MASSACHUSETTS SCHOOL OF PROFESSIONAL PSYCHOLOGY

Cheetahs on the Couch:

Issues Affecting the Therapeutic Working Alliance

With Clients Who Are Cognitively Gifted

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it takes courage to grow up

and become who you really are.

-- e. e. cummings

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Massachusetts School of Professional Psychology
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Chairperson: Wynn Schwartz, Ph. D.

Abstract

Within the gifted community, the common wisdom is that one must find a therapist who understands the intrapersonal, social, and cultural experiences of being highly intelligent. Without this understanding, informal reports suggest that miscarriages of the therapeutic working alliance may be frequent, and that clients may avoid or leave therapy as a result. However, few therapists or researchers acknowledge intelligence as a dimension of human difference which could be relevant to therapy, or how their own relational selves might be affected by the prospect of doing this work. The specialist literature in the field of giftedness rarely includes consideration of mainstream psychological theories. Thus, little is widely known about how to effectively engage these clients, and there are few opportunities for therapists to recognize when they are making mistakes or to develop competence with this group. This study used a consensual qualitative research model (Hill, Thompson, & Nutt-Williams, 1997), in an attempt to connect these two areas of the literature. Individuals who self-identify as gifted and who have previously been clients in individual or family therapy were asked to describe their felt experiences of the alliance, helpful or unhelpful therapist behaviors, and how the

course of therapy may have been affected. The responses were analyzed thematically and interpreted through the lenses of the specific literature on giftedness and mainstream psychological theories. Respondents in this study described their intelligence as having pervasive effects on their lives, the material they wished to explore in therapy, and the therapeutic relationship itself. Substantial connections to the theoretical literature on trauma and object relations were considered in relational context. Additionally, the data permitted some exploration of the general question of whether some differences between therapist and client may be too great to bridge. Finally, a set of provisional clinical guidelines for working with gifted clients was developed.

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CHAPTER ONE: INTRODUCTION

Within the gifted community, both from parents and professionals, it is standard advice that would-be psychotherapy clients need to find a therapist who "gets it," who understands what it is like to be gifted and how giftedness interacts with all aspects of the human experience (SENG, n. d.; Webb, 2001). However, gifted individuals have often reported that when they have inquired from professionals about their experience and competence in this area, the response has been dismissive. Some even say that they have received harsh responses, along the lines of, "There's nothing *to* get. You're a narcissist for even thinking about this." My own conversations with other therapists on the topic have yielded similar responses: some ignorant, some uninterested, and a few overtly hostile. Outside of those professionals who specialize in this area, giftedness may not be seen as a relevant dimension of human difference. The idea that a client might self-identify as gifted may be seen as inherently problematic, or even pathological. As will be described at length below, significant literature within the field of gifted education, as well as the experience base reported within the community of gifted individuals, has identified cultural and cognitive experiences common within this group. However, the literature base within the field of psychology has largely ignored the significance of these experiences to research and clinical practice.

This fundamental disconnect in the meaning that is made around the idea of giftedness may have the effect of reducing access to psychotherapy for this group of clients. I have heard informal reports within the community that many highly intelligent individuals are wary of the prospect of therapy, concerned that they may not be able to form effective therapeutic working alliances with their therapists and get the help they

need. Some report that they have avoided entering therapy, terminated without having worked through the problems that brought them there, or remained in therapy but failed to truly engage with the process. The clinical literature has thus far not formally investigated how widespread or severe these occurrences may be, or whether there are any qualitative differences between the reservations cited by gifted individuals or those common in the larger population.

The psychology literature has thus far given little consideration of the therapist's relational self in work with gifted clients. One can easily conjecture that the therapist's own self-identification as gifted (or not), or their prior experiences with other people who they perceived as gifted or who identified themselves as gifted, may contribute to negative countertransference reactions, which may then interfere with the development of the alliance.

Additionally, the existence of gifted clients touches on the more fundamental underlying question of what kinds of client-therapist differences can be tolerated within any therapeutic relationship. Whether or not "you've got to be one to see one" is an issue raised often when considering therapist-client dyads who differ by race, gender, class, or other obvious sociocultural markers. However, differences can also include an infinite variety of other statuses, such as, "knowledgeable about how to deal street drugs," or, "grew up in a divorced family." Much discussion of this question occurs in the literature, but there is little consensus about the answer. Schwartz (2008) points out that both therapists and clients may recognize status differences but may be reluctant to discuss them or even to bring them to conscious awareness. This reluctance may have its roots in a variety of factors, including social taboos or "political correctness," in which one or

both partners may feel that the status is something which *should* not be important or *should* not be talked about. They may fear that discussing it would result in a degradation of the other, that it might cause too much stress for the other, that it might lead them to appear biased themselves, or that it might trigger some form of retaliation. Alternatively, feelings of competitiveness or envy may interfere with their ability to recognize or acknowledge difference. The existence of gifted clients raises the possibility of a client who, even with their adaptive range constricted by psychopathology, may have a range of adaptive behaviors, in some or many domains, which exceeds those of the therapist. Whether a difference can be tolerated within the relationship, by either party, and whether it can be discussed openly, may sharply affect the development of the relationship and the course of therapy.

This doctoral project, then, has several goals, which will be addressed concurrently. I will explore common experiences of gifted clients and interpret these experiences in light of current psychological theories; that is, I will discuss what it is that gifted individuals feel that therapists "don't get" and explain why it is important for psychologists to consider this material thoughtfully in developing clinical formulations and treatment plans. Some of these ideas will be drawn from my own experiences as a gifted individual, a client in therapy, a member of the gifted community, and my understanding of how theoretical concepts can be applied to this population. However, the primary goal of this project is to ask highly intelligent individuals who have been in therapy to describe how they have experienced the working alliance, what therapist behaviors were particularly helpful or unhelpful, and how their experiences of the alliance may have affected the progress of their therapy. I will interpret these reported

experiences in light of both mainstream psychological ideas and the current research-based understanding of giftedness. My analysis will be informed by ideas from a wide variety of theoretical perspectives, including psychodynamic, family systems, humanistic, and learning theories, making use of the theory neutral language of Descriptive Psychology (Ossorio, 1998, 2006) as needed to unify various theoretical ideas and clarify meanings. I will consider how gifted clients may raise particular relational issues which could complicate the development of the working alliance. Finally, to the extent that the data supports elucidation of this topic, I will explore the more general nature of the therapeutic working alliance, examining the question of how differences in eligibility may affect how the alliance in any therapist-client dyad can most effectively be formed and maintained.

Definitions of Terms

Therapeutic Working Alliance

Simply put, the therapeutic working alliance is the feeling between the client and the therapist that they understand each other and are able to collaborate effectively. Carl Rogers's classic perspective on the nature of the bond included empathy, unconditional positive regard, and congruence (Rogers, 1961). To the bond between client and therapist, Edward Bordin added the concepts of explicitly negotiated and mutually agreed-upon goals and tasks, and pointed out that the importance of this connection cuts across theoretical boundaries (Bordin, 1955, 1979, 1994).

Combining Rogers's and Bordin's constructs, therefore, we can conceive of the alliance as having five major aspects:

Clients perceive *empathy* when they feel that the therapist truly understands their experiences and in some fashion knows what it is like to be in their current or past situation. Schwartz (2002) refines this idea, saying that clients want their therapists to understand and appreciate what the clients know about themselves and their environment, their desires and motivations, their competencies, and the significance their actions have for them. He points out, in the tradition of Winnicott (1971) and Kohut (1977), that even partially incorrect understandings can support the development of felt empathy, as clients learn to tolerate the therapist's imperfections and experience the effort the therapists put in to understand more accurately. Schwartz (2002) also cautions that therapists must reflect their empathic understanding in a way that clients can tolerate; there can be a risk of being overly intrusive or presenting material in a way that a client does not yet feel comfortable accepting.

Clients perceive *unconditional positive regard* when therapists consistently value the client as a human being, even if they may not agree with everything the clients think, desire, say, or do. A nonjudgmental stance is often difficult to maintain when a client has, in some fashion, violated the rules for proper behavior held by the therapist or by the larger culture. It is even more difficult when there is a conflict of values.

Congruence is reflected in the therapists' honesty about their own perspectives and their genuineness of self-in-relationship. At times, congruence and unconditional positive regard can be difficult to hold simultaneously, as a therapist may wish to conceal responses to the client's actions or status claims which may be (or may be seen as) judgmental.

In order to establish therapeutic goals, clients and their therapists must jointly negotiate a *shared understanding of the nature of the problem*, and come to some agreement about what a good outcome would look like. Agreement on this topic can be complicated when there are large differences between therapist and client in status, personal characteristics, or view of the way things are in the world.

Clients and therapists must also jointly negotiate a *shared understanding of the tasks of therapy*, what they will actually do together to reach the agreed-upon goals. Typically, tasks are defined in part by the therapist's theoretical background; savvy clients who are interested in a certain type of task often identify their interest explicitly when seeking a therapist.

Although there are slight differences between various theorists as to the precise definitions of each aspect of the alliance, and a continued disagreement among theoretical schools as to whether the alliance is facilitative of change or whether it is itself a primary cause of change (as noted in Horvath, 2001; Horvath & Bedi, 2002), for the purposes of this work, these broad definitions will be sufficient.

Giftedness and Gifted Individuals

Current State of the Literature

An enormous quantity of ink has been spilled over the last century in the field of intelligence and giftedness in an effort to define the terms and to establish procedures for drawing a bright-line distinction between those who are gifted and those who are not. At times, it seems that the field is more focused on figuring out who these people are than on figuring out anything useful about them. Outside of the field of education, this trend is

even more shocking, with the overwhelming bulk of the psychological literature on giftedness devoted to issues of identification.

However, these attempts to figure out what intelligence is, how to measure it, and how to figure out who the gifted people actually are, are then continually criticized. On the one hand, they are seen as unfairly excluding people who are informally believed or conjectured to be gifted, but whose giftedness does not manifest in the ways measured by those instruments or to the extent required by those measurements, whose giftedness is masked by concomitant learning or psychological disabilities, or whose giftedness is not cultivated or permitted full expression due to social, economic, cultural, or motivational factors. On the other hand, they are seen as casting too broad a net, including far too many people who are not "truly" gifted, giving too much consideration to behaviors which are common within the general population, and watering the term down until it loses all real meaning. As Dash says in *The Incredibles*, if everyone is special, then no one is.

Is It Even a Real Thing?

Furthermore, the entire notion that intelligence is a real dimension of human difference has often come under fire. In popular culture, particularly within the world of education, there is a tendency to want to believe that "all children are gifted" (Pyryt & Bosetti, 2005; National Association for Gifted Children, n. d.; Winner, 1996). Howard Gardner's theory of Multiple Intelligences (Chen & Gardner, 2005; Gardner, 1983, 2006), has become tremendously popular in education (Gardner, 2006; Klein, 1997). With its emphasis on ipsative (within-individual) strengths, it is too often used to suggest that nomothetic (compared to the population) strengths do not exist or are unimportant (e.

g., Armstrong, 1998, 2000, 2009). Gardner explicitly states in his work that he does not want objective, norm-referenced tests to be established to measure these facets of cognition; rather, he proposes performance-based assessments which would be evaluated informally by classroom teachers according to vague observational checklists (Chen & Gardner, 2005; Gardner, 1983, 2006). However, these methods are cumbersome and impractical for routine classroom use. The questionnaire measures typically used by classroom teachers to evaluate learning style tend to be based upon self-reported preference for learning modality, rather than any actual ability in a domain (e. g. Armstrong, 1999), further muddying the waters. The egalitarian bent and nonfalsifiable nature of this theory make it particularly appealing to those who would prefer to deny the reality of individual differences (Klein, 1997, 1998). While it may be comforting to believe that all children are gifted, particularly to those people who fear that they or their children might not be seen as gifted if someone were to actually measure some aspect of their performance, or to teachers who fear the possibility of liking some students better than others or of some students being smarter than they are, this notion seems to lack validity. Certainly, it would be difficult to believe that "all children are mentally retarded."

For the purposes of this discussion, I am taking as axiomatic that intelligence is a real difference among people, imperfectly defined and imperfectly measured, and probably formally impossible to ever perfectly define or measure. It is a continuous and multidimensional variable, not a categorical or linear one. There are many different ways to be gifted, not all of which are easily measured. The ways in which high ability may manifest in the world or be measured through testing are inextricably bound to culture.

However, giftedness is a real thing, not merely the product of narcissistic imaginations. Perhaps the simplest definitions are the best: high intelligence is the ability to catch on, to make sense of things, and to know what to do about it (Kerr, 2007).

I am also explicitly separating the notion of high achievement from giftedness; the two are related but not identical. Because many of the problems that lead gifted individuals into psychotherapy relate to differences between what someone thinks they can do or should be doing and what they actually are doing ("underachievement"), the assumption that someone ceases to be gifted when they lose motivation to achieve, or when they fail to achieve despite high motivation, is not likely to be helpful in guiding therapists.

The "G-Word"

As with physical disabilities and mental retardation, there is much controversy over language. The word "gifted" is problematic -- it suggests that one has received something perhaps undeserved, that one already has been given an advantage and should not be seen as in any way in need of yet more. In fact, it is often used to connote the idea that the gift must somehow be repaid, by providing service to society (Kerr, 2007). This idea of giftedness as obligation is borne out in the word "underachievement," a failure to meet one's implied quota of productiveness. The gift, whatever its form, is something of a white elephant; it cannot be returned and is difficult to use, and the cost of upkeep is crushing. Giftedness is both a valued asset and a significant burden.

People wonder whether using the "g-word" will contribute to arrogance, sadistic backlash, or both. However, it is the word we are, for better or worse, stuck with. It is the term which is used, both within the community and outside it, and it is the term under

which research literature may be found through database searches. Circumlocutions or euphemisms only contribute to the idea that giftedness is something to be ashamed of, and, as with euphemisms for dark skin, low intellectual ability, physical limitation, will tend only to acquire the negative connotations of the original word. Furthermore, they interfere with the progress of science by making it hard for professionals to share a common language. I will use a number of different words throughout this doctoral project, in order to avoid linguistic monotony, but will not shrink from the use of the most common term.

Not Test Scores, But Cultural Experience

In the early stages of the development of this doctoral project, while I discussed my ideas with various people, one of the most frequent questions I was asked was, "How are you going to define 'gifted'?" The nature of a dictionary-like definition is that it attempts to draw a sharp line of demarcation between those who fall into the class and those who do not. However, real people rarely fit neatly into dictionary definitions. Many different dictionary definitions of giftedness have been advanced over the course of recent decades, but all are unnecessarily restrictive or overly broad, and all miss essential experiences of this group. Despite all careful wordsmithing, they tend to give the feeling of the proverbial blind men describing the elephant.

After I considered and rejected many different methods as being overly simplistic, in a fit of annoyance, I answered one questioner, "When you define 'African-American' for me, I'll be happy to define 'gifted.'" My point, at the time, was that not every commonly used term *has* a clean and clear definition, yet we can still think constructively about these ill-defined people in the theoretical, clinical, and research literature.

The more I considered this rather impertinent comment, however, the more I realized that it revealed a crucial point. Like many other aspects of identity, giftedness does not and probably *cannot* have sharp boundaries. People disagree about what the proper basis for the boundaries would be, where the boundaries should be drawn, who should be allowed to decide whether a given individual is or is not a member of the group, what role the individual's own self-perception should play in that decision, whether acknowledgement of one's membership to oneself or professing that membership to others is a good thing or not, how one can identify other members of the group, whether or how one can move into and out of membership, and even whether the group exists as a real thing. Naming issues are highly contentious. People who might be assumed to be members of the group are often heard to deny their own membership or the validity of the group's existence; some of the harshest responses I have heard about the existence and relevance of giftedness come from such places as a mailing list for pediatric neuropsychologists, hardly a group centered around the mean of the normal curve. As with all cultural groups, people who are on the boundaries, or outside of the group altogether, are often just as important in defining the full experience of the group as those who are central paradigm cases.

In short, for the purposes of this discussion, and indeed for the broader purposes of considering how best to do psychotherapy with gifted individuals, it seems to be most productive to sidestep the question of definition altogether and to consider giftedness as an aspect of *culture*. The very nebulousness of the definition is an important part of the cultural experience of being gifted; so many other people seem to attempt to seize control, or are granted control for various reasons, over one's personal identity and the

meaning that can be made of it. By construing giftedness as a cultural experience, we no longer have to worry about whether someone "truly" is gifted or not: it hardly matters. What matters is whether we as therapists can develop cultural competence with this group of clients, just as we would with any other ambiguously-defined cultural group. We would never ask a client to prove that they were really gay, or really Latino, or really a Red Sox fan, before agreeing to consider those issues as important in therapy.

Nevertheless, I understand that many readers, particularly those whom I most desire to reach, may not be familiar enough with giftedness and gifted individuals to be aware of many of the paradigmatic experiences of this clinical population. Those who have been in the field for years generally recognize gifted children and the kinds of things that often happen to them, while those who are new to the field often do not recognize just how common these stories are. As with many nebulous classes, it tends to be easy to recognize examples near the center of the group, but it is much harder to identify less-typical examples near the edges.

Following Peter Ossorio's (2006) suggestion, throughout this doctoral project, I will present paradigmatic cases, "common experiences" of gifted individuals; except where I identify them as unusual, these descriptions should be taken to represent modal experience. When names or other specifiers are used, these stories are not composites, but actual stories from individual informants, fictionalized to preserve anonymity. Within the gifted community, these stories are told, in their varied forms, over and over. Ironically, they are often introduced with, "I don't know if anyone else has ever had this happen, but…" Not every highly intelligent person has experienced all, or even most, of them. Not every person who has had these experiences is unusually brilliant. However,

these are cultural experiences which are described frequently by gifted children and adults. I hope the reader will resist the urge to criticize and question the validity of these reported experiences, and instead maintain an attitude of openness to the reported experiences of a clinical population which is hoping to be better understood.

Paradigm Case Formulation

A paradigm case formulation (Ossorio, 2006) is a description anchored by a case example which most observers would agree clearly falls within the class. To this description we add a series of transformations, changes to various parameters of the paradigm example, which still allow for the case to remain within the class. As transformations are combined with each other and made more extensive, the example's membership in the class becomes more and more arguable. Eventually, the changes become sufficiently broad that most observers would not consider the example to still be within the class. It is important to recognize that various observers might differ in the weights they would place upon each transformation and which transformations or combinations would lead them to decide that a given case no longer fits into the class.

Paradigm Case

The paradigmatic gifted individual would be a school-aged child, who has earned a recent score in the top 2% of the population on an individually-based standardized measure of intelligence. The child has achieved recent standardized scores of achievement in all school subjects above the 98th percentile for his or her age, and achieves at a consistently high level in the classroom as well. The child has skipped one or more grades, and/or participates in gifted programming or honors classes at school. The child manifests solid organizational skills, excellent motivation, strong emotional

self-regulation, and positive social skills with peers and adults. The child has no learning disabilities, disorders of executive functioning, sensory disabilities, physical disabilities, or psychological conditions which affect learning and performance. The child is aware of him or herself as a gifted individual.

Transformations

Individual is of any age.

Test data is not recent.

Individual does not have data from individually-administered standardized tests, but has other test data indicating intelligence or achievement, e.g., group-administered tests, talent search tests, or tests for entrance to high-IQ societies.

Individual has test data, but the scores are not as high as those of the paradigm case, or scores are only high in certain domains.

Individual has no test data confirming intelligence and/or high achievement.

Individual achieves highly in some but not all domains.

Individual has achieved highly in the past, but does not do so at present.

Domain of high achievement are not relevant to the classroom, e.g., music or art.

Individual is no longer in a school environment, but excels in a similar way in a postsecondary or vocational environment.

Individual is in a postsecondary environment, but does not excel at present.

Individual has not received educational services relevant to giftedness, or does not receive these at the present.

Individual achieves at a high level in academic areas, but not within the traditional classroom milieu.

Individual has poor organizational skills.

Individual does not consistently display high motivation to achieve.

Individual has difficulty regulating emotions.

Individual is socially isolated from peers, displays difficulties in social cognition, or does not have a suitable repertoire of socially adaptive skills.

Individual comes into frequent conflict with parents, teachers, coworkers, employers, or other authority figures.

Individual has one or more learning disabilities (e.g., Reading Disorder, Disorder of Written Language, Communication Disorder), disorders of executive functioning (e.g., Attention-Deficit / Hyperactivity Disorder, Asperger's Disorder), sensory disabilities (e.g., blindness), physical disabilities (e.g., uses a wheelchair), or psychological conditions (e.g., Major Depressive Disorder, Generalized Anxiety Disorder) which affect learning and/or performance.

Individual is not aware of him or herself as a gifted individual, either because the information has never been provided, or because the individual does not believe the information that is available.

Individual does not have formal evidence of giftedness, but is regarded by those around him or her as being highly intelligent.

Other Relevant Psychological Topics

There are a number of terms, theories, and ideas which I will use rather freely throughout this analysis. Thus, it would be helpful for a reader to be aware of how I understand them.

Accreditation and Degradation Ceremonies

It is important to consider the role of accreditation and degradation ceremonies in the establishment and maintenance of the therapeutic alliance, as well as in the overall action of therapy. These ceremonies were formally described by Harold Garfinkel (1956), and the specific nature of the processes of accreditation and degradation were further explicated by Schwartz (1979) and Ossorio (2006). The ceremonies are parallel in structure, and are fundamentally identical, except for their positive or negative nature. Each has three players, who may or may not be distinct individuals. The *initiate* (accreditation) or *perpetrator* (degradation) is a person who has performed some behavior or who has some personal characteristic. The *accreditor* (accreditation) or *denouncer* (degradation) is a person who is seen as a member in good standing in a community of people who share certain values, skills, or personal characteristics. The *witness* is a person who observes the ceremony taking place. The ceremony, then, involves the accreditor (or denouncer) making a statement to the initiate (or perpetrator) in front of the witness, saying that the action the initiate (or perpetrator) has taken is a true reflection of their personal characteristics, and that it is (or is not) in accordance with the values, skills, or personal characteristics shared by the community, and thus that the person is assigned a new and better (or worse) status within the community.

A person's self-concept can be construed as the sum of all of their own beliefs about their status, including traits, social roles, relationships, and the like, and is built upon the accreditations and degradations they have experienced. In particular, the problems that lead clients into therapy can often be construed as a series of degradation ceremonies, where they have systematically failed to live up to the expectations of a

community. Often, they have chronically been assigned statuses which limit their eligibility to act, including the act of assigning their own status, by important others in their lives, such as parents or teachers. Self-awareness and internalization of other people's expectations often leads them to have become their own witnesses, and, in fact, they have often become caught in a cycle in which they play all three roles in the degradation ceremony simultaneously and repeatedly (Bergner, 1999; Bergner & Holmes, 2000).

By contrast, the role of therapist is often to serve as an accreditor and witness. The action of therapy, then, is to create a microcosm of a community, in which the therapist assigns statuses which increase the client's eligibility, and consistently treats the client as a person who has those statuses. Status assignments relevant to the working alliance in general include such ideas as the client being acceptable (corresponding to Rogers's [1961] idea of unconditional positive regard), important enough to take seriously, able to think and act in ways that make some degree of sense, possessing strengths and resources, and able to act as an agent in their own life (Bergner, 1999; Bergner & Holmes, 2000).

As with all accreditors, the therapist must be seen by the client as having the eligibility to make these status assignments. The client must see the therapist as an independent actor, who is not only a member in good standing of the community, but also eligible to criticize the culture which has previously degraded the client. The therapist must be able to withstand the client's efforts to disqualify them as unacceptable, unbelievable, irrational, or not really aware of who the client is and what their statuses really are (Bergner & Staggs, 1987).

As Rogers's (1961) notion of congruence would suggest, it is important that the therapist's actions reflect authentic beliefs about the client. Clients tend to recognize when the attempted status assignment is not viewed by the therapist as true, which can cause the process to backfire: "Not only am I actually rotten, you also think I'm stupid enough to believe you when you lie." Bergner and Staggs (1987) suggest assigning a status that more honestly reflects the client's process, such as, "You are someone who is capable of improving in the following way."

The goal of therapy, then, regardless of modality or methodology, is to help the client more habitually serve all three roles, becoming their own accreditor in a way that is effective in helping them act effectively in their world (Bergner & Staggs, 1987; Schwartz, 1979).

Self-Determination Theory

My own work in helping clients develop self-regulation in the educational realm has led me to place a great deal of credence in self-determination theory, a theory of motivation (reviewed in Ryan & Deci, 2000). Ryan and Deci found that individuals are motivated to do those tasks which provide support for *competence*, *autonomy*, and *relatedness*. Competence is approximately equivalent to Bandura's (1997) notion of self-efficacy, the feeling that one can effectively perform challenging tasks which are valued by the individual or the culture. Autonomy is the feeling that one has choice and control about what one does and how one does it. Relatedness is the sense that one's actions bring one closer to a valued other. It is commonly thought of in terms of interpersonal connection, but it can also relate to an experience of relatedness to a domain or an idea. All three notions are very similar to the higher levels of Maslow's (1968) hierarchy of

human needs; relatedness corresponds to love and belonging needs, competence corresponds to esteem needs, and competence is similar to self-actualization needs. Ryan and Deci have applied their theory to a wide variety of human activities; most importantly for this study, they have described the importance of client autonomy, connection within the therapist, and competence with change-related tasks, as facilitative of therapeutic progress (2008). They draw a connection to an important therapeutic technique, Motivational Interviewing (Miller & Rollnick, 2002), which also emphasizes the development of client autonomy and competence. They point out how a harsh client introject, regardless of its basis in current reality, may create in the client the feeling that they do not have true autonomy. Furthermore, one must consider how pressures from parents, schools, managed care companies, or other authorities, as well as internal pressures to ensure a rapid and positive outcome to therapy, may result in therapist behaviors which are overly controlling.

Psychosocial Development

Erik Erikson's theory of development (1950/1963) is well-known, but requires some clarification as it applies to the context of giftedness. Erikson views lifespan development in terms of a series of conflicts, which the individual must resolve. Each conflict is typically associated with a particular developmental stage: trust vs. mistrust (infancy), autonomy vs. shame and doubt (toddler), initiative vs. guilt (preschool years), industry vs. inferiority (school age), identity vs. role confusion (adolescence), intimacy vs. isolation (young adulthood), generativity vs. stagnation (middle adulthood), and integrity vs. despair (older adulthood). Optimal resolution of each conflict may be different for each individual, but it is rarely true that a move all the way to one pole or the

other of a conflict is adaptive. I have found it useful to think of each stage as representing a fundamental question: Is the world safe? Can I control myself? Can I make good choices? Can I do valuable things well? Who am I? Can I connect to others? Can I create something new? Is it all worthwhile?

Some believe that the stages represent an inviolable progression; each stage must be resolved, once and for all, before one can move on to the next. Although it might seem like an inherent contradiction, many of those same people believe that each conflict is tied inextricably to an age range. Although cultural forces and typical cognitive developmental patterns combine to make it likely that the most prominent conflict at a given age would be the one associated with it, Erikson points out that any conflict or combination of conflicts can become important for an individual at any age. Particularly for gifted clients, where their cultural experience and cognitive developmental patterns may not be typical of the age, it is important to consider all possibilities as being available. Furthermore, Erikson states that no resolution is permanent; any conflict might be revisited at a later time. One way to conceive of the work of therapy, in fact, is to reawaken an old conflict and to help it toward a new and more adaptive resolution.

Attachment Theory

While originally conceived of as a phenomenon of infancy (e. g., Bowlby, 1988), attachment theory has since been found to apply to the broad sweep of human relationships (e. g., Hazan & Shaver, 1994), as well as to the processes of therapy (e. g., Fonagy, 2002; Fonagy, Gergely, Jurist, & Target, 2005). Early experiences of relationship create an internal working model, an expectation that these experiences will be repeated in later relationships. Attachments are typically described as exhibiting one

of four styles: secure, where the person has a sense of safety, trust, and calm within the relationship and is able to use the relationship as a base from which to explore the world and take risks; avoidant or dismissive, where the person expects that the other will disappoint and thus preemptively withdraws from connection; anxious or preoccupied, where the person fears loss and acts frantically to cling to the object of the attachment; and disorganized, where the person has become confused about what to expect, often because of a history of trauma, and uses many different but often ineffective strategies, at times including hostility, to attempt a connection or to protect themselves against betrayal.

As with many theories, it is important not to oversimplify. People do not always act according to their general attachment style; rather, stressful situations tend to bring out more anxiety over the possible or actual loss of the attachment object, and thus evoke more attachment-related behavior in an attempt to preserve or regain it. Grieving can be thought of as a way to reshape the attachment to a lost object, to create a new relationship accommodated to the new reality. When a person's anxiety mechanisms are triggered by one attachment threat, the reaction may be diffuse, affecting their reactions to other situations unrelated to the threat. This phenomenon creates many of the same behaviors that in psychodynamic theory are characterized as transference reactions. Within a reciprocal relationship, individual attachment styles can interact, with the patterns of interaction possibly becoming entrenched over time. For example, one classic pattern involves a preoccupied female and a dismissive male, where disagreements cause the male to back off and the female to pursue, creating a self-stoking cycle. While an individual's general attachment style may color many different relationships, it is also

quite possible to have different styles of attachment within different relationships -- to be securely attached to a spouse, while anxiously preoccupied in most other relationships, for example. Attachment objects are not always human individuals; one can form an attachment to a group of people, a role one serves, an aspect of the self, a field of endeavor, or an abstract idea.

Object Relations

A complete explication of object relations theory is well beyond the scope of this project; however, some concepts are relevant. Erikson (1950/1963), Kohut (1977; Baker & Baker, 1987), and Winnicott (1971) all place a similar emphasis on the development of basic trust in infancy and early childhood, as the caregiver responds reliably to the child's expressed needs. As the child comes to trust that the caregiver will respond, he is able to hold onto the memory of being comforted when the caregiver is briefly absent. Over time, he can tolerate longer and longer absences, maintaining the internal object awareness to regulate his own emotional responses to stress. Winnicott's description of the "good-enough" mother, although often thought of merely as a way to comfort mothers who despair of being perfect, actually describes the importance of not immediately gratifying a child's every wish. A child who does not experience sufficient manageable frustration, because of a too-good mother, is unable to use the experience to develop his own internal resources.

Kohut (1977; further explicated by Baker & Baker, 1987; Stark, 1999) described three basic relational needs, experiences which, over time, enable a person to build a strong sense of self. The person who serves these needs is referred to as the selfobject. The selfobject is often not experienced as a whole person with their own individuality,

but merely in terms of the role they serve for the developing individual. The child must find a person whom they can idealize ("You are perfect…") and imagine being fused with or someday becoming just like ("…and I am one with you"). That valued other must then offer accurate empathic mirroring: they must see what the child is or has done, see it accurately, understand its significance to the child, and offer approval ("Look at me!" "I see what you've done… that's wonderful!"). While the child cannot yet see himself through his own eyes, he can see himself reflected in the eyes of this valued other ("If you are perfect, and you like what I did, it must be good, so I must be good."). Over time, these experiences are gradually internalized and become functions of the child's own ego; this is the basis of what is popularly termed "self-esteem." The parallels to the accreditation ceremonies described earlier and to the importance of felt competence are obvious.

As the selfobject functions are internalized, the child becomes increasingly able to tolerate the imperfections of the selfobjects, coming to experience them as real and complex people with their own needs and wants. The child also begins to recognize the dialogue between their ego-ideals about what would constitute perfection, and their ambitions to meet those ideals; they can gradually become comfortable both with their own striving to meet the ideal and with the impossibility of doing so.

If the selfobject needs are not met with at least some reasonable level of reliability, problems in the development of the self may result. For example, those who cannot find an appropriate selfobject to idealize and merge with may either frantically search for anyone to connect with, submerging their own thoughts and intentions in those of anyone who seems likely; they may isolate themselves as a way to protect against

being engulfed; or they may despair entirely of finding connection, coming to believe that they are so worthless that no one would want to look at them. Similarly, those who do not receive sufficient empathic mirroring may work harder and harder, continuously trying to get other people to notice how good they are; or they may withdraw in shame. These various stances are not mutually exclusive; rather, a person in deep and chronic need may move unpredictably between them, further confusing and alienating those who might be helpful.

While these theories are typically seen as focusing on early childhood, they do apply throughout the lifespan. Kohut pointed out that there is a normal sequence of developmental transitions in terms of who serves one's selfobject needs, moving outward from parents to teachers, peers, intimate relationships, social groups, and the professional world. The therapist can be conceived of as a selfobject who provides a corrective experience.

Some aspects of Fairbairn's theory of object relations are also relevant (Armstrong-Perlman, 1994; Padel, 1986). He worked with children who had experienced traumatic relationships with family members and attempted to explain why the children nevertheless clung loyally to their abusers. However, since no one has a perfect childhood, he found that similar dynamics would play out in people without trauma histories, to less extreme degrees. In his theory, an object which chronically fails to meet a person's selfobject needs may be split into its good and bad aspects, the exciting object which continually entices and offers the possibility of nurturance or empathic connection, and the rejecting object which is overtly frustrating. The person may become rageful, not just at the rejecting object, but also at the part of the self which held out hope for the

exciting object's being able to meet their needs ("How could I have been so stupid?"). Furthermore, he recognized how terrifying it can be for a person, particularly a child, to come to recognize an important figure in their life as being bad or failing to meet their needs. Rather than accept this possibility, a person may use the moral defense, coming to believe that it is their own fault that the object is neglectful or cruel ("If only I were less rotten, then they would love me.").

False Self

Although the idea did not originate with him, Winnicott (1960/1965) more fully explicated a continuum of relationships between the false self and the true self. A psychologically healthy person is aware of the need at times to conform their behavior to the expectations of society; they are in touch with their true thoughts and feelings, but are aware of when it is appropriate to refrain from expressing them. There is always a certain level of tension between the need to express one's individuality and the need to maintain relatedness to others.

For some people, however, their false self may be based upon identifications or learned roles, but tends to allow the true self to come through most of the time. Moving toward the more pathological, the false self may protect the true self, but have as its main purpose the search for situations where the true self can be expressed. If the false self comes to despair of the possibility of working itself out of a job, it may lead the individual towards suicide, as the only way to eliminate the need for its own existence. Alternatively, the false self may tell the true self that it must stay always hidden, because it cannot be safely expressed. In the worst case, the false self may set itself up as real, and the individual may come to forget that the true self ever existed.

Winnicott points out that high levels of intellect potentiate the development of an intellectualized false self which continually strives to please others through intellectual accomplishments, as well a separation between intellectual and emotional or physical activity. His own clinical observations are very much in line with what is described in the clinical literature about giftedness:

> A particular danger arises out of the not-infrequent tie-up between the intellectual approach and the False Self. When a False Self becomes organized in an individual who has a high intellectual potential there is a very strong tendency for the mind to become the location of the False Self, and in this case there develops a dissociation between intellectual activity and psycho-somatic existence… When there has taken place this double abnormality, (i) the False Self organized to hide the True Self, and (ii) an attempt on the part of the individual to solve the personal problem by the use of a fine intellect, a clinical picture results which is peculiar in that it very easily deceives. The world may observe academic success of a high degree, and may find it hard to believe in the very real distress of the individual concerned, who feels 'phoney' the more he or she is successful. When such individuals destroy themselves in one way or another, instead of fulfilling promise, this invariably produces a sense of shock in those who have developed high hopes of the individual (p.144).

