

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 themselves 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 themselves 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 patient’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 themselves 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

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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

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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		
	<i>n</i>	<i>r</i>	<i>p</i>
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		
	<i>n</i>	<i>r</i>	<i>p</i>	<i>n</i>	<i>r</i>	<i>p</i>
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.

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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