A Psychotherapist's Exploration of Clinical Intuition: A Review of the Literature and Discussion

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Abstract:

The psychoanalytic and psychotherapy literature, including Transactional Analysis and Integrative Psychotherapy, have long acknowledged the role of intuition in clinical work. More recently, cognitive psychology researchers have begun to explore the phenomenon in a more general sense. This article presents an overview of the concept of clinical intuition, and a case study that demonstrates some ways that clinical intuition may be a valuable tool in psychotherapy. In keeping with the relational emphasis in Integrative Psychotherapy, the clinical example explored in this article both arises out of and strengthens the therapeutic alliance and contributes to positive treatment outcomes. The increased awareness of the potential benefits of the phenomenon of clinical intuition suggests the advantages of further legitimizing its use and training thereof.

Key words: Clinical judgement, therapy process

There is a small but growing body of research on intuition from the perspectives of Cognitive Psychology. This work investigates intuition across contexts (see Sinclair, 2011). In addition to this more general research, there is a small corpus of research that focuses specifically on clinical intuition - therapists'

use of intuition in the treatment process. There are also a number of schools of psychotherapy that have produced theoretical treatments of clinical intuition. Noteworthy among these works is that of Eric Berne from the perspective of Transactional Analysis (Berne, 1949/1977). Integrative Psychotherapy represents an expansion and refinement of the early core concepts of Transactional Analysis (O'Reilly-Knapp & Erskine, 2003), and so perhaps not surprisingly one may conclude that clinical intuition is acknowledged as an important element in the clinical process. This becomes clear in a close reading of the importance of the therapeutic relationship and attunement.

Following an overview of the concept of clinical intuition in psychotherapy and the research on the topic, the authors present an example from a larger multiple case study on boundary dilemmas. This example demonstrates how one intuitive therapist used her ability in a clinical encounter. Three issues emerged as important in this case. First, those who have studied clinical intuition have found that research participants report that intuition emerges from a deep connection with the client (Charles, 2004; Jeffrey & Fish, 2011; Petitmengin-Peugeot, 1999), a theme that is front-and-center of Integrative Psychotherapy (Moursund & Erskine, 2004). The case example presented here suggests that the use of intuition may also enhance the therapeutic alliance.

The second point is that intuition is not antithetical to, nor employed as a substitute for, solid clinical judgment. It can be, in fact, a valuable tool in the psychotherapy process. Indeed, in some cases intuitively derived insights may contribute to a successful treatment outcome.

Finally, the therapist in the case example reveals some uneasiness in discussing her use of intuition. As the concept of intuition gains legitimacy in psychotherapy, the authors hope to mitigate such uneasiness and help therapists use intuition ethically and successfully in their professional work.

The Growth of Interest in Intuition

While intuition has always seemed to lurk at the edges of the psychotherapy literature, based on the material explicated in this literature review, it would seem that in the past twenty years this interest has expanded. Different perspectives represented in this literature review share some common, as well as divergent, features regarding how intuition is defined, how it operates, and the legitimacy of intuitively derived information. One of the most notable differences between

existing models is in the definition of intuition. Arguably the most commonly agreed upon definition is "k*nowing without knowing how you know*" (Radin, 2006, p. 142). Perhaps one of the reasons this definition is rejected in some circles is because it is so nebulous. However, a glimpse at the use of the term in the literature reveals that this vague definition may be as close as one can get to agreement on what, exactly, intuition is.

Cognitive Psychology Research on Intuition

In the past several decades cognitive psychologists have productively researched intuition. Psychologists who have studied intuition hold nuanced differences in how they define the term yet they agree on several key points. One notable feature of their definition is that they limit the use of the term to the decision-making processes. This point differentiates intuition from insight (Hogarth, 2010; Lieberman, 2000). In other words, one must decide on a preferred course of action in order for the experience to qualify as an intuition (Betsch, 2008), whereas an insight is simply acquiring some knowledge. For example, to tie this to clinical experience, cognitive psychologists would not classify a therapist sensing that a client may have been abused in childhood as intuition. Rather, they would describe the intuitive aspect of the experience as the automatic judgment to employ a specific course of action; to react, or decide not to react, in one way or another in response to the *felt sense* that the client may have been abused. Additionally, cognitive psychologists hold that intuition is a separate phenomenon from instinct or innate reaction (Hogarth, 2010). Hogarth (2010) has used the example of the professional tennis player who decides to swing his racket at a specific speed and angle in relation to an oncoming ball. This is not an innate reaction or reflex, nor is it instinctual or in-born. Instead, it represents true intuition in that the professional is automatically applying a complex mixture of information, resulting in a split-second decision-making process.

