessary. All tapes and transcribed data, identified only by number, were kept in a locked cabinet where no one other than the researcher and her advisor had access to them.

Limitations of the Research Plan

Researcher biases, theoretical and interpersonal (including personal reactions to participants), certainly impacted the results of this study. Researcher field notes were

used as a tool to acknowledge such reactions and to limit their impact. A second limitation to the validity of this study is that there was no way to absolutely know that what participants say is what participants do in treatment situations. Multiple interviews highlighted consistency of participants' ideas. Three interviews provided significant saturation of ideas.

Researcher bias was also limited by two types of review of findings. First, some committee members, also clinicians, reviewed sections of transcripts and researcher interpretations to monitor for researcher intrusion into the narratives. Second, participant reviews of individual case reports assisted the researcher in considering and presenting alternative views of the data.

A third study limitation relates to generalizability. The sample size is too small to claim any generalizability. This study does not seek to generalize its findings. It seeks to illuminate personal theories of deepening treatment, not create general theory. Finally, in both hermeneutic and psychoanalytic traditions, the reader has the capacity to consider what is presented and decide what makes sense and what resonates as meaningful.

CHAPTER V

FINDINGS

Sample Profile

In accordance with the parameters for study participants, five participants are clinical social workers who identify as psychoanalytic or psychodynamic psychotherapists, have participated in personal psychotherapy, have completed or are involved in some form of extra-practice, post-masters study, and have been in clinical practice for at least twenty years. Four participants are female, one is male. All practice in the Chicago area. Three participants are in full-time private practice, one is in part-time practice, and one was in the midst of leaving an agency position and continuing with her already existing part-time practice. All participants work with adults in individual treatment, some also work with children and with couples. While several participants have been involved in teaching and consulting, they are all first and foremost, and most enduringly, clinicians.

Responses to the Researcher

All participants expressed the belief that this study topic, deepening the treatment and how one functions to invite or provide such treatment opportunities, was relevant in their day-to-day work. As presented in the individual case reports, some started with

theory and moved more slowly into discussing cases while others jumped in with many case examples and did not explicitly address much theory at all. All participants wanted to give the researcher what she was looking for, that is , expressed some level of checking in with statements such as, “Is that what you’re looking for?” or “Can you use that?” The researcher’s strategy in response to these questions was to consistently express that she wanted what participants thought, felt, and did in their work, what was true for participants. This seemed to address participants’ concerns and over time, such questions diminished or disappeared.

The researcher asked participants to define depth in treatment rather than providing her definition to them. This allowed insight into core beliefs of participants. Each person defined depth in treatment differently and used metaphors based on theoretical ideas they find most useful. This was a fascinating aspect of the study. Definitions of depth by all participants are constructed out of their theoretical beliefs, core metaphors, and significant years of experience.

All participants expressed gratitude for the opportunity to talk about this topic. Several felt the interview process provided a chance to re-connect with their endeavors as, in fact, good, depth-oriented work.

Within-Case Analysis

In order to bring to light aspects of participants’ functioning in depth-oriented treatment, the researcher interpreted and culled the major themes or “categories of meaning” (Tolleson, 1996) from each participant’s interview data and from the researcher’s experience of talking with participants. Coding of themes in the data was

specific to each participant. In other words, similar themes have different labels based on participant language and presentation. Additionally, case reports use either “client” or “patient” based on participants’ language. Following is a case report for each of five participant clinicians.

Clinician 1

Clinician 1 is in private practice. He completed an advanced clinical training program at a psychoanalytic institute. He has also been a teacher and supervisor to many over his fifty-year career and he related as a teacher to the researcher. It is clear that he has thought a great deal about the topic of study. Teaching and learning have played a big part in his orientation to treatment, his own and his patients’. He seeks to offer people the opportunity to learn what they actually think and feel on the unconscious level. Clinician 1 is comfortable with his beliefs and his techniques. They have served him well over the years. Even so, he expresses caution and temperance about the efficacy of the therapeutic endeavor.

> I try not to avoid the interactional understanding of the communication and talk about it as if it’s something over there and out there and in the past far away. So that’s how I think about it, that’s what the issues are, and I try not to do that but it’s never more than just a little bit successful. I don’t think we’re ever greatly successful. I think the longer I go at this, I won’t say the more successful I am, but the more I can feel some peace with where it is and what’s possible.

Depth is the difference between an avoidant misalliance and a trustworthy situation whereby unconscious relating by the patient to the therapist gets acknowledged and discussed. Depth must include transference interpretation in the here and now because that is a route to understanding unconscious functioning. Clinician 1 credits Robert Langs and Roy Schafer for shaping his thinking about his work.

Depth Defined

Clinician 1 began with Freudian theory.

> I think depth is a murky word because, and this is way too general I suppose but, in a real important way Freud made a mistake and it was a mistake which was okay within his system. But it left psychoanalysis kind of stranded in no where, some place between physiology and theology where it should have been grounded in biology. And it should have been grounded in evolution.

He identifies a much expanded concept and functionality for unconscious operations. Rather than the narrower view that the unconscious is the receptacle for dangerous id impulses, Clinician 1 assigns unconscious functioning as the primary way human beings communicate and organize behavior, awareness, cognition, and affect in order to adapt to circumstances, in order to get along.

> What is unconscious is more usefully approached from an evolutionary point of view which would have it that like other functions and structures in our make-up, something has evolved over time for reasons and does stuff for reasons.

The goal of treatment, then, is to create and provide a situation whereby the patient can learn what he knows, but could not know in a sustained way, about how and to what he has been unconsciously adapting. This includes what he has needed to leave out of awareness in order to adapt. The treatment relationship offers a chance to study what gets recapitulated in the present from the patient's habitual mix of structured relations, self-deception, and wishful thinking. For the sake of the continuity, control and confidence needed for living, human beings want to maintain this habitual mix. For the sake of wanting to know one's experience, self, and life more deeply and truly, human beings want to break out of their adaptive way of relating and living. Thus a conflict, most often manifested as anxiety, always accompanies a new patient to the consulting

room. Not a conflict born of id, ego and superego demands but a conflict born of the overwhelming anxiety that comes from acknowledging what was and what is.

> To go deeper is to create the context in which something like trust can be established in small experiential increments. I think that is what therapeutic regression amounts to—the gradual capacity to be less threatened by the overwhelming, claustrophobic anxiety of being, in effect, exposed, trapped, and all the ways we try to avoid the trap. So as a human endeavor, I think that trying to avoid that kind of closed-in dread and panic is a very large motivator that expresses itself in all kinds of ways, especially in anxiety about intimacy.

Clinician 1 identifies two primary roles for which he is responsible in order to create the context in which incremental trust to go deeper can be established. First, he provides a secure frame. Second, he listens for and gives voice to the transference relationship as he understands it from often indirect, verbal and behavioral references by the patient and from observations of his emotional state.

Secure Frame

For Clinician 1, frame is first and foremost a psychological construct that resides in him.

> The frame is not an out there thing. It's not what you do, it's how you think and understand what is required of you as the therapist in order to provide the best kind of context in which to do the therapeutic work and create a process. It's a point of view maintained by the therapist, a set of rules the therapist lives by. What comes from this point of view are such things as predictability, stability of time—we meet so many times a week at this hour for this many minutes for this much money—that's a basic frame. The idea is that the therapist is, in effect, not a good buddy. It's not you tell me and I'll tell you, show me yours and I'll show you mine, it doesn't work that way.

Holding the frame allows the dyad access to unconscious communication regarding developing transference elements (what is being brought to life from the patient's habitual mix of structured relations, self-deception, and wishful thinking).

People tend to want to break the frame as a way of escaping the anxiety that comes with such an exploratory therapeutic process. Clinician 1 interprets this. Clinician 1 also keeps a close eye on himself and his maintenance of the frame.

> Where do you find a such a friend, a friend who will not join you in your efforts to maintain stability but will be your friend while you are off, you know, racking it around in your head, trying to stay stable when you are threatened? One of the things about frame is that although therapists would perhaps consciously agree with the kind of description that I gave, many are unlikely to live by it. It takes one of the major efforts of consultation and supervision to help a therapist maintain a rational stance in relation to being in the role of the therapist and not get knocked off balance by seductions of various sorts and wishful fantasies, or evasions of anxiety, of one's countertransference. So, to my mind, it all goes back to providing this kind of psychological framework which is in the therapist's head and then it's dealt with through the therapist's behavior. Also, you know what you don't do.

The patient hears not only the therapist's words but also registers the attitudes of the therapist. The patient is working to adapt to a new context from the beginning of treatment. Clinician 1 asserts that the therapist must work to convey openness and a commitment to realness of communication, not adaptive deception and hiding. He intends that his communication to the patient reflects his understanding that such adaptation is in play. He connects the capacity to hold the frame, even under sometimes enormous pressure to let it go, to the experience in one's own treatment. The therapist needs to understand from experience the dual desires as patient—the desire to look at one's self and the world in new ways alongside the desire to not look—and the self-awareness that develops in treatment, in order to trust that, for the patient, holding the frame is a relief, creates a trustworthy situation to look—acknowledge, think, feel—and is at the same time, a new experience. A secure frame allows the patient "to get to know about how he deals with what he feels, how he reacts to what he feels and how he reacts to his reaction to what he feels" (Interview 2).

Adaptation and Unconscious Functioning

Clinician 1 is impressed with the human capacity to assess and adapt to the environment and the role of unconscious processing and communication used to do so.

He states,

> I would have it and I think evolution would have it that we know gazillions more than we know we know. And we are operating and navigating in a much more wise and effective way on a moment to moment basis, particular to the environment and other people.

Clinician 1 relates the process of childhood development to adaptation and unconscious functioning. In order to develop an adequate amount of confidence in one's environment, the child must structure relations with caregivers in a way that is predictable and minimize that which does not fit into the created predictability. Clinician 1 gives an example; an infant and mother are not a good fit; they rub each other the wrong way. How does the infant handle such a situation?

> Well, that baby has got to adapt to that. At the same time, that baby has got to be able to, in order to survive, have some kind of an idea of ongoing-ness and confidence, however misguided. We know, for example, that children will hang onto their parents no matter how god-awful they may be rather than face the truth about them because it's so terrible. Well as that child grows and creates a personality, fundamentally there is a flaw. There is an inner failure to evolve certain kinds of capacities, for empathy or for a sense of personal soothing, those kinds of words we talk about. So with all this going on, this person has to evolve a capacity for—either they're going to be massively paranoid, or paranoid in some way, or they are going to try structure relations in such a way that there's predictability and a certain amount of confidence and they have to bury the rest. They have to bury the irritation, the aggravation, the frustration of ongoing rage because things aren't really right, you just have to make it seem like they're right.

His therapeutic functioning keeps in mind this adaptive capacity as the primary way patients relate to him and the setting of therapy. His main goal is to provide the conditions by which such adaptation, for example, transference, can be revealed and understood. Clinician 1 feels it is easy to miss the adaptive, "making it right" quality of

patients relationships to therapists and therefore, many treatments never get to the level of depth that listens for and inquires about the buried aspects of the relationship. Clinician 1 believes this is a common misalliance that therapists often create.

> If a therapist misaligns with a patient then the treatment is not gonna go very far. The alternative is if a therapist really understands all that's involved in this notion of frame, they will recognize when they are involved in a misalliance and they will recognize they are acting something out because they listen to the patient's unconscious communication and the patient will tell them. [If we don't listen in this way] we won't hear the message and will talk about it as if it's a problem between the patient and whoever they are talking about and miss the fact that they are telling us about ourselves and then it's just more grinding away at the wrong things, it's not going to go anywhere.

For Clinician 1, transference is not simply the recreation of the relationship with one's parents or siblings. Transference is found in the adaptive capacity to deceive one's self and the belief that one is required to do so in order to maintain the relationship with the environment, now represented by the therapist. This idea, that therapists can listen for the adaptive whitewashing by the patient, takes transference out of its often formulaic, reified state represented by such questions as, "What is the patient's transference to you?" It brings transference to the level of active relationship development, past and present represented by such questions as, "What adaptive patterns of relationship-building is the patient revealing in their relationship with you?" Clinician 1 is also referencing the therapist's countertransference—unconscious adaptive relating to the patient out of anxiety that the therapist will lose the relationship to the patient—and the patient's interpretation of it via stories about how things are going with others in the patients' life.

Transference Interpretation as Trustworthy Experience

Speaking to the patient about how he works to "make it right" or avoid the claustrophobic anxiety of revealing what is intimately real in the therapeutic situation is transference interpretation on meta-communicative, emotional, and unconscious levels. For Clinician 1, it is this functioning of the therapist that helps the patient trust the therapist and the setting to reveal aspects of self and experiences that have been set aside or discarded in order to get along in life.

> So that's what people come with. They say, "Of course I trust you, therapist." They have no reason to because they don't know me from bupkis. Who am I that they should trust? So we know that people deceive themselves. We know that people wish to believe—that is a powerful urge to create believable, reliable objects, we create gods forever and ever—even in the face of considerable evidence to the contrary… So you get to the questions of trust and how do you do that with a person who is all guarded. We know that if you say to a person—the classic story—"Okay, tell me whatever's going on and whatever you are thinking." The first thing that happens is they say, "I can't think of anything." Automatically, people say no, I don't want that. At the same time saying give me that. They want it but they can't stand it. So you confront the absence of trust and then the problem which you [the researcher] are raising is how do you get beyond that? That's what I think you mean or that's what depth means to me.

Working to avoid misalliances that support the denial of buried aspects of relating creates a trustworthy experience for the patient. Clinician 1 highlights consistency of this stance to describe how it contributes to the incremental movement of such trust-building.

> Researcher: What are defining as real change?
>
> Clinician 1: A woman moved here from New York. She had a treatment with a therapist there. His heart was sort of in the right place but he was so provocative and seductive that it invited her to do the same thing that she always does with men which is to indulge them at her expense. She had lots of bad experiences along those lines. She finally had the courage to break it up and to leave and so we started with that the idea of trust. We've been over and over so many things. For example, she will talk about therapy as just a business proposition and if she doesn't pay me, I won't see her. Well, there is that part and we talk about trust. And she'll ask, "What if I just took that vase? Suppose I just took that when you weren't looking? What would you do, call the police?" I say, "No, I'll try to think

> about what it meant to you to do that and bring it up and talk about it and I'll assume that it has some meaning about what's going on." She would kick and scream about that, it can't mean that, she couldn't believe that somebody really had her best interests in mind. If there's anything that made a difference from my side it was that constant attention to that threat and that uncertainty and trying to give her an experience that was different. You know, these things are never perfect and she's never going to totally forget all of those bad things that happened to her, but she doesn't repeat it now actively and it's a memory and that's a change.

Transference interpretation, speaking to the patient about how they are relating to the therapist, is crucial because the patient unconsciously knows about this and knows when it is being avoided. The therapist must have the courage to resist the pressure to be false.

> The patient unconsciously knows the truth. People do know the truth about what's going on. It's just that there are social rules and constructs and personal stories [self-deceptions]. This person could talk to me about being defiant with her father's rules, some kind of [warranted] defiance against an unreasonable father. I could then talk about the rules in therapy like having to pay for sessions and then she can talk about it's not just about defiance but it is also about the threat of feeling intimate, of feeling the very thing she said she wants which is a kind of predictable security, then we've got another conversation there. And I think this is more likely to lead to something true than say the therapist being deceived by this story of defiance and agree with her about her father and all that kind of stuff. It seems to me that that's going to fall falsely even though it might be gratifying at the moment. But in truth, it's not going to be a good thing and at some level she's going to know it and that's going to be a game-breaker as far as treatment is concerned.

Clinician 1 thinks about what happens when the therapist believes the story of the exclusively bad parent and may try to be a better one as a result of unanalyzed countertransference. He sees this as coming out of a sloppy frame, a false promise of what treatment can provide for the patient.

> One of the things you hear about with young therapists is how many phone calls they have to return at the end of the day. Every patient is calling and reporting and all kinds of things are going on. Almost never is that really useful but almost always is that kind of thing happening because unconsciously the therapist is inviting this kind of almost shapeless frame that anything goes, I'm here for you

> forever, anything you want, I'll sacrifice. There's a kind of acting out of rescue notions that the patient recognizes unconsciously because we know more than we know we know and so patients go along with therapists doing that, and of course, therapists go on to say that they're simply meeting a need when, in fact, they are inviting acting out. There are so many ways we act out and create a misalliance with a client defensively for reasons we don't understand and it could all look very homey and very positive and very giving and wonderful and it's all bullshit.

Clinician 1's assessment of the above stance as acting out behavior on the therapist's part leaves out the possibility of anything new happening.

> It leaves out, well, it's what it contains. It contains repetition of the old trauma and the old defenses and both people get together to sustain that and nothing new happens. It's what's left out, there's no sense or seldom enough sense that the therapist has conveyed unconsciously to the patient, "I don't want to go there," and the patient will always gratify you and never go there. They may hold it against you because they want to go there, know that they need to go there and so they blow the treatment up for some other reason because you didn't help them, or they'll go along and finally weasel out of the whole situation because unconsciously they know nothing is happening, but they don't know why. The alternative contains such notions about the frame and limits.

Such notions of the frame include the understanding that the therapeutic relationship is the vehicle by which the patient tells the therapist about their unconscious functioning in relationships; it is what allows the therapist to identify and offer exploration to the patient about such functioning. The patient tells the therapist whether or not the therapist is helping to maintain the frame in order for this unconscious knowledge to come into being. If the therapist does not hold a functional frame and avoids discussing the patient's unconscious functioning in relation to the therapist then the therapy is of little value to the patient's need to learn something new about how the patient operates.

> The patient can feel free to raise hell and it's never going to touch me and we know it's never going to touch me so it's just a lot of loose talk. These are the ways the notion of the frame is a large holding pen that contributes to the possibility of a trustworthy experience versus wishful thinking.

In order for something new to happen, the therapist must be more focused on listening in a particular way and less worried about responding quickly. He relates how he listens and his understanding that the patient, too, is listening.

> I assume when people come to me and I get as far as first base, that is, we've established something and they keep coming in, my task for a long time is just to try and listen for the kinds of things they tell me about and what I can connect for myself between what's going on here and what they tell me to see if I can begin to decipher and decode how they talk. Now, in a sense, you got to speak with forked tongue, on the one side you need to be talking reasonably with another person in a fairly ordinary frame of communication at the same time you have to know that what the person is hearing is not just these words but they are hearing and registering an attitude, this sense of frame, they are adapting to a new context, from the very beginning. And so what you hear has to do with that adaptation. Now for a long time it seems to me, not a really long time but it takes awhile before you can intervene by making an interpretation that connects what they are talking about and how that might apply here. What I want to be doing is letting them know that what they say matters, that I'm listening to what they say, that what happens here matters to them even if they don't know exactly how that works. And that I'm paying attention to that and we can talk but I'm also listening to how they feel about what's going on and that could build a teeny tiny increment of trust. It's not going to be conscious and it's building that kind of thing session after session fairly consistently that will make a difference.

Listening for what people talk about and how that may apply in the treatment situation thereby giving the patient the opportunity to talk directly about oneself in a live, developing relationship is what will be new, and trustworthy, for the patient. It will allow for finding what is available to be found by the patient about the patient.

Self Awareness

> I think, you know people talk about callings, well, that's a little fancy but in a certain respect I feel like that's what this is. There is no other job like this. Doing this work to me is, and the way I look at training is, that it's a step in the ego development. It's a phase of ego development and like any other developmental phase, it's uneven and depends on where it is coming from and where it's going and what it means and all kinds of things enter into what it winds up being. It seems to be that it's in you to do. It's not news to know that most of us started off this way as children, that somehow this grows out of a child's struggle to help

> parents get well. So if you have that kind of calling and you can find a way to do it and not get crazy or greedy or rigid or blind about it, great. I guess I have a lot of feeling for—I remember work in that welfare department, I was really involved there, I had a small caseload but I was involved with those people and I learned a lot about them and they talked to me and kind of counted on me to help out. I felt the injustice of people who need stuff and can't get it because they can't afford it. And I never thought that was right, I always thought, "I don't see why things have to be all about money." I just don't believe it.

Clinician 1 connects his capacity for self-awareness and his ways of using it in his work to his personal therapy experiences. He was patient to four therapists. One guiding principle developed out of his treatment experiences is a stance that prioritizes treatment needs over money.

> I can adjust my fees; I always do if they need to. I try to make my fees work so that the therapy works. I don't want to interrupt therapy on the basis of money. That's a personal thing because I went through that two or three times in treatment in my life and I thought that was wrong. So I make it a point to try not to do that. I've never had anybody quit because it was too much [money] and I've been able to carry people through these recessions in one way or another because I want that to happen. I'm not here just to collect money. I want to do the work, that's what I live for, that's my work. So I try to make my work, work.

His first treatment was with an analyst and due to financial limitations, affordability translated to once a week sessions. Clinician 1 credits his first therapist with teaching him about the ways of the world, helping him transition from a boy into a man.

> I was right out of the Navy. I was 21 years old and I was a total loss. I was a mess and this guy was very cool. He was sharp to me. He was older, maybe 50. I remember being in his office and I remember that he had clothes that looked right and I didn't know anything about anything. I was a real mope. He taught me a couple of things. I always paid him cash and he said, "You know, men of affairs have checking accounts." Bingo, I got a checking account. And he dropped a couple other little things, one about how I dressed which was kind of, I mean I'm embarrassed to tell you, I was a loss and it straightened me out. I was looking for that kind of model and I remember one interpretation that he made. I was lying on the couch and I was describing how I felt this terrifically tight band around my head and he said, "That's repression." I was really looking for a way to grow up and he was very helpful about that and at some point I ran out of money and I had to stop.

Next, in graduate school, Clinician 1 entered treatment with a clinical social worker. Here he learned about unconscious communication which sparked his interest to learn much more about this type of listening and working.

> We were talking and I said to him, "you know, there's a song going through my head" and I couldn't really think what it was and I started to focus on it and realized it was a song called Shuffle Off to Buffalo. Now that's a strange tune, why would I think about that? And then it dawned on me that he had just gone off on a vacation and he was from Buffalo and I was having a reaction to that. So I told him and we worked out that that's what it was about. So I learned about unconscious communication. I left there to go into analysis because I was going to a program where you needed an analysis. The first guy I called, my therapist's recommendation, was an analyst and he said, "Well, you have to come four times a week at $25 an hour, can you do it?" That was a lot of money in those days. Ordinarily people would charge $10. So this was very high dues and I said, "Well, that's $100 a week and I only make $200 a week." And he says, "Sorry, it saves us both a lot of time," click. So then I called another guy and I told him that I can only do, best, three times and he said okay we will start with that and I did that for as long as I could and ran out of money there too and that was the end of that. We had a little termination time; it was not a good termination actually. And then after that I had a couple experiences with another guy when urgencies came up on and off as a sort of finishing off experience. So it took a long time, probably 18 or 19 years altogether.

While it was frustrating and disappointing to have to adapt his treatments to monetary issues, Clinician 1 feels that therapy and its meaning for him in his life and his work cannot be overestimated.

