THE NEW SCHOOL PSYCHOLOGY BULLETIN

The New School Psychology Bulletin (NSPB) is operated by graduate students in psychology and published by the Psychology Department at The New School for Social Research.

Focus and Scope
The articles that appear in NSPB represent the work of students from graduate psychology departments. Published work includes theory, research, literature reviews, and commentaries on the field. NSPB considers articles from all schools of thought on all topics relevant to psychology. NSPB may be particularly attractive to authors whose work does not fit the missions of larger psychology journals, and those looking to gain exposure to academic publishing. NSPB prides itself on publishing the early work of new and budding scholars.

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Letter from the Editors

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Dear Readers,

We are proud to present you with the seventeenth volume of the New School Psychology Bulletin, dedicated to the legacy of Dr. Jeremy Safran. Dr. Safran was a cornerstone both at the New School and in the psychotherapy research community for over 25 years. Among his wide range of achievements and interests, he is perhaps best known for producing several seminal works of clinical theory and empirical research that were focused on understanding and facilitating the repair of interpersonal ruptures in therapy. This shone through in his teaching and mentorship, as Dr. Safran advocated the importance of creating space for clients to speak and be heard, and for therapists to process and constructively address their own emotions.

Our work on this issue began in December 2018 at a small meeting table in our psychology department, only a few months after his tragic death. Dr. McWelling Todman and Dr. Adam Brown approached us with the idea to publish an issue with research and commentary in Dr. Safran's vein of psychotherapy research. It was a fitting gesture of tribute, as Dr. Todman worked with Dr. Safran and the founding editors to pull together the funding for the journal back in 2003. Dr. Brown, then a doctoral student, was one of those editors. Shortly after, we all convened alongside our faculty advisor, Dr. Howard Steele, and while conversation was brief, together we built an early blueprint of what the issue might look like.

Those of us who worked directly with Dr. Safran, or Jeremy as we referred to him, hold memories of participating in a wide range of lively discussions in his research lab, whether examining the latest in psychotherapy research, unpacking psychoanalytic theory, or discussing a training paradigm meant to help address moments of rupture in treatments. We still recall his inviting office space where we were invited to develop our research ideas, to pick his brain, or simply to speak openly about our experiences in the psychology department. We also remember fondly the annual holiday parties Jeremy hosted in his own home. We share an appreciation of Jeremy's genuineness, never afraid to share his thoughts while allowing for an open dialogue. As students working closely with him, he made us feel seen and heard.

Today, we consider Jeremy's approach to addressing interpersonal conflict in therapy and examining the larger context of the world we find ourselves in now: a period marked by uncertainty and division, with particular difficulty in finding social spaces where people can comfortably talk through difference. It speaks volumes that during a pandemic, the people of the United States are unable to collectively agree upon and follow public health guidelines. Meanwhile, the killing of George Floyd, one man amongst a list too long of extinguished BIPOC lives at the hands of the police, has sparked protests across the country. The Black Lives Matter movement has placed the impacts of systemic racism at the center stage of public discourse. As an institution with power, the field of psychology must embrace the moment to mindfully consider themselves within this context of turmoil, social tension and gross disparity. We must listen and respond to criticisms and concerns from communities of color about our practice. It is time to explore the wounds spotlighted by the present ruptures. Until members of the field do the work to repair these ruptures, we remain in a milieu of white privilege. What we need is a milieu of trust and respect for all human dignity. We will not have it until we are willing to listen with full attention. It is only then that we can reach our goals of understanding human behavior and treating the full breadth of issues

affecting one's mental health. We, as a journal, commit to taking on the important responsibilities of identifying, questioning, and assessing our deeply-held assumptions – about our knowledge, the way we perceive events and issues, our beliefs, feelings, and actions. We also pledge to create and maintain a culture of intersectional inclusivity within our editorial board, authorship, and subject matter.

We are thankful to the former students of Dr. Safran's Psychotherapy Research Lab for helping us put together this special issue with works representative of a wide range of interests held by his students and himself. Those who had a chance to work with him, whether as researchers, students, or supervisees, carry on his legacy. We join his family and loved ones in remembering him.

Sincerely,

Greg Weil
Liam Bang
Lorraine Afflitto
Emily Weiss

Rupture and Repair: A View From New York City in Honor of Jeremy Safran

June 12, 2020

Howard Steele, PhD
Chair for the Clinical Psychology Faculty
The New School for Social Research

This note is being written in memory of Jeremy Safran, shortly after the 2nd anniversary of his tragic and violent death. Jeremy was a tireless psychoanalyst and clinical psychologist and public intellectual, perhaps best known for his therapy process research on how patterns of 'rupture and repair' typify the interactions and experiences of therapists and their patients. The word 'rupture' captures our painful present moment, and one that would have resonated deeply in Jeremy. The global Covid 19 crisis, and the universally witnessed lynching of George Floyd, have revealed a deep and severe rupture rippling through society, pushing health services to breaking points, deepening health disparities, bringing illness and death arising from a virus on a scale not seen for over 100 years. Perhaps it was the fact that the virus has disproportionately and adversely impacted African-American and Hispanic-American communities, coupled with Black Lives Matter protests that have erupted across the globe, a seismic rupture is rippling through American life, and nations around the globe. In its wake, change is coming, with important moments of repair and resolution, but further ruptures, Jeremy would caution, are inevitable. This is a lesson Jeremy's students learned well, i.e. that mis-steps and errors in communication are part of the ebb and flow of human experience. The crucial next step is to seek clarification, and achieve a resolution to conflict if possible. Restrictions on police in terms of outlawing chokeholds and redirecting funding away from police to social work, and other mental health services, are causes Jeremy would have embraced. He would have seen the task of reimagining safety, and advancing mental health, as essential to the achieving a reduction in health disparities and the banishment of systemic racism from American life, after a 401 year history of white supremacy.

One outcome of the present moment is sure to be an increased need for mental health services. Across New York City, at all the major teaching hospitals there are mental health services, and within them are specialized services for first responders, family members of victims, and the few survivors of 9/11. Come September it will be 19 years since that fateful day when nearly 3,000 people were murdered in New York City. A number in excess of 17,000 is the current count of deaths arising from the Covid 19 crisis in New York City. The virus is currently the leading cause of death in the United States, with no clear end in sight.

The burden of coping with this monumental rupture is being carried by first responders, health care workers, other 'essential workers', and grieving family members. Current levels of traumatic stress are almost unthinkable. And, while many of these citizens most severely influenced by the trail of illness and death caused by the virus will show resilience in the aftermath of this pandemic, there will be many others who will need mental health consultation, therapy, and counseling on account of understandable addictions to alcohol or drugs – on the rise since 'shelter in place' mandates came into effect some eight weeks ago.

This enormous need for mental health services is likely to be profound, require enormous amounts of government resources, and a dedicated trauma-informed professional staff.

At the New School For Social Research, there is a MA program in Mental Health and Substance Abuse Counseling, and a PhD program in Clinical Psychology, nurtured for years by Jeremy Safran, now in the hands of a diverse and robust faculty group providing courses that include Gender Studies, Global Mental Health, & Culture, and Ethnicity and Mental Health. Our academic programs that train mental health workers have been popular for years. Now they are essential.

Our graduates will be called on to help meet New York City's expansive mental health needs over the coming decades. Ruptures can be repaired, but only with substantial effort, reflection, planning, preparation and resources.

It is a pleasure to see this special issue in honor of Jeremy Safran, produced by our in-house peer-reviewed scientific psychology journal that was initiated by New School graduate students, and is edited and managed entirely by graduate students. Jeremy was around when this journal was launched, and he was ever supportive of this venture. In his memory, we should be mindful of ruptures and seek repairs with compassion and wisdom.

On Supervision

March 5th, 2019

Medea M. Elvy, PhD

Safran makes an essential distinction between will and willfulness when discussing the quality of interaction. Willfulness has the desperate feel of trying to force any moment to be bent to the needs of oneself. To not be able to recognize the intricacies of interaction because one is stuck in their own impinging needs. It comes from a fear that attachment is fragile and connection is broken if one tries to assert one's needs directly. Conversely, will is borne out of the faith that the world is fairly benevolent. One does not need to be a slave to one's outcomes because one believes that the future will bear out well enough. This is also related to the idea that if one can hold connection and all of its limitations, one can have compassion for interpersonal losses, failures and intermittently find some comfort in self and other.

This distinction is key and we try to come from a place of will with and for the supervisee and his/her patient. We start with the idea that all will go fairly well as long as we can embrace the subtleties and the underbelly of any interaction. As long as we can withstand and not disavow darkness, it will be all right. It is even okay when one of us cannot stand or needs to disavow because the other will be there to find a light to guide us. Disappointment and failure does not need be experienced as catastrophic, even in the face of real tragedy.

There is an experience of mastery we can offer anyone we mentor or teach in our own acceptance of being unknown/unknowable to ourselves and others. There is no complete connection. If we are lucky, life becomes a long lesson in the art of losing gracefully. We can bring calm to meet the fear that we are all ultimately alone in our struggle. Having wrestled with our own isolation and disappointment allows us to offer faith in connection and in our ability to help patients and supervisees hold hope despite their own weaknesses. There is a paradox there. No one can alleviate the singular reality that we are alone and in the dark but acceptance of that somehow allows us to be soothed and held, even momentarily. We learn to take what we can get and appreciate it. Interacting in this way helps the supervisee learn to tolerate their own fear and blindness and gain a feeling of confidence despite their own and our own lacking. The seeing is in the lacking, in being okay in the lacking; we don't have to - can't if we want to - get it all right. We are making a concerted effort but we are relaxed in our delivery; as much as we can, we come from will and not willfulness. The supervisee does not need to become us or see it our way. They need to learn to have faith that they will see at all, that they will sometimes be very alone in the seeing, that they will have to hold on despite their best efforts being unseen and unknown, many times over. Good supervision does not appear to be in any one ability or another, it is more in the mindset in which we enter the endeavor. We have to be a little loose and a little bendy. We attempt to enter therapy with our patients in a similar way. How do we add some comfort, acceptance, love to this person's life? How do we aid in any small way to lessen the burden of existence; of loneliness? How do we get some comfort for ourselves in doing this? This kind of work can bring us moments of real joy and connection woven amongst our inevitable disappointments.

Sometimes supervision and treatment can have that battleground feel where parties are wrestling over what is "true." This tends to be a fairly profitless albeit unavoidable endeavor. When we find ourselves trapped in this type of interaction, if we cannot agree in the seeing, maybe both of us are bound up in some relentless need to be the *right*, *good* or *sane* one;

we have slipped into willfulness. We can back down then, unless it is a question of real safety, and circle back and try again in a more relaxed way. We try to see the supervisee's or patient's fear that if they let go, if they get lost, they will be lost forever. They do not always have the experience of losing and surviving, of losing irretrievably not only others but versions of the self one must shed in order to survive, tunnels of identity that were carved and held by lost parts of the self and lost connection to another. We cannot give them that experience if they have never had it but we can model our own flexibility. That's when we extend a hand and demonstrate that maybe we are not lost for good, only confused for a little while and can navigate our way back.