Transference and Countertransference

As before, a complete explication of these ideas and the many ways they have been defined is beyond the scope of this project, but it will be important for the reader to understand how I will use the terms and some of the major pitfalls for the therapeutic relationship. Although we may try to always be in the here-and-now in a relationship and to perceive things as they truly are, it is normal for various aspects of how the other person presents themselves or the events that transpire to remind us of something similar that happened in the past, and thus to color our perceptions of it in the present. This process is not necessarily completely unconscious; we may become aware of the similarity even while continuing to be affected by the transference reaction. In the process of projective identification, one person's transference reaction may recruit the

object of the transference to act (again, often but not necessarily always unconsciously) in accordance with the role that is being imposed upon them. For example, if a student had a history of being treated harshly by authority figures, then when the student is called up to speak to a teacher, he may expect the teacher to treat him harshly, and may act in ways which she experiences as inappropriately hostile, thus triggering her to act more harshly than she might have otherwise (Dalenberg, 2000; Davies & Frawley, 1994; Stark, 1999).

Countertransference is not fundamentally different from transference; it represents the totality of the helping professional's own responses to the client. Although some theorists attempt to draw distinctions, claiming as noncountertransferential responses which are based in objective reality, which are not evoked by client transference, which are not harmful to the client, which the therapist is conscious of, or which are not based in the helper's own neurosis, I find myself in agreement with Dalenberg (2000) and Bollas (1983) in taking a totalist view. Understanding that therapy takes place in the complex intersubjective space between the client and therapist, and that it is never truly possible to make clear and unambiguous determinations about the origins of one's own responses, I believe that drawing these distinctions serves only to potentiate therapists' self-serving claims that their countertransferential responses were not truly countertransferential and thus not relevant to consider.

Many therapists and other helpers continue to hold onto the ideal that they must remain free from countertransference. However, it is impossible to avoid countertransference, and the attempt to avoid it can become counterproductive. By disowning their own negative responses, the therapist risks losing self-awareness and gives up the opportunity to use these responses productively. In current psychodynamic

thought, countertransferential responses can be used as a way to help the therapist become more aware of the client's inner world ("If she is making me feel this way, perhaps this is a reflection of how she herself is feeling.") or of the kinds of reactions the client evokes in others ("If I am responding to her in this way, then perhaps other people in the world respond to her in a similar way, and perhaps this is why she has the experiences she does."). Furthermore, allowing the formation of a more honest relationship, where clients are able to trust their own perceptions of the therapists' responses, can be very helpful in working with clients for whom attachments have historically been problematic (Bollas, 1983; Dalenberg, 2000; Davies & Frawley, 1994; Stark, 1999; Winnicott, 1949).

Brightman (1985) pointed out a number of countertransferential pitfalls specific to the helping relationship. People who see themselves as helping others are often motivated by narcissistic strivings; the image of the self as hero, sage, or healer is not uncommon and not inherently problematic. However, it is often tied up in fantasies of being able to solve every problem (omnipotent), to know everything that needs to be known (omniscient), and to be always kind and altruistic to everyone (benevolent). When the real world presents helpers with something they cannot fix, something confusing or ambiguous, or a person they wish to help but who evokes unpleasant feelings (e. g., anger, hate, frustration, disdain, envy, or jealousy), they experience a threat to this ego-ideal. Without sufficient self-awareness, helpers often act in ways that function to protect their idealized self-images, frequently to the detriment of the person they might be trying to help. They may take an overly-intellectual stance, refusing to act until perfect knowledge can be found, or blaming the lack of progress on an external

environment which does not provide sufficient information. Conversely, they may repress their upsetting thoughts and glamorize an unfocused intuitive stance, refusing to consider information which might run counter to their gut feelings. They may act frantically, pushing harder and harder to control the relationship and create visible results, while undermining the client's autonomy. They may engage in splitting, identifying some aspect of the client or the system as wholly and irremediably "bad," thus creating a reason why they and the other "good guys" are unable to be successful, or romanticizing their own noble quest. And finally, they may withdraw from real engagement, simply going through the motions. Although Brightman spoke specifically about psychotherapists in training and their supervisors, I have found that his ideas apply very well to other helpers as well, including school counselors, teachers, administrators, advocates, parents, and even researchers. Because training in how to become aware of these responses and how to work through them productively is not available to most of these other helpers, there is quite a serious potential for problematic reactions, and for the reactions of one person to trigger even more problematic reactions in another.

Trauma

The DSM-IV-TR conceived of trauma in terms of specific "Criterion A" events, where a discrete event places an individual in severe risk of death or serious injury, or when an individual witnesses such an event happening to someone else (APA, 2000). However, current thought within the field of trauma (e. g., Herman, 1997) considers this definition to be far too narrow; trauma is considered less in terms of the actual events and more in terms of the relational meaning to the person experiencing it. Furthermore, many tiny painful events, none large enough to be considered traumatic in their own right, may

add up over time. Without ever experiencing a Criterion A event, an individual may experience significant changes in attachment and relationship patterns, moving to a place of basic mistrust and chronic relational failure. Joseph (1995) conducted an extensive theoretical analysis of what it is that makes one experience traumatic and another not, condensing the definition down to six words: "No map. No exit. No help." That is, when someone feels aware of being in a situation which they do not know how to navigate given their current competencies, does not feel that they are able to escape or change the situation, and does not perceive themselves as receiving effective help or comfort from others, they are at risk for experiencing the situation as traumatic. Although many individuals are resilient in the face of even horrific trauma, as clinicians, we are often working with those for whom resilience was insufficient. Our work may involve helping the client connect with their own strengths in order to develop a sense of competence to manage or escape the situation.

Many psychodynamic theoreticians have described the notion of projective identification with the aggressor as a common response to trauma (summarized in Stark, 1999). It is, as the song says, better to be a hammer than a nail: the person takes on the characteristics or actions of the abuser, acting out by attacking at others, or even engaging in self-destructive acts, rather than remaining always in the victim role. In the field of therapy for trauma and addictions, Miller (2002; Miller & Guidry, 2001) has expanded this idea to include a third character, the helpless bystander who observes the trauma but does not intervene effectively. Those who have experienced trauma take on each of the three roles at different times, and recruit others to serve the other roles in the drama.

Dalenberg (2000) described many countertransferential patterns which occur in trauma work. She explored the relational consequences of therapist self-disclosure or non-self-disclosure, the use and inadequacy of language around the description of trauma, the therapist willingness or even eagerness to discuss traumatic material, belief or disbelief of the client's felt reality, issues of shame and blame of self and other, feelings of helplessness, frustration around the tendency to repeat traumatic material in session and in the world, feelings of anger or fears of being manipulated, and changes in the relationship as the client heals.

Without any intention of devaluing the very serious Criterion A traumas that occur in the real world, it is Joseph's (1995) broader conceptualization of trauma which I will use in considering some of the cultural experiences of being gifted. Informally, I have found that many gifted clients experience the educational system as traumatic, offering a series of microaggressions and invalidations, confining them in a place which they cannot navigate effectively and providing little appropriate guidance or comfort. These individuals may also experience developmental transitions without the help of a relevant map provided by an empathic other. Similarly, while I do not necessarily expect that these same transferential and countertransferential patterns will arise in the experiences of clients who have experienced educational or social trauma, I will be attuned to the possibility and will describe parallels if they arise in the data.

Cultural Identity Development and Cultural Competence

Another area where I think there may be important parallels to existing theoretical and empirical literature comes from viewing giftedness as a dimension of culture. Much

of the work which has been done in this area relates to racial and ethnic minorities; however, the ideas seem applicable to almost any cultural group.

Social identity is, of course, multifaceted. People are generally motivated to view themselves as belonging to various social groups, and to build some of our sense of identity around group identification and comparison to other groups. We view ourselves as being situated simultaneously in many places within our ecological system, identifying according to ethnicity, age, gender, sexual orientation, ability, family, profession, religion, political community, nationality, for example: the possibilities and combinations are infinite. We may choose to emphasize or conceal various aspects of our social identity, depending upon the circumstances, and our social experiences are likely to shape our internal views about the balance and relationships among them. In the process of therapy, the multifaceted social identity of the client interacts with the multifaceted social identity of the therapist; the therapist must consider both where the client is in terms of identity development within each facet, how the problems that bring them to therapy may relate to changes in social identity, and how the therapist's own identity development may be affecting the client's self-understanding and self-presentation (Bronfenbrenner, 1986, 1992; Moghaddam, 2008; Yakushko, Davidson, & Williams, 2009).

There is a large theoretical and empirical literature about the identity development with respect to underprivileged minorities (most notably African-Americans), which has been extended to describe the parallel experience of developing an identity as a member of a privileged group (e. g., Cross & Cross, 2008; Vandiver, Fhagen-Smith, Cokley, Cross, & Worrell, 2001). In this literature, the development of a sense of racial or ethnic identity is seen as often going through a series of stages. As with any stage theory, the

stages and the boundaries between them are not rigid, the progression is not always linear or even always forward, and a person may become "stuck" at any point; the stages may be better thought of as a series of stances. Initially, people are not really aware of the group's existence or significance. They seek to downplay differences and assimilate into the dominant group, and may hold negative beliefs about the nondominant group and its insistence upon being different, or naive beliefs about how all people have equal status and opportunity. Next, people become aware of how differences really do exist, and how these differences may in fact affect their lives, for good or ill. At times, there are specific moments where the differences are thrown into sharp relief, while at other times, the individuals may experience a series of microaggressions, none large enough to be serious in itself, but powerful in the aggregate. They may feel surprised, devalued, attacked, or rejected, and may in their own turn reject the groups that they feel have rejected them. This experience may trigger a move into a stage where the individuals search enthusiastically for more information and deeper connection with this aspect of their identity. They may begin to romanticize it and see everything through this lens, and may experience rage, anxiety, or guilt about having been either the victim or in league with the perpetrators of injustice. They may endorse the ideals of tolerance, but be unable to perceive how their own actions might contribute to the problems. At times, the desire to elevate the oppressed group may spill over into a desire to punish the oppressors and denigrate their culture. Conversely, those who are members of the dominant group may experience a sense of pride, a feeling that their superiority is well-deserved because of the inferiority of the nondominant group's characteristics or behavior. Eventually, people may come to a stage where they can integrate this aspect of social identity into the full

complexity of their selfhood. They may come to view themselves as multicultural rather than assimilated, more willing to establish meaningful relationships and move fluidly across group boundaries. They may even become something of an ambassador between their group and others (Vandiver, Fhagen-Smith, Cokley, Cross, & Worrell, 2001). Cross and Cross (2008) have made explicit the idea that the development of group identity can apply to many different groups, and have integrated it with Eriksonian developmental theory.

Theories of cultural competence in the helping professions posit a somewhat analogous continuum. Initially, practitioners or organizations may be openly destructive, working against the interests of a particular cultural group. Somewhat less problematically, they may have unconsciously internalized or systemic/structural biases which are unintentionally harmful or unhelpful to the group, and may not view having the capacity to meet the group's needs as important or relevant. Blindness is the next stage along the continuum, where the philosophy is expressed that they view and treat all people as the same and have little awareness of possible relevant differences. In the pre-competent stage, they have become aware of the problem and may articulate a commitment to improve, but meaningful change that affects all relevant groups has not yet been implemented. Cultural competence reflects a broader and more integrated commitment to learn about the needs of a group and meet them effectively, while cultural proficiency takes it one step further, taking on a leadership role in terms of adding to the knowledge base and helping others along the path toward competence (National Center for Cultural Competence, n. d.). Naturally, it is also important for practitioners to be aware that any given individual may not conform to their expectations of the group;

stereotyping can be another form of cultural incompetence, still harmful to the therapeutic relationship. Cultural competence can thus be thought of in terms of awareness of the possibilities of difference between self and other, and openness to the possibility that therapeutic dialogue can engage productively with these aspects of individual identity (Brown, 2009). Fundamentally, cultural competence is often more about knowing which questions to ask than about knowing what the answers will be.

At present, the explicit conception of giftedness as an aspect of cultural identity has been largely absent from the literature. I found only a single paper presenting guidance on how to apply the tools and ideas for understanding a client's cultural experience to understanding the cultural experiences of gifted individuals and applying this understanding to counseling practice (Levy & Plucker, 2003). In reviewing the clinical literature, it seems that therapists who work extensively with gifted clients take this position, encouraging the clients to explore how giftedness affects their internal and external worlds; however, the connection is not made in a way that can be instructive to a clinician who is unaware of the relevance of this aspect of cultural identity. Part of what I hope to accomplish in this study is to understand what it is that mainstream therapists are seen as "not getting" about the cultural experience of living as a gifted person in the family, school, workplace, and community.

Parametric Descriptions of Behavior

Along with the description of status assignments through accreditation and degradation ceremonies, I will use other terminology from Descriptive Psychology (Ossorio, 1998, 2006). This is a theory-neutral conceptualization of the formal possibilities that can exist, providing clear and common-language terminology for talking

about persons, action, language, and environment. It can be useful for explicating the precise nature of what is happening in a particular interaction, in a way which does not depend upon any particular psychological school of thought. Although I will generally not capitalize these terms, throughout this discussion, I will be using them with these meanings.

Intentional Behavior can be described in terms of a number of different parameters:

Identity refers to the "who it is," the person who is doing the action.

Know refers to the information the person has and the distinctions they draw; it represents the cognitive aspects of behavior.

Want is the motivational aspect of behavior, the change in the state of affairs toward which behavior is directed.

Know How is different from Know, in that it refers to the person's actual competence to perform the intended behavior. It reflects the person's history of learning and acquired skills.

Performance is the actual behavior that can be observed in the world. Because of problems in Know and Know How, performance may not always be in accordance with the person's intentions.

Achievement refers to the change in the state of affairs, however tiny, which occurs because of the Performance.

Significance is the meaning of the behavior to the person, the social practice or goal that they are pursuing, or the Person Characteristic they are expressing, through engaging in the action. Long sequences of behavior can be united by their Significance.

Person Characteristics refers to various attributes of the individual. Every behavior expresses one or more of these; if the Person Characteristics were different, the person might well have engaged in a very different behavior. Person Characteristics can include Dispositions (tendencies to act more frequently in a certain way because of a Trait, Attitude, Interest, or Style), Powers (the realm of possibilities for that specific person because of their Abilities, Knowledge, or Values), or Derivatives (aspects of the person which may or may not connect directly to behaviors, including temporary States, Capacities to acquire new Person Characteristics under certain situations, or Embodiments, aspects of the physical body)

The *State of Affairs* is the totality of related objects, processes, and events. Each of these can be made up of smaller states of affairs, objects, processes, and events; an event is a change from one state of affairs to another.

Behavioral Potential refers to the sum total of all behaviors that a person could actually engage in, given the constraints of external reality and their own Person Characteristics. *Eligibility* is a more limited set of behavioral possibilities, constrained by one's position within a Culture.

Culture itself can be described parametrically. A culture is, as social identity theory might suggest, a way of living, generally embodied within a society or group of individuals who live that way. The community does not have to be geographically defined, and a person is generally a member of many different cultures simultaneously.

World refers to the set of beliefs and practices about the community and its relationship to other communities.

Members are the people who live in accordance with the culture, and whose actions embody the culture.

Social Practices make up the available behaviors which manifest the culture, the things that members of the culture do.

The culture generally has explicit or implicit *Statuses* which govern the differences in activity, standards, and values amongst the members.

Language can refer not just to the obvious linguistic concept (e. g. "Serbo-Croatian"), but can also refer to a set of agreed-upon meanings and concepts which may differ from those of other cultures.

Choice Principles are the principles or values by which the culture informs its members as to what behaviors are desirable.

In order to understand why behavior occurs, it is also important to consider a number of other concepts. People may act for a variety of reasons, including *Hedonic* (pleasure-seeking or pain-avoiding), *Prudential* (in one's self-interest), *Ethical* (because one believes that it is the "just" thing to do), or *Esthetic* (because it seems to fit in well with one's ideas of beauty, rigor, elegance, closure, or some other idea of what "seems appropriate"). They may place differing weights on various reasons. They will come to a decision about what to do based upon their evaluation of their current and possible future circumstances and their understanding of how those circumstances are relevant to them.

Relationships are also broadly defined; any person can have a relationship with an object or person within their circumstances. The behavior of a person with respect to the object of behavior will express that relationship, unless another relationship takes priority

(different Want), they do not recognize the relationship (different Know), they are unable to act in a way which expresses the relationship (inadequate Know How), they make a mistake in deciding which behavior would express the relationship (different Significance), or they err in actually doing the behavior (problems in Performance). Relationships can change over time through a person's actions or changes in the circumstances.

When a person regulates their own behavior, they are acting in three different roles: *Actor*, the person doing the action, *Observer*, the one who recognizes the action and its effects on the state of affairs, and *Critic*, the one who evaluates whether the action is satisfactory in its achievement, determines what might have gone wrong if it is unsatisfactory, and suggests corrective action to the Actor. Action does not take place at a single time; rather, it is taking place within a continuous system of feedback loops.

CHAPTER TWO: LITERATURE REVIEW AND SENSITIZING CONCEPTS

Therapeutic Working Alliance

A wide variety of measures have been developed to quantify the clients' and therapists' perceptions of and behaviors related to the working alliance, including questionnaires for clients, questionnaires for therapists, and direct observation of therapist behaviors (e.g., Gaston & Marmar, 1994; Horvath & Greenberg, 1989; Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983; Marmar, Horowitz, & Weiss, 1986; Pinsof, Zinbarg, & Knobloch-Fedders, 2008; Price & Jones, 1998; Shelef & Diamond, 2008; reviewed in Horvath, Gaston, & Luborsky, 1993; and Horvath & Bedi, 2002). A great many studies have been done, consistently finding that the outcome of therapy is strongly linked (with mean effect sizes in the .20's) to the quality of the alliance (Castonguay, Constantino, & Holtforth, 2006; Horvath & Bedi, 2002). Comprehensive meta-analyses of the importance of the alliance are found in Martin, Garske, and Davis (2000), Horvath (2001) (both of these reflecting studies of therapy with adult clients), Karver, Handelsman, Fields, and Bickman (2006), and Shirk and Karver (2003) (these two based on individual and family therapy with child and adolescent clients). While a detailed analysis of the multitude of ways in which the therapeutic alliance has been measured is beyond the scope of this investigation, the semistructured interview questions I will use are based on a synthesis of the topics and question wordings found in the literature.

Factors Affecting the Alliance

Client factors related to the development of effective working alliances are related primarily to their readiness to form relationships: clients with more severe psychological

problems, particularly those who have poor object relations or insecure attachment styles, have more difficulty. While therapist training and experience are not strongly correlated to alliance development, early career therapists tend to have more difficulty in becoming attuned with severely impaired clients. It is possible that these clients place a greater strain on the therapist's self-awareness and evoke more responses that are detrimental to alliance development; alternatively, those clients may make it more difficult for the therapist to establish credibility as "someone who can really help" (Castonguay, Constantino, & Holtforth, 2006; Horvath, 2001; Horvath & Bedi, 2002; Karver, Handelsman, Fields, & Bickman, 2005).

Therapist factors correlated with successful alliances include empathy, openness to exploration, and the ability to clearly communicate understanding of the client's experiences. Therapists who are able to clearly communicate with the client, providing a comprehensible rationale for treatment and methodology, corrective or reinforcing feedback, and guidance about how to make lasting change, are better able to establish and maintain an effective alliance. Furthermore, those who actively incorporate the client's words and ideas, taking a stance perceived as collaborative, are more successful. There is strong support for the idea that therapist attempts to exert control within the relationship, as well as hostility toward or competition with the client, tend to interfere with the development of the alliance (Ackerman & Hilsenroth, 2003; Castonguay, Constantino, & Holtforth, 2006; Horvath, 2001; Horvath & Bedi, 2002; Karver, Handelsman, Fields, & Bickman, 2005).

Although therapist and client perceptions of the alliance tend not to be closely correlated early in the relationship, as time goes on, they tend to become more similar,

and this similarity is correlated with better outcomes. It is important to focus on alliance early in the relationship, rather than attempting to intervene or "fix" too much too early; poor initial alliance is associated with premature termination, and alliances that have not "come together" by the fifth session tend never to develop well (Castonguay, Constantino, & Holtforth, 2006; Horvath, 2001; Horvath & Bedi, 2002).

Individual or family therapy involving child or adolescent clients presents an additional challenge, because in the vast majority of situations, the client is not there by choice. Some adult has typically decided that the client needs help and may have imposed their own ideas about the nature of the problem and the methodology to be used toward the solution. The child may be unaware of the problem, or may be in frank conflict with the referring adults about it. Although the other relational considerations mentioned above remain important, respecting the child or adolescent client's autonomy is crucial to establishing an alliance. Without this, underage clients may attend therapy, but may not participate actively in the therapeutic process, and thus may not derive any benefit. However, it is important at the same time to maintain an alliance with parents, who may fail to participate themselves if they feel that the therapist is working with the child but against them (Karver, Handelsman, Fields, & Bickman, 2005, 2006).

Rupture and Repair

All relationships are marked by moments of relative distance and closeness. Within the therapeutic relationship, ruptures, points where the alliance is threatened or failing, are normal, but they must be handled well if the relationship is to continue. Unrepaired ruptures can lead to a client's premature termination from therapy, or, especially if complicated by a therapist's countertransference or in a situation where the

client is mandated to participate, to actual client harm. However, object relations theorists (Kohut, 1977; Winnicott, 1949, 1971) and current research on alliance rupture suggest that the experience of rupture-and-repair can actually be beneficial, helping the client learn to accept failures in self and other, and may even be part of the means by which therapy is curative. Strains in the alliance are most commonly found in the mid-phase of treatment, after the early idealization of the therapist may have broken down and before significant change has been effective. However, the research base suggests that steady strong alliances, gradually increasing alliances, and alliances marked by many small tear-and-repair events are all common. Once an alliance is reasonably well-formed, brief ruptures tend not to be globalized by the client and can generally be dealt with as they occur (Castonguay, Constantino, & Holtforth, 2006; Safran & Muran, 2000; Stevens, Muran, Safran, Gorman, & Winston, 2007; Stiles, et. al., 2004).

Despite the wide variety of theoretical approaches used today, Safran and Muran (2000; Safran, Muran, Samstag, & Stevens, 2001; Safran, Muran, Stevens, & Rothman, 2008) have developed an integrated model of the various types of relational rupture which can occur and a generalized approach to working with them, which can be adapted to many different methodologies. They note that there are two primary types of rupture.

In a *confrontation* rupture, the client directly expresses anger, resentment, criticism, or dissatisfaction with therapy or the therapist. Therapists are often taken aback by what they feel is an attack and often respond with defensiveness or counterhostility; they tend to construe the problem as something wrong with the client. Not surprisingly, these hostile interactions tend to become entrenched, often creating a vicious cycle from which the therapeutic relationship cannot recover (Rhodes, Hill,

Thompson, & Elliott, 1994; Safran & Muran, 2000; Safran, Muran, Stevens, & Rothman, 2008).

In a *withdrawal* rupture, clients are unsure of whether it is safe to express their unhappiness or feel that they do not have a right to their feelings They therefore disengage from the therapist, the therapeutic process, or their own emotions. Qualitative research indicates that clients often feel a sense of deference toward the therapist, feeling that they must protect the therapist's feelings in order to maintain the relationship. They may have doubts about the goals or tasks of therapy, be concerned that the therapist may not be acting in a skillful manner, hope that the therapist will notice the signals they are sending, feel that they must live up to the therapist's expectations and tolerate their failures, or feel indebted to the therapist. If they do engage in brief aggressions, these are quickly disowned (Rennie, 1994). Although most therapists think that they themselves would be aware of the signs, the evidence suggests that therapists more often than not fail to accurately identify information or emotions which clients conceal from them and may not be particularly accurate about judging client reactions to what they do in therapy (Hill, Thompson, Cogar, & Denman, 1993; Regan & Hill, 1992). The signs of a withdrawal rupture are often subtle, including changing topics, speaking in a flat tone of voice, speaking in generalities, and avoiding the here-and-now, for example. As described by Winnicott (1960/1965), a client may consciously or unconsciously present only a false self for therapy. Faced with a withdrawing client, therapists may feel bored, confused, or frustrated, and may react by increasing their efforts to control the therapy, tell the client what to do, or adhere more strongly to their preferred methodology. Rather than recognizing the nature of the problem and shifting strategy, they tend to work harder

at their existing strategy. As before, the attempt at control tends to provoke further client withdrawal. Although the client may not leave therapy, or may drift away slowly through missed appointments, lateness, or similar acts of passive resistance, the therapy often becomes "stuck" (Castonguay, Constantino, & Holtforth, 2006; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Rhodes, Hill, Thompson, & Elliott, 1994; Safran & Muran, 2000; Safran, Muran, Samstag, & Stevens, 2001; Safran, Muran, Stevens, & Rothman, 2008).

In both types of rupture, the unhelpful therapist reactions tend to reinforce the client's existing dysfunctional relational schemas. One strategy, which can be adapted to any theoretical approach, requires that the therapist first become aware of the client behavior or countertransferential feelings which mark the rupture, and refrain from retaliating, becoming more rigid, or devaluing the client. Although some clients are willing to openly confront a therapist who is disappointing them, often the signs are quite subtle, in the form of side comments, fleeting nonverbal expressions, or little jokes. The therapist's own feelings of frustration, confusion, distraction, or boredom may also be important indicators (Safran & Muran, 2000, 2001; Safran, Muran, Samstag, & Stevens, 2001; Safran, Muran, Stevens, & Rothman, 2008).

The next step is for therapists to recognize what is actually going on within the relationship, so that they can disengage themselves from the system. It is crucial that therapists be able to speak about themselves nondefensively and take responsibility for their own contributions to whatever problems have appeared, so that clients do not feel that they are the ones being blamed for the relational breakdown. By modeling appropriate expression of negative or uncomfortable feelings, therapists communicate

that this expression is acceptable and show the client how it can be done (Safran & Muran, 2000, 2001; Safran, Muran, Samstag, & Stevens, 2001; Safran, Muran, Stevens, & Rothman, 2008).

Many types of intervention are possible, depending upon theoretical orientation. Interventions can be classified as to whether they are *direct,* overtly discussing the problem within the relationship and continuing the process of intersubjective negotiation, or *indirect*, performed with the goal of repairing the perceived rupture without explicitly interpreting the situation as a possible rupture. Interventions can also be classified as to whether they address the relational bond between client and therapist, or the goals or tasks they are working on together. Direct interventions tend to involve metacommunication, talking about the relationship and the feelings being evoked on each side in the here-and-now. A direct bond-oriented intervention might be to clarify the misunderstanding which has left the client feeling a lack of trust or respect. Alternatively, the therapist might discuss the core interpersonal themes in the client's life which this incident evokes, including disclosing the therapist's own feelings or empathically mirroring those of the client. A more indirect method might be to offer empathic mirroring for the client's style in a supportive and accepting way, for example, reframing their resistance to disclose as judiciousness. Another approach might be to provide a corrective emotional experience, acting in a way that is inconsistent with the dysfunctional internal schema, or gratifying the unspoken need. A direct goal/task-oriented intervention might be to discuss the rationale and make sure that the client is still in agreement, or to encourage the client to experiment with experiencing their feelings and expressing them clearly without being hurt. A more indirect approach to a goal/task

intervention might involve changing the goal or task to something more relevant to the client's expectations, without discussing it in terms of the relationship, or to reframe the meaning of the task or goal in terms more acceptable to the client (Safran & Muran, 2000, 2001; Safran, Muran, Samstag, & Stevens, 2001).

In the model proposed by Safran, Muran, and their colleagues (Safran & Muran, 2000, 2001; Safran, Muran, Samstag, & Stevens, 2001), they recommend interventions focused on exploring the client's construal of the current situation and jointly negotiating a shared understanding. By having the therapist self-disclose in a way which positions them not as an expert telling them how they should act, but as a curious partner in understanding, the space can be cleared to permit the client to experiment with experiencing feelings, asserting needs, and working out problems with another person, without focusing on blame or shame. The goal is not just to help them understand at the cognitive level what is happening and understand their own contributions to the relational rupture, but also to work at the emotional level. Rather than seeing this as a distraction from the main therapeutic event, this is considered part of the essential work of therapy. The client is likely to experience significant ambivalence around expressing their feelings. They may fear that the therapist may retaliate against them, or they may criticize themselves and doubt the validity and the value of their own perspective. Thus, they may express their needs in qualified ways, or make statements but back off from them quickly and deny that there is any real problem. It is important for the therapist to facilitate appropriate assertion without appearing to demand disclosure. During this process, attention must be paid to any anxiety and avoidance provoked by the process; these feelings should be explored and processed in their own right. In the end, the client can be

helped to express the underlying wish or need that they feel is unacceptable or that they despair of having fulfilled, so that it can be gratified appropriately, accepted, or tolerated within the relationship (Safran & Muran, 2000, 2001; Safran, Muran, Samstag, & Stevens, 2001).

This model of therapy, which the authors refer to as brief relational therapy, shows some empirical promise, particularly with clients who are most at risk for problems in the therapeutic alliance: those with personality disorders. In an initial pilot study, a sample of 60 clients with Cluster C personality disorders (avoidant, dependent, obsessive-compulsive), or personality disorders Not Otherwise Specified, were randomly assigned to thirty sessions of short-term psychodynamic therapy or cognitive-behavioral therapy. Both clients and therapists filled out questionnaires after each session, including questions about their experience of the alliance within the session. After eight sessions, 18 clients were identified as having difficulties in the alliance severe enough that they were likely to drop out. They were offered the option of being reassigned to a different form of therapy and encouraged not to worry about therapist reactions should they do so. Ten agreed to switch. Of these, five controls were assigned to the other therapy method, and five were assigned to brief relational therapy. All of the controls began therapy with the new therapist, but eventually dropped out. There was only one premature termination in the BRT group, and one planned termination for reasons unrelated to therapy, with the client making good progress and reporting a solid alliance. The three remaining clients completed the brief relational therapy, and all were clinically significantly improved on a variety of measures, particularly when data was taken six months after completion. Video analysis of the most intense ruptures was consistent with previous data indicating

that both cognitive-behavioral and psychodynamic therapists tended to react negatively and to become more rigid, controlling, and harsh with clients when ruptures occurred, while brief relational therapists were much more able to resolve the ruptures in ways which the clients found helpful. The 50 clients who were not included in the pilot study, along with other similar clients, for a total of 128 participants, were included in a similar study that did not involve switching therapies. Of these, 84 clients completed therapy and were available for follow-up. There were no significant differences among the three methods in terms of treatment efficacy, but brief relational therapy was significantly better than the other two methods in retaining clients. They also examined therapist and client ratings of rupture intensity and resolution. Therapists and clients reported fewer ruptures in cognitive-behavioral therapy, although those therapists seemed to miss a larger fraction of client-reported ruptures than in the other forms of therapy. Lower rupture intensity was correlated with higher eventual outcome on measures of interpersonal functioning. It is, of course, possible that those with better relational skills were better able to avoid having overt ruptures. Higher resolution of ruptures was a solid predictor of retention in therapy (Muran, Safran, Gorman, Samstag, Eubanks-Carter, & Winston, 2009; Muran, Safran, Samstag, & Winston, 2005; Safran, Muran, Samstag, & Winston, 2005). The rupture-resolution-focused approach, while not necessarily a replacement for other forms of therapy, may be an important way for therapists to conceptualize their awareness of and approach to maintaining the alliance within any therapeutic modality.

Giftedness and Psychological Health

State of the Literature

There is a vast literature in psychology on intelligence, with various attempts to define the nature of intelligence and to identify who is more and less intelligent. Within education, there is a significant literature about the advantages and disadvantages of various models of education for high-ability learners. However, giftedness as a dimension of human experience that might affect the course of therapy is largely ignored in the mainstream psychological literature. There is a sense of "parallel play," where those already knowledgeable about giftedness speak to each other in one corner, while those not already interested in the topic have no opportunity to develop competence.

Searching the major psychological research databases under "gifted and (therapy or psychotherapy or counseling)" for articles in peer-reviewed journals, published in English, over the last twenty years, with the removal of duplicates, book reviews, and obviously off-topic articles, yielded fewer than one hundred articles. Of those, approximately twenty were in general educational or educational counseling journals; high intelligence is presented as an issue that school counselors or career counselors should be aware of, but most papers provide little to no in-depth analysis of therapeutic techniques or relational issues. Well over half of the articles found were in a set of small-circulation journals devoted to issues of giftedness, particularly as it affects education (*Roeper Review, Advanced Development, Journal of Secondary Gifted Education, Journal for the Education of the Gifted,* and *Gifted Child Quarterly*). Most of these were theoretical articles or individual case studies. As with the general educational journals, psychologists not already interested in issues of how giftedness would affect therapy

would typically not read these journals. Furthermore, much of what is published in these journals does not have the kind of scientific rigor or theoretical sophistication that would typically attract respect from a skeptical audience.

Within the more general psychological literature, over the past twenty years, there were four case studies, five articles in a special issue reviewing the worldwide state of affairs for school-based counseling of gifted students, three on career-guidance issues, and twelve articles on issues of providing therapy to gifted clients, primarily from the same authors who published in the gifted-specific literature. As in the educational literature, these publications largely report the authors' personal clinical experiences and beliefs. Efforts to go beyond simple keyword searches, particularly by avoiding the reliance on the term *gifted,* were able to ferret out more of the extant literature, but yielded no significant differences in terms of the attention given to various topics pertinent to giftedness.

Searches attempting to connect giftedness with more sophisticated psychological topics, such as transference, countertransference, or the therapeutic working alliance, come up almost completely empty. Only a handful of papers draw connections to object relations theory, countertransference, or similar psychological topics.

In the world of books, the American Psychological Association lists in its catalog only four books on giftedness within the past century (Hollingworth, 1926; Friedman & Rogers, 1998; Friedman & Shore, 2000; Horowitz, Subotnik, & Matthews, 2009). All but the last are out of print. Both the Friedman and Shore and the Horowitz, Subotnik, and Matthews volumes consider talent as being fundamentally separate from the human beings it resides in. In fact, the most recently published book takes as its premise an

explicit rejection of giftedness as being inherent in individuals, and, in the introduction (Horowitz, 2009), states that the focus of the book is only on the development of the externalized talents themselves. There is no chapter on issues related to psychotherapy or counseling; the idea is touched on only briefly in the last chapter (Matthews, Subotnik, & Horowitz, 2009).

Most major psychology-oriented academic publishers have not published books on giftedness at all; one recent book from Springer (Pfeiffer, 2008) is a notable exception. As with the periodical literature, books on giftedness are, in general, published by publishers specific to the field, such as Prufrock Press, Great Potential Press, Gifted Education Press, and the National Association for Gifted Children, and most are written for a lay or educational audience.

There are a few books written for an audience of professional educators or counselors which discuss issues related to the social-emotional development of highly intelligent individuals (Silverman, 1993; Neihart, Reis, Robinson, & Moon, 2002; Mendaglio & Peterson, 2007; Peterson, 2009b; VanTassel-Baska, Cross, & Olenchak, 2009). However, these sources tend to be, from a psychologist's point of view, quite simple and often repetitive; a few ideas are presented, often with only thin support from research or clinical data, and then are repeated by other writers. Gifted clients are presented as suffering from little more than various forms of adjustment disorder. There is little, if any, consideration of sophisticated psychological topics and how those might affect gifted clients or the course of doing therapy with them.

Characteristics of Gifted Individuals

While most authors agree with Boland and Gross (2007) and Thomas, Ray, and Moon (2007) that there is no "gifted personality," there are a number of cognitive, conative, and affective traits which have often been identified, in both formal and informal studies, as being typical of gifted individuals. None of these should be construed to be categorical; rather, these traits may be found in greater or lesser degrees in any given individual. As described above, not all of these are found in every highly intelligent person, and many of them are found at times in people who are otherwise unremarkable from a cognitive perspective, but this constellation is paradigmatic of what the mind of a gifted person is like.