> It gave me an appreciation for the idea that this is not something that you do and get it over with, it's always open-ended. Freud always said it's an endless proposition and it is and I got blessed. I tell you if I hadn't had those experiences, well, I know I wouldn't be here, I wouldn't be able to operate the way I do. I was really nowhere, I was a high school dropout and when I went to see this first guy, I didn't have anything, no job, no money. All I had was the GI bill and that saved my butt and I managed to parlay that into what I got. So analysis and therapy were hugely meaningful to me and I couldn't even begin to know all the ways that it helped me to deal with patients and with life, kids, wife, the whole thing. So I think it's been very important and I try to make it as important to people as I can and I think pretty good so far. Among my friends I'm probably the oldest of the bunch that's still working. I finished graduate school in 1959, I had my first job in June of 1959 and that's 50 years. People ask me if I want to retire and I say, "For what? I have the greatest job in the world, why should I drop this? Where else am

> I going to get to know a lot of interesting people, do something that makes some sense?" It's not screwing anybody; it's not making a mess. And all that I think is a consequence of experiences of being a patient.

Core Techniques

Listening for unconscious communication, especially that related to self-deception and adaptation, and speaking to the patient about what he hears are primary techniques for Clinician 1. Following is extended transcript from our second interview that brings to light these core techniques. It also highlights the clarity that Clinician 1 brings to his work and his identity as a teacher. The researcher had asked if he could think of a case in which to anchor his discussion of therapeutic functioning.

> Clinician 1: Now, do I have a particular? [silence] I'm blank about that at the moment, something will come up, but I don't—[silence]
>
> Researcher: I associated to a case of mine during our last interview. This is a young woman just starting graduate school. She is coming in overwhelmed. She grew up with pretty disturbed parents and she has a lot of care-giving responsibility for them. She is also in a relationship and is wondering about whether it is a good fit. She has never been in exploratory therapy. So these are the beginning things. She came in the second session and said she had enormous anxiety over the weekend. She was very worked up and I said, "I think you should come more often." So we made a plan to meet twice a week and then she started canceling. I think instead of interpreting it as anxiety based on beginning this more exploratory process with me, I interpreted from my own anxiety.
>
> Clinician 1: So she unconsciously recognized that you feel threatened? And she tries to change the frame. Okay, that's a good example.
>
> Researcher: So recently, I told her I had interpreted her reaction as anxiety out there but in fact, it was anxiety about starting this therapy. And I said, "I think I really scared you by saying you should come more often. I think we don't yet know how often you are going to come in and we will start with once a week." She visibly relaxed.
>
> Clinician 1: That's where you re-introduced the frame recognizing you had gotten out of it.

Researcher: Yes, and it was my responsibility to communicate it, not just ask her to tell me about what was going on.

Clinician 1: Yeah, that's great. That's good, to me that's exactly what I'm talking about and that is the therapeutic function. Years ago I started thinking about what is it that the therapist does, what is the therapeutic function versus anything else? And I think the example is that the patient tells you something unconsciously and you correctly decipher it, you play it back in an effective way as you can and recognize the consequences of doing that, like you did. She relaxed and felt better and then you re-establish the relationship in a more truthful way. Well that experience, that piece of therapeutic function is essential. I used to think a lot about how can you teach that, how can you get people to think about things that way because that is by no means how people think about it. I don't know how you come to it, or even how I come to it but I know that some people come to it and many do not. Your reaction, your first reaction to that girl was more characteristic of what people would do. The anxiety about being the therapist is different than being the rescuer, it's different than not having a suicidal patient which is probably somewhere in your thoughts, that a destructive person looks bad on your resume, that kind of thing. So we get very anxious about that and want to cover all that up and make it nice and show that we really know what we are doing and we're going to do more of this because you really need more of this and if you'd pursued that and she had gone along with you, you would have had a train wreck before too long. And you would have thought rightly, given that context, well, this girl just couldn't handle it and she was crazy and her craziness just wasn't contained and what she really needs is medication, you would have somebody else to pump pills into. Well, maybe you can say that but boy, try to get people to operate with that self-awareness on a consistent basis is very hard.

Researcher: It makes me think about what you said about consultation and supervision. These interviews are not that, but served that purpose for me with this case. What do you rely on within yourself that you can articulate?

Clinician 1: Well I know when I'm upset and I know when I get it wrong because I feel terrible. There's a way I end up of feeling which is agitated and impatient and almost obsessively absorbed with trying to think through what happened over and over, looking at all the corners. I will go back over a session and kind of comb through it and see, you know, how I feel and catch myself at being defensive and then try to go into that; I do that kind of self-analytic stuff. I know that I do that and I know that when I am doing that, it always turns out okay. I could be in a psychological kind of panic but I know that if I stick with it and I do the work that I do, as far as I know, maybe not 100%, but in a high percentage of times, it's going to work out okay. I'm still aware of wanting to be good enough and feeling a little narcissistic injury when I miss the boat about something or when I failed somebody or hurt somebody's feelings or something like that—if I've said something stupid or inadvertent or hostile. But you are never going to get rid of narcissism; the question is what happens when you feel injured? My

sense is that what I don't want to do is simply react defensively or attack. But you know, that's there and we're all going to feel that way and I think that is all pretty natural. One of the things that I think a secure frame would allow you to do that a sloppy frame won't is something like this, let's use your client as an example and make some story about that. She comes in and she's very stimulated by something, it is not clear what that is yet, what kind of particular fantasies were involved. So she's telling you a little bit about uncertainties, threatening, exaggerated relations in which she gets kind of swallowed up and buried in somebody else's demand. Who knows how that all contributes to her first unconscious evaluation of you? Okay, so she feels all these things, she feels anxious and threatened and she creates a certain kind of set of notions about ideas about you. Well, you are like her mother or her father, so she's got to be careful. What is she going to do, how is she going to hold her anxiety, how is she going to deal with this? Is she going to hurt herself in some way and then what? Well, she is going to come and tell you about it. Then you will know that she is more in need than you are. So she's going to tell you by this that she's not going to take care of you, she is going to take care of herself. But if she tells you that, then she's given up on her mother getting better. She's abandoned the only mother that she has, can she do that? I'm making this all up, but probably not beyond real. The thing is she may know all this but she doesn't know that she's doing it. All she knows is she's doing something and she thinks that's real. People seldom go beyond that level. So people can often get that far in their minds. To the question, "Your boss tells you that you were not doing a good job, how do you feel about that?" they might say, "Oh, it hurt my feelings but really I thought that I was doing a good job." So okay, he knows his feelings were hurt, that's what he knows. Well how did he feel about being hurt or angry? Well, he felt ashamed of that. Why? What is so shameful about feeling hurt? Well it goes against his grain as man. He thinks he should be bigger than that. And so, now you have a different story, now you got that this is nothing to do with his boss, this is how he deals with shame. So, that next step of thinking about how you feel about how you feel about how you feel is where you can get into something.

Researcher: And get to know something that we don't know yet.

Clinician 1: We don't know yet.

Researcher: And that is the anxiety that the therapist interested in deepening must contain?

Clinician 1: That's right. Freud used a preconscious notion about that. There is stuff that we know that we don't know we know it, but we do. And we can resist knowing that, deny knowing that, and have lots of defenses against knowing what we know. Now the aim of a therapeutic proposition like that is to make it possible to get to that place. To get to know how you deal with what you feel. How you react to what you feel and how you react to your reaction to what you feel, the whole backsliding kind of notion and I think that requires a good enough holding

> frame. And I suppose we all have to come to do, in a way, what Freud did. You got to come to know what that is and you got to know by the work, you can't know it because somebody tells you so. I went to talk to a consultant my first year out of graduate school. I was working in a mental health center and we had all kinds of analytic consultants and so I went to this guy. I tell him, "I've got a technical problem I don't know how to deal with." And he listened to me for awhile and then he said, "Well, you don't have a technical problem. Your problem is you don't know your patient well enough. When you know your patient, you'll know what to say and if you don't know, you do what Freud said, keep analyzing." But you got to know when you don't know. That's very difficult because anxiety forces us to want to know, like it forced you to want to know something before you knew. We do that, click and then, you know, we have egg on our face. So that seems to me a critical thing, trying to know what you don't know. Being able to tolerate not knowing and work with that, that's the electricity in the process and that's very hard to hold because it's like live wires and people get upset. This is the process of knowing your patient deeply and it's difficult to tolerate not knowing until you know.

To get himself in a position to have some understanding of unconscious unknown, to learn his patient, Clinician 1 uses a formula. Freud's theory of day residue is to dreams as unconscious perception of the therapist by the patient is to patient communication. The patient is communicating about how the therapist is registering or not registering the patient.

> If you listen for the patient to tell you, as they would a dream, their associations, and you can accept the idea that it has something to do with you and something that you may have done, that you're being told how you are functioning, then you better listen. That lends itself to an entirely different kind of interaction between patient and therapist because you can really help a person then to understand what it is they are, in fact, feeling and thinking and doing.

Frequency of sessions contributes to this process of hearing unconscious communication. There is a somewhat simple equation here. More time means more opportunity for hearing unconscious communication if trust has developed. Clinician 1 does not necessarily get too focused on establishing frequency. He seems to have an organic kind of stance regarding frequency; decisions about frequency emerge out of the unconscious communication that patient and therapist create together. In the process of

these interviews, the researcher realized an answer to a puzzle she had been pondering. Trust creates frequency; frequency does not create trust.

> The first thing I would say is that it's really important that the therapist have some experience with frequency in their own treatment and therefore, some experience with a therapist who is not threatened by intimacy and frequency, whatever that means. So given that I don't have any fears about frequency, I've seen many people three and four times a week for long periods of time so that's familiar to me. I usually think in terms of what does this person actually need and how are we going to get there. And frequently, I can ask them. I say, "Have you thought about how often you want to come?" Stuff like that. The patient may say, "Well, I don't know, once, twice a week." I might say, "Let's try once a week and then we will pump it up if we feel like it." I try to leave that door open because I want to be able to refer back to it down the road. But I try to introduce it on the basis of their understanding of their need; I don't impose it, I wouldn't do that. It will start to appeal and start to make sense and people get over the anxiety about it and start approaching it thoughtfully and in terms of realities. When are you going to do it and how much is it going to be? So yeah, I would say that I recommend it when I think I can and I'm available if people want it. To me, the real point of frequency is that it creates a bigger presence about the treatment in both parties, hopefully. I mean the reason for going more often, or inviting more often, is when you feel like there is more possibility and you want to take advantage of it. If there is not possibility or if you don't really mean it, if you're just doing it to perform, as if you're supposed to and because the patient is willing to, you know, you can see a person four times a week and it's dead as a doornail. So, I'm always opting for a well, I suppose I'll call it more of an analytic process but given what you've got, you got to be judicious about interpretation, you got to be thoughtful about what the person can manage and work within the limits that they present.

Clinician 1 uses a combination of techniques that include listening to learn and hear his patients' unconscious communication, making interpretations about the adaptive, patterned emotional and relational elements within that communication, and using the emotional flow he is experiencing while listening to his patients.

> Hopefully, I am listening to learn. Here's a little example from this morning. A woman I've been seeing for a very long time once a week said she wanted to come twice a week. Why does she want to come twice a week? Because it's been building, it didn't happen overnight but in the last session she was able, she felt that she was able to tell me things about her experience with her father; the way he created a kind of shameful setting, especially for an adolescent girl. Most of the session today was her kind of telling me how she felt relieved and that she found that her memory was working better, that she could remember stuff about

> this whole adolescent period in the last week that she hadn't thought about in many, many years. She realized that she had kind of clamped down on herself and kind of built a hiding place for herself which she took everywhere including putting on a lot of weight. And now she is losing weight. So what are we doing today? I'm listening but I'm also feeling. I was aware that I was feeling a little parental, maternal, and I realized that I was saying things, not interpreting especially, just sort of echoing what she said, emphasizing that I could appreciate the trauma for her. She was talking about going to a dance, a father/daughter dance in a small town and all the girls were supposed to wear pastels. Well, she didn't know what pastels meant and there was nobody, she was too ashamed to ask and there was no mother to ask. And so she bought a black and white dress, she said it looked like a granny dress, and she goes and shows up at this thing in black and white dress with her father who had been drinking. Well, I mean all I could do with it is, you know, kind of be with it, just sit with it, just speak words that sounded like I got it which I did. So I guess my point in bringing this up is my feeling that I was trying to be kind of maternal. And it was interesting that what she picked up from that was to begin to tell me about other women in her life or neighbors who had been maternal.

These techniques help patients break up the way they have patterned their experience in order to have fuller access to it and to re-integrate it differently.

> Now I hear all that, first of all, as she's feeling better because she's been able to be more trusting and been able to talk about stuff that she has been too shameful to mention. That added something that allowed me to respond in this kind of interested maternal way without being too broad about it but sincere and that led her to associations about maternal care. Now that to me, that's how it's supposed to be, in a very small kind of way, that I give something which then comes back in forms of new memories, new associations, new affect, stuff like that. So things that she could now feel, and even some things about her father which had never come out before, some good things that he did with her, pleasant things instead of just terrifying her all the time which he usually did, but there were other moments. So this whole idea, this hard and fast trauma with her dad is beginning to break up a little bit and new corners or new affect are coming into it and something new with me, in the transference, is opening up a little bit. Well, I think that's the way it's supposed to be. Am I just sitting? No, I'm doing something—trying to relate and particularly listening for whether she gets it and she did get it, she got it in a very positive way and that's a building block, a big trust element there, I think.

Core Beliefs

Clinician 1 loves his work and is certain in his methodology. His beliefs include the conviction that psychotherapy can help people know themselves deeply if both parties can tolerate the ambiguity of the undertaking. He has learned over his many years of practice how he functions. He remains skeptical that there is any one, agreed upon way to practice.

> I think this is a very strange profession. It's probably only moderately true that any two people in it have anything like the same real approach and this sort of superficial agreement about theories is a misnomer to begin with…And I think, particularly when you get started, you need some sort of grounding, even if it's false. And brand new theories often turn out to be retellings. There are new perspectives and it's great that people are engaged and thinking but it's still mysterious and it's not going to be less mysterious until we have a way of really demonstrating unconscious communication and can develop a language for that. I think [Robert] Langs does that best. I think [Roy] Schafer makes a good contribution too.

Clinician 1 believes that billing insurance negatively impacts his functioning and detracts from trust-building. He has several patients who submit his paid statements for whatever reimbursement their policies allow. That is the extent of his involvement with insurance companies.

> I remember years ago when that managed care thing first started. I thought it was terrible. I didn't want anything to do with it and so I don't. I just don't see getting involved in that kind of thing like somebody telling me how many sessions there could be or what I'm supposed to do. The patient is going to be unconsciously, if not more directly, knowing that somebody else is in their business and they will often say that they don't care. Well, you know after square one, it's not okay and people discover that they don't really mean it. It's not okay for somebody to be looking in on their private life. So, it's no good for patients and it's not a good thing for therapists and it's a stupid thing for therapy and it's a ridiculous waste of money. So there's no reason that I could see to participate in that, it doesn't add anything.

Some of Clinician 1's patients recline on the couch for sessions. He estimates that four or five of his patients use the couch. While discussing this, he associated to a

situation when he was a teacher. There was a student with very little experience using the couch with patients. There was great concern over this situation at the school. It was suggested that she meet with Clinician 1 to sort this out. He assessed that she did not understand what she was doing, that it was causing trouble in her treatments, and it was the wrong thing to do. What is of note is the association to the use of the couch as controversial and inappropriate. Of his beliefs on the use of the couch, Clinician 1 speaks about context and meaning.

> It's an okay thing. It's not as important to me as it used to be. I think I used to have a more, I don't know, it was probably defensive to some extent on my part. I think that it makes some difference in what people do but I'm not sure that it's the best thing always, it's a something and it works sometimes for some people and some conditions. It's not a requirement. But I do think it's a good idea to be at ease about that. I guess my sense is that I think it can be a good idea if the therapist is really tuned into what the patient is doing, that they're listening like we've been talking about, and not just using it as some kind of prop or technique of some sort. There are so many ways to be defensive, so many ways to create misalliances, so many ways to act out, so many hiding places, it's very tough proposition and the couch, like anything else, could be used that way.

Everything that happens in therapy does so within the context of the therapeutic relationship. Clinician 1 consistently comes back to his role of listening for and speaking to the patient about what might be happening in this context. He believes this gives permission and space to the patient to speak to the same. For Clinician 1, going deeper happens in a therapeutic relationship where trust can be established in small, experiential increments. Trust allows a patient to reveal, acknowledge and move through the profound anxiety that comes with connecting, not only with another person in an intimate way, but also with long neglected aspects of self and one's experiences. Such relinquishing of anxiety occurs in small pieces and takes its own time. Learning that such anxiety is survivable is part of relinquishing it and occurs in the context of a therapeutic frame that

exists in the therapist as experiential knowledge and is manifested by the therapist in his day-to-day work.

Frame allows therapist and patient to discover the patient's habitual adaptation along with his desire for something new including his desire to re-connect with hidden aspects of self and experience. The patient pays the therapist to listen for and to speak about such discoveries. This is the crucial role that transference interpretation plays in Clinician 1's functioning. Clinician 1 processes his work with careful attention to any resistance within himself to listen to and to speak to the patient about what is happening in his consulting room.

Clinician 2

Clinician 2 was in the midst of termination with many clients and with her agency position of 20 years during these interviews. She has been a senior clinician at the agency with a part-time private practice. [It is of note that Clinician 2 is the only participant discussing agency cases and that they seem more difficult than other cases discussed.] Clinician 2 views her ability to understand and tolerate clients' early attachment styles and dependency needs as contributions to deep work. Therefore, she is aware that in leaving many of her clients, she may need to be somewhat distant from the range of her emotional responses in this transition.

> I'm saying goodbye to one client, a family that I've seen since their son was 3. He is in his first year of college. I feel like I raised them and they're going to terminate. It's appropriate for them to stop and this is a major thing to see. I quite honestly find myself shedding some of it off. I have a feeling it's going to take me at least a year or two to let out my feelings because that's how profound it is and I know how I function. There is someone at the agency leaving at the same time and we have very different styles and she is crying and crying, which I envy. I mean I wish I could cry because that seems like it would feel so good and people can see it. But the group at the agency has been together so long and I'm so open,

> I mean we are all open with each other, and so I can share my difficulty in what I'm experiencing and people understand. It's very safe. So they know I'm going through a lot. I can't quite put my finger on it to myself. Although I have cried in the group on a couple of occasions, they know why I can't cry, why it's hard for me to cry, they know my history. So, what I'm saying here, it's a profound time but I couldn't begin to, and I've spent so much of my life being intellectual that I don't—I'm not in any rush to find words to put on it. I'm just going to let it play out in whatever way it goes and if I look like a cold, hard bitch, so be it. Even though I know that's not the case. It's like someone who can't cry at a funeral and it's their own spouse.

There is a developmental thread that runs through discussions with Clinician 2 from her life's current phase to her understanding of her own treatment as a process of re-working early attachment issues to the developmental metaphor she uses to sit with and tolerate very difficult clients. For Clinician 2, depth includes connecting at the pre-verbal level of development.

Depth Defined

> I think depth means getting to the non-verbal and pre-verbal level of connecting, doing a lot of work non-verbally as well as verbally, depending on where the client is at. And it means using, basically, my whole self, because I think you only get half, you only get part of it through the overt verbal and physical goings on in the room. I also have to search what's happening inside me. So when I'm doing that and when the client is really letting me in—it's a very subjective kind of term—but then I know that there's something in-depth going on. And when I have a client and I'm having trouble feeling [connected], something is missing, then I feel like there's a way in which the client is really not connected to themselves very well and I am finding it much harder to connect. But that's still dealing with the in-depth of the treatment.

Generally, in order to offer an in-depth treatment situation, a therapist should have some access to and acceptance of her most vulnerable self for use in her work. If one has done such personal work and there is a client who consistently walks through the door, depth will happen over time. Signs from the client that a deeper connection, one that can

be used to understand the past and create something new, is developing include some willingness to lean on the therapist and to share vulnerability.

> Clients start to show signs of attachment behavior, they start reacting to absences or reunions. I have a client who was rather regressed in a lot of ways. I'm leaving the agency, I've seen him for four years and I'm ending with him at the end of the month. And he gave me a doll with my name and it was very touching and of course, it was very in line with his level of emotional development.

Some cases become overt due to consistency and patience.

> I had one client for 13 years who ended about 5 years ago and he literally used to come in and say, "You're the only reason I'm alive." Now that's a very overt sign that he was letting me into his suicidal despair.

Other cases show more subtle shifts toward revealing vulnerability and need.

> I had put a doll another client had given me in my office so he could see it. This client made a suicide attempt right after she came to the agency a year and a half ago. She is beginning to connect with me and she is coming with me [to my practice]. She kept talking about how the doll didn't fit in. She has tight rein on herself to keep herself from regressing. She was asking why I put the doll there because it didn't fit. And then she said "Its eyes are looking at me and it's making me think of, you know, Rod Serling and the Twilight Zone television show that I used to watch and the movies where the dolls come alive and be creepy and butcher people." Clearly she's going into some primary process material and this was new in our relationship. She couldn't tolerate much interpretation so I just said, "Why don't I move the doll this way." She was talking about the eyes looking right into her and I think she was talking about me. By the end of the session I sort of brought up the fact that she's frightened about a lot of things and she could accept that; she's financially insecure and this and that. She could deal with that but she would not have been able to deal with me making some in-depth—what I'm saying is that, to me, is a sign that she's starting to let some of her guard down and it is thick, let me tell you.

Signs that Clinician 2 is beginning to connect to something deeper, something non-verbal include an increase in uncomfortable feelings such as worry or fear in relation to the client.

> A lot of times, and I know this is a very subjective thing, when I'm sitting with a client and they are newer and I haven't worked with them long, when they leave at the end of the session and I go home feeling worried or scared or uncomfortable, I always say to myself "Okay, they are starting to connect with

> me." So, go figure, it's true every time because they are starting to give me their projections.

In some treatments there are very few signs and in those cases, Clinician 2 relies on her general rule; keep showing up, manage any feeling of rejection, stay in the room because you don't always consciously know what it means to the client.

> When I told him I was leaving—he's a tough client, I mean he's the kind of client where you spend fifty percent of the time trying to stay in the room with him and not throw him out. Anyway, he asked me, "If I change, will you stay?" Oh my god. So there was no question to me that he was giving a momentary glimpse into the fact that I meant something to him and he was frightened to lose me. He fought that and put up all kinds of barriers all the time.

Put too simply, depth is attachment and the deepest work is addressing the emotional aspects of derailed attachments and offering opportunity to experience healthier bonds. Her theory of treatment is strongly connected to working to understand early attachment experiences and dependency needs, often via projective identification, and responding from that understanding in order to be available as interpreter and new attachment figure.

The Primacy of Development

Clinician 2 looks through a developmental lens in order to imagine and intuit what kinds of relating and healing her clients might need from her and the therapeutic process. This developmental focus comes, in part, from her history and how that connected to a pull to understanding early attachment and trauma issues.