This highlights an aspect of intuition on which all of those who study the phenomenon agree: *intuitive responses are reached with apparently no conscious effort.* There is little or no awareness of deliberation (Hogarth, 2001). This does not vitiate the fact that intuition is a legitimate cognitive process, different from, yet related to, what is traditionally understood as "thinking". As Gore and Sadler-Smith (2011) wrote:

> System 1 thinking and reasoning [intuition] is hypothesized as evolutionarily the more ancient of the two systems… its core

> processes are rapid, parallel, and automatic, permitting judgment in the absence of conscious reasoning… System 2 [deliberative problem solving] is more recent, its core processes are slower, serial, and effortful, permitting conscious abstract reasoning and hypothetical thinking (p. 304).

The fact that one cannot typically analyze the cognitive processes that lead to an intuitive conclusion may be one of the reasons the vague definition of intuition as, *knowing without knowing how you know*, crosses disciplinary lines.

While there is some accord among the cognitive psychology researchers concerning intuition, there is a great deal of disagreement about the phenomenon as well. They agree that intuition is the non-conscious processing of information, but they dispute the nature of that process. One hypothesis is a model premised on "the role of resemblance in prediction" (Kahneman, 2011, p. 6). That is, one uses simplifying shortcuts or heuristics to find a pattern from past experience that matches the current situation in order to draw conclusions. Kahneman (2011) has suggested that one of the most common short-cuts used in the intuitive process is to replace the actual problem at hand with one that is more readily solved. Such cognitive shortcuts are highly biased, as they are based on the ease of retrieval of variables against which one matches the current situation (Kahneman, 2011). This renders the resulting judgment vulnerable to emotion-based biases. Thus, Kahneman and other heuristic-model advocates believe that intuition is unreliable in many, if not most, circumstances. Kahneman has noted that the unreliability of the heuristic model seems to fall away in the special condition of experts using intuition in their specific field. So-called "expert intuition" (p. 11) is based on situationally triggered cues that allow information stored in the memory to tacitly supply a heuristic. This recognition is very much in keeping with the learning theory model of intuition.

There are actually several different learning theory models of intuition (see for example, Plessner, Betsch & Betsch, 2008, for several such models), but they all share the point that intuition is the product of implicit learning. The proponents of this approach tend to give a positive valence to emotions. Rather than being a source of unwanted bias, as the heuristic approach suggests (Kahneman, 2011), those who forward a learning theory perspective suggest that emotions allow one to bypass the process of scanning memory. "[I]mmediate feelings can reflect the sum of experiences made with an attitude object" (Betsch, 2008, p. 13). Those who endorse this model tend to emphasize the reliability of intuition rather than its pitfalls, although they warn that intuitive judgments are best double-checked.

One aspect of the cognitive models of intuition that may be quite important to the application of these research findings to clinical conditions, is the use of experimental protocols in which the participants must make decisions that are centered on impersonal issues. Chief among these are probabilistic inferences. For example, perhaps the most widely used protocol requires the research participants to quickly determine such information as whether or not a city is the state capital (Glockner, 2008). Such judgments have limited relevance to a clinical context, where a therapist is experiencing intuition about another person with whom they are closely involved.

Perhaps due to the impersonal nature of the research protocols the cognitive psychologists employ, intuition from this perspective is understood to arise from within the individual. In this research, the process of arriving at the judgment is understood to be interior to the person having the intuitive experience. That is, there is no discussion of the possibility that the subject of the intuition plays any role in the process. In a clinical context, two subjectivities may operate in relation to each other, rendering it a different phenomenon from that studied in either the heuristic or learning theory models of intuition in which there is an intuiting subject and the object of intuition.

Psychoanalysis and Psychotherapy: Theoretical Treatments of Intuition and Therapy

Within the history of psychotherapy, beginning with Freud, intuition was a concept that received some attention. Not all of this attention was positive. Throughout the history of psychoanalysis, attitudes regarding the use of clinical intuition span the spectrum of outright rejection, to endorsement of its use. In some texts Freud overtly eschewed intuition. He related intuition to occultism, religion, and other forms of extra-sensory perception, which he soundly devalued (Reiner, 2004). For example, in *Beyond the Pleasure Principle* (1920/1989), Freud clearly rejected the role of intuition in the clinical process. In T*he Question of a Weltanschauung* (1933/1989), he affirmed his position that psychoanalysis is a science, and therefore distinct from lower forms of religious thought. He asserted that, as a part of the scientific project, psychoanalysis should be grounded in empirical research. Thus, it should admit “no knowledge derived from revelation, intuition or divination” (Freud, 1933/1989, p. 784).