There are core lessons about withstanding failure to be found in grief. When we lose the people we love, when we lose versions of the self that we once depended on, the illusion of control is absorbed; we are humbled, if we are fortunate, we learn through experience how to discern our own will from willfulness. These experiences shape who we become and force us to grow around and through exposures; what we once hid from ourselves is shone as mostly facade. Loss is a bedfellow one can never misplace; one can only learn to warm to it and accept it lying there. One can never shed the notion that tragedy is absolutely real and at work somewhere, all the time. To lean away from it is to cut off one's own vitality but before one can stand again, one must first learn to accept what feels like disintegration, to bear what feels catastrophic and survive. To get lost in one's head, lost in darknesses new and old, lost in real fear and panic. To get lost in the unfathomably deep pockets of shadow in the human psyche, one's own and that which is shared with others. It can be such a lonely cavern, full of despair. The flip side of the pain is finding a level of bedrock endurance; there is freedom in there as well. One can come back knowing what is worth seeing, what is worth lighting up and what to shed.

We can come back from loss and disappointment knowing that we cannot know it all, we can't always get it right. We learn that we cannot even present our own wholeness to ourselves or others without having to whittle it down to this or that. There is something that aches about that but also something that is relieving. Everyone is in the same boat; there is a togetherness in that elemental aloneness! If only in fleeting moments, we practice tolerating and bearing witness to others' shadow without having to disavow or reject our own. We can learn the value of dwelling there with our patients and supervisees. There comes a level of confidence that one can soothe in despair and create warmth in the cold; one can laugh at one's own ridiculousness and smallness. One can find comfort in limitations, in fractured moments of pleasure. Nothing has to be or can be absolute or complete. Nothing has to be just how one wanted it to be, in fact, that might be a prison. Alongside our patients and supervisees, we keep trying to come from a place of will and wisdom, to employ effort and calm, to have integrity in our work, and reverence for the vital roles played by both fortitude and failure.

Thirteen Ways of Looking at Therapeutic Neutrality

April 24th, 2019

Joshua Maserow, MA
PhD Student, Clinical Psychology
The New School for Social Research

I
Sat within the ochre expanse of Atacama,
The lone cactus slowly grows
Under the blanket of an aloof sky.
II
The elastic band,
signs a covenant
with almost-all the strangers and shapes
it meets.
III
The engine splutters,
A diapason of rust.
You can't go far in neutral.
IV
Are we to watch
With our father's binoculars
As Jakobshavn
Topples into the ocean?
V
How do we address
the attachment style
Of cats
Who turn their burning eyes
From the invitation they seek?
VI
The western meditator
Travels East
To learn the Dharma.
There he hears nothing
but
The torsions of his master's
Bowels.
VII
As the windswirls

With rage and unforgiveness
The supple reed
Bends headlong over the bellicose river
but refuses to break.

VIII

Standing over the supine man
Casting an inherited shadow
The surgeon inserts
The stent
void of memory and desire.

IX

The red in the twisting
Patterns of the analyst's rug
Bubble-hot
With the larva of unthought knowns

X

What are we to make of the mirror,
Brocaded in thumbsmudged gold,
Echoing the image of the onlooker,
Before the cloudbursts sing their acid dirge?

XI

Alone at the trattoria
The professor tamps
The crumbling focaccia
Down on the chipped porcelain plate
And wonders:
Does it really matter whether we mix –
in
The olive oil with the vinegar
Or
Vice versa?

XII

Will the winter-tired man,
Alone in his apartment writing Amazon reviews,
Be forever haunted
By the broken umbrella
He tossed on the piss-stained stairs
Of his subway stop?

XIII

Kant gave us the moral imperative
Levinas the cry of the Other
Stevens the estranging word.
Which path should we take
Without mocking the blackbird?

The Dream in the Therapeutic Encounter:
A Theoretical Formulation and Single Case Study

Liam Bang
The New School for Social Research

The present paper seeks to better understand the underlying mechanisms and phenomenology of dreaming and dream telling in the psychotherapeutic encounter. Toward that end, this paper offers a theoretical framework regarding the interplay between intrapsychic and intersubjective mechanisms underlying dreaming, dream telling, and dream interpretation in psychodynamic psychotherapy, with a focus on the capacity of the dream to facilitate unique communicative pathways. This theoretical framework informs a discussion of the results of several self-report psychotherapy process measures from a single 12-session treatment, including the Working Alliance Inventory, Session Evaluation Questionnaire and Session Impact Scale.

Keywords: introjection, projection, projective identification, introjective projective identification in the dream, transitionality, dream telling in psychotherapy

The present paper formulates an account of the overlapping intrapsychic and intersubjective mechanisms that inform dream content formation, dream telling, and dream interpretation in psychodynamic psychotherapy. The experience of dreaming during sleep is understood as an early effort to communicate with others and influence the external world. Though dreaming is an apparently intrapsychic phenomenon directed toward the preservation of sleep through mechanisms such as displacement, condensation, and reversal (Freud, 1916/1973), dreams also function to promote object-relatedness through mechanisms such as introjection and projective identification within the dream. By introjecting objects into the dream experience and projecting intolerable difficulties onto those objects within the dream, the dreamer establishes a transitional space within which they can process intolerable difficulties and render them tolerable in conscious thought.

Articulation of the dream in psychotherapy, in writing or in any other medium of communication embeds the dream in language, thus solidifying it in the discourse of the external world and negating its transitional quality. The solidification of the dream account in the external world enables the dreamer to communicate that which is otherwise not possible to communicate. By solidifying the transitional phenomenon of the dream into external discourse in the therapeutic

encounter, the patient introduces a third entity into the therapeutic encounter, which reconfigures the form of the encounter from dyadic to triadic. The triadic configuration established by the dream narrative functions to antagonistically regulate the analytic encounter between relatedness and withdrawal, enabling the patient to communicate that which is otherwise intolerable. The dream account is not unique in its capacity to reconfigure the analytic encounter from dyadic to triadic. Discussion of a variety of internally and externally generated experiences such as memories or people, are also potentially conducive to a triadic configuration of the therapeutic encounter. However, the dream experience and in session dream account occupy an exceptional position in psychotherapy. The dream experience enables a working through of that which is intolerable in a transitional space and communication of previously intolerable material in external discourse, which renders the intolerable tolerable to conscious thought and enhances the dreamer's object-relatedness.

The potential of dreams to elucidate unconscious conflict is a foundational proposition of psychoanalysis. In his *Revision of the Theory of Dreams*, Freud (1933) writes that the theory of dreams "occupies a special place in the history of psycho-analysis and marks a turning-point; it was with it that analysis took the step from being

a psychotherapeutic approach to being a depth-psychology" (p. 7). Dream interpretation is a unidirectional process directed toward identifying the latent dream thought that is shrouded within the manifest content of the dream and explaining how the latent dream thought has manifested in the way that it has in the analysand's mind (Freud, 1933, pp. 9-10). As Freud outlines, the interpretation of a dream follows a process whereby the analysand relays the dream narrative to the analyst. The analyst, freeing themselves from the impression of the manifest dream narrative as a whole, must obtain associations from the analysand to distinct portions of the manifest dream narrative. Though the associations may appear irrelevant to the analysand at first, they, "throw a surprising light on all the different parts of the dream, fill in the gaps between them, and make their strange juxtapositions intelligible" (Freud, 1933, p. 12). However, the associations in themselves do not elucidate the latent dream thought. As Freud also writes, "an association often comes to a stop precisely before the genuine dream-thought: it has only come near to it and has only had contact with it through allusions" (p. 12). The next step toward elucidating the latent dream thought is for the analyst to "fill in the hints, draw undeniable conclusions, and give explicit utterance to what the patient has only touched on in his associations" (p. 12). In this way, the analyst functions as a skilled external observer of something that exists in the analysand's mind.

Sándor Ferenczi, a contemporary of Freud, acknowledges the influence that the relationship between analyst and analysand has on dream content formation and dream telling. In an insightful and very brief chapter, *To Whom Does One Relate One's Dreams*, Ferenczi (1923/1994), writes, "We analysts know that one feels impelled to relate one's dreams to the very person to whom the content relates" (p. 349). In a broad sense, Ferenczi's insight means that the dreams the analysand chooses to bring into analysis are informed by the relationship to the analyst. Moreover, it also means that the content formation of the dream is influenced by the analytic relationship. In acknowledging the analyst's influence on the analysand's dreams and dream telling, Ferenczi identifies a dialectical interplay between dreaming and dream telling, and thus positions the dream as an inherently communicative mechanism.

This difference in theory also translates into divergence in technique. In describing his method of dream interpretation, Freud (1933) describes that while the analysand describes their dream, the analyst will have "listened passively, without putting our powers of reflection into action . . . We decide to concern ourselves as little as possible with what we have heard, with the *manifest* dream" (p. 10). This passive attention diverges strikingly from the way in which Ferenczi suggests analysts should attend to the narration of dreams. In *Attention During the Narration of Dreams*, Ferenczi (1923/1994) writes, that while the analyst should normally listen with "suspended attention" and "allow scope to his own unconscious" during the narration of dreams, they should listen with strained attention as "every detail, every shade of expression, the sequence of the content, must in the interpretation be put into words" (p. 238). Ferenczi emphasizes the significance of the words used in the narration of dreams and notes that he often has the analysand repeat complicated dreams two or even three times. In this way, he embeds the analyst more actively in listening to the dream. Ferenczi's contribution marks an early contribution to understanding of the intersubjectivity of dreams that has been expanded upon by later theorists.

In his paper, Kanzer (1955) recalls Ferenczi when he addresses a fundamental antagonism of dreaming. That is, the antagonism between its fundamentally intrapsychic nature and communicative elements. Kanzer (1955) writes:

> The dream is inherently – in appearance at least – a narcissistic phenomenon, entirely intrapsychic . . . Nevertheless, there are communicative elements about the dream and . . . within the dream itself that are of great importance not only for the therapeutic approach but for the theoretical formulation of dream psychology (p. 260).

For Kanzer, the intrapsychic nature and communicative elements of the dream are reconciled in a form of secondary narcissism whereby "the dreamer, withdrawing from the outer world, can relinquish objects only by introjecting" (p. 260). Broadly, this means that the content formation of dreams is directly informed by the dreamers' relations to external objects. More specifically, he means that in order to fall asleep and thus shut out the external world, the dreamer must introject external objects. In this way, the boundary between the intrapsychic and intersubjective is blurred.

In order to understand what Kanzer means by introjection, it is helpful to understand Ferenczi's distinction between the paranoiac and the neurotic. In *Introjection and Transference*, Ferenczi (1916) writes,

"Whereas the paranoiac expels from his ego the impulses that have become unpleasant, the neurotic helps himself by taking into the ego as large as possible a part of the outer world, making it the object of unconscious fantasies" (p. 47). The paranoiac's expulsion of unpleasant impulses is understood as projection, while the neurotic's taking in of the outer world is understood as introjection. Within this distinction, it is no stretch to suggest, as Kanzer does, that the unconscious fantasies informed by introjection become manifest in the dream. It is of course important to note that the introjection of the neurotic and projection of the paranoiac are extreme examples of the unconscious processes that occur in the normal functioning of the mind (Ferenczi, 1916, p. 48).

In itself, the claim that the content of dreams is informed by introjection remains vague in that it accounts for the source of the objects in dreams but does not describe how the objects are utilized once introjected into the dream. Contemporary contributions to group analytic theory inform a clarification of the role of introjected objects in the dream. Friedman (2004) describes a process that he calls "projective identification in the dream" whereby the dreamer utilizes stored objects to "contain and elaborate conflictual and sometimes unbearable material" (p. 510). In this way, the dreamer, "imaginatively tries to work through difficulties by projecting them on to Others and their relations" (p. 510). For Friedman, the dreamer utilizes introjected objects in the dream to project conflictual and unbearable material, so that the dreamer does not need to directly identify with the material to begin processing it. Friedman takes a Bionian perspective whereby dreaming is a space for 'thinking' in which emotions that are unbearable to the dreamer can be transformed into material that is bearable for the dreamer to process consciously (p. 509). Integrating introjection and projective identification in the dream, we understand that the dreamer, burdened by unbearable and unconscious material, must introject external objects through dreaming and project the unbearable material onto the objects in the dream. Thus, the dreamer is able to experience and work through unbearable material from a tolerable distance in the apparently intrapsychic simulation of the dream. Just as the dream is at once intrapsychic and directed toward communication with the external world, the mechanisms underlying the content formation of the dream are informed by introjection and projective identification. Just as the dream blurs the boundary between intrapsychic and intersubjective phenomena, utilizing introjected objects

for projective identification blurs the boundary between introjection and projection, as the two occur as part of the same process in the dream. Thus, the dreamer's simultaneous utilization of introjected objects for projective identification in the dream constitutes a phenomenon which can be called introjective projective identification in the dream.