> I learned it by solving, having to solve my own problems. I think it was by breaking down my own barriers; we all have things that we have to work through. And I came from a family—my mother lost her mother when she was 15 months old. If you think of Margaret Mahler and when that was, that's kind of where things centered in my own journey, things I had to patch up. I was getting my masters in French. I came from a very academic family and feelings weren't

> really discussed, they were just discharged. At a certain point, being in academics wasn't doing it for me and that's when I started my own journey into solving my own problems. In the late 1960's and early 1970's there was a horrible teacher shortage in the Chicago public schools and they would take any warm body off the street as long as you agreed to get your teaching certificate while you were teaching. And so the beginning was having this kindergarten class in the inner-city and I was just amazed at the problems they came in with. I just knew; it grabbed me. There was this little boy who was shot in the stomach when he was three years old and he would go into this trance, he would just dissociate and you could go like this [wave a hand] and nothing would happen. And then he would come back, you know. I guess I was just aware of this, I was sensitive to it. There was a little girl who would sit at the table and just withdraw into herself but it was an angry withdrawal. I learned that if I sat across from her and imitated her, she would finally smile. All this was before I had any training whatsoever. It was all instinct.

Experiences like these with her kindergarten class led her to work in a day treatment center for emotionally disturbed children. This was a learning experience full of daily dread. Clinician 2 looks back on this dread with the understanding that she was at once facing into her own childhood pain along with the pain of the children in her charge. Clinician 2 learned she had a knack for this difficult work. Along the way, she became a mother and cites parenting has having been her biggest challenge of all. When her youngest child was three years old, she decided to get her masters in social work. This led her to her own treatment.

> When I went to social work school one of my classes was taught by someone who was in her fifties and I remember saying to myself that this woman is not trying to prove anything. There is a way in which I could just tell she didn't have to prove anything; she was just there and she was just being herself and you could see when she felt self-conscious she would button and unbutton her top button. Eventually, strangely, that woman became my therapist.

She could choose this woman as her therapist because she seemed not competitive or intellectualized; this woman was different from Clinician 2's family. She came to believe that she needed to learn how to be comfortable without an intellectual facade, to be using her "whole self" in her work. She needed to tolerate the vulnerability that comes

with being emotionally present in her work and in her family. She eventually began working at a child development center with a therapeutic nursery school.

> When I first came to the child development center, I thought I would just stay for two years because I wanted status, I wanted a shingle. That's the biggest change, because I really wanted status. My therapist didn't have anything to prove. She was very bright and I went from being conscious of status to being aware of how that was getting in my way. It's just if I'm too concerned about my status, how could I be not defensive with the client? And then I really got into the work and the work itself really has no status; if that's what you are into then you are not doing the work because there are many clients who need to poke our most vulnerable spots as their defense. It all came together at the child development center—the early attachment piece and the pieces that were missing in me and what I wasn't conveying to clients and what I was, you know, defending against.

When Clinician 2 discusses using her "whole self," she is referring, in part, to her ability to have connected to and used treatment to heal her own internal, traumatized infant and therefore, able to connect with the same in others, to be able to receive those aspects of clients.

Imagining the Infant Within

In order to understand and interpret, especially in her own reverie activity, the non-verbal and pre-verbal context of therapeutic relationships, Clinician 2 turns her mind to imagining infantile experience.

> I use a metaphor for myself based on my life, of early attachment and infancy. Often when I'm working with someone who is difficult, I picture them at their emotional developmental level. I've often used this metaphor with a client who will be the hardest for me to separate from; I've seen her for ten years. There have been times when I sat with her and listened to her and actually felt nauseous and hateful and I have pictured holding a baby that's vomiting and you know, you kind of want to wipe yourself off but then you don't want to push the baby away. I often have that metaphor when I'm working with something that is very early attachment derailment.

Using this metaphor as a way to picture her client's emotional needs allows her to take the client's way of connecting in stride, even when it seems to be not deep at all.

> I think the first thing I am trying to do is attune and this is time-honored, start where the client is. Sometimes it might mean chatting because they want to chat and they are too terrified to do anything else. So to give you an example, I have a client who came in as part of a couple in their sixties. The man is very concrete and said this was not about him, he was here to talk about his son. He wanted to make it clear and he tested me on it severely. He would say, "I don't believe in all that Freud stuff and I'm not here for therapy." So we spent all of our time talking about their adult son who has mental illness and was not in the room. But I did notice—in the waiting room there is a candy dish and when he came in, he had this piece of candy. He said, "Look what I got." So I asked myself, "What age is that?" It was just like a four or five year old and of course, I didn't comment on it. But I picked up on something and I did not push him. This may sound crazy, but I made sure that there were chocolates every week when they came in. And I've responded to his humor and I've kidded about the fact that he doesn't like it when I talk this way. And over time, this is now four years later, he talks at great length about himself and has deepened his insights about himself and I think that is because I took him where he was. It was almost like he required a certain kind of eye contact. I really felt like I was tuning into a little boy who hadn't grown up in many ways and who had been deprived of certain things.

Clinician 2's use of her developmental metaphor situates her to receive and respond to nonverbal, developmental needs. She considers this activity to provide healing experiences to her clients.

Fear, Fearlessness, and Safety

Nonverbal aspects of Clinician 2's own treatment were an important part of establishing the safety needed for her to face into and heal her unmet, developmental needs. She speaks about her therapist.

> She just let me be. I think her best work was when I was really searching because she sat back and let me do it. She didn't put any restrictions on it, on what I said or how I said it but I just knew—it wasn't even that—it was her demeanor, she was just very solid and she was there week after week. She established a safety and she didn't use words that tend to be judgmental and if she did, she caught on. I could actually feel her move back to shift her position so that she didn't do it

> anymore. I mean I could see changes in how she responded—that she took my discomfort—she actually changed and that was amazing to me. That really meant a lot. And she didn't make me feel—she left a lot unspoken actually—she didn't overtly analyze my every move or make lots of interpretations until she really felt I was ready to hear it. I think her timing was good. And she wasn't afraid. There were some times when things got pretty rocky and she wasn't afraid. She said, "No, I'm not afraid; whatever comes out, whatever happens, we'll deal with it. If you go crazy in the office, we'll deal with it." That was her stance and that made it very safe. That was a major piece that allowed me to open up. I learned a lot from her.

Clinician 2 considers such fearlessness a primary ingredient in what it takes to do deep work. Being unafraid of what may come, staying consistently available, working to be non-defensive, these are the basic building blocks that Clinician 2 uses to offer safety and space to grow to her clients.

Clinician 2 reflects on her experiences of group supervision. She has had group supervision that did not feel safe as contrasted with that which came to feel very safe. In the milieu setting in which she worked, while group supervision taught her a great deal about the power of projections, it was too competitive to provide the kind of safety that would allow her to let her guard down. The competitiveness along with her desire for status made for a learning environment that allowed for some but not enough growth in capacity to be open to her own vulnerabilities. Her most recent group supervision experience allowed for much deeper growth.

> By the time I got to the last office I was at which was a more traditional office setting for adults and families, I kind of brought with me my understanding of the way projections get played out in groups. We all learned about group process and how everyone holds a different projection. And we could talk about it. And we would notice what the tensions are in the room or if it gets real depressed or whatever. If you really want to do some good work with clients, try to include some kind of group supervision, especially if it's a group that can hold you. At the child development center I did not feel held, I felt jumped on because I would be in the parents' corner and someone else would be in the child's corner but it was so competitive that I didn't feel held so it became threatening. But when I got to the next office, it was a different atmosphere altogether. It was competitive in its

> way but it wasn't as—I don't know, maybe at the child development center, it was the primitiveness of the work that got in the way.

Clinician 2 does fear a couple of things based on how well she knows herself. She may be a bit haunted by her old desire for status and the competitive, academic goals her family represented. At this crossroad in her career, she is reflecting on this theme. She related her ambivalence about joining discussions in a clinical association online list-serve.

> I know a lot about a topic on the list-serve but I don't know where I am in wanting to participate in it. It's like I am still a part of all that and I used to want to enter into it and put out my thoughts and beliefs; there's a way it's informative and yet it's competitive. I mean even the lists bring up thoughts like people are going to read this and what are they going to think and will my comment be better than his and all of that. I think it's the fear of arrogance. I think what's behind that is the fear of unavailability—that if people become too wrapped up in what they know and too competitive wanting to share all the stuff they know, then that would make them less available to me let's say I want to get to know them. Or if I get too wrapped up, I mean I think I made mistakes as a parent because I felt I had to know and to be perfect. I think it has to do with when I was into knowing so much it made me less available and when other people are into the heat of their knowing so much it makes me feel like they are out of reach. So it sort of makes me feel lonesome or something.

Clinician 2's journey includes movement from being wrapped up in what she knew, intellectual knowledge, to being open and non-defensive with clients, and able to sit with not knowing. She identifies these abilities as the benefits of her personal work and yet, also cautions herself to be alert to the ways she can slip into emotional unavailability and intellectual defensiveness with clients.

Receptivity

Clinician 2 reflects on learning about unconscious, projective communication as data about clients' complex affective states.

> When I first started out, if I felt a certain thing in session, like if I thought, "I am never going to know what to do with this," that sort of inadequacy, I used to take it as something that was a shortcoming in me and I would never discuss it with my supervisor. I thought this was just something that I had to bite the bullet and get through and build up my confidence. So I took the projection that I might be receiving from a client and I took it to be the truth. So that was how I started and I would spend a lot of time at the moment, a lot of time ruminating about my inadequacy during the session. I mean I could see how I was so less available to my clients because I was thinking about me. And then, over a period of time, I began to see it differently. I would think, "Wait a minute, where is this feeling coming from? Is this really about me, does it really mean I'm inadequate or is this a projection, a feeling I'm getting from the client about something they feel inside?" That was such a breakthrough for me. So then, I could focus on them. This was about them.

Clinician 2 works to know her clients via receptivity to their projections and clients' ways of engaging. Clinician 2 believes clients need to recreate their internal, affective states in her and that tolerating and containing such affective states is crucial to depth-oriented treatment. One must be able to be receptive to such feelings and therefore, vulnerable with clients.

> There are many clients who need to poke our most vulnerable spot as a defense. I had one client—I have ankles that swell not to mention varicose veins, blah, blah blah, and I was wearing a sandal that had an ankle strap. This client came in and it was the first or second session and she was talking about herself and some things I think she felt some shame about and it was the end of the session and she looked down at my feet and said, "You shouldn't wear those kinds of straps because it's not good for your ankle, especially if you have swollen ankles." I just felt embarrassed to beat the band because I was self-conscious about my ankles. It was sort of like sitting with a bee sting and I thought, "Damn, she must feel so ashamed that she needed to produce shame in me." I think I was correct, I didn't say it, but that was my assessment and that allowed me to not hate her and to maintain empathy.

Clinician 2 asserts that sometimes being receptive and not knowing, letting clients just be, staying present, containing affect, and fighting the idea that she should insist on interpretation, is the bulk of the therapist's work in a treatment.

> Clinician 2: The case that's the most amazing to me is the case where I felt the least connected. This one woman, I've seen her for three years and we have three

more times left to meet. I know she'll cancel at least one of them because she's cancelled ever since I've known her, that's been an issue. She's a woman I've always watched the clock with. I've had a hard time sitting with her. It took four months to get her to come in because there was this and there was that. Finally, she started coming and she would still cancel quite a bit. I see many clients for 60 minutes, I see her for 50. I couldn't tolerate a minute more. And I had never felt connected to her. I've never felt fond of her. I don't dislike her. She seems more attractive to me now that at the beginning, she literally seemed almost ugly in a way. So that's the main change that I see. I find her more attractive. And doesn't that sound very superficial? But that says something. So it's been about three years and as we are talking about the work, reviewing it, she's made a lot of changes. She's getting along better with her children—that was one of her presenting problems—her adult children. She's in less of a victim stance with her ex-husband who is horribly abusive. She has a better relationship with her boss at work. She said "You have helped me so much." And it's like, "Oh my god, I have?" I think just the chair helped her. This is astounding to me. So of all the clients, that's the most amazing outcome to me.

Researcher: What do you think happened?

Clinician 2: I think that it was all on a nonverbal level. There is some way in which she felt accepted nonverbally. I think I metabolized the rage, including my own and that helped. I think maybe nobody had ever done even that amount of work with her. I didn't retaliate.

Researcher: Even with all the cancellations. I mean, that's somebody who would never have become a client for many therapists.

Clinician 2: Well that's where an agency is a wonderful thing because sometimes I could say, "Let it be." I mean I didn't always do well with that part. I did say things like, "I wonder about all these cancellations." I did the whole number there but it didn't go anywhere so I stopped. And then I started to value that extra time that I had. I could do paperwork and I just let it be which you're not supposed to do. As a conscientious therapist you somehow always have this feeling that you are supposed to do something with it, you know, like interpret it. I did nothing, I just let it be and I think that's what she needed. So I ended up doing the right thing that was best for her.

For Clinician 2, her receptive, non-defensive stance allows her to respond in variable ways depending on the client's engagement style.

I try to be attuned and I just receive whatever the client is giving. There might be another client who requires a very active response on my part or a very behavioral sounding response because I feel that would be less scary to them. I have a client who is 52 and who had a specific complaint at the beginning. She would talk

> about her kids. Her youngest was a junior is high school and then the crisis sort of passed and she would cancel with plenty of warning. When she would come she would talk about her knitting or maybe her week. I often thought, "What the hell are we doing?" But then, six months later, she made some reference to our discussion about what her son needs. So she was using it and that was her optimal distance.

Core Techniques

As noted, Clinician 2 works, in great part, from a developmental perspective. She works to attune to clients' earliest experiences and dependency needs and to clients' expression of optimal distance and intensity. Clinician 2 deciphers unconscious communication via projective processes in order to learn about the intrapsychic and developmental status of clients. In doing so, Clinician 2 is able to be flexible and variable in her use of several techniques that may deepen clients' connections to her and to themselves. She may talk about process (within her or between her and a client) or not. She may listen, sit with intensity and not formulate. She may interpret what she has learned. Finally, she usually trusts in the nonverbal process of any given treatment.

> I hold what I think I'm being given as a possibility. And I'm deciding what I might do about it or if and where to even say anything. I'm getting something from the client that they are probably unconscious of. And when I have enough of a bond with them I may say, "I'm wondering if sometimes you end up feeling not good enough or inadequate." I throw that out at a place where it seems like a good place to throw out. You get a sense of where they are. Are they available to make a connection? And if they blow it off, that's information and I don't push it. A different way of responding would be—I had a client who was used to throwing his weight around. That was just his way of relating to people, kind of bullying. On a certain occasion with him, and it just seemed right, he was sitting there and being very intimidating with his bullying behavior and I said, "You are really intimidating. The way you are talking to me makes me feel intimidated and the thing is that if you need to intimidate me and if I feel intimidated, I don't know if I can help you." That was a case that I just went for it, and it cut through the shit basically. He was probably testing me and I could refer back to it and say, "You know sometimes I think you do that to feel like you have the upper hand and to

> make yourself feel safe." So eventually, over time, we were able to get to that. So, these are different ways of deepening.

Talking with clients about the process in the room, including transference interpretation and countertransference disclosure, is also considered a flexible technique by Clinician 2.

> It depends on the client. I've had some amazing experiences of feeling like I don't know if a therapy is very deep and it is. I had one client who came for seven years and at two years, he went to once every other week which seems like not very much. I didn't make very many interpretations and I didn't share a lot of process with him. He never asked me about myself. He terminated because he was retiring and moving to another part of the country. He said, "I've learned so much, I tell you things I had never told anyone and I never dreamed I would tell anyone." This was so meaningful to him and I was stunned. He learned about himself and he made major changes and that was from every other week which is not my personal style because I tend to do things more intensely. And this was without talking about a lot of process. Although, if I felt mixed, I would share that. I would say, "On the one hand, I feel like I want to respect your wish to have distance and on the other hand, I feel the need to explain this to you." But I think he needed to be fed with an eyedropper and these were the ways he titrating the closeness.

Clinician 2 associates to another case in which she did share a great deal of her subjective experience with a client whom she felt needed such disclosure.

> I have this other client who is totally at the other end of the spectrum. Because we are ending, she is crying and just grieving and mourning. I have shared so much process with her because I think she grew up with a mother and family who shared nothing. I think she had no window into what was going on inside her parents; there was aloofness or a barrier that was devastating. I would say things like, "When you say that, it makes me feel sad." When she was threatening suicide, which she did a lot for awhile, I would share how it made me feel and I would say, "I don't know what to do, I don't know how to reach you and this is really upsetting. I'm feeling isolated and alone." I let her know what was going on inside me, a lot. I would explain, almost like you would with a little kid, that if she learned to talk about her feelings with me, then maybe she could learn to talk about her feelings with a friend. I felt like I was teaching her. I've done a lot of reading about the infant learning about herself by being able to witness mother's process so I believe in that very firmly. But some clients can't tolerate it and some can and need it and some don't.

Trust in the nonverbal process has become closely related to trust in herself over the course of her professional development. Alongside these internal aspects of her functioning is her understanding and acceptance that deepening is often marked by clients' acting out the very things that brought them into treatment.

> This is a terrible thing to admit but when I have a pretty deeply dysfunctional client, at the beginning, I always feel "Oh god, this is hopeless." And then after I get to know them that feeling just kind of fades away and faith takes over. It's happened so many times that I really do have faith in the process. An example is a client I am currently seeing. She's a real handful and we touched on something in one session and she called me, ranting and raving about a new psychiatrist who hadn't called back, that he didn't care. I said she needed to call him and she was going on and on saying she couldn't call him, that if I wanted to call him, maybe he would listen to me. Finally, she screamed, "I WON'T CALL HIM." I was so riled up internally, this was on the phone, and I told her I was perfectly willing to call him if that would help and that it is really important for her not to give up because she had given up on a lot of psychiatrists. I put the phone down and I did call him and I remember thinking to myself—first, I wanted to climb the walls, and then thought, "What the hell did I get myself into, why am I seeing this client? Am I going to be able to help, et cetera, et cetera." Then it really hit me. She's getting more attached to me, she's acting out like a little child and I was absorbing it and if I stood firm, I mean just be there and not crumble and not retaliate and all of those things that we talk about, she'll calm down. That's having faith in the process. I wouldn't have been able to do that maybe seven years ago. So, a lot of times, when it smells the worst, something happens for good. Because sometimes it feels terrible and then you realize that okay, they are really experiencing me, I'm really experiencing them.

Finally, regarding technique, Clinician 2 is aware of the inevitability of limits. On the topic of mistakes, Clinician 2 is philosophical. On the one hand, mistakes are inevitable, on the other, mistakes are not easily defined.

> If you're not ready to make mistakes, don't even start. If you think you're going to avoid them, just go back to bed. I think that it's easy to get carried away. The more proud you feel of your intellectual achievements and your achievement that you've now become a therapist and a good therapist and then a competent therapist, you can never give up the idea that you really don't know and you're going to mess up. However, my view of mistakes is that it's part of being in a relationship. Just like in an intimate relationship of any kind, you're going to miss the mark with the other person; you're going to hurt them. So the saving grace, since you're going to make mistakes with clients is that you don't become

> defensive. I think the difference between a therapist who can really help a client grow and a therapist who can't is the ability to be non-defensive about mistakes, to be able to say I think that was an error and I'm sorry. Mistakes can help the process deepen as well but you have to—that's where again consultation and objectivity come in—get enough distance to know when you've made one, especially if you don't get immediate feedback from the client. I look for when I feel a client distancing or getting angry, canceling appointments or shutting down in a way that might even feel like they are spiraling down too much into a depression. That's when I look to see is this about something that I've done, is this because they got to close to something and it touched a nerve and so this is a normal reaction because it is hard to grow? Or did I actually push them too fast or did I misunderstand and can I address that with them?

Core Beliefs

Clinician 2 is grounded in the belief that nothing is one thing. Mistakes are usually not just mistakes but also opportunities. One must grow to trust oneself and yet always needs others to rely on in the murkiness of clinical work. Healing happens concurrently, client and therapist, side by side. Distance and closeness are intertwined. Certainty is rare and transitory. She believes psychotherapy offers opportunities to heal infantile, emotional trauma, to re-work dependency needs, and to have a sturdy partner in the therapist as necessary grieving, healing, and transforming is taking place.

Clinician 2 is aware of what she needs to sustain her optimal functioning as therapist. She needs the freedom to follow the client's lead, autonomy to make clinical decisions, and time and space to allow the client to learn what is most important to the client.

> [In order to deepen the work] you have to let go of needing to control what goes on. You have to let go of your timeframe because profound change takes a long time. Of course, there is less permission for that these days with insurance and all of that. And then one of the things that I'm still struggling with is letting go of being responsible for your client. I can't make him get better, I can't make him decide to live; it could be any number of things. Another thing that is really important is not becoming invested in certain things. One example would be this

> man and everyone was on his case to get a job. And god knows that he needed to have a job, even just to structure his day. He would either immediately lose the job or refuse to take that kind of job. It was his defensive way of dealing with his tremendous deficits. There were times when I would find myself questioning him about what he was doing to find a job and getting into what he should be doing which is the last thing he needs from me. So then I would try to step completely out of the struggle because it's distancing not to. You will maintain a distance from your client if you get into those should areas.

Over time, changes at her agency were chipping away at these aspects of her functioning and it became clear that she needed to leave. Her crucial therapeutic stance was under attack.

> By the time I left, there were 10 or 15 forms that had to be filled out in the first session. And then there were the much expanded assessments and evaluations. They were developing a 79 question form. Every six months you had to update your treatment plan. The client was supposed to look at their goals and rate how they thought they were doing, whether they had made progress. And that was the point at which I was saying that I had to get out of there. It was so invasive. It inhibits your ability to make a decision about timing and when you or the client wants to address something. Instead of following the client, the client has to follow your lead. Clients would ask, "If I don't make progress will they fire you?" Those are the kinds of questions that would come up.

Clinician 2 strives for balance between her gut instincts and the opinions and ideals of others. That balance was no longer possible to find and sustain in the agency setting. About rules and theorists' ideals, Clinician 2 is reflective about finding what works for her. Her choice of consultant highlights her commitment to such balancing.

> Well, there were rules when I was new and I had to follow the rules and do it right or I was a bad therapist. It was pretty simple back then. And then I learned there was some flexibility. I remember reading Michael Basch and I was so relieved when he said it doesn't matter if you are not exact, if you run over a little, the message is that it has to end. It doesn't have to be so rigid. To some extent, I can still struggle with that. I have a way that I might do something and then I find out—you know it's interesting because the consultant I see, I look at him as being very rigid about the frame and he's sort of an austere person. I would say he is probably my total opposite and I've often asked myself why I chose him as a consultant since I am so go with the flow. I think the truth lies somewhere in the middle. At first I would feel very threatened because I would think he would just see me as someone who couldn't keep the boundaries or was too self-revelatory in

> certain circumstances. I saw him as someone with astute insight but someone who probably didn't share enough of himself. So, I went for the insight part of it because his reading of the situation, 98% of the time, has been right on and it also helps to balance me.

Clinician 2 feels she has been fortunate to have both the agency and private practice venues for her clinical development and work and is proud of her work.

