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The Spaces In-between: How the Art of Intuition Informs the Science of Evidence Based Practice in Psychotherapy

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The Spaces In-between: How the Art of Intuition Informs the Science of Evidence Based
Practice in Psychotherapy

Submitted by Heather M. Smith
May 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Abstract

Evidence-based practice methods are a central component in the psychotherapy profession and an important backdrop in the therapeutic endeavor. Yet a therapeutic relationship that leads to healing is often one that exists within an intersubjective space, one that is outside the field of manualized interventions. The purpose of this study seeks to explore the role that intuition plays in the therapeutic process, how it informs the use of evidence-based practice methods, and its contribution to the change process in psychotherapy. Scholarly research on the use of intuition in the therapeutic process is sparse and indicates a need for more in-depth inquiry. Data analyzed from 7 semi-structured interviews with psychotherapists showed that the use of intuition was indeed a central aspect in their work.

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Introduction

Beautiful is what we see. More beautiful is what we understand. Most beautiful is what we do not comprehend.

-Nicolaus Steno

Evidence based practice has become a common framework among psychotherapists from which treatment modalities are drawn and translated from clinical research. Evidence based psychotherapy practice relies heavily on quantitative research results. Empirically supported therapies have become the new roadmap for practicing clinicians, yet the therapeutic experience is, at its core, a creative collaboration that cannot be manualized (Bohart, 1998). In a culture that centers its beliefs around absolute truths of epistemology and universal realities, usually little credence is given to experiences that cannot be tangibly observed and quantified. Yet the very nature of the therapeutic process requires that clinicians are able to tune in to the “nonconscious processes or implicit cognition” (Rea, 2001) of their clients. In her book *Awakening Intuition*, psychologist Frances Vaughan writes that “intuition allows you to see and to sense possibilities that are inherent in a situation but have not yet been realized.” (Vaughan, 1979).

The role of intuition in psychotherapy is not a new concept, but the academic research on the topic is sparse due to the inability to conceptualize intuition, and hence, inability to analyze it. Yet despite the lack of scholarly review, many have argued that intuitive knowing is a core component in psychotherapy. Paul Trad, MD spoke to this

when he wrote that, “competent psychotherapists rely strongly on their intuitive capacities – whether they’re aware of it or not.” (Trad, 1993).

Most people are familiar with the concept of intuition, yet a phenomenon that exists outside the realm of conscience is difficult to describe. Webster’s Dictionary defines intuition as “the act or process of coming to direct knowledge or certainty without reasoning or interfering: immediate cognizance or conviction without rational thought.” (Websters, 1981). In fact, many therapists rely on intuitive “knowing” to detect holes in patient narratives, and to respond to differing personalities (Trad, 1993). Carl Rogers summed up the intuitive experience:

As a therapist, I find that when I am closer to my inner, intuitive self, when I am somehow in touch with the unknown in me, when perhaps I am in a slightly altered state of consciousness in the relationship, then everything I do seems to be full of healing. (Rogers, 1986)

In a profession like social work that is concerned with all that encompasses the human mind and condition, we are often required to break out of the walls of conventional ideas and thinking. It is in this vein that clinicians must recognize that while evidence based practice provides the necessary groundwork for therapeutic interventions, human needs and problems are holistic in nature and call for an intuitive knowing wherein everything is continually changing and transforming.

My research seeks to explore what role intuition plays in the collaborative process between therapist and patient, and how it informs interventions that lead to change and contributes to the role of empathetic understanding of the client by the therapist. My approach will be qualitative in nature, and will focus on the personal narratives and

experiences of practicing clinicians. I will also seek to understand how clinicians define “intuitive knowing” and whether this definition develops through experiential knowledge or something less definable such as a “gut feeling.”

The aim of this research is to better understand, provide a way of conceptualizing psychotherapist’s subjective experiences of nondeliberate knowledge and meaning in the therapeutic process, and perceived understanding of its contribution to the change process. The evidence based model of quantitative measurement leaves little room for creating therapeutic interventions that respond holistically to individual clients. Evidence based practice models are necessary roadmaps from which to navigate through the complicated journey of change, yet ultimately require the creativity of the practitioners who employ them. The next section of this research project will review the literature that relates to both the holistic and scientific components of psychotherapy.

Literature Review

The most beautiful thing we can experience is the mysterious. It is the source of all true art and science.

-Albert Einstein

The field of psychotherapy bears ideological differences that have spanned from its inception to present day. The battle is exemplified in the struggle to find balance and meaning between the artful and scientific qualities in our practice with clients (Powell, 2003). With the medical model that now dominates the profession, leaving space for the

art of practice has become precarious at best. In a profession that is intrinsically concerned with helping people, the scientific paradigm or medical model fails to leave room for the space in-between theory and practice, that is, where the connection between therapist and client takes place, a meeting of the minds.

In the 1974 book *The Myth of Mental Illness*, Thomas Szasz proclaimed mental illness to be a “metaphor for bodily illness” (Szasz, 1974) and thought that the profession of psychotherapy did little more than address problems in living. Advances in neuroscience and the subsequent adoption of the medical model has now clearly debunked that notion, yet perhaps due to the ambiguous nature of the profession itself much uncertainty still surrounds what psychotherapists really “do”.

In an attempt to bring conceptual meaning and understanding to this dilemma, Jon Allen proclaims “The fundamental basis of psychotherapy is our natural ability to make sense of each other – and ourselves- as persons with minds.” (Allen, 2008). Psychiatrist Jerome Frank defined psychotherapy as “the relief of distress or disability in one person by another, using an approach based on a particular theory or paradigm, and a requirement that the agent performing the therapy has had some form of training in delivering this. It is these latter two points which distinguish psychotherapy from other forms of counseling or care giving (Frank, 1998). But perhaps the biggest challenge for those in a profession aimed at “helping people” has been the ability to explain and define psychotherapy in substantive terms.

If we take an overarching view of the therapeutic process and define it in simplistic terms, our focus would inevitably be on theories of change. For it is the moment when a shift occurs, clarity is reached, or a healing moment takes place, that we

are able to begin to define what psychotherapy really is. Yet the real debate is not about the change in and of itself, but rather, how to measure and qualify the change process in a society that only places value on empirical evidence. It is from here that the evidence based practice movement was born in an attempt to find a place on the map in the hierarchy of empirical science.

Along with the medical model came validation of the psychotherapy profession in the form of sound empirically based scientific research, known to the profession as evidence based practice. Palmer (2002) speaks to the profession's adoption of the scientific paradigm as:

A means of framing explanations of and solutions to human and environmental problems. This paradigm included the importance of measurement and objective observation, the belief in cause and effect, the reduction of the whole into quantifiable parts, the separation of observer and participants, and the ideal of control and mastery" (p.194).

Indeed, without the scientific knowledge provided in evidence based practice the job of psychotherapy would "constitute a fundamental ethical shortcoming: failure to relieve suffering." (Allen, 2008). Because ultimately, the psychotherapist must not only have a broad understanding of all psychopathologies, but also sound knowledge of the psychological treatments to address them. Yet, despite the manualization of psychological treatments it's important to be reminded that the treatments grew out of psychotherapy itself (Barlow, 2004).

The widening gap between the art and science in practice is viewed by many in the field as the direct result of professional practice turning to a scientific basis from which to build, and thus pushing "the art" to the fringes of the discipline. In his editorial

Doing it Artfully (2003) author William Powell speaks to this as a separation of “head from heart” and “mind from spirit” (p.457) in the profession. The following review of literature aims to examine the dimensions of intuitive knowledge and empathetic understanding in the therapeutic process, the role they play in the collaborative alliance between therapist and client, and the contributions they have to effect real change.