While it is clear that Freud shunned intuition, there is also a good bit of

evidence that he changed his mind regarding intuitive knowing as a form of telepathy over the course of his career. In fact, there is some compelling evidence that Freud had a personal telepathic experience that reversed his position (Radin, 2006). Ernest Jones (1957), a student of Freud, documented his teacher's foray into the world of "occultism." Perhaps made clear by the use of this terminology, Jones (1957) was not approving of Freud's apparent shift in perspective. Nonetheless, he presented a persuasive case that such a shift indeed occurred. For example, in 1921 Freud wrote in a letter to the psychic researcher Hereward Carrington, “If I had my life to live over again, I should devote myself to psychical research rather than psychoanalysis” (Jones, 1957, p. 392). In 1932 Freud declared in his *New Introductory Lectures*, that "telepathy might be the kernel of truth that had become surrounded by fantastic occult beliefs" (Jones, 1957, p. 405). Jones appears to suggest that Freud wrestled with the conflicting need to root his new therapy in science, as understood in the early part of the 20th century, in addition to acknowledging his personal experiences of the capacity to “know” through means other than the five orthodox senses.

As psychoanalytic thinking has continued to evolve over the past century, some of its schools have softened considerably regarding Freud’s original position about the role of intuition in the clinical process. Brown (2009) observed that Freud’s suggestion to use one’s unconscious as an instrument of analysis was inspirational to Bion’s (1970/1977) development of the importance of intuition in analysis. Bion stated

> The physician can see and touch and smell. The realizations with which a psycho-analyst deals cannot be seen or touched… For convenience, I propose to use the term ‘intuit’ as a parallel in the psycho-analyst’s domain to the physician’s use of “see,” “touch,” smell,” and “hear” (Bion, 1970/1977, p. 7).

Following Bion (1970/1977), Jarreau (2012) has elaborated on the use of intuition in the psychoanalytic encounter. Like Bion, he equated the phenomenon with listening with the unconscious mind. He stressed that one must stop thinking, or at the very least not pursue more formal forms of theoretical cognition, in order to fully experience emotions that arise during time with a patient. In this state, free of memory and desire, one is able to apprehend the patient’s emotional experience. For Jarreau, intuition brings insight into important aspects of the patient’s unconscious gained through unconscious communication.

Contemporary analytic literature of diverse schools has suggested that two human minds are capable of interpenetrating and reciprocally influencing each other. One person can "know" both some of the content as well as processes of another's mind without explicit verbal communication or deductive reasoning based on observable evidence (see Bass, 2015; Beebe, Knoblauch, Rustin, & Sorter, 2005; Campbell & Pile, 2015; Sands, 2010). That is, one person can come to know the subjective experience of another without explicit communication or even the overt intention to acquire that knowledge.

In addition to its presence in contemporary analytic thought, intuition is a cornerstone concept in Jungian psychology (Pilard, 2015). Pilard (2015) has noted that there is widespread popular recognition that Jung postulated intuition to be among the capacities that constitute psychological types. Jung's treatment of this conscious level of intuition represents, however, the tip of a proverbial iceberg.

> …intuition in Jung's theory comes from the abysses of the deepest unconscious of psychology… intuition is present everywhere instead of just in types and functions. To try to untangle all the forms of intuition present in Jung's writing is to expose its central and pivotal position in his psychology" (Pilard, p. xiii).

Because of the centrality and complexity of Jung's treatment of intuition, a full explication of his theory is beyond the scope of this article. The interested reader is directed to Pilard's text. The important point here is that for Jung and Jungians, intuition is an important component of clinical method.

Carl Rogers (1980) also recognized the role of intuition in the clinical process, although he did not formulate an explicit theory of the phenomenon. It appears from the quote below that Rogers understood intuition to be part of a transcendent core, and a well-spring of healing.

> When I am at my best, as a group facilitator or as a therapist, I discover another characteristic. I find that when I am closest 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, then whatever I do seems to be full of healing. Then, simply my presence is releasing and helpful to the other. There is nothing I can do to force this experience, but when I can relax and be close to the transcendent core of me, then I may behave in strange and impulsive

> ways in the relationship, ways which I cannot justify rationally, which have nothing to do with my thought processes. But these strange behaviours turn out to be right, in some odd way: it seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself and becomes a part of something larger. Profound growth and healing and energy are present (Rogers, 1980, p. 129).

Eric Berne (1949/1977), the creator of Transactional Analysis, gave a prominent role to the concept of intuition. He defined the phenomenon as "knowledge based on experience and acquired through sensory contact with the subject, without the 'intuiter' (sic) being able to formulate to himself or others exactly how he came to his conclusions" (Berne, 1949/1977, p. 4). He suggested that this knowledge can arise out of a number of different processes. The first process is the application of logic to conscious perception. The second process is through "unverbalized processes and observations based on previously formulated knowledge which has become integrated … through long usage… below the level of consciousness" (Berne, 1949/1977, p. 1). The third process occurs through implicit cues. Lastly, he described a process that is "quite unexplainable by what we know at present concerning sense perceptions" (Berne, 1949/1977, p. 3).