> There were so many benefits to being at the agency. I think the biggest thing that comes to mind is the holding environment of the agency, if it is well run. It was an atmosphere in the group of honesty and safety and yet at the same time, an atmosphere where people could bring up their differences and you don't have to pretend and just make nice; there were fights sometimes. The group supervision is fabulous if you have that kind of environment. I also think private practice has its benefits. If I did not get out and have my own practice, I think I would have felt very sheltered. Having my own practice helped me grow beyond that a little bit. I started with private clients after 10 or 12 years at the agency I also did a lot of reading and writing on my own. Overall though, the agency suited my temperament because I felt so much support. I was able to learn to ask for what I needed and to push for what I needed.

Clinician 2 is now looking back and wondering what comes next for her.

> I was so involved in being a therapist and social worker, not just because of the agency. So much of my energy went into it and that's changing. It really triggered me when I became a grandmother last March and then I began to ask what I really want to be doing now. Is this really where I want to put all of that energy now? This has all been related to my own personal work and overcoming, sort of healing myself. So the focus of the work and the focus on changing and healing really went hand in hand and they were very central in my life for a long time. I've felt blessed that I had a job and work that I liked. I don't think I want to give so much energy to it anymore. At the same time, I worked hard to learn this, why wouldn't I want to keep doing it? So that's what is bouncing around.

It seems clear that Clinician 2 will continue to process the depths of this important transition in her life.

Clinician 3

Clinician 3 is a graduate of an advanced clinical training program at a psychoanalytic institute and is in private practice. Over the course of the research

interviews, Clinician 3 noticed that her work held more depth than she initially believed. In the process of talking about her work, she was able to identify aspects of depth that she had not formulated in some time. In this instance, it seems that depth was more appreciated upon reflection and verbalizing.

Depth Defined

Clinician 3 thinks about the feel of sessions and of a treatment overall. For her, depth is personal and dependent on the capacities for connection and insight of each patient. Clinician 3 rates some treatments as deeper than others. Deeper process includes increased self-reflection and acknowledgment of agency in one's own life which leads to growth and change.

> What comes to mind is working with people on a level that is life-altering, that is self-reflective. It's one of those things that you certainly know when it's happening and you certainly know when it is not happening. I guess I feel it more with certain patients—those who are more capable of self-reflection, those who are more capable of insight, who want more than the problem fixed, who want to feel differently about themselves. They might want to alter their situation or self-perception but may not know how—patients who have a sufficient degree of unhappiness and can own it, can see it as self-created rather than externally created even if they cannot verbalize it.

Depth work, work that includes some increase in looking at one's responsibility for one's own life, is seen by Clinician 3 as a choice and a capacity.

> I'm not sure that everyone has the capacity to go deeper. I always wondered if it can be cultivated or is it something instinctual. I'm not sure I've ever answered it. I think it is a little bit of both, some parts can be cultivated but other capacities are instinctual.

Clinician 3 associated to a patient and treatment process that she feels to be one of depth. The patient is a woman in her thirties that she has seen for about eight years. She describes the treatment.

> Clinician 3: There wasn't initially an indication that this would be a treatment of much depth. The patient presented as very closed off and emotionally constricted. Even in the summer, she wore a coat to stay covered up. I became a consistent, empathic figure for her. At first she just needed somebody to listen, just to be there and hold her, as a container for this material that had never come out of her before. She had been traumatized by medications so she didn't want to touch them. She lived with her depression and anxiety in her small home. For a long time all I could do was be that presence that held her, that was steady for her. She began to trust me over the years and began to open up more and more to where we were able to get near the abuse, a life of abuse. She would come in sometimes and sob and sob and sometimes I would literally hold her because she would just be crumbling. There weren't even a lot of words. As the years progressed and she was able to confront her father, she was able to open herself up to life. She does volunteer work and she's told her family about the abuse. Now she has been able to convey to them what she has been going through and the family has been supportive.
>
> Researcher: For this woman, what are you aware of having done or not done to facilitate trust that led her to open up?
>
> Clinician 3: I think it was the acceptance which is something she never had, an unconditional kind of acceptance, that you are an okay person and you were strong enough to have survived the neglect and abuse. She was living with chronic fear and she was finally able to relax with me. The acceptance and safety of the therapeutic relationship facilitated her capacity to look at herself and be exposed enough to truly connect in a relationship.

Clinician 2 describes a case with an outcome of change in the patient's ability to acknowledge her agency in her own life; an example of a patient slowly moving from externalization of blame to understanding her contributions to the state of her existence. Clinician 3 talks about her patient from a place of readiness for the long haul.

> We are in a process of movement from externalization to her recognizing her own authorship in her life. I have been seeing her for ten years, at least. It's been a difficult journey. The tough part is mostly behind us but I still watch my phrasing when I talk with her because it has been a struggle. It's interesting because when I first started with her I was still more into my proper roles with strict boundaries

> and she liked that, she needed that. It's been quite a transition for her to accept my changes as well as for us to be able to go to new places. It has felt almost like war at times. I would leave and go talk to a colleague because I would feel so beaten up at times that I needed someone who could remind me that the fact she could say these things to me reflected the intensity of the treatment. I was so concerned I was not helping her. Of course, that was what she needed to play out with me. When it started off, it was her husband, it was her mother, it was her father, it was everybody outside of herself. If I even hinted that there could be something of her in her interactions with these people, she felt blamed. I had to proceed cautiously because of the intensity of her reactions. It was so difficult at times; it made me question why I was in this field. I would have to struggle to get outside the circle and observe our process. It was my letting her into my vision of the treatment process. She is now so much less tortured and functioning with peers in less conflictual ways. Her need to externalize and displace is tremendously decreased.

Acceptance, focused and attentive listening, believing in her patients despite intermittent hopelessness, confronting when necessary, being transparent about her intentions—for Clinician 3, these are some of the contributions she makes to offer a potentially deeper process of growth. She believes such growth comes about, in part, by patients' internalization of her valuing and acceptance of them. She works to meet patients at the depth which matches their capacities.

Differential Depths

Over the years, Clinician 3 has learned that all that seems deep can at times be defensive and all that seems superficial can be quite meaningful and useful. There is no way to know what depth will come at the outset of a treatment because character structure and capacity are revealed over time.

> I've come to realize that even the patients that you feel like are just doing chit chat with you—that this is their process. They maybe can't reveal or communicate depth often but you sort of meander around and sometimes you just dip down a little bit. That's how it works for some people whereas with others you can go deeper more consistently. But then there are others where I don't initially grasp what is transpiring. I know that they are not fully present and are closed off.

Clinician 3 adjusts her stance as character and capacities are revealed. Her deepening understanding of such things helps her to identify her role in facilitating a process that is more supportive and containing versus a process that is more focused on disruption of self-perception, change and growth. Being open to variable qualities of depth according to patients' styles, choices and capacities is where Clinician 3 works to position herself. Gratifying her wish to do mostly analytic, interpretive work as she had imagined when starting her career is not her priority at this point.

> People use you as they can and what comes to mind is—this is not something I would have said years ago—that I can be real, that I'm not so much playing a role. We have a partnership. I communicate what I perceive and she or he may be able to hear it and build on it or not. We create a narrative together.

Whatever depth patients choose or can achieve, Clinician 3 relates the importance of investing in people and processes as her responsibility in creating a working relationship.

> That's why one's own treatment has to be highly recommended. Because all we have to work with is who we are. All the theories are helpful, but it is how we have integrated them into ourselves and who we become as a result of them. We have to connect with that person because if we are not authentic, people sense that. Like many relationships in life the most gratification and the most pain often come from the same cases. It's part of the wisdom of age as well as the therapist; what you invest in, you get the most out of.

Having a sliding fee scale has given Clinician 3 access to gratifying cases that she would not have had otherwise. She talks about the role it has played in her practice.

> I think it has played a very positive role even though I know there is a flip side. I would love to be one of those people who could sit back and say I will not accept below $120 and then I could work less and travel more. But the tradeoff is some of my most rewarding patients are those of lower fee. A young woman I saw paid me $25 a session and started off working in retail. She now has her PhD and teaches at a university. She credits our work together as enabling her.

Other factors that partially determine depth are referral sources, frequency, and one's limited energy.

> I talked about my patient for whom treatment was more of an analysis than any other because it was focused on understanding the transference and how it played out. One couldn't possibly see 30 people and do that level of work with them because it can be exhausting. I used to see many people two and three times a week and had more opportunity to go deeper when people come in more than once a week. Now I see more patients once a week because these are the constraints of insurance-referred patients. On the other hand, a woman I've been seeing over 12 years used to come twice a week and remained pretty much surface level because she could just not reveal feelings. Now, after all these years, she can give up simply reporting and can explore feelings intermittently so…it's not always about frequency, sometimes it's about consistency and duration of treatment.

Clinician 3 conceives of the capacity to go deeper, to acknowledge agency in one's life, as variable among patients. However, she does not consider it to be static or absolute and believes that if you stay with people, they can surprise you. She learned about the value of consistency early in her career.

> Sometimes I found that even in the most desperate situations, in my early days at the clinic when I used to see children from the projects. It seemed like the one thing that made the difference and that would facilitate our connections was that they came every week. Often, they had the most horrifying stories and lives, but yet, they came every week and you could see changes just out of that consistency of coming. I could say that now as well for a woman I see who is not the most insightful but has lots of opportunities in life. She has been coming for many years and it is just that consistency that allowed a bit of opening up in her which I had initially wondered whether it was possible. I think it is the consistency which often facilitates change even when the change is a totally unconscious process.

For Clinician 3, depth, process that includes change in perception of self and others, relating, or behavior can be met, fostered, or patiently courted.

Internalization and Growth

Clinician 3 credits her own treatment experiences and her advanced training, particularly work with supervisors, as her primary growing ground. She reflects on the ways in which growth happened both naturally and differently than she imagined. When asked what enables her to sit with the anxiety and fear that comes with some cases, Clinician 3 immediately spoke of her own treatment.

> Primarily I would go to my own analysis which was four times a week for nearly twelve years and prior to that I had intensive treatment for many years with an LCSW. That's a lot of time to reflect so that when listening to yourself, little is shocking anymore. So many of my analyst's phrases like—"Why are you surprised?"—have been helpful in my own coping through the years.

Clinician 3 speaks about her analyst and his role via deepening her treatment in the service of her growth. He made it clear that he believed in her and she grew to connect with herself as a competent person and a competent therapist. Internalizing other clinicians' beliefs in her, learning to trust herself, and the passage of time while gaining experience have combined to shape her therapeutic functioning.

> Acknowledgment and validation from supervisors and therapists kind of pushes us forward and helps us to be able to do it for ourselves. My advanced training has helped with self-trust. It almost feels magical. I remember starting off at the institute and talking to one of my first supervisors and thinking, "How can he not be judging?" And as the years passed without focusing on it, I realized I woke up one day and thought, "Oh my god, I'm not judging them, I'm really not judging my patients." Most of the time I can connect and I don't choose to not judge; it's just not there. So I can see there has been some evolution because I've had very good supervision and good training; a lot of it occurred without conscious effort. You evolve through this process and some of it is conscious evolution and some of it is just going where it takes you naturally.

Clinician 3 asserts that given the right conditions, growth happens naturally and at its own pace. She has let go of a significant amount of illusions of control and stands as firmly as she can in a conviction that her job is to help people find their own answers and

healing. She also acknowledges that the wish to provide the right answer never really goes away.

> You know you can't anticipate your development as a therapist. It's like aging, you can't anticipate the wisdom you will have at 45 that you didn't have at 35; you're not there yet. There will always be those difficult times when a patient is feeling totally helpless. Rudolph Eckstein, MD said something like, "We have to remember that it's not the therapist who cures the patient, it's the patient who uses the therapist to cure himself, therefore, omnipotence gives way to omni-potentiality." Whenever I start to feel helpless with a patient, I remember that.

Clinician 3 has come to find herself and her style in the real world of psychotherapy rather than her fantasy of the rule-bound psychoanalytic text book. She reflects on growth in her ability to be at ease in her work.

> We grow tremendously in this process. It's a reciprocal process based on who we are, who they are, and the relationship we can create. One patient who loves cooking has started to bring me food that she makes. In the old days it would have been a struggle for me, like it's not allowed. Now, I accept this mutually pleasurable experience of her giving a part of herself in a way which is comfortable for her.

Of what has been hardest to learn and establish for her work, Clinician 3 ranks setting boundaries as toughest.

> I think learning to set boundaries has been the hardest struggle for me; it's not something that comes easily to me. But it's critical. Ending sessions within the time frame has always been a struggle but I've learned from many patients that it provides a comfort as much as a frustration—to have that boundary firmly in place.

Setting boundaries has included arranging her schedule based on what she has learned about herself. Besides knowing her preferences and limits vis-à-vis her optimal work rhythms along with the knowledge that all cannot be planned, Clinician 3 reflects on what else she needs to sustain herself in this work.

> It's the combo of all the things we talked about. It's one's own therapy, colleagues who understand the work, my [internalized] self-soothing. The

> capacity to self-soothe is really a big part of it. Being able to detach and know that work is being done within limits which are possible and reasonable is helpful.

Core Techniques

Clinician 3 focuses on how she can help her patients heal and find avenues for growth. She consciously works at avoiding the pull to rescue. Rather, she tries to position herself as non-judgmental listener, empathic partner, and receptive transference object. Positioning herself in these ways reflects her hope that her patients will be able to and will choose to use therapy in order to grow in awareness of how they create and impact the dynamics and circumstances of their own lives. Growth, even in very small increments, in such self-reflective capacities is believed to come through a therapeutic relationship whereby one is listened to and understood.

> Part of what allows me to sit with somebody for a long time with minimal gratification in terms of changes is the wish to enable the person to grow. As a young student, I always enjoyed sitting with a counselor and having that undivided attention. It was a kind of communication with that part of oneself which is not just giving the facts but is conveying who you are. I remember walking out of sessions feeling, "God, she really heard me." That's the sense I feel I need to give and that I really can give. There is something about that kind of "third ear" level of connecting which one doesn't get in daily living and which is gratifying to both give and receive.

Being with her patients in this focused, empathic way, Clinician 3 is aware of how easily she can get caught up in the affective flow, thereby losing her optimal distance from the patient. This is where she reminds herself to pull back, that it is not her job to fix things but to help her patients see their own paths.

> The thing I've learned over and over is that capacity to detach because I can get too absorbed in peoples' issues. When someone is chaotic and describing chaos in their lives, it's too easy to get absorbed in their anxiety; it is real anxiety about intense life situations. This is where I have to mentally take a step back and say,

> "Wait, your job is not to fix this, it's to observe and see where she's going and to offer some observations, support, or insight but not to fix it."

Clinician 3 offers insight through transference interpretation and reflects on its importance while at the same time recognizes limits on how important she is or needs to be for her patients. She speaks to the illusory quality of the transference relationship.

> As a young therapist, it was very difficult for me to verbally deal with transference in the therapeutic situation. It was hard to convey when someone is complaining about their husband and mom and dad that it might actually have to do with us. I've learned over the years that people often need to keep it external, outside themselves and the room. I'm more at ease with integrating it now. And then there are the patients that live out the transference, become very dependent, who say, "I can't live without you." While there are those patients who enact the transference and convey extreme dependency, especially around scheduled vacations, I am now able to honor their feelings while helping them to recognize the transference elements involved.

When she can, Clinician 3 offers ideas to her patients about what element of the past is being played out with her. Other times, she stays in the present and offers information about what is happening from her perspective as a way to demonstrate how the present is different from the past. A patient was upset about how something was billed, accusing Clinician 3 of being unethical.

> Even though I tried to discuss feelings of degradation and feeling short-changed by me, it was very hard for her to leave the concrete topic of the billing. While I feel sad that we can't get to what is underneath, I realized a need to stay grounded in the present topic so we could come out of this enactment with increased understanding.

Clinician 3 works to be a partner to her patients as they indicate their ability to use her. This may be from problem-solving to affect management to exploratory and growth-promoting insight and new relationship experience. She models patience for the pace of their process and revelation of capacities.

> I don't end therapies. I usually let the patient take the lead and if they ask me, then I will give them feedback. I've never said, "I think that you've been coming

> long enough and it doesn't seem that we're doing any work." Even when the defense is one of affectless, routine reciting of weekly events, I try to recognize that's where this person is, that's where the issues are being played out. I believe that's where they need me to be with them until they are ready to move forward.

Core Beliefs

Clinician 3 takes the long view when considering what she believes. There are days when it is difficult to see her impact and the value of her work. She pulls back to find the philosophical, retrospective view.

> On some days I wonder, "Why did I ever go into this field?" It's easy to lose track when you're drowning in paperwork and you're exhausted and there are grey skies. But when I look at a bigger linear history, I find a meaning to this work because it deals with the essence of life itself—enabling people to live more fulfilling lives. This is why I know I've made a good choice in choosing this field.

She has grown, via experience, in her knowledge and acceptance of the opportunities and limits that psychotherapy can provide to people. She began with the hope that she would find the right answers at the right moments; through her studies of the masters, she would know. When she began her advanced program, she wanted those answers.

> I remember upon starting analysis, my analyst saying that I only seemed to want knowledge and thinking that was right. Knowledge was the answer to all. Now I see more. What I've learned—letting go of the end goal and learning to focus on the process and the journey of our lives is what it's all about.

It seems not an unusual idea for young therapists, that one "gets there" or reaches a pinnacle of knowledge. The process toward appreciating the journey of a treatment and her career has been marked by some disillusionment for Clinician 3. She now believes that the way to depth and to keep growing is to let go of the idea that she can have packaged, secure knowledge. Also integrated in her functioning is the acknowledgement

that while she gives a great deal to her patients, she is always getting something personal from them.

> What do I value most in my work? The first thing that comes to mind is the learning, the growing, and the new places it takes me. But obviously, there is more. Any of us that go into this field get gratification from helping others. I think it's the good feelings that we get from seeing patients' growth, the self-respect, and our own growth.

Clinician 3 believes that psychotherapy can provide an experience of being listened to, joined with, and understood in a way that promotes healing, inspires curiosity, and offers internalization of the therapist's belief and value in one's uniqueness and capacities to find the way to one's own solutions and resolutions in living. She believes that she plays a crucial role in being a partner on patients' journeys of discovery and healing.

Clinician 4

Clinician 4 is in private practice. Clinical social work is her second career. Her professional history includes teaching high school, and after completing her masters in theater and oral interpretation, teaching at the university level. She recalls an internal debate of professional interests between theater and therapy. When she decided to shift from theater to therapist, she chose to pursue a social work degree because it was the fastest way to become a therapist. She had an intensive, psychodynamic supervision early in this career. She has also been a member of a consultation group for eight years. Its leader is a psychoanalyst.

Depth Defined

Overall, the question of depth is tied up with ambiguity for Clinician 4 and as a result, she works to offer as much space as possible for clients' points of view. She understands her role in deepening to include connecting to meaningful aspects of the client's narrative through empathic attunement and understanding clients' object relationship needs. In clinical processes, depth is marked by clients' curiosity about their thoughts, feelings, and actions along with increased self-reflection. She strives to create an atmosphere in which clients are not censoring themselves in great measure but also feels that can be hard to know.

> To me, when you start to have depth is when you can help somebody to really be curious about what they are doing and to start to self-reflect. I want to create an environment where it is obviously safe, that they feel—well, what you don't want is for them to be censoring themselves all the time and you don't always know if that is happening or not.

Affective Responsiveness

Clinician 4 considers her affective responsiveness to clients, her countertransference, as both something to be monitored and managed and as projective data that may become opportunities for deepening. When Clinician 4 is feeling frustrated or unsure, she considers that a cue to check out her assumptions, notice her level of patience, and probably bring the case to her consultation group. She discusses such a case.

> When I think about cases where I'm feeling frustrated is often when I feel I'm working on the surface. I think there are people that can size somebody up and know if they are going to be able to go deeper or not. I don't have that ability. I have a case that I saw at least 25 years, maybe more, who recently just decided to terminate. I would go crazy with this case. I would keep thinking, "Why is this person still coming?" I would feel frustrated and I would feel guilty, like am I

> committing malpractice here? I would bring it up in seminar because I couldn't tell what this person was getting. It was like some good things had happened since she had been in therapy and therefore, that was something she wanted to continue. But she resisted self-reflection or going deeper. My colleagues felt she was a woman that had a lot of trouble expressing anger and my consultant's feeling was not to worry about how long she had been in treatment but just to go with it and to keep working on trying to get at the negative feelings and confirming any negative feelings, which I had been doing. That sort of helped me deepen; I got that input so I could then focus on that. And she actually made strides. When she did terminate, I tried to get her to talk about her frustrations with me, what she felt that she didn't get out of it. She felt sometimes that I tried to get her off her subject or I tried to—she's right, I was trying to deepen something or to go into another direction with something. And she felt that as an intrusion so I thought that was really interesting. It wasn't like I did that a lot because I had picked up on that but that was interesting that she could finally tell me that. I could never get her to say that to me before. It would have been fabulous if she could have said it really frustrates me when you do that and we could have figured out what that was about but I couldn't and she couldn't. Everything was happy and nice. She used me as she wanted to use me and I couldn't have an agenda, like deepening.

Deepening, increasing curiosity and self-reflection, is sometimes the therapist's agenda and therefore, not likely to happen despite therapist hopes. This was a case in which Clinician 4 felt extremely constrained and not allowed to bring her affective experience to the table for use in deepening the treatment in a particular way. Following is an example of a case where she was able to use her affect directly towards impacting the depth of things.

> I guess I am sort of equating safety and even deepening to those moments when you really are able to connect to the material in a way that's meaningful to the person. And sometimes it comes from your affective cues. This is a client who was a guy that I guess you could have said was sexually addictive. I don't even know what that means but he was a very good-looking guy who was—if a woman would come on to him, he would feel it was his obligation to perform and it would be a kind of empty, lonely thing. The thing that was kind of an interesting breakthrough was—he would drive me nuts paying me each session. I would say our time is up and then he would take out his check and he would write it and it just felt it was this drawing out the session and I was getting frustrated with it. There was a piece of it that felt like a prostitute waiting for her pay and I thought it was his way of keeping one foot out the door. If he paid per session and walked off, he wouldn't owe me anything; that is where I felt it was coming from. One day I just had to speak up and I said, '"Why don't you just pay me at the end of

> the month, I'd like to try doing it that way." He told me when he left that session; he sat on the stairs of the building and cried because I had trusted him. Now, isn't that interesting? I was picking up a dynamic, I didn't really understand what the dynamic was, but my frustration was coming from something that was going on between us with the payment. So I guess what I'm saying to you is you don't always know what you are looking for or seeing and I think the more you can trust using yourself, the better.

Clinician 4 uses her affect in other direct ways with clients in an effort to increase their acknowledgment, curiosity about and acceptance of their own emotional worlds. She speaks about offering what she feels as a way for clients to locate a feeling in themselves. She reports doing so more and more as her trust that her reactions are coming from somewhere productive has grown. She works to limit disclosure of her subjective affect to that which is most connected to responsiveness to the client's experience. However, she does consider some benefit to sharing her own spontaneous reactions when it does happen.