The Science

Evidence Based Practice

Evidence-Based Practice is defined as “treatment based on the best available science” (McNeece & Thyer, 2004), essentially empirically supported therapies aimed at developing treatments to address specific disorders (Westen & Bradley, 2005).

Psychotherapy has essentially been “evidence based” since the late 1970’s when Smith and Glass published the first meta-analysis of generic psychotherapy treatment, but it is only in the last ten years that the push to operationalize EBP has gone front and center (Westen, 2005). According to the *Social Work Research Journal* (2003), the evidence-based practice movement was fueled by the expectation that practice decisions by clinicians must be based on scientific knowledge (Rosen, 2003). Operationalizing evidence-based practice methods was a welcome change for the psychotherapy profession, as it often took a backseat to psychiatric treatment models that were heavily influenced by pharmaceutical companies (Westen, 2005).

Over the last decade the field of clinical social work has also made a steady shift in the intervention methods and theoretical models it relies on to help people. Evidence-

based practices have provided the means to demonstrate validity of intervention methods, and have enhanced the credibility and professionalization of clinical social work practice. The use of empirically supported treatments has had significant implications for psychotherapy and psychotherapy research (Reynolds, 2000). Although systematic empirical research has provided useful frameworks for clinicians, the mandated use of evidence-based protocols in assessment and diagnosis are often viewed as incompatible with the holistic nature of the therapeutic process (Garland, 2003).

Despite the fact that evidence-based practice in psychotherapy has been embraced by most clinicians, there are many considerations that still remain. At the forefront of the debate lies the question of how to bridge the gap between research and practice, moving from concept to implementation. Translating evidence into practice proves difficult in that the “science” of evidence follows a mono-causal map, while the “art” of therapeutic change is anything but linear. (Pollio, 2006). Additionally, in the *British Journal of Social Work*, author Stephen Webb (2001) suggests that, “the epistemic process (e.g. practical knowledge-based actions) of practitioners in social work, particularly in relation to decision making and predicting outcomes does not adhere to the tenets of evidence-based practice.” (p.59).

The reality for practicing clinicians is one that exists within a technocratic culture, one that is deeply conditioned by its scientific beliefs and commitments. We operate through a lens of conceptual foundations tinted by Newtonian physics – that is, “we believe in a universal applicability of objectivity, strict causality, absolute fixed space and time, and in independently existing objects” (Mansfield, 1995, p.49). But science rarely enriches us beyond a material level, and as consumers and disseminators of empirical

scientific methods, we have a responsibility to search out other epistemic knowledge bases for our practice (Bergner, 2006).

Nonetheless, employing interventions that are empirically supported provides the necessary framework for therapists to work from. In an article published by the American Journal of Psychotherapy, Dr. Raymond Bergner argued that although scientific theories are important when designing treatment plans in therapy, implementing such therapies is dependent on a therapist's conceptual knowledge (Bergner, 2006). In other words, competent therapeutic practice relies on the clinician's ability to have a "strong command of a lexicon of concepts" (p.228).

There is an apparent contradiction between the rational and scientifically based principles of evidenced based practice and what many therapists view as most fundamental about their work. Evidence-based research is founded on the "ideology of science which suggests that the correct approach to knowledge is through rigorous interchange of reason and systematically acquired experience." (Goldberg, 1983). Yet understanding the human condition in all its vastness and complexities cannot be achieved through a universal explanatory framework for, "it is the duty of the human understanding to understand that there are things which it cannot understand, and what those things are." (Dru, 1938).

The therapeutic enterprise is a hugely complex process that requires the therapist's ability to construe human problems and apply interventions to understand and solve them. It is a moment-to-moment dance between two people, where the therapist must be attuned to what is salient in the exchange, what should be focused on, and ultimately, what intervention to employ. Essentially, "there is no algorithm that therapists

can follow” (Bohart, 1998, p.301), and the use of evidence based practice interventions in psychotherapy depend on the intuitive application by the therapists using them. Perhaps this is where the science is most lacking – providing empirical evidence about which intervention works for whom (Allen, 2008). It is from this space where we move from the science to the art in psychotherapy.

The Art

Intuition

The etymological roots of “intuition” stem from the Latin term *in-tuir*, “looking, regarding or knowing from within.” (Hodgkinson, Langan-Fox, Sadler-Smith, 2008). Yet over time intuition has been defined in many ways – insight, knowing of the third kind, practical wisdom, creative cognition, or perceptual knowing. Sigmund Freud called it “evenly suspended attention” while Einstein coined it “following a feeling”. Whatever the definition, intuition or “intuitive knowing” appears to be a form of unconscious processing that everyone experiences and is common to everyday functioning (Rea, 2001).

Over the years researchers have attempted to empirically measure intuition with marginal success, part of the difficulty has stemmed from a debate over what the nature of intuition even is, and how to measure it when there isn’t a clear understanding of its mechanism of functioning. Throughout the decades perspectives on the nature of intuition have varied widely.

In the beginning of the 20th century scientists considered intuition to be a powerful force in guiding scientific discoveries. In fact, it was widely recognized that

“intuition was considered the pinnacle of rationality, a peak beyond rationality that was only reserved for the genius” (Welling, 2005, p. 21). Jung (1926) was one of the first psychologists to theorize intuition as a cognitive construct, even postulating that intuition was one of four fundamental mental processes, with the others being thinking, feeling and sensation (Welling, 2005). Beginning in the 1960’s the pendulum swung in the other direction as scientists began to view intuition as the counterpart to rational and reasoned thought and analysis. The pendulum appears to be swinging back now, and as noted in the *Journal of Psychotherapy Integration* “intuition has undergone a revival in new age movements” (Welling, 2005, p.22), and has been researched in the fields of medicine and management – with some supporters believing it should be used to guide professional judgments and decisions.

Recent studies by cognitive psychologists have placed the construct of intuition in a dual-process model. According to Pretz & Totz (2006) “In the dual-process framework, intuition is part of the system that is automatic, holistic, affective, fast, and associative, as contrasted with rational thought which is deliberate, analytical, non-affective, slow, and rule-based” (p. 1248). Psychoanalytic literature has also firmly placed intuition in a cognitive construct, believing that intuition functions as a “unconscious pattern matching cognition” (Rosenblatt & Thickstun, 1994. p. 696). Psychoanalyst Thomas Ogden speaks to a universal humankind, that is, a handful of human qualities that exist within all of us in differing variations (Ogden, 2003), and therefore, the stories that are brought to us in therapy will in some ways resemble patterns from another - much like Jung’s idea of a “collective unconscious”. Yet despite attempts

to conceptualize intuition as a cognitive process it remains largely unexamined in the field of psychotherapy.

The art of psychotherapy requires an empathic relationship between therapist and client that is essential to the change process. In her book *Intuition in Psychotherapy and Counselling*, psychologist Rachel Charles states that empathy and intuition are interconnected states of being, involving a way of knowing that is cultivated outside of one's awareness (Charles, 2004). Central to the task of creating a therapeutic alliance, is the therapist's ability to be emotionally attuned to her client, which is dependent on picking up on information tacitly as well as perceptually (Bohart, 1998). Empathetic listening is essentially a capacity to "understand the emotional experience of another person" (Trad, 1993, p.475). According to recent literature in neuroscience psychotherapy changes people because "it is possible for one mammal to restructure the limbic brain of another brain" (Dales, 2008, p.307). This limbic resonance that can occur between therapist and client can essentially help the client with their own implicit affect regulation. As noted by Dales (2008), "the therapist does not just hear about an emotional life. Through right-brain to right-brain resonance, both members of the dyad experientially encounter it" (p.308).