The categorization of the dream is thus located somewhere between the intrapsychic and intersubjective. The ambiguity of this space in which the dream is at once an entirely intrapsychic and narcissistic phenomenon and a mechanism which dynamically utilizes external objects to communicate with the external world, as well as the integration of the seemingly divergent mechanisms of introjection and projective identification to inform dream content can be reconciled by considering Winnicott's conceptualization of transitionality. Winnicott (1958) introduces the concepts of transitional objects and transitional phenomenon to designate:

> The intermediate area of experience, between the thumb and the teddy bear, between the oral erotism and true object relationships, between primary creativity and projection of what has already been introjected, between primary unawareness of indebtedness and the acknowledgment of indebtedness. (p. 230)

The transitional object is thus the original not-me object that occupies a space neither fully acknowledged as internal to the infant nor as belonging to external reality. For Winnicott, the transitional object or phenomenon can be something such as a bundle of wool, corner of a blanket, word, tune, or mannerism which becomes vitally important in order for the infant to sleep and functions as a defense against anxiety (p. 232). In normal development, the transitional object and phenomena ultimately lose meaning as they "become diffused" and "spread out over the whole intermediate territory between 'inner psychic reality' and 'the external world as perceived by two persons in common' " (p. 233). Thus, transitional objects and phenomena serve to help one negotiate the boundary between self and other. Once the boundaries between self and other are negotiated in successful development, transitional objects and phenomena become obsolete. In light of the way in which the dream utilizes introjected objects to work through difficulties via projective identification and the way in which these mechanisms

blur the boundaries between the intrapsychic and the intersubjective, as well as between self and other, the dream is understood as a transitional phenomenon.

In its being told, the dream functions as a third in the analytic encounter, moderating the exchange between analyst and analysand. Though the dream necessarily communicates something about the inner experience of the analysand, it also functions as an external object that relates ambiguously to the analyst and analysand. Pontalis (1974) describing the location of the dream narrative in the analytic encounter, writes, "Each of us ascertains that the dream, however misleading its content, is placed between the analyst and analysand: *a no man's land* that protects the two, though none is certain from what" (p. 127). This function of the dream in session relates analogously to the simultaneous introjection of external objects and withdrawal from the external world while dreaming, in that the narration of the dream entails a withdrawal from the dyadic intersubjective space while also functioning to promote object-relatedness. The dream and dream telling are analogous in their antagonistic nature. This 'no man's land' to which Pontalis (1974) refers, within which one may very well derive meaning from the dream, necessarily entails a dampening of the dream affect as well as a reduction of the dream itself as it is articulated and thus reduced in language. He writes:

> In fact, however, many of the networks established in an associated way are convergent; no matter that the affect cannot be changed, there still remains a divergence between the dream put into images and the dream put into words – one might almost say put to death. (Pontalis, 1974, p. 127)

Though the associations made in relation to a spoken dream may converge thematically, Pontalis claims that this exercise necessarily changes the dream, as the original dream is diluted by its being put into language, or in his words, death. The dilution of the dream in its being put into language means that it is not possible to fully convey a dream to another. Similarly, Freud (1933) claims that articulating a dream in language through writing would make it inaccessible to interpretation. Freud writes that when the dreamer writes down their dream in order to remember it, "the resistance from which he has extorted the preservation of the text of the dream will then be displaced on to its associations and will make the manifest dream inaccessible to interpretation" (p. 14). Though the

resistance may function differently in the case where the dream is written prior to the session and when it is articulated for the first time in session, both Freud and Pontalis identify a solidification of the dream as it is articulated in language. Pontalis (1974) engages further with the intersubjective dynamics of dream interpretation and identifies how the dream comes into being as a third entity in the analytic encounter.

Pontalis is not alone in his claim that the dream narrative plays a regulating role in the analytic encounter. For instance, Mathys (2012) writes, "Introducing a dream into the conversation establishes a triadic form of communication out of a dyadic one. This is equivalent to a form of regulation of relation between analyst and analysand" (p. 221). This phenomenon is referred to as "the triangulating function of sharing dreams" which means, quite straightforwardly, that the relationship between the analyst and analysand is regulated by a third point, the dream. For Mathys (2012), the analysand's introduction of a dream into dialogue can function to distance themselves from the 'here and now' of the encounter. However, this distance does not hinder therapeutic traction. Mathys (2012) also claims that the distance resulting from the introduction of the dream can achieve a successful compromise whereby the analysand, in communicating through a dream narrative, speaks from a distanced perspective and thus takes less responsibility for the content of what they communicate. This temporary distancing, which without the theoretical framework of the triangulating function of sharing dreams may be observed as a withdrawal rupture, enables the analysand to talk about "delicate, shameful, or unpleasant things" that may be otherwise unspeakable (p. 221).

The triangulating function of sharing dreams bears a striking resemblance to the dreamer's utilization of introjected objects for projective identification in the dream. In both dreaming and dream telling, the individual utilizes external objects to distance themselves from things that are otherwise not possible to communicate or bring to conscious thought. In both cases, there is a necessary distancing through which the individual processes difficult thoughts, experiences and emotions. In the dream, the distancing from intolerable content that is facilitated through the utilization of introjected objects for projective identification functions as a pathway for the dreamer to process otherwise intolerable material. The telling of the dream in-session functions analogously in that triangulation creates distance between the analyst and analysand that

counterintuitively functions as a pathway for communication and object-relatedness.

In addition to enabling communication, dream telling may also be directed toward containment. As Friedman (2004, p. 511) claims, this function is most clearly observable in children. Friedman writes that young children commonly wake up screaming due to insufficient self-containment abilities and that:

> While comforting the child, the awoken parent will often unconsciously 'take in' his/her fears and be left with the unspoken dread. This is a normal 'meeting' between a child's request for containment, in which a child demands nocturnal help and unconsciously transfers his/her anxieties to a 'container on call', the (pre-consciously) prepared and willing parent. (p. 511)

For Friedman, this containment function in childhood informs future containment patterns in adulthood. The present framework suggests that containment is one mechanism in the communicative process. The role of containment as a communicative pathway can be understood through the role of regressive containment efforts in the context of nightmares. Kanzer's (1955) framework of dreaming as an introjection of external objects in order to withdraw from the external world, nightmares, which often force one to return to the external world, can be understood as a failure to tolerate the introjected object and thus a failure to withdraw from the external world. In the case of the nightmare, processing of intolerable content is interrupted. Thus, the dream telling may be directed toward containment as well as communication and object-relatedness.

Kanzer (1955) also writes that the child's crying out for their caregiver during a nightmare can be understood as a panic resulting from their inability to communicate with the external world during sleep. "Nightmares pass directly into communication when the child cries for his mother, or reflect the paralyzing fear of being unable to establish such communications" (p. 261). In this way, the child screaming during a nightmare is an attempt to communicate with the external world, and the nightmare is an early effort in the communication and can be considered to be analogous to the adult analysand describing a dream in analysis. This image is not to suggest the that adult analysand is as regressed as a screaming child, but rather that the regressive image screaming child captures a core element of

the communicative function of dream telling that this paper seeks to investigate.

Current Study

The current study addresses the relationship between in-session dream telling and self-report scores on the Working Alliance Inventory (Horvath & Greenberg, 1986), Session Impact Scale (Elliot & Wexler, 1994) and Session Evaluation Questionnaire (Stiles, 1980). Results of this exploratory study are discussed in reference to the proposed framework within which dreams are directed toward processing intolerable content in the dream experience and in the telling of the dream. Further, the proposed framework suggests that the dream in the therapeutic encounter functions as an analytic third entity which antagonistically regulates the encounter between relatedness and withdrawal.

Method

Participants

This case study was selected from archived psychotherapy video data and questionnaires originally collected from 12-session treatments at an urban Northeastern university. The therapist is a doctoral candidate in clinical psychology. Patient and therapist selection was informed by existing notes on the data set indicating that the patient discussed their dreams during multiple sessions. All videos of the case were watched by the author.

Measures

Working Alliance Inventory. The Working Alliance Inventory (WAI), developed by Horvath and Greenberg (1986) is a self-report measure of the therapeutic alliance, defined by Bordin (1979) as a combination of patient and therapist agreement on goals, patient and therapist agreement on how to achieve those goals (tasks), and the development of a personal bond between patient and therapist. These aspects of the therapeutic alliance are delineated in the subscales of task, bond, and goals. The WAI is a self-report measure administered to patients and therapists to apply across theoretical orientations. The present study utilizes a shortened 12-item WAI developed by Tracey and Kokotovic (1989). It is worth noting that while the version developed by Tracey and Kokotovic administers

questions on a 7-point Likert scale, the therapy site (data collection site) for this study administered the measure using a 5-point Likert scale. However, we do not expect this difference to have a meaningful effect on the results of the present study.

Session Evaluation Questionnaire. The Session Evaluation Questionnaire (SEQ) developed by Stiles (1980) is a 27-item semantic differential measure which assess patients' feelings about the session. Patients rate on a 7-point scale, the extent to which a given session felt difficult (1) or easy (7), for example. Subscales of the SEQ include session depth, smoothness, positivity and arousal.

Session Impact Scale. The Session Impact Scale (SIS; Elliot & Wexler, 1994) is a self-report measure administered to patients to assess the patient's experience of the impacts of therapy. The SIS is a 16-item measure consisting of items such as, *realized something new about myself,* and *realized something new about someone else*, to which patients rate their agreement on a scale of 1 (not at all) to 5 (very much). Subscales of the SIS include Helpful Impacts and Hindering Impacts. The Helpful Impacts subscale is further divided into Task Impacts and Relationship Impacts.

Procedure

Dyad selection was based on a preliminary search through existing process notes collected by first year master's students in The Safran Psychotherapy Research Lab at The New School for Social Research. The dyad was selected after a keyword search for the word "dream" showed that a student had noted that the patient discussed their dreams in sessions 8 and session 12. Existing data did not include note of patients discussing dreams in any other sessions. However, a review of all the video data for this patient revealed that the patient also discussed their dreams in sessions 3 and 4. As students were not instructed to make note of the discussion of dreams in session, the archived video data likely includes other videos of patients and therapists discussing dreams.

As video data was missing for sessions 7 and 12, and video data of session 9 was missing audio, all data collected from these sessions was excluded from analysis. The SIS, WAI and SEQ were administered to this patient after each session. The relationship between self-report scores on the

WAI, SIS, and SEQ and in session dream discussion is measured using paired samples t-tests.