> With one client, I told her it would be great if she got to the point where she could say, "Fuck off," when her ex-husband did something mean because I was pissed at him. I wondered if she was angry. She came back and said she had been really angry. That's big for her, instead of feeling ashamed. At this point in my career, I trust that my reactions are coming from somewhere important but I think about how I share them. I'm not against relational theory, but I'm not comfortable saying that when you do that, it makes me feel blah, blah, blah. I do feel like I can say I'm feeling very sad when you say that. I actually think it would be better if you could do without saying "I feel" but just to say that's very sad. Sometimes my [spontaneous] reactions have been a deepening. For instance, I had a client, a young guy that was a student and he's got loans and he would get his family these absurdly expensive presents for Christmas. He would spend $600 on a present and when he told me that, I went, "WHAT!" I was so shocked and he told me how eye-opening that was to him, how I reacted. It was just totally a gut reaction. I think that's sometimes helpful. Obviously, other people might be very insulted. The problem with doing spontaneous things is there is no way always to figure out when it is okay and when it is not okay and you need to pay attention to that.

Clinician 4 recalls the consultation relationship most influential to her use of empathic attunement. Her first job as a therapist was at a psychodynamic clinic connected

to a Chicago hospital. Her first post-graduate clinical consultant provided her with valuable learning about the importance of attunement.

> I did have consultation for several years which I loved. She was at the Institute [for Psychoanalysis] and I had gotten a child case that I was going to see privately. She was a self-psychologist and where she was absolutely brilliant—and I think that this is really what a good supervisor does—was to plug me in empathically to the client. She could zero in on where the focus needed to be and then that would open up everything. I think when you are struggling; it is because there is something off, you are struggling to have that empathic connection. She was able to sense the pain of the client and somehow give you a view of that pain. And then I would take that back in my head to the client and listen differently and pick up differently and respond differently. I think I always knew my feelings were important. I think earlier I wasn't as aware of it or I would have sat on it more. I think now, trusting my gut more, I am freer to check it out with the client.

Ambiguity and Play

Clinician 4 consistently represents her beliefs as existing side-by-side with what she considers an inescapable unknown quality of the work with any client. She works to accommodate and to tolerate that ambiguous aspect.

> There is always that piece, that you don't get everything and you don't quite know what you're getting or where it's going to fit in and you keep working on that and thinking about that and when it gets really hard, you get consultation. Still, I think you have to be comfortable with ambiguity. There is that process where you have to let things unravel and you don't really know where it's going, what it means totally. I think if you are someone that really needs to know, that is an uncomfortable position, and you will be exerting pressure on your client. Being comfortable with ambiguity—I think a lot comes from the ability, which waxes and wanes in each of us, to sit with the ambiguity in ourselves. That's really the process. I know my process is often feeling overwhelmed when I don't know and then just working to sit with it.

Using her first career in theater and oral interpretation, Clinician 4 uses the metaphor of play to enhance and sustain her ability to tolerate ambiguity. She describes a theater game in which one person is labeled the "neutral" and does not know who he or she is. The other people in the scene know the identity of the neutral, a king or a queen or

a beggar, for example, and treat and respond to the neutral as if they are in that role. The neutral has to figure out who they are and the scene does not end until he or she can name their identity.

> I think play is the ability to step into the moment without knowing what is going to happen and to go with that sort of interaction. I think it allows you to step into the moment and not take yourself so seriously. So that game with the neutral is an example of how I think we are always trying to figure out who we are with our clients, how we're being used, what they think of us. And it changes. It could change from session to session or even in a session. I really enjoy that. I really enjoy what I do. There really is a curiosity about people and figuring out what makes them do what they do and how you could be helpful.

Clinician 4 errs on the side of keeping the therapeutic space open for clients to guide her. She works to maintain such openness out of her recognition that human beings are always projecting and making assumptions and so, she is careful about asserting her perspective as fact.

> She [client] was interested in the fact that I didn't talk about myself. She felt that there was so much she didn't know about me but never asked. I think she asked something once and I asked her if that was really what she wanted to know. As we explored it, it was more a sense of obligation to ask me about myself. But you know how you think you know someone but then you think that you really don't know them? When you talk about deepening, I guess the deepening I'm trying to understand—that we're always struggling with—is not making an assumption, which is very easy to do. So that you see from the point of view of the patient/client versus what you think you are seeing. And I think that's something that is a life long struggle. I'm constantly amazed, and I think that it's a pitfall with me or maybe all of us, at how much you do project, think you know somebody and that may not be really where they are coming from. I'm constantly feeling like I need to check in on that. I think I try to keep myself clean in a sense by remembering, for example, that I may be thinking I am being so empathic but really I'm projecting the whole thing that I'm being empathic about.

Understanding Based on Transference

> I think to talk about transference a lot is not done as much anymore. You know, when I was trained, it was like every session was thought of around the dynamic between the two people and I don't know that that's true anymore. I think sometimes you can say something like, "Are you really talking about being angry

> at me?" I mean if you figure it out, sometimes you're right but you certainly cannot do that with everything that happens. I sometimes have clients talk about a few odd dreams the night before a session or the night of a session. I will talk about how it may or may not have anything to do with it but sometimes a dream may have something to do with what is going on between us. So I invite them to look at that to see if there is any possibility. But that is different than making declarative statements about how they feel. If I was going to fault myself, I think that I don't do enough declarative statements, but I don't know when you know that or not. It's more about my style.

There is an interesting mix in Clinician 4's discussion of her work in relation to the concept of transference. On the one hand, she reports that she does not make many transference interpretations to clients. On the other hand, she focuses on working to limit the amount of projection and assumption-making she does and she does not do much personal self-disclosure. In other words, she uses techniques that are thought to allow transferences to develop and become available for formulation but does not usually verbalize them. She formulates her understanding of object relationships, based on transference, which clients create with her. This allows her to identify how they are using her and highlight what might be new experience. Her intention is to keep as much space as possible in the therapeutic relationship for clients' relationship needs, especially when the need is for an attentive, receptive, and non-directive object or other. In these kinds of therapeutic relationships Clinician 4 works to remain available as a consistent object.

Clinician 4 uses her consultation group as a check on her affectively-fueled assumptions and to help her formulate a more declarative statement when she feels it is needed.

> I think sometimes there is a bigger punch. If you are able to say, "I think that you are doing this because of this," instead of wondering. That's a technique. There was a case where I could deepen the therapy by saying something like that. It came out of my supervision with my seminar. This was a young guy and there was a piece of him, a grandiosity. He would want things and then on the other hand, he would totally sabotage himself. He would step into a hole and make up a

> lie that was so outrageous and yet, he was a very put together guy. So what came out of my seminar, I said to him, "On the one hand you say you want blah, blah, blah and on the other hand, look what you are doing." His comment was he felt like I had kicked him in the stomach but it moved him. He actually thanked me for it later. It was a wake up call to what he was doing. So that was a case where I could say what I needed to say and could be fairly open and that was freeing for me to speak and then it helped free up the treatment. I was stuck. The sticking point for me with this client is that I was just appalled by some of the crazy acting out that was happening and I wasn't sure how to contain it. I felt this great pressure to make it go away and that wasn't what was dealt with at the seminar; what was dealt with was something more obvious, to point out his goals versus what he was doing.

Her ways of working with transference are in contrast with the kind of work her therapist did in her personal treatment. She describes two aspects of her therapist's functioning that deepened the process and her curiosity about and understanding of herself.

> Clinician 4: I think for me, some of the things that deepened it were when my therapist could point out the transference. For instance, she was able to show me what I was interpreting in her that really wasn't the way she was feeling and how that was really my past being present. I don't think I do that as much with my clients because I don't know whether I really have, I don't think that I have as many psychoanalytic-type clients as what I was doing. The other piece that my therapist did which I don't—well, I do but this part, again, I'm not as comfortable with. My therapist—I don't think I knew anything personal but I knew things about her life and I had images of her and her family that actually were very important to shaping my concepts of family and relationships. They were little things that she would tell me. For instance, she and her mother disagreed with how to make scrambled eggs, they each thought you should do it a certain way. Her whole point was you could disagree and see things differently and still be connected. And somehow that was more powerful than somebody just saying that you could love someone and disagree with them too. Now did she know that, was that her technique? I have no idea.
>
> Researcher: How did her pointing out the transference help things deepen?
>
> Clinician 4: Well, it made me realize how I projected and how that really wasn't where she was coming from and that somehow did deepen it. I'm not exactly sure. It was sort of shocking when you were so sure that someone thinks a certain way and then you find out that they really don't. That's obviously what you felt your mother thought. But maybe you weren't even aware that that's how you thought your mother thought, that kind of thing. The other thing that deepened it was

> pointing out to me things that I was doing like showing anger towards her when I was unaware of it. I found that deepening and helpful. But I'm not sure I would ever do that with my clients particularly. I mean I might do it in a much different way. But, you know, I was seeing her three times a week and I was in a different kind of situation than I have with my clients. She was more psychoanalytic too; she was more from a Freud model than I think I am, than I know I am, than I know anybody is today.

Clinician 4 errs on the side of caution when it comes to interpreting transference with her clients. One reason for this seems to be her need to guard against acting out of her impatience. She does not want to turn up the heat in a way that comes out of her need for quicker movement.

> If I were going to criticize myself, I think one of the things that I struggle with is impatience. I want things to go quicker. Sometimes the process isn't going as quickly as I want, that's only my "ADDish" quality. So, I think that I struggle with that and so that would in turn—I would think about whether I should do the feelings or not, whether I am pushing something they are not ready for.

Core Techniques

Clinician 4 works to understand, use, and offer her affect in therapeutic relationships, check out her assumptions, manage her impatience, and give her clients space to locate their curiosity about themselves and their process of therapy. She is aware that her technical choices come with certain costs; that she tends to not make more authoritative statements and therefore, she may not assert her perspective on some aspect of clients' behaviors or interactions in the room with her.

Primary and consistent techniques used by Clinician 4 break down into two categories. First, she tracks the process in order to stay as close as possible to clients' points of view by checking out her assumptions, offering her thoughts rather than imposing them, and tracking clients' reactions. She also limits personal self-disclosure

and tries to avoid making demands on clients for other ways of relating. Second, she uses empathic attunement to provide her with opportunities to help clients locate their affective functioning, often by sharing her affective responses to their narratives.

> I think I wonder with them. I say, "I wonder if it's this; I wonder if this is possible; I wonder if this is connected to that or is it possible that this is what happened?" I've never thought about it like this but in a way I'm sort of mirroring my thinking. It is not hocus-pocus where I have some magic that I know something that they don't. I think an important piece of the process is that we are in it together and I'm wondering out loud. So that is something we are doing together and I am trying to figure out if they can become curious about connections. Even if they don't know, it's great they can say, "I don't know." That's at least not a defense like, "Oh no, it's not that!"

In this way, Clinician 4 gages clients' readiness to think about themselves and their experiences in new ways. Her theory of treatment includes the idea that the new relationship provides opportunities to experience new growth and change patterns of relating and behavior.

> I do believe we have an unconscious and I do believe making things conscious that are unconscious is helpful but that, by itself, won't do the job. I think having an object that can be used in a way that the person lacked and can be used to grow in a new relationship is an all-important piece of helping somebody change patterns. That's basically what I think we are doing. People have patterns that are no longer working for them or maybe never were working for them that are causing some agony, discomfort, pain and they are coming to you to change that. It's the things that are not working for them—these are what we are trying to figure out.

Of personal self-disclosure, she expresses caution about its use, not because she sees it as a bad technique necessarily but because it does not feel comfortable to her. Her training discouraged it and she believes it has more chance of negatively impacting the therapeutic relationship than strengthening it. She describes one case in which she disclosed that her daughter had a baby and she would be traveling to New York to see her. The client terminated soon after the disclosure.

> Clinician 4: My guess it that it was a really narcissistic injury that I had something else in my life but I couldn't process that with her; it wasn't like this was somebody that you could say, "How did you feel about me saying that." There was nowhere to go. She called me a year later and wanted to come in and the date she asked for was my vacation and I told her that. She said, "Oh, you're going to New York?" I told her no, not New York. When she did come in she would ask, "How is your grandchild?" So it was a mistake, it was definitely a mistake. I could have just said that everything was okay to her initial question.
>
> Researcher: Is it your sense that had she been able to tolerate it, it could have been a situation where talking about the injury could have deepened an understanding and a chance to work something through with her?
>
> Clinician 4: I tried to float it and talk about it and really couldn't get there. She could not look at that. But there are therapists that have no problem saying, "I'm going to visit my daughter." So, we're into self-disclosure. I don't know. That's a piece of me that has not been worked out.
>
> Researcher: Are you considering the idea that if you were more comfortable with it, she wouldn't have had such a big reaction?
>
> Clinician 4: Maybe. It's possible because I'm really not comfortable with self-disclosure. I'm really not sure when it is appropriate and when it's not. Therefore, I don't really like to traffic in it. I'm sort of envious of people that are very comfortable with it and it doesn't seem to be an issue. I don't know. I think it is sort of a slippery slope.

Clinician 4 works to deepen her understanding of how a client is using her. In the case below, it is as container and as provider of hope.

> I'm not really sure how depressed she is. I'm not sure how much it is that I've become the container to sit and cry and outside of here, she's got it all together and is not going around depressed. She is definitely upset about being all alone and pregnant and that she doesn't want the baby and how hard that is. But how could that not have been thought of before? I mean we are talking about a bright human being here that is just so cut off. So, I don't know what kind of self-reflection this person would ever be able to do. So I sit with her ambiguity and keep wondering if once she sees the baby, it's going to be okay and maybe at some level she knows that. I have no idea. So how do you deepen with someone like that, can you deepen someone like that? I think that's a good question. Or do you sit with them and you're used. I am used as a kind of positive voice in her life because I'm not sinking into the despair but feeling there is hope that she will get a job, that something will come through, that she will feel differently when she sees the baby and she nods almost as if saying, "Maybe I will."

Clinician 4 uses consultation when she feels she needs to try something different that her usual techniques with clients. She describes a treatment in which felt twice a week was indicated because the client was slow to talk and it often felt like they ran out of time. When Clinician 4 offered twice a week, the client "got nervous about that intruding upon her life." The idea of a double session came out of consultation and the client was willing to try that.

> It came out of my seminar. We were talking about Winnicott and giving people what they needed. The double session really made a difference. Until that time, there were a lot of missed sessions. Once we had the double session, cancellations would be at appropriate times and there was very little of that because I think I was answering what she needed. She said it takes me a little while to talk and to think and so it was good for her to have that time. That's just recently; I don't think I would have done that before.

Core Beliefs

Clinician 4 has several core beliefs about her role and her functioning. She believes in establishing collaborative processes with her clients.

> I think the relationship is not a hierarchy in which I know something and they don't. I think that there are a lot of people that come into therapy feeling that way. I remember somebody saying that they were in analysis and how they would feel totally on the spot and totally bad if the analyst gave them an interpretation that they hadn't thought of, like there was something wrong with them. I guess that stuck with me because that's not what you want. It's not like there is a right or a wrong. A lot of people feel very stymied when you ask how they feel. That's a really loaded question, that's a very scary question. What you're working at is for people to know that it's okay not to know how you feel. Ultimately your agenda, if you have an agenda, is that they can do for themselves what you are doing for them.

She also believes her role is to help clients with what they want help with and to limit the imposition of her own agenda on them.

> Researcher: What do you believe your role is vis-à-vis your clients' problems?

> Clinician 4: That a hard question because I think it is very hard not to have an agenda which you work real hard not to have—not to want to see movement, I mean I think you do want movement, I think you do want something, that you're getting paid for doing something, I think that's true. But your role really is to keep trying to figure out where they want to go, what they are about, it's really not what you would like to see happen. That's hard and I think we all struggle with that, you know, not to have an agenda.

She operates from the belief the trust needed to get into highly vulnerable emotional aspects of relating, for example, dependency and early attachment issues, takes time, especially in once weekly treatments.

> I think it is hard for people to open up to all of those feelings like dependency. Unless you are doing an analysis where you are going to have somebody that is really going to be open about how they feel about you and the process, like expressing anger directly at you. I think in once a week therapy, you are working a long time before you get to that point where they can feel that comfortable looking at those feelings. I think maybe seven years minimum. I would say seven to ten years. I mean not that people don't come for shorter times but I think that the ones that I feel come to a logical termination and it felt right for them and worked for them were seven to ten years. It depends on the person, obviously. But I don't think there is a quick fix on that. I mean it takes a long time for someone to trust you and feel comfortable. You're talking about lifelong patterns to change. I think with more than once a week people do move more quickly, no question about it. I think frequency really helps. Nowadays, because of finances, people don't do twice a week as much.

Clinician 4 works to establish the space for depth and receives it as it comes. She believes psychotherapy can offer clients opportunity to grow their capacities for curiosity and self-reflection. This can allow deeper knowledge about how they operate emotionally, behaviorally, and in relationships, which can lead to new acceptance and new choices. She positions herself to hear and feel clients' points of view, to reflect what she hears back to them, and to limit imposition of her perspectives on them and their processes so that they can find and connect with themselves.

Clinician 5

Clinician 5 is in private practice. She works with older adolescents and adults in individual and couples treatment. She has been part of a psychodynamic consultation group for over twenty years. Clinician 5 moved to Chicago for graduate school and clinical social work is her second career. She was a teacher and principal in another state before becoming a therapist.

Depth Defined

For Clinician 5, deepening is a quality of relating. A deepened relationship to one's own self in psychotherapy is accomplished, in large part, by a therapeutic process in which the relationship between therapist and client is deepened through trust-building. Clinician 5 describes psychotherapy as an opportunity to have new relationship experiences and to know one's self in new ways. According to Clinician 5, these are aspects of depth that can be healing.

> I guess I feel there is an opportunity for a unique relationship in the room that provides a safe place for trust to develop with somebody to understand and join them in a way they've never really experienced before, or if they have maybe not in the concentrated way that it can happen in therapy. Probably the deepening of the relationship with me comes to mind first when you ask about what depth in treatment means. I'm not really sure you can help somebody deepen their relationship to themselves unless you also deepen a relationship with you because most people come in—I don't want to call it stuck because not everybody is in pain about it but—in a fairly familiar way of thinking about themselves. Some people might be stuck and it's painful. It is the therapist's curiosity, empathy, kindness, humor; et cetera that I think engages the person's curiosity and comfort about knowing themselves in a different way.

Given the variability of issues, character structures, histories, and life circumstances of clients and therapists, defining depth is specific to each case. Some

cases may have more room for new understanding and experience than others but all cases include a therapeutic relationship that has potential to deepen and to help.

> It depends on what clients' needs are and how they are coming in, how they are distributed, how undeveloped they are psychologically, how complex their circumstances are. I'm not alone in saying this to people, I'm sure. But I tell people, "You're not coming here because you know what to do. You wouldn't be here if you knew what to do. We will figure that out together." Obviously, some people are more able to engage in whatever it is we're calling depth. You may have to make a different definition for each person.

Clinician 5 considers herself to be an instrument, not a director, for a deep process. When discussing her role in treatments, she places emphasis on her availability and specifically, her capacity to be available from the heart.

> It's not me, it's the client. I mean I can not do this for anybody. I can make myself available but big fucking deal. She [client] has used me, she has made choices, and she has allowed herself to be vulnerable. I join her in that but I'm responding to her. I am an instrument of the other person; my way of being in the room is in response to the person. It's cool that she met me as opposed to some other therapist who may not have been willing or open or understands her or has as much love to give, but for someone like that I feel like she did the work.

Here, Clinician 5 is discussing her longest client relationship of twenty-two years. When the relationship began, the client was highly disorganized, severely bulimic, and probably struggling with a psychotic depression. The client came to Clinician 5 less than a year after her mother's death and her mother had been very disturbed. The case was referred to Clinician 5 based on her experience with eating disorders. However, while there was focus on the bulimia with behavioral interventions, the treatment has been primarily around the use of the relationship to help the client become more cohesive.

> Our relationship, I would say, in many ways is probably the deepest client relationship I have. She was very accomplished when I met her but I could not understand her; the stories in her life were so complicated, I could not keep anything straight. I could not follow her and I have a very good associative memory so that's why I call her psychotic; she was just so disorganized. I met her when she was in her twenties and now she is in her forties. We've gone through

> some things; she's been with me through three babies. When I had my third baby, she was so mad at me and so hurt, she tried to leave treatment. She got us into a lot of trouble because she went all around and talked to different doctors and told them what a horrible therapist I was. She scared the heck out of me but we got it worked out. That was fifteen years ago. It ended up deepening our relationship. Now she is this person who is so insightful and very capable of managing her issues. She's still bulimic but it's down to a couple times a week. When we started, she was throwing up five times a day. She's in a long term relationship. She's able to keep friends. When I think back on the time [when she was acting out her reaction to Clinician 5's pregnancy], I think the answer to your question about trust is that I always stayed with her. Also, I know this is weird, but I trusted her. As sick as she was when I met her, she has made her life better, she perseveres. I can't stand it when people don't try. She always tries, even when she was at her sickest. One way that I tolerated the acting out is my amazing consultation group. But honestly, the real answer is because I love her, I just love her. I don't know why you love somebody, you just do. She recently moved to another state so our relationship is in a funny place because she is trying to figure out what to do with me. I am so proud of her [tears up.] She feels like my kid. It's not going to be a classic termination because even if I end up only hearing from her on a periodic basis, she'll always be present to me in some way. I mean one of us will die in our relationship, that's how long it's going to be.

Clinician 5 reflects on being available to establish relationships from a place of respect and mutuality. For Clinician 5, such relationships have the power to heal.

> I talk to my clients not much differently that I am talking to you except that there is a different agreement about what we are doing. I'm very available and it's very easy to read my face. I take clients seriously; I have a lot of respect for my clients as people.

Relationship

Clinician 5's thinking about depth and healing is organized around relationship. Relationship is both technique and product of successful psychotherapy. Her value in the power of the relationship outweighs other techniques such as interpretation or behavioral interventions. While those techniques may be part of her therapeutic activity, they are just pieces of a larger, unseen whole.

> I'm very real. The theories that make the most sense to me in the practical realm are the relational theories. At this point, this far into my practice, I trust myself a lot to be doing therapy even though we might be talking about something that doesn't sound like therapy, including talking about myself. I feel like, especially in those deeper, longer therapies, the relationship in itself is healing. The opportunity to be in relation to me as a unique person in their life is way more healing than any one thing or another that I can say. We used to be so focused on the interpretation, like there was some interpretation that was going to have all this meaning and just click for the person. Certainly, that can be helpful to alleviate initial confusion some people have, to structure and organize or put words to what they are trying to figure out. It's often helpful to have a different light shown on things. I really don't know how healing that is though. What feels healing is feeling understood more than the understanding itself. You can act on certain understandings; like if I say to somebody with bulimia, "Can you delay throwing up?" That's pretty boring but they might be able to use it. I think they bother to try it because they trust me or they believe I have a good idea based on their perception of the relationship. I think it's a feeling in the room. I think it's my smile when you walk in the door, it's my laughing with you, and it's my concern.

On the subject of trusting herself, Clinician 5 relates to the idea of relaxing into therapeutic relationships rather than getting caught up in making something happen.