Intuition is not a new phenomenon in medicine or science. In fact, it is reported to be the most common guiding principle among scientists finding solutions to scientific problems (Welling, 2005). In a study that explored how physicians diagnose depression, Maclean, Stoppard & Miedema found that in addition to screening tools, physicians relied on "strong gut sense" or "intuitive understanding of patients and their experiences" (Maclean et al., 2005, p.1102). Yet the scientific community has hardly embraced or

acknowledged the role of intuition in science. In his book *The Power of Premonitions* (2009) physician Larry Dossey speaks to this rigid knowledge construct in medicine:

My training in medicine has sensitized me to premonitions. Health and illness, clinics and hospitals, are prime stalking grounds for these phenomena. Yet we physicians have a tortured relationship with them. We are trained to honor evidence-based medicine, with its rigid algorithms and decision trees. This approach deliberately excludes hunches, intuition, premonitions, and other varieties of knowing that don't conform to reason and analysis (p.11).

The Role of Understanding

The fundamental essence of psychotherapy practice is facilitating the process of change; to alleviate psychic pain, problems in living, or simply to become more acquainted with one's inner landscape. Perhaps the most difficult part of this journey for both therapist and client is reaching an understanding of the problem, and discovering where to begin. It is only from there that therapists can begin to construct a framework of change from their knowledge base.

The very basis for discovery lies in understanding. That is, trying to make sense of and find meaning in our client's lives and stories, and it is from here where the focus must shift from the *what* of understanding, to the *how*. Understanding is what anchors us to reality and ourselves. Goldstein (1999) argues that this is where the artistry of our practice is born, and "the fragments that clients (or other humans) will (and will not) reveal about themselves, the stories they tell, depends on a certain artistry and creativity" (p.386). Goldstein also points out that instead of viewing this artistry as a threat to

scientific inquiry, it must be seen for what it is, “a concomitant attribute to great science” (Goldstein, 1999, p.386).

Our ability to truly understand, empathize, or make meaning of another person relies heavily on the act of mentalizing. In his article *Psychotherapy; the artful use of science* Jon Allen (2008) defines mentalizing as “a form of imaginative activity, mainly, perceiving and interpreting human behavior as based on intentional mental states” (p.174). It is the very act of making sense of the subjective mental state of oneself, and the intersubjective mental state our clients that is at the heart of understanding, and the foundation for true change. In order to navigate through a journey towards change, people must know their experience is being “shared by others, without those others becoming disabled or incapacitated” (England, 1986, p.23). For it is our ability to mentalize that lays the foundation from which our clients can find safe ground to go deeper within themselves, knowing we are there with them “in mind”.

Perhaps most central to the role of understanding is our capacity to find meaning within experience. Hugh England (1986) posits that it is the therapist’s intuitive ability to “make meaning” that is the most artful realm of our practice (England, 1986). When we are faced with a vast amount of material and information from clients, our central task begins with sifting through, and finding, what is most meaningful and important to our clients. And it is only from within our own meaning of similar experiences that produce the seeds of understanding (England, 1986).

The Integration of Art and Science

Much of the debate about bridging the artful and scientific dimensions in psychotherapy is based heavily on how to identify, measure, and objectively observe a phenomenon such as intuition, that fits neatly within a scientific paradigm to give it credence. Social work developed initially from a theological base that had plenty of room to embrace the artistic dimensions of practice, but as the profession moved toward professionalization that only research based practice could provide, the space for its artistry was lost (Palmer, 2002). And yet, as noted by Laqueria (2005):

Investigations of the subtle, often inexplicable, shifts in perception emanating from the depths of the psyche that often guide the analysts' responses rarely appear in the literature. And yet it is these unexpected and emotionally charged responses that frequently yield the most dramatic clinical results. (p. 68)

In evidence based practice research it has been acknowledged that perhaps one of the best indicators for client change in the therapeutic process is not the intervention itself, but the *therapeutic alliance* between therapist and patient (Bergin & Garfield, 1994). Research into attachment and affect regulation in psychotherapy has suggested that it is in fact the nonverbal aspects that occur between therapist and patient that are the most crucial to forming the therapeutic alliance (Dales & Jerry, 2008). In fact, Dales et al. notes that many researchers have emphasized that, "all of the techniques and tools of therapy rest upon the foundation of the relationship" (p. 292).

The recent intersection of neuroscience and psychotherapy has begun to highlight the important role of nonconscious affect-based processing and communication within

the therapeutic relationship (Grosjean, 2005), and that the “nonverbal aspects of attachment are critical to the therapeutic alliance” (p.284). Intuition, intersubjectivity, and perceptual awareness are all nonconscious processes that are now shifting into the focus of neuroscience research (Schore, 2003).

Graybeal (2007) likens the balance between the art and science in psychotherapy to the works of Picasso and Miles Davis. Both Picasso’s unveiling of a new perspective, and Davis’s unique ability to transcend the constraints of musical form are artistic endeavors striving to find truth through experience.

There is an art to social work practice, but it is an informed art, born of a balance between the structured, general knowledge that prepares the practitioner for categories of concern, and the intuitive, improvisatory understanding that is expressed in the immeasurable details of being fully present to another human being (p. 514).

Anderson (2000) suggests that bringing intuitive inquiry to our scientific endeavors is simply a “collective field of reasoning” (p. 31), that allows us to incorporate both the subjective and objective knowledge that is necessary in understanding the human experience.

Conceptual Framework

Ways of Knowing

Inherent to the human condition lies a curiosity to discover truth, and with each new discovery another dimension is added to our view of the world. Equally important to the *why* of what we’re seeking is the *how* in our pursuit of knowledge. Indeed, there are many ways of knowing, with each knower grounded in different “ontological, epistemological, and value assumptions” (Hartman, 1990, p.4). These assumptions need

to be considered, as the knowledge or truth being espoused, are only relevant in the context for which they are framed (Hartman, 1990).

The scope of inquiry in this study was viewed through the lens of Aristotle's intellectual virtue's of *Episteme*, *Techne* and *Phronesis*. *Episteme* is defined as the scientific understanding of the eternal and unchangeable things in the world, *Techne* as the analysis of what should be done to increase happiness, and *Phronesis* as ethical deliberation about values with references to praxis (Denzin & Lincoln, 2005). It is within this philosophical view of knowledge that we may begin to see the bridge between science (episteme), art (techne), and clinical wisdom (phronesis) in the therapeutic process. While theory is necessary to guide practice, its application relies on the artistry of the clinician. Acknowledging the artistic dimension in practice does not refute the scientific dimension, but rather expands the scope of the scientific inquiry (Graybeal, 2007).

According to Oliver (2011) the theoretical constructs from which research methodologies are based, directly influence the fundamental issues of truth and evidence (Oliver, 2011). Traditionally social science research methodologies are grounded in positivist paradigms, that is, an empirical epistemology that bases truth on what can be "seen" and therefore measured. By its very nature, intuitive knowing is an inexplicable aspect of human experience that cannot be seen, and historically research into these dimensions of experience have been stymied by positivist paradigms of research. As noted by Anderson (2000) "Thwarted by reductionism, the study of the more subtle dimensions of human experiences often elude our best research endeavors" (p. 32). Aristotle's *ways of knowing* construct rests on the belief that "the fact that something

cannot be observed does not mean that it does not exist” (Mantysaari, 2005, p.92), and therefore offers a sound philosophical foundation for the research in this study. This ontological stance surmises an “objective reality which exists independently of our thoughts and whose discovery is one purpose of knowledge acquisition” (Oliver, 2011, p.4), yet also acknowledges that interpretations of reality will always be done through the bias of one’s own perspective, as we cannot extricate ourselves from our human existence (Anderson, 2000). Therefore, “the gap between the real world and our knowledge of it can never be closed” (Oliver, 2011, p.4). After all, our theories and beliefs can, at best, only be an approximate of the truth.