From the cognitive perspective, highly intelligent people often display a high level of perceptual sensitivity, noticing detail which others may miss (Boland & Gross, 2007; Glickauf-Hughes, Wells, & Genirburg, 1987; Hoh, 2008; Lovecky, 1993; Mendaglio, 2003, 2007). They tend to process information rapidly, dislike slow-paced work, and some tend to jump to a correct understanding without necessarily being aware of the intervening steps. Even those with a more deliberate working style are often simply processing more information than others are and being careful to avoid mistakes. They often have a superior memory, prefer complexity, and can visualize dynamically. Most are able to conceive of abstractions and generalizations, both at younger ages than is typical and at a level of depth or complexity that may be unusual even in adults. Gifted individuals also often display a high level of metacognitive awareness, as well as an ability to efficiently coordinate synergies among their various cognitive skills (Boland & Gross, 2007; Hoh, 2008). Dickens and Flynn (2001) point out that high-IQ children are

both better at encouraging the environment to teach them new ideas and information and more likely to be born into high-IQ families which provide richer and more stimulating environments, thus creating increased opportunities for learning. In stage-based developmental theories, gifted individuals tend to move through the stages more quickly and to be more likely to reach higher levels in adulthood (Dixon, 2008; Hoh, 2008). I have personally observed formal and postformal Piagetian reasoning in the domain of mathematics in children as young as 6 years old, and find that these are common in gifted children by the upper elementary years. Particularly in childhood and adolescence, gifted individuals often display uneven cognitive, academic, and psychological profiles (Winner, 2000), often labeled with the term *asynchronous development* (Columbus Group, 1991; Morelock, 1996). Asynchrony can be exacerbated when there are concomitant learning disabilities or psychological disorders. There is also a small literature suggesting that there are real differences in executive functioning (Arffa, 2007; Johnson, Im-Bolter, & Pascual-Leone, 2003; Mahone, et al., 2002; Swanson, 2006) and brain activity (Alexander, O'Boyle, & Benbow, 1996; Jin, Kim Park, & Lee, 2007; Jin, Kwon, Jeong, Kown, Shin, 2006; Martin, Delpont, Suisse, Richelme, & Dolisi, 1993; Singh & O'Boyle, 2004; O'Boyle, Gill, Benbow, & Alexander, 1994) between gifted and average individuals, with gifted individuals showing more efficient, effective, or mature patterns.

These high levels of cognitive development often result in precocious skill development, particularly in the areas of language and mathematical reasoning, and a large knowledge base, both of content-area knowledge and of skills and strategies. Gifted individuals are also often capable of recognizing connections among various

domains, seeing and creating novel patterns. They tend to be "systems thinkers," recognizing the broad range of interlocking influences. Academically, they are typically able to engage with intellectually demanding work. Again, this advanced development reflects not just a more rapid pace of learning, but also often a higher ultimate level of achievement (Boland & Gross, 2007; Clark, 2007; Hoh, 2008).

Gifted individuals also often display conative differences from what is typical (Hoh, 2008). In particular, they are often highly curious, to the point at times of obsessively fascinated, sometimes with a particular area of passion and sometimes with a very wide variety of interests. Learning is extremely pleasurable, rising to the level of need rather than want (Grobman, 2006; Kerr, 2007). Ellen Winner (1996) referred to this trait as a "rage to learn." Lovecky (1990, 1992, 1993) termed this common characteristic *entelechy*, or drive. It is also reminiscent of Maslow's (1968) need for self-actualization. Renzulli (e.g. 2005, 2009) considers "high task commitment" as one of the requirements for a person to be considered gifted. However, his model has been criticized as not acknowledging the loss of motivation that often comes as a result of long-term frustration and isolation in mainstream educational environments, and his more recent work (2009) emphasized the importance of supporting the development of conative traits rather than simply assuming that they must exist on their own. Gagné (2004, 2005), similarly, viewed motivation and access to support as mediating factors between giftedness and its expression in concrete products or performance.

Other differences common in children who are gifted, likely related to advanced levels of abstract thought and access to content that is uninteresting to or unreadable by their agemates, include a philosophical bent, divergent thinking, a strong sense of justice

and fairness, advanced moral development, a high level of empathy for others, and a sophisticated sense of humor(Boland & Gross, 2007; Hoh, 2008; Lovecky, 1992, 1993, 1997). When considered in light of Kohlberg's theory of moral development (Kohlberg & Hirsch, 1977), gifted individuals are more likely to reach postconventional levels of moral reasoning, often at young ages. Chovan and Freeman (1993) found that gifted children and adolescents demonstrated more sophisticated moral reasoning than average-ability agemates when responding to moral dilemmas, such as the famous Heinz dilemma, on the Defining Issues Test. Tolan (n.d.) described how asynchronous development may result in significant distress; for example, children who have cognitive access to information about the world's problems may not yet have the emotional resources to process this information adaptively. They may find themselves overwhelmed by existential dread at an early age (Ellsworth, 1998; Webb, 2008); I personally recall one parent describing how her kindergarten-aged son dreaded his upcoming birthday because it was, in his mind, just "one year closer to death."

Some literature suggests that, on the Meyers-Briggs Type Indicator questionnaire, gifted adolescents are somewhat more likely to score as introverted, as well as intuitive and perceiving (Cross, Speirs Neumeister, & Cassady, 2007). However, all types were represented in this sample. Winner (2000) pointed out that some of the tendency to report an introverted personality may reflect not so much true introversion as a learned habit of expecting and tolerating the experience of being alone, because of the social isolation experienced by many gifted children and adolescents.

There is much discussion in the giftedness-specific literature (and virtually none outside of it, since literature searches for this study turned up no peer-reviewed journal

articles in the past twenty years related to this theory which were not explicitly related to giftedness or creativity, published in a gifted-specific journal, or written by an author whose focus of research was high ability) of "Dabrowski's overexcitabilities." Kazimierz Dabrowski was a Polish psychologist who developed a theory of personality emphasizing moral development, called the theory of positive disintegration (Dabrowski, 1964, 1967, 1972; Piechowski 2002). A complete explication of this theory is beyond the scope of this project; what follows is a brief summary. Dabrowski hypothesized that some people, particularly those of high ability, are more sensitive than others to environmental and internal stimuli, resulting in patterns of hyperreactivity in five domains: psychomotor, sensory, intellectual, imaginational, and emotional. Taking in so much information and having such at-times overwhelming reactions to it may lead to an intense personality and can result in maladaptive or ineffective behavior. Overexcitabilities can often be mistaken for immaturity or psychopathology, can exacerbate existing psychological problems, or can place an individual at risk for developing psychological disorders (Eide & Eide, 2006; Lovecky, 2004; Webb, et al., 2005).

However, key to Dabrowski's theory was the idea that psychological distress brought on by overexcitabilities, which he called psychoneurosis, was actually a sign that the individual was becoming aware of legitimate problems in the world. These breakdowns, therefore, were not necessarily bad things; rather, they heralded progression from lower to higher levels of moral development. Those who were less sensitive to the environment were thus less able to experience these problems and to move forward in development. Some therapists who specialize in work with gifted individuals (e.g., Lovecky, 1997; Silverman, 1993a) organize their approach specifically around helping

clients work through this developmental process. Piechowski's more recent theoretical work (2000, 2001, 2002) has focused around the application of these ideas to spiritual development and self-actualization; he believes that some gifted children are also likely to be gifted in the spiritual realm. Mendaglio (2003, 2007) criticized the tendency to assume that maladaptation in gifted individuals indicates higher spiritual development. Rather, he connected the idea of overexcitabilities to Aron's (1996) description of the "highly sensitive person." Mendaglio suggested using the less loaded terminology of "heightened multifaceted sensitivity," and emphasized both its the positive and negative effects.

While Dabrowski's own work did not focus exclusively on high ability, the notion of overexcitabilities has held a great deal of face validity for many highly intelligent people and has provided a great deal of comfort to those who feel that their giftedness is misunderstood by others (Piechowski, 2006; Silverman, 1993b). However, it has also at times served to complicate the diagnosis of legitimate psychological disorders, serving as a distraction from or even an excuse for some very real problems. (Lovecky, 2004; Webb, et al., 2005; Eide & Eide, 2006). Thurman (2009) pointed out that in gifted individuals who were also on the autism spectrum, the extremes of sensitivity to stimuli could combine to create extreme and chronic distress.

There is a small amount of empirical literature investigating whether overexcitabilities are real differences in the high-ability population (Piechoswki summarizes three of his own studies in his 2006 book; ten other studies related to intellectual giftedness are reviewed in Mendaglio & Tillier, 2006). However, the literature is not very strong from a scientific standpoint. Of those thirteen studies, eleven

are based upon self-report questionnaires, where individuals describe their own experiences of overexcitability, while the remaining two are based upon non-blinded observer nominations. All of these methods could be subject to confirmation or self-serving biases. Furthermore, most of the studies use small samples; except for one large-scale study with 567 participants (including both gifted and non-gifted groups), sample sizes of the gifted groups ranged from 5 to 96, with a median of 34. Samples were generally samples of convenience, and were often self-selected, which limits generalizability. Six do not contain non-gifted control groups, while three other studies rely on a single data set from a previous paper for a non-gifted comparison group. With all of these caveats, there were some moderately consistent patterns in the data. When comparisons were possible, gifted adult participants tended to yield higher ratings of imaginational, intellectual, and emotional overexcitabilities than did non-gifted participants. Gifted child participants tended to differ from non-gifted comparisons in intellectual and psychomotor overexcitabilities, with psychomotor differences being more prominent.

A related approach was taken by Gere, Capps, Mitchell, and Grubbes (2009), who found that parents of gifted children were more likely than parents of average children to report, on the Sensory Profile questionnaire used by occupational therapists, that their children displayed sensory sensitivities. An exploration of archival data from a clinic in Australia serving high-IQ children (Alsop, 2003) found that, at quite high rates, parents reported their children as being emotionally sensitive. However, there was no comparison group, and the authors pointed out that families who sought them out were generally doing so because the child was experiencing problems at home or at school.

Benbow (1986) found high frequencies of asthma or allergies in mathematically precocious youth, suggesting a possible physiological component. Working from a different angle, Shamosh and Gray (2007) tested whether actively suppressing the emotional response to an evocative video (as compared to merely watching the video) affected subjects' ability to perform a task requiring significant self-regulation (a complex interference task based upon the Stroop procedure). Two groups of students were studied, a high-ability group (measured by high performance on Raven's Advanced Progressive Matrices) and an average-ability group. The investigators found that high-intelligence subjects were more likely than average-intelligence subjects to have their abilities to regulate their behavior depleted by the effort of suppressing their emotional responses. This study suggests that, if emotional overexcitabilities are present in gifted individuals, that the effort required to manage these responses may tire them out, resulting in reduced abilities to regulate their everyday behavior.

While the theoretical concept of Dabrowski's overexcitabilities holds a great deal of currency within the gifted community, the actual data in this realm is still quite preliminary. It is not clear if this theory offers explanatory or predictive power beyond more mainstream, classic psychological theories such as Chess and Thomas's work on temperament (e.g., 1987), Kohlberg's work on moral development (e.g., 1963), and the work of Maslow (e. g., 1968) and other humanistic theorists on such topics as self-actualization. It is possible that the wide endorsement of overexcitabilities within the gifted community merely represents a group organizing around a cultural meme with little basis in reality. It is also possible that differences among gifted individuals, in terms of which overexcitabilities they experience most strongly, create enough "noise" in

statistical analyses of groups that it is harder to see the effects on individuals. However, it is difficult to ignore that many highly intelligent people, adults and children alike (myself included), strongly endorse the experience of Dabrowski's overexcitabilities on an informal basis, and that those unfamiliar with the theory frequently greet it with, "Oh, yes, that's exactly what it's like to be me!"

Is Giftedness a Risk Factor?

One of the longest-standing conflicts in the field of giftedness is whether, as the classic Terman studies of giftedness (Burks, Jensen, & Terman, 1930; Terman, 1925; Terman & Oden, 1947, 1959) might suggest, gifted individuals are like Mary Poppins, "practically perfect in every way," or whether Hollingworth's (1926, 1931, 1942) perspective on gifted individuals as being uniquely at risk is a better description. As with almost every such dichotomy, the answer is, of course, "yes." Current thought within the field is that while being highly intelligent may not in and of itself be a disability, high intelligence certainly does not confer immunity, either from adjustment disorders or from more serious forms of psychopathology. While gifted individuals may have more cognitive resources to draw upon in order to cope with life's problems, they are also faced, often from an early age, with both internal stressors and asynchronies, as well as with an environment that is often poorly matched to their developmental and learning needs. Thus, there is often much more for them to cope *with* (Boland & Gross, 2007; Grobman, 2006; Lovecky, 1986, 1990, 1992, 1993, 1997; Mahoney, Martin, & Martin, 2007; Moon, 2007; Peterson, 2008; Peterson & Moon, 2008; Pfeiffer & Stocking, 2000; A. Robinson & Clinkenbeard, 2008; N. M. Robinson, 2008; Silverman, 1993b, 2002). A

popular metaphor (Tolan, 1996) compares gifted individuals to cheetahs living in a world of lions; not better or worse animals, but different in many important ways.

The literature on psychological disorders among the gifted is limited, although slightly more attention has been paid in recent years to those with ADHD or Asperger's disorder, as well as to the psychological consequences of being twice-exceptional (Eide & Eide, 2006; Lovecky, 2004; Neihart, 2008; Webb, Amend, Webb, Goerss, Beljan, & Olenchak, 2005). Twice-exceptional individuals are both gifted and have some form of learning disability, problem with executive functioning, psychological disorder, sensory disability, or physical disability. Frequently, those with multiple exceptionalities find that neither talent nor disability is recognized, as they are not able to do well enough to be seen as gifted, but are able to use their high intelligence to partially compensate for the difficulties they encounter, without truly being able to do the tasks effectively. My own and other professionals' clinical experience in providing cognitive and educational assessments to gifted and twice-exceptional learners has been that average or even above-average test scores can at times mask significant educational problems (Eide & Eide, 2006; Lovecky, 2004; Webb, Amend, Webb, Goerss, Beljan, & Olenchak, 2005; Yermish, in press). The psychological consequences can be severe. The students frequently receive neither appropriate challenge nor academic remediation, being simultaneously bored and incapable in the classroom. In addition, they are usually deeply aware of the fact that they are not able to live up to their own or others' expectations, often without understanding why (Eide & Eide, 2006; Lovecky, 2004; Neihart, 2008; Webb, Amend, Webb, Goerss, Beljan, & Olenchak, 2005). I recall one 5th grade boy, with a verbal IQ of 137, who was afraid to read *The Cat In The Hat* to a

kindergarten class, because he knew that he would be humiliated; he was, at that point, suicidal and self-injurious.

Large-group studies of psychological health do not, however, support the idea of an epidemic of psychopathology among the highly intelligent. In examining the medical histories of 1900 high-school-aged participants in a residential summer program for gifted youth, Jarosewich & Stocking (2003) found that parents did not report higher frequencies of psychiatric diagnosis or treatment than would be expected for the age group. It is possible, of course, that parents chose not to mention some problems because of concerns for privacy. Similarly, on the Minnesota Multiphasic Personality Inventory, Adolescent (MMPI-A), students at a residential academy for the gifted did not show more pathological profiles (Cross, Cassady, Dixon, & Adams, 2008). However, it is important to note that children had to demonstrate a high level of achievement in order to be eligible for both of these programs. Moon (2007) points out that, as a group, gifted individuals do not appear to suffer from more psychopathology than those of average intelligence, but that there are very large within-group differences. Some are extremely well-adjusted, while others struggle greatly. There is both risk and resilience present (Keiley, 2002; Neihart, 2002b).

Academic Mismatch

One important potential risk factor is that gifted individuals are often poorly matched to their academic environments. They commonly prefer a level and pace of learning that is often not available in the classroom (Robinson, 2008). The overwhelming majority of structured learning environments are based in the factory model of education, developed along with the assembly line in the early 20th century.

Students are grouped strictly according to age, and they move along the production line in an orderly fashion; few question the implied notion that age is really all one needs to know about a child in order to determine the best academic and social environment for them. Because of concerns about "fairness" and job performance evaluations for teachers, most administrators tend to spread gifted children across the classrooms at a given grade level, isolating them rather than clustering them within a few classrooms where they could serve as peers to each other (Gentry & Owen, 2004). School personnel also commonly hold many misconceptions about giftedness. Although a detailed listing and research-based refutation of these myths is beyond the scope of this literature review, the beliefs most relevant to the psychological development of highly intelligent children are as follows (excerpted and summarized from National Association for Gifted Children, n. d.; Winner, 1996):

- All children are gifted.
- Gifted children will do fine on their own.
- Other than being good at academics, gifted children are no different from anyone else.
- Gifted children have already received their "gift" and do not deserve any additional "special treatment."
- Gifted children have an obligation to serve society.
- Gifted children must learn to fit in with everyone else all of the time.
- Gifted children must work with average kids in order to avoid becoming arrogant.
- Gifted children are obligated to serve the average kids by teaching them, and will learn the content better by doing so.

Most educators believe that ability grouping and academic acceleration in all their forms are bad for the academic and social-emotional development of gifted children, despite an extensive research and experience base establishing precisely the opposite (Allan, 1991; Colangelo, Assouline, & Gross, 2004; Fieldler, Lange, & Winebrenner, 1993; Gross, 2004, 2006; Pyryt 2008). The "rage to learn" is often frustrated, ignored, or even denigrated in the traditional classroom (Grobman, 2006; Gross, 2004, 2006). Similar biases and inflexible systems administered by professionals with little understanding of giftedness exist in other developed countries as well (New Zealand: Blackett & Hermansson, 2005; Germany: Heller, 2005; Canada: Lupart, Pyryt, Watson, & Pierce, 2005; Sweden: Persson, 2005; France: Vrignaud, Bonora, & Dreux, 2005). In qualitative studies of how gifted students viewed their own experience, feeling that schoolwork was too easy and unrewarding was a common theme (Galbraith, 1985; Kunkel, Chapa, Patterson, & Walling, 1992; 1995). Cooperative projects, mixed-ability grouping, and peer tutoring often leave gifted youth feeling further frustrated or even taken advantage of in the classroom (Matthews, 1992). With the advent of the No Child Left Behind Act of 2001 in the USA, gifted children are seen as a low priority, because they are typically already able to meet the standards (Duffett, Farkas, & Loveless, 2008; Gentry, 2006). Children may display areas of giftedness not commonly valued in the traditional curriculum (Olenchak, 1999; Piirto, 2008). As mentioned above, for twice-exceptional students, their needs for challenge and assistance often go unrecognized. Even when there is no diagnosable learning disability, many teachers focus only on areas of low skill development, such as handwriting or fluency in math facts, leaving the children feeling that their true passions are unseen or unimportant, or even that the

teacher is trying to punish them (Boland & Gross, 2007). Because of the conflicted values held in society about whether it is good to be smart, gifted children and adolescents often complain that they are not told what it means to be gifted and wonder if it is some kind of shameful secret (Galbraith, 1985; Kunkel, Chapa, Patterson, & Walling, 1992, 1995).

A tendency for postconventional and divergent thinking, as well as a more intense and reactive style, may create the appearance of oppositionality or attention deficit, leading to conflicts with educators (Grobman, 2006; Lovecky, 1992, 1993). When high awareness of self and other combines with high emotional sensitivity or high psychomotor reactivity, children may be seen as "oversensitive" or even "immature" (Robinson, 2008). Hartnett, Nelson, and Rinn (2004) found that school counselors in training who were not specifically cued to consider giftedness as a possibility to explain behavior would tend not to consider it on their own. Both learning disabilities and psychological disorders can be very difficult to diagnose accurately within the context of giftedness; there is a tendency toward both overdiagnosis and underdiagnosis of twice-exceptional children (Eide & Eide, 2006; Lovecky, 2004; MacEachern & Bornot, 2001; Webb, Amend, Webb, Goerss, Beljan, & Olenchak, 2005). Educational mismatches or disagreements as to the meaning of a child's behavior often set the stage for conflicts between family and school, where at-times unrealistic expectations by parents in terms of what can be provided combine with educator misconceptions and misperceptions about high intelligence (Alsop, 1997). The children are often then caught in the middle of these conflicts.

Coping strategies may be more sophisticated for these individuals. Preuss and Dubow (2004) found, on a self-report questionnaire about coping strategies, that gifted middle-school students indicated significantly more problem-solving responses than their age-peers. Through in-depth interviews of gifted students ages 9-14 and their family members, teachers, and peers, Sowa and colleagues (Sowa, McIntire, May, & Bland, 1994) found that these children used quite a wide variety of cognitive appraisal strategies to cope with environmental stressors. They were able to think at a sophisticated level, more typical of adults, about what the situations were and what competencies they might have to solve a problem actively or to cope emotionally with an unpleasant situation. However, because children are typically expected primarily to conform to adult demands in school, the authors pointed out that assertive strategies, which would be valued in adults, could easily bring these children into conflict with teachers.

Social Isolation

Gifted individuals also often do not fit in well to their social environments (Grobman, 2006; Robinson, 2008). As gifted children move into latency age and beyond, they may be looking for a level of intimacy and trust within friendship that is not yet available from typical agemates (Gross, 2002, 2004). In qualitative studies, gifted children and adolescents described how difficult it was to find friends who deeply understood them and valued them for who they were (Galbraith, 1985; Kunkel, Chapa, Patterson, & Walling, 1992; 1995). While many are able to leverage their high intelligence to develop proficiency in the social realm, a questionnaire study (Janos, Marwood, & Robinson, 1985) found that the fraction of high-intelligence children who cited loneliness and isolation was much higher (often twice as high or higher, depending

upon the specific question) than of moderately intelligent children, and that their parents' observations were consistent with the children's reports. Highly intelligent children who did have friends were considerably more likely to have friends who were older than they were, suggesting that the typical childhood experience of being with friends every day in the classroom might not have been available. Dauber and Benbow (1990) found that adolescents with the highest scores on talent search tests were the most likely to have difficulties in social adjustment, despite participating in social and athletic activities at a similar rate as those with lower scores.

Advanced cognitive development may also contribute to isolation. Mahoney, Martin, and Martin (2007) find in their clinical work that precocious language development also often sets gifted children apart from others their age; they may be seen as acting as if they "know it all," or they may simply not be understood. They may have areas of interest which are markedly different from those of their age-peers, often driven by their greater cognitive access to information and to interests in philosophical topics (Gross, 1998, 2002, 2004). When the children are asked to describe the experience of being gifted in qualitative terms, a common theme involves worrying a great deal about world problems, while feeling helpless to do anything about them (Galbraith, 1985; Kunkel, Chapa, Patterson, & Walling, 1992). Clark and Hankins (1985) interviewed 324 children ages 6-10, half of whom were identified as gifted. They found that gifted children were far more aware of current events and politics than were their classmates, and they thought about issues such as good and evil with far more sophistication. At times, even when an area of interest is shared, the specific nature of that interest may be different; for example, young gifted boys who have cultivated an interest in the latest

collectible card game may find that their agemates enjoy the cool pictures and superpowers, but are not able to engage with the game at a strategic level.

Furthermore, the talented may be painfully aware of their own isolation (Mahoney, Martin, & Martin, 2007), or how their intelligence may make others feel inadequate (Fahlman, 2004; Robinson, 2008). Kerr, Colangelo, and Gaeth (1988), in a questionnaire study of 184 high-achieving adolescents, found that while they tended to hold positive attitudes about their own giftedness, 90% of them reported "social problems" as the worst aspect of being gifted, and 43% of them felt that their giftedness had a negative impact on others. Qualitative inquiry into the experience of gifted children and adolescence yielded a theme of being harassed or harshly judged for being smart (Galbraith, 1985; Kunkel, Chapa, Patterson, & Walling, 1992, 1995). Peterson and Ray (2006a, 2006b) found that gifted students were somewhat more likely than average to be bullied before the end of middle school. Many who were being bullied reported feeling that they were at fault for being victimized and that they needed to suffer in silence or deal with the problem themselves. Sowa, McIntire, May, and Bland (1994) found that gifted children were far more consciously aware than average children would generally be about the social double-binds in which they often found themselves.

Having realized that others may not approve of how they present themselves, or even deciding that who they are may not be a good thing, gifted children often choose quite deliberate strategies for hiding their true nature. They learn to put on masks early (Gross,1998, 2004). Cross and colleagues (Coleman & Cross, 1988; Cross & Coleman, 1993, 1995; Cross, Coleman, & Terhaar-Yonkers, 1991; Cross & Swiatek, 2009) conducted questionnaire-based studies of almost 1500 students in a summer program for

high-achieving adolescents to determine if gifted children's social perceptions and reported behaviors were consistent with they hypothesis that these students perceived giftedness as a stigmatizing condition. They found consistently that gifted students were likely to see themselves as different from age-peers at their regular schools, to believe that these differences had a negative social effect on them, and to report that they would use social strategies (such as dishonesty, hiding accomplishments, or making self-deprecating statements) to minimize the level to which other students were aware of their high intelligence or achievement. Students who felt more different from others were more likely to report using concealment strategies and to report that they felt that they couldn't really "be themselves" in their regular school programs. In interviews, students stated that a year-round program with students like those at the summer program would be like "heaven," not just because of the academic opportunities, but also because of the opportunities to fit in socially. Similar results were found in a study of 3rd-7th graders in another summer program for gifted children (Swiatek, 2002). Silverman (1993d) pointed out the deep conflict between the need to be recognized and valued and the need to fit in, and raises the concern that too much effort to hide can result in problems in identity development. Mahoney's model of therapy is based around the need to provide support for identity formation (Mahoney, 1998: Mahoney, Martin, & Martin, 2007). These research and clinical observations bring to mind D. W. Winnicott's theoretical idea of the false self (1960/1965), which may serve to protect the true self, but can too easily come to suppress or even replace it.

Gender, Cultural, and Family Issues

Gender sterotypes may also present a challenge, as both boys and girls of high intelligence tend to present with somewhat androgynous interests and habits. Females often present as more analytical and tomboyish than the norm, while boys are often more sensitive and empathic (Cohn, 2002; Kerr, 1991, 1997; Kerr & Cohn, 2001; Kerr & Nicpon, n.d.). Piirto (1998) found that this pattern was also evident in MBTI types of gifted adolescents, with girls more likely to report thinking types and boys more likely to report feeling types than the average for their age and gender. Peterson and Rischar (2000) found in qualitative research that gifted adolescents who were also gay, lesbian, or bisexual, experienced increased isolation, feeling that both giftedness and gayness were shameful; many reported throwing themselves into overachievement in order to maintain acceptance from peers and family.

Conflicts between affiliation and achievement are often particularly intense for girls and young women (Kerr, 1991, 1997; Kerr & Nicpon, n.d.; Lovecky, 1990; Reis & Hébert, 2008), especially in young adolescence (Blackburn & Erickson, 1986; Gross, 1998). Both in informal research drawn from a large clinical sample (Noble, 1989) and grounded-theory methods (Fahlman, 2004), many gifted adult women report feeling strong internal conflicts, sensing that in some way it is not possible to be both gifted and a woman or mother. Women often disown their own intelligence and achievements, while readily agreeing that their partners or children are gifted. Prober (1999) described clients in her workshops who expressed feelings of needing to be a perfect mother, while also being torn between pursuing their own passions and supporting their children. Furthermore, while these feelings are rampant within the high achieving population,

bright women are especially vulnerable to feeling that their achievements are only illusory, that they are really "impostors" who will soon be found out (Clance, 1985).

The tension between achievement and affiliation, between being a good student and a good member of the group, can also be intense for gifted children who come from ethnic, cultural, or socioeconomic backgrounds which do not strongly value educational achievement, which may be viewed as "less than" by the mainstream culture, or which may not have the resources to provide academic challenge (Day-Vines, Patton, Quck, & Wood, 2009; Diaz, 1998; Evans, 1993; Ford & Whiting, 2008; Graham, 2009, Kwan & Hilson, 2009; Robbins, 1991; Tonemah, 1987; Worrell, 2009). Olszewski-Kubilius (2008) pointed out that families can differ widely in how much they explicitly value intelligence, achievement, quality, competition/independence, and cooperation/interdependence, and may hold different relative values for the achievement of males and females. Furthermore, they may act in ways inconsistent with those values, saying that they value education but putting explicit or implicit pressure to "not forget where you come from" (Lubrano, 2003). Intelligent individuals find themselves needing to code-switch (Day-Vines, Patton, Quck, & Wood, 2009), may feel that they are forced to choose between identities (Ford, Harris, & Scheurger, 1993), or may feel that they cannot fit comfortably in either identity (Lindstrom & Van Sant, 1986).

By contrast, some families and cultural groups are at risk for over-embracing the idea of their children's giftedness. Kwan & Hilson (2009) pointed out that perfectionist pressures on children are a particular pitfall for Asian families, but are found in many different groups as well. Feeling overly pressured to be perfect and to put forth maximum effort, and the challenge of being good in so many domains at once are

common complaints of gifted children and adolescents (Galbraith, 1985; Kunkel, Chapa, Patterson, & Walling, 1992, 1995). In some cases, a pattern of underachievement can represent a rebellion against the family's overinvestment (Rimm, 2008a, 2008b; Whitmore, 1980). Miller (1981) pointed out the potential risk of parents relying too extensively on their children's achievement for their own narcissistic fulfillment, and other writers (Glickauf-Hughes, Wells, & Genirberg, 1987; Grobman, 2006; Rotenberg, 2006) have pointed out that they see the predicted narcissistic dynamics in their own clients. In the realm of elite sport, Ogilvie, Tofler, Conroy, and Drell (1998), and Tofler, Knapp, and Drell (1998, 1999) have conceived of an "achievement by proxy spectrum." They described the differences between healthy and unhealthy reciprocal interactions between parents, coaches, and children, as the child is increasingly used as an object for the gratification of adult needs or fantasies. This model does not appear to have been empirically verified in either domain.

Problems can also result from a family adopting an overly child-focused stance, overempowering the child and making excuses for their poor performance, rather than seeking solutions to problems that arise (Rimm, 2008). In a study combining individual, family, teacher, and peer interviews, Sowa and May (1997) found that gifted children who came from families which focused heavily on the need for the child to conform to adult expectations tends to adopt a perfectionistic style, ignoring their own emotional needs in a continual effort to please parents and teachers. By contrast, when a child came from a family that was overly centered around the child's needs, where parents assumed that any conflict between child and environment was merely evidence that their child was not properly understood and valued, the child tended to refuse to adapt to social

demands. A balanced approach within the family was more conducive to the child's developing a more flexible and adaptive stance when interacting with the world.

Intensity and Psychopathology

The patterns of emotional and ideational intensity described above can be both blessing and curse. Gifted individuals often display high aspirations, as well as creative and divergent thinking (Boland & Gross, 2007; Lovecky 1986, 1992, 1993). Some literature (reviewed in Keiley, 2002) suggests that gifted individuals may have weaker abilities to regulate affect, although the data is inconsistent and firm conclusions cannot yet be drawn. Lovecky (1992) pointed out that cognitive strengths commonly found in gifted individuals can also function as risk factors. Rapid, intense, and divergent thinking, combined with drivenness, can interfere with concentration, and even result in rumination, difficulty in reflecting and relaxing, or insomnia; emotional sensitivity, combined with perceptiveness, can result in overwhelming feelings of grief, fear, perfectionism, need for justice, existential crisis, and self-doubt. In particular, internalizing issues, such as depression, anxiety, obsessive-compulsive disorder, eating disorders, and perfectionism, are not uncommon in the gifted (Grobman, 2006; Keiley, 2002; Neihart, 2002a; Schuler, 2002). A survey of 112 gifted middle schoolers (Schuler, 2000), showed that 87.5% of them were perfectionistic, with 29.5% endorsing neurotic levels of perfectionism. In Jackson's (1998, 2003) qualitative research, she presents the experiences of depressed gifted adolescents; they speak vividly of how their feelings of isolation and shame contribute to depression, and how they feel the need to hide their distress even from those closest to them.

As with many other psychological problems, when viewed as a group, gifted individuals do not appear to be more or less likely to express suicidal ideation or to engage in successful or unsuccessful suicide attempts than those of average intelligence, once variables such as age, gender, and MBTI personality dimensions are taken into account (Baker, 1995; Cassady & Cross, 2006; Cross, Cassady, & Miller, 2006; Delisle, 1986; Gust-Brey & Cross, 1999). It is relevant to note, however, that Cross's research is based, like the Terman studies, on a population already selected for positive adaptation: 11th graders with a strong and multifaceted history of high achievement, at a public residential high school for gifted students. Furthermore, the self-report questionnaire about suicidal ideation was given just as these students began at the school and asked for students to report their feelings over the past 30 days. This is hardly a time when students are likely to be stressed and despairing, much less willing to admit to those feelings on a questionnaire. Cassady and Cross (2006) did note that, in doing exploratory factor analysis, the suicide-related thoughts these high-achieving adolescents did express were more multidimensional than are those of students with average intelligence. These students considered not just the pragmatics of suicide, as adolescents of average intelligence commonly do, but also expressed rigid cognitive ideas about what they viewed as untenable situations, as well as concerns both about people being sad that they were gone and people being happier without them.

Lifespan Developmental Concerns

As highly intelligent individuals go through developmental stages, they have, more or less, the same needs as everyone else, even if the timing and the precise details of the stressors may be different. However, because of internal asynchronies and

differences in the larger systems in which they typically find themselves, the kinds of specific experiences they may have may be quite different from the norm. When considered in the context of Erikson's (1950/1963) developmental psychosocial conflicts, gifted children often show a mix of conflicts atypical for their age. At the same time, they may have difficulty addressing the conflicts typical for their age. For example, it can be difficult to develop a sense of competence in the school-age years when work tends to be far too easy, but systemic rules and social or emotional immaturity restrict their access to more appropriate classrooms. Bright students may have difficulty finding adults capable and willing to serve their normal selfobject needs for idealization, twinship, and empathic mirroring, as described in Kohut (1977). Instead, they may feel unappreciated, misunderstood, or even openly rejected and may retreat into patterns of nihilistic or perfectionistic underachievement. It can also be difficult for them to establish a sense of identity with a peer group in adolescence when they have so often been isolated from peers, or when they fear that high achievement will result in social rejection. Those who have learning styles poorly matched to the usual classroom practices, or who have concomitant learning disabilities, are further at risk (Assouline, Nicpon, & Huber, 2006; Blackburn & Erickson, 1986; Kerr, 1991; Olenchak, 1999; Peterson, 2007b).

The transition from "child prodigy" to "skilled practitioner" to "eminent adult" is fraught with pitfalls. Some choose a life direction too early, based upon their early mastery of basic content in a domain, and realize much later that the life of the profession is different from what they expected as children. Some are confused by the many possibilities available to them, and find it difficult to narrow their interests enough to

permit focused study. At some point in the process, they "hit the wall," reaching a level of complexity and difficulty where things do not come easily. Similarly, at some point, the "adoring public" becomes less concerned about the manifestation of prodigy and promise, and more interested in the actual production of useful work. Gifted students tend to experience these changes as narcissistic injury. While some are resilient in the face of challenge and possible disaster, others are not; they may avoid or devalue tasks, people, or environments which threaten their "always effortlessly perfect" self-image. "I didn't try very hard" becomes an excuse for incomplete success. Alternatively, they may drive themselves harder and harder, becoming increasingly self-critical over their perceived failures. (Blackburn & Erickson, 1986; Dweck, 2007; Glickauf-Hughes, Wells, & Genirburg, 1987; Kerr, 1991; VanTassel-Baska, 1989). Peterson, Duncan, and Canady (2009) found, in their longitudinal study of gifted students through grades 2-12, that the subjects tended to report experiences related to achievement (academic challenges, school transitions, and overcommitment), as well as peer relationships, as the most stressful, even when they had also experienced significant life events (e.g., death in family, trauma) that most adults would assume would be more challenging. Although this phenomenon is not extensively studied in the literature, my experiences with highly intelligent adolescents and young adults with serious emotional problems, including suicidality, has been that their distress is often related to a narcissistic injury, some threat to their perception of themselves as perfect, that is for them a novel experience (for example, the first B+ grade, not experienced until college). Many theorists (e.g., Simonton, 1998) have suggested that early misfortune well-navigated is important in the development of genius.