> I think that I'm not in a hurry and I'm not worried about every single word and every session. When you are a young therapist and you are writing those freaking process reports, every sentence feels like it's something. It's different now. Maybe it's that I trust that relationship-building is happening and that is what counts most. I sometimes wonder if someone was looking in, we probably just look like we are two people who like each other having a conversation. I'm pretty interactive. I think I'm saying I don't add all this anxiety about things anymore. I mean there are times when I definitely need to get some support and consultation about what's going on but more often than not, a relationship is going on. So, I'm not in a hurry. The relational context, being able to experience me as a new and different opportunity for being in relation with someone means I share who I am. I don't really think, in the end, they know much personal stuff about me but they feel like they do because they know my personality.

Resolutions and Integrations

Her warmth and her directness are two aspects of herself that Clinician 5 offers to her clients. She makes circular connections between her style, her caseload and trust.

People who stay with her will probably work well with her. People whom come to trust her and proceed to live a deep process with her are probably people whom she can trust to try, to work, and to be open to developing a relationship with her. Clinician 5 is committed to talking to her clients, even when she has hard things to say.

> I'm a very warm person. I think that's been very important for the therapy that I have done or the type of clients that stay with me. I'm willing and able to love a lot of people and I also think that's important to a lot of people. I count on the relationship with my client. I always say at the beginning of a treatment—it's just one of my things; I tell them that I hope they will find some way to let me know if they've been struggling with something that I said or did or made them feel in the course of the last couple of sessions, even if they can only give me a hint because I don't expect myself to be perfect and it really is part of the treatment for me to make mistakes. So, I don't know that I bring that up out of the blue anymore after the first time that I say it but I do think I invite that. And, you know, just like every other therapist who has been doing this awhile, I pussyfoot my way into saying what I need to say based on how I understand the client. And I wait for the right moment if I can.

Clinician 5 feels she has been able to integrate her authentic self into her therapeutic style. In fact, Clinician 5 does not feel there is much difference between her therapeutic style and her personal identity. This sense of how she uses her self and what she offers her clients are in contrast to her experiences in her personal treatment.

> I wish, in retrospect, I had a therapist like me. I'm not saying I want me as a therapist but I grew up in a time where relational therapy had not really been thought about. My first therapist—my first real therapist, the one I stayed with a long time, was when I was twenty. He was a resident in a psychiatry program. He took an interest in me but it was pretty much traditional therapy—he didn't self-disclose, didn't chat, didn't engage in much besides clarification of something I was saying or trying to put it into context of some interpretation of some line of thought he was developing about me. And then here [in Chicago] I saw a woman who was older and did a lot of work with kids. She was also more traditional but she helped me understand myself in a way that I really needed to understand myself and I stayed with her for a long time. But I haven't had a therapist who was as personable as I am in therapy. So I feel like my own therapies haven't affected my therapeutic style very much. Maybe when I was a beginning therapist and was real close to my therapist here.

Clinician 5 speaks about having resolved questions regarding what kinds of work she does and does not want, and where she is willing to expend her energy. She is almost un-ambivalent about her desire to set things up to do the kind of work she is good at and enjoys. They are the same. These are the measures she uses rather than a more distant ideal about what a therapist is supposed to be.

> On the topic of what I don't do anymore that I used to do—if somebody doesn't show up and somebody does a lot of acting out around not coming, I address it for a little while and then I say, "Uh-uh, I'm not doing this." I mean most of the time—I hate to make a huge rule because I told you about that person who is a liar and misses sessions and I stay with her. It depends. But if it is a lot of that and you feel far away from ever understanding any of it, I don't keep them, I don't want them and I refer them to clinic settings or someone young who is establishing a practice. [Those ideas about what we're supposed to be or do as therapists], I don't care, I really don't care anymore. I'm full enough in my practice most of the time so I'm not scared that way. Probably, if they are not connecting to me, it's going to be really, really hard work to connect to them and, um, I just don't care. I don't mean that in an icky way like in the past where it felt like a failing, a short-coming of mine that I had to overcome; maybe it was in part, I didn't know as much as I do know but I don't really care.

While she is willing to choose her clients, she finds that she rarely needs to not choose someone referred to her. Her referral sources are her clients and a group of therapists that know her very well.

> When I was younger, it didn't make sense to me how your clients would refer to you. For one thing, obviously, most of my clients were still with me and the ones that left were not necessarily leaving in great shape or were leaving unsatisfied. Now, a lot of my clients have either finished their treatment or might be seeing me periodically but referring a friend of a friend or certain types of friends. I don't usually see close friends because it gets hard to hear the story twice from different points of view. I have just been around a long time and so now they haven't seen me in a few years or they are settled in the relationship with me that to send me somebody isn't going to affect much. I just think the longer you are in practice, you don't get the chaotic, wacky cases the way you do when you are a young therapist. I think when you are young, you tell people you will take anything because you need to fill your practice. Eventually, I think we attract to us the people that are meant to be with us.

None of this means she does not work with disturbed people; it is not level of pathology that determines her caseload, rather, it is willingness to be involved with her in a way that includes some limits.

> Researcher: In thinking about one of the things I might say about you, it would be that you offer everything you can while at the same time communicating that there are always limits. It feels like there is a real joining of those things in how you think about them.
>
> Clinician 5: That's true and I think the limits—what's nice as you get older is you can communicate the limits as integrated into, and this is probably also about being a mom, but you can communicate the limits as integrated into everything else you are saying. When you're young, you feel like you have to say, "I only take phone calls that last five minutes." Well, now it just is. My phone calls last five minutes.

Clinician 5 has also resolved the question of insurance panels based on her abilities and her preferences about using her time. About five years ago, she withdrew from all insurance panels except one as she got fed up with having to ask for sessions and making mistakes with those administrative requirements. She decided she was not good at it, did not need to be on the panels, and would be happier dispensing with them. One area of intersection between personal and therapeutic style in which Clinician 5 has some discomfort is in the discussion of establishing fees with new clients. While she is resolved around sliding her fee in order to work with a variety of people, she feels more hesitant than she wants to be.

> The people I assess as able to pay my full fee pay me my full fee. I have a lot of people who don't pay me my full fee and that probably fits in there with the relationship issues. I just figure that I'm not hungry. I'm fine. And I went into social work. I want to see regular people; I don't just want all wealthy people. So, if I want to see young adults, I have to be willing to take $60 sometimes. That's what I used to get from some panels; I'd rather work directly with my client. Actually, I find that conversation to be one of the most uncomfortable conversations at the beginning of a treatment when I don't know someone's actual situation. If I'm sure when you walk in that you can pay my fee, then I just tell you my fee. But when I am not sure, I probably err too much on the side of letting

> it be less. I've been trying to deal with that but I'm not particularly motivated by money. I would like to be able to say, "This is my fee and this is what I'm willing to do." What works better for me is to say, "What do you feel like you can do?"

Clinician 5 reflects on her growth related to resolving and integrating who she is, the work she wants to do, and how best to establish a caseload in which she can do such work. She strives to create and participate in solid, working relationships with her clients that include mutual respect and trust. These are the elements that Clinician 5 believes bring depth into the room which can translate into depth in clients' processes.

Core Techniques

Core techniques of Clinician 5 designed to deepen the treatment are in sync with her core techniques for treatment in general. She accepts clients based on the likelihood that she can develop a working relationship with them. A working relationship is loosely defined as one in which clients can use her, can show up and try, and can accept the inherent limits of therapy. They are also relationships in which she feels she can be herself and not need to bend herself into someone else. She strives to contribute emotional availability, respect and trust to relationships with her clients. She works with intentionality to speak directly to her clients, to honestly share what she is thinking with them.

> I'm a very direct person on both the positive and worrisome side. Oh, that's an interesting word I picked. I think sometimes by worrisome I meant things that we sometimes have a hard time saying because we fear the delicacy of the topic. You know if you're dealing with somebody fragile, you can't always—I mean I'm direct but you have to be a different kind of direct with a fragile person. What I'm trying to say is I don't avoid saying things that feel hard to say. With my longest client relationship, I often call her on her stuff. She's a good talker and she does dance around. She often can't own things exactly and I let it be, sometime I voice it for her and don't expect her to say an "I" statement about it. But there are times when I just lay it out. When she was causing all that chaos about her treatment

> with me, there was a psychiatrist she consulted that got what was going on and was able to talk with me about it so it clicked better for me. At that point, I said, "You need to get your ass back in here so we can figure this out." And she did.

Clinician 5 analyzes the dynamics in the relationship based on transference and countertransference enactments so that she and her clients can understand what is old, what needs healing, and what may be new experience.

> I have a client who is so perceptive of any shift in my state. That makes things tough sometimes. Thank god she is lovable and I do love her, because it was hard. What the treatment has been about with her for years is that she goes after people in a way where she ends up completely losing them. When she gets hurt or when she gets offended, and she can read everything and is from a family where nobody attunes to anybody, she goes after it in a way that alienates people even more. She certainly has done that with me a few times and it can get so confusing. I think I made a mistake once by getting distracted when I was on the phone with her. And she came after me and then that engages my defensiveness and I am fighting back. Then she feels distant from me and there we are, right in the middle of it. So that's what we talk about.

Having established relationships marked by mutual respect and trust, she is able to rely on them to sustain her therapeutic functioning. In other words, she trusts her agreements with clients. She also counts on her long-term consultation group to help her understand the relationship dynamics with clients and to get support in general and in particular, when she is stuck. One example of such a case follows.

> The last client that I presented in my consultation group is somebody where I've been finding myself having a really hard time saying things to her that I normally don't have any trouble saying. It wasn't a very complex countertransference. I think what got really clear in consultation is that I was protecting her. She is so easily humiliated and then she starts lying to protect herself and she came to me to help her with her lying. So I would get flummoxed in the moments when I needed to be able to question whether she was lying, because I couldn't always tell, without humiliating her. Anyway, it remains a challenge in the treatment although my group helped me find ways to start talking about that with her.

Finally, Clinician 5 reports that she does not spend much time worrying over the

quality of depth in her therapeutic relationships. Rather, she trusts that relating is relating and it is in the service of trust-building and therapeutic work.

> I don't worry too much about each interaction or whether it's deep. I've been going back and forth to California to take care of my father and I've had to tell my clients because I've been gone more than I normally am. So, you know, as expected some of my clients want to know more, they are kind people and they just care, and some don't ever bring it up. Sometimes it leads to a conversation about the weather in California. It's just a way of being close to sometimes talk about light things, like where you got those cool jeans or something. It depends on the person.

Clinician 5 considers relationships that include affective bonds and therefore, allow for deepening as the primary path to clients' deeper connections to themselves. Of course, as in therapy, therapeutic technique, and the nature of human existence, there are no absolute rules or guidelines. Clinician 5 shared a case in which the therapeutic relationship has not grown in the direction of closeness, mutuality, and depth. In contrast, it is a case, her hardest, that seems to have gone the opposite way.

> This is a case that my best friend referred to me when she moved. I used to like her more. That's what worries me. I bought into that she was working on herself in a way that she doesn't seem to be able to. I felt embarrassed about this but there was a period where I thought, "You are so narcissistic. I can't believe I thought that I was this magician therapist over my best friend." Then I tried to figure out what that was all about. I've talked with my friend about all of this including my delusions. I think that she might make people feel that way initially but nothing has helped. Nothing. She can't get herself to finish her resume. She's been planning to look for work for three years. I can't have a structured session with her around organizing her. I can't have that help anymore than the meaning thing. She can't stay on topic and she goes through her week and then digresses and tells me the same things over and over again. Now, I don't trust her to get better. I think that's why I don't have the same feeling about her. I do care about her, I feel really horrible. She does not feel close to me. She does not inspire warmth. I've always cared about her but I felt more interested in her halfway through the treatment and that was four years ago. I tried to get her to get psychological testing. I'm pretty sure that she has ADD. She'll make an appointment and then she won't go. She owes me so much money. And she points to that as evidence that there is hope. She'll say I must have hope that's she's going to do better in her life because I believe she will be able to pay me someday. She's more real in

> some ways but she looked better, she was doing better when she was her false self.

Again, Clinician 5 values and honors the existence of relationships, whether they feel good or not.

Core Beliefs

As noted, Clinician 5 believes in the power of the therapeutic relationship as a primary resource for psychic healing, depth in relating, and increased knowledge of self which is an outcome of depth-oriented treatment. Clinician 5 works to position herself to be available to care deeply for her clients. She reflects on how being "available from the heart" came to be.

> First of all, I've always been a self-observational person. One of the books that had a humongous impact on me is "Prisoners of Childhood" or "The Drama of the Gifted Child." I've always been a caretaker so that probably fits in there. But being a mom—I have loved being a mom. I'm starting to cry here because my kids are all growing up and leaving. Being a mom is probably the coolest thing ever in my whole life and that's probably a big part of it. that unconditional love. Many of us didn't feel that we received it ourselves. I had a quite a bit of therapy before I came to graduate school to be a therapist and then more after that. It was really important to me that my kids not have any of the doubts that I had about being loved or being valued. And then there is my consultation group. I was invited in right after my oldest was born. It's just been a safe place to grow up. It's been really important to how I am with my clients. I don't know what I would have done without them. We meet every single week; we have been meeting at the same time for twenty-two years.

Of mistakes, Clinician 5 believes they cannot be anticipated, rather, she believes they can provide valuable learning regarding clients' patterns and needs and in building new experience in the therapeutic relationship. She works to stay available to whatever understanding and working through may be possible.

> I can't predict what the person is going to consider a mistake so right there you have sort of the whole answer. This is not about a client; it's an interaction with

> my 14-year old daughter. She is writing a paper and I think the topic is too broad and I was trying to say that to her. She got very aggravated and of course, we've been here many times, it's all developmental. Finally I said to her, "I don't feel any more understood than you do." And she started laughing and it felt like, "Ah, break through." A relief because she felt so defensive that I was criticizing her and it didn't matter how many times I said I wasn't criticizing her, she still felt criticized. Now, if that were a therapeutic intervention, I guess we might call that a mistake because I said something to a client in a way that was not experienced empathically or may have been experienced as a rupture. But it is unavoidable, especially when you think of really brittle or defensive people; it's really hard not to do that. So do we call it a mistake or do we call it the treatment? So you stay with it and learn together.

Currently, most of her clients are in therapy at a frequency of once a week which is a change from her earlier years. She believes more frequency has the potential to create acceleration, closeness, and continuity in treatments.

> When I was first in practice, I saw almost everybody twice a week, it was standard. It made the work easier. I liked it. I would tell people we have one session to sort of tell me what went on in the week and one session to really dive in to stuff. That's a little bit simplistic but, in a way, that's why it works so well. I would also tell people this is not about being two times as crazy, it's more being able to work two times as fast and closer, something dumb like that. But it really helps you hold onto people, helps you to be conscious of someone, the experience of someone in here [head and heart].

She reflects on the reasons for the decrease in frequency of session in her caseload overall.

> Now, I have one person that I see twice a week. One. It's changed a lot. I think there are lots of reasons for that. I think it has nothing to do with us. I think it has a lot to do with changes in cognitive behavioral therapy, insurance, developments in psychology and psychopharmacology. A huge portion is economic. So now, it's once a week. And I have an amazing number of people, only in the last year, that I see every other week who are not in the end of their treatments. There are two groups. One group is people who can't afford and really want to come to treatment and this is all they can do. And how am I going to disrespect that? Then there is another group of people who are so fucking busy and so crazy in their work schedules, or two schedules with marital couples, that they can't get in every week and that's been very frustrating. My preference is at least once a week. I think it is much easier, even just with basic object constancy.

Clinician 5 summarizes theories that have resonated and been helpful to her. She finds ideas about the value of relationships most congruent with who she is in general and how she works specifically. She describes herself as integrating a number of ideas.

> Early in my career I found self-psychology helpful, more helpful that Freud or Jung, not that I don't incorporate some of that. I found some of the object relations people very helpful when I was getting started and I still have some of that as a foundation. Finding the Stone Center [in Boston] was really a big sigh of relief because I was already working that way and it was very comforting to see that I was kind of in a group of people. I think that was a real turning point for me. Just the significance of relationships, especially what they were writing about women and how we use them to feel better, and how we use the therapeutic relationship, how being genuine and truly available was so important. And mutuality, that is big for me. Also, I actually use a lot of cognitive behavioral stuff in an unstructured way because it helps with things like anxiety. I mean it's great to understand what it means but it doesn't make it go away if you're a person whose brain runs in the anxious mode. I've gotten more practical. People come in and they want to know what to do and that's okay. That's more okay with me than it used to be. People want to feel better and I get it. And it's easier to understand yourself when you feel a little better. I like the psycho-neuro-social-bio stuff. I struggle to understand it but it's very useful to me and my clients to understand something like an over-active omigdila; it helps people be more non-judgmental about themselves. Then, the other stuff that I've been using a lot more is mindfulness. Again, it's especially helpful with anxiety. It all goes together—mindfulness, cognitive behavioral techniques, understanding the brain more. I don't usually recommend medication. I started from a place where I thought there was always a way to avoid it but I completely disagree with myself now. I recommend it if I think it would be helpful.

Finally, Clinician 5 expresses what she values most in her work.

> I feel unbelievably honored to be allowed into peoples' lives the way that I am. I wish sometimes I was a writer because I feel like I have such profound material for writing stories. It's a really good fit for me. I'm fortunate to have found something that allows me to be myself all day long, everyday, and not have to go and put on a work persona. I really appreciate that because I can't stand being phony or playing a role. It makes me uncomfortable. I feel appreciated by the people I work with for the most part and that is nice. My life is integrated and yet, separation is important too. I think we have to be cautious. I feel grateful for all the relationships that I have with different kinds of people but I think there can be a danger if they become your whole relationship world; that can be worrisome. I haven't had that because I have been distracted by my family, being a mother especially. So since my kids are almost grown, we will see how that transition goes. I'm finding it hard to believe that I'm fifty-six years old and that my kids

> are or will soon be in college and raising children was like a blink. I'm kind of in awe of the passage of time.

Clinician 5 believes in the power of relationship over time, mutual trust, keeping her emotional self as available as possible, and the importance of talking with clients about what she thinks. These are the themes that come up consistently in her discussion of depth in therapy. She works to provide grounding in relationship to her in order for clients to do whatever problem-solving or exploratory work they choose.

CHAPTER VI

DISCUSSION

This study focused on participants' beliefs and techniques related to depth in psychotherapy. Each participant defined depth based on theories about the possibilities and limits of psychotherapy. They have divergent ideas and beliefs that are reflected in their practices. There are also general similarities amongst participants. Their contributions to depth-oriented work are considerable and integrate cognitive and emotional activities. The clinicians in this study feel that one does not need to choose between insight for structural change and support for emotional healing, between focus on intrapsychic and interpersonal aspects of life. They share the belief that the value of intellectual insight cannot be separated from the reliable, trustworthy, affective bond created in the therapeutic relationship (Stolorow, 1990; Saari, 1991). Participants' attitudes for deepening integrate an assumption of the presence of anxiety, the need for fearlessness regarding intimacy, the value of patient revelation, and limits on expectations. These are the common themes and ideas for a theory of deepening psychoanalytic therapy in clinical social work. There are also intriguing differences between participants and in relation to the literature review on deepening treatment. These are presented as divergences.

Cross-Case Findings

There are five major common themes resulting from the cross-case analysis of the interview data and the researcher's experience with the participants. These are presented as therapist contributions toward depth. Formal theoretical ideals are embedded in definitions and activities related to depth and are transformed into personal beliefs via therapists' individual treatments; development and use of self-awareness is a necessary tool for depth work; comfort with intimacy promotes an exploratory process; patient revelation is a primary goal of depth work; and the practice wisdom of psychoanalytic therapists integrates lived knowledge of limitations and self-acceptance. Each of these categories is discussed further and where applicable, specific strategies are identified.

Therapist Contributions toward Depth

Embedded Theory

Participants described depth work in variable ways based on formulations from psychoanalytic theory regarding goals of psychotherapy. For Clinician 1, the deepest work results in learning unconscious knowledge that is related to adaptation, often accomplished by disavowal, denial, and anxiety. In order to establish work at that level, the therapist needs to discuss what unconscious communication they may see and hear from the patient as the patient enters and adapts to the therapeutic setting. The therapist speaks about what the patient is doing with the therapist. Clinician 2 considers that the deepest work results in affective resolution, especially grieving, of painful, destructive, or profoundly unsatisfying attachment patterns and the development of new, healthier attachment bonds. In order to work at that level, the therapist may need to be doing or

have done their own attachment pattern mourning and re-working and be willing to engage in a process where the therapist's most vulnerable self is available, either nonverbally or verbally. This may include sharing with the patient one's own experiences of the attachment pattern with the patient. Clinician 3 holds that the deepest work listens for and assists in the development of increased capacity for patients' acknowledgment and use of agency in their lives. In order to work at that level, the therapist needs to accept, acknowledge, and value aspects of the patient, connect them to contexts of developmental experiences, and offer ideas about how the patient's agency is identifiable in the therapeutic relationship. For Clinician 4, depth is reflected in the creation and maintenance of space and time for the patient to locate that which may be described as their unacknowledged truths. In order to work at that level, the therapist listens carefully to her affective responses to the patient's narrative and offers ideas about what the patient may be searching for. She also conscientiously attends to the process and avoids interjecting her own "truths" in the ongoing creation of the aforementioned space. Finally, Clinician 5 conceives that the deepest work may be in the formation and holding of mutual, trustworthy, caring relationships that provide healing and companionship on the journey towards accepting life's joy and despair. In order to work at that level, the therapist need be comfortable with intimacy, talking in a straightforward way to patients, and being known emotionally.

Each clinician's preferred theories about what psychotherapy can offer create guides to what depth in treatment looks like and how to get there. The above formulations include theoretical aspects of classical analysis, object relations theories, attachment theory, self-psychology, relational theories, humanistic, and existential psychology. What

the therapist believes about what is possible, what is healing, and what revelation and learning by the patient is most beneficial for their lives is directly related to how the therapist conceives of his or her role and what activities he or she can consciously employ.

Participants can track their process of making formal theory part of their beliefs and values regarding depth to their own psychoanalytically-oriented treatments, consultants, and teachers. Clinician 3 internalized her analyst's belief in her and therefore, she offers belief to her patients for internalization. Clinician 1 learned from his therapist what he was communicating unconsciously and therefore, focused his learning on how to help his patients do the same. Clinician 2 used her therapist and the treatment space to mourn her early attachment loss and therefore, offers herself to her patients for similar opportunities to heal. Clinician 5 values and credits the learning she did about herself to her therapists, although she identifies her style as more open and accessible. She offers relationships to her patients in which they can learn about themselves in new ways. Clinician 4 learned from her therapist how transference can create ambiguity in the interpersonal field and how to use empathic attunement and to trust her affective resonances from her consultant.

Over their many years of practice, participants have integrated and personalized these beliefs. However, in many ways, they were initially formulated in participants' personal treatments. Theories become personal beliefs that are then integrated into the clinician's self and work in the process of using treatment and consultation to become a psychoanalytic therapist. In fact, for several participants, theory is integrated into their personal therapeutic styles to such an extent that render specific theoretical constructs

nearly invisible. Beliefs based on formal theory that will become useful as guides to depth work develop in the context of relationships with therapists, teachers, supervisors, and patients. Defining depth is an aspect of day-to-day work where one can integrate theoretical constructs in a practical way without losing sight of patient's self-determination and capacities.