Grounded Theory

Grounded theory was developed as an alternative to standard deductive research methods, and utilizes a systematic development of theory that is the most widely used research method in the social sciences (Oliver, 2011). The process of determining categories in content analysis, can be developed inductively, deductively, or a combination of both (Berg, 2009). An inductive approach requires the researcher to be immersed within the data, and from there allows themes to emerge through a constant comparative analysis that is “grounded” in the data. A deductive approach relies on theoretical perspective to guide a hypothesis, and then finding themes within the data as a means to assess the hypothesis (Berg, 2009).

According to Oliver (2011) the traditional approach in grounded theory where a level of “saturation” is reached while analyzing the data has now been reframed to “embrace the fluidity of knowledge creation” (Oliver, 2011, p.8). The process of constant

comparison and analysis allows for new meanings and perspectives to organically emerge, as well as moving the researcher away from preconceptions.

One of the central tenets of grounded theory is a belief that “all theory is modifiable” (Glasser, 1998) and it is because of this that it is well suited to operationalize an inquiry with a philosophical underpinning that all truth is fallible. By approaching scientific inquiry inductively without predetermined theoretical frameworks or ideas, meanings and interpretations are formed and “contextualized for practical application” (Oliver, 2011, p.7). The process of open coding and constant reexamination of data in grounded theory, serves to expand awareness and understanding in the researcher with a critical realist perspective. Contemporary approaches to grounded theory methodology seek to move beyond surface level inquiry, with the realization that often meaning and truth are elicited through individual perspectives, and as noted by Oliver, more focused on “participants theories and beliefs, not just their stories” (Oliver, 2011, p.11). Hence, the researcher approaches inquiry with a willingness to disregard preconceptions in the pursuit of discovering new theory and understanding.

It is because of the nature of the inquiry, one that is exploring something that cannot be seen, measured or quantified, that it was necessary to approach the research from this ontological stance. From within this theoretical framework, the researcher developed semi-structured interview questions for the qualitative interviews, hoping to uncover new meanings and experiences from the very people to whom this research will inform.

Methods

Research Design

The purpose of this study was to explore psychotherapist's views on the role of intuition in the therapeutic process, and how this artful dimension of practice informed their use of evidence based interventions to facilitate the change process in their clients. The research design in this study was explorative and qualitative in nature. A qualitative design was chosen in an effort to gain in-depth insight into a subject matter that cannot be quantified or empirically measured. The study was explorative in nature with the hopes that discoveries would take place if the researcher allowed the narratives to lead the way. The research was viewed through the framework of Aristotle's intellectual virtue's: *Episteme, Techne, and Phronesis*, and analyzed with a grounded theory approach.

Sample

The sample technique that was used to recruit participants in this study was a purposeful sampling of psychoanalytic therapists that belong to the MN Psychoanalytic Society. A letter of support from the society is attached as Appendix A. The sample size is 7 clinicians. Four of the psychotherapists in this study practice from a psychoanalytic model, and three considered their model eclectic. All seven were interviewed to obtain data for the purpose of this research study. The respondents vary in years of practice and experience.

Protection of Human Subjects

The respondents agreed to the interview and the terms outlined with recording of the interview, which included maintaining their confidentiality and destroying the audio tape and any identifying data subsequent to the completion of the research. The participant's confidentiality was maintained by storing recorded data on a password secured computer until the research has been submitted. Audio-recorded data was transcribed by the principle researcher. Once the research was submitted all recorded interviews were destroyed. Consent form attached in Appendix B, was given to the respondents prior to the interview to ensure subject privacy and protection. The consent form was approved by the University of St. Thomas Institutional Review Board, and contained the appropriate information to ensure the respondent's privacy and anonymity. In addition, the consent form maintained compliance with the Protection of Human Subject requirements. The researcher decreased coercion by distributing consent forms and interview questions prior to the participant's decision. The society to which the respondent's belonged was not made aware of who did and did not participate.

Instrument

The interviews, which lasted approximately 45-60 minutes, were recorded for content analysis and accuracy. Appendix C contains the questions that were used for the

interview. All questions were reviewed by the research committee prior to the interviews to ensure appropriate content and reduce researcher bias. The interviews consisted of 10 semi-structured interview questions. In addition, the questions were open-ended to ensure that few restrictions were placed on the respondents' answers as well as for the exploratory nature of this study. The questions covered a variety of topics, including general demographic data of the therapists, philosophical views, experiences and beliefs about the therapeutic process, views on the role of intuition, empathetic understanding, and evidence based practice models in therapy. The beginning questions focused on gaining an understanding of the clinician's general views and beliefs about the therapeutic process, and then gained complexity by addressing issues such as specific beliefs about the role of intuition in the change process. The interviews were transcribed by the principle researcher for data analysis and reliability.

Data Collection and Analysis

Data collection was obtained by conducting semi-structured interviews with open-ended questions that allowed for elaboration. The data was analyzed using a grounded theory approach. Grounded theory was developed as an alternative to standard deductive research methods, and utilizes a systematic development of theory that is the most widely used research method in the social sciences (Oliver, 2011). The process of determining categories in content analysis, can be developed inductively, deductively, or a combination of both (Berg, 2009). An inductive approach requires the researcher to be immersed within the data, and from there allows themes to emerge through a constant

comparative analysis that is “grounded” in the data. A deductive approach relies on theoretical perspective to guide a hypothesis, and then finding themes within the data as a means to assess the hypothesis (Berg, 2009).

According to Oliver (2011) the traditional approach in grounded theory where a level of “saturation” is reached while analyzing the data has now been reframed to “embrace the fluidity of knowledge creation” (Oliver, 2011, p.8). The process of constant comparison and analysis allows for new meanings and perspectives to organically emerge, as well as moving the researcher away from preconceptions.

The principle researcher transcribed all recorded data, and then conducted a content analysis, which included open coding, thematic coding, labeling and indexing, and finally axial coding. The coding then allowed the researcher to discover emerging themes, find relationships among them, which in turn allowed the theories to develop.

Researcher Bias

The researcher had bias concerning the role of intuition in psychotherapy in that the researcher has studied and been interested in intuition for some time, and has experienced it in her own practice. However, the researcher also strongly believed in the importance of using empirical evidence to inform and guide practice. The bias was addressed by reviewing interview questions with committee members to ensure that the questions were not leading or too narrow in focus.

Strengths and Limitations

Strengths of the research were found in the qualitative nature of this study, drawing meaning from the participant's narratives led to exploring the therapists' personal experiences with intuition in the therapeutic process. Because prior research on this subject is limited, this study contributes to expanding the knowledge on the use of intuition in psychotherapy and clinical social work.

Limitations of the study included drawing data from a relatively small sample size of clinicians that practiced predominantly from a psychodynamic model, and therefore knowledge obtained may not generalize to other clinicians in other settings. Further research should be expanded to other therapeutic models.

Results and Findings

Sample Demographics

Data obtained in 7 semi-structured interviews were collected between February 11th and March 12th, 2012. There were 5 female and 2 male respondents who sat for the entire interview. Credentials of the respondents included 3 Licensed Independent Clinical Social Workers (LICSW), 1 licensed Marriage and Family Therapist (LMFT), 2 licensed Psychologists (MA and PhD), and 1 child & adolescent psychiatrist (MD). Four of the respondents identified their model of practice as psychoanalytic or psychodynamic, and the other three identified their model as eclectic or cognitive behavioral.

Subjective Experiences of Intuition

All respondents spoke to the role that intuition played in their practice, and while many had difficulty articulating a definitive construct for it, most felt intuition was a non-cognitive way of getting information – often “knowing” something in the absence of reason, or without any element of conscious deliberation.