Despite the field's extensive focus on giftedness as a school-bound phenomenon, the cognitive tendencies toward intellectual restlessness and creative, unconventional, and philosophical thought do not go away with high school or college graduation (Lovecky, 1990; Nauta & Corten, 2002; Plucker & Levy, 2001; Willings, 1984). Gifted adults often experience difficulty in adjusting to the expectations of many workplaces or other hierarchies for conformity, "team play," and the balance between "making it better" and "not making other people look or feel bad." At times, the jealousy of others may interfere both with professional relationships and career development. Some find themselves frequently coming into conflict with authorities and changing careers. They may also have difficulty in making role transitions — from student or mentor to colleague, for instance. A number of strategies have been described (Nauta & Corten, 2002), including attempting to remain inconspicuous, finding a niche where high intelligence is valued or tolerated, developing social skills to adapt to the workplace, remaining isolated, or remaining true to the self but coming into frequent conflict with others. With the last strategy, gifted adults typically attempt to keep the focus on the quality of their work. Prober (1999) finds that many gifted women find the everyday tedium of motherhood stultifying. Although the extant research base has not included direct comparisons to individuals of average intelligence, Chauvin (2000) found in clinical work that the cognitive characteristics of gifted adults render them particularly concerned with spiritual or existential matters. In a study combining questionnaire and interview methods, spiritual concerns were found to affect the work, relationship, and life satisfaction of gifted adults (Perrone, Webb, Wright, Jackson, & Ksiazak, 2006).

Summary

In general, the literature regarding risk and resilience factors for gifted individuals and psychopathology tends to take on a flavor of advocacy for one point of view or the other. Some writers attempt to show that highly intelligent people are frail, tortured geniuses, who desperately need extra help in order to be able to survive. Others hold up the image of the super-genius who is good at everything and can easily manage whatever stressors the world presents. They quite reasonably raise concern about the perils of too enthusiastically embracing a victim role. Typically, the first group are clinicians; by definition, the clients they see are more likely to be those who are having difficulty in adaptation. At conferences and in journals, they tend to present qualitative research, in part because they often do not have access to samples large and homogeneous enough to do large-scale quantitative studies, and in part because the complexities of individual experience would be lost if boiled down to numerical form. Similarly, the second group tend to be researchers and educational administrators who oversee programs with competitive admissions policies. Their experience is with gifted individuals who are typically not in crisis, and who typically had to demonstrate consistently high patterns of achievement before they could be accepted into the programs from which they were recruited as research subjects. As with the original Terman studies, they have selected a subgroup of individuals based upon their ability to respond optimally to the environment and have attempted to generalize the results to the entire group.

Naturally, both perspectives are oversimplified. Like everyone else, gifted individuals have strengths and weaknesses. The population is tremendously diverse; exactly how the balance of any particular individual's life plays out can vary widely. If

anything can be concluded from the literature, it is that widespread preventative psychotherapeutic interventions for this group may be a poor use of resources, and that many of the most valuable prophylactic strategies may be inexpensive or cost-free ones which serve merely to break the isolation that gifted individuals often experience. Because the current study is about the process of conducting individual psychotherapy for gifted clients, we must take it as given that for some individuals risk does, at least temporarily, overwhelm resilience, and that these painful experiences may be part of what brings them in for therapy. Given that they are in our offices, it would behoove us as practitioners to understand better how to collaborate with them effectively in therapy.

Providing Therapy for Gifted Clients

Availability of Professional Training

Sadly, despite the fact that gifted individuals are likely to be present in almost every environment where therapists work, there is little guidance available for professionals. The guidance regarding therapy for highly intelligent clients has largely come from those clinicians who have chosen to work with this population, often because they themselves identify as gifted. Their ideas have generally been drawn from their own clinical and personal experiences. Many models have been proposed, representing a wide variety of theoretical backgrounds and therapeutic modalities (Moon, 2007, 2009; Peterson & Moon, 2008). However, there has been little empirical work to test the efficacy of any of these approaches. Probably because of the common misconceptions that smart people will do just fine without help (National Association for Gifted Children, n. d.; Saunders, 2007; Winner, 1996), or that, even if they do need help, high intelligence

would be irrelevant to the therapy, there has historically been little interest in research into the therapeutic needs of this group.

With little interest comes little funding; federal, state, and professional organizations provide little or no money for this purpose (Peterson & Moon, 2008). There is a small amount of money for research of gifted children and adolescents available through the American Psychological Association, but this is only because of a single individual who donated the bulk of her estate with the proviso that it be used for this purpose (Friedman & Rogers, 1998). No funding is available for studying gifted adults. At the federal level, the only public funding is a relatively tiny amount of money (totalling $7.5 million nationwide in FY 2008), through the Javits grants, to fund local short-term demonstration projects in the public schools aimed at educating gifted students from underserved minority groups. Research into therapeutic issues would not fall within the purview of this grant program (United States Department of Education, n. d.).

Furthermore, the continual struggle over definition has sharply interfered with the ability of the field to move forward. In a survey of experts in the field of giftedness, Pfeiffer (2001, 2003) found that the almost universally identified problems of definition and identification methodology were the most pressing issues and unanswered questions in the field. Much smaller percentages (not enough to merit categories of their own in Pfeiffer's analysis) identified developmental, environmental, and family issues, while issues of providing psychotherapy were not even mentioned. Many of the most clinically relevant samples, such as gifted individuals with concomitant learning disabilities or psychological disorders, are extremely difficult to identify and recruit in ways that would allow the resulting research to be convincing to a skeptical audience (Peterson & Moon,

2008). While other areas of psychology certainly argue over definition, they do not seem to be paralyzed by this perfectionist trap: refusing to study "it" until we can all conclusively agree on precisely what "it" is.

Even what is generally accepted about counseling highly intelligent people, gleaned from the clinical literature, is rarely taught to preservice or inservice professionals. Peterson & Wachter Morris (in press) found that, of all masters'-level training programs certified by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), 38% devoted no training time at all to the needs of the gifted, 8% gave an hour or less, 39% gave 2-3 hours, 11% gave 4-6 hours, and only 4% required more than 6 hours. Respondents cited a lack of available information, a lack of local expertise, a lack of interest in the topic among the faculty and administration, and the fact that there were no state, national, or accreditation agency standards requiring the inclusion of information about this population in the already packed curriculum. Since the study was done (in 2007), the National Association for Gifted Children has prevailed upon CACREP to include a few rather vague references to ability and exceptional ability in their standards (CACREP, 2009; J. S. Peterson, personal communication). Other developed countries are similar in their absence or near-absence of professional training for school counselors about the needs of gifted students (New Zealand: Blackett & Hermansson, 2005; Germany: Heller, 2005; Canada: Lupart, Pyryt, Watson, & Pierce, 2005; Sweden: Persson, 2005; France: Vrignaud, Bonora, & Dreux, 2005). At the doctoral level, there have been no studies of training program curricula or licensure requirements. Training in how high intelligence in a client can affect the practice of psychology is not required for licensure in Massachusetts, for example.

Within the APA, there does not appear to be much interest in the topic of understanding how to provide therapy for highly intelligent people either. As Robinson, Zigler, and Gallagher (2000) point out, there is an entire division (Division 33) devoted to issues of developmental disability; at the time of their writing, this division had approximately 750 members. In contrast, fewer than 70 members of the APA self-identified as being interested in giftedness. While one might suggest that the gifted are a small fraction of the population, perhaps not deserving of a division, it is worth noting that the APA has other narrowly-focused divisions, including military psychology (Division 19), applied experimental and engineering psychology (21), hypnosis (30), peace psychology (48), and psychologists in the media (46). As mentioned above, the only reason there is a Center for Gifted Education Policy in the APA Education Directorate is because of a restricted donation (Friedman & Rogers, 1998). Its mission is explicitly focused around "enhanc[ing] the achievement and performance of children and adolescents with special gifts and talents" (American Psychological Association, 2009). Note that gifted adults are not considered, nor does there seem to be much consideration of the psychological needs of the human beings in which these gifts are embodied. The language implies that these are perfectly ordinary people who happen to have come into possession of some odd thing, which itself is what requires nurture.

Approaches Used for Therapy With Gifted Clients

Gifted individuals and families seek out counselors and psychologists for a wide variety of reasons, most typically when a significant environmental mismatch has resulted in problems for a child, such as underachievement, peer conflict, or conflict with teachers. Counselors, therapists, and psychologists are often called upon to serve in a

consultative role within the educational system (Edwards & Kleine, 1986; Peterson, 2007a; Wolf, 1989). Typically, when parents speak with psychologists, they are seeking standardized assessment and recommendations to use in an advocacy situation. However, parents also seek out therapy to help themselves or a child manage complex family relationships, confront life cycle transitions, adjust to issues raised by an individual's high intelligence, or cope with a frank internalizing or externalizing disorder (Kerr, 1991; May, 2000; Peterson & Moon, 2008; Yoo & Moon, 2006). Gifted adults often have problems with fitting in socially or at the workplace or finding an appropriate direction for their life (Willings, 1984). A number of different therapeutic models are reported in the literature, primarily as reports of individual clinicians' ideas and practice.

Academically-Focused. One of the most common issues triggering clinical intervention is underachievement, when a child fails to live up to the expectations parents or teachers have for them. However, as Ziegler and Stoeger (2007) propose, a more general model of increasing an individual's range of behavioral potential through targeted problem-solving interventions can be considered. The most well-known model for addressing underachievement is the Trifocal Model (Rimm, 2008a, 2008b), in which the individual, the home system, and the school system are encouraged to coordinate a joint effort. It involves six stages: a comprehensive assessment of the factors contributing to underachievement; a conference with parents and teachers; interventions to modify the expectations of the various players within the system, including the student, peers, siblings, parents, and teachers; helping the student identify with positive role models; correcting any specific skill deficits; and providing more targeted interventions as needed, depending upon the child's psychological motivation for underachievement,

whether it be anxiety, lack of motivation, a hidden learning disorder, an identity problem, or rebelliousness. Understanding the defense mechanisms underlying the problem is crucial in guiding the development of targeted interventions (Mandel & Marcus, 1988; Rimm, 2008a, 2008b; Saunders, 2007). Saunders (2007) pointed out the importance of maintaining a safe and trusting counseling environment, since children and adolescents are likely to view the counselor as an ally of the adults and a continued threat to their autonomy.

Career Counseling. Gifted individuals are also sometimes referred for career counseling or mentoring. Although little if any formal effectiveness research has been done, the clinical and theoretical literature has a relatively strong consensus about the issues (Casey, 2000; Greene, 2002, 2006; Kerr, 1991, 2007; Sampson & Chason, 2008; Silverman, 1993f). With early prodigious talent often comes a difficulty in choosing a direction, either because the individuals have too many options or because they are encouraged to foreclose their options too early. Career development and self-actualization are lifelong processes, which should begin quite young and be revisited throughout development. It is wise to focus on transferable skills and connections between fields, and to explore carefully which strengths can be the foundation for a career and which can evolve into a fulfilling avocation. Personality assessments can inform a sense of "match" as well. Mentorships and internships can help a youth understand what the daily life of a practitioner is like and how it might differ from that of a student of the domain. Special attention may need to be paid to those who emerge early from the home into specialized training or employment environments. While they may be functioning at an advanced level in the career domain, they may have other

developmental needs that are more typical of their age. It is also helpful to connect high-ability clients to adults who have changed careers, so that they can view that kind of change as a normal experience rather than as a sign of failure. It is important to help both children and parents achieve a healthy balance between rationality and hopeful fantasy, as well as between the need for guidance and the need for the child to have freedom of choice.

Parent Guidance. There are a number of forms of parent guidance presented in the clinical literature. Probably the most widespread is the Supporting the Emotional Needs of the Gifted (SENG) parent group model (Webb & Devries, 1998; Webb, Meckstroth, & Tolan, 1994), where parents are brought together in multi-family groups which are both psychoeducational and supportive in nature. Trained facilitators present information about what parents can expect as their children approach various developmental tasks, as well as about effective parenting strategies. However, one of the major purposes of these groups is to connect parents to each other and to help them consider how to reduce the isolation and negative judgment that many parents experience. Some groups also organize joint child care during the sessions, which serves not only to make it possible for both parents to attend, but also to encourage social contacts among the children. Many families develop long-term social contacts through these groups. There appears to be no outcome research on this approach, but many families informally state that they find it very helpful.

A related approach was developed by Morawska and Sanders (2008, 2009). Through questionnaire measures, they found that parents of gifted children were concerned about their childrens' emotional symptoms and their own difficulties with

parenting. These authors developed a brief multi-family group psychoeducational curriculum, focused primarily around positive parenting skills, and found that parents largely reported improvements, both in their confidence in using these parenting skills and in the children's emotional symptoms. For families not interested in group work, there are a great many psychoeducational books; a comprehensive and recent example is Webb, Gore, Amend, and DeVries (2007).

Group Therapy. For gifted and twice-exceptional children in the schools or in summer institutes, several authors recommend peer support group counseling, with a mixed psychoeducational and process approach (Colangelo & Peterson, 1993; Hébert, 2009; Mendaglio, 1993; Moon & Peterson, 2007b, 2008, 2009a; Peterson, Betts, & Bradley, 2009; Silverman, 1993d; VanTassel-Baska, 2009). These are typically designed as preventative measures. Youth are helped to learn relationship development, communications, and interpersonal effectiveness skills; to develop relationships and a sense of camaraderie within the group, reducing systemic isolation and achievement-affiliation conflicts; to learn about themselves as learners; to give and receive support around developmental transitions; to learn about self- and other-directed emotional awareness and to explore evocative issues, guiding the development of affective and behavioral self-regulation; and to develop a sense of life purpose or philosophy. Groups are generally more appealing to students if they are framed as "discussion" groups rather than therapeutic groups and if they are advertised as a resource for talking with "interesting" people about "stress," rather than initially using terms like "gifted." Some groups include bibliotherapy, videotherapy, art therapy, or guest speakers around topics related to intelligence and the experience of being different from agemates. Moon and

Hall (1998) suggest the use of psychoeducational books for gifted children and teens (e.g., Galbraith, 2009; Galbraith & Delisle, 1996) or those presenting the voices of gifted individuals describing their own experience (Schultz & Delisle, 2006a, 2006b). Very little consideration has been given to group therapies for highly intelligent adults; however, Prober (1999) described a set of workshops for gifted mothers in which she raised various common issues, the group chose the ones which resonated for them, and the participants journaled, discussed, and engaged in expressive therapy activities around them.

Within Native American communities, gifted adolescents are seen as being particularly at risk, both alienated from both their family and unrecognized within the mainstream educational culture (Robbins, 1991; Tonemah, 1987). Robbins, Tonemah, and Robbins (2002) developed a multi-family intergenerational group therapy model based in Native American traditions. They brought adolescent-parent or adolescent-grandparent dyads together in psychoeducational and experiential activities designed to increase trust and communication, and then had the groups work together on jointly-chosen leadership and community projects. Participants reported increased pride and identification with Native American heritage, confidence in their own leadership abilities, and communication within the family. However, these authors did not report data about changes in academic self-concept.

A similar approach was taken by Barnette (1989). A large group of gifted middle school students from rural Arkansas, attending a three-week summer residential program, engaged in an intensive three-day seminar on communications skills, group dynamics, personality types, problem-solving, and the balance between cooperation and

competition. They were then brought together in small groups with elderly retirees and assigned to work together with them to present a media project on some aspect of the experience of aging. Student self-reports during and after the program showed increases in self-esteem and group cohesion, and informal feedback suggested increased intergenerational understanding.

Expressive Therapy, Bibliotherapy, and Videotherapy. Expressive and literature-based therapies are also proposed as models for counseling highly intelligent individuals, typically as part of the preventative group therapies mentioned above, as well as in individual therapy. VanTassel-Baska, Buckingham, and Baska (2009) suggested incorporating drama, music, and the visual arts into therapy, both by presenting works of art by others which evoke relevant thematic material for the client to respond to, and by providing a forum for clients to express their own feelings and ideas. Because many gifted individuals are voracious readers, books can be particularly good prompts for encouraging them to explore ideas of identity and experience (Hébert, 1991, 1995, 2009; Hébert & Kent, 2000; Hébert, Long, & Speirs Neumeister, 2001), but movies can also be used effectively (Hébert & Speirs Neumeister, 2001; Milne & Reis, 2000) in work with many different demographics. Furthermore, non-print media may be more accessible to those individuals who are not avid readers. By engaging with a book or video in which the main characters grapple with problems similar to the readers', clients can be guided through a process of identification (recognizing that the character is like them), catharsis (realizing that other people have coped with similar problems), insight (understanding the coping strategies used by the characters) and application (using the ideas to inform their own real-world actions). Common themes include dealing with adversity, image

management, self-inflicted pressure, being labeled as "different," friendship, cultural expectations, gender role conflict, mixed messages, conflict within a family, emotional sensitivity, competitiveness, and conflicts between affiliation and achievement. Biographies can be particularly useful to help youth develop role models, although it is important that these be chosen for their relevance to issues the children struggle with, not merely selected from the popular athletes or celebrities of the day. Besides discussions within the group or with the therapist, reflective writing, roleplay, and other creative problem-solving activities can be used for follow-up activities. It is important to encourage affective engagement in the process, rather than a more distancing and intellectualized analysis. Halstead (2009) presents an extensive list of books that address various topics likely to be relevant for gifted youth. As in much of the literature on therapy for the gifted, case studies are presented, but no systematic research regarding efficacy has been done.

Family Therapy. There has been little formal research done on gifted families and specific issues of how high intelligence affects family dynamics; most of what has been suggested is based on theory or clinical observation. In general, families of high achievers tend to be supportive, well-adjusted, cohesive, communicative, and oriented around the needs of the child. Parents tend to be older and more highly educated. However, children often experience significant pressure to meet at-times unrealistic family expectations and may feel that their worth as a person is conditional upon their high achievement in everything they do. Families of creatively gifted children typically value nonconformity, which may create risks for children as they interact with the educational system (Bourdeau & Thomas, 2003; McMann & Oliver, 1988; Moon, Jurich,

& Feldhusen, 1998; Moon & Hall, 1998). However, it is possible that these above-average family images may reflect more of a need to present a positive front than actual reality (Glickauf-Hughes, Wells, & Genirberg, 1987). Silverman and Golon (2008) pointed out that because intelligence is highly heritable, families often include many members, not just the identified individual, who are bright, intense, curious, energetic, argumentative, and concerned with issues of justice and fairness; these authors use the term "living opera."

If parents, siblings, and others within the extended family hold misconceptions about giftedness, endorse differing values about some aspects of the gifted experience, or have not fully metabolized their own relationship to intelligence and the effects it has had on their own lives, the stage can be set for intrafamilial or extrafamilial conflict. Siblings may compete for parental approval or affection; roles may become rigidly defined as the "good child" and the "scapegoat." Parents may feel guilty over having a child who is not "normal," inadequate to the the challenge of caring for a child with unusual needs, or intimidated by a child whom they may see as superior to them. They may feel the need to project an idealized image to outsiders or may feel burdened by the implied responsibility to society of raising a future Einstein. They may have difficulty trusting their own perceptions of their child's abilities or in establishing trusting relationships with professionals. Inappropriate educational environments and the at-times harsh views of others about intelligence are often grist for considerable family stress (Alsop, 1997; Bourdeau & Thomas, 2003; Fornia & Frame 2001; McMann & Oliver, 1988; Moon, Jurich, & Feldhusen, 1998; Moon & Hall, 1998; Silverman, 1993d; Silverman & Golon, 2008; Thomas & Ray, 2006; Thomas, Ray, & Moon, 2007; Wendorf & Frey, 1985). I

personally have seen many conflicts where one parent (usually the mother) takes on a rescuing "mother bear" role, often openly warring with educators, while the other parent, or a grandparent, does not view the child's situation as problematic and may undermine the efforts.

Furthermore, the child's high intelligence can potentiate a process whereby a child takes on too much power within the family. Giftedness can become an "organizer," where family identity and resources are overly invested in the child's academic and emotional needs, and where all problems are attributed to the child's intelligence. Alternatively, when the parental subsystem is weak, when one parent (often the father) is absent or distant, or when there is conflict between parents for any reason, the child's advanced cognitive development and perceptiveness can draw them into a parentified role. A child may become triangulated between the two parents, may become a buffer between them, may become a "third parent," or may become so focused on the parents that they have difficulty in developing other relationships (Alsop, 1997; Fornia & Frame, 2001; Glickauf-Hughes, Wells, & Genirberg, 1987; Lovecky, 1992, 1993; McMann & Oliver, 1988; Miller, 1981; Moon, Jurich, & Feldhusen, 1998; Moon & Hall, 1998; Wendorf & Frey, 1985).

Very little work has explored sibling relationships within gifted families. Although early research suggested that siblings not labeled as gifted were at increased risk of low self-esteem (Cornell, 1983), there seemed to be little risk over the long term (Colangelo & Brower, 1987a, 1987b). Tuttle and Cornell (1993) found that a mother's identifying one child as gifted and one child as not gifted did not cause problems in the sibling relationship, although relationships in which the gifted child was older were seen

by the nonidentified child as being warmer, while those in which the age pattern was reversed were seen as more distant.

Most of the extant theoretical and clinical work revolves around the experiences of middle-class Anglo families. Exum (1983) pointed out that, in conducting therapy with African-American gifted families, it is important to consider where the family and child are in the process of ethnic identity development (Cross & Cross, 2008; Vandiver, Fhagen-Smith, Cokley, Cross, & Worrell, 2001). Parents, concerned that they will lose authority over their child, or that their child will lose respect for them or for their community culture, may become increasingly authoritarian. They may worry that their child will lose the ability to interact normally with other people within their community if they develop their talents and independence too greatly. Alternatively, the tension between their pride in the child's accomplishments and their fear of losing the child or their own status within the community may become enacted within the relationship, sending deeply mixed messages to the child.

In terms of therapy models, three primary methods appear in the literature: gifted-specific methods, methods based in structural-strategic and other classic family therapy ideas, and postmodern approaches. These methods are often used in combination within a single treatment. The Belin-Blank model of therapy is designed around the needs of families who are generally well-adjusted, but who are experiencing specific stressors around a child's giftedness; referrals are typically made when a child is seen as underachieving. It is a brief, problem-solving model, often involving significant psychoeducation and connection of the family to resources within the gifted community, as well as educational observation, problem-solving and even advocacy. It is typically

more directive than other therapy models (Thomas, Ray, & Moon, 2007; Wendorf & Frey, 1985). Other clinicians report focusing therapy around helping the family come to an integrated understanding of intelligence and how it affects family life. In particular, Silverman (1993e, Silverman & Golon 2008) emphasized the importance of parental self-discovery. Structural-strategic approaches (e. g., Minuchin, 1974; Minuchin & Fishman, 2004), including the use of genograms (Gerson, McGoldrick, & Petry, 2008), are widely cited as being important in helping gifted families whose internal relationships have become distorted (Moon, Nelson, & Piercy, 1993; Thomas & Ray, 2006; Thomas, Ray, & Moon, 2007; Wendorf & Frey, 1985; Zuccone & Amerikaner, 1986). Postmodern approaches, such as narrative therapy (Combs & Freedman, 1996; Freeman, Epston, & Lobovitz, 1997; White, 2007), may be particularly well-suited to the communicative, analytical, postconventional, and imaginative strengths of these families. Although families typically come to therapy looking for an expert to help them solve their problems, Bourdeau and Thomas (2003) presented three case studies showing that families were able to adjust to a nonhierarchical therapy model with little difficulty. Techniques such as externalization of the problem, thickening of problem descriptions, imagining of the solution, and the use of story, metaphor, and fairy tale can be helpful for families to put the past into perspective and construct new systems of meaning (Fornia & Frame, 2001; Thomas, 1995, 1999; Thomas & Ray, 2006, Thomas, Ray, & Moon, 2007).

Individual Therapy. A number of clinicians have written about their own work with highly intelligent clients in individual therapy. Some of them specifically organize their work around the cognitive and affective characteristics and the common cultural experiences of gifted individuals. Others provide more general types of therapy, but

remain aware of how these traits can affect the content or course of therapy. These describe a wide range of therapeutic approaches, representing behavioral, cognitive, systems, psychodynamic, and humanistic perspectives. Most authors describe integrative approaches which they personally have found effective. Unfortunately, no formal research studies have established whether any of these methods are efficacious or whether they provide improved outcomes for clients as compared to treatments that are not based in an awareness of giftedness, and no curricula have been published to train therapists unfamiliar with this population.

One common theme in the literature is the need to guide clients toward a greater understanding and acceptance of the very fact of their intelligence (Boland & Gross, 2007; Grobman, 2006; Gross, 1998; Hazell, 1999; Jacobsen, 1999; Lovecky, 1986, 1990, 1992, 1993; Mahoney, 1998; Mahoney, Martin, & Martin, 2007; Rocamora, 1992; Silverman, 1993c). Although the concept may be unexpected for a therapist who has not shared this experience, many gifted clients are unaware of or are conflicted about their intelligence, even if it was officially recognized in some form during childhood. Without a true peer group for reference, and often after a series of social or vocational failures, they may have come to believe that there was something wrong with them because they were unable to "act normal" or because they believed they made others feel bad. They may have been officially identified as gifted at some point, but may have felt the need to disown the label, assumed that it expired when they were no longer placed in special programming, or believed that the identification was merely a mistake and that they were actually impostors. Part of the work of therapy, then, becomes to help them integrate intelligence into their self-identity. Schwartz (2010, personal communication), suggests

that this area may be one where the therapist's own manifest intelligence may be particularly important in establishing the therapist's eligibility to recognize and appreciate intelligence in a client.

Tied in with the need for acceptance of the fact of one's intelligence is the need to for a client to understand how intelligence may have affected their experience of the world (Chauvin, 2000; Grobman, 2006; Hazell, 1999; Jacobsen, 1999; Lovecky, 1986, 1990, 1992, 1993; Mahoney, 1998; Mahoney, Martin, & Martin, 2007; Mendaglio, 2003, 2007; Peterson, 2007b; Peterson & Moon, 2008; Rotenberg, 2006; Silverman, 1993c). Many clinicians cite the importance of providing psychoeducation about the cognitive and affective characteristics of gifted individuals. On the one hand, clients may need validation and normalization for experiences that they and others may have seen as pathological; for example, as described above, a tendency toward sensitivity and compassion may have been seen as immaturity, an intense personality may have been interpreted as mania or hyperactivity, or divergent thinking may have been seen as a sign of distractibility or insubordination. Existential thinking and passion for justice may not have been recognized or supported, particularly in the younger years. Those who are highly perceptive and intuitive may wonder what is wrong with *them* that they do not see things the way others do. On the other hand, these personality traits may well have created difficulties in adaptation. Rather than maintaining the comforting fiction that all of their problems result from being misunderstood or from other people's being stupid, highly intelligent clients are likely to benefit from work on accepting the world as it is, understanding their own role within what they have experienced, and learning to manage their intensity effectively. They may need to learn how and when to point out when

things are wrong and to fight for what they believe and how to tolerate not doing so. Similarly, they may need to learn to guard their own vulnerability, while staying attuned to the needs and feelings of others, and to navigate developmental transitions without becoming overwhelmed by change and loss.

Many authors describe the tension between achievement and intimacy, or between self-reliance and interdependence, as being crucial themes in individual therapy (Anthony, 1988; Boland & Gross, 2007; Chauvin, 2000; Glickauf-Hughes, Wells, & Genirberg, 1987; Grobman, 2006; Gross, 1998; Jacobsen, 1999; Kerr, 2007; Lovecky, 1986, 1990, 1992, 1993; Peterson, 2007b; Rocamora 1992; Rotenberg, 2006). Winnicott's notion of the "false self" (1960/1965), which may be created to protect the true self, but may end up completely hiding or replacing it, is often cited. Clients may have submerged essential aspects of themselves in order to be successful in jobs or relationships, having found that the traditional advice to "just be yourself" was counterproductive. Some may have avoided rejection by accomplishing what other people expected from them, or avoiding situations which risk exposing their true and imperfect selves. Meanwhile, a deeper sense of life's purpose may have been left unfulfilled. One part of themselves may crave excellence and recognition, or desire to use their strong intellect to get what they need from others, while another part may hate themselves, or may fear that others will hate them, either for feeling superior or for "misusing" their talents. One part may wish to connect with others and to receive nurturance, while another part may despise these feelings of neediness, weakness, imperfection, or incompleteness. Conversely, they may struggle with the difficulties involved in serving others. All of these tensions may have been complicated by unusual

developmental patterns, such as a difficulty establishing connections with age-peers, or precocious entry into adult responsibilities. An essential element of therapy then becomes to understand the complexity of these contradictions, to learn how to accept the various aspects of self and other in an integrated fashion. Neihart (1999) suggested using systematic risk-taking, both in academic and social domains, as a specific intervention for the fear of failure and rejection.

Relational Challenges. Despite the common assumption that intelligent clients are easier to work with, several authors have noted that they may also present unusual challenges within the therapeutic relationship. They may have had a history of problems with previous helper or authority figures, whether teachers, counselors, or therapists; particularly if clients are not the ones choosing to enter therapy (e.g., in the case of most child or adolescent clients), they may be quite wary. Furthermore, therapists must take care to reflect on their own feelings about achievement, underachievement, intelligence, self-regard, and their own educational and social experiences (Peterson, 2007).

The therapist should remain aware of how advanced cognitive development can affect how a client responds to therapy (Boland & Gross, 2007; Lovecky, 1986, 1990, 1992, 1993; Peterson, 2007; Silverman, 1993c). The client may need a faster pace; it may be hard for a therapist to keep up with the flow of ideas in all directions, to recognize the themes which are most significant, and to focus the client on what is salient for constructive problem-solving. Particularly for younger clients, it is important not to underestimate what they can comprehend about what is going wrong in their lives, what therapy is, and how therapist and client will work together. Gifted children may experience not just an insult, but also a failure of empathy, when a therapist does not

quickly grasp the level of their capacity for linguistic complexity and abstract thought. Furthermore, young gifted clients do not appreciate a therapist taking on an overly positive stance, with a fake smile, a simple answer, and an attitude that does not take seriously the pain they are experiencing.

Highly intelligent clients may feel that therapists do not fully understand them, and, in fact, therapists may not always be able to keep up with the complexity of their clients' associations. Furthermore, when clients have particular domains of passion or expertise, they may feel that therapists do not understand how they view things in these domains. If therapists cannot manage the anxiety provoked either by their own recognition of what they are missing or the clients' accusations of their lack of understanding, they may be tempted to try to pretend that they do understand and hope that the client does not see through the falsification. However, it would be far wiser to simply agree that they do not know, but will try to understand what the ideas mean to clients and how they might be relevant to therapy (Jacobsen, 1999; Lovecky, 1986, 1990, 1992, 1993). As Kohut (1977) suggested, an honest effort, even if unsuccessful, may support the relationship.

Several scholars have noted that clients may constantly question the therapist's premises or technique, may have considerably more knowledge of psychological theory and technique than the typical client, and may take a more openly skeptical, controlling, or even contemptuous stance toward the therapist (Anthony, 1988; Glickauf-Hughes, Wells, & Genirberg, 1987; Jacobsen, 1999; Peterson, 2007; Silverman, 1993c). Because many exceptionally intelligent people learn through an active, argumentative confrontation with material, they may seem oppositional, even when they are merely

trying to understand. Furthermore, they may become so interested in the content that they forget the presence of the therapist as a person, and may need guidance in how to maintain more reciprocity in relationships. They may also expect a less hierarchical relationship with the therapist, demanding more honesty and self-disclosure than many therapists are comfortable with. A collaborative stance, with the client as an empowered agent, may be particularly important. As with all self-disclosure (Gaines, 2003; Geller, 2003; Knox & Hill, 2003), therapists should consider which aspects of their personal history or in-session experience would be appropriate to disclose. For example, identifying as a gifted individual could provide confirmation of the therapist's eligibility to engage in the relationship and to accurately understand the clients' experiences, or might be seen as competitive with or devaluing of the clients' talents. Similarly, the therapist's disclosure of their immediate experience with the client might or might not be tolerable to the client, even if the client had asked about it.

Lovecky (1986, 1990, 1992, 1993) pointed out that a therapist may also be surprised, or even taken aback, by a perceptive client's ability to intuit the therapist's unspoken thoughts and feelings. The client may speak about this material openly, or may use the knowledge covertly to manipulate the therapeutic process and avoid real engagement. There may be a tendency for the roles of therapist and client to reverse, with the client trying to take care of the therapist. Alternatively, the client may become overinvested in impressing or pleasing the therapist. The therapist may need to explore this underlying assumption of being responsible for everything and needing to have every offering accepted, so as to help the client become more comfortable with receiving nurturance and with differentiating their own needs from those of others.

Many clients who might appear brilliant and confident on the outside feel internally that their true self is inherently defective or socially unacceptable. A number of clinicians have found that this often-unspoken feeling may affect the relationship (Jacobsen, 1999; Peterson, 2007; Rotenberg, 2006; Silverman, 1993c). Both because of ambivalence about change and because of possible real-world painful experiences, they may be particularly vulnerable to believing that the therapist is trying to change them into something they are not, to "cure" their giftedness. Often, in the push to help a client have what the therapist believes would be a "normal" life (particularly a "normal" childhood), the therapist sends the message that something is "wrong" with the client's experience, that the client should "just stop being so sensitive," or make more socially-prescribed choices about how to spend time and energy. However, on the other side of the coin, a therapist who suspects that disowned giftedness may be part of a client's distress should not push this label too emphatically, because doing so may provoke additional anxiety and resistance to therapy (Jacobsen, 1999).

Similarly, within the therapeutic relationship, clients may require considerably more validation than one might expect (Boland & Gross, 2007; Lovecky, 1986, 1990, 1992, 1993; Peterson, 2007). They may say that they feel stupid, incompetent, or fraudulent, and the therapist must understand that these feelings may be very real, even if the outward evidence of accomplishment seems incontrovertible. It is important for therapists to validate surface strengths without being seduced by them and without forgetting that they may mask a vulnerable core. However, clients may reject reassurance if it is too obvious or condescending, or if therapists cannot establish their

right to an expert opinion. The failed attempt may be seen also as a failure of empathic connection.

Especially when clients have been referred because of chronic underachievement, or an interruption in a previously-excellent string of achievements, they may feel that the therapist is more interested in the products of their talents than in them as a person (Jacobsen, 1999; Peterson, 2007; Rotenberg, 2006). They may feel a subtle or overt pressure from the therapist to get back to the business of manifesting their talent, or may suspect that the therapist sees them as an object through which to live vicariously, or about which to brag. When clients bring the products of their talent into therapy, either in concrete form or through discussion, the therapist must figure out whether this is an attempt to impress or placate the therapist, or whether it is an attempt to help the therapist understand their experience. If the therapist fails to notice this bid for connection, or even resists allowing the client to bring it up, the client may feel that these parts of the self have been rejected.

The appropriate balance between the intellectual and the emotional may be different for the client whose mind delights in ideas (Boland and Gross, 2007; Silverman, 1993c). Even at young ages, philosophical exploration or sophisticated humor may be effective ways for bright clients to "mess around" with new concepts and come to accept them. However, insight at the cognitive level does not always translate immediately into affective or behavioral change. Clients may need to learn to play in these less-familiar realms as well. Furthermore, clients who are a fascinating conversationalist may lure both themselves and the therapist away from their deepest pain; both may think that

therapy is occurring, but it is the "false self" (Winnicott, 1960/1965) who is participating (Hazell, 1999; Glickauf-Hughes, Wells, & Genirberg, 1987).

Therapists may feel envious of or in competition with the client (Anthony, 1988; Jacobsen, 1999; Peterson, 2007; Rotenberg, 2006). They may feel the need to engage in one-upsmanship, showing off their knowledge of the client's domain of talent. Alternatively, they may attempt to demonstrate their own superiority within the therapeutic relationship by providing too many answers, too much advice, insisting upon too much control, or even by frankly degrading the client. The struggle for dominance would be, of course, highly countertherapeutic.