Berne (1949/1977) focused primarily on process number three - implicit cues. He postulated that this implicit knowledge leads one to perceive another based on patterns developed early in life. As Schmid (1991) observed, "Berne assumed that people react to their intuitive perceptions by alterations in their experience and behavior" (p. 145). By interacting with the other in a way that is consistent with this patterned perception, one elicits a response from the other that indeed repeats the pattern.

Berne (1949/1977) suggested that for intuitive judgments to be accurate, an "intuitive mood" (p. 22) must be present. "The intuitive mood is enhanced by an attitude of alertness and receptiveness without actively directed participation of the perceptive ego. It is attained more easily with practice; it is fatigable, and fatiguing" (Berne,1949/1977, p. 25). The intuiter should be free of pressure to perform. He also noted that intuition seems to be enhanced once one has established "proper rapport" (Berne, 1949/1977, p. 22) with the subject of the intuition.

Schmid (1991) has broadened Berne's (1949/1977) definition of intuition. He has given a decidedly constructivist interpretation of the process. Based on the

work of Jung (1921/1972) and the Jungian theorist von Franz (von Franz & Hillmann, 1980), he suggested that intuition is not simply the application of a pre-determined template onto the current situation, but an ability to apprehend what could be, what is possible, or potential. In keeping with Berne's (1949/1977) understanding of intuition existing outside of conscious awareness, Schmid (1991) suggested that while a therapist may not be consciously aware of what they know, they nonetheless communicate in a way that actualizes the potential growth in the client. It is this unconscious communication that embodies and constitutes the content of the therapist's intuitive process. He also suggested that this capacity may be relevant to the therapeutic alliance.

The work of Eric Berne provided a foundation upon which Integrative Psychotherapy was built (O'Reilly-Knapp & Erskine, 2003). Yet, as central as the concept of intuition is to Transactional Analysis, there are few direct references to the word in the Integrative Psychotherapy literature. There are, however, two very important direct references to intuition in Erskine's work. In his 2008 article on unconscious experience, Erskine directly referenced Berne's use of the term, and defined the phenomenon as "the therapist's unconscious connecting with the client's unconscious communication" (Erskine, 2008, p. 129).

Prior to this insight, Moursund and Erskine (2004) referenced intuition in relation to attunement. Attunement is perhaps one of the most prominent concepts in Integrative Psychotherapy (Erskine, Moursund, & Trautmann, 1999). Moursund and Erskine (2004) differentiate attunement from empathy: they define the latter term as "vicarious introspection" (p. 98). In distinction from this activity of imagining how one would feel if one were in another's place,

> Attunement involves using both conscious and out-of-awareness synchronizing of therapist and client process, so that the therapist's interventions fit the ongoing, moment-to-moment needs and processes of the client. It is more than simply feeling what the client feels: it includes recognizing the client's experience and moving—cognitively, affectively, and physically - so as to complement that experience in a contact-enhancing way (p. 98).

The relationship between attunement and intuition is then explicated by Moursund and Erskine (2004). In discussing developmental attunement, the authors stated that an awareness of child development is crucial in order to attune to the client's developmental level. But, they also cautioned that this form of attunement is also premised on intuition.

> Probably the most important set of guidelines, though, comes from our own intuitive, emotional response to the client's behavior… We are often able to pick up tiny cues, cues for which we are consciously unaware, from the nonverbal behavior of our clients; such cues can aggregate out of our awareness and make themselves known as a general hunch about how to respond most effectively (Moursund & Erskine, 2004, p. 105).

Thus, one may conclude that in Integrative Psychotherapy intuition is understood to be identified with attunement. Marks-Tarlow (2012), in her treatment of clinical intuition, also viewed intuition in terms of attunement.

Marks-Tarlow (2012) has championed the use of intuition in psychotherapy. She argued that clinical work that is not informed by intuition is ultimately unethical. This is because theory-driven work, what she referred to as "top down" (Marks-Tarlow, 2012, p. 8) processing, biases a clinician to see whatever the theory posits, rather than the client's experience. Marks-Tarlow suggested that clinical intuition is the result of right-brain to right-brain unconscious communication, as described in the work of the affective neuroscientist Allan Schore.