The integrative process is both an act of rational discipline and an attunement that you might call intuition... other ways of knowing, other ways of comprehending, organizing experience that's unconscious.

It doesn't necessarily fit the content of the words. Somebody's talking about something and you're sitting there and your intuition is picking up on something else. So there's a dissidence between the verbal words and what you're picking up.

This is very hard to explain. It's kind of like information that I don't have any direct pipeline to... like it's not based on what I gather from working with a client, it's more about being in the presence of a client and picking something up. Kind of like creativity, it's just something that comes to me. It can come as a word, an image, it comes in different ways for me.

I would say that it's a knowledge that you can't quite put words to where it comes from, but it is a type of knowledge that has more evidence than people, even than I used to attribute to it.

I consider myself an intuitive person. I think intuition means that you have an awareness of what's happening in the room that's non-verbal. You go with your gut about what someone might be saying.

An interesting theme that emerged through the data was the way in which psychoanalytic oriented therapists believed that intuitive knowing was specific to their practice model, and that less intuitive therapists would more likely practice within cognitive behavioral models.

I consider myself very intuitive and I think it's pretty central to the work that I do. When you ask this question though it's confusing to me because as an analyst I've been working so hard to learn how to listen to the unconscious. So, I think my intuition is very much a part of that process too.

I've known that I'm intuitive for a long time. I've known that about myself. Like picking up information that I have no way of knowing cognitively.

Well I don't think you can be very effective if you don't use it, or have it. I think that if you don't have the ability to sense.. I think of it as sensing something? Then I think you can probably be a cognitive behavioral therapist.

Felt Sense

Many respondents spoke to a non-conceptual awareness that arrived in many ways for them throughout the therapeutic process with clients. Often, they reported this awareness as a “felt sense” that came to them either in somatic or visual ways.

Well I think it comes in a lot of different ways, and a lot of times it comes in a body way where you'll pick up something in your body? For me, I pick it up in pictures sometimes... I start to get a visual about something, and I can't tell. For me that's the question – am I picking up the unconscious here, or is this my intuition? Well I guess your intuition is so central to picking up on the unconscious anyway – so maybe you can't have one without the other.

With me, it happens up here in my brain, in my mind, in my skull... but I think my whole body feels it. I think that's the most common way that I feel intuition. I guess what happens to me is it's like a split second of dissociation, almost like an out of body experience. Maybe a millisecond where you're like, wait, something is happening here. And in that way I think it's happening all the time.

I am able to recognize knowing not always in the moment but a little after. Sometimes in the moment, and I would describe that recognition as a sensation ... it's not an intellectual feeling, it's more, it's actually a really positive feeling of connection. And it feels somehow a little bit deeper than just getting the right answer.

I'm very visual, so I'll get a picture or an image and then I'll have to find words for what I'm getting. But I think you're right, it's also a body thing that you will feel in your body.

You have to let go, be a child yourself. To be that child you have to give up those grown up things, the more cerebral things. Keep them close by though if you need them. I wonder if the process of giving up those formal stances brings you closer

to intuition? Because when you're rolling around in the mud with kids you have to rely more on your intuition.

Patterns and Experience

A common theme that emerged from the data was that respondent's subjective experiences of non-conceptual awareness was often viewed or understood through patterns or past experiences. Often respondents had difficulty in discerning between experiential knowledge or intuitive knowing, and most viewed the two as separate entities versus parts of a unified whole.

I think it's a place that I haven't gotten to – really discerning where is this information coming from? Or all of a sudden I have a thought... is that coming from intuition, is that coming from experience, or is it coming from something else? That would be nice, although I'll probably never get there.

It's hard to know where my judgments are coming from all the time, it's a little bit of this and a little bit of that. It's experience of having worked with people with similar issues in the past.

One of my teachers said something that I will always keep in my mind, and has been very helpful. Dr X, he said once you've been around long enough there's only so many stories and they just keep coming up in different forms. I thought that was very wise. And of course, I haven't been around long enough, but still that concept... in other words I feel like if I've had x number of certain stories then the moment someone comes in... then I get an intuition.

It often helps me when I make connections between clients. And sometimes it's clients I've seen recently, or clients that I saw in my internships, and I start to notice patterns. I think that's the way my brain works... I notice patterns within one person's life that might in some way resemble the patterns in another person's life.

Intuition can be influenced by experience and training. Um, you know so, my intuition was very different in 2003 when I started psychotherapy, and I would say if you ask me what my intuition is now it's evolved over time.

At this stage since I've been doing this so long it's hard to know when I have a thought about a client, or something I want to suggest, a perspective I want to suggest to them, if it's coming from experience or coming from intuition. Kind of hard to discern at this point.

Intervening Factors in Intuitive Knowledge

Many themes emerged among respondents that spoke to multiple intervening factors that were believed to either enhance or interfere with the intuitive process in the therapeutic setting.

Counter-transference and Projective Identification

An unexpected theme, but one that came up in almost all of the interviews was that of counter-transference and projective identification. Respondent's spoke to the difficulty they experienced in teasing apart what they would consider intuitive knowing, counter-transference and projective identification. Often, the biggest challenge appeared to be finding the balance between intuition and counter-transference reactions. Most of the respondents expressed the importance of their own psychological work and internal balance, and felt that one's own unresolved issues was the biggest obstacle to using intuition in the therapeutic process.

I think you have to be open to being wrong, because your intuition... the countertransference enters into it.

This speaks to the psychodynamic principle of countertransference, without countertransference there's no relationship – that is, there's no connection. There's absolutely no truth to the idea of a blank screen. On the other hand, a certain degree of separateness or sense of yourself in an organized way enables you to have a close emotional encounter. So, when your own life experiences, belief systems and meanings are held with a kind of defensive urgency and operate out of awareness for defensive reasons, self protective reasons... then what passes for intuition is truly coercion. It's the imposition of your own mind on the mind of the patient.

It's usually when I feel really familiar with somebody. Like when they're easy to talk to and be with, and there's a lot of overlap. Or maybe they describe things in the way that I feel, so it's kind of easier then because it's so familiar and I feel

like 'oh, this is easy! I know just how they feel!'. That's not really intuition, more a projection really. So I kind of have to tease it out and be careful.

Self-Awareness

The respondent's all spoke to the importance of their own analysis or therapy, and believed it was a necessary component in their work with clients that allowed for a depth in the work that could not be achieved otherwise.

Another thing I would say is that to the extent that you yourself have in your life, or in your own therapy, opened up spaces internally that are very difficult. Very hard because it's so disruptive and painful and we tend to want to defend against them. But if you've been willing to open up to those things, then when your patient opens up to them you can be there in a particularly empathic way – in a way that another therapist could not. Otherwise it may be that the treatment never goes deep enough.

I think that's probably the most central thing that helps people to be good therapists or analysts, is if you do understand and have made peace with your own experiences, so you can know when it's coloring something or when it's not. As best you can. It always will, but when I can sit and think... that's the place I always go, or that's about me, it really helps me because if it's not about me than I can know it's about the other person so much more clearly. And sometimes it's not easy to know, and sometimes we overlap, because we all have central things, we're all a part of humanity.

I think that you can be trained in a lot of ways to pick up what's a projection and what's not. I think what might get in somebody's way is if they haven't figured themselves out well enough, and then want to make everything a projection.

I'm not a pure vessel for my intuition because all of that other stuff factors in as well. Maybe helpful at times, and maybe less helpful at times. But it kind of requires that I keep asking myself about my own work and if I've processed my sessions..... particularly ones that have felt challenging, or its stirred something up in me and I'm getting into countertransference.