Results

Presence of Dream Narratives

The present study consists of one case; therefore, results of the relationships between dream telling and patient and therapist self-report measures are intended to provide an impressionistic understanding of the dyad of study which may function to generate hypotheses for future large scale studies. The patient discussed dream narratives during sessions 3, 4, 8 and 11 (4 sessions) and did not discuss dream narratives during sessions 1, 2, 5, 6 and 7 (5 sessions). It is unknown whether the patient and therapist discussed dreams during sessions 7, 9 and 12 (3 sessions) due to missing video/audio data. Data collected from sessions 7, 9, and 12 were excluded from analysis. A paired design was used to compare sessions containing dream narratives to sessions without dream narratives.

Dream Telling and the Therapeutic Alliance

A paired samples t-test found no significant relationships between dream telling and any items or subscale on the WAI.

Dream Telling and Session Evaluation

A paired samples t-test indicated a positive relationship between the patient's score on the session positivity subscale (Likert scale 1 to 7) of the SEQ as well as several individual items on the SEQ. Results indicate that following sessions involving dreams, the patient reported feeling less happy, less friendly, faster and rated the therapist as less skillful than after sessions that did not involve dreams. The patients rating of session positivity was substantially higher after sessions in which they discussed their dreams, $M_{Dream} = 5.28$, $SD = 0.92$, than after sessions in which dreams weren't discussed, $M_{Nodream} = 3.52$, $SD = 0.81$ ($M_{diff} = 1.76$), $t(8) = 2.64$, $p = .057$, 95% CI [-0.08, 3.60], $d = 1.18$. The patient reported feeling less happy after sessions that involved discussion of dreams, $M_{Dream} = 2.75$, $SD = .1.26$, than after sessions in which dreams were not discussed, $M_{Nodream} = 5.25$, $SD = 0.96$ ($M_{diff} = -2.5$), $t(8) = -8.66$, $p = .003$, 95% CI [-3.42), -1.58], $d = 4.33$. The patient reported feeling less friendly after sessions that

involved discussion of dreams, M_{Dream} = 2.5, SD = 1.29, than after sessions that did not, $M_{Nodream}$ = 5.5, SD = 1 (M_{diff} = -3), $t(8)$ = -3.28, p = .046, 95% CI [-5.90, -.095], d = 1.64. The patient reported feeling faster after sessions that involved discussion of dreams, M_{Dream} = 4, SD = 1.15, than after sessions that did not, $M_{Nodream}$ = 2, SD = 1.5 (M_{diff} = 1.75), $t(8)$ = 7, p = .006, 95% CI [0.95, 2.55], d = 3.5. The patient reported feeling more aroused after sessions that involved discussion of dreams, M_{Dream} = 4.25, SD = 1.258, than after sessions that did not, $M_{Nodream}$ = 1.5, SD = 0.58 (M_{diff} = 2.75), $t(8)$ = 5.74, p = .010, 95% CI [1.23, 4.27], d = 2.87. The relationship between the patient's rating of the therapist's skillfulness following sessions that involved dreams M_{Dream} = 6, SD = 0.82, compared to those that did not, $M_{Nodream}$ = 6.75, SD = 0.5, approached significance (M_{diff} = -0.75), $t(8)$ = 3, p = .058, 95% CI [-1.55, 0.05], d = 1.5.

Dream Telling and Session Impact

Paired samples t-tests indicated that the patient reported feeling more aware (Likert scale 1 to 5), more supported, more relieved, as well as more distracted and confused after sessions that involved dreams than after sessions that did not. The patient reported—more awareness following sessions that involved discussion of dreams, M_{Dream} = 4.33, SD = 0.58, than after sessions that did not, $M_{Nodream}$ = 3, SD = 0 (M_{diff} = 1.33), $t(8)$ = 1.19, p = .057, 95% CI [-0.10, 2.77], d = 2.31. This relationship trended toward significance. The patient reported feeling more supported after sessions that involved discussion of dreams, M_{Dream} = 4.67, SD = 0.58, than after sessions that did not, $M_{Nodream}$ = 3.33, SD = 0.58 (M_{diff} = 1.33), $t(8)$ = 5.19, p = .057, 95% CI [-0.10, 2.77], d = 2.31. This relationship trended toward significance. The patient reported feeling greater relief following sessions that involved discussion of dreams, M_{Dream} = 4, SD = 1, than after those that did not, $M_{Nodream}$ = 1.33, SD = 0.58 (M_{diff} = 2.67), t(8) = 8.66, p = .015, 95% CI [1.23, 4.10], d = 4.62. The patient reported feeling—less distracted or confused after sessions that involved discussion of dreams, M_{Dream} = 1, SD = 0, than after those that did not, $M_{Nodream}$ = 3.67, SD = 0.58 (M_{diff} = -2.67), $t(8)$ = -4.7, p = .015, 95% CI [-4.10, -1.23], d = 4.62.

Discussion

Results from the Working Alliance Inventory, Session Impact Scale and Session Evaluation Questionnaire are speculatively compatible with the triangulating function of the dream in which the dream regulates the therapeutic encounter between relatedness and withdrawal. In sum, the self-report results indicate that after sessions in which the patient discussed a dream, they felt more aware, supported, relieved, positive, faster, and more aroused than they did after sessions in which they did not discuss their dreams. However, after these sessions, the patient also reported that the therapist was less skillful and that they felt less happy, less friendly and more distracted and confused than after sessions in which they did not discuss their dreams.

Taken together, the positively and negatively valanced results of the self-report measures indicate that the dream has a potentially disruptive effect on the in-session experience of the patient, in that it facilitates an oscillation between relatedness and withdrawal. This coheres with a conceptualization of the dream as directed toward processing intolerable content, and the telling of the dream as a step in the processing of intolerable content. This concept may in part account for some of the negatively valanced patient self-report data, including distraction and confusion and diminished feelings of happiness and friendliness. Based on subjective observation of the videos of the sessions, there is often an observable misattunement between the patient and the therapist in the moments before the patient describes a dream. During this misattunement, it seems as if the patient is trying to communicate something to the therapist while the therapist attempts to direct the dialogue in another direction. The patient appears to take a heightened level of agentic control over the dialogue, which disrupts the previously established equilibrium. The therapist seems to eventually adjust, albeit with some delay, and listen passively. It is possible that these moments influence the patients self-report that the therapist was less skillful during sessions in which they describe their dreams.

Though disruptive, the dream, via triangulation, is conducive to communicative pathways otherwise unavailable. This may be related to the increase in positively valanced self-report items, including heightened feelings of being aware, supported, relieved, positive, faster and aroused. Moreover, based on observation of the videos, the dream narratives always appeared to hold the interest of the patient and therapist. The heightened level of relief reported by the patient following sessions in which they described a dream can most likely be attributed to the containment function of dream telling. The relief reported by the patient may also

be related to the processing of previously intolerable unconscious material that takes place in the telling of the dream.

Notably, the significant relationships between self-report process measures were only derived from responses of the patient, as responses of the therapist to self-report measures did not differ significantly between sessions that involved discussion of dreams and those that did not. Broadly, these findings suggest that the phenomenology of the dream in the therapeutic encounter is more pronounced for the patient than the therapist. To broadly dichotomize, the therapist's approach to dream narratives bore more resemblance to the Freudian approach or passive listening rather than the Ferenczian approach of more active engagement. One may speculate that a more active approach to the patient's dream narrative may be related to a heightened phenomenological impact of the dream on the therapist.

Limitations

As a single case study, the extent to which the results generalize to a broader population is speculative. The study is limited in that video data is missing for several sessions. The present study is also limited in that it relies solely on self-report data, which is understood as an artifact of a relational exchange between patient, the therapist, and the clinic in which the therapy took place rather than an accurate representation of the phenomenological experience of the patient and the therapist. Given that video data was missing for several sessions, it is possible that a complete single case would provide clearer results with higher statistical power. Moreover, the self-report questionnaires all utilize scales which limit the depth of understanding that can be gained from a response.

Future Directions

These limitations highlight a number of directions for quantitative and qualitative approaches to studying the intersubjectivity and phenomenology of dream telling in psychotherapy. Future qualitative research would benefit from utilizing open ended questionnaires to patients and therapists. Future quantitative research would benefit from including a larger sample, as well as coding video recorded sessions using an observer-based coding system, which would potentially provide empirical support for some aspects of the triangulating function of the dream. Future research would also

benefit from comparing the intersubjective qualities of dream telling to those of other types of narratives. While the present paper maintains that the dream facilitates unique communicative pathways and processing of unconscious material, it is possible that other types of narrative may present similar intersubjective patterns in session. A clear understanding of the triangulating function of the dream, and potentially other narratives, may inform more adept therapeutic responsiveness.

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Investigating the Roles of Therapist Experiencing and Therapist Reflective Functioning in the Therapeutic Environment

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This study evaluates several factors that may contribute to the creation of a therapeutic space in which a client feels supported in their growth. Experiencing, the ability to focus on the data of one's experiential awareness, moves people to explore and address problems in their lives by encouraging the recognition of internal struggles. Reflective functioning, or mentalizing, is the level to which one is aware of one's own internal states, and to which one can understand others in terms of mental states; the thoughts, intentions, feelings, and beliefs of self and other. Proposing the theory that experiencing and reflective functioning are important skills for therapists in the creation of a holding environment (in which patients can safely explore their internal conflicts) two hypotheses were tested: (1) Therapist Experiencing (EXP) scores will correlate with therapist Reflective Functioning (RF) scores, demonstrating that therapists who are skilled in experiencing will also be skilled in mentalizing, and (2) Therapists with higher-level EXP scores and RF scores will encourage growth toward better functioning, as displayed in outcome measures (Inventory of Interpersonal Problems; IIP, and Symptom Checklist; SCL). Results did not support these hypotheses; in fact, a negative correlation was shown between outcome measures and high EXP/RF, linking high therapist experiencing and reflective functioning to lower resolution of patient's interpersonal problems and psychological symptoms.

Keywords: therapist experiencing, reflective functioning, therapeutic environment, therapist relational interview at midphase (TRI-M), psychotherapy outcomes

In consideration of best practices in the therapeutic environment, one can trace many facets of modern therapeutic custom to the father of traditional psycho-analysis, Sigmund Freud. In "Recommendations to Physicians Practicing Psycho-analysis" (Freud, 1912) outlines the practice of free association, labeling it the "fundamental rule of psycho-analysis; the patient must at all times bare his honest experience to the therapist, relat[ing] everything that his self-observations can detect" (p. 112). Furthermore, Freud required that just as the patient must hold back interpretations and deductions in the course of their elaborations, the therapist too must open themselves to everything they are told, withholding reason and conscious influences. Freud states that the therapist "should simply listen, and not bother about whether he is keeping anything in mind" (Freud, 1912, p. 112). The patient should be able to bare themselves fully without restraint, and the therapist must orient themself to the patient's unconscious, "as a telephone receiver is adjusted to the transmitting microphone" (Freud, 1912, p. 115).

Bordin (1979) describes the free association rule as an alternatively implicit and explicit request for the "patient to replace his attention toward his specific hurts and self-dissatisfactions with a free-floating set, and tells the patient that the therapist will at least temporarily take over the executive functions for him" (p. 255). Yet, how does the patient position themself in such a spot of candid exposure, trusting the therapist to receive their innermost confessions; how does the therapist receive everything they are told without the application of their logical censors and selections? The creation of an environment in which the patient feels safe with forthright exposure would seem to be a necessity; a setting that is protective, yet encourages exploration.