Schore (2005) has studied the right hemisphere of the brain for several decades. While his research was originally aimed at mother-infant interactions, he has stated that his work has direct relevance for therapist-client interactions. Through the use of positron emission tomography (PET scans) and functional magnetic resonance imaging (FMRIs) to study brain functions that occur in time frames beneath conscious awareness, Schore has documented,

> . . . bidirectional implicit affective communications embedded in proto-dialogues… [C]oordinated visual eye-to-eye messages, tactile and body gestures, and auditory prosodic vocalizations [serve] as a channel of communicative signals that induce instant emotional effects… The dyadic implicit processing of these nonverbal… communications of facial expression, posture, and tone of voice are the product of the operations of the infant's right hemisphere interacting with the mother's right hemisphere. (p. 833).

Thus Schore, like other infant researchers, merges intuition with the non-conscious communication of micro-expressions and other non-verbal behaviors (see the Boston Change Process Study Group, 2010).

Research on Clinician Use of Intuition in the Therapeutic Encounter

There is a limited but growing body of research on therapists' use of intuition in clinical practice. In 1999, Petitmengin-Peugeot undertook a broad-based study of intuition that included non-clinical contexts. However, within this study, she examined a subsample of psychotherapists. These therapists discussed intuition as part of their concerted efforts to connect with their clients. They reported how focusing on specific parts of clients' bodies generated a visual, kinesthetic, or auditory image of connection, such as a channel of light or energy vibration that created a bridge between the therapist and the client.

Charles (2004) has also explored clinical intuition. She gathered her information from two sources of data: a focus group of psychotherapists who self-identified as intuitive, and the diaries of therapists who self-identified as intuitive. The focus group participants discussed the irrational nature of the experience, which rendered it difficult, if not impossible, to explain. They reported that the resultant understanding seemingly comes from nowhere.

As in the Petitmengin-Peugeot (1999) study, the self-reported intuitive clinicians in the Charles (2004) study also discussed the importance of the connection between themselves and the client. They suggested that there must be some "accord between the therapist and client" (p. 71) in order for the connections between the pieces to emerge. The participants also discussed the need to validate their clinical intuitions by checking with clients for accuracy and appropriateness. As Charles (2004) stated, "subjective certainty does not guarantee veracity" (p. 71).

Jeffrey and Fish (2011) undertook a qualitative study of marriage and family therapists in which the participants described their understanding of intuition, its function in their clinical work, and how they experienced the phenomenon. Their findings fell into five basic categories: a) the nature of clinical intuition in marriage and family treatment; b) intuition and the therapist-client relationship; c) the spiritual dimensions of intuition; d) intuition and clinical training; and e) the felt resistance to recognizing the role of intuition from within the discipline.

In the first category, participants described the affective and sense-centered experience of knowing about their clients. The second category involved the relationship between the clinician and the client, again suggesting that intuition is not a "one person" phenomenon. The research participants discussed the role of the client in facilitating or disrupting the intuitive process, thus suggesting that the client is clearly a co-participant in the process. The respondents elaborated on the topic of the connection between the client and the therapist by endorsing the belief system that there is a force that connects everything. Intuitive therapists seemed clear that they drew upon this connection in order to allow for an intuitive understanding with a client. The fourth category was training. The respondents were clear that when they observed the use of intuition as modeled by supervisors, they were more comfortable using it in the clinical setting. Some of the respondents elaborated on the sense of frustration they experienced because intuition was not taught in their curricula. They felt that the de-valuation of this important clinical tool was a deficit in their education as therapists.

Three Theories Regarding Intuition

In general, the literature cited above highlights three different theories regarding the nature of intuition. Certainly, general theories and clinical theories need not be mutually exclusive, as intuition in general and clinical intuition specifically may be more than a singular phenomenon. Nonetheless, the three theories currently represented in the literature include two cognitive theories: 1) the heuristic model, which purports that intuition is a "quick and dirty" problem-solving strategy that is highly prone to error due to retrieval bias (Kahneman, 2011); and that, 2) intuition is the implicit application of tacit learning (Plessner et al, 2008). An alternative explanation, that intuition may be a form of unconscious communication, is represented in the work of analysts and psychotherapists, including the Integrative Psychotherapy theorists. This theory suggests that the unconscious communication may be based on subliminal micro-expressions and non-verbal cues (Schore, 2005), or that it is the result of a basic connection between people (Jeffery & Fish, 2006).

An important difference between the cognitive psychologists' theories of intuition and those of the psychoanalysts and psychotherapists is the degree to which clinical intuition may be interactive. The former posits a one-person model, or a process that occurs in the mind of the intuitive. The latter suggests that intuition can be a two-person phenomenon in which the intuitive clinician is engaged in a

specific type of relationship with his or her client, and that intuitive knowing is the result of some type of communication. To further elaborate on the ideas discussed thus far, a case example follows that demonstrates how one therapist used her intuition to make an important clinical decision.

