What Happens Next? A Developmental Model of Therapeutic Spontaneity: Commentary on Paper by Philip A. Ringstrom

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What Happens Next? A Developmental Model of Therapeutic Spontaneity

Commentary on Paper by Philip A. Ringstrom

Russell Meares, M.D.

Philip Ringstrom tackles a neglected but important topic—therapeutic improvisation. In my view, this is better termed spontaneity. A central issue is the therapist's freedom of mind, which, in the typical case, is restricted by the transference-countertransference field. I argue that the value of spontaneity, on the part of both partners, lies in its contribution to a growing "aliveness" in an individual previously "dead." In this commentary, three forms of spontaneity are distinguished: The therapist, immersed in the patient's experience, is able to resonate with and amplify a moment of vitality in the patient's expression; in pseudospontaneity, the therapist believes he or she is responding spontaneously but is acting under the influence of the transference-countertransference field; and there is a spontaneity in the therapist's "leap to freedom" from the constriction of this field. In that this expression is genuine, and new to the patient, it may have benefit in the manner of a "corrective emotional experience." The example of therapeutic spontaneity that is given suggests that, ideally, all therapeutic language is, in a nonsalient way, spontaneous—fresh and unscripted. In this example, the therapist's form of responsiveness leads to the emergence of a larger, reflective form of consciousness in the patient—a state toward which the therapeutic endeavor is directed.

Philip Ringstrom considers the significance of his "spontaneously saying" something that was not prescribed by orthodox theory and technique. In doing so, he approaches an important subject that has been relatively neglected not only in psychoanalysis but also

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in the related disciplines of psychology and philosophy. In what follows, I focus on the notion of spontaneity rather than the improvisational, as I believe the former is closer to the therapeutic behavior that Ringstrom advocates. Improvisational, to my mind, has connotations of the makeshift, of the ramshackle, of flying by the seat of one’s pants. Although both words imply a spur-of-the-moment response, spontaneity has additional meanings. First, according to the Oxford English Dictionary, the spontaneous has a “self-contained cause or origin”; second, to act spontaneously is to “act of a free and unconstrained will.” Freedom is a central issue.

The first question that arises is this: Why should we be spontaneous? What is the point of spontaneity in therapeutic terms? The answer lies in what the therapist believes to be his or her goal. As Ringstrom points out, through a comparison of Klein and Kohut, psychoanalytic views of therapeutic purpose are diverse. Cultivation of the spontaneous is an aspect of an approach to treatment that is a manifestation of a paradigm shift that is slowly taking place. The nature of the shift seems to be suggested by Ringstrom’s remark, the meaning of which is not quite clear, concerning “fears about working in the analytic dyad without consideration of some version of a ‘psychoanalytic third’—that is, an independent theory of mind.” I take this statement to mean that mind, or what it is to be “myself,” arises as a third thing between the dyad. It is out of this idea that an argument for spontaneity develops. The argument depends on a schema in which, though recognizing the abstraction, a distinction is made among “I,” “me,” and “myself.” Each thing points to a distinguishable aspect of personal existence (Meares, 2000a, pp. 7–14). Consideration of the development of the third thing, myself, provides a model for guidance in the use of therapeutic spontaneity and leads to a view that supports, with some modification, Ringstrom’s thesis.

**A Developmental Model**

The notion of a theory of mind was neglected, for much of the 20th century, by the disciplines of psychology, philosophy, psychiatry, and even psychoanalysis. Hughlings Jackson’s idea that the study of mental illness is in essence a scientific investigation of mind (Meares, 1999a) was forgotten after World War I, when notions such as personal being
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and self were thrown out of academic psychology in what has been called a “radical behaviorist purge” (Harter, 1983, p. 226). In the sphere of philosophy, the notion of an inner life, the essence of personal being, or self, as William James (1890, 1892) understood it, was officially derided in influential publications such as Ryle’s (1949) The Concept of Mind.