Winnicott (1965), in his studies in the theory of emotional development, cultivated the notion of a "holding environment." Speaking from the developmental perspective, Winnicott described the nature of effective caregiving in the infant-mother relationship as one that requires the construction of a context in which the mother establishes safe boundaries around a protective space. Within this safe space, be it the physical space of mother's arms in early infancy, or a metaphorical space provided throughout development, a "good-enough" caregiver gradually strengthens the child's "capacity to handle environmental impingement" (Kahn, 2001, p. 262). Balint (1968) maintains that one's original experience of being securely held in the early developmental years is related to ego strength. Creation of the holding environment is an intentional process of building a safe place for growth:

Holding environments are marked by a shifting of the task, through the conscious intervention of a member or leader of a dyad or group, toward holding…. In each case, people deliberately create the psychological space in which the task becomes surfacing and working through anxiety. (Kahn, 2001, p. 265)

Kahn considers Winnicott's and Balint's notion that the space created in therapy, the therapeutic environment, must replicate this feeling of a safe place — it must be a holding environment in which the patient feels safe to explore problems that arise in exhibition.

Psychoanalytic therapists try to create environments in which patients are enabled to temporarily regress without fear of impingement…. The analyst creates the holding environment through unwavering attentiveness to the patent's experiences, needs, and development; by facilitating the patient's arriving at her own insights; by allowing, without judgment, the expressions of affect, dreams, wishes, creativity, and play; by containing strong emotion, and by offering empathic interpretation. (Kahn, 2001, p. 262)

From an attachment perspective, the therapist must be able to act for the patient as an attachment figure providing a secure base, a safety net that delivers protection from harm as the patient walks the tightrope of personal exploration. Mary Ainsworth (1967) conceptualized the secure base in her studies of Ugandan toddlers, whom she observed to "move away from their mother to play, returning every now and then to touch base" (Byng-Hall, 1995, p. 45). Proximity to an attachment figure provides the individual with support from someone who is perceived as skilled in coping with situational demands; this applies to the therapeutic environment as well as with a caregiver.

What is the means by which we foster attachment security in psychotherapy? In a word, mentalizing. Plainly, Rogers was on the right track in focusing on relationship conditions, and a trusting relationship is one facet of the needed therapeutic alliance. In the context of attachment relationships, we have construed mentalizing as a fundamental common factor in psychotherapy. (Allen, 2011, p. 3)

Allen (2011) discusses the importance of the therapist taking a "mentalizing stance" by mindfully expressing nonjudgmental empathetic curiosity about the patient's experience and the patient-therapist relationship. Bateman and Fonagy (2004) further this assertion, stating that "a therapist needs to maintain a mentalizing stance to help a patient develop a capacity to mentalize" (p. 41). Forming an attachment relationship in the therapeutic setting is analogous to the use of attachment figures throughout the life course, as many such relationships develop throughout life, "such as partners or friends, who may then provide each other with a mutual, secure base, making care available in times … when either of them is in need. In situations of stress, even strangers, such as therapists, can also rapidly become temporary attachment figures" (Byng-Hall, 1995, p. 45).

How an attachment figure is able to present themself as a secure base, even a stranger in the form of therapist, depends on their understanding of the subject's inner experiences, and their ability to respond appropriately (Fonagy, Target, Steele, & Steele, 1998). "It is the [attachment figure's] capacity to reflect upon the child's internal experience that is so crucial to the development of a secure attachment" (Slade, 2005, p. 270). Mentalizing, making meaning of the internal states of others, guides the subject to develop self and affect regulation structures. According to Slade (2005), "It provides the means to discover and give voice to vital aspects of subjective experience, and allows for deep and broad self-knowledge" (p. 270). In a secure attachment,

the parent reflects upon the child's behavior, and responds in a way that at once soothes the child's distress (promoting intimacy and sameness) and also suggests a mode of coping (promoting autonomy and separateness) (Fonagy et al., 1998, p. 7). Thus, the act of mentalizing communicates to the subject a sense that their internal working model (a cognitive scheme of mental representations for understanding the self and others in the world) is understood and provides an opportunity to develop the support needed to bear its consequences.

Background for the Present Study

A holding environment is necessary for the safe exploration of difficult self-constructs. "It is the mother's observations of the moment to moment changes in the child's mental state, and her representation of these … that is at the heart of sensitive caregiving, and is crucial to the child's ultimately developing mentalizing capacities of his own" (Slade, 2005, p. 271). Demonstration of this mentalization skill, perceiving and understanding the mental states of oneself and others, has been operationalized by Fonagy and colleagues (1998) as the Reflective Functioning (RF) scale. The RF scale is an observational measure that quantifies an individual's capacity to mentalize and perceive intentionality in the other.

> In order to enter into another's experience, or make sense of his own, he must recognize that his ideas and feelings do not define those of another, that what is subjectively real for him is not necessarily subjectively real for another. He must also be able to imagine what is in another's mind, to (in essence) pretend to enter into their experience. (Slade, 2005, p. 272)

Mentalizing involves both a self-reflective and interpersonal component. While the Experiencing Scale (EXP; described below) quantifies an individual's ability to focus on their own internal experience, the RF Scale seeks to quantify an individual's capacity to conceive of the "beliefs, feelings, attitudes, desires, hopes, knowledge, imagination, pretense, deceit, intentions, [and] plans" of others" (Fonagy et al., 1998, p. 5). It is contrastable to the EXP in that RF assesses one's ability to determine inner from outer reality, unrealistic from realistic ways of functioning and intra-personal from interpersonal communication. Reflective functioning is the capacity for theory-of-mind, one's ability to attribute mental states to others, to predict and make meaning out of other peoples' behavior in reference to the self.

Fonagy et al. (1998) consider RF to be "a developmental achievement which is never fully acquired" (p. 6), rooted in attachment security and the developmental process of learning to identify the self in the mind and behavior of others. According to Fonagy and colleagues, "mentalization by the parent provides or confronts children with a presentation of the contents of the parent's mind that is *both the same and different* from the contents of the child's mind" (p. 7). Development of reflective functioning is indeed crucial, as the inability to characterize the actions of others leads to attribution errors.

> Prior to the development of reflective functioning, inconsistency or hostility from others is more likely to be taken at face value as showing something bad about the child. In contrast, if the child is able to attribute a withdrawn, unhappy mother's apparently rejecting behavior to her emotional state, rather than to himself as bad and unstimulating, the child may be protected from lasting injury to his view of himself (Fonagy et al., 1998, p. 10).

One must be aware of one's own experience in the moment in order to ascribe meaning to one's self-state. Gendlin's definition of experiencing (as cited by Klein, Mathieu, Gendlin, and Keisler, 1969) describes experiencing (operationalized by the Experiencing Scale) as the basic referent for inwardly focused attention, the ability to attend to current experience and the "continuous stream of sensations, impressions, somatic events, feelings, reflective awareness, and cognitive meanings that make up one's phenomenological field" (p. 4). A person's manner of experiencing encompasses their quality of awareness, acceptance of feelings and inner life, and the extent to which one is experientially aware of thought and action. Gaining experiential awareness assists one in reorganizing internal models, moving from a state of incongruence to one of congruence. According to Klein et al. (1969), "experiencing is a dynamic process (not a trait or developmental milestone); a developing ability that facilitates focusing on the referent of an experience, and allowing root causes to emerge." (p. 7). At the lowest levels of experiencing, the individual has a blockage of internal communication and is prevented from growth by an avoidance of feelings. Removal of

these internal communication blockages is apparent at higher levels; as problems become salient, and the subject makes efforts to reconcile dissonances and develop self-authenticity. To offer oneself as a secure base, the therapist must cultivate a relationship with their patient, supported by the therapist's understanding of their own self and experiencing, and their understanding of the patient's internal working models, mental states, intentions, and their behavioral correlates.

While discussing their rupture resolution model, Safran & Muran (2000) highlight the intersubjective nature of the therapeutic process. Therefore, it would seem to follow that the most optimal therapeutic exchange is a holding environment in which the therapist can keep both minds in mind. Klein et al. (1969) stipulate that clinical skill is only one factor that drives the therapeutic relationship. Kolden (1996) indicates, "therapy techniques and procedures do not generally appear to directly influence session progress significantly in early sessions of therapy, although … experiential interventions may play a role" (p. 494). Klein et al. (1969) reminds us that a therapist must guide the patient to move just beyond their current level of experiential awareness; "it is his sensitivity to the client's referent to his expressed mode of experiencing that enables the therapist to help the patient find the next-most-important thing in his experiencing, and thus to communicate with and effectively influence the patient" (p. 9).

The creation of an optimal environment hinges on the therapist's ability to attend to the inner state of the patient without being directed by sub-textual draws apparent in the therapist's own experiencing. Gendlin (1968) remarks that "the therapist's experiential responses draw the client's attention directly to his own felt-meaning. The therapist merely aids" (p. 211). The therapist must be able to guide the client in their experiencing, to focus on and shift felt-meanings — yet, this should not be an overly directional process. Freud (1912) warns: "young and eager psycho-analysts will no doubt be tempted to bring their own individuality freely into the discussion, in order to carry the patient along with them and lift him over the barriers of his own narrow personality" (p. 117). However, this may lead the dyad down a rabbit-hole of selection and self-fulfilling prophecy. He cautions that, "in making the selection, if he follows his expectations he is in danger of never finding anything but what he already knows; and if he follows his inclinations he will certainly falsify what he may perceive" (p. 112).

Reik's (1948) aptly titled *Listening with the Third Ear* explains that many of the subtler and more nuanced aspects of communication are expressed and perceived below the level of conscious awareness, and thus must be attended to with a more intuitive sense. Safran (2011) notes the necessity for the therapist to turn their attention inwards, in order to understand their own reactions in the therapeutic relationship. He discusses the potential consequences for therapists who find it difficult to become aware of their own negative countertransference feelings, resulting in inadvertent and unacknowledged hostile or complex communications that may perpetuate vicious cycles of hostility and counter hostility. Change occurs when the analyst is able to acknowledge their own contribution to the enactment (Safran, et al., 2014). Safran and Muran (2000) contend that the therapist's ability to acknowledge emerging feelings in the therapeutic negotiation plays an important role in working through alliance ruptures as they arise. These authors assert that therapists who are self-accepting and can acknowledge the feelings that they have toward their patients can better work through therapeutic ruptures, and that the working through of these relationship problems is in and of itself a mechanism of change. Kazariants (2011) tested the hypothesis that "therapists with a higher capacity of engaging in a self-reflective exploration of subjective experiences of their work with patients will be more effective at repairing alliance ruptures" (p. 17), and found that there was a correlation between EXP scores and improved scores on the Working Alliance Inventory (WAI). The WAI measures the degree of agreement on tasks, goals, and bond; it is essentially a measurement of collaboration in the change process. The therapist's awareness of their own internal processes prevents acting upon and acting-out these internal states, and allows the therapist not to become hung-up on expectations or conclusions (as Freud warned us).

Present Study

The present study sought to investigate how therapists' objectively scored levels of Experiencing (the degree to which the therapist is able to honor and live their own inner concepts) and Reflective Functioning (the degree to which the therapist is able to hold the therapist's and the patient's mental states in mind) interact in the therapeutic setting. As independent constructs, these variables were investigated as separate entities in relation to the outcome variables. It was

predicted that a therapist with high-level Experiencing rating would display a correspondingly high-level Reflective Functioning rating. The theory underpinning this hypothesis relies on the assumption that one who knows how to keep one's own mind in mind might be well suited to keep the mind of another in mind. Furthermore, the present study investigates whether growth in the therapeutic context is supported by the creation of a safe-space/secure-base wherein the therapist mentalizes and also attends to their own felt experience.

Two main hypotheses were tested in this study: (1) Therapist Experiencing (EXP) scores will correlate with therapist Reflective Functioning (RF) scores; that is, therapists who are skilled in experiencing will also be skilled in mentalizing. (2) Therapists with higher-level EXP scores and RF scores will encourage growth toward better functioning, as displayed in subjective outcome measures. Specifically, it is predicted that patients will show fewer psychological symptoms at termination of therapy than at intake, and fewer interpersonal problems at termination of therapy than at intake.