Julie's Intuition – An Example of the Use of Clinical Intuition

This case material was collected during a multiple case study on boundary dilemmas as experienced by therapists. The study received Institutional Review Board Approval, and the participants provided informed consent. Participants engaged in a recorded semi-structured interview, which was transcribed. The material presented here has been altered by moving chunks of data to give the piece narrative coherence. That is, the words are the actual words of the participant, excepting those in brackets. The bracketed information is supplied for clarity. The re-arrangement is supported in Constructivist research (see Rodwell, 1998), in which the inquirer is encouraged to use narrative and creative non-fiction techniques necessary to tell a story. As the nature of narrative data is such that any given event or topic may arise repeatedly in different parts of the interview, rearrangement renders the narrative more cohesive.

"Julie" (a pseudonym) identified her approach to treatment as, "Humanistic, probably a little Existentialism, problem solving, Acceptance and Commitment Therapy and… Cognitive Behavioral Therapy, Solution focused. It's fairly humanistic, as integrated, relying most heavily on Humanist Theory". She is in private practice as a contractual employee of a psychiatric practice and had been licensed for twelve years at the time of the interview. She is a Licensed Clinical Social Worker. She became a psychotherapist somewhat later in her career, having worked as a non-clinical social worker since the 1990's.

> One day I disclosed to [a client who was struggling with alcoholism] that a member of my family is an alcoholic and I had had some experience with various treatment centers and this is what I knew.
>
> Now why did I disclose that, why did I tell her that? My gut. Just my gut. That intuitive feeling. It should-of been the Code of Ethics. I've since gone back and reviewed the Code of Ethics. I didn't consult, I didn't evaluate, I didn't do all of the process thinking. It was more or

less intuitive and from my gut. I had a feeling that it would be okay. I was comfortable with that.

I know I should have consulted a colleague. Even more important than that I think I should have followed up with her… I missed the boat on that one. I consult with my colleagues I do, I don't hesitate. I didn't do it on this one, why? I didn't consult, I didn't evaluate, I didn't do all of the process thinking. It was more or less intuitive and from my gut. I had a feeling that it would be okay.

I thought about [why I disclosed] when I was thinking about this on the way over [to the interview]. I did think of the word credibility. I wanted her to see that I just might have an understanding of her perspective, I might have an understanding, a better understanding. This might put me in a position to have a better understanding of what she could be going through. Her struggle was known to me. Credibility, but a different kind of credibility from a more personal perspective I think. I disclosed that information, she was surprised that I had. Not surprised at my disclosure but surprised to learn that I had dealt personally with this issue.

I do think it helped her to understand that this had touched my life personally in a very meaningful way. Just as it was touching her life as well. Perhaps it was to lend itself to that, I'm not sure. It would do no harm, but there was a potential that it could do some good. I thought my disclosure would help her to understand as I said that maybe I do have the knowledge to think - that maybe I do have a different kind of understanding about what she's going through. I wanted her to see. I wanted to - if there was any barrier there where she felt you don't understand, you don't get what I'm going through.

I guess the fact that she disclosed [her drinking] at all said something about the level of trust in our relationship. That was important to me and the fact that I disclosed to her said something about the level of trust I had in the relationship, I think.

[I]t maybe lent itself to her feeling that I really could empathize with her. I mean really could empathize with her. It took empathy maybe to another level, maybe I don't know. Maybe that's what it did. I had

hoped that - and I do hope that it inspired her in some way to perhaps towards going to detox. To joining a group, to admitting to a group of women that she is an alcoholic. Maybe it just helped to move her a little farther along. That it just crosses, alcoholism crosses all lines. It was an equalizer.

Before I made that disclosure I certainly thought about her ego strength, what about her developmental history, what about this, what about that. I think maybe I had those things in my… those issues wrapped up somewhere else. Yes, I certainly thought about her ego strength and I thought about her history. I thought about her situation, I thought about the context of her life and the context of - how our relationship fit into that context. I guess context is very important to me. The context, what's going on in a client's life, what's going in mine that makes me maybe compelled to share this. All these things were going on in my head and I hadn't shared it with her. I'd been working with her for a long time and we had consistently talked about inpatient treatment and whether or not she felt she needed that and how I could be helpful in this process.