While significantly different, participants' theories of treatment can also be generalized. They can be summarized as follows. Psychoanalytic therapy provides patients' opportunity for increased self-reflection and acknowledgment of what was, what is, and what never was or will be. Such reflection and acknowledgment in the presence and with the assistance of a relatively fearless partner in the person of the therapist can result in conscious and deliberate mourning, revelations, resolutions, and transformations which manifest in patients' psyches, relationships, and life conditions in countless yet limited ways.

Self-Awareness

Self-awareness is also developed in context of emotionally-based relationships. Several conclusions regarding self-awareness and deepening treatment can be made. First, personal treatment is crucial to the achievement of usable self-awareness in the role of the psychoanalytic therapist. Second, there are ordinary, everyday uses of self-awareness that are indispensable tools for contributing to deep clinical processes regardless of one's theoretical orientation. Third, self-awareness fuels self-analysis when treatments are at an impasse, mistakes are made, or treatments feel "off" in some way.

Personal Treatment

Many clinical writers have noted the importance of the therapist's own treatment that results in deepened knowledge about one's self in the presence of another and increased capacity for self-reflection and awareness (Borden, 2009; McWilliams, 2004; Tessman, 2003). Participants assert that their functioning regarding self-awareness is directly tied to their personal treatment processes and outcomes. Consistent across participants is the belief that one must experience treatment that provides guidance, support, and belief in the process of achieving honest self-investigation and acknowledgement in order to help another person to accomplish such work.

There is no substitute for this experience; one cannot help others get to depths that one has not traversed and survived themselves. Theodor Reik (1948) writes, "What emerges from the depths can only be caught with something originating in the depths" (p. 217). Several participants feel the benefits of their treatments cannot be overestimated. Three of five believe they have achieved their long-standing careers as psychoanalytic therapists because of their treatment experiences. The self-awareness they have developed in therapy has become, for participants, sources of measurement for assessing their work.

For the most part, these personal measures have superseded any formal theories that participants had previously held as ideals regarding what their role in practice should be. There is a circular formulation here. Theoretical beliefs and self-awareness are identified and developed in treatment. Conceptions of depth are highly connected to theoretical beliefs. Along the way in participants' careers, knowledge of self and self in intimate connection with another have become the manifestation of theoretical beliefs so

much so that self-awareness is the primary ideal. Reliable self-awareness is almost always knowable whereas theory is almost always more distant. The process of personal treatment makes therapist's formal theories intimate as manifested by everyday use of self-awareness.

Everyday Uses of Self-Awareness

Part of what cannot be known in advance is where patients need to and can go, and what it will require of therapists in terms of containment, action, verbalization, and acceptance. As a result, most therapists working to establish exploratory treatments feel anxiety or tension in their day-to-day work. Reik (1948) labels this a necessary state of suspense that allows being open to thinking and feeling, especially unanticipated, undigested, new, and non-logical things. He discusses a process of searching and using one's self-awareness for readiness to hear the unknown. Reik asserts the value of response from within the therapist's self,

> The response of the analyst is the emotional answer to the communications of the patient. It is that which takes place in the analyst's mind from the first vague impressions until he sees the unconscious processes of the other person with full clarity. ("The other person" is, of course, oneself in the case of self-observation and self-analysis.) Response at the moment in which we reach the deepest insights into the unconscious has the nature of surprise. Such surprise-response will, of course, never emerge when the analyst approaches unconscious material theoretically (p. 270).

The study's second conclusion about self-awareness is seen in participants' articulation of the ways they have learned to stay available to their patients and use their self-awareness as contributions to treatment processes that are as intimate and deep as possible. During sessions, these therapists work to pay attention to patients' narratives while at the same time listen to their own emotional and intellectual responses. They

listen to two dialogues at once. Self-awareness is always in play, often in the form of reminders to the self based on experience in one's own treatment and ideals about depth. Such reminders might sound like the following.

- She is talking about her boss; what might apply here and how might I say that?
- Remember, your job is not to fix this but to help sort it out and explore it.
- I feel completely inept and stupid; remember, this is how my patient might have felt with his sadistic brother.
- This reminds me of when I was terrified to tell my therapist about X and he gave me space to consider taking the risk.
- Don't let your experience of having a family member with cancer become an assumption about her experience.
- Remember, your presence in the process of feeling this pain is valuable.

Internal dialogues of the therapist are a specific strategy for use of self-awareness in the service of deciding what to say, what not to say, when to stay silent, when to offer reflective comments or new ideas, and many other decisions made by the therapist with an eye toward his or her definition of depth. The therapist's uses of self-awareness are considered crucial to the possibility of any depth in psychoanalytic therapy.

Another everyday use of self-awareness for participants is the knowledge of what they do not do in their roles to contribute to depth. Clinician 1 discusses this knowledge as a part of frame maintenance. Establishing and maintaining one's preferred therapeutic frame is done, in large part, through self-awareness of one's comfort level and capacities. Clinician 4 is not comfortable with personal self-disclosure and so it is not part of what she does. Clinician 3 knows that she does not end treatments and so potentially, patients do not feel pressure to get to depth faster. Clinician 1 does not believe that trust needed for depth work exists at the beginning of a treatment and so he does not move forward as if it does. Therapists often need time to reflect on what is best in a given clinical moment and still, the patient needs the therapist to respond. Trust is at issue; revelation is at issue;

avoiding new shame may be at issue, and on. Participants' use of knowledge of what they do not do allows them to quickly dispense with certain possibilities of response in their search, in a given moment, for what fits with who they are and their patient's need. Frame is often maintained by this use of self-awareness.

Self-Analysis

Self-awareness allows for self-analysis which is an important aspect of the therapist's functioning when the inevitable happens; treatments come to an impasse and the therapist needs to find and bring some understanding to bear. Here, self-analysis includes inquiry designed to highlight, for example, whether one is colluding with resistance to pain or intimacy, whether one made a mistake of containment or lack of attunement, whether one's agenda is in the way of the patient's work, or whether one needs further assistance in the form of another mind (colleague, supervisor, or therapist) to sort things out. Self-analysis is the therapist's use of knowledge of her affective patterns, vulnerabilities, defensive strategies, and preferred relational configurations to recognize when for example, to set or re-establish a boundary, take responsibility for a misstep, share one's dialogue with a patient, identify an enactment, or check something out with a patient. More generally, self-analysis is an inward search to access and identify some piece of one's countertransference and then decide how to make use of what comes into awareness. It is the process whereby countertransference is made usable (Heimann, 1950).

Clinician 2 feels impatient with a client because he won't let her in. She employs self-analysis to look inward and to access her loneliness and feelings of rejection in her

very early childhood years. She can then return to her patient with these feelings in awareness so that she can continue to be open to the patient. Clinician 1 feels terrible as the patient leaves his office and is not sure why. He sits down and searches himself, tracking his emotional flow during the session and finds a moment when the patient referenced her mother; the description reminded him of something painful about his relationship to his mother. He realizes because he was preoccupied with his own memory of pain, he missed an opportunity to inquire with the patient about whether there was something similar and possibly painful going on with him. He assures himself there will be another opportunity to inquire about this as long as he listens for it. These are examples of the use of self-awareness to accomplish retrospective self-analysis to address a glitch in a treatment. The capacity to employ self-analysis is a result of the internalization of an important function of one's therapist; inquiry into thoughts, feelings, and actions from a stance of curiosity and acceptance. Lora Tessman (2003) studied psychoanalysts' experience of internalization of their own analysts' functionality. She writes,

> Many Participants spontaneously alluded to self-analytic modes as keeping them steady company in one way or another. It was particularly emphasized as steadying and useful when engaging with a patient, a simultaneous track of affectively colored association about what the patient communicated and one's own response. Regardless of their theoretical orientation, most Participants assumed that such "uses of the self" for a simultaneous perspective on the patients' and their own reactions were an integral feature of their analytic work. For some, self-analysis had become an automatic channel of experience, without the necessity of conjuring it up. Others spoke of access to it when intentionally invoked (p. 263-64).

Self-awareness is an indispensable function in one's role and presence as a psychoanalytic therapist in day-to-day, moment-to-moment work and for use in

retrospective self-analysis that is often necessary to stabilize a treatment. Such usable self-awareness develops in personal treatment, consultation and experience with patients.

Comfort with Emotional Intimacy

Participants' comfort with emotional intimacy—openness to receive the fullest expression of another's subjectivity—is considered a critical contribution to creating exploratory processes with patients. It allows therapists to be present, to be patient, and to listen, not for solutions or ways patients must change, but to come to know their patients. Clinician 5 asserts that an important avenue toward and outcome of patients' deepened relationship with themselves is a deepened relationship with the therapist. Clinician 2 describes herself as unafraid of her patients' expressions of dependency. Clinician 1 considers comfort with emotional intimacy a quality of a trustworthy environment. He notes that therapists who are comfortable with emotional intimacy learned it in their personal treatments from therapists who were not threatened by such intimacy. Learning that anxiety associated with intimacy is survivable allows for gratification of the human need to be affectively known by others as part of knowing one's self (Schore, 1994).

Patients read their therapists. If therapists' convey desire to know their patients, patients come to be at ease with exploring thoughts and feelings in the presence of and in relation to therapists. Paradoxically, intentionality to come to know another person without requiring change is part of what allows people to identify ways in which they might want to be different. Emotional intimacy includes acceptance and acceptance encourages further exploration.

Patient Revelation

Revelation is the avenue by which self-awareness is achieved. A primary goal and indication of depth work, in whatever ways it is defined, is patient revelation. Therapists' activities are designed to create environments and relationships in which patients can trust and act on whatever level they may need to or wish to reveal themselves. Participants describe a range of activities aimed at freedom and safety for patient revelations; intrapsychic, interpersonal, dissociated or disavowed, needs, and reactions to needs, in fact, anything that is human.

Listening, Receptive Relationships and Intense Affect

First, therapists work to establish relationships with patients that are characterized by nonjudgmental listening, receptivity, trustworthy responsiveness, and fearlessness regarding intense affect. Participants convey intentionality to engage with patients in ways that are thoughtful about their patients. Clinician 1 conveys that he holds what is happening between him and his patients as important and can be discussed. Clinician 4 wonders aloud about what feelings might be just out of reach for patients. Clinician 2 conveys acceptance of vulnerability. Clinician 5 asks patients how things are going in relation to her. All participants put emphasis on consistency of responsiveness within their definitions of depth. Such consistency leads to trust. All participants position themselves in order to get to know their patients as deeply as possible. Often, this means receptive listening. Listening allows the therapist to learn about patients but also allows patients to hear from themselves in new ways. Listening harvests revelation.

Relationships marked by therapists' relative fearlessness of intense affect are part of creating safety for patient revelations. Fear of pain is often an obstacle to revelation. Therapists ought to be less afraid of psychic pain than their patients whenever possible. Patients may need to reveal and work through the ordinary pain of growing up, suicidalility, traumatic experiences, profound disappointments and losses, fear of death, and all range of intense life experiences and reactions, past and present. In addition to free-floating attention, the therapist should have a free-floating emotional sensibility (Heimann, 1950) that is available for patient use, either verbally or nonverbally. Clinician 2 wrote an article on attachment and relational treatment. She discusses a patient and notes, "It would be a long time before Mr. B. would utilize me as a secure base from which to explore his inner world." She also writes,

> It was not until I ventured into the darkest parts of my own inner world that I saw the wall that, I too, had put up to protect myself from Mr. B.'s rejection. Realizing this made me less afraid to go with him to his darkest places. It was only then that I could leave the safety zone of focusing on his resistance and help him identify the relationship dynamic between us. In return, Mr. B. began to lower his wall, and the nature of the relationship between us changed dramatically…he began to express more affect. Much of it was hopelessness, emptiness, and dread, so each step of the way I had to struggle with his pain, jarred by its echoes in my own world of childhood loneliness. (Quoted by permission of the author)

Defenses designed to protect the self from intense affect resulting from conflict (shame, guilt), developmental derailments (anxiety, rage), or trauma (uncontainable terror), can make revelation feel dangerous and impossible (Coen, 2002). Treatment is often the first opportunity for patients to get the necessary help to develop abilities to tolerate and work through intrapsychic and interpersonal experiences of intense affect rather than coping through habitual projection, disavowal, denial, and dissociation. The therapist's ability to receive and contain intense affect, not always needing to discharge it

through interpretation, is considered an integral part of patient's ability to reveal and work through such affect (Winnicott, 1958; Bion, 1959, 1962). All participants' spoke about "sitting with" intense affect as part of responding to patients' needs to integrate affect and experience. They also express great respect for patients' needs to titrate the expression of such affect while at the same time hold it as a goal and work to be in position to receive such revelations. Clinician 5 is unafraid of loving her patients. Clinician 3 shares her dilemma with patients when she feels torn by her role in exploring something with the patient and the patient's need to defend against intense affect. Clinician 4 tests patient's readiness to reveal and connect to something highly charged by offering her emotional association.

Talking to Patients

A second set of strategies that participants employ to contribute to the process of patient revelation is to talk to their patients about what they think is being revealed. These verbalizations are offered as ideas for consideration and come out of therapists' intellectual and affective functioning in the process of listening and observing. Given the "live wire" (Clinician 1) feel of anxieties to reveal, implied in talking to patients is the ability to feel afraid, vulnerable, or unsure and to say something anyway (Bollas, 1983). It also implies the ability to tolerate rejection, anger, and love.

Talking to patients reveals at least something about the therapist (Aron, 1991). What is revealed, verbally or nonverbally, may be the therapist's world view, emotional state, neurotic trait, subjective reaction to the patient, wishes, and so on. Participants believe it is sometimes important to acknowledge that something of them is being

revealed for patient use or consideration. Clinician 4 asks if she understood something or not, revealing her human limitations of perception and her willingness to learn from the patient. Clinician 1 reveals his understanding of a misstep by re-aligning the frame, implicitly revealing not only the misstep but also his belief that frame maintenance is his responsibility. Clinician 3 reveals how she feels about a patient's dilemma, experience or decision. Clinician 2 reveals her subjective experience of being with a patient in order for the patient to learn something new about his relationship patterns.

Talking to patients about what one thinks or feels encourages revelation by elaboration, clarification, or discovery. It has the power to increase what is sharable, with another and with one's self, for patients. Increasing what is sharable impacts capacities for self-awareness, self-reflection, and self-acceptance (Stern, 1985). It may also result in more choices for the patient to change what is ineffective, destructive, or painful.

Containing Ambitions

A third strategy used to encourage patient revelation is for therapists to work to contain any conscious ambitions and agendas for patients. This relates directly to offering freedom to the patient to choose what and when to reveal aspects of self and experience. While the treatment situation exerts some inherent pressure on the patient as the primary focus of investigation, participants assert the importance of taking time to understand and integrate respect for patients' capacities, needs, and paces. Participants show respect for patients' self-determination in a number of ways. Clinician 1 asks patients what they think they need regarding frequency of sessions. Clinician 5 conveys her understanding to patients that they do not yet know the solutions that they will find together. Clinician 4

works to de-mystify the process and makes it clear that she does not have ready-made answers.

Safety and trust to reveal happen in their own time for each patient. Participants' years of experience have given them trust in the process of relationship development and treatment. For these therapists, such relationships take time, especially at a frequency of once per week. They are not in a hurry to get to depth's revelations. Rather, they focus on what they know about trust to reveal and how they believe it develops. It cannot be instructed, forced, manipulated, or rushed. Trust to reveal comes, in large part, out of the therapist's consistent, receptive, and patient-focused stance.

Practice Wisdom, Self-Acceptance, and Limitations

Psychoanalytic therapy and the therapist's contributions to depth exist in a context of limitations. Some cases reach therapist's definitions of depth while many do not. Resolutions regarding what cannot be changed and what is out of one's control are part of what the seasoned psychoanalytic therapist brings to any treatment. There is no substitute for the time it takes each therapist to live into this wisdom. A therapist who has lived into this wisdom which integrates limits allows them to offer exploration rather than instruction to their patients more consistently and to stay emotionally available. Participants' many years of experience have allowed them, for the most part, to temper grandiose ambitions and omnipotent fantasies for their work so that they do not need their patient to protect them from disappointment or prop them up. They have lived experience of working through such ambitions and learning their own and therapy's limits without descending into despair so that they can appreciate and celebrate each patient's process

and small changes as good enough. In Clinician 1's words, "We are only ever a little bit successful."

Self-acceptance plays an important role in knowing one's limits. Participants are serious about their work and take themselves just seriously enough to stay available to be important to their patients. They do not need to take themselves so seriously that they imagine they can be the right fit for every patient or that they will not make mistakes. They have a sense of humor about themselves and can acknowledge their failings and their quirks while retaining hopefulness and readiness to work. Erik Erikson's stages of psychosocial development entitled "generativity versus stagnation" and "integrity versus despair" apply to discussion of participants' resolution of limitations (Newman, 1991). Participants are in process of navigating these phases with outcomes of generativity (caring for others) and integrity (self-acceptance through introspection).

All participants acknowledge that depth work can be made more accessible in an organic way with greater frequency of sessions. It may be that depth in once-weekly treatment requires greater conscious contribution from the therapist. Participants show up and do the work required of them to get to whatever level of depth is possible. They have come to terms with the differences between ideals and reality in a way that values what is possible. Clinician 4 accepts that ambiguity is always part of the process. Clinician 1 does not expect trust to come easily and then only in small increments. Clinician 3 reminds herself that sometimes people are limited by powerful brain chemistry that will not change. Clinician 5 presents herself as extremely available within limits. The ability to accept and integrate limitations while enthusiastically believing in what can be done is an important aspect of what patients need from psychoanalytic therapists.

Self-acceptance can also be part of establishing and maintaining the kinds of work one is best at and wants to do. Doing so increases the likelihood that one's practice will be gratifying enough and sustainable. Self-acceptance provides valuable information about professional strengths, limitations, and preferences. Acting from such knowledge and acceptance creates practice that has sustainability, authenticity, and gratification. Participants use their self-acceptance to make decisions about what kinds of work they do best, and what kinds of work they do not want. Examples of such decisions are offering reduced fees, accepting cases or referring cases to a better-suited provider, where to have one's office, whether to work four or five days, and whether to opt out of insurance panels. Given the inherent and necessary not knowing and suspense that is part of depth-oriented therapy, it seems a good idea to make attempts to establish practice that one has some confidence with and enjoys. This does not mean it always feels good, just that trying to work in ways that conflict with core knowledge of oneself probably creates more chance of burn out, demoralization, and dissatisfaction with professional life. All of the participants expressed gratification with their work and their use of self-acceptance in this arena is connected to such satisfaction and readiness to offer their patients all that they can.

Resolutions about the limits of psychoanalytic therapy are also part of the patient's emotional work. Patients may need to learn and grieve limits; that they cannot have new parents or change past choices; that their therapist cannot protect them from pain or rescue them or have ready-made answers; and that they are good at some things and not so good at other things. In the process of revelation in a trustworthy relationship fueled, in large part, by the therapist's self-awareness and self-acceptance, patients have

the opportunities to learn and accept their strengths and limitations thereby developing capacities for self-reflection, awareness and acceptance.

Divergences

Theoretical Differences between Participants

Relationship

Participants differ in their conceptions of the roles of the therapeutic relationship. For Clinician 5 it is both means and end, concurrently. She considers a deepened relationship with her as healing in itself while it opens more access for the patient to learn about self in new ways and deepen self-understanding and acceptance. When in doubt, Clinician 5 reminds herself that there exists a relationship in the room that she can probably deepen. Clinician 4 sets up time and space for the patient to create a relationship with her as prototype from which old patterns of relating can be discovered and new attempts at different kinds of relating can occur. Her willingness to be moved emotionally and as object offers her and her patients a chance to gain access to and study their relationship forms. Clinician 3 views the therapeutic relationship and her contributions to it as the raw material for patients to internalize the therapeutic capacities of empathy, curiosity, and acceptance which often leads to the patient's ability to see their contributions to their own life from a compassionate and understanding stance. Clinician 2 considers the therapeutic relationship to be a co-creation that consists of both participants' early attachment patterns as they exist in forms of repetition, resolution, working through, or as-yet unacknowledged. She believes that her receptive stance to patients' relationship needs, especially early, dependency needs allows patients to come

to terms with such needs, either through mourning or through developmental work now available via the therapeutic relationship. Clinician 1 views the therapeutic relationship as the means by which patients come to slowly trust the analyzing function that is his primary contribution to the relationship. The relationship, as manifested by the frame, highlights patients' habitual relationship-building. Such forms of relating are often based on what patients' imagine they must do in order to have relationships but also based on avoidance of the anxiety that comes with the opportunity to acknowledge what they have forsaken in order to stay in the arena of the familiar.

There are at least two uses of the therapeutic relationship that can be gleaned from participants' conceptions—relationship as new emotional experience and relationship as route to identify transference and countertransference dynamics. In the first use, the relationship between therapist and patient is seen as part of what is healing for the patient. In this view, the relationship with a therapist who is caring, accepting, and listening non-judgmentally offers many patients new relationship experiences, the absence of which have caused great pain and distortion in how patients see themselves. For Clinician 5, such new experience allows the patient to know what it is to receive unconditional love. Clinician 3 conceives this aspect of relationship as the way she offers her belief in her patients to her patients. For Clinician 2, relationship is available for the patient to practice new forms of attachment. This stance sees value in facilitating an authentic relationship between therapist and patient as part of what is therapeutic. The therapist makes herself available in a sort of holistic way which might include personal disclosure. In listening to descriptions of this use of relationship that provides emotional supplies to the patient, the researcher began to hear it as the kind of relationship that exists around and between

transference relationship work and that is hoped for as transference perspectives get worked through. These participants relate to the patient as not-transference objects as they listen for the relationship created by transference and countertransference. Their side of a straightforward, caring relationship in which their patient is not created by their countertransference has always been and it is hoped that the patient can feel and find the way to the real. The new relationship between patient and therapist is seen as process and outcome and exists from the beginning for these therapists.

The second use of the relationship is less a therapeutic provision and more a tool for facilitating a primary relationship between the patient and himself. In this use of the relationship, the therapist is prepared to receive un-acknowledged aspects of the patient and the patient's experience. The relationship is seen as a vehicle by which the aspect of the therapist's self most present is their self-defined therapeutic functioning. There is more focus on the fantasy, transference relationship created by the patient with the therapist. For Clinician 1, it is focus on listening for and interpreting here-and-now transference in order to learn about the patient's past and present relating. For Clinician 4, therapeutic functioning in the relationship is to listen for and encourage the patient's freedom of affective expression. For Clinician 2, her functioning in this version of relationship is to offer patients ideas about their early emotional experiences as she feels them via projective processes. Clinician 3 sees her therapeutic function in this use of the relationship as her ability to observe how the past is present. In this view of the relationship, there is little value in the therapist disclosing anything besides what is revealed in their therapeutic functioning. The point is to gain access to the patient's creation of the relationship based on transference.