Components that Influence and Inform Practice

A common theme that was central to all participants was what they believed ultimately guided their practice with clients. While all spoke to the importance of having

evidence-based theories underpinning their clinical judgments and decisions, it was also acknowledged that intuitive knowledge was an essential, and possibly most important component in guiding their practice. Some believed that an intuitive awareness helped them to form a working hypothesis about their clients, while others believed it was central to making interpretations. All spoke to the fact that an intuitive awareness was necessary when trying to understand the subjective meaning of a client's experience.

I think clinical decisions have to be rational most of the time, but I also think that sometimes you don't get all the info from just asking questions. And check listing? You might be able to get to the bottom of it that way... and I guess if you were just exhaustive in your questioning. But I think that sometimes you get a lot further when you just feel, when you just intuit what's going on. But I don't just do that because it would be unprofessional and you could be really wrong. So I would say I use both, and I temper one with the other.

I have a couple of theories that I rely on heavily that are very much a part of how I think about things, how I frame what's going on – they're the backdrop. They're always there in the backdrop and when I'm really confused about something they're there for me...they hold me. In the midst of that holding I think I can kind of let my intuition go to see where it takes me. But they have to work together.

How do you come to make sense of the pieces that are brought in? How do you listen in a particular way that draws you to the underlying narrative, the underlying person and what the person is trying to say or do. I think that it's almost an entirely intuitive process, right? But it's not the mind of the analyst that uses their abracadabra, it's that the patient has presented fragments of themselves, pieces of who they are, anecdotes about other people or things. Our mind in all its capacities looks for order in it, or the meaning in it, or the vector, direction in it. Based on your clinical theory, you may make different meaning of things.

What guides my practice is supervision, training, classes, experience, personal development... and an openness to reverie and intuitive knowing.

What Heals

Evidence-based practice models and theories seek to prove through “evidence” what effectively leads to change and transformation in the therapeutic process –

following the linear cause and effect model of empirically supported research.

Participants in this study couldn't speak to such a linear path, but instead gave voice to multiple ways in which they experienced healing in the therapeutic encounter. Common themes that emerged were empathetic resonance, deep connection and understanding, and above all the relationship between client and therapist.

Empathetic Attunement

A common theme among respondents was the belief that having the ability to resonate with their client's inner experience was imperative to developing a therapeutic alliance, which in turn fostered the change process.

I think empathy is huge for people. It's not a one up one down situation. It's not like my client is one down from me – we're on the same plane. I'm interested in finding out together. I think that's important to note, that I'm not the authority.

Sometimes you feel particularly positively drawn to patients, sometimes you're alienated and you find yourself pulling back. All of those are forms of empathy. It's an internal containment, a responsiveness. Now in some forms of treatment the therapist only takes it so far, really leaves it at the surface of themselves. They don't want to be disturbed so they provide dutiful mothering. They feed on time, but are not really emotionally deeply engaged.

I think that empathetic understanding, empathy, is something that people.... They intuit it. But I also think you have to have some understanding of the realities. So I don't think of empathy as having a mutually being able to feel what the other person feels, but you're able to experience what they're feeling with you, to get an understanding of them, so you're kind of with them.

Deep Connection and Understanding

All respondents spoke at length about the importance of their clients feeling deeply understood, as well as the endeavor of reaching and connecting with their clients.

Often in treatment there are things that are happening both within the paradigm of our shared understanding, as well as outside. And sometimes the most important things, I would say almost always, begin to emerge in ways that are difficult at first to grasp. There's a whole literature on enactment in which you are pulled into living out something with a patient. These things get kind of get pulled together and made sense of during and after the fact. Sometimes the moment is the culmination of understood communication between you and the patient, through the patient to you. And other times something begins to happen, something moves in the patient... patient collapses, gets angry.... something changes and you're not entirely sure what this is all about.

I think what clients need to heal is to feel deeply understood. They need to feel like someone really gets them. I think the intuition of the therapist is a really important ingredient of that – intuiting what the client needs on a non-verbal level.

I think I experience these moments all the time. I think that they are when I actually understand on an emotional level a truth that someone is trying to communicate to me on an emotional level. When I can say that and they get it, and they get that we've connected on that level, and that I've put words to something. There's a pause, sort of an OK, that it made sense.... And we both realize that we got something, that something was deeply understood. We both know when it happens, and we both know when it doesn't.

The Relationship

Above all other factors, every therapist interviewed for this study conclusively believed that the most important component of the therapeutic process, and what ultimately lead to transformation and change was the therapeutic alliance between therapist and client, and the intersubjective space that was created within the relationship.

We're in the process of discovery and you don't always know. So the truth of things arrive, it arrives in a way, kind of both from the mind of the analyst and the mind of the patient, but in a kind of in-between place that is kind of created by both but belongs to neither. Some third space. It's called an analytic third.

I do feel more than anything it's the relationship that cures. More important than the words that are exchanged, I think that it's what happening between us. We're both there together and it's incredibly powerful and curative. Something happened between them and me that was helpful, and really, that's all we need to know.

I think it's the central piece of the work, to make meaning of it. And I don't think I do it by myself, I need a partner – we're making meaning together. I can make an intuitive guess, so to speak... I can say I wonder if this is going on? Or this is what it means? But we'll come to something in a collaborative way about the meaning – I think it's just central to the healing process.

It's about listening, really listening and paying attention. Just helping the client really feel accepted and heard.... And interpretation isn't even part of it. It's more about the person comes in the room and they feel they're being seen, understood and accepted. So, it's all about the relationship.

All the great words and beautiful things I can come up with to say? They mean nothing if someone doesn't feel like I care about them as a human being... and they know it. People know it. Whether you're present with them, or whether you care about them. And your words mean nothing. They're picking up with their intuition all the time too. It goes both ways.

Discussion

As a newly practicing clinical fellow in my last year of graduate school, I have often struggled with the translation between what I've learned in the classroom and applying it to my work with clients. Often when I sit with clients I find myself distracted as I rack my brain trying to find the theory or intervention to apply. In my struggle to bridge theory with practice I realized I was absent from the present experience of the person sitting in front of me – the very reason I was drawn to the profession in the first place. I began to wonder why in the midst of being taught how to work *with* clients, we often aren't taught how to *be* with clients. At the center of the therapeutic encounter lies the relationship, and only from there can we truly examine the human subjective experience. Even in the very brief work I've done with clients I've already come to realize that most of what happens in the therapeutic interlude occurs in the spaces in-between, and it is for this reason that I chose to take a closer look.

The purpose of this research study was to examine the role of intuition in the therapeutic process, how it informs the use of evidence based interventions for psychotherapists, and its perceived contribution to the healing and change process in psychotherapy. Evidence based practice interventions in psychotherapy have gained more attention in the last quarter century, with differing opinions on both its positive and negative contributions to the field. For the most part, psychotherapists have embraced empirically supported therapies, yet still struggle with applying theory to practice. While therapeutic models are necessary, perhaps the difficulty lies in the realization that human beings often don't fit in theoretical boxes. Intuition has often been described as “the ability to effectively draw conclusions and effectively solve problems, even when lacking necessary information and/or time” (Karwowski, 2008, p.115). Conceptualizing intuition in this manner begs the question as to whether or not intuition could in fact play an important role in the integrative process of therapy - occupying the spaces in between.

Subjective Experiences of Intuition

In the gap between thoughts, nonconceptual wisdom shines continuously.