I think the reason why I disclosed to her, one of the reasons again not somebody else—other people I worked with similar problems - is that I felt something for this woman. There was a real connection there. I knew her, I felt I knew her as much as I could and felt safe. I felt safe in making that as safe as I could in making that disclosure. It was a good relationship. There was something else with this particular - there was a closeness. I want to make room - I want to preserve the connection but make room for growth and the connection. I don't want to do anything because of my own self-interest known or unknown to jeopardize the potential that's in that connection. That potential for change in a client that's in that connection. [The disclosure] solidified [the connection]-not "solidify." What's the word I'm looking for? I can't think of - essence. Adds an essence, something more. I guess I really felt it would lend itself to the therapeutic relationship. I really liked this woman; I really respect her. I want the very best for her in terms of helping her to make better, healthier choices for herself.

I felt I guess, one of the things I felt was that she was asking for help. I mean she was desperate, she was asking for help and I felt an

obligation to do what I could to help her make different choices, to get on track again. The client was absolutely desperate. She was drinking quite a bit, excessively at night again. [She felt] guilt, shame, remorse, self-hatred. Yeah, all of that, some of the same emotions that I have felt in my personal experience with this family member, but from a different angle.

I no longer see her privately. I assisted her in getting into detox for about a week. Then she came out and then she saw me one other time before she could meet with the other therapist in town [who is an addictions specialist]. She is now engaging in group therapy and individual therapy with this other agency and seems to be doing well.

Now I do see her once every other week, I do a woman's support group where I am, and the beautiful thing is that she was able to disclose just only recently to the other women that she is an alcoholic. It just was wonderful.

Discussion

This example of a therapist's use of intuition illustrates three important points regarding clinical intuition that were noted in the literature review. Given the emphasis in Integrative Psychotherapy on the relationship (O'Reilly-Knapp & Erskine, 2003), perhaps the most important point the case illustrates is that the use of clinical intuition is a relational phenomenon. The second point is that the use of clinical intuition is so closely associated with good clinical judgment that the two are indistinct. Finally, Julie anticipated that she would be criticized for using her intuition.

The first point focuses on the therapist's intuition as a relational experience. From the perspective of Integrative Psychotherapy, the importance of the therapeutic relationship cannot be understated (Erskine, 2011; Erskine & Trautmann, 1996; O'Reilly-Knapp & Erskine, 2003). Erskine and Trautman (2003) have noted that the importance of relationship to human well-being is widely recognized by various schools of psychotherapy, and thus can form the foundational construct for integrating different theories and types of therapy. Integrative Psychotherapy in particular, stresses the need for contact-in-

relationship (Erskine & Criswell, n.d.) as the centerpiece of the therapeutic process. Erskine (in Erskine & Criswell, n.d.) stated:

> The quality of the relationship we build becomes the heart of everything else that happens in the therapy… It is not the techniques that heal… It is the contactful (*sic*) therapeutic relationship that heals our clients' relational wounds. Our therapeutic involvement is honed by the way in which we understand the client's experience and how we bring our own experience into the therapeutic relationship: (para. 1-5).

Julie's narrative speaks directly to this quality of relationship. Her decision to act on her intuition was premised upon her profound contact with her client and the client's situation:

> I think the reason why I disclosed to *her,* one of the reasons again not somebody else - other people I worked with, with similar problems - is that I felt something for this woman. There was a real connection there. I knew her, I felt I knew her as much as I could… There was something else with this particular - there was a closeness.

The therapists who participated in the studies cited in the literature review, above, suggested that they actively generated and/or held in high importance a sense of connection between themselves and their clients during their use of clinical intuition. Julie's case takes this information a step further since it suggests that not only was the relationship between the therapist and client an important prerequisite for clinical intuition, but the use of knowledge gained through intuitive means deepened the therapeutic alliance. As Julie noted, "[I]t maybe lent itself to her feeling that I really could empathize with her. I mean really could empathize with her. It took empathy maybe to another level…" Julie's motivation to use her intuition to make a clinical decision was based on her desire to deepen the existing connection. She wished both to "even the playing field" in terms of enhancing the felt sense of mutuality and also be seen as human. Thus, Julie's use of intuition did not simply emanate from the therapeutic alliance but may have enhanced it by communicating her "contactful psychotherapeutic presence" (Erskine, 2011, p. 10).

The second point, regarding how clinical intuition is so closely associated with good clinical judgment that the two are often indistinct, is more complex. It

involves three related points: 1) that Julie used intuition to make an important treatment decision, 2) that the intuitively derived decision is enmeshed with solid clinical judgment based on clinical data, and 3) that this use of intuition was both ethical and successful. First, it came as a surprise to the researcher who gathered this data, that the therapist freely revealed that the means by which she resolved a boundary dilemma was intuition. Julie is clear that the decision was based on intuition. She used the word "intuition" explicitly and referred to her "gut." This information appears to have remained on an implicit level: "I think maybe I had these things… wrapped up somewhere else." Indeed, the explicit knowledge appears to have surfaced only as she contemplated participating in the interview: "I was thinking about this on my way over."