Slowly, without significant confrontation with the older paradigms, in a quasi-underground manner characteristic of the unobtrusively subversive work of Winnicott (1971), the idea is being formulated, bit by bit, that a disruption of personal being is the principal problem that confronts us in our therapeutic work. The task is increasingly seen as fostering the emergence of “aliveness” from a state in which personal existence is impaired, stunted, or destroyed, and the individual is, in an experiential sense, “dead.” Ogden (1997a, b, c, 1998, 1999) has contributed to this new direction by pointing out the significance of certain forms of language in fostering “aliveness.”

It is implicit in the new paradigm that at least part of the therapeutic endeavor has a maturational purpose, an aim made explicit in the writings of Kohut (1971, 1977) and Winnicott (1965). Such a purpose should be guided by a theory of maturation that is necessarily built around some definition, however preliminary, of “personal being.” As the behaviorist-positivist “purge” had cleared the decks of such intellectual baggage, no background was left against which writers such as Kohut and Winnicott could work toward a definition. Kohut (1977) did not provide one, declaring the self “unknowable” (pp. 310–311). Winnicott did not attempt the task. We have to return to James for a suitable definition.

In essence, James found our sense of personal being in an awareness of the movements of inner life—what he called the “stream of consciousness.” Although this view may not appeal to the logician, it is, nevertheless, “what we mean by personal selves” (James, 1892, p. 153). James identified a process in which there is a sense of something happening, an experience of kinesis. The stream of consciousness involves a kind of thinking that James called “spontaneous.” It moves by associations: “The train of imagery wanders at its own sweet will, now trudging on sober grooves of habit, now with a hop, skip and jump, darting across the whole field of time and space. This is revery, or musing” (1892, p. 271). Mental activity during reverie, when the stream of consciousness is particularly salient, has a “shape” that differs from what is more clearly purposive, when attention is directed at
particular events, external or internal. This latter, stimulus-directed thought can be seen as linear, whereas “spontaneous” thought is nonlinear, shifting capriciously, wandering, moved not only by association but also by affect and analogy. The Jamesian descriptions show an interweaving of “spontaneity” and “the stream of consciousness,” suggesting that the development of personal being must be linked to the spontaneous and to the potentiation of a form of nonlinear mental activity. The shape of this mental activity is manifest in play (Meares, 1990, 1993, 2000a; Meares and Lichtenberg, 1995). This leads to the notion that playlike activities are essential to the emergence of personal being. They begin at birth, when the mother initiates the game of conversational play, pretending her baby can understand and talk with her (Meares, 2000a, pp. 15–21).

The mother’s part in this play is not random but is linked to her baby’s emotional states, which are shown in bodily movements and vocalizations—what Winnicott might have called the infant’s “gestures.” “Periodically,” he wrote, “the infant’s gesture gives rise to a spontaneous impulse; the sense of the gesture is the True Self, the gesture indicates the existence of a potential True Self” (Winnicott, 1960, p. 145). The mother’s answering gesture is not mere mimicry. She is not only a mirror, showing the baby what he is like; her response is her own, but it is resonant with her baby’s state. Characteristically, her vocalization and facial expression somewhat amplify those of the infant (see, e.g., Penman et al., 1983).

The mother’s response to the baby’s gesture gives form to, makes recognizable, what is going on in the baby’s body. In this way, bodily states are joined with emotions. Under these circumstances, the baby’s emotional expression includes all the vitality of its bodily accompaniments. Put another way, her response is vitalizing, potentiating the sense of “aliveness.” Her response has the kind of spontaneity that is important in the therapeutic setting.

The mother’s behavior during conversational play, however, shows something of a paradox. It is not “self-contained,” as the definition requires. Rather, her behavior is determined by the field of influence between the dyad. If the maternal behavior is seen as an early, and limited, model for the spontaneous behavior of the therapist, we reach the somewhat startling conclusion that the so-called spontaneous gesture is not spontaneous at all—at least in terms of the definition. Indeed, it can be said that, if the responses of the therapist are “self-contained,” they are a consequence of a rupture of the connectedness between patient and therapist or, as Kohut would put it, of the self—
self object bond. In this case, the “gesture” of the therapist is his or her own, equivalent to the mother imposing her own “gesture” on the infant. In the “good enough” situation, the mother bases her response on her understanding of her baby’s state. In this sense, her behavior involves a double-awareness. It is combined with a feeling of freedom, a matter I touch upon later.