Method

Participants

Patients were all clients of the Brief Psychotherapy Research Program located at Beth Israel Medical Center, recruited through publication advertisements, locally posted flyers, professional referrals, and finding the clinic website through self-initiated internet searches. Patients were included in the program if they accepted short-term (30 sessions, usually weekly) treatment, and were able to pay a discounted fee for treatment determined via sliding scale. Patients were excluded from research if they were currently undergoing another psychotherapy treatment, or if they were on psychotropic medication that had not yet been stabilized for at least 3 months. Substance dependency, psychosis, and suicidality were also exclusion criteria.

Data from twenty-one patients (4 male, 17 female) was analyzed. Patient age ranged from 27 to 68 ($M = 38.14$, $SD = 11.32$). 52.38% were single, never married, 28.57% were married or remarried, and 19.05% were divorced or separated. All patients had at least some college education, with 38.10% holding college degrees and 52.38% holding graduate or higher-level degrees. The majority of patients (76.19%) were employed at the time of therapy. Racial/Ethnic composition was 75.19% Caucasian, 9.52% Asian or Pacific Islander, 4.76% Hispanic, and 9.52% other. Many of the patients (76.19%) met criteria for at least one *DSM-IV* Axis-1 disorder and 33.33% met criteria for at least one *DSM-IV* Axis-2 disorder.

Each patient was paired with a psychotherapist and engaged in Brief Relational Therapy (BRT); 21 therapists (5 male, 16 female) participated. Nineteen of the dyads (90.48%) completed between 25 and 30 sessions of treatment, and 2 dyads (9.52%) completed less than that (15 and 17 sessions).

All therapists participated in BRT modality-specific training, including supervision designed to teach therapists to be mindful of countertransference. Emerging from the foundation of BRT, Alliance Focused Training (AFT), developed as a relational therapy training program that integrates relational principles focused on resolving alliance ruptures. AFT teaches therapists to "attend to and explore their own feelings as important sources of information about what is going on in the therapeutic relationship …provid[ing] trainees with the opportunity to explore their own feelings and internal conflicts as they emerge in the moment" (Safran et al., 2014, p. 272). AFT views the therapist's feelings as a valuable source of information regarding the interchange in the relational negotiation. Therapists are encouraged to express their feelings and intuitions.

Measures and Assessment

The Experiencing Scale. The Experiencing Scale (EXP; Klein et al.,1969) was developed to operationalize and elaborate upon a strand in Carl Roger's writings about the basic processes of psychotherapy and personality change. The scale offers a dimensional approach to the evaluation of an individual's experiencing of the self and is depicted by stages that range from 1 to 7. Evaluation is based on the individual's verbal communication. The scale organizes communication into stages that range from superficial communication, to somewhat meaningful communication to deeply meaningful communication where feelings are intentionally explored and experiences are recruited to instigate shifts in one's frame of reference. The speaker's communication is evaluated as follows: impersonal, distant and remote from feelings (Stage 1); demonstrates an emerging personal perspective, though personal reactions still are referred to indirectly or abstractly (Stage 2); refers to one's own feelings, though they are expressed circumstantially; deep personal ramifications are not yet

expressed (Stage 3); describes feelings and personal reactions and the felt inner referent starts to be used to address the meaning of feelings, this represents a shift in set quality (Stage 4). Stages 5 to 7 elaborate a progressive exploration of the inner referent, with an increasingly complex sense of meaning and impact, and provides for resolutions to be made. While at stage five it is a struggle to maintain set and focus on the referent to make for change, stage seven expresses a confident process of identifying the referents of thoughts and actions, as well as constant feedback and adjustment with new experiencing. The experiencing scale has been determined to be a small to medium predictor of treatment outcomes when compared to self-report outcome measures such as the Inventory of Interpersonal Problems (IIP) and the Symptom Check-List (SCL), $r = -.19$ (Pascual-Leone & Yeryomenko, 2017).

The Reflective Functioning Scale. The Reflective Functioning Scale (RF; Fonagy, et al., 1998) was developed to operationalize and measure an individual's underlying capacity to mentalize. The Reflective Functioning rating system is an observer measure, set to an ordinal scale ranging from -1 to 9; each utterance is scored for level of expressed Reflective Functioning. Zero (0) and negative 1 (-1) ratings are included on the scale to allow the rater to identify a complete lack of reflection, or even an utterance that is inappropriate or seemingly bizarre. These remarks may be obviously evasive or overtly hostile. A score of Level 1 is applied when the subject demonstrates a lack of reflection without repudiation (repudiation is seen in zero or negative scores), or is sociological, generalized, or egocentric. Level 3 indicates that the subject expressed oneself using the language of mental-states, but abstained from exhibiting genuine reflection or understanding of the mental-states of others or their implications. Level 5 is ordinary Reflective Functioning, indicating explicit reflection and reference to mental-states and their affects; the reflection needn't be particularly sophisticated. Level 7 requires a demonstration of understanding mental-states of self and other, in such a way that the rater believes their understanding to be sophisticated, complex, causally sequenced, and interactional. There must also be willingness to accept rather than avoid or defend against the problems. Less than ten percent of scored passages are rated level 9, as an exceptional level of sophistication is required. The RF scale has strong inter-rater reliability, $r = .91$ (Fonagy et al.,1998).

The Therapist Relational Interview-Midphase.

Therapist RF and EXP scores were assessed at the mid-point in therapy using the Therapist Relational Interview-Midphase (TRI-M), a semi-structured interview administered to the therapists by trained research assistants in the Brief Psychotherapy Research Program (Safran & Muran, 2007). The TRI-M is modeled on the Adult Attachment Interview, during which individuals are asked to describe attachment related experiences and evaluate the influences of these experiences on their functioning (Hesse, 2008). Therapists are asked to provide 5 adjectives that reflect their feelings toward their patient, and to give open ended descriptions of their experience. They are probed to explore tensions and conflicts that they may have experienced with their patient.

Research assistants who are trained (reliable within and between coding groups) in coding interviews for RF and EXP evaluate and score the therapists' responses to the interview. An overall RF score is generated, as well as mode and peak EXP scores. Because subjects tend to vary in EXP expression throughout the duration of an interview, a combined score is generated by summing the mode and peak scores of a session, providing additional means for differentiation between interviews. To borrow an example from Kazariants (2011), if there are three scored sessions with mode scores of 2, 2, and 3, and peak scores of 2, 3, and 3 respectively, combining the mode and peak scores elucidates three contrastable scores of 4, 5, and 6.

The Inventory of Interpersonal Problems. The Inventory of Interpersonal Problems (IIP-64) is a self-report measure that assesses interpersonal difficulties (Horowitz, Alden, Wiggins, & Pincus, 2003). It is based on a theoretical foundation that interpersonal experiences are represented emotionally and cognitively in an individual, and that these schemas influence one's interactions with those around them. The IIP-64 serves to identify common interpersonal problems, match particular problems with specific treatment goals, and aid clinicians in identifying progress in treatment. The IIP-64 is a strong measure of interpersonal difficulties, $r = .96$ (Horowitz et al., 2003). The IIP-32, utilized in this study, is a short version of the IIP-64, containing 32 items. The IIP manual reports a reliability coefficient of .93 for the IIP-32 (Horowitz, et al., 2003).

The Symptom Checklist. The Symptom Check-List (SCL-90) is a self-report symptom inventory that measures psychological symptoms and psychological distress, designed for community, medical, and psychiatric settings. Distress is measured in nine principle

dimensions including somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism (Derogatis & Unger, 2010). The measure was designed to be a useful meter of patient progress or treatment outcome. Questionnaire items ask participants to report (on a Likert scale of 0-4) the degree to which they have recently experienced certain symptoms that are indicative of psychological distress, including items such as nervousness/shakiness, poor appetite, loneliness, and spells of terror or panic. This study used the Brief Symptom Inventory (SCL-53). The SCL-53 is a 53 item version of the SCL-90 with good internal reliability r = .7 for the scales (Derogatis, 1993).

Procedure

All treatment took place from 2005 - 2014. Pre- and post-session questionnaires were issued to patients at the start and end of each session, and patients completed a battery of assessment measures (including the Symptom Checklist; SCL-53, and Inventory of Interpersonal Problems; IIP-32) at intake and termination of treatment programs.

All therapists participated in the Therapist Relational Interview at Midphase (TRI-M), around the time of session 15, and their interview transcripts were scored for both Experiencing and Reflective Function (EXP and RF ratings are based on the same transcript, coded by different coders).

For the purposes of this study, SCL and IIP data was used to measure progress. IIP data was used to see if patients displayed reduced interpersonal problems at termination of treatment compared to intake and SCL data was used to determine symptom reduction from intake to termination. At the start and termination of treatment, patients completed the IIP-32, which asked the patient to report (on a Likert scale of 0-4) the degree to which certain items cause problems. Part-I probed for things that are hard to do with other people, such as joining groups, keeping things private, and showing affection. Part-II probed for things that the participant felt they do too much, such as being persuaded, being too aggressive, or trying to please others. An overall IIP-32 score was generated by averaging the item-by-item scores. Termination scores were subtracted from intake scores to indicate the magnitude of interpersonal problem reduction.

The SCL-53 data was used to determine if patients showed overall reduction in self-reported psychological symptoms. Like the IIP-32 it was administered at intake and termination, and item scores were averaged to provide overall scores for each measure. Termination scores were then subtracted from intake scores to indicate magnitude of symptom reduction.

Results

Table 1 shows the correlation coefficients generated by testing the first hypothesis; predicting a correlation between therapist EXP scores and therapist RF scores. Twenty-one therapist Reflective Functioning (RF) scores and Experiencing (EXP) scores (mode, peak, and combined) were measured and analyzed for correlation. Pearson's r correlation coefficients were calculated and, contrary to predictions, weak relationships were found between RF and EXP mode scores (r = .15, p = .53), RF and EXP peak scores (r = .05, p = .82), and RF and EXP combined scores (r = .11, p = .63).

Table 1
Pearson's Correlations Between Therapist EXP and Therapist RF

	RF		
	n	*r*	*p*
EXP mode	21	.15	.53
EXP peak	21	.05	.82
EXP combined	21	.11	.63

Note. Therapist Relational Interview-Midphase (TRI-M) was coded for each therapist with the EXP and RF Scales. Correlations were then run between these scores.

Table 2 shows the correlation coefficients generated by testing the second hypothesis; predicting that therapists with higher-level EXP scores and RF scores to have patients who display improved change scores on outcome measures. Nine patients (8 female, 1 male) had complete data for the Inventory of Interpersonal Problems (IIP-32) from both termination and intake, and their scores were analyzed for correlation to therapist RF and EXP scores. Pearson's r correlation coefficients were calculated revealing, contrary to predictions, a strong negative correlation between therapist EXP mode score and IIP-32 (r = -.74, p = .02), and a strong negative correlation between therapist RF score and IIP-32 (r = -.67, p = .05).

Seven patients (6 female, 1 male) had complete Symptom Check-List (SCL-53) data from both

termination and intake, and their scores were analyzed for correlation to therapist RF and EXP scores. Pearson's *r* correlation coefficients were calculated revealing a strong negative correlation between therapist EXP combined score and SCL-53 *(r = -.8, p = .03)*, and a strong negative correlation between therapist RF score and SCL-53 *(r = -.87, p = .01)*.