As mentioned above, highly intelligent clients may appear aggressive within the relationship. They may show their knowledge in a way that can intimidate or distract the therapist. At times, this may be the result of a misunderstanding, with the client merely exploring an idea aggressively, but it may also allow them to create "noise" within the session, avoiding an exploration of their true vulnerability (Anthony, 1988; Glickauf-Hughes, Wells, & Genirberg, 1987). The therapist may be hard-pressed not to either retaliate or to appease, but to share the impact of the aggression and explore its learning or protective functions in a way that the client can tolerate.

Another important countertransferential trap is the mutual admiration pact (Glickauf-Hughes, Wells, & Genirberg, 1987). Bright and appealing clients may ingratiate themselves with the therapist, with the latter basking in the reflected glory of the client's accomplishments. A client's charisma and perceived vulnerability may evoke rescue fantasies. Therapists may come to believe that they are themselves special, the only ones who can truly understand the special clients. The therapists are then likely to

fail to confront the client when appropriate, for fear of losing the client's flattery or their own superior status. Just as for the clients, therapists must struggle with the balance between appropriate self-esteem and unhealthy narcissism.

In summary, while little formal research has been done, the current literature seems to support a wide variety of methods and ideas for conducting therapy with gifted clients. Whether giftedness or high achievement was part of the original reason for referral, or whether the client is asking for help with one of the many other problems that might ail any human being, therapists need to develop cultural competence. Rather than assuming that gifted people are just ordinary people who happened to do well in school, therapists need to educate themselves about how high intelligence can affect a client's life experience, as well as the course of therapy, and how their own history and preconceived notions might affect their ability to engage productively with these clients.

Summary

While an astute reader may recognize that these two areas of the literature have much to say to one another, there has been little integration of the two knowledge bases. Psychologists remain largely unaware of the gifted as a cultural group with whom they could or should develop competence. Meanwhile, those who specialize in therapeutic work with gifted clients largely rely on their personal experiences for guidance, and pass on clinical lore as if it were established truth. Their attempts at advocacy in the broader clinical literature are often unsuccessful, because they are unable to produce research data which could be convincing to a skeptical audience. Furthermore, because so many of the gifted-oriented researchers and clinicians who do exist are coming from an educational rather than a psychological background, the wealth of theory which could inform practice

and guide research is too often ignored or misconstrued. Difficulties in the definition and identification of giftedness and twice-exceptionality have further complicated the progress of research. It is possible, although there has not yet been significant research on the topic, that much of the dismissiveness and even overt hostility, in some situations, relates to unresolved feelings regarding intelligence, achievement, affiliation, and rejection.

Research Question

In this project, I was curious to find out what has gone on in therapy to create the common belief among gifted clients that therapy is not accessible or emotionally "safe" if it is provided by mainstream clinicians. I predicted that when those in the gifted community say, "Most therapists don't get it," they are talking about problems they have experienced in the therapeutic working alliance, and that these problems may have been potentiated by some of the characteristics and cultural experiences common to gifted individuals which are not well-understood by those outside the community and not integrated into the therapist's theoretical understanding. Furthermore, I suspected that when those problems have occurred, therapists may not have acted in ways that supported the development and repair of the alliance, and that the client responses have been as they would be in any population, to become confrontative or to withdraw from the therapeutic process. When therapy has gone well with a gifted client, I believed that it would be likely that the therapist has been aware of the issues gifted clients often face and how those might affect their needs in therapy, has been successful in attending to the various dimensions of the alliance, and has been invested in repairing ruptures as they have occurred. The aim of this study was to find out about the experiences highly intelligent

clients have had in therapy, and to draw connections between these experiences and the psychological and gifted-specific literature bases.

CHAPTER THREE: METHOD

Researcher Perspective

As described above regarding cultural identity development, I view myself as multicultural, something of an emissary between the gifted community, the educational community, and the professional psychological community. I have always self-identified as gifted, and bear many of the conventional markers of the paradigm case formulation. I have been an active member of the online gifted community for approximately ten years. As a classroom teacher and as an educational therapist, I have assessed, taught, and advocated for gifted and twice-exceptional students. This project represents the culmination of my predoctoral training in clinical psychology, so I also strongly identify as a therapist and a future psychologist. I have been a client in therapy on a number of occasions over the course of my adult life and have generally had positive experiences in which I felt a strong therapeutic alliance. I believe that my long-term involvement with all of these communities will help me interpret my data from a culturally competent perspective. Furthermore, having had a broad experience within these cultures increases my ability to put responses into perspective and to avoid overgeneralizing from either my personal experience or a few interesting but atypical stories.

High intelligence does not immunize anyone against depression, anxiety, schizophrenia, or any other psychological disorder. Although much of the extant literature seems to conceive of giftedness as solely a school-bound phenomenon, part of my goal for this project is to help therapists see these clients as multifaceted human beings who may present with a wide variety of issues. It is my hope that the findings from this study may provide therapists with rich information about how members of the

cognitively gifted client population experience the therapeutic alliance, so that they may be better able to support the development of the alliance in their own work with these clients. Furthermore, after completing the coding process, I compared these findings with well-established psychological theories. To the extent that the data supports such interpretations, this study may help psychologically-sophisticated professionals use ideas they are familiar with to achieve a more full and compassionate understanding of this client population and their cultural experiences. Similarly, this analysis may provide those in the field of gifted education a vocabulary to express the psychological significance of the issues that highly intelligent individuals often face. Finally, it is possible that gifted individuals may find the information in this study to be helpful in advocating for themselves within therapeutic relationships.

I am aware of the possibility that my own conscious or unconscious assumptions about giftedness, therapists, the working alliance, or other related topics, as well as the extensive review of the published literature presented in the first two chapters of this document, might have created in me an unconscious set of expectations (Glaser & Strauss, 1967; Hill, Thompson, & Nutt-Williams, 1997; Maxwell, 2005). If present, these expectations might have affected my behavior during response collection, subtly encouraging respondents to answer in ways they believed would please me. Furthermore, my expectations might have affected my interpretation of the findings, leading me to find only what I looked for. While it is not formally possible to completely eliminate these effects, self-awareness and consultation are methods by which they can be minimized. I have taken care to phrase the question scripts in a neutral way so as not to suggest that I would prefer to hear any particular kind of story. I have also given the questions to

colleagues for feedback and revision. Similarly, although I have given a great deal of thought to the the development of a conceptual framework and sensitizing concepts based on extant theoretical and empirical literature, I did not want these concepts to constrain the results. In keeping with the principles of consensual qualitative research (Hill, Thompson, & Nutt-Williams, 1997), a form of grounded theory research (Bowen, 2006; Glaser & Strauss, 1967), I have bracketed these concepts, laying them aside in order to experience the data from as fresh and open a perspective as possible. I purposefully maintained an open and curious mind while doing interviews, reading written responses, and coding the data. I have also sought consultation during the coding process. I have been guided in this mindset by the words of Thomas Huxley (1860), a classic philosopher of science: "Sit down before fact as a little child, be prepared to give up every preconceived notion, follow humbly wherever and whatever abysses nature leads, or you shall learn nothing." In short, although true objectivity is never possible, I have attempted to take a stance of self-aware disciplined subjectivity.

Procedures

Eligible Participants

In order to study the experiences of gifted clients who have been in therapy, I have made use of a criterion-based selection system, also known as purposeful sampling (Fassinger, 2005; Hill, Thompson, & Nutt-Williams, 1997; Maxwell, 2005; Wertz, 2005). Participants have been those who both identify as gifted and are able to report on a current or past experience of individual or family therapy.

Gifted

I am conceptualizing giftedness as a dimension of cultural experience. Fundamentally, test scores or other formal identification measures are not important when one is a psychotherapist. When one is an educational administrator deciding which children shall receive services targeting their cognitive differences, it can be important for a variety of practical reasons to find a reasonably defensible means for determining which individuals "are" and "are not" eligible for those services. In contrast, as a therapist, "proof" and the implied but indefensible binary classification are unimportant; what matters is what the clients' real or perceived experiences have been, and what meanings they have made of those experiences. It would be ridiculous, and obviously counterproductive toward the formation of any therapeutic alliance, for therapists to insist that clients prove their intelligence. Pertinent to this insistence, it is helpful to consider what clients' reactions might be if a therapist insisted that they prove that they were really gay or lesbian, really Latino or Latina, or really a proper Red Sox fan, before accepting these self-descriptions as part of the therapeutic dialogue.

Therefore, for the purposes of this study, anyone who is willing to self-identify as cognitively gifted has been considered as part of the target population. Typical means of formal identification include IQ tests, talent-search results, past participation in academic programming designed for gifted and talented students, whole-grade or subject acceleration, early participation in college courses, or membership in high-IQ clubs, for example. However, there are many different ways in which high intelligence may manifest, both in and out of educational environments, and whether any particular individual was ever formally identified is highly dependent upon the specifics of the

systems they found themselves in. Family, school, cultural, and other variables often contribute to individuals' not having their own high abilities formally recognized by others or being willing to acknowledge them themselves. My experience in the community has been that true poseurs (people who believe they are extremely intelligent but are really quite average, yet who maintain a long-term identification as members of the gifted community) seem to be rare. This is not surprising: such a poseur position is essentially narcissistic. However, lively interaction with people who actually *are* much brighter than average would create frequent experiences in which poseurs would be faced with evidence contrary to their assumption of giftedness. From such injuries to the narcissistic defense, the typical self-protection is devaluation or withdrawal (Baker & Baker, 1987; Brightman, 1985; Dweck, 2007; Kohut, 1977).

The major weakness of requiring some level of self-identification in order to participate is that I was unlikely to hear from clients who emphatically *resist* identifying as gifted, even though objective analysis might reveal abilities or achievement far above the norm. Particularly for such a small-scale exploratory study as this one, it would have been impractical to attempt to locate the segment of this population which actively avoids being so identified. Finding out more about this subpopulation and exploring their ambivalence would be an interesting long-term scientific goal, but is beyond the scope of the current project.

I was aware of the possibility that I would attract some participants who are ambivalent about their right to consider themselves highly intelligent, even though they bear clear markers of giftedness as described in the paradigm case formulation (e.g. cognitive test scores in the top 2% of the population). In the section of the informed

consent form where I described who may participate, I attempted to welcome participation by these internally conflicted individuals by stating that the study is intended to be inclusionary: "If you think of yourself as gifted, if your teachers thought of you as gifted, if everyone in your family thinks you are gifted, or if you think everyone *else* in your family is gifted, you probably qualify."

I was also aware that a skeptical reader might prefer to read responses elicited primarily from informants who are close enough to the paradigm case formulation to be considered unambiguously gifted. I therefore asked individuals to disclose the nature of the evidence that they have to support their self-identification and have considered this information in my analysis of the data and my selection of respondents for interviews.

Therapy Client

As with the criterion of high intelligence, I have cast a relatively wide net regarding the criterion of therapy client, in order to hear a variety of stories. In particular, I have not required that high ability or any related issues (such as underachievement, conflict with teachers, or school refusal) have been explicitly identified as part of the reason for therapy. In fact, I was curious as to whether it may be particularly useful to therapists to hear how clients felt that their giftedness was or was not empathically understood when it was not "officially" part of the reason they were in therapy.

I was interested primarily in talking with clients who have been in individual therapy about their experience of the one-on-one therapeutic alliance. These dyadic relationships, with their at-times intense transferential and countertransferential relationships, are the paradigm cases for the exploration of the therapeutic alliance. However, particularly because I wanted to be inclusive of clients whose therapists come

from a wide variety of theoretical stances, I also included those who have been in family therapy, even if my informant was not the identified patient. Because of the strong genetic and environmental components of giftedness, I suspected that family therapy would tend to include multiple powerfully intelligent clients within the family system, and that many of the same relational issues between client and therapist might arise. Furthermore, because most forms of child therapy include significant work with at least one parent, and because a parent's felt alliance with the child's therapist is likely to affect whether the parent continues to bring the child for therapy, parents who participated in therapy for their child were also eligible be considered clients.

For the current study, I have not included clients whose only therapeutic experiences have been in groups. I had two reasons for this choice. First, group therapies are more likely to have been primarily psychoeducational in nature, or based in a structured treatment manual, reducing the emphasis on the therapeutic relationship. Second, to understand what occurred in a group therapy experience, it would require that I investigate whether the other clients in the group were gifted, the specific clinical focus of the group, and how the complex between-member interactions were understood and processed. This would be a fertile area for future study, but is beyond the scope of this project.

Although I predicted that most of the people willing to be my informants would be adults, whether they were reporting on therapy that occurred when they were adults or when they were children, I was willing to accept reports both from adult and child or adolescent clients. Adults are more likely to be able to speak articulately about their experience, but I did not want to exclude children or adolescents who were willing to

participate and capable of doing so. In order to focus on the subjective experience, however, I was only willing to accept first-person narratives, although some children might have chosen to provide these by dictating their responses to their caregivers.

Adults tend to have considerable choice in terms of whether to enter into therapy and with whom, and they are more likely to have been able to arrange their occupational and social lives such that issues of cultural "fit" are less extreme than they were when they were children. By contrast, children are more likely to be, in some fashion, coerced, with the adults deciding that they have a problem that requires therapy and being the ones to choose the therapist. Thus, I expected that some illustrative stories of problems within the alliance might come from informants who were children or adolescents at the time of their therapy. However, I do not want to contribute to the misconception that giftedness is only a school-bound phenomenon. My informal experiences with gifted adults fit well with the findings in the literature that high intelligence continues to permeate individual experience throughout adulthood (Chauvin, 2000; Clance, 1985; Fahlman, 2004; Glickauf-Hughes, Wells, & Genirberg, 1987; Grobman, 2006; Hazell, 1999; Jacobsen, 1999; Lovecky, 1990; Nauta & Corten, 2002; Noble, 1989; Perrone, Webb, Wright, Jackson, & Ksiazak, 2006; Plucker & Levy, 2001; Prober, 1999; Rotenberg, 2006; Willings, 1984).

Soliciting Participants

I submitted requests for participation to a large number of online mailing lists and social networking groups focusing on gifted individuals (e.g., the GT-World and TAGFAM groups of mailing lists), the Davidson Institute for Talent Development, the major university talent search programs (e.g., Johns Hopkins University Center for

Talented Youth, Duke University Talent Identification Project), Mensa, the Triple Nine Society, and other similar organizations or groups which specifically serve high-ability populations or which have populations highly enriched for these individuals. I was also permitted to distribute the call for participants on a mailing list for psychologists interested in gifted issues, in the hopes that they would inform their clients. Additionally, I included individuals who heard about the study through other formal or informal channels.

I provided access to the informed consent form and the participant questionnaire on my professional website. I also sent it by electronic mail or by hardcopy to those who requested it. In this way, I hoped to recruit a large number of participants with a broad variety of experiences.

As an incentive to participate, I offered participants the opportunity to be entered into a drawing for one of three $25 gift certificates to Amazon.com.

On the informed consent form, I provided a place for individuals to indicate whether they would be willing to be contacted for followup. In some cases, I was aware of the possibility that I might want to inquire via email about a specific aspect of the reported story, in order to make sure that I had understood accurately, or to learn more about the specifics of what had happened. My original plan was that, after examining the stories and observing the broad categories of respondent which emerge, I would select a group of subjects to be interviewed in depth. My goal in selecting these subjects would have been to choose a group representative of the larger group of respondents. If any particular subgroups appeared (e.g., those who had therapy as adults vs. those who had therapy as children), I was planning to attempt to stratify the selection by those groups.

Alternatively, I was aware of the possibility that the focus of the study might need to be narrowed.

However, upon reading the responses, I changed my original plan. Most of the subject responses were extensive narratives, requiring little clarification. Interviews would thus have been superfluous. Rather, I chose to interview respondents who had provided briefer or more vague descriptions, or who had reported on one therapeutic relationship in depth, while speaking only in passing about another that had gone very differently. These respondents were approximately evenly split between those who described strong therapeutic alliances in depth, while saying little about alliances which had not gone well, and the reverse. I was careful not to privilege any particular type of alliance outcome in my selection of respondents to interview. Interviews were held in person or via telephone or videoconference, at the subjects' convenience.

Most researchers have found that 8-15 in-depth subject interviews are sufficient to achieve saturation, the point at which additional subjects yield only minimal new information (Hill, Thompson, & Nutt-Williams, 1997; Maxwell, 2005; Wertz, 2005). I planned to do 10-12 interviews for this study. In fact, I did fewer interviews, because of the richness of the written data. However, because of the diversity of experiences reported, I continued to collect responses until I reached saturation.

Measures

Fundamentally, I am interested in hearing the authentic voices of the members of the community as they describe their lived experience. Thus, a qualitative method, using open-ended questions on a semistructured questionnaire and interview, is more appropriate than a survey or other quantitative method.

Although many questionnaires and observation-based methods exist for evaluating the quality of the therapeutic working alliance, these are generally designed for use with people who are currently in therapy or have recently completed therapy. Therefore, they would have questionable validity when administered to someone reporting on a therapy that had possibly concluded years before. In developing the questionnaire, I reviewed a number of inventories of the working alliance, attending to the concepts addressed and the wording used (Gaston & Marmar, 1994; Horvath & Greenberg, 1989; Luborsky, Crits-Cristoph, Alexander, Margolis, & Cohen, 1983; Marmar, Horowitz, & Weiss, 1986; Pinsof, Zinbarg, & Knobloch-Fedders, 2008; Price & Jones, 1998; Shelef & Diamond, 2008).

I used the parameters of intentional behavior (Ossorio, 1998, 2006) in order to create prompts which direct the informants' attention to the various aspects of behavior and experience they might want to report on. By being explicit about all of these possibilities, I reduced the risk that informants would assume that I was interested only in certain things and encourage them to consider their experience more comprehensively. Furthermore, this type of questioning is helpful in eliciting "thick" descriptions of experience, rather than broad summary judgments (e.g., "therapist didn't get what it was like to be gifted,") which provide little elucidating information. My goal was to understand, as well as possible, what actually happened and what meaning the clients made of it.

Instructions to Participants

The description of the study on the questionnaire, found in Appendix B, contains a brief definition of the five domains of the working alliance, as well as a description of

the idea of relational rupture and repair. I felt that it was important to direct respondents to focus on the aspects of their therapy experience which are of interest in this study. Without this guidance, it is possible that they would focus on the *content* of therapy, rather than the *process,* and reveal more about their personal lives than is necessary for this study.

After reading this introduction, informants were asked to write about "the story of their experience of the therapeutic alliance," without other specific instructions. My goal in doing this was to elicit the initial story in the form most meaningful to the person speaking.

After having told their stories in unstructured form, they read the rest of the semistructured interview questions and were invited to use those questions as a basis for considering any additional aspects of their experience they wished to report. I did not expect that respondents would answer every question; rather, I specifically invited them to choose those which spoke to the most personally salient aspects of the felt alliance. I asked them to leave their initial description intact, but to clarify responses as they choose. I was aware that some individuals may have read the entire questionnaire before beginning their response. However, I do not consider this to be a significant problem. In fact, Hill, Thompson, and Nutt-Williams (1997) pointed out that they have actually found it helpful to provide respondents with the entire list of questions several days before an interview, permitting respondents to reflect on their experience more fully. If participants granted consent, I followed up as appropriate with additional questions about specific elements of individual stories, or performed member checks with them to verify that I correctly understood their meaning.

As described above, I identified participants whose stories left me wondering about what had been left unsaid about their experience and who had consented to participate in interviews. I used the same questions for the interview, but the semistructured interview format enabled me to ask these participants to elaborate on their reported experiences and permitted me to inquire about areas they did not report on in the original response. The procedure was similar: I oriented them to the definition of the therapeutic alliance, asked for an unstructured narrative of their experience, and then followed with specific questions from the questionnaire. I did not ask all of the questions on the questionnaire; rather, I used the questionnaire as an outline of topics to address.

Ethical and Privacy Concerns

Participants were reminded that they were free to refuse to answer any question or to discontinue their participation in the study at any time with no negative consequences. They were also given the same cautions about the limits of confidentiality (e.g., mandated reporter laws, suicidality) as any therapy client would be.

Data was collected in text form, whether directly by electronic or hard-copy mail, or by transcribing interviews. It was stored in password-protected files on my computer and backed up to services which use strong encryption to protect data privacy.

Anonymous written submissions were accepted. Participants were permitted to choose to provide contact information for any or all of four specific purposes: if they were willing to be contacted for brief follow-up questions or member checks, if they were willing to be contacted for complete interviews, if they were interested in being eligible for an incentive drawing, or if they were interested in being informed of the results of the study when it is complete. Contact information provided for these purposes was not

considered part of the raw data for this study. Any contact information acquired incidentally in the context of data collection (e.g., return addresses on letters or email submissions) was destroyed. When respondents did provide contact information, this information was kept in a separate password-protected file and connected by pseudonyms to the original data. If the raw data is shared other investigators for any reason, this file will not be included.

To protect their privacy, participants are not identified by name or through information which could easily be connected to their real identities. When individual stories are reported, participants will be identified by pseudonym, gender, and approximate or exact age. Because the gifted community can be a small world, in which individuals might have highly identifiable life stories, details unimportant to the analysis will be disguised or redacted as needed.

Because of my concern that children who are currently in therapy may be in some form mandated or coerced into attending, I was concerned that they may not have felt free to comment on any perceived limitations of their therapists, particularly if they were concerned that their parents would not agree with their characterization. Therefore, I did not accept reports on current therapeutic relationships from children under 18 years of age.

Although participants may have wished to identify a particular therapist by name or position, I promised not to disclose therapist identity in the written document. However, where it was relevant to the analysis and reporting, I stated whether or not a therapist has published extensively in the field or otherwise strongly identified as a specialist in high intelligence.

No deception was involved in this study, and the study methodology was not expected to produce any significant emotional distress. Therefore, no debriefing was necessary. If respondents had evinced unusual levels of distress, I would have used my clinical and case-management skills to help them cope in the moment and connect with appropriate local professional resources for ongoing support as needed.

Data Analysis

The data were analyzed through a flexible coding method (Fassinger, 2005; Glaser & Strauss, 1967; Hill, Thompson, & Nutt-Williams, 1997; Maxwell, 2005). I summarized each interview, in order to maintain a context for any illustrative quotes I might derive from it (Hill, Thompson, & Nutt-Williams, 1997). In order to increase the trustworthiness of my analysis, I performed member checks as necessary to verify the accuracy of my understanding and interpretation (Fassinger, 2005; Glaser & Strauss, 1967; Hill, Thompson, & Nutt-Williams, 1997; Maxwell, 2005).

I began with open coding, a search for a clear description of the reported phenomena. My goal was to describe the facets of experience that presented themselves within the data and to understand the underlying themes into which these elements could be grouped. Furthermore, I identified variables which were relevant to describing participant experience and the potential range of each variable. The terminology which Descriptive Psychology (Ossorio, 1998, 2006) provides for describing parameters of behavior and experience in an atheoretical fashion was useful in maintaining the focus on actual reported experience rather than interpretation of it. As I revised the list of themes, I returned to previously-coded documents in order to ensure a consistent lens on the data. When the categories of response became clearer and more consistent, I moved to a

process of axial coding, in which I looked for causal and mediational relationships among the codes. That is, I attempted to draw connections between codes, looking at how the various coded experiences and variables affect each other. Finally, in a process of selective coding, I attempted to organize these categories into several core concepts, developing a clear storyline of how the reported experiences related to each other. As I moved through the process of coding and interpretation, I documented some of my own thought process in researcher memos (Fassinger, 2005; Glaser & Strauss, 1967; Hill, Thompson, & Nutt-Williams, 1997; Maxwell, 2005).

As suggested by Hill, Thompson, and Nutt-Williams (1997), I have considered as "typical" experiences that are reported by at least half of the respondents. Experiences reported by two or more subjects, but fewer than half, will be considered variants. Experiences reported by a single informant will not be considered descriptive of the group. However, I did at times broadening categories in order to include these discrepant ideas, if I was able to do so without the result becoming so vague as to be uninformative. Additionally, some of these uncommon variant and unique stories suggested directions for future research.

CHAPTER FOUR: RESULTS

This chapter begins by presenting basic information about the demographics of the individuals who chose to share their experiences in therapy. Following that, I will describe themes which emerged from the axial coding of their narratives. The themes primarily related to the respondents' experiences of being highly intelligent, how they felt those experiences were construed by their therapists, and how the therapeutic process was affected. Several particular areas of concern regarding therapist understanding or the therapeutic process will be highlighted using the heading "Risk." Selective coding of the data will be discussed in chapter 5.

Note: Throughout this analysis, informants will be referred to by pseudonyms. Some of the names may seem unusual; these are aliases specifically chosen by the respondents. If the gender of the respondent is not obvious from the alias, it will be indicated the first time that alias is used. If the respondent was a child or adolescent at the time of the therapy described, this will be indicated. Other relevant information, if necessary for understanding the context of the quotation, will be enclosed in square brackets.

Participant Demographics

Location

During the one month of data collection, 30 individuals, all adults, provided substantive responses to the written questionnaire. Most (25) reported on therapies which took place in the United States. Those who provided more specific geographical information represented at least fifteen different states from multiple regions of the country. Four respondents were from Canada, and two respondents were from other

developed countries, one of whom also reported on a therapeutic relationship which took place in North America.

Gender

The respondents were primarily female (24 females, 6 males). Within this sample, no obvious thematic differences emerged between the male and female informants. Participants of both genders reported a broad range of presenting concerns, relationship lengths, and experiences of the therapeutic alliance.

Ethnicity

Those who responded to the question about ethnicity primarily described themselves as White or Caucasian. Other ethnicities reported included Cherokee, Chinese-East Indian, European, French, Jewish (3 participants), Sicilian-Mallorcan, Swedish, and White Hispanic American. Although the questionnaire did not ask for information regarding socioeconomic status, most respondents described an educational and work history consistent with present membership in the middle class. Several respondents volunteered that they had been brought up in working-class households.

Age

Participants' present ages ranged from 24 to 63, with a mean of 44. Two reported on experiences of therapy when they were children, seven reported on therapy that had taken place during their adolescence, six reported on therapy during emerging adulthood, and 22 reported on individual therapy during adulthood. Many participants provided information on multiple experiences of therapy. Modalities were primarily individual, although some of the therapies involved multiple members of a family: six informants

described therapy in which their role as a parent was an important part of the purpose of therapy, and five engaged in couples therapy.

Giftedness

The questionnaire invited participants to describe their reasons for identifying as gifted, providing ten descriptions based upon the paradigm case formulation described in chapter 1. All of the respondents, including those who identified as twice-exceptional, endorsed multiple indicators (range = 3-9, mean = 5.6). Of those who stated that they had been identified as twice-exceptional, there was no obvious difference in the number of indicators endorsed. Except for one participant, every respondent was able to identify some objective indicator of high ability level: cognitive test results, achievement test results, regional talent search qualification, being identified for gifted services in school, grade acceleration, or early college. Twenty-eight participants identified two or more of these markers, with the mean number of those markers being 3.0. This last participant (Alien) had a very difficult experience in his K-12 schooling, although he identified significant evidence of musical talent. He returned to college as an adult learner and has been highly successful: he earned an advanced degree, during which his professors differentiated normal classroom instruction to provide him with additional challenge.

Therapeutic Relationships

Approximately two-thirds of the participants described more than one therapeutic relationship, and a few described four or more relationships. In total, 61 different relationships were described. As planned, neutrally-phrased member checks were used to clarify my understanding of specific content. Because of the richness of the written responses, it was clear that large numbers of interviews were not necessary to reach data

saturation. Therefore, the original plan to select a representative subgroup for interviews was changed. Instead, I primarily interviewed respondents whose initial responses were relatively nonspecific or difficult to understand. Additionally, several participants described one therapeutic relationship in detail, while mentioning another one that had gone very differently, either much more smoothly or in which there were significant problems. I encouraged participants to report on all of the significant experiences of the therapeutic working alliance they had encountered, rather than highlighting only the best or the worst experiences. Therapists who were seen only briefly, typically in the context of a psychiatric hospitalization, were not inquired about.

The contrasts between the relationships in which one therapist had established an excellent alliance with the client, while another therapist had not done well in this arena, were often very instructive. Those contrast experiences helped identify key areas of client experience that were understood or misunderstood and key aspects of the therapeutic process which were helpful or unhelpful to the clients. Additionally, the fact that some therapist had been successful with the client reduces support for the possible assumption that the client might have had a significant lack of relational capacity. Virtually all respondents reported that they had been able to establish a functional alliance at least once in the past. Of the three respondents who believed that they had never experienced even a moderately workable alliance with a therapist, two of them were in situations in which they were mandated to participate in therapy. The third respondent who reported only negative experiences of the relationship had met with a single therapist and had not made other attempts to find a good match.

Theoretical Orientations

Regarding the therapists' theoretical orientations and methodologies, a broad range was reported, including behavioral, cognitive-behavioral, skills-based, supportive, psychodynamic, psychoanalytic, Jungian, depth, systems, trauma-focused, emotion-focused, mindfulness and body-focused, humanistic, play, developmental, psychoeducational, humanistic, pastoral or spiritual counseling, substance abuse treatment, medication management, integrative approaches, and "just talking." There were no clear thematic connections found between the theoretical orientation of the therapist or the type of therapy and the effectiveness of the alliance, consistent with the research literature summarized in chapter 2.

Therapist Training

Similarly, a broad diversity of therapist training levels was reported. The sample was well-balanced between masters-level clinicians, doctoral-level psychologists, and psychiatrists. Two relationships with professionals who were not formally trained as therapists (a craft director in a psychiatric hospital and a Reiki practitioner) were highlighted as demonstrating particularly strong and effective working alliances, after professional therapists had been largely unsuccessful. There were no correlations between the training level of the therapist and the success of the working alliance or of the therapy itself, a finding again consistent with the research literature summarized in chapter 2.

Presenting Problems

Although, as will be discussed below, clients typically did feel that giftedness was intertwined with their problems, the vast majority of reasons for referral, as they were

described and understood by therapists at intake, were not explicitly related to issues arising from giftedness. Rather, the range of presenting problems reflected the diversity of problems that commonly affect people in general in the industrialized world as they develop through the lifespan.

Children were referred for a variety of reasons including tantrums, panic attacks, or depression. Several children and adolescents were being bullied or having difficulty making friends. Reasons for adolescent referrals including their being angry, noncompliant with rules, or in conflict with their parents and teachers; abusing alcohol or drugs; coping with panic attacks or other anxiety disorders; or depressed, despairing, or suicidal. Most of the adolescent clients were also coping with separation and individuation issues, or with the transition to college and emerging adulthood. Several of the children were identified as having been diagnosed with disabilities, including Attention-Deficit Hyperactivity Disorder, Asperger's Syndrome, Expressive/Receptive Language Disorder, Sensory Processing Disorder, Obsessive-Compulsive Disorder, and Tourette's Syndrome. One child (Sharon) was specifically referred for therapy after her learning disabilities were identified, to provide her with a venue to process the new information.

Reasons for referral of adults similarly included generalized anxiety, social anxiety, or panic attacks; substance use disorders, whether their own or a family member's; depression or suicidality. Several adults described themselves as struggling with grief, whether past bereavement or anticipatory grief related to taking care of aging parents; or adjusting to their own or family members' serious mental health, medical or fertility issues. One respondent mentioned wanting to lose weight as one of her goals.

Financial and job stressors were frequently cited, as well as conflict within social networks, such as church. Individuals or couples presented with marital stress, feeling trapped within a marriage, adjusting to the parental role, or having difficulty with the balance between work and family. Couples and families wanted to work on improving their communication and mutual understanding. Several individuals wanted to explore existential issues and to explore role changes in adulthood ("My sense of self crumbled and fragmented… I sought help in 're-inventing' myself." [Emma]).

Trauma was an important factor for many clients. One adolescent (Kimberly) repeatedly informed counselors that she was being physically abused at home, but was not believed. Seven other respondents described families of origin in which emotional relationships were chronically chaotic and where there was little sense of safety; two of them were adolescents living in those homes during at least one of their therapy relationships. One of the respondents (Luci) who had a history of childhood and adolescent trauma, including the deaths of several close-in-age family members, grew up to marry a man who was physically, sexually, and emotionally abusive to her. She entered therapy in order to figure out how to safely extract herself and her child from that relationship. All of the respondents who reported chronic trauma within their family of origin turned to therapy in adulthood to help them establish and maintain boundaries within relationship, to work on issues of trust, safety, or emotional self-regulation, or to help them understand how their early experiences had come about and how these experiences had affected their present lives. One parent (Astrid) reported that her son was deeply affected by the death of his infant sister, several years previous to the start of

therapy. Another respondent (Dove), who did not report a history of childhood trauma, entered therapy in adulthood after she was raped.

Several adults initially entered therapy during graduate school or professional training, whether because they were suggested or required to do so, or because they felt the need for some help in managing the stresses of very difficult training programs or high-pressure, emotionally evocative careers. One cited particular difficulty with learning how to assert herself and to manage institutional and interpersonal politics more effectively. Two had left their programs, and worked on the readjustment those experiences brought as well. One adult found it particularly stressful, after she had graduated, to adjust to teaching at a college where the academic standards were much lower than at the top-tier schools where she had studied, and where most of her students and colleagues were more average in intelligence ("It was culture shock… I felt like an alien." [Helen]).

Those who entered therapy in connection with their children's adjustment issues typically did explicitly cite their own needs for practical guidance in how to raise a gifted or twice-exceptional child. They also described wanting to process their experience of other adults' reactions to their child's giftedness and of the effects of their child's experiences on their own lives, as Erika did here:

> I was coming to terms with the fact that my life was not going to be "normal" and that my kids would never fit into existing system "boxes." I felt like I was jumping off a cliff. I still had dreams of returning to my engineering career full-time, and I never wanted to be a stay-at-home mom. I felt trapped, which created resentment. (Erika)

Although the number of child and adolescent clients within the sample was small, and may limit the generalizability of interpretations drawn solely from those experiences,

the reports of their experiences are largely consistent with the reports of those who were adults at the time of therapy. Exceptions to this pattern will be discussed below.

Thematic Analysis

Many different themes emerged from the analysis of participant narratives. Although the questionnaire asked for all forms of experience, participants virtually all described experiences which they viewed as related to their high intelligence. These fell into a number of broad categories: how they and their therapists understood giftedness as affecting all aspects of their everyday experience and with the problems which led them into therapy; general experiences of trust, safety, and agreement within the therapeutic relationship; ways in which they perceived their intelligence as affecting therapeutic process and technique; how intelligence itself became part of the conversation and appeared to affect the therapists themselves; and the paths taken by respondents over time.

Broad-Ranging Effects of Giftedness

Without exception, every participant stated that giftedness affected the life experiences for which they sought empathic understanding. Almost all stated that they felt their giftedness was intertwined with the problems that brought them into therapy, as well as with many other aspects of their life, even if they themselves did not recognize these phenomena at the time. Several participants felt that giftedness was a double-edged sword in their experience, a source of both problems and strength. Examples of these responses included the following:

> Giftedness, mine and of those around me, and all it encompasses, will always be part of the joys and the problem. (Luci)

> I think that giftedness is for me a primary underlying factor in a lot of the things I struggle with (not the only one, but it so strongly colors how I experience the

> world). Now giftedness is regularly acknowledged as part of the context in which I navigate life. My therapist recognizes and tacitly acknowledges (and at times does explicitly validate) the fact that giftedness is, for our whole family, part of the fabric of our being. You can't separate it out from who we are or how we experience and interact with the world. I think giftedness is intertwined into everything. It is an intrinsic part of who I am and how I experience the world. I don't see how I can get away from this. (Pollyanna)

> Being highly gifted, it's really different. It's not abnormal, it's just rare. It's a different kaleidoscope of skills and reflexes. (Helen)

> Giftedness did not directly affect the problems that led me to therapy. But in some ways it underlies everything I am, including the things that led me to needing therapy. It affected my education, my career and its path -- it's connected to everything. (Andrew)

> It was imperative for me to find people who already understood and did not dispute the experience of being a gifted female in North American society. I wanted someone with whom I did not have to prove or justify all that "stuff" before we got to work on the issues it has created for me. I cannot imagine working with someone who doesn't "get it." At the same time, I wanted (and found) people who refused to use that to justify victimhood. (Joan)

> Giftedness probably provided me with the capacity to continue functioning as well as I was, despite the circumstances I was in. That may have prevented diagnosis for a long time. (Kimberly)

Clients reported a wide range of therapist reactions to their general experiences of being gifted, ranging from enthusiastic acceptance to outright pathologizing. In the latter two situations, clients typically reported that the therapists either did not recognize or did not accept the ways in which the client's giftedness was intertwined with the original reasons for referral or with the types of interventions which would be most appropriate. More specific subthemes emerging from these descriptions will be discussed below.