The aim of therapy is not, of course, to replicate conversational play. Rather, the goal in therapeutic terms is the emergence of the “third thing” that emerges spontaneously, bit by bit, out of the form of relatedness shown in conversational play in which both partners behave as two parts of a single system.

Conversational play is dyadic, carried out between the baby as “I, and the other. There is no self in it. A third element needs to be found for self to evolve. This element is the world-to-be-manipulated” (Meares, 1993, p. 33). Over the first six months of life, while the infant is with the mother, its attention to other things increases. Playing with these things in the presence of mother, and involving her, becomes a feature of the first year of life. Out of this trajectory of the child’s increasing interest in manipulating physical things, symbolic play is established during the second year of life. This scene shows the “third thing” and the self in embryo.

In symbolic play, beautifully described by Piaget (1926, p. 243), the child is absorbed, like an adult lost in thought, apparently ignoring the parent, though the parent’s presence permeates every act and thought. The chattering that accompanies the child’s play has a curious shape, described by Vygotsky (1962), that differs qualitatively from that of ordinary communicative speech. Whereas ordinary communicative speech can be seen as linear, chattering accompanying symbolic play is nonlinear. It is associational. At times, its condensations and jumps are such that it is incomprehensible, leading Vygotsky to conclude that its purpose is not communicative. I have suggested that its purpose is the representation, and so the bringing into being, of a sense of personal existence (Meares, 1990, 1993; 2000a; Meares and Coombes, 1994).

The kind of activity manifest in symbolic play is the foundation of the sense of “myself.” It is this experience toward which therapy is directed. Moreover, the essential features of the field of symbolic play can be seen as providing a metaphor for guiding therapeutic activity. These features, including the form of language and a kind of relatedness in which the other is felt as part of one’s own existence, are all internalized somewhere around about age four or five, when, according
to Flavell, Green, and Flavell (1993), the child discovers the stream of consciousness.

What Happens Next?

Whether a particular “spontaneous” remark of a therapist is useful, appropriate, or “correct” cannot be determined in any prescriptive way, as it depends on the therapist’s capacity to be “within” the patient’s experience. What emerges, in many cases, could not have been described in a textbook. The therapist can know whether his or her response is beneficial only by what happens next. The criteria chosen for this judgment are determined by the maturational purposes of the therapeutic endeavor.

Whether a particular so-called spontaneous remark of a therapist “works” is shown by a potentiation of the features of the experience of the stream of consciousness, which includes the Proustian kind of memory (Meares, 2000a), now called autobiographical, that involves the reflective capacity. On the other hand, when the intervention does not work, there is a loss of vitality—perhaps the expression of negative affect, linear rather than associative thinking, attention directed toward external events rather than those that are more personal and inner; and, overtly or covertly, the emergence of negative transference–countertransference phenomena (Meares, 1992). Reflective function is diminished.

The following anecdote illustrates an effect of therapeutic spontaneity.

The patient, Vera, is in her 30s. Her history is a terrible one. She was conceived in rape and had to endure, for her entire life, her mother’s hatred and continued accusation, “You’re just like your father.” The mother had married when Vera was about four, a kindly man. However, he died a few years later. Vera’s adolescence was troubled. She, like her mother, was raped. In her 20s she developed the stigmata of a borderline personality disorder. There were overdoses, self-mutilation, hospital admissions, and dissociative episodes. Some of these episodes reached the severity of fugue and involved auditory hallucinosis. Despite this, she managed to stay in a marriage with a kindly older man who may have evoked the positive experiences with her dead stepfather.
After eight months of treatment with Dr. A, Vera has made remarkable progress. However, Dr. A has been maintaining her on antipsychotics, which she was taking at the time of her referral. Seeing that Vera is now greatly improved, Dr. A wants to modify this medication as a means of working toward its cessation. He remarks that he is “anxious” about its potential side effects. Vera, in a cheerful voice and in a teasing way, says, “What, you suffer from anxiety? Is that what you’re saying?” Dr. A laughs, reiterating that he is worried about her developing side effects. She is now also laughing, “I was going to say that’s different—a doctor suffering from anxiety and trying to treat it.”