Working with Unconscious Process

While all participants made some direct and implied references to accessing unconscious process over time, often as a result of established trust and safety, Clinicians 1 and 2 were clearest regarding conceptions of unconscious process and their technical activities designed to access it. For Clinician 1, unconscious communication is contained in how the patient relates to him and the treatment setting or frame. They are a new environment for the patient to adapt to in automatic, habitual ways that are probably not consciously known to the patient and certainly not yet verbalized. Clinician 1 relies on his techniques to maintain the frame, listen for adaptive, unconscious communication, interpret how the patient is relating to him when he can, and to privately analyze and limit his resistance to maintaining the frame. He also connects to his affective resonances as projective identification data and wonders what there might be for him and the patient to discover about the patient's emotional experiences, interpersonal and intrapsychic. His beginning stance might be characterized by a belief that patient and therapist are two people who do not know all that may be learned over time about the patient but that he knows something about what might yield such discovery.

Clinician 2 also conceives of unconscious knowledge as conveying aspects of patients' experiences of early care-giving environments. She listens for aspects of unconscious experience from the patient as they get emotionally stirred in her via projective processes. She relies on her interpretations of projective data from patients in order to learn about the work they may need to accomplish with her. By taking seriously the ways in which she feels moved by interactions with patients, she opens the nonverbal, often developmental, dialogue with patients. She may or may not share the ways in which

she feels moved, for example, countertransference disclosure, as a technique to further understand the unconscious process within and between her patient and her. However, disclosure is not the goal. Crucial to her therapeutic functioning is to be receptive to unconscious, projective communication and to metabolize pieces of it so that it can be available as something understood, transformed and now known by the patient.

It is of note that Clinician 1 has been described as using the therapeutic relationship as tool to focus on the intrapsychic and unconscious aspects of the patient while Clinician 2 as using the therapeutic relationship as both provision for healing and tool for analysis that may include countertransference disclosure. It would seem that intent to work with unconscious process does not rely on preference of philosophical models regarding uses of the therapeutic relationship and how much of the therapist's subjectivity is made available to the patient. Clinicians 1 and 2 work to consistently relate to their therapeutic functioning that helps to create access to unconscious process in the presence of the patient so that the patient may come to trust, relate to, and eventually participate in this aspect of their therapeutic functioning. Intentionality to work with unconscious process seems to be a necessary mental state for the psychoanalytic therapist who wants to work with unconscious process.

Intrapsychic versus Interpersonal Focus

The view of the relationship as tool for analyzing places emphasis on exploration of the patient's intrapsychic or internal world. The view of the relationship as providing new or more consistent emotional experience emphasizes the importance of the interpersonal, interactive dynamics and their exploration. Like many debates in

psychoanalytic theory, it may be that philosophical discussions about what patients need from their therapists, "real" emotional relationship experiences or more detached, analyzing functions, create a false dichotomy. As previously noted, any perspective or technique designed to further analysis or exploration can become just the opposite, a defensive obstacle to do something besides analyze or explore, perhaps especially unconscious elements and anxieties. Too much focus on the healing power of the relationship creates a situation whereby that which cannot be healed but need be known may not be available to the dyad. W.R. Bion (1970) discusses the importance of the therapist eschewing memory and desire in relation to the patient, to enter a space where the patient is not tied to the therapist's needs to help, to make better, or to provide caring and understanding. He writes,

> A psycho-analyst who remembers that A is the same person as A was yesterday indulges a column 2 element [collusion]. Nor is there any reason for the analysand to believe that the analyst is the same person as the analyst of the previous day. Such belief is suspect as the sign of a collusive relationship intended to prevent emergence of the unknown, incoherent, formless void and an associated sense of persecution by the elements of an evolving O [the unknown and unknowable] (p. 52, content in brackets added).

In this instance the present day relationship and its emotional resources might be best conceived of as in existence but not in focus providing the dyad with a sense of safety to venture into the unknown of the patient's psyche. While relationships ameliorate the existential aloneness in life, for example, the fact of death, they do not change that essential truth.

Conversely, too rigid a focus on the patient's intrapsychic dynamics can also become an obstacle to receiving the unknown. Not allowing exploration of the present-day relationship that exists between two people in the consulting room can lead the

patient to feel crazy and as if he has nothing to teach the dyad about the therapeutic interactions. Such feelings have the power to limit the patient's expressive freedom and the dyad's ability to hear the unknown.

Whenever possible and no matter what philosophical model one works from, the therapist should have some awareness of whether one's desire to avoid analyzing or exploring, to just "not go there," may be in play. Focus on the interpersonal aspects of the relationship can become a way of colluding with anxiety-based motivations to hide what has always been hidden; especially the patient's unconscious wishes, fears, and fantasies. On the other hand, exclusive focus on the patient's internal world may leave out important expressions of the emotional resources in the relationship in this moment that can highlight the new experiences the patient is integrating into their understanding of themselves which can then support further exploration.

Several participants strive for a balance between these focuses and to respond to the patient's lead about what the patient needs to work through. Such a balance is difficult to achieve, probably especially in once weekly treatments. Once weekly treatments need a great deal of time to live into an agreement to explore both intrapsychic and interpersonal aspects of the process as the exposure to the experience of containing the anxieties that come with open-ended exploration is very limited. The most salient question may be which focus, in this moment, intrapsychic or interpersonal, will help the dyad agree to and allow for intentionality to gain access to something previously unknown, unaccepted, or unformulated, something unconscious?

Irwin Yalom (2008), an existential analyst, speaks to the benefits of relationship as a way into that which is most difficult to navigate. He posits that human despair is

evoked in struggles with our biologic and genetic makeup, our struggles with repressed, instinctual strivings, our internalized, damaging or unloving significant care-givers, our imperfect forms of thinking, our traumatic memories, conscious or unconscious, and also from a confrontation with existence. He identifies four ultimate concerns with such a confrontation with human existence; death, isolation, meaning in life, and freedom. He writes of acknowledging and working through death terror, perhaps the deepest psychotherapeutic work, through connection with an expert in a process whose philosophical stance is one of equal humanness.

> When I keep my gaze fixed on the existential facts of life, I perceive no clear boundary between my patients, the afflicted, and myself, the healer. Ordinary role descriptions and characterological diagnoses impede, rather than facilitate, therapy. Because I believe that the antidote to much anguish is sheer connectedness, I try to live in the hour with my patient without erecting artificial and unnecessary barriers. In the process of therapy, I am an expert but not infallible guide to my patient. I've taken this journey before—in my own voyage of exploration and as a guide to many others. In my work with clients, I strive for connectedness above all else. To that end, I am resolved to act in good faith; no uniforms or costumes; no parading of diplomas, professional degrees, and awards; no pretense of knowledge I do not possess; no denying that existential dilemmas strike home for me as well; no refusal to answer questions; no hiding my role; and finally, no concealing my own humanness and my own vulnerabilities (p. 205-206).

This view describes a model of treatment in which the therapist is not an expert on the patient but asserts expertise, commitment, and intentionality to explore what is most difficult to explore, especially unconscious process, and that allows for variability in use of self and patients' use of therapist to accomplish such exploration. This expertise, commitment, and intentionality are perhaps the therapist's primary theoretical contributions to depth.

Psychoanalytic Theory and Participant Priorities

Participants' beliefs in relation to priorities identified in this study's review of the literature are an interesting aspect of the findings. All participants referenced and are guided by the need to establish and maintain a therapeutic frame that creates reliability, consistency, and the opportunity to understand transference and countertransference dynamics along with development of new relational experiences.

Participants understand free association or patient-driven content not only as data for transference interpretation but more importantly, as the route by which patients come to learn about themselves in new ways and transform old, habitual ways of viewing themselves, others, and what might be possible in life. In fact, patients' expressive freedom ranks as the highest priority for all participants.

All participants used transference data to better understand their patients while some discussed it with patients more than others. Clinician 1 viewed transference interpretation as the most important technique in working toward depth. Other participants saw it as one of many techniques available to them. Several participants distinguished between the "real" relationship and the transference relationship and saw value in the present-day, emotionally fueled relationship as part of what is healing for patients.

Regarding countertransference, as already noted, all participants discussed the importance of reliable abilities to be aware of themselves in ways that allow them to recognize how best to use countertransference data and when to seek assistance in sorting out such questions. Some saw benefits to countertransference disclosure as a technique in service of both intrapsychic and interpersonal exploration.

What is of particular note is that general priorities based on theory, such as the primacy of transference interpretation, do not necessarily translate to priorities in working toward depth in any individual treatment. Participants do not seek to interpret transference as a priority in working toward depth if what a patient needs is help with metabolizing intense affect. Participants do not seek to point out a patient's resistance to free associate if a patient is having trouble feeling grounded by any kind of coherent narrative about his or her life. Participants do not seek to reveal countertransference if a patient is clearly indicating that they are fearful of learning about their therapist. In a general way, participants do seek to become instruments for the patients' process of discovery and to use techniques that are appropriate to the patient at each clinical moment. Christopher Bollas (1991) writes,

> We shall always distinguish in our unconscious the precise idiom of any individual patient's impression upon us, but this is more a matter of form than of content, known through the odd experience of being deeply affected by the way a patient exists through us, even when he says little of significance to us. This knowledge will be forever unthought even as it is known, simply because we do not have the means of thinking it. Marion Milner (personal communication, 1977) believes that at this level the analyst's goal is often to serve as a "medium" for the patient. We could think of the analyst as being composed by the patient much the way a writer composes a novel, or a painter a painting, or a musician a score (p. 60).

It is the researcher's contention that all participants would agree with this description of the use of psychoanalytic thought in their work to conceive of and offer opportunity for patients to become aware of their compositions and potentially, their therapists' role in them. More than any theoretical priority or technique for establishing depth in treatment, participants believe in and trust in this process. Trust in the process that psychoanalytic therapy works, however one defines depth, comes from lived experience. It is their steadying and consistent priority.

Finally, participants' descriptions of what constitutes depth were divergent across cases and in some cases, different from psychoanalytic theories that assign to depth the seemingly objective measure of working with unconscious process. This is a result, in part, of the study's design which asked participants their beliefs about depth rather than providing a definition of depth for participants to react to. It also seems to be an indication that depth is actually a subjective phenomenon and up to each therapeutic dyad to define.

Implications

There are several implications resulting from the study's findings. They are organized here as clinical and theoretical implications, and as training and policy implications or questions.

Clinical and Theoretical Implications

While participants did not always explicitly refer to social work values, findings are consistent with the following values: respect for client self-determination; understanding that integrates intrapsychic (person) and holding environments (interpersonal—family, culture, society); and the primacy of the relationship as medium for the work of problem-solving, exploration, revelation, expansion of self-knowledge, and even, opportunity for non-relating. Also, while not always discussed as resulting from their social work beginnings, all participants expressed the view that it is not feasible or appropriate to "get rich" as psychoanalytic therapists. They have found ways to provide depth-oriented therapy, often at reduced fees, and sustain their practices. In

fact, many expressed their priority as being able to stay with treatments rather than being able to earn their full fees. Creating processes that hold potential for depth, then, is the driving force for participants over many other considerations. Depth, as idiosyncratically defined, may be considered a core value for clinical social workers who are psychoanalytic therapists.

For the most part, participants engage patients around what patients' identify as priorities. They do so with a foundation of understanding development, unconscious processes, transference, and countertransference from psychoanalytic points of view and offer feedback based on such theoretical foundations. They build relationships that may begin with focused problem-solving, providing a safe and consistent presence, offering what they think for patient use, or mirroring and organizing patients' communications. Such relationship-building lays the groundwork for trust to reveal more. Many people become more curious about themselves when met where they are with psychoanalytic knowledge, beliefs and techniques. Some patients will choose to stay and go deeper. Some will choose to end once they have understood or impacted their chief complaint or because they decide they do not want to explore and reveal more. It is of note that while participants listened and took seriously patients' focus on symptoms, they did not talk about symptoms in relation to their conscious activities designed to offer depth-oriented treatment other than responding to patients' beginning focuses. In fact, they talked very little about symptoms. Rather, they discussed the intention of getting to know each of their patients in a holistic way at each patient's pace.

Training and Policy Implications

This study ranks the therapist's use of self-awareness, self-acceptance, and comfort with emotional intimacy as her most important contributions to depth in patients' treatments. The therapist's personal treatment is considered indispensable for the development of such usable contributions. However, while personal treatment designed to increase self-awareness, self-acceptance, and comfort with emotional intimacy is often underway when a psychoanalytic therapist begins seeing patients, it is usually not complete. Every new patient creates hope and dread in their clinician, beginner or seasoned (Mitchell, 1995). It is lived experience that helps therapists to maximize the hope and contain the dread.

Along the way to living into the experience (personal and professional) that integrates trust in the psychoanalytic therapy process, therapists must find reliable ways to accept and manage dual anxieties—the anxiety that comes with their own journey toward emotional intimacy (with self and other) and the anxieties that come with not knowing where patients may need to go, how they may need to get there, and for less seasoned therapists, whether they have been there yet themselves. Often, supervision can help to even things out in order for the newer therapist to contain these anxieties not yet significantly worked through in treatment. In addition to personal treatment, The American Association for Psychoanalysis in Clinical Social Work recommends a minimum of 150 hours of individual supervision for at least two different cases as a training standard for psychoanalytic psychotherapists (2008). This standard is reinforced by the findings of this study.

Psychoanalytic therapists in training would also benefit from exploration of what depth means to them. This might include a class or seminar that organizes reading and discussion around the question of depth. As seen in this study, it is an excellent way to highlight what theories are most meaningful and connected to how one conceives of the day-to-day practice of psychotherapy without requiring students to choose one school of psychoanalytic thought. It also helps students to understand what they value in their developing practice, what they want more of, and what strategies they might use. For example, moving to more frequent sessions before significant trust is developed for the patient might deter from depth. Depth needs trust and increased frequency of sessions without an understanding of the status of trust may increase patients' anxiety and lack of feeling safe.

In discussion of self-awareness, it is implied that it is wise for therapists to act in concert with their knowledge of self in decisions about their practice. No one can be all things to all people and psychotherapy includes great limits. Therapists will be served, as well as their patients, by giving themselves permission to use that self-knowledge to identify the work they are best at and want to do. It is hoped that they will come to do so without becoming overwhelmed by shame and other emotional reactions based on competition, mentor preferences or investments, or formal theoretical ideals.

There are some troubling changes in mental health agencies related to insurance company-driven goals for psychotherapy that are inconsistent with laying the groundwork for psychoanalytic therapy. In fact, Clinician 2 decided to leave her agency because her autonomy to provide psychoanalytic treatment was increasingly impinged upon. William Meyer writes,

> It is telling that in my computer-generated literature review for this chapter, I found nearly 300 papers extolling the benefits of brief therapy and fewer than five specifically addressing its limitations. This steady barrage of such communications cannot help but have an insidious impact on the confidence with which contemporary clinicians approach longer-term, slower-paced psychotherapy. As a consequence, clinicians are at risk for caving in to outside pressures, to becoming ever more involved in the treatment of symptoms rather than people (1996, p. 373).

Such pressures for short-term, non-exploratory treatments also have profound implications for private practice. Four participants in this study are either providers with only one insurance company or have opted out of insurance panels altogether. Only one participant is a provider on many insurance panels. All participants express the belief that use of insurance for treatment detracts from depth, whether because it creates obstacles to patient revelations or because it distracts therapists from their open-ended focus on patients' needs and agendas. This raises important questions about how psychoanalytic therapists interested in private practice can make a living without relying on insurance companies. Most of the participants in this study supplemented their private, clinical income for several years with other kinds of work including teaching, consulting to agencies and individuals, and part-time jobs in clinics.

Newer clinical social workers who wish to practice psychoanalytic therapy are well-served by connecting with existing communities of psychoanalytic therapists in order to learn but also to be in position to receive referrals from established members of these communities. Established therapists are invested in the continuing survival of psychoanalytic therapy. Such connections might help newer practitioners to be able to limit their involvement with insurance companies. Strategies for connection to communities of psychoanalytic therapists include post-masters advanced education and training programs, outpatient clinics at psychoanalytic institutes, and participation in

psychoanalytically oriented, individual or group consultation. Practice that does not follow profit-driven agendas has the best chance of offering therapy that is exploratory and increases self-knowledge. This raises questions for how and whether agencies can be financially viable and set such program goals.

Summary

This qualitative research used case study methodology and produced five case reports of participant clinicians and their core beliefs and techniques related to offering patients depth in treatment. Case reports present idiosyncratic definitions of, beliefs about, and techniques in service of depth. The cross-case analysis has several findings.

First, it revealed that each participant defined depth based on theoretical beliefs about psychoanalytic therapy overall. These ideas are characterized by beginning as formal psychoanalytic theories which were then transformed into personal, experience-based beliefs in the process of personal treatment and experience with patients.

The second finding is that the self-awareness developed in personal psychoanalytically oriented treatment is an indispensable contribution of the therapist to deepening treatment. Self-awareness is used everyday by psychoanalytic therapists, specifically as internal dialogues of the therapist to make moment-to-moment decisions about therapeutic functioning, to establish and maintain therapeutic frames with patients, and as the foundation for the self-analysis needed when treatments are at an impasse.

Third, the therapist's comfort with emotional intimacy provides patients with the safety and acceptance needed to enter and continue moving more deeply into an exploratory process. Such exploratory processes whereby patients experience being

known emotionally and not required to change often create a paradoxical process of change.

Fourth, patient revelation is both an indication and the goal of depth. Regardless of theoretical allegiances, patient revelation, often in the form of free association, is the shared goal of any analytic process (Bollas, 1999). Psychoanalytic therapists work to create trustworthy relationships within which patients can feel safe enough, over time, to reveal whatever they need, can, or want to reveal. Therapists function in several ways to create such relationships and environments. They listen a great deal. They talk about what they think and feel with patients in ways that are highly connected to what they've learned about their patients. They reveal aspects of themselves, implicitly or explicitly for patient use.

Finally, there is no substitute for the years of experience that allow psychoanalytic therapists to come to the self-acceptance that allows for the providing therapy in the context of limitations based on therapist and patient strengths, capacities and preferences along with the inherent limitations on what psychotherapy can achieve. Self-acceptance is also an important ingredient in establishing practice that provides the best chance for professional satisfaction and sustainability. In fact, self-acceptance that comes with the experience and knowledge of limitations makes what one believes and does feel even more important and valuable. Such wisdom comes only with practice experience.

Depth, then, is a metaphor, an idea that structures the exploration of boundless intrapsychic and inter-psychic aspects of human experience. Depth is also subjective as each therapist and each therapeutic dyad creates differential experiences of depth. In general, depth is important because it contributes to the possibility of psychotherapy

offering a process in which patients can learn something new about self and have new interpersonal experiences. Such learning and experiences lead to greater capacities to acknowledge and be less restricted by psychic pain and to accept the ambiguities inherent in life. Discussion about depth and the variable conceptions of it in this study is important to clinical social work because it reflects the value of understanding each person's uniqueness.

Working with deep affect in connection with insight is considered the best way to offer people choices about what may be worth risking to change. Additionally, depth of affect between people, to be touched deeply, is ultimately what makes life worth living. Clinical social workers who practice psychoanalytic therapy bring a strong value of relationship and its power to impact change. It is the framework by which depth is discovered and achieved.

There are obstacles to using depth as a guiding metaphor. First, and perhaps foremost, is the often intense anxiety that comes with venturing into the unknown, unconscious or otherwise. A second obstacle can be the pressure to be helpful or to know something before it can be known, especially in once weekly psychotherapy. Finally, there are not reliable shortcuts to the knowledge and experience gained in exploratory, depth-oriented treatment. We live in a fast-paced, profit driven society where we want answers quickly. In many ways, it is a sort of anti-depth era in American history. In order to conceive of and use depth as an organizing idea in psychotherapeutic work, the therapist's personal treatment is essential. Additionally, ongoing connection to and support from other therapists who have found ways to integrate depth as a primary value in their work is more and more important.

APPENDIX A

CONSENT FORM

Individual Consent for Participation in Research
INSTITUTE FOR CLINICAL SOCIAL WORK

I,_____, acting for myself agree to take part in the research entitled: Clinical Social Workers and Deepening Treatment

This work will be carried out by Joan Servatius, LCSW, under the supervision of Jennifer Tolleson, PhD, Dissertation Committee Chair.

This work is conducted under the auspices of the Institute for Clinical Social Work, 200 N. Michigan Ave., Suite 407, Chicago, IL 60601, (312) 726-8480.

PURPOSE
The purpose of this study is to complete a dissertation using a qualitative research design in order to gain insight into the subjective experience of clinical social workers that practice psychoanalytic therapy about the work of facilitating depth-oriented therapy. Findings will be included in a bound dissertation document and may also be used to develop papers for conference presentation or journal submission.

PROCEDURES USED IN THE STUDY AND THE DURATION
Participating in this study includes three to four interviews focused on your thoughts about deepening treatment with your patients. Interviews will be recorded and transcribed by a professional transcriber. Transcriptions will be used in a case study design method to develop your thoughts into a report that covers aspects of your subjective process and personal theory of deepening treatment. These in-person interviews will take place over a course of several weeks depending on your availability. Each interview will last approximately 1 to 1 and one-half hours.

BENEFITS
This research will contribute to the knowledge base of clinical social work and clinical process theory. There is no direct benefit to you for your participation beyond the opportunity to share and clarify some of your thoughts on this aspect of your work.

COSTS
The cost to you for your participation is 3 to 4.5 hours of your time.

POSSIBLE RISKS/SIDE EFFECTS
The very limited risk of this study is the potential for feeling professionally exposed in relation to discussing the topic. However, your identity will be confidential; no one will know your identity but me. While this risk is extremely unlikely, the plan for responding to feeling exposed will be a de-briefing session(s) with me or another person identified by you.

PRIVACY/CONFIDENTIALITY

Procedures for insuring confidentiality are as follows. Privacy will be provided during interviews as they will take place in your home or office, or in my office. I will not share your identity with anyone. No actual names will be used in the dissertation and other identifying information will be disguised as necessary. All tapes and transcribed data, identified only by number, will be kept in a locked cabinet where no one other than the researcher and her advisor may have access to them. Tapes will be destroyed after transcription.

Selected sections of transcriptions without identifying information will be compared to researcher interpretations by the committee chair and by selected participants in order to minimize researcher bias and develop alternative views of the data.

SUBJECT ASSURANCES

By signing this consent form, I agree to take part in this study. I have not given up any of my rights or released this institution from responsibility for carelessness.

I may cancel my consent and refuse to continue in this study at any time without penalty or loss of benefits. My relationship with the staff of the ICSW will not be affected in any way, now or in the future, if I refuse to take part, or if I begin the study and then withdraw.

If I have any questions about the research methods, I can contact Joan Servatius, 30 N. Michigan, Suite 1908, Chicago, IL 60602, (312) 345-0201 or Jennifer Tolleson, PhD, at (312) 409-2851. If I have any questions about my rights as a research subject, I may call Daniel Rosenfeld, M.A., Chair of Institutional Review Board, ICSW, 200 N. Michigan Ave., Suite 407, Chicago, IL 60601, (312) 726-8480.

SIGNATURES

I have read this consent form and I agree to take part in this study as it is explained in this consent form.

_____ _____

Signature of Participant Date

I certify that I have explained the research to _____ and believe that they understand and that they have agreed to participate freely. I agree to answer any additional questions when they arise during the research or afterward.

_____ _____

Signature of Researcher Date

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