-Milarepa

In the study of the mind, Western philosophy has long focused on conceptual and reasoned analysis, paying little attention to what eludes thought by focusing on the “contents” of the mind, rather than the mind as an experiential process. Buddhist psychology speaks to these in-between moments of conceptual thought as *nonthought*, a “presence of nonconceptual awareness” (Welwood, 2000, p.49). As psychotherapists, we are trained to be attuned to our clients – their language, affect, non-verbal

communications, but often miss the most salient and meaningful information because of our mind's tendency to focus on formal thought and perception. Psychotherapist John Welwood offers this explanation:

The mind's tendency to grasp onto solid forms is like a bird in flight always looking for the next branch to land on. And this narrow focus prevents us from appreciating what it is like to sail through space, to experience what one Hasidic master called the 'between-stage' – a primal state of potentiality that gives birth to new possibilities (Welwood, 2000, p. 51).

The therapists interviewed for this study all acknowledged that they considered themselves intuitive in differing degrees, and all believed that intuition entered into the therapeutic process in one way or another. Therapists practicing within the psychoanalytic model tended to associate intuition more with the deliberate process of attending to the unconscious, while therapists from more eclectic models didn't explicitly make this association. Two of the psychoanalytic therapists made reference to their belief that intuition was a necessary component in psychoanalysis, and that therapists that didn't operate with an intuitive knowing would be more likely to practice from a cognitive behavioral approach. Yet the therapists that considered themselves primarily eclectic or cognitive behavioral considered intuition a very central piece in their work with clients.

The study showed that all interviewees identified recognizing intuitive knowing as a bodily sensation, visualization, or a felt sense of a deep understanding with their clients. Clinical psychologist Dr. John Welwood defines this "felt sense" as an implicit felt meaning:

Felt refers to the bodily component; *meaning* implies some kind of knowing or patterning, though not of a logical, conceptual kind; *sense* indicates that this meaning is not yet clear. *Implicit* literally means 'folded into, enfolded'. (Welwood, 2000, p.89)

Respondent's all spoke to the notion of having a sense of awareness that couldn't be articulated in a logical, conceptual way – an implicit knowing without explicit expression.

Intervening Factors in Intuitive Knowledge

Six of the interviewees believed that their experiential knowledge influenced their intuitive knowing, as well as their ability to both decode intuitive meanings, and trust the accuracy of their intuition. According to Baylor (2001) there are two different types of intuition, mature and immature. He postulates that while the intuition arrives in a similar manner, mature intuition tends to result in more successful solutions due to a more advanced metacognition (Baylor, 2001). Yet the generation of knowledge, particularly in the context of human behavior, can only be interpreted and measured by one's ability to make meaning of ambiguous or incomplete data, a process that "is based on experience and imagination. It is built upon previous knowledge and understanding as well as creative ideas. Clinical intuition is compatible with analytical critical reasoning and is often used in a complementary manner" (as cited in Higgs & Titchen, 1995, p. 527). In fact, it can be argued that the underpinning of intuitive knowing is at its core, tacit and implicit knowledge that is "extracted both perceptually and conceptually from experience" (Bohart, 1998, p. 293).

There has been ample research in the psychotherapy profession into the role of understanding in the therapeutic process, and how it contributes to the relationship between therapist and client. In his book *Social Work as Art*, England (1986) speaks to the idea that defined and experiential knowledge inform the therapist's ability to gain an understanding of their client's lives. In other words, the experiential knowledge of the

therapist informs his or her “intuitive knowledge and intuitive behavior” (England, 1986, p. 37).

Much has been written about counter-transference and projective identification in the psychoanalytic field, and it is widely believed that these components are central to any therapeutic work. Jacobs (2002) summarizes the counter-transference experience as, “Countertransference, like transference itself, is a creation fashioned out of components that shift and change in response to the developing process and changes in the psychology of the analyst” (p. 31). And as Weiner (2007) points out “is a joint creation between patient and therapist, implying as it does the significance of both the therapist’s subjective responses and projected aspects of the patient’s inner world” (p. 63).

Counter-transference and projective identification were mentioned by all of the therapists interviewed for this study. Counter-transference and projective identification have been described as nonlinguistic, nonconscious transmissions that “can influence the receptive functions of another unconscious mind” (Dales, 2008, p. 298). Many interviewees described the overlap that can occur between intuitive knowing and counter-transference, and therefore the importance of self-awareness and working through personal issues. According to Dales & Paul, the “intersubjective relational experience” in therapy calls for an expanded self-awareness and self-integration in the therapist to allow for a broader capacity within the therapist to help clients in their own self-integration (Dales, 2008). The study revealed there was a correlation between more experienced therapists and ability to recognize and separate intuition and counter-transference reactions. As one therapist remarked, “Analysts probably use intuition first, like a first thought, like you’re guided by it. But you have to always check in with yourself and

wonder where it's coming from". Rea (2001) acknowledges that this may be one of the reasons therapists so commonly dismiss intuitive insights, "perhaps for fear of issues of counter-transference clouding our judgment – we may either fail to notice or disregard important intuitive insight in favor of prepackaged, needlessly mechanical conclusions" (p. 102). More experienced therapists also noted that when they did attempt to communicate an intuitive thought to a client they were careful not to offer it as a truth.

Psychoanalyst Thomas Ogden writes,

The analyst's feelings regarding what is true are mere speculations, however, until they are brought into relation to something external to the psychic reality of the analyst. The patient's response to an interpretation –and, in turn, the analyst's response to the patient's response – serves as a critical role in confirming or discontinuing the analyst's sense of what is true (Ogden, 2003, p.595).

Components that Influence and Inform Practice

The study explored what the therapists believed guided their practice with their clients, and whether or not they believed they used intuitive judgments to inform clinical decisions in practice. All the therapists interviewed for this study acknowledged that some form of intuitive knowledge informed their practice, yet most reported that it was always tempered with EBP. The responses given by the interviewees spoke to the notion of bridging theory and practice. England (1986) notes "This explanation of the way in which the social worker makes use of knowledge in turn explains the way in which the worker integrates knowledge, or integrates one theoretical perspective with others; it is an aspect of intuition" (p.37).

Two of the interviewees also acknowledged that often the intuitive knowing that guided the course or direction of the therapy was coming from the client as well. If viewed from the transference/counter-transference matrix, it can be inferred that the

movement in the therapeutic process is essentially guided through the intersubjective transference material being evoked in both therapist and client, and “implies a profound commitment by both participants in the therapeutic scenario and a deep emotional involvement on the therapist’s part” (Dales, 2008, p. 300).

What Heals

When interviewees were asked if they experienced curative or transformative moments in the therapeutic process in the absence of well-articulated reason, all respondent’s reported that very rarely, if ever, were they able to identify a single concrete reason for change. Yet, through the process of this study’s data analysis three separate themes emerged in all interview transcripts that spoke clearly to what essentially contributed to healing in the therapeutic process. Because these components were intersubjective and relational by nature, it is understandable that it was difficult to articulate in a coherent manner.

The study found that therapist’s believed the capacity for *empathetic attunement* was essential in their ability to make meaning of their client’s lives, stories and experiences. As therapists, one of the most difficult tasks we face is our ability to resonate with the subjective meaning of our clients lives. The words our clients articulate often fail to convey the emotional content underneath. Psychoanalyst Theodore Laqueria (2001) notes the neurobiological reasons for this difficulty:

In the treatment room, the analyst sits in a special silence. As he listens to his patients, he becomes aroused with thoughts, feelings, and ideas and assigns meaning to the unfolding narrative from his own theoretical perspective. This theoretical operating frame, neuroscientists tell us, resides within the neocortex, the topmost stratum of the cerebral cortex, the area of the brain responsible for higher level thinking; the techniques that flow from it are arrived at in a

systematic way. And yet, analytic experience is neither logical nor systematic. In fact, the multiplicity of emotions that the analyst feels within himself and within his relationship with the patient are, I believe, much more complex than the explanatory power of any single theory (p. 61).