They now go into a kind of laughing banter they both enjoy. In a way, they are playing a game. Their behavior resembles that described by Ehrenberg (1990) and Feiner (1990) in their advocacy of “playlike” activity in therapy. It should be noted, however, that Dr. A is acting with a double-awareness throughout the exchange. He knows what he is doing. He sees his responsiveness as something like the amplification that the mother’s resonance brings into conversational play.

At the height of their enjoyment, and laughing, Dr. A spontaneously tells a brief joke about a doctor in need of medical treatment. After their laughter dies down, the patient says, “He was forgetting he was a doctor himself?”

In what follows, Dr. A judges the effect of his unorthodox behavior. There is a pause. She says, “Weird,” in a reflective way. This is a word she uses often. It presumably has a personal significance.

There is another pause. Then she says, in a quiet and contemplative voice, “I like this weather we’re having.” At this point, Dr. A’s judgment about the effect of his spontaneity is equivocal: On one hand, Vera’s attention is directed outward, suggesting a disjunction; on the other hand, there is a tone of positivity in the remark. The conversation continues:

Vera: I love it when it rains. Mmm. I like the cooler weather, yeah; I don’t like the heat.
Dr. A: Yes, yes.
Vera: Cold weather.
Dr. A: Yes, and playing with the rain. And it’s like a child, isn’t it? Children like the rain.
Vera: Mmm. Yeah, it feels very—also when it’s raining—in the car—it feels very secure like a security thing when I’m in the car.
Dr. A: Yeah.

Vera: And the rain’s falling.

Dr. A: And you’re not getting wet.

Vera: Mmm. I’ve always felt like that, but I don’t know why, but that’s how it feels.

Dr. A: Interesting.

Vera: Mmm. I’ve always felt like that, but I don’t know why, and yeah, I remember when I was—um—I was in a pram, and I was a baby, and I remember my mother and walking one night, and I could see, you know, the traffic lights changing colors and the cars, and it looked really pretty. I remember that. I remember feeling very secure and warm, sort of snuggly sort of thing.

In an individual whose conversation earlier in therapy was stimulus-entrapped, replete with somatizing references (Meares, 1997) and in the style of a chronicle (Meares, 1998), this is a remarkable movement. The beautiful autobiographical memory of the streetlights in the misty rain is the first of its kind to emerge in this therapeutic conversation. Its appearance indicates reflective activity and evidence that Dr. A’s spontaneity “works.” What happens? It seems likely from the repetition of the word secure that his responses create a feeling of security, that he is “with” her. Out of this sense of connectedness and security comes the “third thing.”

It must be noted that Dr. A’s telling of the joke is not his only spontaneous offering. He is spontaneous all the time. Nothing he says is scripted, rehearsed, or secondhand. His remarks about “playing with the rain,” and children, and “not getting wet,” though brief, have a linking effect, in the manner of conversational play. They are based on his empathic understanding of his patient’s experience. As Ringstrom points out, empathy underpins an effective spontaneous responding.

Self-Contained Spontaneity

Not all so-called spontaneity is of the kind described so far, which arises as an expression of a mutual field of influence. Another kind of spontaneity is truly “self-contained” and represents an attempt in the part of the therapist to break free from the constraint, the entrapment imposed by the patient’s form of relating. This therapist’s experience
is very different from that of Dr. A’s, whose responding is accompanied by a sense of freedom.

The spontaneity that is a response to a feeling of being closed in and that seeks to shrug off the shackles is risky, to which I can attest from my own experience. However, such spontaneity is sometimes beneficial. Here is an example.

Dr. B has begun working with a borderline patient, a man about 40, with no significant relationships. Dr. B dreads the sessions. The patient is sullen and often silent, obstructive, covertly contemptuous and rude, and dismissive of Dr. B’s remarks. Finally, Dr. B “loses it.” He points out the uselessness of the patient’s behavior, “You come in here, you block any attempt to understand, you’re ceaselessly negative, . . .” and so forth.