Intensity

As part of their experience of giftedness, participants typically identified that they wanted therapists to understand their intense intellectual, emotional, and empathic

responses to the world around them. Many reported becoming easily overwhelmed, and some noted that their intensity was often upsetting to those around them. For example:

> I was just slowly getting worn down. I've always been highly sensitive and I absorb the emotional energy of those around me. In these super emotionally charged situations [pediatric emergency medical care], it was like I was buzzing with the electricity in the room. (Claire)

> From before I could talk, I was taught to dumb myself down because my "muchness" (as Alice in Wonderland says) was Too Much for adults to handle...My way of existing and responding to the world -- body, mind, and soul -- has been completely colored by this early training. And I was not even able to put all of that into words before I started therapy. (Joan)

> I recall talking to my therapist about a weekend excursion my husband and I had at Barnes and Noble. I was so angry at him because when I told him I needed to leave, he didn't understand. He has the ability to hyper-focus, but I was unable to deal with the five separate sounds, and the smells coming at me at once. [My therapist] understood, although she didn't use the word "Dabrowski" or sensory issues. She was later able to comprehend how awful the abuse [which I had suffered as a child] had been with issues such as these, and how it complicated things. (Shelley)

> Then, the whole darn family can be intense at times. Fortunately, while we are not all introverts, we do all have our introverted sides, and we have a big house, so we can all carve out our own physical space. Time is a bigger problem! (Pollyanna)

> The second round of consultations we had with him, which were as a result of my spouse's severe depression and my (then 3-year-old) daughter's extreme intensity, were directly related to giftedness in the family. My daughter added a lot of intensity to the mix as only such children can… (Lily)

Some of the respondents found that these experiences of intensity were understood, tolerated, and even validated by their therapists. Rather than being seen as something which needed to be fixed, these therapists framed intensity as both an inextricable part of the client's experience and as a potential asset but also one which might affect the therapeutic relationship. However, a large number of therapists were not able to come to a satisfactory shared understanding of this conative trait typical of gifted individuals. At times, their responses were openly invalidating:

> [When I described my long history of failed relationships and my genuine regret at having tried to reach out to others, and my intention to commit suicide because I saw little point in living], he said that I'm very sensitive. I instinctively look for depth and intensity that is beyond what most others look for and that as a result I wouldn't settle for less -- I couldn't settle for less if I tried. His words echoed the words of so many others. I think too much. I'm too sensitive. I have too much energy and need to settle down. I'm too intense. Etc. However, others including other counselors, tried to correct me on this score. This guy did not. He said that I am this way and can't shut down. It was very liberating. It was like permission to be. (Alien, male)

> At termination, my therapist said that I communicated my feelings and thoughts to her in all modalities (speaking, writing, and drawing) in a very powerful way, which she experienced as "edgy," and which tested her ability to maintain appropriate boundaries… She said that in the beginning, she was unsure about how to interpret my symptoms and behavior… she had consulted with a psychiatrist and had been considering all sorts of diagnoses, but her instincts kept telling her that I was a normal, even resilient person, but that I had had, as a child, a very anxious attachment with my mother because of the way she treated me. (Nicole)

> Neither of the therapists [mine and my son's] acknowledged the depth and intensity of my feelings, and the amount of work I put in to modifying my own reactions in order to help my son [who was struggling with serious psychiatric disorders]. (Erika)

> My son's therapist seemed to think that *I* was nuts. She just sort of kept looking at me, asking, "Do you think that's really true?" The more I opened up to her, the more judgmental she was. Then it clicked. I don't think she was used to highly intelligent, high-strung people. (Helen)

Perceptiveness and Drive to Learn

Another common theme typically cited by respondents about the experiences of giftedness that their therapists did or did not understand, was a combination of perceptiveness and entelechy. Their strong need to continually seek out information and ideas from the world around them, their ability to recognize and learn things that others might not easily see, and their capacity, often at young ages, for high levels of abstract thought, all appeared to reflect this theme, as represented in the following:

> I do not think it is possible for me to turn off my mind for seven hours a day, five days a week, nine months a year [in school]. I crave mental stimulation and will spend most of my time exploring and learning. (Mick, female)

> The one thing I have to do is keep learning. I can't bear tedium. If I have a job where I can't learn, I really have psychological problems. Most people want to buy things. We have to learn. (Helen)

> I experienced what I experienced at a depth, and with a huge difference in quality, than many other people do. (Luci)

> My own self-education has never ceased. (Alien)

As an interesting variant of this reported experience, several clients reported that that their intense reactions to the information they learned had at times caused problems for them:

> [Intelligence was intertwined with my problem in that I could] think more than three or four things simultaneously, had the ability to abstract and feel at the same time, and had a quasi-Aspie sense of intolerance of stupidity and manipulation for the sake of some silly power game, versus the values of truth, honor, beauty, and community. (Brenda)

> I seem to think about things a lot *more* than many other people do… I developed painful self-consciousness at a young age… Sometimes, I have to purposefully distract myself from thinking too much about my own situation, because I get overwhelmed with the reactions, and that's not a good thing when you're driving. That's how I started my audiobook habit. (Pollyanna)

> I was able to see what was happening in the country in general and in my workplace in particular (racism embedded in the national policies and within the education system, including at the university), and this bothered me terribly. I discovered that my colleagues in general were not as troubled by inconsistencies in standards and unfair policies and etc as I was. (Lily)

One aspect of this experience, reported by eight respondents, was that their curiosity about or emotional response to hypocrisy or injustice often led them to wonder about things that others did not. They would then make observations or ask questions which others were uncomfortable with. Several also mentioned that they had learned to suppress this behavior, and carried that assumption into therapy:

> I try to be as honest as possible at all times [including with my therapist], and I'm a bad liar anyway. This has frequently gotten me in trouble, because people don't like hearing the truth. (Kimberly)

> I think I could see things that I did not have the emotional maturity to process and I could see it in my parents and I felt sad for them. I also felt hurt, betrayed by them for not helping me. I also felt like there was something wrong with me for asking things, too many things, and challenging my parents. For example, I would say things like, "Daddy says he wants us to be strong and independent but then he controls everyone. You cannot be strong and independent if you are controlled." Or, "Daddy, you think people do things because they respect you but really I think they are just afraid of you." I think this hurt and baffled him coming from a 6-year-old, and so he would not talk to me and I would feel very hurt… [In therapy,] I usually did not raise problems in the alliance directly, because I had previously learned that when you ask too many questions or challenge people they get really upset. (Megan)

> At school, I often asked questions that were seen as irrelevant and off topic. I would ask questions about some sort of science topic, doing a deeper and fuller inquiry, and the teachers didn't know what to do with me. At home, I often asked questions that made my mother uncomfortable. I wouldn't ask her why the grass was green. I would ask her why she did something, why she treated my brother differently from me, etc… I learned that asking questions tended to create problems for me, so I began to avoid asking questions totally, and I learned to just answer, "Fine." … In two and a half years of therapy, my therapist never got past "Fine." (Sharon, child)

As with intensity, the empathic quality of therapist responses to the clients' inquisitive and perceptive nature varied widely, ranging from empathic understanding to dismissiveness to openly pathologizing, as reflected in the following:

> During the course of the therapy, we worked on accepting that there were certain aspects of my situations that weren't fair and that I should deal with. She would help me figure out ways to deal with them, in a way that at least attempted to be congruent with my personality. (Splash, female)

> My second therapist accepted that I knew what I was talking about, and that I knew what I wanted and needed, and she accepted that these things were valid and worth knowing… I would come in with all this swirling knowledge of religion and philosophy and a bit of politics… She made it okay that I was smart and that I had all these thoughts and ideas. (Sharon, adolescent)

> I think all of the therapists I saw lacked the intellectual willingness and probably ability to follow/understand my view of myself or the world. My view was not simplistic, and they had trouble listening long enough to grasp the distinctions I

> was making… Their attempts to make me "feel better" were consistently insulting, and I *think* they truly did not understand me when I explained why. (Doreen, adolescent)

> I do think they [her therapist and her son's therapist] missed the impact the death of a baby sister [from SIDS] had on my son [who was 6 years old at the time of therapy, 3 years old at the time his sister died]. Today I believe he should have been diagnosed with Post-Traumatic Stress Disorder. Being super intelligent didn't help us here. On the contrary, I think it made him understand things that no ordinary 3-year-old would have understood, but that doesn't mean he had the emotional maturity which would ordinarily have come with that understanding. (Astrid)

> My son was in therapy for depression after 2nd grade [stressors were interpersonal conflict with teachers and peers because of the manifestations of his intelligence]… After listening to his concerns (possibilities about the world ending, invasion, explosion of the sun, the Apocalypse) for three months, she said he was out of touch with reality, verging on schizophrenia. His school counselor said he was bipolar. Both thought he should be treated with drugs… It's so exciting and dramatic… he wasn't so much *afraid* of it was he was *fascinated* by it. Whatever he gets into, he really gets into… As soon as we switched schools to one where his intelligence was valued and got him into a social skills group, everything resolved itself. (Helen)

Philosophical Interests

An interesting variant of the experience of deep thinking, reported by eight participants, involved an intense interest in philosophical, moral, or spiritual topics, and in exploring these within the context of therapy. When therapists were able to accept and work with these interests, clients reported that these explorations were extremely helpful in the therapeutic work. However, several therapists had difficulty in meeting these clients where they were, in some cases causing deep ruptures in the relationship. The following quotations illustrate a range of possibilities:

> There are times when I think what I'm looking for is a clinical philosopher more than a clinical psychologist. (Pollyanna)

> [My second therapist] claimed to be open-minded about many things, but had a hard time concealing her bias. Despite calling herself integrative, she wasn't willing to work with some of the meditative and dream material I presented… [My most recent therapist] was not only open to some of the alternative

> modalities I work with (I'm a Witch and use various energy modalities, meditation, past life regression, and shamanic journey as self-improvement techniques) but even knowledgeable about some of them… She continues to be able to work within my frame of reference, and remains nonjudgmental through everything I've presented. (Kimberly)

> I was repeatedly told that I was not old enough to form my own moral values or hold universal principles at 14, and several of my counselors could not understand my empathy for others, to the extent that I could feel what they felt, and did not understand my desires to be heard by those in authority and to leave my mark on this world… I quickly came to feel as if I could not share the meaning I attributed to my experiences at school and at home, as well as the depth of this meaning and its interconnectedness with other experiences. It was treated as a problem on top of my substance abuse/dependence. (Mick, adolescent)

> One therapist understood basic things like my desire to live a moral life, but in a superficial way. The other did not understand basic things like this -- there seemed to be an assumption that teenagers were amoral creatures with no understanding of the world beyond self-interest and people pleasing, which was how any altruism was recast. (Doreen, adolescent)

> [Emma was coping with medical problems which seemed to compromise her independence, and was struggling to rebuild a sense of self after multiple significant losses and life-stage stressors.] I began to reassess what the remainder of my life would be like and kept asking, "What's the point?" I was *not* suicidal. I really wanted to know what "the point" might be. The question, as I saw it, was existential… My therapist, however, seemed in a near panic and refused to entertain any way of viewing my statements except as life-threatening… I continued to see her and tried to explain that the problem was existential, not chemical. However, she did not seem to credit my words until the psychiatrist concurred. I felt my therapist had questioned my ability to author my own life. This was especially detrimental since I'd gone to her in the first place for help in reinventing myself. (Emma)

Unconventional Interests

Another variant on the theme of curiosity was that several participants described areas of interest that were atypical for their mainstream culture, particularly as regards gender expectations. When these interests were raised in the context of therapy, some of these clients reported being specifically directed to take up more "normal" interests as part of their treatment. Both their understanding of themselves as atypical and some of the unhelpful therapist responses are illustrated by these quotations:

> One way in which giftedness affects my life and my husband's life is that we are not typical for our gender, not so extreme -- I am straightforward, brusque, outdoorsy, while my husband likes furry animals. I watched Oprah, read *Men Are From Mars, Women Are From Venus*, and it was horrible. The books didn't say, "These are generalities," they said these were true. I am from Mars. I am not a woman. I would have thought, "Maybe I'm a lesbian," if I had read it when was a kid. (Helen)

> I began to feel that my therapist adhered to some script of what "normal" meant and that she wanted me to be compliant and complicit in her understandings. (Emma)

> I am pretty much a homebody. I like to read and garden. I homeschool, grow organic vegetables, and my mother lives downstairs. Getting my hair colored and buying new clothes wasn't really my thing… [My therapist] seemed to think that many of my problems would be solved if I went shopping and got my hair done. She even suggested I buy Spanx (gut sucker underwear). I guess she thought that if I looked better, I would feel better. (Karen)

> [Several therapists stated directly that] they expected me to want to show an interest in dating, fashion, and hanging out with people my age… In addition, several therapists expected me to be able to deal with boredom and a halt in my learning, as if I could turn off my thirst for knowledge or the intensity with which I learn. (Mick, adolescent)

By contrast, three informants reported being comfortable enough within their therapeutic relationships to bring up issues regarding sexual orientation, sexual practices, or other interests which they were generally keeping secret, and that their therapists were able to be empathic and supportive:

> There was a point at which I needed to talk about some BDSM [bondage-domination-sado-masochistic sexual practices] issues which were impacting my life (I have perceived an overlap between "gifted" and "kinky."). This was a very hard thing for me to do as at the time I was very self-conscious and closeted about my interests in that area. She had built enough rapport with me that once I realized i needed to talk about it, I was able to bring myself to do so… and, as I did, I could *see* her actively *being nonjudgmental.* By which I mean, I could see that the subject made her uncomfortable and that she felt some personal disapproval, but she also knew that her personal disapproval wasn't relevant to the conversation. (Andrew)

> Some things I waited to introduce (polyamory) until I felt like I had the trust of the therapist more… [The therapist my husband and I went to couples therapy with] was very accepting of our alternative choices. [The trauma specialist I

> worked with individually] didn't know anything about polyamory at first, but was willing to listen and learn about it. She continues to be able to work within my frame of reference, and remains nonjudgmental through everything I've presented. (Kimberly)

> I told her a number of things that I held as secret at the time, like that I called myself a witch, a pagan. She was entirely accepting. I purposely told my mother about this in her office so she would make Mom listen and understand that I wasn't sacrificing any babies. I also shared the fact that I was a lesbian with my therapist at a time when I wasn't ready to come out to my family in any way. It was almost two years before I was ready to tell my mother. (Sharon, young adult)

Achievement Orientation

Another issue typically raised by clients within therapy was their focus on high achievement, both in school and career, and how this focus at times related to the stresses they experienced. Informants were generally unambivalent about viewing their intelligence as an asset in their efforts to achieve their goals. However, many respondents also described ways in which their achievement orientation had placed them at risk for social and emotional stress, giving these as examples of experiences which their therapists had or had not understood empathically. These findings are consistent with the issues found in the literature on giftedness, as reviewed in chapter 2. Representative comments follow here:

> I had started college full-time and had some traumatic experiences with professors and advisors who wanted me to leave college for derailing their lessons and turning in assignments that they did not believe an undergraduate student from a background like mine (high school in our city's trailer park) was capable of producing. (Mick, emerging adult)

> As a child, I was constantly bragged about, especially by my father, for things that I didn't perceive to be exceptional. I came to doubt my own perceptions and to doubt myself. I think there is a possibility that Impostor Syndrome is part of the causative etiology of many of the problems I have with asserting myself in professional relationships. (Splash)

> I think a lot of my social anxiety was related to being intelligent. I could do anything I imagined and that was overwhelming to me in my career choice… I had terrible social troubles in college because people were always trying to

> outshine me. Guys didn't want to date a girl who was much smarter than them. I 4.0'd the classes others said were so hard. I feel moral issues very strongly, in a way that I could not connect with others on. (Victoria)

> I discovered that I may be a visual-spatial learner. I think in pictures and when I read or learn anything I put figures together in my mind that are like blueprints or schematics. I get a picture of the whole that I can sort of flip around and look at in different ways… I seem to have trouble concentrating sometimes because my mind moves like a tornado… I did badly in school after grade 7 and dropped out. (Alien)

> Most of my experience in college and work had been with people who were pretty intelligent. [Teaching at a state college] was my first exposure to people who had Ph.D.s but weren't very bright, or who were bright but bitter and apathetic… I stayed eight years and got tenure, but I felt worse and worse as time went on. I felt like I was getting more stupid because I was getting so little intellectual stimulation and support on a day-to-day basis. I never did get used to it… I ended up changing careers and moving to a location where there were lots of intelligent people and a wide variety of intellectuals. I feel so very much at home, and my children benefit from this environment. (Helen)

A particular variant experience noted by approximately one-quarter of the respondents was feelings of perfectionism. For the most part, respondents reported feeling that their therapists understood these feelings well and were able to help them process, as described in the following:

> I received many mixed messages about whether my intelligence was a good thing or a source of shame. I came to believe that I was inherently defective, and that I had to live up to unrelenting standards in order to overcome my defectiveness. I felt like I had to be useful enough to other people in order to be tolerated socially… When I have disclosed things that I felt to be potentially shameful, the reaction has been very empathetic, supportive, and nonjudgmental, and focused on my feeling of safety… My therapist has suggested that giftedness plays into this in a sort of self-stoking way. Giftedness allows me to be successful in meeting those standards enough of the time that it allows me to continue to believe that trying to meet them is necessary. I have generally been able to avoid finding out what happens if I fail to meet my own standards, so I have not learned that in fact the world does not come to an end, and people might still like me anyway, and that they might still think I was doing enough even if I did less… but I'm afraid to find out! (Pollyanna)

> The major goal of therapy was to help me find a niche for my powerful mind so that I didn't chew myself up or get mired in a cycle of perfectionism/indecisiveness. I was able to generate displacement arenas, where I

> could shine my powerful light outward rather than always pointing it inward. (Thomas)

> Since I knew so much about psychology and stuff, having minored in it in college, I thought I shouldn't have failed at what I was doing [in business and with my family]. The fact that I was unable to resolve the issues on my own seemed to add insult to injury. (WiseEye, male)

Three respondents mentioned another variant experience. They had a feeling that being gifted created obligations that they were unable to meet:

> I felt like a failure for not using my degree, because of my intelligence. It was a responsibility that I was shirking. (Victoria)

> My giftedness created problems for me because it evoked unrealistic academic expectations from teachers. I heard tons of "She's so smart, but she's lazy, not working hard enough, not working up to potential." I heard them all. "She's so smart. But." … It wasn't a gift from God that I had to use to its fullest. It's just what it was. (Sharon)

> I had picked up a sense of responsibility to use my gifts to make things better in society, an obligation I subconsciously felt I had not met, even though I was doing pretty well all things considered. [In therapy,] I learned better techniques to deal with my sense of failure to not reach the promise that being gifted seemed to offer, as well as the sense of persecution for being different… I'm managing to work on satisfying projects that make use of my talents without feeling a need to change the world. (Gary)

Feeling that the therapist was similarly gifted and had similar experiences of high achievement was reported as being particularly helpful in building the alliance, as represented in these quotations:

> [My therapist] was one of the few remaining psychiatrists that also did psychotherapy. She was great. She was literally a life saver. I could tell her all of my horror stories without having to translate all the medical jargon. She understood what it was like to be on call and to be responsible for all those lives. She had been through codes. Seen the darker side of humanity. She's the first person who helped me see my emotional sensitivity as an asset as a doctor and how to start controlling my environment to protect myself emotionally… (Claire)

> This was a senior level therapist who only rarely had openings. Her and my educational backgrounds easily identified us as both intelligent and diligent… It was like two very talented musicians sitting down to jam together -- there was no need to discuss it -- we just went with it. (Brenda)

However, as will be discussed later, high levels of intelligence and achievement orientation in a therapist were not a guarantee of a successful alliance.

In contrast, a substantial number of clients reported feeling that their previous achievements or desires to achieve in the future were not understood empathically, or even openly dismissed by their therapists. The following excerpts reflect client perceptions that therapists lacked understanding and did not respond with compassion:

> The problem was when I discussed these issues [frustration with the level of academics at the state college where I was teaching] with the therapist, it was clear she didn't believe me, because she thought it was a marvelous first rate university... She couldn't imagine the qualitative difference in intellect, environment, and resources I was experiencing. So we really couldn't communicate that well. She didn't believe the reality of what I was experiencing. (Helen)

> As an engineer, brainstorming is something that I do innately, so when I say that I have no choices, I really did analyze many options. Thus, I felt totally dismissed when my therapist disagreed with me. Also, I don't think she understood that my personal identity at the time was wrapped up entirely in being an engineer. Life with my son was requiring me to switch around to identifying myself primarily as a stay-at-home, homeschooling mom. Not only was this an identity crisis for me, but I was also switching from something that I was good at (being an engineer) to something that I was decidedly not good at, at least not initially. (Erika)

> He didn't understand how much it hurt to lose my chance at a Ph.D., or the feeling that I was somehow going the wrong way, or that I had betrayed my childhood dreams… I was constantly told that getting a Ph.D. would not solve my problems (I never said it would). (Vevina, female, adult)

> I was quite misunderstood by most of my therapists, especially earlier in life… many did not believe that my IQ scores or achievements meant that I was any more capable than any other child my age and that I was the product of pushy parenting and being spoiled with books and outside opportunities to learn. Further, some urged me to give up advanced study on my own and to "get a life" and be a normal young person. (Mick, describing therapy during her adolescence)

> My therapist seemed not to understand how I understood the reality of the situation. I loved hearing that I had a learning disability. It made sense! I knew how hard I tried and still failed. I was glad I knew, that there was a reason why things were hard for me. It wasn't my fault. I don't think she believed me when I said I was happy with the testing. (Sharon, referring to therapy in childhood)

A particular variant, cited by approximately one-fourth of the respondents, of the difficulty some therapists had in empathically understanding their experiences of high achievement, was derived from therapists' apparent efforts to validate the client (or the client's child) which were paradoxically seen as misunderstanding or even invalidating. By attempting to accredit an achievement which a client knew or perceived to be not of great difficulty, or arguing against the client's perception of self in the world, the therapists seem to have marked themselves as not truly sharing the client's understanding. Excerpts here underscore this point:

> One time when I was talking about feeling inadequate, [my therapist] said that she thought I was "very high-functioning"… I was left with the feeling that she didn't understand the degree of functioning that I feel myself to be capable of, or what I want to be capable of, or what I think I should be capable of. (Nicole)

> My therapist's attempts to build my self confidence by showcasing my exceptional talents backfired. My abilities had never been treated as special when I was growing up so I could not believe this woman; she must be wrong. (Victoria)

> She (like many people) often expressed admiration of something or other than I had done, which I felt was easy for me and therefore not worthy of any particular admiration. She'd say, "That must have been really hard," and I'd reply, "No, actually, I found it pretty easy." There was probably a point where she thought I was minimizing my own accomplishments out of depression or poor self-esteem, when it was really out of *high* self-esteem: that was no big deal because I'm so smart it was easy. (Andrew)

Two clients described at least one therapist who clearly stated the viewpoint that the client's high achievement orientation itself represented an aspect of pathology:

> My participation in college courses and advanced research opportunities was deemed the root of my issues, though these were the only times in which I was not using or acting out… In middle school and high school, I spent my summers doing research on cancer, marine biology, and politics… Many times, [my giftedness] was brought up by my therapist, concerned that I was not following a normal developmental trajectory. (Mick, adolescent)

> During the second session [with my third therapist], I mentioned that I was working on a novel (that I had started at 16). She asked me to bring it in. I did. I

> laid out everything I had created for the universe: maps, timelines, and family trees, and additional plots, and everything. For my trouble I was awarded with the offhand remark that it was "grandiose." I refused to go back because she had made it clear that she simply was not prepared to deal with me. (Vevina, age 19)

In order to understand Vevina's quote, above, the reader should be aware that the kind of world-building and character-creating work that she had engaged in, and the level to which she engaged in it, would likely be seen as normative within gifted culture. Many science fiction and fantasy authors develop their worlds in similar depth. People who participate in tabletop or live roleplaying games, common forms of entertainment and social interaction within the gifted community, often develop extensive backstories for their characters and worlds. This process is often deeply connected with the individual's own self-exploration, with the development of key characters who allow them to explore or contrast with different aspects of their personal characteristics or values. It is likely, therefore, that the transaction between Vevina and the therapist she was trying to get to know was experienced as a significant degradation: she presented something connected with her sense of self, and it was openly rejected.

Relationships

As described in chapter 2, giftedness is commonly believed to be a school-bound phenomenon. However, the vast majority of respondents in this study reported extensively on how their high intelligence had affected their relationships, and how well their therapists had understood these experiences.

Peer Relationships

It was typical among the respondents to describe how their high intelligence had served to isolate them from peers. Most described childhood isolation; several of these mentioned extensive bullying which they felt was construed as their own fault. Several

respondents also described problems in adult collegial or social relationships, some with their roots in childhood relational problems. Therapist reactions to these statements were mixed. Some clearly understood how much and in what ways the clients wanted to relate to others, but others had more difficulty in manifesting accurate empathy. Some respondents felt that they were being blamed for their own problems. Representative quotations follow:

> [The reason I entered therapy was that I was] stuck in an existential crisis: What is the meaning of life for a mid-life gifted woman who has lifelong experience of social punishment for being different from the "norm"? (Joan)

> [My therapist] did for the most part understand very well that I wanted to be like other people… I wanted to feel a part of something and not like an outsider… At times, I could tell she did not get me, but she always showed respect and concern for me… She said, "Why would all these people be hard to understand? Why would your experience be so different?" I did not know why -- I just felt it! She asked as if challenging me that I must be either making it up or making it happen. (Megan, describing therapy in adulthood)

> I never felt safe and appreciated in that relationship and I don't feel like she understood my experiences either. I have had an extremely difficult childhood, and I was struggling at that time to find what was normal. I wanted more than anything to be just like everyone else… She always seemed so positive when speaking about intelligence. I wish she could have understood that I would have given anything at that point to feel like I belonged somewhere, including losing 20-30 IQ points. (Victoria, describing therapy in adulthood)

> My first therapist was good, up to a point [discussing issues related to abuse in childhood]… But, sometimes I would bring up other issues, like the strain on my friendships with other moms in town due to their competitive jealousies of my daughter who is profoundly gifted. I felt uncomfortable with how my therapist handled those issues. She told me frequently I was "highly intelligent" and "obviously gifted," but she wouldn't agree that other parents would have any reason to be jealous of my daughter and take out those negative feelings on me. I felt she was being intellectually dishonest as competitive parents are not unheard of. That made me not trust her and I felt like I needed to find someone who was willing to be honest with me. (Lindsey)

> [My second therapist showed me that he did not understand my social isolation] by saying "I understand *you think* your giftedness has something to do with your difficulties making friends here… At first he thought all my problems stemmed from my mother and that the gifted issues were just a defense I made up… This

> was about my giftedness contributing to my isolation living in a small Midwestern town. He felt I should be able to find common ground with many people, connect with them and feel close to them regardless of our differences in IQ… I did raise the issue. I was actually mad about it and I knew I could find the information to prove my position. Happily, he seemed willing to change his mind. But I still don't think he really understands… Sometimes I want to say, "How would you feel if you had to move to a town full of fifth graders? How satisfied would you be?" But I think he would think it is totally mean to say something like that. When I discuss giftedness I try to be very reasonable, because I am worried he might think badly of me and not understand if I am too passionate or sound bitter. (Lindsey)
>
> Intelligent parents have intelligent children but [my therapist] didn't seem to "get" the isolation of having a gifted child. (Karen, describing therapy in adulthood)
>
> During our sessions, I learned that my status as a gifted child had contributed to my anxiety attacks because of my experiences being targeted by mean kids… The latest therapist understood best, because she specialized in dealing with children who feel they stand out and away from the rest of society… [She showed me she understood by] explaining how other cases were similar to mine. (Gary, describing therapy in adulthood)
>
> During early elementary school, I was socially withdrawn and had severe social phobias. This would often lead to "tantrums" that were only later diagnosed by [my fourth therapist] at age 17 as panic attacks. These "tantrums" got me labeled as a cry-baby and I quickly became the target for severe bullying that resulted in both psychological and physical abuse through the end of high school… I was told repeatedly by teachers and therapists that the other kids were jealous and I had to stop acting so smart… I was often told that I was exaggerating, that I was wrong about other kids' behavior and that it was mine that had to change. (Jay, child and adolescent)

Jay's situation, described above, is of particular concern, in that he was continuously in therapy for twelve years, with three different doctoral-level therapists, from ages 5 to 17. According to his report, his problems were consistently construed as a lack of knowledge of or competence in correct social skills; this was similar to how other child or adolescent clients reported therapist responses to their being bullied. Jay reported that he knew quite well at the time how to act socially, but did not want to interact with the other children who were being cruel to him. When he was 8 years old, one of his therapists recommended keeping him out of the school's gifted and talented program, where he

thought he might find social acceptance, because of his poor social skills. Like several other respondents, Jay stated that he did not find social acceptance until he went to a highly selective college. He has remained in therapy with the fourth therapist, whom he found highly empathic and helpful, until the present day; he was 30 years old when he provided his response.

Several participants mentioned recognizing that they had to purposefully change the way they presented themselves socially in order to avoid intimidating others. A few of those expressed concern about possibly needing to do so even in therapy. Examples follow:

> The fourth therapist simply refused to see that [my intelligence] should matter in any way. He felt that I was a snob for making the perfectly obvious observation that I liked talking to very intelligent people because the average person simply couldn't keep up with me. I was simply told that I should talk more at their level. I teach introductory math for a living, and, frankly, it can be done, but it's work. Why should I have to work 24/7? Why should that be normal? Why shouldn't I want a vacation from it occasionally? These arguments fell on deaf ears… He did not really understand what it was like to be unable to communicate with the average person easily, and to be looked at as bizarre and incomprehensible… He diagnosed me as narcissistic, because I guess he didn't think I was as smart as I said I was. (Vevina)

> From conversations with friends, I knew something of what to expect [from therapy]. However, I remained cautious. Experience had shown me that I sometimes scare people, without intending to, especially when I talk about things I find important that others do not comprehend. I didn't want to feel I had to "dumb down" what I said, not when I was exploring how to reconstruct myself. (Emma)

Family Relationships

Although family relationships were not specifically asked about in the questionnaire, a number of respondents volunteered information about various ways in which giftedness affected the relationships within their families. Intensity and high expectations were emphasized; responses in these category have already been presented

above. As mentioned earlier in this chapter, however, several family experiences were described as being painful in various ways.

Four parents of gifted children reported that they were construed as the source of their children's problems or that their therapists openly disagreed with their choices regarding their children's education. Three of them felt that they were unable to receive support in therapy because of those disagreements. The following quotations illustrate these problems:

> [My son's therapist] was initially offended that I questioned [his knowledge of giftedness], asking me why I needed my son to be gifted. I told him that I didn't *need* it, it simply was part of who my son was, like being a boy -- and just as relevant… My focus in therapy was on learning to parent my older son -- and losing myself in the battle… I couldn't tell [either of two therapists] about the times that I failed to act appropriately with my son -- when I yelled -- lost my patience -- cried for hours -- expected too much or too little. Without any understanding of how difficult it all was for me, I couldn't really share my personal disappointments and failings… This left me with little help on an ongoing basis, which is what I needed. (Erika)

> [I felt judged] because my child was in trouble… Their goal was to change my way of being a parent. Reasonable if you assume that this was the basic problem… I still claim the problem was very much a school issues and also a basic feeling of insecurity. I had not been able to keep his sister alive and that scared him… I was told off in no uncertain terms at times… I knew my son needed help that I could not provide, so I just kept in line so as not to make things worse. (Astrid)

In addition, a number of respondents reported traumatic childhood experiences: physical abuse, parent-child conflict, and sibling conflict, that had long-term emotional effects on them.

> There were various other therapists who didn't help me between [8th grade and] my suicide attempt as a junior in college. Mostly I felt like none of them took me seriously. They all had a bad case of, "Things like that don't happen in educated households." Well, guess what? They do. (Kimberly)

> My essential problem stemmed from my relationship with my mother. I have never felt accepted or understood by her. Although she is proud of my giftedness, I think she feels that my pursuit of my talent area was a repudiation of her.

> However, that is a relatively minor part of the difficulties within our relationship [which included significant emotional abuse]. (Nicole)

> Despite having two very intelligent and highly educated parents, I was not raised in a family where "scholarship" was openly valued and cultivated. I was expected to "live up to my potential" (acknowledged to be very high) and to downplay it, because "bragging" was not nice and would make other people feel bad. (I would say that I got this same message from several teachers along the way, too.) In my family, things were complicated by the obvious but unmentionable differences between my abilities and those of my sister. So my giftedness became something that could not be mentioned… I was supposed to be "perfect"… "because I had been given the ability"… and felt there was something shameful about doing well, because it could not really be acknowledged wholeheartedly as good -- since by comparison it would imply that my sister was "bad." (Pollyanna)

Kimberly, Nicole, and Pollyanna all reported participating in long-term therapy relationships in adulthood, where these experiences were understood empathically and became a major part of their therapy. After a great deal of family trauma and degradation from multiple therapists, Erika began working with a Reiki practitioner, whom she described as providing the empathic mirroring she needed.

General Alliance Variables

Trust and Safety Issues

In the areas of congruence, unconditional positive regard, and general trust and safety within the relationship, therapists were typically seen as being generally honest, trustworthy, and capable of maintaining appropriate boundaries. Problems in the bond between therapist and client were largely related to failures of accurate empathy or open disagreement about the nature of the problem. A number of individual therapists were identified as having specific difficulties in terms of opacity, oversharing, dishonesty, or judgmentalism, but these appeared to be isolated cases within the sample. Except as noted in other sections of this chapter, these difficulties did not appear to relate to any experiences specific to the highly intelligent population.

Agreement on Goals and Tasks

Clients who felt empathically understood and valued by their therapists also virtually all reported successfully negotiating a wide variety of goals and tasks of therapy. In a few cases, the specific, problem-solving nature of the goal or task was such that the client felt that complete therapist understanding was not truly necessary. In these cases, they were still comfortable with the jointly agreed-upon methods. Respondents who felt misunderstood by their therapists also generally had difficulty in jointly negotiating goals and tasks which related to the areas of misunderstanding. While most left therapy if they felt they had a realistic option to do so, some chose to remain in therapy while focusing the work on the areas where they did experience empathic understanding.