Table 2

Pearson's Correlations Between EXP/RF Scores and Outcome Measures

	IIP			SCL		
	n	*r*	*p*	*n*	*r*	*p*
EXP mode	9	-.74*	.02	7	.65	.11
EXP peak	9	.21	.60	7	.58	.18
EXP combined	9	-.40	.23	7	.80*	.03
RF	9	-.67*	.05	7	.87**	.01

Note: * = p <. 05; ** = p < .01. Therapist Relational Interview-Midphase (TRI-M) was coded for each therapist with the EXP and RF Scales. Patient IIP and SCL scores at termination were subtracted from scores at intake. Correlations were then run between those scores and therapist EXP and therapist RF scores.
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Discussion

The aim of this study was to determine how Experiencing and Reflective Functioning are related to one another in the capacity of a therapist to present oneself as a secure base for their patient, and to create a holding environment in which the patient can explore difficult self-constructs. Specifically, the study predicted that therapists who are able to bring to awareness and focus upon the felt datum of their immediate experience would also be competent in the process of being aware of the internal states, needs, and intentions of their patients, within the dynamic context of psychotherapy. Therapist EXP and RF scores, therefore, were expected to correlate highly. Furthermore, it was predicted that therapists who function with high level EXP and RF would be apt to present themselves as understanding attachment figures and would thus facilitate the construction of an environment that was conducive to focus and exploration, leading to reduction in interpersonal problems and psychiatric symptomatology.

Firstly, the primary hypothesis of this study, that there should be a correlation between therapist EXP and RF scores, was not supported by the results. The data does not indicate any significant correlation between therapist experiencing and mentalizing. Secondly, not only was the expected correlation between high RF/EXP and outcome measures not confirmed, it was significantly rebutted by the data. Results indicated that therapists with higher RF and EXP scores were in fact more likely to have patients with less reduction in interpersonal problems and psychiatric symptoms than those with lower RF and EXP scores. Among the sample, as RF and EXP scores increased, patient improvement decreased.

These results directly contradict the study hypotheses. It would seem logical to presume that a therapist who is better able to understand patients' needs would be best able to create an environment that is matched to patients' needs. The Reflective Functioning scale is designed to quantify an individual's ability to understand the internal states, affects, motivations, and intentions of others in relation to the self — one may expect that having this "inside information" would be an invaluable asset to a therapist, whose goal is to anticipate the needs of the patient, and provide the opportunity for exploration.

Alliance Focused Training (AFT) holds that attending to and non-judgmentally accepting internal experiences are important components in the relational setting. Safran et al. (2104), hypothesized that therapists who participate in AFT would demonstrate a greater tendency to reflect on their relationships with their patients. Their investigation demonstrated that trainees' EXP scores were indeed higher after AFT training (compared to Cognitive Behavioral Therapy training). These authors reasoned that AFT has the capacity to augment a style of therapist reflection hypothesized to be advantageous in the context of therapeutic interactions (Safran et al., 2014).

While Kazariants's (2011) study indicated that therapists demonstrating high-level experiencing show an improved agreement on therapeutic tasks, bond, and goals (as measured by the Working Alliance Inventory), the results of the present study indicate that high levels of these skills may rather be a detriment. A therapist highly-attuned to their own inner experience may distract from the patient's own process, crucial for the reduction of patient psychiatric symptoms and interpersonal problems. Interestingly, Reading, Safran, Origlieri, and Muran (2019) tested the hypothesis that therapist capacity for reflective functioning could play an important role in the therapeutic relationship and therapy outcome. Results of this study did indicate a

strong predictive relationship between therapist RF and therapist reported WAI scores, however patients did not report better WAI scores when they had therapists with higher RF scores. These authors reasoned that therapists with greater reflective functioning may encourage deep exploration and this "may result in experiencing therapy as more challenging, and ultimately lead to increased experiences of strain and difficulty in the working alliance by the patient" (Reading et al., 2019, p. 125).

Slade (2005) posed the theory that "mental states are the key to understanding behavior, in oneself or another. A reflective individual has, in effect, an internal working model of emotion and intentions" (Slade, 2005, p. 274). However, while attending to one's internal mental states and feelings may seem to be integral in understanding the needs of another, it may be possible that encouraging attention to oneself is overly challenging or acts as a distraction from the moment. "Indeed, someone who is completely immersed in strong feelings of anxiety, guilt, or depression may be so involved in the feeling or its situational or behavioral details that he has no grasp of experiencing it, he is unable to focus on it" (Klein et al., 1969, p. 7). Klein and the authors of the Experiencing scale assert that focusing on internal referents is an integral part of growth, however this may not be advantageous for a therapist, with regard to patient outcome scores.

Returning to Freud's warning to maintain free-floating attention, it may be interpreted that a therapist skilled in attending to their own and their patient's internal states could have the unintended effect of redirecting the session in a particular direction; "as soon as anyone deliberately concentrates his attention to a certain degree, he begins to select from the material before him; one point will be fixed in his mind with particular clearness and some other will be correspondingly disregarded, and in making this selection he will be following his expectations or inclinations" (Freud, 1912, p. 112). As experiential focusing is integral to experiencing and is indicated by high EXP scores, it may be that those therapists with higher EXP scores inadvertently misdirect the therapeutic process towards one direction or another instead of "turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient" (Freud, 1912, p. 115) and direct the patient's exposition.

Furthermore, reflective functioning is an automatic function that is invoked unconsciously when engaged in interaction with an interlocutor (Fonagy et al., 1998). As previously discussed, reflective functioning provides the individual with information regarding how one perceives and understands oneself and others in terms of mental states (desires, feelings, beliefs, intentions). However, Fonagy and colleagues (1998) "see it as an over-learned skill, which may be systematically misleading in a way much more difficult to detect and correct than mistakes in conscious attributions may be" (p. 9). It is thus possible that therapists with strong reflective functioning make automatic attributions that are coded as being highly tuned towards mentalizing the patient; but that also serve the function of untraceably directing the treatment through the filter of the therapist's latent perceptions.

While the findings of this analysis lead us to consider the relative value of therapists' reflective functioning and experiencing in the consultation room, their consideration must be understood in the context of the present study's greatest limitation, a very small available sample size (this was in order to only include cases that had completed both client IIP and SCL, as well as therapist RF and EXP). Due to this limitation, the data are not widely distributed enough to illustrate a possible mid-range effect, in which it could appear that there is a "goldilocks zone" of RF/EXP for therapists. Whereas a weak or strong capacity for these skills may be deleterious in the therapeutic dyad, a larger study sample might reveal what intermediate level is most advantageous. Reik (as noted by Safran, 2011) stressed the importance of "oscillating back and forth between an internal focus and external focus" (p. 208). Thus, while it is possible that too much attention to this process draws the therapist away from the moment, future studies may indicate just how much is enough.

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Nonverbal Synchrony: A New Approach to Assessing Therapeutic Alliance Ruptures

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Nonverbal synchrony is the degree to which individuals' nonverbal cues, such as body movement, implicitly coordinate in time. Within the psychotherapeutic dyad, nonverbal synchrony has been shown to correlate with therapeutic alliance and therapy outcome. However, nonverbal synchrony research has yet to address therapeutic alliance ruptures. Furthermore, many difficulties in assessing for ruptures have been identified, due to the fact that rupture assessments rely upon explicit observation of therapists, patients, and/or observers. To address this obstacle the present paper discusses the assessment of ruptures via the analysis of psychotherapy dyads' nonverbal synchrony. Motion Energy Analysis, an adjunct to the standard assessment of ruptures within the psychotherapy dyad, is described as an efficient and reliable method of therapeutic relational dynamics analysis. Motion Energy Analysis allows for an algorithmic and straightforward approach to quantifying nonverbal synchrony. Clinical applications and relevance to the extant literature are also discussed.

Keywords: nonverbal synchrony, therapeutic alliance, alliance ruptures, motion energy

It has been consistently demonstrated in psychotherapy research that the quality of the therapeutic alliance is a robust predictor of therapy outcome (e.g., Horvath, Del Re, Flückiger, & Symonds, 2011; Martin, Garske, & Davis, 2000; Samstag, Batchelder, Muran, Safran, & Winston, 1998). Weakened alliances have been shown to correlate with unilateral termination by the patient (e.g., Muran, Safran, Gorman, & Samstag, 2009; Samstag et al., 1998). In addition, hostility in therapy correlates with poor outcome (e.g., Samstag et al., 1998). As a result, one aspect of the alliance which has received increasing attention is the alliance rupture, which has been defined as "a tension or breakdown in the collaborative relationship between patient and therapist" (Safran, Muran, & Eubanks, 2011, p. 80).

The nature of rupture presentations can vary considerably. They can range in intensity from relatively minor tensions, which may be only vaguely apparent to one or both individuals, to major breakdowns in collaboration, understanding, or communication (Safran et al., 2011). Ruptures can manifest in two ways: 1) as confrontation ruptures, wherein a patient expresses resentment or hostility toward the therapist, as well as 2) withdrawal ruptures, wherein the patient expresses discontent by disengaging (Safran & Muran, 2000; Harper, 1989). Because of their pervasiveness in psychotherapy, ruptures have been described as "an ongoing relational 'push and pull'," reflective of processes which are "inherent in all relationships," and therefore a natural, ongoing component of psychotherapy (Safran, Muran, Stevens, & Rothman, 2008, p. 138).

A study by Muran, Safran, Gorman, Samstag, Eubanks-Carter and Winston (2009) analyzed the relationship between the therapeutic alliance and self-reported alliance ruptures. In addition to identifying the occurrence of the rupture, Muran and colleagues (2009) also measured rupture intensity and resolution using self-report data in post-session questionnaires. Results indicated that lower rupture intensity and higher rupture resolution were correlated with better ratings of the therapeutic alliance and session quality. Lower rupture intensity also predicted good outcome on measures of interpersonal functioning, while higher rupture resolution predicted better retention. Results also indicated that a

failure to resolve ruptures was predictive of dropout (Muran et al., 2009). Notably, the results did not indicate a significant relationship between alliance ratings and rupture occurrence. This finding, or lack thereof, provides support for the theory that ruptures are a natural component of the alliance.

Alliance ruptures have been assessed using a variety of research methods, which aim to tap the perspectives of patients, therapists, and/or observers. One method involves obtaining questionnaires from the patient and therapist regarding potential shifts in alliance quality, or perceptions of alliance rupture and degrees of resolution within a session (Muran et al., 2009). Another method is to track fluctuations in patients' alliance scores across the course of therapy (e.g., Strauss et al., 2006; Muran et al., 2009). In addition, researchers may use observer-based methods, which can involve hand-coding transcriptions and video recordings of therapy sessions (e.g., Muran et al., 2009). Observer-based assessment tools, such as the Rupture Resolution Rating System (Eubanks-Carter, Muran, & Safran, 2009), may also be used to mark potential moments of rupture exhibited by the patient's behavior and the therapist's attempts at resolution. Therefore, assessing for ruptures typically involves assessments of changes in the therapeutic alliance which rely upon the explicit, yet subjective observations of the patient, therapist, and/or observer.

Many issues in identifying ruptures have been realized, in part due to difficulties in defining the concept of a therapeutic alliance rupture (Safran & Muran, 2000). There has been much disagreement on how intense a rupture needs to be in order to be considered a rupture (Safran & Muran, 2006). Similarly, there has been considerable variability on how significant the quantitative fluctuations in alliance ratings must be in order to signify a rupture (Samstag et al., 1998). Another criticism of the assessment for ruptures is that traditional conceptualizations of the alliance may overemphasize the role of conscious collaboration between therapist and patient, while underestimating the pervasive role of unconscious factors in both patients' and therapists' participation in the relationship (Safran & Muran, 2006). Therefore, there remains considerable opportunity to refine methods of assessing for ruptures, particularly with regard to processes that may be subtle or difficult to identify from anyone's subjective perspective.