So, much like the mother/infant relationship, when a therapist is able to listen and engage in intuitive processing, or a “limbic resonance” with their clients, they are more likely to be empathetically attuned, and in turn, derive a better understanding of emotional content trying to be conveyed (Laquercia, 2001).

Interviewees also spoke to the importance of their clients feeling deeply understood and connected with on a non-verbal (or unconscious) level. Beebe (1998) suggests that these moments of meeting are “moments of reciprocal recognition or shared awareness that occur with or without words” (p.337). As one therapist remarked, “Sometimes in the moment, and I would describe that recognition as a sensation ... it’s not an intellectual feeling, it’s more, it’s actually a really positive feeling of connection. And it feels somehow a little bit deeper than just getting the right answer”.

The most prominent theme, one that came up in every interview, was the belief that what was central to all healing in the therapeutic process was the relationship between therapist and client. Recent research into what facilitates change in psychotherapy support these findings. As suggested by Dales (2008):

Researchers in neuroscience, and researchers in psychotherapy process do not appear to propose one specific modality as essential in assisting with affect regulation in all clients. A variety of psychotherapeutic techniques and tools may be useful in helping clients achieve self-organization. Concerning client change, key points underscored in the literature are that the alliance is directly responsible for change and that the technique ultimately rests on the relationship (p.294).

This intersubjective field within the therapeutic alliance is the space in-between where new experiences and meanings can be created for both therapist and client.

Implications for Social Work Research

The aim of this study sought to understand the role that intuition played in the therapeutic process, how it informed the use of empirically supported interventions, and its contribution to the change process. While it was acknowledged that evidence-based practice therapies had a role in the matrix of psychotherapy, it was also acknowledged that what constitutes as “evidence” is often restricted and not easily applied in day-to-day clinical practice. The therapists interviewed for this study spoke to the importance of their theoretical frameworks – how they serve as the essential backdrop for the therapeutic interlude, which in turn allows them to intuitively explore both the conscious and unconscious aspects of their client’s lives.

These moments of meeting in the intersubjective space between therapist and client are derived from implicit structures, where as theories and techniques are explicit in nature (Dales, 2008). Further research and improved understanding into clinical intuition is needed to create “interventions shaped not only by an intellectual understanding of theory but also an emotional resonance with the patient informed by intuition” (Laquercia, 2005, p. 69).

Clinical social work education is derived from a strong empirical foundation, which emphasizes effective theories and techniques as building blocks from which to draw meaning. While these remain important aspects of effective clinical social work practice and education, the parameters must be broadened beyond one-dimensional theories and techniques. The science of evidence-based practice is a starting point in the therapeutic alliance between therapist and client, but true healing occurs within an

intersubjective space outside of manualized interventions, and perhaps the true art lies in our intuitive ability to find it.

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Appendix A

December 13, 2011

To whom it may concern:
Re: Heather Smith

I am the President of the Minnesota Psychoanalytic Society. Today our Executive Committee voted to support Heather Smith's research paper on Intuition. She will now have access to approximately 100 graduate clinicians who are members of our Society and I am willing to add a letter of support on her behalf encouraging our members to participate in her research.

If you have any questions or if I can be of further assistance, please contact me at 612-XXX-XXXX or via e-mail at XXXX@hotmail.com.

Sincerely,

Hal Steiger, PhD
President: Minnesota Psychoanalytic Society

Appendix B**Consent Form
University of St. Thomas****The Spaces In-between: How the Art of Intuition Informs the
Science of Evidence Based Practice in Psychotherapy.****288839-1**

I am conducting a study that explores the role that intuition plays in the collaborative process between therapist and patient, how it informs the course of action that leads to change, and contributes to the role of empathetic understanding in the therapeutic process. I invite you to participate in this research. You were selected as a possible participant, because you are a practicing psychotherapist and member of the Minnesota Psychoanalytic Society and Institute. Please read this form and ask any questions you may have before agreeing to be in this study.

This study is being conducted by: Heather Smith and supervised by Dr. Felicia Sy, Assistant Professor in the School of Social Work at St. Catherine University and the University of St. Thomas.

Background Information:

The purpose of this study is: to explore and gain insight into psychotherapist's subjective experiences of nondileberate knowledge and meaning in the therapeutic process, and perceived understanding of its contribution to the change process. Exploring therapist's subjective experiences around this topic may provide insight for clinical social workers on more effective and productive ways to engage their patients in the treatment process, thereby positively impacting treatment outcomes.

Procedures:

If you agree to be in this study, I will ask you to do the following: complete a live, audio-taped interview of approximately 45-60 minutes in length. You will receive, in advance, a list of the questions you will be asked during the interview. You will be able to choose both a time and place for the interview that is convenient for you. In addition, you will be invited to a presentation of this research in May, 2012.

Risks and Benefits of Being in the Study:

The study poses little risk to you. It simply asks you to review the ways in which you use nondileberate and intuitive knowledge to inform your work with your patients. Reflecting on your work with patients may stir up some emotions associated with current or past patient dyads or experiences. These possible reactions will likely be significantly

minimized in the context of your reflecting back on them as compared to the more emotionally potent experience that direct work with patients may have evoked in the past.

The direct benefits you will receive for participating are: the opportunity to revisit the theoretical influences in your work with patients in light of a less researched and understood aspect of therapeutic interventions; and to possibly highlight new ways of thinking about the collaborative process with your patients.

Compensation:

There is no compensation offered for participating in this research.

Confidentiality:

The records of this study will be kept confidential. In any sort of report that I publish, I will not include information that will make it possible to identify you in any way. The types of records that I will create include audio-taped interviews, transcripts of interviews and researcher notes on these interviews. I may hire a transcriber to assist in preparing the research data for review. This transcriber will be asked to sign a statement of confidentiality assuring his/her ability to protect the privacy of the data being transcribed, thereby maintaining the integrity of the research project. Also, any information identifying research participants will be kept from the transcriber. All data collected in this study will be kept in a locked filing cabinet in my home office. Only I will have access to these materials. Furthermore, all data collected will be either erased or destroyed by June 1st, 2012.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the researcher, Heather Smith, her chair, Dr. Felicia Sy, your place of employment or St. Catherine University or the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to and until the research's completion date of April 30th, 2012. Any data collected will remain confidential regardless of whether or not you complete this study. You may choose to complete all or part of the interview without consequence to you. Your participation in the study to the extent you're able is highly valued.

Contacts and Questions

My name is Heather Smith. You may ask any questions you have now. If you have questions later, you may contact me at 612-275-6987. You may also contact my chair, Dr. Felicia Sy, at 651-962-5813. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age.

Signature of Study Participant

Date

Print Name of Study Participant

Date

Signature of Researcher

Date

Appendix C

The Spaces In-between: How the Art of Intuition Informs the Science of Evidence Based Practice in Psychotherapy.

Researcher: Heather Smith

IRB # 288839-1

Interview Questions:

- 1.) How long have you been a psychotherapist, and what's your model of practice?
- 2.) What does intuition mean to you? Do you consider yourself an intuitive person?
- 3.) Are you able to recognize intuitive knowing? And if so, how would you describe that recognition?
- 4.) What guides your practice with patients (i.e. do you believe you apply intuitive judgment to clinical decisions)?
- 5.) How are you able to "make meaning" of your patients lives / stories / experiences / feelings?
- 6.) How do you achieve an empathetic understanding with your patients?
- 7.) How do you think your experiences, belief systems, and meanings affect the accuracy of your intuition?
- 8.) What do you think are the consequences (negative or positive) of using intuition in the therapeutic process?
- 9.) Describe how you are able to helpfully respond to a patient's nonverbal emotional communication.
- 10.) Have you ever experienced a transformative or curative moment in therapy in the absence of well-articulated reason?