Therapeutic Process

As with the rest of their lives, clients typically felt that their own or their therapist's intelligence affected the therapeutic relationship and process. In fact, every participant described experiences during which giftedness facilitated, distracted from, or in a few cases destroyed the work between therapist and client. Thomas summed up the experience well:

> I don't think you can separate my unique cognitive profile from the work -- it was one and the same. It both informed treatment and was the reason for treatment. (Thomas)

Rapid Progress, Rewarding for Therapist

A number of therapists were noted as having explicitly described enjoying the work they did with clients, and being impressed at the rapid progress the clients made. All of the reported conversations seemed to have been experienced by the clients as accreditating. Three examples support that interpretation:

> As one therapist told me, "One thing I appreciate about working with you is that I can tell you something and you just get it right away." [Both of my therapists seem] appreciative of being able to work together at the same intellectual speed and being able to use big words. The appreciation shows in both spoken and body language. I believe this because this is what we do together, and I know from much experience that this is not what happens with most other people I know in the world. (Joan)

> She actually talked about how much she enjoyed working with me because of my intellect. We had interesting conversations. (Dove)

> She has said that I make progress "at lightning speed." (Nicole)

Depth of Analysis

Not surprisingly, clients typically commented on how their intellectual prowess contributed to their ability to make sense of themselves and of their experiences with depth and complexity. Those who mentioned this aspect typically also commented on the importance of the therapists' capacity to collaborate effectively in this process, as reflected here:

> At the time, I knew that my intellect positively facilitated the clinical work, but I did not truly understand how my own giftedness really affected the process of the work. I knew I had a strong capacity to critically-think, that I could make meaning with the best of them, and that I had a knack for building bridges from the therapy office to my world; but in the moment, my therapist and I weren't using that lens. Over the years, I've revisited the work in my own head and only then did I begin to realize how my own giftedness truly affected the work on a variety of levels… Sitting with someone who was an intellectual peer, being able to question and challenge -- it was all quite invigorating. (Thomas)

> She is probably highly intelligent herself. She is certainly highly accepting of giftedness in others. When people can follow your narrative, with all the ins and outs and complexities, and without questions that betray lack of understanding, then you feel that she is accepting you and your giftedness. (Splash, the only client whose therapist was a recognized specialist in gifted issues)

> I never felt I was being talked down to, and I never felt I had to explain things one-syllable-at-a-time. (Brenda)

> The first session assured me that [my therapist] could -- and would -- follow me and I spoke my feelings aloud, that metaphors, myths, stories, and philosophies could be tools rather than impediments. I felt confident that she would listen

> deeply, that she would not be confused or put off by my sometimes quirky sense of humor, could appreciate it as another tool with which I could reconstruct a me-in-the-world. (Emma)

Risk: Not Being Able To Keep Up

Naturally, not every therapist was capable of keeping up with the client. In fact, as described elsewhere, Emma later came to believe that her therapist was not able to understand the complexity of her experience of her relationship history, and felt that therapy became ineffective for her in exploring this area. Like Emma, clients who found that their therapists could not understand the intricacies of how they analyzed their own lives tended to report that therapy was disappointing. Two such situations are described here:

> I tend to make leaps. I see patterns and connections fast. It takes somebody to keep up with that. Not everybody can. Not everybody wants to. They'd give this blank look and say, "Say more," and I'd feel frustrated. There's the "say more" because there's more to say, and then there's the one of "I don't get it." It was like their were trying to find their way through a dark tunnel, to see through. Others had a light. (Shelley)

> I'm not sure if me being gifted affected that [first] therapeutic relationship as much as *her* being gifted did. I felt that we related so easily on an intellectual level so I was free to let my guard down and explore my emotions. I know that sounds odd but I think most gifted people spend a huge amount of energy hiding their intelligence so the people around them feel more comfortable. This is emotionally exhausting and often prevents us from truly connecting with other people. (Claire)

Several clients described their therapists as being willing to admit when they did not understand the client's ideas, and willing to inquire patiently until they did arrive at a shared understanding. Although the tone of these descriptions was not as enthusiastic as those which described a therapist who was able to follow the client with ease, informants seemed to appreciate the effort. They reported that even a therapist who was not quite as intelligent as they were could still, with joint effort, come to some shared understanding

that was therapeutically useful. The following description illustrates this finding, including an insight about the professional skills of a therapist:

> She was a very good listener. She made it clear early on that she didn't have a lot of experience working with technology and didn't know much about it. That meant I often had to describe things in language that wasn't the most natural for me -- for example, with most of my friends, I could say, "It feels like there's some process using up 50% of my cycles leaving only half for whatever I'm trying to be doing;" my therapist wasn't going to understand that metaphor so I had to phrase it differently. That wasn't usually very difficult, and it may even have helped sometimes, but it did impair communication at times… I felt she understood my *emotions* better than I did myself, but it was clear she did *not* understand much of my experience. She understood that I had skills and competence and was good at what I did, but she didn't have any understanding of what that really meant or what that sort of work was like -- but she was good at listening to me talking about them, asking non-condescending clarifying questions when appropriate, and most importantly getting to the emotional core of what was going on -- why it was important enough for me to mention. And she was good enough to convey to me that what she was asking was important, even if I couldn't yet see why, so I didn't get impatient the way I often would with teachers… I was able to adapt pretty well to her style. (Andrew)

Risk: Balance between Intellect and Emotion

An important variant noted by a number of respondents was that their intellectual prowess brought with it the risk of therapy becoming an empty intellectual exercise, or that they were able to use their intelligence as a defense against actually doing difficult emotional work. When this potential pitfall was processed explicitly and understood empathically, the responses suggested that exploring the balance between cognition and affect was an important and beneficial part of the work, as is evident in the following quotations:

> One of the things we worked on was my ability to go to my intellect as a way of covering my emotions. I could dodge into an analytical discussion of what happened the moment any emotion began to rear its ugly head. It was very easy for me to analyze myself in a very dispassionate fashion. I could be very rational and factual about what happened. I think that if I had less intellectual capacity I might have had an easier time getting into and accessing my emotions… I was trying to read the score of the symphony and missing the entire experience of hearing the music. My therapist helped me hear the music. (Dove)

> I was/am a gifted left-hemisphere learner. My capacity to think and use words was always exceptional. My therapist understood the double-edged nature of that strength. He recognized my propensity for navel-gazing and over-thinking. Within the work, he often encouraged me to utilize other modalities such as action and fantasy. It was liberating and life-changing. (Thomas)

However, not every therapist was reported as being able to explore this balance in a way that felt safe for the client, as illustrated by the following:

> I know I'm particularly good at hiding my emotions, but [my first therapist] always seemed to push me to realize them. These two [therapists] seemed content with a few tears and then a very superficial gloss over anything that came up. I always sort of got a sense that we were talking as colleagues [because I was a physician and they were psychologists] and that I needed to maintain a certain decorum. (Claire)

> He has remarked that I am "Spock-like" in my rationality. He was joking and I took it as a compliment, but I don't think he meant it as one… I feel like he wants me to cry or show more emotion, maybe because I am a woman. But I don't feel like it. Sometimes I feel "bad" because I won't cry. (Lindsey)

Risk: Emotional Flooding

Another key variant, reported by several clients, was that the intensity of their emotions could at times result in their becoming overwhelmed. As with the general balance between intellect and affect, when this experience was understood empathically and processed explicitly, it was beneficial to the alliance and to the client's work in therapy, and when it was not, it interfered with the alliance.

> One of my main frustrations was that I had all this [intelligence] and when I got upset I couldn't use any of it, because the emotional experience took up too many channels in my head for the language to get through… I think it was obvious that although I had these difficulties in coming up with the language when I was in an emotionally charged situation, when I had my full processing capabilities, me and her alone in the room, I had these incredible abilities to create these images of what I meant and what I wanted... She accepted it as valid and not something that needed to be fixed, just something that could be accepted and worked with… We worked on accepting some of my limitations but still trying to capitalize on the strength of when I could communicate. Also, she helped me learn to communicate in a limited way to people who knew me, so that I could cue them when I needed to take a break… She would make my mother slow down and

> listen to my point of view. That was amazing… fabulous. (Sharon, describing therapy when she was an adolescent and emerging adult)

> I never felt I was understood by [one of my therapists]… she was obviously confused at me breaking down emotionally, and fiercely demanded that I explain why, at a point when I was not very articulate… Up until very recently I have never questioned a therapist on any point. I did not feel competent to do so, and/or felt too upset to be articulate if there was a major problem. (Kimberly)

Hard Work

Another key variant in the client descriptions of how their giftedness affected the process of therapy, cited in approximately one-third of the responses, was that their giftedness potentiated a strong desire to work hard in therapy and to make the most of the experience. Of the clients who described these experiences, they typically also felt that their therapists appreciated or at least accepted their drive to accomplish. The following quotes are representative of this experience:

> I vividly remember at the end of my first session, I was feeling highly uncomfortable and unsure of whether to continue. She looked at me and asked "Do you want to work?" I experienced the question in my gut as a physical sensation. I intuitively knew at that moment that it would be difficult, but that she could help me. She was different from the others I had worked with in the past, and there were several. (Shelley)

> I do think that my drive to try to accomplish something helped. I used the same skills with which I approach schoolwork and professional work (the same skills that allow me to do the things that got me noticed as gifted) to approach my emotional issues, and I think that helped me to work on them more efficiently and solve them more quickly. I'm not sure my therapist expected that, but I don't remember it being a problem; she was able to adapt pretty well. (Andrew)

> I am very persistent… That persistence definitely affects the way I process what I learn in therapy. When I learn a new concept I want to explore every aspect of it, figure out how it fits with what I already know, and integrate it into the way I think about my life experiences and myself… [My therapist commented that] anything she offered, I took and used to the fullest extent. (Nicole)

Risk: Not Following the Client's Drive

In fact, most of the clients who commented on their own drive for self-understanding also expressed a desire for the therapist to push them *harder*, as illustrated in these quotations:

> She expected us to use the dialogue format on a regular basis outside of therapy, which never really happened. She also gave us other "homework" that we never did, and I can't recall her taking us to task for not doing it. I think she should have done so. (Paula)
>
> There were some times when I wanted her to push a little harder to get to some underlying issue, something I wanted to talk about but didn't know how to approach. (Dove)
>
> My therapeutic relationship is: trust-filled, calm, intellectually interesting (I always end up with things to think about), at times challenging (but maybe not often enough), wistful (don't know why, but that adjective comes to mind…), at times deeply philosophical. What I would like it to be like: emotionally more intense, more challenging, provocative, a bit more confrontational, trust-filled, philosophical, intellectually engaging – a lot like what it is, except she maybe shouldn't let me off the hook as much as she does. (Pollyanna)
>
> In a way, she was a bit too accepting of my analysis and my goals… there have been *many* relapses and it makes me wonder if a bit more aggressive probing of causes might have made longer term solutions come into play. (Splash)

Several clients reported managing the conversation when they were ambivalent about bringing up a topic. Paula's comment is representative:

> There were a few times when I could see the direction a conversation was going, and I often felt I could influence that direction to avoid talking about things I didn't want to talk about… some topics were "missed," and they have come back to bite us… (Paula)

Risk: Perfectionism

However, it is not surprising that the drive to study the self also carried with it the risk of perfectionism within the therapeutic process, cited by several respondents. Thomas offered this observation:

> Because the therapy was seen as part of my "program" and required, I felt like I needed to excel within it, as if I was in class or better yet, doing a directed study with a professor. It took a while for me to move from that initial stance. (Thomas)

Issues of Technique

As mentioned earlier, respondents described their therapists as using a very wide variety of therapeutic approaches. There seemed to be no apparent connection between the theoretical orientation of the therapist and the strength of the therapeutic working alliance. However, several interesting themes regarding therapeutic technique arose from the participant narratives.

Risk: Misunderstanding Developmental Asynchrony

A substantial number of respondents (approximately one-third of the sample) explicitly described situations where therapists were either particularly attentive to or particularly misunderstanding of differences in developmental level with child or adolescent clients. These differences included both differences between the client and between other clients of similar age and differences within the client in terms of domains of development.

> I did not think in any language virtually at that point. I literally couldn't think of anything to say. She said nothing, let me sit and be blank. It was awful. I was bored, I was 11, I was frustrated. She didn't understand in the slightest that I couldn't do what she was asking me to do… I tried to find things I could do… She refused to let me play with any of the games, saying those were for younger children… I got the impression that because I was smart, I could clean up well, sit during adult conversations, be appropriate, she expected me to be able to converse on an adult level… It was like the two were incompatible in her head: if you were smart, then you needed to be grown up. (Sharon)

> My second therapist often told me that she had to remind herself that I was not 28, because I sounded like I was going on 30, even though I was only 15. I just wanted to scream at her, "Yes, *that* is the problem! I am about to go to college at 16 and I was still being treated like a child. I was deeply disturbed, bored, depressed, lonely, and misunderstood, and this therapist was no help whatever. (Vevina)

> My son's therapist did occasionally remark on his cognitive strengths, saying that they enabled her to work with him in different ways than she would with other kids his age. (Pollyanna; her son was a child and adolescent during this therapy)

> I often felt like I had to play at being childish in order to be taken seriously. (Doreen, adolescent)

> I felt like I was often being talked down to. (Jay, child and adolescent at the time of therapy)

Risk: Oversimplified Technique

Similarly, some clients described difficulties in the alliance which could be understood in terms of the joint negotiation of appropriate therapeutic tasks. Clients reported that the techniques the therapists were using were too simplistic, not well-matched to the complexity of the way they understood their situations or needs. The following excerpts reflect such perspectives:

> Many of the therapists seemed, frankly, to be of slightly below-average intelligence, very given to platitudes and paint-by-numbers advice-giving. (Doreen, adolescent at the time of therapy)

> When I spoke of my grief, which frequently assailed me in unexpected ways and places, she seemed often merely to reiterate things she had said before, or to quote passages from books at me… She tried several times to have me do things between sessions that I felt were too elementary. For example, she wanted me to write out a conversation with my deceased mother. I told her this felt artificial and beside the point, but I tried it. It opened little for discussion that I had not already discovered on my own and worked through. (Emma)

> I was beginning to think we had exhausted that method [structured empathic communication in couples therapy]. (Paula)

> [Son's therapist] told us that we should focus on consistent parenting by taking away toys, computers, etc, when his behavior was inappropriate. I was fine with the idea until all that he had left was his books, and the counselor recommended that we remove those, too. My son's reaction to us confiscating his things was to stop caring about them [even after we gave them back, he would never again play with them]. I wasn't willing to affect his interest in books. (Erika)

Written Language

Within the gifted culture, drive to learn and eagerness for high achievement, as described earlier in this analysis, often lead to a high value placed on the written word. Written language is commonly seen both as a prime source of information and means for self-expression. Many respondents described using books or writing to learn more about themselves and to facilitate the process of therapy.

Books

A substantial number of respondents, approximately one-quarter of the sample, reported that they had done extensive reading about giftedness as part of their own process of self-discovery. In most cases, they developed their knowledge in this area separately from the therapy process, becoming in most of these cases more knowledgeable than their therapists. In fact, they typically reported having been the ones to educate their therapists on the topic, providing articles and books for the therapists to read. As will be described below, they met with varying levels of acceptance. Those who felt that their offering of information was rejected typically experienced this as a rupture within the alliance, while those who felt it was accepted tended to feel better about the relationship as a result. However, as will also be explored below, several respondents were introduced to the topic of giftedness by their therapists, with the information processed explicitly in therapy.

These avid readers were also eager to learn about themselves and the problems they were struggling with in therapy by reading books on other topics. Among the respondents who were not professionals in psychology or related fields, it was nevertheless common (reported by almost half of the respondents) for them to mention

having read about topics such as childrearing, pedagogy, anxiety, depression, meditation, or PTSD. Some received reading recommendations from their therapists, while others sought out the information on their own. Some who identified specific sources of information described books aimed at a professional rather than a lay audience. In fact, every single participant asked to be informed upon this study's publication. Additionally, as will be discussed below, respondents typically expressed a high degree of confidence in the depth of their knowledge, as did the two quoted here:

> I was smart and well-read enough to figure out what she was doing and thinking to a large extent. (Astrid)
>
> Having studied (minor) psychology in college, I believe that the therapist gave me credit for that knowledge and permitted me to state issues directly. My memory of the experience was very positive in that he probably accepted that I might really know as much as he did or at least was able to understand all of the issues. (WiseEye)

Writing

Another key variant, cited by approximately one-fourth of the sample, was the use of writing as an important part of the therapeutic process or dialogue. Writing included journaling, memoir writing, preparation of an agenda for the session, and process notes on the sessions themselves. Vevina's offering of her in-progress novel might also be understood in this vein. Not surprisingly, whether these written self-explorations were accepted empathically by the therapist had an effect on whether the client felt understood by the therapist. Evidence of the importance of this acceptance can be seen in the following:

> In my desperate desire to be rid of all the trauma and the intolerable feelings I was experiencing, I wrote it all down (it was about 14 pages) and faxed it to her. She seemed disbelieving that I could have produced such a document on a Friday afternoon… She set boundaries on me communicating things to her in writing which was quite humiliating for me… She became frustrated with me because I was having trouble verbalizing some difficult material (very shameful to me)…

> We ended up making a compromise that I could write down difficult things during session and read them aloud to her or have her read them aloud. (Nicole)

> I kept a notebook of our sessions, as I do now [with a different therapist], and would attempt to bring up some topics again in the next session after formulating a way to try to talk about them. (Vevina)

> I wrote a memoir about the first ten years *after* our reunion [I had given an infant child up for adoption many years prior to therapy]. I did this because I found little information about constructing a sense of kinship where there were blood ties but no shared experiences. I also discussed this with my therapist because it was part of my process of reinvention. (Emma)

> She asked if she could keep and use some of the writing I had done, and she encouraged me to write more. She often suggested that I should write, or submit my work for publication. She encouraged me to return to an academic environment. (Dove)

Autonomy and Competence

An interesting set of themes brought up by many respondents touched on ideas of how the client's autonomy and competence were understood within the relationship. Clients described a strong preference for egalitarian relationships in which their self-determination was respected. When the therapist was not able to take on the role of partner, respondents also described a number of adverse conditions which placed the alliance at risk and interfered with the progress of therapy.

Egalitarian Relationships

Approximately one-third of the participants explicitly described the importance of feeling that the relationship between them and their therapist was a partnership of equals. Therapists were typically seen as valuable sources of information and ideas for the clients to use, rather than as doctors who performed cures upon patients. When clients felt that their therapists respected their autonomy and competence, they were also typically enthusiastic both about the quality of the alliance and the effectiveness of therapy. Two participants described being in intense distress when they initiated the relationship,

feeling very much that they wanted to be taken care of. However, they too described preferring a more egalitarian relationship once the immediate crises were brought under control. The following quotations illustrate the value many respondents placed on the egalitarian nature of the relationship:

> My therapist and I clicked right away. He treated me as an equal so that therapy was an active discussion that revealed his personality and mine, his interests and mine, his thoughts and opinions and mine. He was casual, never authoritative, which was so very different than all but one other therapist… I was not a subordinate, but part of a team -- and I, not he, was the captain… when I understand and develop my own processes, I do very well. I needed a consultant, and we agreed that was how to best proceed. (Luci)

> I've probably read way more on the topic than most therapists who are not gifted specialists, but I don't have the professional training to put my layperson reading into therapeutic practice. In many ways, on gifted issues, it feels more or less like a partnership, and I'm comfortable with that. (Pollyanna)

> I had been prepared before the sessions to be coddled in the therapeutic relationship but was pleasantly surprised by the equality in the discussions… Our discussions were very much ones of support that I was "allowed" to make the changes that needed to be made and that I had the ability, on my own, to make those changes… I left the therapy with a plan, albeit one that would take many years to complete, knowing that someone with some "real" credentials had validated my own thinking and approach. (WiseEye).

> Self-directed: Therapists support me (and my partner) in addressing self-identified needs… In one instance, I felt the discussion was going in a therapist-led direction, not mine. I was able to pause the process, and in subsequent discussion, felt that respect and safety were re-established. (Joan)

By contrast, clients who felt that the therapist was taking on too much authority within the relationship, insufficiently respecting the client's knowledge and right to self-determination, typically reported this experience as injurious to the relationship. The three excerpts below reflect this negative outcome:

> When I sensed that [my therapist was overconfident or just relying on her scholastic achievement, I became angry. I had been through things that this woman had only read about. I had not chosen to go into her field but I could easily have done so. I did not look to her as a person of authority… I do not feel

> like I was treated like an equal, and the relationship ended poorly. (Victoria, adult)
>
> I thought that I was being told that I was wrong and they were right, and that I should agree with them… I tried [to present my point of view] at first and then gave up after a while. I was just a kid, they were the adult and the professional. (Jay, child and adolescent at the time of therapy)
>
> [My therapist] prescribed antipsychotics but said they were antidepressants -- I looked it up before agreeing to take it and refused upon discovering the ruse. (Doreen, young adolescent at the time of therapy)

Nicole described an incident which brings together several issues along these lines. Her therapeutic work was focused on processing relational trauma from her childhood. At one point, on her own, she sought out a book written for clinicians on how countertransference phenomena affect the treatment of trauma (Dalenberg, 2000). She found the book very helpful to her understanding and enthusiastically brought it in to share with her therapist. Her therapist was taken aback by this offering. Not only were Nicole's choice and ability to access the professional literature seen as sharp movements out of the "patient" role; the specific content of the book also seemed to imply a criticism of the therapist's ability to maintain self-awareness and to act professionally. Fortunately, they were able to process this relational rupture positively, and the alliance was strengthened.

Risk: Therapist Becoming Extraneous

While clients seemed to prefer a relationship in which they exerted a great deal of autonomy and competence, they nevertheless typically wished for their therapists to come with them on the journey. A commonly-cited variant experience of disappointment in the alliance arose when the therapist was perceived as being unable to provide a meaningful contribution to the tasks of therapy, becoming superfluous to the client's own work. The comments below attest to this phenomenon:

> Each week became a matter of me narrating the previous week's events and what sense I'd made of them. Most often, she did not challenge or interrogate my interpretations at all… I think sometimes she felt extraneous but liked talking to me… A few times she even processed with me some of her own concerns. It felt like we were friends, except I paid her. (Emma)

> I have done a lot of therapeutical work on my own time, and sometimes I feel like he only listens to me and doesn't give me enough new insight. (Lindsey)

> We have recently re-entered couples therapy. Once again, I feel like I am a co-therapist, though I hope that will change. (Paula)

Risk: Struggle for Dominance

Not every therapist seemed able to establish a relationship in which the client felt that their ideas and wishes were respected. In some cases, an open struggle for control arose. In virtually all of these cases (Thomas was the sole exception), therapist and client were unable to process this struggle within the relationship, and the alliance collapsed. Examples follow here:

> (What it was really like) challenging, life-changing, safe, competitive, intellectually stimulating. (What I would have liked) All of the above, except, I wish that the relationship was less competitive. (Thomas)

> The therapeutic working alliance, except with one of my therapists, was an exercise in human dominance display. I was usually winning, until the point where the therapist took strong measures which I was unwilling to go along with -- at which point I would refuse to return. (Doreen, adolescent at the time of therapy)

> I treated her as a pawn in my own game… It became an exercise of competence for me, and a struggle for dominance. That was my conscious thought at the time. I was looking to win, to get things from her without giving her anything. I never gave her more than a brief story about anything, inconsequential stories, "We had a math test." Most of the things I asked for she rejected, so I learned not to ask, but found ways to force her or trick her into giving me what I wanted. (Sharon, child at the time of therapy)

> My sessions with [my therapist] devolved into discussions of semantics… I was left with a choice -- continue our sessions, without the debates, or end them because I felt she was being less than honest and open. After much consideration, I decided to remain with her, primarily because we could speak well in many other areas [other than the relational issues which had been a primary reason for

> referral]. However, I learned *not* to confront her directly, and I chose not to accept her assessments when she confronted me. (Emma)

> I was pretty much always honest, but it would have been wiser not to have been. (Doreen, adolescent at the time of therapy)

Risk: Resigned Compliance

In some cases, the client perceived that they were not accepted as eligible to be a true partner in the therapeutic process, but also that their attempts to claim this eligibility were not likely to be successful. Some left therapy. Others did not feel that they had a choice but to stay, either because they were children or adolescents, or because, as parents, they needed to maintain the relationship in order that their children would continue to have access to their own therapy. One example of each situation involving no felt choice follows here:

> Because I felt misunderstood and defensive, I stopped sharing my own feelings in therapy… That left me little help on an ongoing basis, which would have been what I actually needed. (Erika, adult and parent)

> Often I just said, "I guess you're right" and resigned trying to get them to understand… At a point I just gave up and saw going to therapy as another chore, like taking piano lessons, or going to Sunday School. I tried to appease them. (Jay, child and adolescent at the time of therapy)

Risk: Manipulation of Therapy

Several respondents told stories of successfully manipulating the therapist in order to protect themselves against those they saw as not sharing their understanding of appropriate goals or tasks for the therapy. The following two quotes exemplify these responses:

> I think my other therapists were not perceptive enough -- I was able to snowball them, to be dishonest with them about my feelings. With the therapist in school, I learned pretty quickly how to give the answers I needed to dodge whatever I didn't want to deal with. He didn't see through it. It's so easy for therapists to get slammed, to manipulate them, to not go places you don't want to go… I would consciously manipulate the conversation in group therapy at the hospital to

> keep the heat off of the other patients… They never caught on. (Shelley, adolescent at the time of therapy)

> [After Sharon told her story about struggling for dominance in therapy] She finally brought out a storytelling game. I told the most horrible, twisted stories I could think of, involving women and children being tortured and murdered by white male bad guys. I always ended my stories with the bad guy captured or killed, because I did not want her to be worried or to have me committed. I don't think she ever realized I was manipulating her… I had no conception at the time how typical 11-year-olds think. Looking back on it now, I can see how incredibly complex my thought process was in my ability to think about the process, my relationships with her, her responses to what I said and did in the room… I would have been much more willing to talk with her if she had let me talk about my family or peer relationships. I would have welcomed some concrete guidance in how to navigate those situations. (Sharon)

Sharon's next story was not about manipulating an existing therapeutic relationship. Instead, she described a similar level of calculated intentionality in her help-seeking behavior several years later:

> Sometime before my 16th birthday, no one was listening to me, I needed things to change, I needed our family to get help. So I faked a suicide attempt. I "ran away" to a park two blocks away, long enough to get them looking for me. I cut my wrists, shallow so it wouldn't do any real damage but would make a lot of blood, and walked home. Dad was just about to start looking for me. I just showed my wrists to him. [Were you aware at the time that you were confabulating?] Totally aware. [You knew you were going to be the identified patient?] Absolutely. I was fine with that. If it got us in the door, I didn't care. (Sharon)

Unique Response: Accepting Pathologization

Mick's story deserves particular attention. Although she was the only respondent to report having internalized the many pathologizing messages she received about her giftedness and its manifestations, the consequences for her of having done so were quite serious:

> I quickly felt as if I could not share the meaning I attributed to my experiences in school and at home, as well as the depth of this meaning and its interconnectedness with other experiences. It was treated as a problem on top of my substance abuse/dependence… I regarded most of my therapists as being quite intelligent, and this led me to believe that I was not gifted, as they did not

> seem to understand any of my unique experiences as a profoundly gifted individual… My issues [were] dismissed time and time again by those in authority…
>
> I caved into their suggestions… I pretended not to feel any of these things and further drank and used drugs… to numb… to eliminate… to destroy my intensity, passion for learning and frustrations with my situation, prompting more counseling… It did much more harm than good… I started to feel hopeless and depressed, as if I had been born as the wrong person...
>
> I did not know why these were problems and why I could not adapt to expectations at school and home until my last round of drug counseling, when the connection between my extreme giftedness and the destructive ways which I had coped with this was uncovered. At 19 and in my last round of treatment [Note: She had been in therapy since age 14] it was explicitly brought up by my therapist, who noticed my high level of awareness, introspection, and diction. She and I discussed how this impacted my experiences earlier in life, as well as how it would impact my program of recovery.

Mick did not experience empathic understanding of her experiences or her problem. But rather than remaining locked in disagreement, she accepted her therapists' definitions of the problem: her intelligence itself. Substance abuse then became, paradoxically, a self-destructive solution. When a therapist was able to view her empathically and to represent herself back to her in a compassionate way, she was then able to experience the therapist as an ally and to move forward. Five years later, in her response for this study, she reported that she had maintained sobriety, and had returned both to higher education and to a more empathic therapeutic relationship.

Conversations about Intelligence

It was typical that giftedness and its effects on the client's life were explicitly discussed at some point in therapy, whether the conversations resulted in empathic understanding or not. The respondents who described these conversations typically reported that they were the ones who brought up the topic, although a therapist introducing the topic was not an uncommon variant. Some discussions focused on the

topic directly, while others tended to view it in terms of how it affected or mediated other aspects of experience.

Two of the most successful alliances reported did not include explicit discussions of high intelligence. The clients described feeling-understood by therapists so well, and believing that the therapists were so similar to them, that this understanding was assumed, evident in the following:

> It was more of an unstated mutual recognition that didn't need to be discussed much more than the fact that both of us are female. (Brenda)

> Occasionally we would talk peripherally about giftedness, but both of us accepted it as a given, so it wasn't a matter of debate, so much as part of the given background. (Splash, the only respondent whose therapist was a nationally-recognized expert in gifted issues)

Several other largely successful alliances were reported as not including significant discussions of giftedness, because the specific nature of the agreed-upon goals and tasks was very concrete and specific. These therapies involved short-term or highly structured work, rather than being broad-ranging explorations of client experience.

For the remainder of the reports, the participants' perception of the overall quality of the alliance and the effectiveness of therapy was strongly correlated with whether intelligence and high achievement were areas which could be discussed openly, understood empathically, and recognized as intertwined with the rest of their lived experience. In short, giftedness had to not be unspeakable, as Joan explained:

> Giftedness not only affects [my experience of the alliance], it is integral to it… I brought it up explicitly from the beginning, although I am still extremely uncomfortable using the G-word to describe myself to others, even those in the know. It is no longer treated as an issue in itself, but as one of many components that make up the whole person that I am. (Joan)

Those therapists who were knowledgeable because they themselves had lived the experience and had integrated the experience into their self-concept appeared to be better

able to discuss the topic of giftedness with their clients than those therapists who were not gifted. The following two quotes illustrate this idea:

> I felt relief at being heard and respected and not told I was wrong for being me. Relief at being treated as a very smart person, by very smart therapists (as discussions often go amongst the gifted, you can "see it in their eyes." Completely immeasurable.) Strengthening: learning to understand with my mind and my body that what I have been taught are weaknesses (intelligence combined with physical and emotional sensitivity and social perceptiveness) are actually strengths… If I had not [had this experience of the alliance with] my therapists, I would not have been willing to continue the hard work I am doing in therapy. Their unconditional support, open-mindedness, integrity, and belief in the validity of how I define my concerns, create a safe place for me to engage deeply in the process. (Joan)

> He spoke of his growth rather than his achievement, and shared achievements in the format of sharing an interest or hobby. (Luci)

Luci described her therapist as highly intelligent and perceptive, but was particularly drawn to his position as valuing his own learning process.

Lack of Client Awareness

An interesting variant in the discussions of giftedness in therapy was that a substantial number of clients (approximately one-fourth of the sample) did not at the time think about themselves as highly intelligent or construe their intelligence as being potentially intertwined with the situations they were exploring in therapy. It was only later that they came to believe these ideas. There were three different versions of this experience, each cited by more than one respondent. In one version, the client did not want to think about the topic in therapy, because they did not feel that the therapist properly understood the negative effects of intelligence. Some of these therapists were able to help the clients explore those effects without directly tying them to intelligence; others were not. The examples which follow represent both categories:

> I did not conceptualize the problem as having anything to do with giftedness or intelligence. I thought I was just weird or that my family was weird… She was

> very focused on the feeling of being different and how that was for me. That was way enough for me. I think that if she had said it was because I was smart, I would have felt blamed. I think that would have made me feel like it was my problem. (Megan)

> I was in gifted denial. It was normal for me to ace mathematical statistics. I never understood why others made a big deal about it. When my therapist tried to convince me that this was an unusual trait, I did not want to hear it. I didn't want to be different. It has since taken me years to realize all of the issues I had with being an underserved gifted person. While my therapist recognized my talents, she seemed completely clueless about problems related to giftedness. (Victoria)

In the second version, clients was not particularly aware of giftedness as an issue. They may have known they were smart but did not consider it as anything beyond what enabled them to do well in school. It was also typically not addressed in therapy either. The clients later learned about giftedness and incorporated it into their view of self, typically in the context of having recognized that their children were gifted and in need of support. In some of the long-term therapeutic relationships, the client was then able to introduce and process this understanding within the therapeutic context. However, most of those who explored their own intelligence did so on their own, as was the case here:

> I am 49 years old, and never heard of the idea of giftedness until four years ago when my son was in public school and tested as gifted. I have read up on the concept since and realized I am highly gifted. [Helen then cited a long list of clear paradigm case indicators from her childhood, adolescence, and early adulthood.] But I was never aware I was gifted because I had never heard of the concept. (Helen)

The third pattern was one in which the therapist introduced the idea in a way which the client was able to understand as empathic. Processing was able to occur in a supportive way within the therapeutic alliance. These interventions were described as highly effective, as is apparent here:

> I am currently in counseling. A few weeks ago my counselor challenged me with the idea that I am gifted. I've done some research… and it does indeed appear I may be gifted. This is news to me; however, much of the reading has helped me

> clarify what has happened to me and is providing confirmation and confidence, because I see myself in so many of the experiences of other gifted people. (Alien)

> The validation was immediate… and he very quickly let me know how smart he thought I was, and why he thought so. And just because of the way he presented that opened a discussion on giftedness and what it meant. (Luci)

Therapist Knowledge about Giftedness

When respondents discussed their therapist's knowledge of giftedness, they reported that therapists were typically not particularly knowledgeable about the subject. Typically, this lack of knowledge was seen to characterize therapists who were seen as less intelligent than the client. However, a number of respondents felt that their therapists were quite intelligent themselves, but were nevertheless relatively uninformed about how intelligence might relate to the process or content of therapy.