At the next session, Dr. B waits apprehensively to see if his patient will show up. To his surprise, he finds, that not only does his patient show up, the patient has experienced a major shift. The patient explains that it was valuable to see that Dr. B is a real person, not someone playing a therapist role. Some months later, the patient says, “I prefer to know if I’m pissing someone off. Honesty is important; those relationships will last. They don’t have to coddle me, just be real.”

The kind of spontaneity exhibited by Dr. B is qualitatively different from that of Dr. A. Its positive effect is likely to have a different explanation. The patient’s remarks suggest that Dr. B’s behavior offers something of a “corrective emotional experience.” One wonders, in line with Ringstrom’s suggestion, whether the positive effect of his own spontaneity had a similar basis. Ringstrom felt “trapped.” His spontaneous remark was an escape. He “blurted” it out. His patient Jonathan’s laughter conveyed a sense of shock, as if he were suddenly confronted by a different view of the world. To see Ringstrom behave as a real person must have been an extraordinary relief to Jonathan, after having lived so long in thrall to his mother’s falsity and fake niceness. In the typical patient suffering from obsessive-compulsive disorder, as Jonathan does, the therapist’s “reality” is essential to the therapeutic process (Meares, 1994, 2001).

**Pseudospontaneity**

So far, I have described the spontaneity that is potentially beneficial and that involves a sense of connectedness with the patient. I have
also described a category of spontaneous remarks that come from the therapist’s own personal system rather than from the intersubjective field. There is a third kind of spontaneity, which arises from the intersubjective field, that is potentially malignant.

Unconscious traumatic memory systems create a field of influence into which the therapist, as other, is drawn. Expectations of the other, based on the past traumata, are conveyed by subliminal cues and unconsciously “perceived” by the other, who begins to respond in accordance with these cues. He or she is “constructed” by them (Meares, 2000a, b). In this circumstance, the therapist’s unexpected or even uncharacteristic responses might, to an outside observer, appear to be spontaneous. Although “new” to the therapist, they are not new to the patient. They are repetitions of the traumatic past. The “genuineness” of the therapist has a catastrophic result (Meares and Hobson, 1977).

This idea, anticipated by the concept of projective identification, receives support from recent work showing the powerful effect on brain function of stimuli that are not consciously perceived (Morris et al., 1998, 1999).

How does one know that one’s response has been made on this basis? Once again, the central issue is freedom. Dr. A found himself in a fluid form of interplay that was associated with a sense of well-being, of connectedness with his patient, and with a personal freedom reminiscent of the mother engaged in conversational play. In the case of Dr. B (and, one supposes, of Ringstrom), the therapist’s spontaneity represents a leap to freedom and toward an expression authentically his own. In the third situation, there is neither well-being nor connectedness. Rather, there is a subtle form of alienation between the therapeutic partners (Meares, 2000a). In addition, as Ogden (1979, 1982, 1990, 1994, 1997a) has pointed out in his explorations of projective identification, a faint sense of coercion, of which the therapist may be unaware, underpins the response. The expression is not freely made. What results, as Ringstrom points out, is “seemingly spontaneous,” a pseudospontaneity.

Pseudospontaneity is also a potential risk when play and spontaneity are “prescribed.” The therapist plays out the role of playing—like the child told to “go out and play.” Pseudospontaneity may, in addition, contribute to a kind of reverse-accommodation, or participation in an endless and useless “attunement.”
Discussion and Conclusion

Ringstrom challenges us to consider the role of spontaneity in therapeutic practice. This consideration leads to several surprising and even paradoxical conclusions. First, in arguing from a developmental perspective, we discover that, in ideal circumstances, spontaneity is not an intermittent behavior. Rather, every contribution of the analyst to the therapeutic conversation should be spontaneous and have the quality of freshness. Because these expressions seem natural, their spontaneity is usually not obvious or salient.

A developmental model of therapeutic spontaneity reveals a paradox. Although freely made, the spontaneous contribution arises in an intersubjective field and is linked to a feeling-based understanding of the other’s immediate experience. This kind of spontaneity is not “self-contained,” as the definition of the word requires. In this way, it is unlike the spontaneity of a man who, while out walking, starts to whistle and swing his stick at tufts of grass. These spontaneous and unpremeditated acts are internally generated expressions of his own state of well-being. They are unlike, though not entirely unlike, therapeutic behavior. In my view, the therapist should not “leap before he looks,” as Ringstrom suggests.