It must be immediately noted that the use of intuition was not a departure from solid clinical judgment but was so interwoven with clinical data that the two cannot be distinguished. Julie had a great deal of information about her client's functioning. Her intuitive decision was based on a nuanced understanding of what the client needed and what was in the best interest of the client. In describing her process in this particular case, she demonstrated a broad understanding of several important clinical factors, specifically identified as ego strength, developmental history, and context. In addition, she brought in her own life experience that informed her professional decision-making. Thus, her intuitive decision was well-grounded in a thorough knowledge base regarding herself and the functioning of her client. It was not a substitute for, nor antithetical to, appropriate clinical judgment.

One may question the ethical aspects of basing therapist self-disclosure on intuition. Clearly, Julie placed the welfare of her patient at front and center. She stated, "I don't want to do anything because of my own self-interest known or unknown… I want the very best for her in terms of helping her to make better, healthier choices for herself." In the face of her client's pain, Julie stated, "I felt an obligation to do what I could to help her make different choices, to get on track again. The client was absolutely desperate". Even though her focus was to lessen her client's pain, Julie questioned if her actions could in any way serve her own needs. She believed that if the client was aware of the degree to which this therapist could relate to her experience, it may lessen the client's shame-response and mobilize her ability to enter into a treatment program. Confident that ultimately, she was serving her client's best interest, Julie acted on her intuitively derived decision. After the fact, she reviewed the National Association of Social Workers'

Code of Ethics (National Association of Social Workers, 1999), and was "comfortable" with her decision.

Finally, Julie's clinical acumen, which included the judicious use of her intuition, contributed to a successful outcome for this case. Julie had hoped that her disclosure would help the client seek appropriate treatment, including detox, and the client did so. Subsequently the client entered detox with on-going treatment and appears to be past her shame, as she has disclosed to group members her status as an alcoholic.

The third point illustrated by this case is that while this clinician's use of her intuition was an integral aspect of her practice, she anticipated criticism for using it, and a general negative valuation of her use of clinical intuition. Therefore, she was conflicted over her use of intuition in making an important clinical decision. Although she affirmed that she felt comfortable with her decision, she second-guessed her use of intuition. In an almost confessional tone she suggested that she should have consulted a colleague, or she should have looked at her professional code of ethics sooner. The "shoulds" appear to undermine her confidence in her professional mastery, in spite of the successful outcome. In response to this common dilemma, the authors are in agreement with the Jeffrey and Fish (2011) participants: had this therapist been exposed to the value of clinical intuition during her education and socialization as a therapist, she may have been spared some stress.

In the ever-evolving attempt to find what works in psychotherapy, researchers have determined that there is a vast and complex set of factors to consider. The question of which of the nearly infinite factors to consider, in conjunction with how they are likely to interact, requires clinicians to individualize treatment. The American Psychological Association has suggested that relationship factors are at the heart of this process (Norcross, 2011). This case demonstrates the clinician's individualization of treatment and her ability to use the relational context of psychotherapy was enhanced through her use of intuition. In a deep state of connection and empathy that is at the very core of Integrative Psychotherapy (O'Reilly-Knapp & Erskine, 2003) the psychotherapist in the case example was able to go beyond treating symptoms. By connecting at a deep human level she enabled her intuition to inform her on how to best reach the treatment goals.

Conclusion

There is a modest but growing body of literature about intuition in general, and clinical intuition specifically. Research in academic and non-academic settings has focused on defining what intuition is, how it operates, and the legitimacy of intuitively derived information. While there is widespread disagreement concerning these questions, there is also a significant core of agreement between the different perspectives. One possible source of disagreement is perhaps that what we refer to as "intuition" is actually several distinct phenomena, indicating the need for further research and investigation.

Julie's case demonstrates important aspects of intuitive decision-making in the clinical context. Perhaps the most obvious, yet also the most important point to understand, is that therapists in fact use intuition to make clinical decisions. However, it is important that they do so as part of an overall understanding of individual clients' functioning and needs and are able to use intuition ethically and effectively. This case also illustrates that clinical intuition is in some cases derived from a strong connection between the therapist and client and is also a source of potential enhancement of this connection. As is highlighted in Integrative Psychotherapy, this relationship is at the very core of the healing process (O'Reilly-Knapp & Erskine, 2003). Thus, intuition should be taken very seriously as an important therapeutic tool. Finally, this case illustrates that the current negative climate regarding the use of clinically based intuition by psychotherapists may be doing a disservice to clinicians, as well as their clients, by ignoring or even denigrating the importance of clinical intuition. It is the authors' sincere hope that this topic may be openly discussed and studied among our colleagues, for the benefit of our clients.

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