Nonverbal Synchrony

There is another approach to observing the relational dynamics between a therapist and patient, which involves an assessment of nonverbal synchrony. Synchrony refers to a natural interpersonal phenomenon in which individuals' behavioral, physiological, and/or affective experiences and responses spontaneously occur at the same time (Koole & Tschacher, 2016). Because it is an implicit, relational phenomenon, studying synchrony in the context of psychotherapy can allow for objective observation of aspects of the therapeutic relationship, which would be difficult or even impossible to study using most other alliance measures.

In order to understand the unique role of nonverbal synchrony in the therapeutic relationship, it is beneficial to conceptually differentiate synchrony from other similar constructs, such as contingency. One distinction is that synchrony, coming from the Greek roots *syn* ("same") and *chronos* ("time"), refers to a spontaneous simultaneity of phenomena between two individuals (Koole & Tschacher, 2016); contingency describes "the temporal process of relating from moment-to-moment" (Beebe et al., 2016, p. 2). With this consideration in mind, contingency may be described as a type of synchronous behavior, and therefore studies in other domains which assess contingency should be included under the umbrella of synchrony research (Koole & Tschacher, 2016).

Studying *nonverbal* synchrony (the synchrony of the dyad's nonverbal cues, such as body movement) is an effective way to observe nonverbal patterns in the alliance, which receive far less attention in psychotherapy research than the verbal aspects (Koole & Tschacher, 2016). Psychotherapy studies have measured a variety of manifestations of nonverbal synchrony, such as body position matching (e.g., Scheflen, 1964; Trout & Rosenfeld, 1980), imitation of mannerisms (Chartrand & Bargh, 1999), matching of nonverbal emotional display (Hatfield, Cacioppo, & Rapson, 1994), matching of vocal tonality (Reich, Berman, Dale, & Levitt, 2014), and matching of body movement (Ramseyer & Tschacher, 2011). The aforementioned studies demonstrate a variety of ways in which nonverbal synchrony has been addressed in psychotherapy research.

The relevance of nonverbal synchrony in the context of psychotherapy research has been thoroughly demonstrated by studies which link synchrony to many key facilitative interpersonal processes. For example, nonverbal synchrony has been linked to establishing rapport (Vacharkulksemsuk & Fredrickson, 2012), promoting feelings of social connectedness (Marsh, Richardson, &

Schmidt, 2009), encouraging perspective taking (Wheatley, Kang, Parkinson, & Looser, 2012), positive affect (Tschacher, Rees, & Ramseyer, 2014), developing adaptive emotion-regulation (Feldman, 2007), and mutual experiences of being in the here-and-now (Tschacher, Ramseyer, & Koole, 2018). It has also been shown to predict diagnostic features such as depression and anxiety (Paulick et al., 2017). Nonverbal synchrony has even been shown to positively correlate with social competence and social functioning in schizophrenic patients (Kupper, Ramseyer, Hoffmann, & Tschacher, 2015). The existing research in which nonverbal synchrony has been included shows that it is an increasingly important area of study.

In the context of psychotherapy research, higher nonverbal synchrony is generally linked to better psychotherapy outcome (e.g., García & Di Paolo, 2018; Ramseyer & Tschacher, 2011; Kupper et al., 2015; Reich et al., 2014; Galbusera, Finn, & Fuchs, 2016). This finding has been identified across a wide range of clinical populations, such as those diagnosed with social anxiety disorder (e.g., Altmann et al., 2019; Schoenherr et al., 2019), psychosis (Dean, Samson, Newberry, & Mittel, 2018), and schizophrenia (Galbusera et al., 2016). Interestingly, in one recent study by Paulick and colleagues (2017), nonverbal synchrony was shown to have a curvilinear relationship with therapy outcome. The results indicated that cases with high synchrony showed higher rates of non-improvement and consensual termination, cases with low synchrony led to more non-improvement and dropout, and cases with medium synchrony showed the most improvement. Paulick and colleagues described this finding as coinciding with the mutual regulation model of dyadic meaning making, wherein interactions are characterized by alternating matching, mismatching, and reparation (Tronick & Beeghly, 2011; Paulick et al., 2017).

While correlations between nonverbal synchrony and outcome have been demonstrated, research assessing links between synchrony and the therapeutic alliance remains sparse and heterogenous (Paulick et al., 2017). Some researchers have identified a positive correlation between therapeutic alliance quality and nonverbal synchrony (e.g., Paulick et al., 2017; Ramseyer & Tschacher, 2011; Ramseyer & Tschacher, 2008). However, another study found a negative relationship between therapeutic alliance quality and prosodic synchrony (vocal tonality patterns; Reich et al., 2014). Thus, further research in this area is certainly warranted. To date, no psychotherapy study has specifically addressed links between nonverbal synchrony and therapeutic alliance ruptures (Paulick et al., 2017).

Motion Energy Analysis

Conventional methods for assessing synchrony have involved analyzing video recordings of therapy sessions and measuring specific elements of the interaction. For example, in one study, researchers measured nonverbal synchrony by manually coding the amount of movement between teachers and students as observed frame-by-frame (Bernieri, 1988). Many synchrony studies have involved similar coding methods, which are often highly labor-intensive. However, recent technological advances have allowed for methods of assessing nonverbal synchrony by automatically analyzing therapy session recordings using computer algorithms (e.g., Ramseyer & Tschacher, 2011). Therefore, this proposed methodology can significantly reduce workload and increase intercoder reliability.

One new and increasingly popular method of calculating nonverbal synchrony involves the usage of a software program called Motion Energy Analysis (MEA; e.g., Dean et al., 2018; Kupper et al., 2015; Paulick et al., 2017; Ramseyer & Tschacher, 2011). MEA quantifies on-screen motion by converting a video to a grey scale, capturing frames at a predetermined frame rate, and then counting the number of pixel changes as the video advances from frame to frame (defined as motion energy by Grammer, Honda, Juette, & Schmitt, 1999). Thus, a small movement on the screen causes a small number of pixels to change, and a large movement causes a large number of pixels to change.

After importing a video, the user sets the frame rate and a minimum threshold for movement detection to automatically exclude video noise. The user then manually highlights regions of interest (ROIs), or areas within which they want to track motion. For example, on a split-screen video, the user can select one ROI for the patient and one ROI for the therapist. MEA allows for up to eight ROIs, which could allow for measuring motion energy in various body parts simultaneously. The software then analyzes the video and uses an algorithm to quantify a time series of motion energy within each ROI. In order to control for differing ROIs and body sizes, the time series data are z-transformed in the statistical analysis stage (Ramseyer & Tschacher, 2011; Grammer et al., 1999).

These corrected motion energy time series are then used to quantify synchrony values using a statistical process of windowed cross-lagged correlation (Boker, Rotondo, Xu, & King, 2002; Ramseyer & Tschacher, 2011; Schoenherr et al., 2019). Time series are cross-correlated within 1-minute window segments. For each window, cross-correlations are computed for positive and negative time lags of up to 5 seconds, using incremental steps of 0.1 seconds. This allows for a realistic flexibility in participants' nonverbal responses to one another, such that their bodies do not have to be exactly-simultaneously mirroring one another in order to qualify as synchrony (Ramseyer & Tschacher, 2010). These cross-correlations are then standardized, and their absolute values are taken (allowing for positive lags and negative lags to have an equal effect). Finally, these values' correlational coefficients are used to constitute quantifications of nonverbal synchrony (Ramseyer & Tschacher, 2011).

By operationalizing nonverbal synchrony as gross bodily movement, this approach provides a means of objectively quantifying nonverbal synchrony in a way that minimizes the importance of interrater reliability. Because the software uses an algorithm to automatically analyze videos, labor intensity is minimized. This aspect of the methodology presents a considerable advantage over most classical nonverbal synchrony research methods, which are typically very labor intensive and requiring of a great deal of time-consuming, tedious work. However, only a small handful of studies have begun to apply using automatic video analysis software in nonverbal synchrony research.

Discussion

In addition to its novel contribution to the literature, there are many clinical applications which can be derived from studying the nonverbal synchrony of psychotherapy dyads. Firstly, assessing psychotherapy session videos for nonverbal synchrony can be used not only for research, but also as a means of evaluation or as a tool during clinical supervision. Tapping into nonverbal synchrony can illuminate aspects of the dynamic between a therapist and patient, which may help facilitate clinical progress. Nonverbal synchrony data gathered from video analysis could then be applied clinically, encouraging the clinician to consider nonverbal cues when interacting with the patient. It may also convey predictive information, which could help identify early in an intervention whether a certain

therapist is a good match for a patient. This speaks to the potential impact of the results reported by Paulick and colleagues (2017). The authors suggest that it may be possible to use nonverbal synchrony data to prevent dropout, promote a strong therapeutic alliance, and facilitate successful therapeutic outcome.

In summary, we may be entering a technological revolution in nonverbal synchrony research, and there remains considerable opportunity for novel research in this field. The clinical applications of this research are indeed promising. Therefore, future research should adopt and advance automatic video analysis-based research methods, particularly in the context of studying the therapeutic alliance and alliance ruptures.

Acknowledgements

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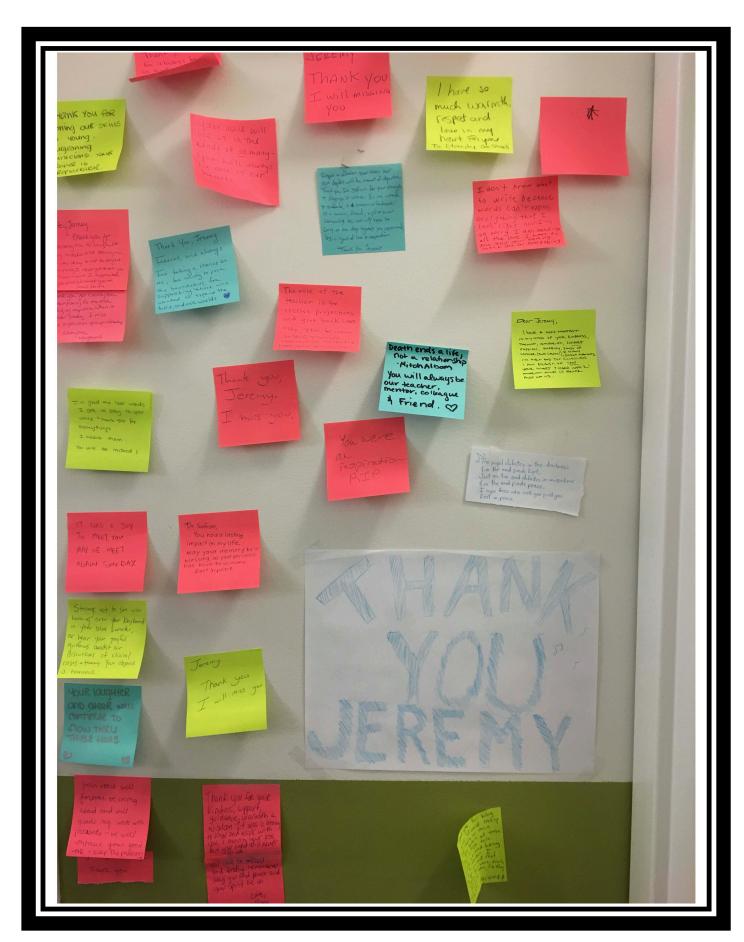
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