How is Ringstrom’s suggestion to be reconciled with a developmental model? A reconciliation comes, I think, with the realization that the behaviors of the mother in conversational play, and of Dr. A, consist of two main parts, one affective and the other verbal. The affective response is immediate, like the smile that lights up when one unexpectedly comes face-to-face with an old friend. This is the “leap before you look.” The verbal component, at least in the therapeutic setting, involves a fleeting evaluation made during the initial affective responding.

The conversation in which spontaneity is evident is a state toward which therapy is directed. In the beginning in a typical case, an implicit constraint is placed on the therapist by the characteristic mode of mental activity of the damaged individual. The conversation has the form of “stimulus entrapment” (Meares, 1993, pp. 101–109; 1997). It moves, as it were, in straight lines determined by environmental events, even by bodily stimuli. It is colored by the reactive emotions of anxiety and anger and is devoid of imaginings and of involuntary memories of earlier life. The conversation has the form of a chronicle or a script (Meares, 1998).
In this circumstance, the analyst who considers his or her task to translate the patient’s productions into secondary process, to turn it into straight lines in the manner of the “orderly therapist” (Meares and Hobson, 1977), impedes the emergence of the patient’s sense of “personal being,” or self. This is often compounded, as Ogden (1997b) remarked, by the therapist’s secondhand language, made up of other people’s expressions and lacking genuine “aliveness” enhancing the patient’s deadness.

As the therapeutic task is directed toward emergence of personal being, the therapist’s goal is to foster a nonlinear form of mental activity that resembles the shape of the stream of consciousness. The process of self is manifest linguistically. Elements of another kind of language, resembling that described by Vygotsky (1962) in observing symbolic play, begin to appear, embedded in the linear language directed toward and by the environment. Spontaneous shifts and movement become evident.

In working toward this state, the therapist tries, against the constraint of the intersubjective field, to maintain his or her own “aliveness” and spontaneity—evidence of which is helpful as a model and also because, as Ringstrom remarks, it may enhance the patient’s sense of trust. In these cases, as Ringstrom points out, where the developmental story is characterized by parental inauthenticity, it may also have the effect of a “corrective emotional experience.”

The therapist’s leap to freedom is often an attempt to maintain his or her own sense of “aliveness”—his or her own self, or personal being, which is stifled by a constrictive intersubjective field. Whether his or her spontaneity is beneficial depends on how free the analyst is of the effect of this field and of the influence of projective identification. A wonderful example was given by the late Robert Hobson (1985).

Hobson’s patient Sam was a sullen, glowering, delinquent adolescent whose surly frowns and brief, grudging replies were his only responses. Hobson wrote:

It went on week after week, until I felt I could stand it no longer. . . . One day, just before seeing Sam, I had been listening to a radio commentary on the Test match at Lords where England was playing South Africa. I forget the details now, but the position was exciting. I was full of it when Sam came in. For some reason I spontaneously and unreservedly poured out my opinions and feelings about the state of the game—an irresponsible piece of
behaviour. Then I asked him what he thought about the state of play and at that moment—this is the vital part—I really needed a response. Sam smiled. For the first time [pp. 3–8].

This was the turning point. However, it is important that, rather than leading at first to better communication in “therapy” mode, they talked, with passion, about cricket for the next few weeks. This led to a widening of their conversation to include discussions of Sam’s ideas, wishes, and impulses. A great change in the boy had begun to occur.

As Hobson was absorbed in the cricket conversation, he was relatively free of influence of the intersubjective field. He, perhaps like Ringstrom, spoke as he often spoke with a friend. His spontaneity connected with something alive in Sam—an answering passion.

As ideally we work according to principles rather than rules, specific therapeutic behaviors cannot be precisely predicted. Responses to the spontaneous behaviors of Drs. Ringstrom, Hobson, A, and B would not have been predicted. What “works” is shown by what happens next.

REFERENCES

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