Openness to Learning

A number of the respondents attempted to inform their therapists about giftedness. Some did this by describing their own experiences; others, consistent with the expressed valuing of the written word, provided books or articles. When therapists were open to learning and incorporating these ideas into their understanding, clients reported high levels of tolerance for the therapists' learning process. That is, therapists who openly admitted the limitations of their knowledge and showed a willingness to learn, were seen as contributing positively to the alliance, as articulated by the following:

> He wasn't particularly knowledgeable about [giftedness], nor did he describe himself as an expert in it, but he was at least open to it and acknowledged that it played a significant part in our (both mine and my spouses) response to the external pressures placed on individuals in [our country]… He acknowledged that giftedness played a major part in our family dynamics. (Lily)

> I don't think she would describe herself as an expert in gifted issues… But the truth is, she knows a lot and seems interested in learning more. The knowledge was presented in context, as she mentioned things she had read, etc. But also, more than anything, she seemed interested in understanding our experience as a

> family, and what we were dealing with, and she has always seemed interested in learning about any resources I have found useful… But I also value that giftedness is not the principal lens through which she views psychological concerns. If she sees it as being a critical factor in something that comes up, I'm more confident that it really is relevant, because she's not just predisposed to see things that way. (Pollyanna)

Risk: Intimidation, Competition, and Countertransference

Some clients reported perceiving their therapist seemed to feel threatened by their intelligence. In a few cases, the competition between therapist and client was able to be discussed and processed in a positive way, exemplified in two excerpts here:

> There were some very interesting transference - countertransference phenomena. Sometimes my ability, or, better stated, my speed at making connections seemed to irritate my therapist. At other times, it was clear that we tried to "top" each other, a cerebral "pissing contest," if you will. He used to joke, "Who is doing therapy with whom?"… Sometimes I purposefully slowed down in the work or held back a bit, allowing him to make the interpretation or clarification, rather than blurting out the spark of insight that had overtaken me moments before… I believed that I was both refreshing and at times threatening to him… We addressed these issues directly -- it was safe to do so, and an important part of the work. (Thomas)

> I knew at times she was intimidated by me and I did not really understand why… I recall her blushing or laughing at times… She even revealed feeling anxious at times in session and not wanting to be judged [by me]. I thought that was interesting and I wondered how many people felt that way around me… But I could also see she was not going to put me down so she could feel better like my father had. This was different and a transformational moment for me. (Megan)

However, most of the clients who reported feeling that their giftedness appeared to intimidate the therapist or arouse competitive feelings also tended to report less comfort within the alliance. Two representative comments follow:

> When I would talk about my daughter in therapy, she would bring up her own grandson. Once she said, "My grandson may not be 'gifted' but he has such a loving heart."… About the third time she brought her grandson to compare him to my daughter I decided I was done and I didn't come back the next week. I really felt like her defending her grandson in my therapy session was unprofessional and weird… I felt like giftedness became an issue that she could not address, and because it is a big part of my life, I felt like I needed to find a different therapist who would understand. (Lindsey)

> Although they both [second and third therapists] knew my history, I felt like I had to be interested and surprised by their recommendations when I'd had these conversations before. I got tired of saying, "Yeah, I already know that." I feel like everyday is like that for me. I don't want people to feel bad because I already know this big, exciting thing they've just discovered. So I play along. Playing along isn't so good for psychotherapy. So I just stopped going… I often felt that there was a certain friction due to our different degrees. I felt like it was an issue that I was an MD. Comments like, "I'm sure you learned this in med school," "I'm sure you've seen this in patients," "I'm not a doctor, but…" My response was to downplay my achievements and intelligence. Once again, not conducive to deep emotional exploration. (Claire)

Long Paths

Many clients took long paths through the system, having negative or unsatisfying experiences with four, five, or more therapists before finding the empathic alliance they were looking for. Others gave up before finding such an alliance. Some settled for working only on topics where they could avoid talking about giftedness. Several respondents reported proactively bringing up the topic of giftedness within therapeutic relationships, or planning to do so if they entered therapy in the future, in order to find out whether their therapists were able to engage in the conversation. The thoughts of four respondents are offered in the following:

> We worked okay together trying to work on specific relationships outside my intelligence, like my relationships with this woman I was in lust with, or the guy I was in love with but who just wanted to be friends, but when it strayed into talking about wanting to be around other brilliant people that I connected with and had things in common with, I was just shot down. (Vevina, emerging adult at the time of therapy)

> Therapy felt like something I should do -- not something that was actually helpful. It felt like I had to carve out time to meet with someone who didn't understand me… I would like to feel acceptance for how hard I worked with my son, understanding for how deeply I feel and how hard I try, acknowledgement for how much my son struggled and how that affected what worked and didn't work with parenting him, and I would have liked to work with someone who could help me brainstorm options that might actually work. I think sometimes that my expectations of counseling are out of sync with reality. (Erika)

> I would not again enter therapy. (Doreen)

> If I or anyone in my family ever sees a therapist again, I would be very careful to make sure they are aware of the issues that gifted people face. (Helen)

However, several other respondents reported enthusiastically that when they felt understood in a deep and complex way by their therapists, then the alliance potentiated highly effective long-term relationships. Goals shifted and changed over time, there was room to explore philosophical topics and developmental challenges in depth, and the therapist became a role model for developmental tasks, as explained by these four respondents:

> I've continued for as long as I have in large part because the fit seems good and because for me there is a strong feeling of trust. And also because I feel like she "gets it," that at least some of what I deal with she has experienced on a personal level and knows of what I speak. She is perhaps a decade older than I, and I also trust her perspective on life and to some degree see her as a viable role model for navigating some o the "developmental tasks," if you will, of the years ahead (grappling with issues of aging parents, aging spouse, aging self, children transitioning successfully to adulthood, etc.) She serves as a reality check for me. (Pollyanna)

> In their work with me and in the community, they model being very intelligent, successful women who are comfortable with their intellectual abilities and achievements. (Joan)

> To me, he became a father figure, mentor, and role-model. My ability to separate and move on from the work with him facilitated my own transition into adulthood as I simultaneously negotiated those same issues with my own father and my family of origin. (Thomas)

> He'd better not die first! (Luci)

CHAPTER FIVE: DISCUSSION

Purpose of Present Study

It must be understood that the purpose of the current study was fundamentally one of verstehen -- interpretive understanding -- rather than erklären -- causal explanation or proof. This study cannot conclusively prove that giftedness affects the life experiences of gifted individuals for which they seek empathic understanding in the context of psychotherapy, nor can it prove that giftedness affects the process of psychotherapy. However, it can provide a potentially valuable window into the subjective lived experience of clients who identify as gifted and how they experience the therapeutic relationship.

It is also important to recognize that this study is not intended to make an essentialist or stereotyping argument; not all gifted individuals will share precisely the same experiences or the same needs in therapy. Even within this study, the respondents manifested significant diversity. However, no individuals within this study appeared to stand out from the others by not manifesting any of the themes described. Each individual presented a unique constellation of experiences, but the vast majority of the described experiences were in some way consistent with these themes. Thus, these themes can be considered as a first step towards a more complete and nuanced description of the experiences of gifted clients in psychotherapy. All interpretations of the data must be treated as provisional guidelines only, topics to be taken into consideration by thoughtful therapists who wish to better understand their clients.

Potential Weaknesses

Sample Representation and Potential Response Biases

The study respondents in many ways are clearly not representative of the gifted population as a whole. First, the sample was predominantly female. This skewed number, however, may not be surprising, given the well-established literature regarding typical male role expectations, beliefs, and behaviors around help-seeking for psychological distress (Addis & Mahalik, 2003). In general, men are much less likely than women to engage in therapy. It is also possible that men who had engaged in therapy were less comfortable disclosing their experiences, even with the provision of anonymity. Additionally, online venues largely populated by mothers of gifted children were the most cooperative in terms of publicizing the call for research participation.

Similarly, study participants largely described themselves as Caucasian or European in ethnicity. In additional, although socioeconomic status was not directly inquired, most of the information provided incidentally suggested current membership in the middle class. Again, this skew in participation can be largely understood in terms of the study methodology, in which participants were largely recruited through online gifted communities. My own observation strongly suggests that members of these communities tend to be more white and more middle-class than the gifted population as a whole, not because of any intentional exclusion, but simply by virtue of who chooses to join and who has access to the computer equipment and spare time to participate. As reviewed in chapter 2, members of minority ethnicities and those of low socioeconomic status tend to experience greater internal and external conflict around identification of themselves or their children as gifted. However, the extant literature does not support the idea that the

conative traits or social experiences associated with giftedness are bound either to social class or to racial or ethnic identity. Thus, it would be unlikely that the reported difficulties in adaptation and in experiencing a positive therapeutic working alliance would be interpretable solely as maladies of the advantaged. Giftedness is not, as it is popularly understood, merely a "disease of the rich." In fact, being of low socioeconomic status or being a member of an underprivileged minority group appears within the literature as being likely to increase the psychological risks associated with high intelligence (e.g., the conflict between affiliation and achievement). Several study participants did refer specifically to having grown up in working-class households, stating that coming from this background had made it more difficult for them to have their high intelligence and drive to learn recognized, understood, or treated as a priority. Thus, while firm conclusions about racial, ethnic, or social groups not well represented in this study cannot formally be drawn, there is little reason to support the assumption that these interpretations could not be at least tentatively generalized to the gifted population as a whole.

Another limitation of this study is that participants were required to self-identify as gifted. In an attempt to locate respondents who fit the dual criteria of being both gifted and having been participants in psychotherapy, calls for participation were distributed primarily through professional networks, support groups, and other social venues which are either explicitly designed to attract those who are willing to consider themselves or their children to be highly intelligent, or those which are organized around interests (e.g., science fiction), which tend to appeal to the high-intelligence population. Significant effort was made in the recruitment documents to encourage participation by those who

might be internally conflicted about identifying as gifted. People who have very high intelligence but who, for some reason, either do not consider themselves intelligent or do not consider their intelligence to be a relevant part of their social identity, would not have been likely either to become aware of the study or to chose to participate. Therefore, it is possible that those who are highly intelligent but who do not so self-identify might have had different experiences, both of the problems which led them into therapy and of the therapeutic working alliance, and thus that the interpretations from this study should again be extended only with caution to the larger gifted population.

However, as with ethnic and class identity, it may not be unreasonable to consider these findings as being tentatively applicable to the population of gifted individuals as a whole. Because of the practical difficulties in identifying people who do not themselves identify as being a member of a group, regardless of the nature of the group, the research literature describing the typical experiences of the unidentified gifted is limited. What literature does exist, as described in chapter 2, suggests that integration of any aspect of social identity into the complete picture of the self, and access to social support from others perceived to share similar characteristics, has generally positive effects on psychological adaptation. The limited literature on the integration of giftedness as an aspect of social identity appears to be no exception to this phenomenon. Thus, those still in the early stages of social identity development with respect to their own intelligence and those with reduced access to social support groups normalizing the gifted experience might be predicted to be at increased risk of negative experiences. Respondents who described the process of becoming aware of their intelligence and its effects on their lives tended to describe improved psychological functioning as a result of this awareness,

provided that this exploration took place within a safe therapeutic alliance. It is conceivable, however, that clients who are in early stages of social identification around the topic of intelligence might be at less risk of coming into conflict in the alliance with therapists who had themselves not arrived at a comfortable level of integration.

Child and Adolescent Clients

The number of respondents who were able to describe therapy experiences that had taken place when they were children or adolescents was not very large. There were no obvious thematic differences between the reports of adult and child therapies, with two major exceptions. First, children and adolescents typically reported feeling unable to leave a therapeutic relationship in which they felt a failure of the alliance, while most adults, except those living in rural areas and feeling that they had few choices of therapist, were willing and able to terminate. As with clients mandated to remain in therapy against their will, and particularly with adolescent clients, it is likely that it would have been difficult for any therapist to establish a positive alliance, or to repair a significant rupture, under those circumstances. Second, children and adolescents were more likely to describe situations in which their therapist misunderstood their developmental capacity to engage in therapy and to understand their world. Adult clients did express misunderstandings of their capacities, but not in developmental terms. This finding is not surprising: adults of all intelligence levels typically construe themselves as having "finished" development, and are thus less likely to think of their strengths and weaknesses in terms of developmental asynchrony. However, the numbers and variety of child and adolescent therapy experiences were not large enough to reach data saturation within themselves. In particular, few positive experiences of the therapeutic working

alliance were described by respondents who reported on therapy which had taken place when they were children or adolescents. Therefore, interpretations specifically regarding work with child and adolescent gifted clients should be considered as more tentative and preliminary than interpretations regarding the work with adult clients or interpretations in which client age was not apparently a factor.

Similarly, only a small number of respondents chose to describe the quality of a working alliance with a therapist they had engaged to help their child. The recruitment materials did not specifically request participation by parents who had had children in therapy, and the questions were not designed to elicit reports of these experiences. As before, there were no obvious thematic differences between these reports and the more general reports of the quality of the alliance, but there was not a large enough number or diversity of these reports to reach data saturation within that topic. Thus, specific interpretations of parental experiences must be considered to be highly preliminary; these experiences have largely been interpreted through the more general lens of client experience.

Potential Reporting Biases

Another important consideration for restraint in interpreting the results was that most of the therapeutic relationships and incidents described had taken place years earlier. Subjects' recall of their experiences in therapy is likely to be imperfect, colored by the life experiences that have taken place afterwards.

In particular, it is possible that some respondents construed their experiences in terms common within the literature on giftedness precisely because they had read this literature themselves or heard about it from others within the community. The literature

might be seen as having created a self-fulfilling prophecy, or a description of experience which appears specific to the experience of being gifted but which is merely ordinary experience presented in language consistent with the literature on giftedness. As described in chapter 2, the experiences commonly associated with giftedness cannot be easily and objectively measured. However, the literature suggests that these traits and experiences are often apparent to observers as well, and that the traits may have a biological basis. Furthermore, it is important to recognize that many cultural groups report common experiences which are difficult to verify empirically. For example, many African-Americans report experiencing "microaggressions" in the form of subtly insulting, distancing, or aggressive acts based upon their race. It is possible that some ordinary experiences are misconstrued as microaggressions as well, simply because microaggressions are presumed by members of the group to be something which often happens to them. In the same way, ideas such as "intensity" have become very much part of the way members of the gifted culture understand and describe their subjective experience. These experiences may be explicitly described by those already aware of them, but are also easily recognized as true or mostly-true by those who learn about them for the first time. As several participants reported, learning about these descriptions often brings both self-recognition and a deep sense of relief.

Along similar lines, participant reports might very well have been affected by the demand characteristics of participating in this study. That is, because this is a study explicitly about the experiences of being gifted, participants might experience the subtle or overt expectation that they present their experience in ways which would please the researcher. Despite efforts to phrase questions in a neutral fashion, it would not have

been possible to recruit subjects meeting study criteria for giftedness and to ask them about how giftedness might or might not have affected their life experience or their experience of the therapeutic working alliance without in any way suggesting to them that they might wish to construe or report their experiences through that lens. Similarly, potential respondents who did not understand their experiences in light of their intelligence might have felt that they had little to say that would be of interest, and thus may have chosen not to participate. In summary, although the overwhelming majority of respondents in this study reported that they experienced their high intelligence as affecting their experiences of life and of therapy, it would be unwise to presume that the same level of near-unanimity must exist within the general population of gifted individuals.

Methodological Note: The Question of Definition

It is of note that the use of self-identification, along with a paradigm case formulation with multiple potential indicators of giftedness, appeared to be effective in selecting respondents for this study. Clients consented to the study and began answering a number of questions regarding their own demographics and the basic logistical details of their therapy before being asked upon what basis they considered themselves to be gifted. This ordering was chosen in part to present a welcoming front even to those who might be unsure of their right to claim the label; had it been placed first, it might have been perceived as a gate denying entry to those who could not check any of the boxes. It is possible that some potential participants did discontinue their participation upon being asked to identify reasons for identifying themselves as gifted, either because they did not perceive themselves as unequivocally carrying these markers or because they did not

wish to disclose this information. These would be considered as false negatives, potential valid participants incorrectly self-excluded from the study. Based upon the data gathered, it would not be possible to determine how many potential participants did not participate at all or discontinued participation upon being asked to describe their reasons for self-identification.

However, the ubiquitous question, "How are you going to define giftedness?" is generally concerned with preventing the participation of false positives, people who do not fit within the paradigm case definition of giftedness, yet who mistakenly identify as such. Yet the study participants appear to raise no concerns in this arena. No single indicator of giftedness was checked by all respondents, but when the indicators were taken as a group, and even when particular attention was given to indicators which are more objective in nature (e.g., IQ testing), virtually all respondents appeared to fit well within the paradigm case formulation. They provided descriptions with multiple clear indicators that would lead most observers to consider them highly intelligent. No respondent would have been excluded had the paradigm case formulation been used as an actual requirement for inclusion.

There were no obvious thematic relationships between how many or which specific indicators an individual endorsed and the respondents' reported experiences in life or in therapy; some of the most internally conflicted individuals and some of those who claimed not to have been aware of their own intelligence were nevertheless among those who might seem most clearly gifted based upon the objective data they were aware of (e.g., IQ test results). It is possible that some respondents were misleading in some of their responses about their reasons for considering themselves gifted, as no actual proof

of intelligence was required. However, it seems highly unlikely that a significant number of markers would have been independently falsified by a significant number of respondents, especially given the high cultural value placed on integrity and other philosophical values, as expressed by a number of participants.

Therefore, while this study was not designed to prove the efficacy of self-identification methodology, it does provide preliminary evidence that such methodology may be useful for future studies involving the cultural experiences of gifted individuals. Specific questions regarding both false negative and false positive choices to participate would have to be addressed through specific studies, which would include the actual gathering of objective evidence and the comparison of that evidence with individuals' self-identifications.

Thematic Findings

While this is only a single study, the findings are highly consistent with the research literature on the therapeutic working alliance and on giftedness, as summarized in chapter 2. There also seems to be substantial thematic consistency within the data.

Giftedness as Pervasive Influence on the Self

The most important overarching thematic finding is that giftedness was typically *not* experienced by these clients as a side issue, unimportant to either the content or the process of therapy. The use of a "person-first" construal, politically popular within the psychological world, to describe "individuals with gifts and talents," appears wholly inadequate to describe how these individuals experienced being highly intelligent. These respondents did not feel that their gifts were separable from their selves. Rather, they described giftedness as permeating their lives, affecting not only their cognitive and

academic functioning, but also their emotional lives, their personalities, their behavior, and their relationships.

Study respondents consistently described both conative traits and psychosocial experiences commonly described in the literature regarding giftedness, as described in chapter 2. They perceived their high cognitive functioning as intertwined with virtually all aspects of their lives, creating both risk and resilience. They described how their intense and often highly empathic personal styles were sources of strength, but also placed them at risk both of becoming overwhelmed themselves and of overwhelming others. They described a strong drive to learn, to explore their passions in depth. At times, their curiosity brought them to an awareness of injustice or pain to which they were unable to manage their intense emotional reactions. They found themselves aware of contradictions and ironies in the world, leading them to investigate philosophical topics, or to ask questions rooted in postconventional reasoning, in ways which brought them into conflict with those around them. They may have developed interests, values, or behavioral patterns which were atypical for their cultural and gender roles or for their ages. A drive to learn also led them to seek high achievement in school and in life, with varying degrees of success. Some experienced significant negative self-judgment when they perceived their own imperfections, or felt obligated to develop their gifts in order to serve others. Throughout the lifespan, many of them reported difficulties in relationship with peers, colleagues, and employers, with those difficulties typically arising out of the same conative traits. Social isolation was common, both in childhood and adulthood. Family life for some was intense and at times overwhelming. Some, who were parents of gifted children, felt blamed for the problems their children were experiencing.

In formal descriptive terms (Ossorio, 1998, 2006), giftedness is commonly thought of as primarily affecting the Know parameter of intentional behavior, with additional effects on Know How, Performance, and Achievement. However, study participants also described giftedness as affecting the Want and Significance parameters of behavior, and Person Characteristics, including Disposition, which included their Traits, Attitudes, Interests, and Styles; Powers, which affected their Abilities, Knowledge, and Values; temporary States (such as "being overwhelmed"), and Capacities to acquire new Person Characteristics. They described experiencing intense frustration when their Eligibilities constrained their Behavioral Potential; that is, when they believed themselves capable of engaging in a particular behavior or acting for Ethical or Esthetic reasons, but were either not permitted to do so or were not seen as being capable of doing so. Some participants also alluded to the existence of a Culture, with other gifted Members engaging in specific Social Practices. Because the nature and content of the culture was not specifically inquired in the questionnaire, information in this realm was thin.

Presentation of Self and Problem

It is interesting to note that the gifted individuals in this study presented for therapy with the typical range of concerns found in the general population. In fact, particularly in the adult population, they were unlikely to explicitly identify their intelligence or problems related to it as the reason they were seeking help. Rather, the reasons for referral were identified as anxiety, depression, trauma, substance abuse, lifespan developmental concerns, family and work stressors, and many of the myriad other reasons that generally cause people to seek psychological treatment.

Giftedness was for some identified as having been a protective factor, having enabled them to adapt even to very challenging circumstances. In some cases, their generally high level of functioning, perfectionism, and/or clinician misconceptions about high intelligence, further interfered with the accurate identification of their problems.

The vast majority of the respondents within this study also identified their giftedness as being intertwined in some way with the problems they were experiencing. Given that they typically experienced intelligence as affecting virtually every aspect of their lives, this is perhaps not surprising. However, there were significant variations among therapist-client alliances in terms of how the interrelationship of intelligence, problem, and solution was understood and discussed.

Many clients openly identified themselves as gifted early in the therapeutic process. Some of these stated that they did so specifically in order to gauge the therapists' reactions. Others expressed plans to do so in the future, out of concern as to whether the therapist could empathically understand their experiences.

By comparison, other respondents did not feel that describing themselves was gifted would be a prudent choice. Some had had negative experiences in prior therapeutic relationships or in the larger cultural milieu. They had come to believe that if they manifested the behaviors which were related to their high intelligence, or if they expressed the belief that they or their children were smarter than most of those around them, others would misunderstand them or judge them harshly. Thus, they often found themselves in a position similar to a closeted minority, choosing to conceal their intelligence and their beliefs about it in order to achieve social acceptance. This study did not explore these "false self" phenomena in detail, but it appears that, as predicted by

Winnicott (1960/1965), chronic presentation of a false self tended to create psychological distress, and presentation of a false self in therapy tended to interfere with progress.

Therapist Understanding of Manifestations of Giftedness

Within the therapeutic relationship, clients experienced the same broad range of reaction to the manifestations of their giftedness and to their espousing the belief that they were gifted as they experienced in the larger culture. Therapists in this study were described as being largely uneducated about giftedness, consistent with the paucity of professional interest and available training described in chapter 2. Only one therapist, who was highly successful with her client, was described as an expert in giftedness. Several others who appeared to be comfortable with their own identity as gifted individuals were also described as highly empathic and successful in developing an effective working alliance. However, a few of the therapists who were the most unempathic were also perceived as highly intelligent; these therapists did not appear comfortable with discussing intelligence within the relationship. Other therapists were initially confused or taken aback, but maintained an attitude of open-minded and patient inquiry. These therapists were generally able to negotiate a moderately well-shared understanding of the nature of the clients' experiences and the problems which led them into therapy. A number of therapists engaged in significant self-education on the topic of intelligence and its effects on psychological functioning; these efforts were largely seen as supportive of the alliance.

In a number of cases, the clients themselves did not initially understand their high intelligence as being intertwined with various aspects of their lives and the problems which led them to therapy. Some of these clients were helped by their therapists to

explore these ideas; those who did found that doing so was helpful therapeutically. Others did this exploration on their own outside of the context of therapy.

Still other therapists failed to understand how giftedness could relate to the problems, even after the clients attempted to communicate that possibility. Of most concern, however, was the fact that a number of therapists interpreted the clients' experience of giftedness or their espousal of giftedness as part of their identity as either reflective of underlying pathology or as inherently pathological. Giftedness, which the clients felt permeated their entire existences, was seen by some therapists as precisely what was *wrong* with them. Furthermore, some of the clients expressed that their therapists construed their open espousal of high intelligence as part of their social identity and their wish to associate with other similarly intelligent individuals, as being themselves part of the problem.

While this study was not able to explore issues of countertransference directly, a number of clients described situations in which the therapists seemed to have some difficulty in this arena. Clients felt uncomfortably aware of how their therapists compared themselves to the clients, expressing intimidation, awe, defensiveness, envy, or competitiveness. In most cases, these feelings were not able to be processed within the relationship, and they diminished the quality of the alliance; in some cases, the clients ended the relationship entirely.

It is perhaps not surprising that highly intelligent clients appeared to engender problematic countertransference responses in some therapists. Brightman's (1985) description focused on three narcissistic pitfalls common to helping relationships: strivings to be omnipotent, omniscient, and omnibenevolent. He also enumerated a

number of common defenses against threats to these fantasies, including attempting to gain control of the situation through intellectual power, glorifying the emotional aspects of experience while devaluing the intellect, frantically attempting to accomplish something regardless of the client's wishes, splitting off some aspect of the client or system as being "bad," or withdrawing from engagement. Gifted clients may well present particular countertransferential risks. If therapists have any unacknowledged worries about their own powers and skills, the mere presence of a highly intelligent client may draw attention to these concerns. Furthermore, as described below, the interplay between intellect and affect, as well as the question of who is in control of the relationship, appear to be areas of particular clinical complexity when working with the gifted population.

Rather than creating a safe environment for self-exploration, a substantial number of therapists described in this study recapitulated the normalizing judgment of the larger social milieu. That is, they expressed the idea that there was a proper way to be normal and that the clients' failure to conform to this normality was something wrong with them. In the vast majority of these situations, little or no therapeutic progress was possible. In some, iatrogenic issues occurred: the client's problems were made *worse* by the therapist's perceived rejection. When the clients perceived the therapist as being themselves quite intelligent, these degradations were particularly painful. Additionally, some clients became reluctant to seek out another therapist at the time, and some, often after many painful experiences, decided that therapy was in general not likely to be a good way for them to solve their problems.

Effects of Giftedness on the Therapeutic Process

Working Alliance Variables

Within therapy, respondents also generally described their intelligence as having important effects on the working alliance they were able to develop with their therapist. Relationships representing all levels of quality and depth were described, from powerful life-changing connections, to efficacious task-oriented collaborations, to unempathic and even destructive struggles.

In terms of the components of the alliance, the clients' giftedness did not appear to have direct effects on the clients' feeling that the therapist was capable of creating a basically safe relationship. Furthermore, except as described below, it also did not seem to have direct effects on the ability of a therapist to jointly negotiate goals and tasks with a gifted client.

Fundamentally, the strengths and failures of the alliance were most clearly tied to the ability of the therapist to provide accurate and mirroring *empathy* for a broad range of experiences which the clients associated with their high intelligence. Those experiences included both those which had taken place outside of therapy and those which directly affected the content or the process of the therapeutic conversation. The topic of empathy will be discussed at greater length in a later section in this chapter.

Aspects of Process and Methodology

In addition to the dimensions of the working alliance originally explored in this study, study respondents mentioned a number of other ways in which their high intelligence appeared to affect the therapeutic process.

It should perhaps come as no surprise that gifted clients appear to bring their intensity, drive, curiosity, and depth of processing to the work of therapy. They worked hard and made rapid progress. Therapy with these clients may have been at times quite a dramatic experience for the therapist. Some clients perceived that their therapists were unable to keep up without the client's help, in a reversal of roles that had the potential to interfere with the working alliance and the perceived usefulness of therapy. At times, the drive to do well at everything brought with it the risk of perfectionism (e.g., the client's felt need to excel in the work of therapy), although respondents in this study reported being generally able to process these feelings within the relationship.

Overintellectualization was cited by many clients as an area of challenge within the work, but also an important area for clinical discussion. Some therapists were able to encourage clients to explore this balance in a thoughtful way which both protected the clients from emotional flooding and resulted in considerable growth in the clients' understanding of their own affect and its relationship with cognition. Others seemed to simply devalue the clients' cognitive strengths.

An important area of complexity within the therapeutic process lay in the therapist's ability to take various aspects of the client's developmental level into account. Developmental issues included both how the client might differ from other individuals and how the client might be internally asynchronous, with different developmental levels in different domains of functioning. In particular, a number of clients reported feeling frustration with one-size-fits-all techniques or with simple answers to what they saw as complex problems.

Consistent with what is generally found within the gifted culture, written language was seen as an important tool within therapy for communication and understanding. Clients reported reading books and articles, including some intended for professional audiences, both to help them understand themselves as highly intelligent people and to find out more about various aspects of the psychological problems they struggled with. Some also used reflective writing techniques to communicate with their therapists or to explore their own experience in depth.

Another aspect of the gifted culture, raised by a substantial number of respondents, was the issue of egalitarianism within relationship. Status is more likely to be defined through established knowledge and competence than through age, official titles, or other formal markers. Consistent with this cultural pattern, and more generally with self-determination theory (Ryan & Deci, 2000, 2008), many clients in this population described a strong preference for relationships in which they and their therapists viewed each other as equal partners. In situations where clients felt that they were not allowed to exercise their own autonomy and growing competence within the relationship, they typically continued to attempt to do so. Some openly struggled with their therapists, while others lapsed into resigned compliance, accepted negative interpretations, or manipulated the process, creating a false self in order to protect their true self.

Underlying Question: Do You Have to Be One to See One?

An important theoretical question raised by this research is the general question of how differences between therapist and client, particularly in the realm of behavior potential, can affect the therapeutic working relationship. Many members of cultural

groups prefer to be seen by one of "their own," because of the presumption of shared experience and compassionate empathy. However, both for systemic reasons (e.g., the lack of availability of a therapist matching specific demographic variables), and because it is never formally possible for there to be an exact match between the lives of two different individuals, the differences between client and therapist are often vast. Some therapists are able to reach across some gaps some of the time. However, intelligence as a dimension of human difference raises the possibility that there may be some areas of experience that *cannot* necessarily be understood by some other individuals. For example, a person who had cognitive limitations might not be capable of the abstract reasoning needed to truly understand higher mathematics. Thus, it is also possible that there might be situations where a therapist of average or even above-average intelligence might not be capable of understanding how their highly intelligent clients experience themselves and their worlds.

Accurate Empathy

We can understand this possibility in formally descriptive terms. Part of the Know variable for each person is that person's self-knowledge, including knowledge of the values of all other parameters of the self and the state of affairs. That is, a client knows what he knows, what he wants, what he knows how to do, what he does, and so on, as well as what is going on in the world around him. Any of those pieces of knowledge may, of course, be incomplete or mistaken; what matters is that the client has an internal representation, a view of the self and world.

Similarly, the therapist has, as part of what she Knows, her knowledge of the client and the state of affairs as it affects the client. In particular, part of what she knows

about the client is what the client knows about himself. And, to take it one step further, part of what the client knows about the state of affairs is the fact that the therapist knows certain things about him.

We can thus formally define *accurate* empathy as when the client knows that what the therapist knows about him matches what the client knows about himself; this is the realm of *shared knowledge.* Inaccuracies in empathy fall into several possible types.

Unknown: Some of what the client knows about himself may not be known by the therapist because the therapist has not yet inquired effectively enough. Without having asked the right questions or having listened carefully enough to the answers, the therapist remains ignorant of information that the client includes in his self-understanding. It is, of course, extremely unlikely that a therapist will have direct experience with all possible client experiences. However, even if surface details of experience are markedly different, abstract reasoning and imaginational capacity can potentially enable a therapist to empathize with what a particular experience was like for a client.

Also within the realm of unknown information would fall information which the client has chosen to omit from his self-presentation out of a belief that it would be prudent to share but would not be helpful in pursuing the goals and tasks of therapy. Similarly, the client might choose to actively conceal information which might be helpful in therapy, and which the therapist might have the capacity to understand, but which the client believes would not be prudent to share.

Unknowable: Some of the client's self-experience may be inaccessible to the therapist. Regardless of how much and how openly the client and therapist discuss it, the

therapist simply lacks the current capacity to comprehend the client's experience in the way the client experiences it. The client, aware that the therapist has never "been there," feels that an important part of the self is not understood empathically. This knowledge itself, that a part of the self is unknown and perhaps unknowable, or that the therapist is disappointingly incapable of knowing, is not without potential emotional consequence. Particularly if the client has had a history of feeling that he was never truly known, therapist incapacity may recapitulate these painful experiences rather than repairing them.

Unconscious: There may be parts of the client experience in which the therapist knows or conjectures accurately about what the client has experienced and how it relates to present functioning, but which the client does not yet himself recognize or tolerate about the self at a conscious level. In some theoretical models, a major function of therapy is to help the client gradually move this information into the realm of shared knowledge.

Inaccurate: The therapist might, however, believe that she is more aware of something about the client than the client is himself, yet be inaccurate in this belief. The therapist might have legitimately misconstrued what the client has presented. This area of possibility carries the most risk of open and intractable rupture within the therapeutic alliance. If the therapist believes the information to be in the category of the unconscious, and is not willing to admit the possibility of her own error, the client may be unable to have his own perspective accepted as valid.

Within this study, all of these formal possibilities were described. The most powerful therapeutic experiences were those in which the therapist was seen as having had analogous experiences of being a gifted person in the world and using those

experiences as a basis for a deep and complex understanding of the client's view of self. Therapists who could perceive what the clients themselves were missing or hiding and represent these perceptions empathically within the relationship were particularly valued. Respondents spoke of these alliances with enthusiasm and warmth, and expressed sincere appreciation for a type of appreciative and knowing relationship which had rarely been available to them.

When respondents described therapists whom they perceived as not being quite as intelligent as they were and not having had similar experiences of the conative traits and social experiences they associated with their high intelligence, much of the clients' self-representation was initially in the realm of the unknown. However, when these therapists maintained an attitude of openness to learning, relationships were still typically described as being at least reasonably effective. Clients whose goals were primarily instrumental found these relationships to be quite helpful, while those who were seeking empathic connection tended to find them only moderately satisfying. In general, clients were patient with and appreciative of therapists who were willing to admit their own ignorance and to do the hard work of learning about them. In some cases, the experience of being seen as "worth learning about" may have been experienced as an accreditation. Furthermore, it is of note that constant learning is strongly valued by many within the gifted community. Rather than being perceived as showing ignorance or weakness, therapists who showed themselves to be committed to learning were generally seen as demonstrating cultural competence.

There were also therapeutic relationships in which the therapist was perceived as incapable of reaching across the gap, at least in some areas, despite appearing to make

efforts to do so and despite efforts by the clients to educate them. At times, they seemed to become extraneous to the therapeutic process. Some therapists seemed unable even to recognize that there was something they were missing. It is, of course, possible that these therapists understood more than they were successfully representing back to the clients, or that additional effort might have enabled them to understand. However, these therapists did appear to disappoint the clients in the task of providing accurate empathy under ordinary conditions of therapy.

It is perhaps not surprising that a number of clients described their therapists' roles their achievement of greater self-awareness. As mentioned above, this process is among the major tasks of therapy. However, it is also interesting to note that a number of clients reported having not been consciously aware at the beginning of therapy specifically of the complex ways in which their intelligence affected their lives. While some of these respondents reported having come to a greater awareness of the effects of intelligence in their lives outside of the context of therapy, others described with appreciation the therapist's active role in helping them do this exploration.

The most painful descriptions of the failure of empathy were those in which the therapist maintained an understanding of the client which was sharply at odds with the client's own self-understanding. Therapists were described as misconstruing the client's desires and actions, imposing normalizing judgments, and inappropriately ascribing pathology to thoughts and behaviors which the clients associated with their high intelligence. In these situations, the therapist's cognitive capacity did not seem to be the major issue; several highly unempathic therapists were described as apparently intelligent. Therapist intelligence, naturally, did not universally prevent misjudgment. In

fact, several respondents alluded to the possibility that a therapist they perceived as being highly intelligent was particularly eligible to create effective degradations.

Based upon the responses provided in this study, it appears that the answer to the question, "Do you have to be one to see one?" is complex. Certainly, many experiential gulfs can be spanned by a therapist who is comfortable with admitting ignorance and capable of remaining curious about client experience. However, in the case of cognitively gifted clients, it appears that, at least in some situations, even the most earnest and hardworking therapist may be incapable of understanding everything that a client knows about himself and his world. In keeping with the general literature on flawed self-assessment (reviewed in Dunning, Heath, and Suls, 2004), it is perhaps not surprising that therapists, at times, are not aware of what they are not aware of. Not only may they be unable to recognize when they are not understanding the complexity of their clients' experience, but they may also be unable to recognize their own lack of capacity to understand.

As in all things, it would be wise for professionals to remain aware of the possibility of their own fallibility (Brightman, 1985). It may be easy for readers to look at some of the egregious failures of the alliance described in chapter 4 and to imagine that they would not make such errors. However, there is no reason to suspect that the therapists reported on in this study were any less competent at general therapeutic skills than any other therapists would be. Therefore, such a self-protective assumption would not be supported.

Mirroring Empathy, Accreditation, and the Role of the Therapist

When we consider the more general question of the nature of therapy and the role of the therapist, the importance of empathic understanding cannot be overstated. As described in chapter 1, therapy can be described as a process in which a therapist serves as an accreditor for the client, gradually helping the client towards becoming his own accreditor (Bergner & Staggs, 1987; Schwartz, 1979). This model clearly parallels Kohut's (1977) model of the development of the self through mirroring empathy provided by an idealized selfobject. We learn to know our *selves* by seeing them appreciated through the eyes of a valued other.

However, as described by the respondents, consistent with the literature reviewed in chapter 2, gifted individuals often have psychosocial experiences in which the normal developmental transitions, in terms of who serves their selfobject needs, often do not take place. Teachers and professors may not be competent to serve as accreditors, if the student believes that they are not sufficiently knowledgeable. They may in fact actively degrade a gifted student (e.g., as one participant reported, accusing her of cheating when the quality of her schoolwork was too high). Gifted individuals may be chronically isolated from peers who could provide realistic competition, so that a sense of self-efficacy could be derived from making comparisons to the achievement of others. The lack of a peer group may also deprive gifted individuals from feeling that they truly belong anywhere. Even in adulthood, coworkers and employers may be incapable of providing the kind of genuine and knowledgeable appreciation that gifted individuals crave. Families may provide support and respect, but this is by no means a given. As several participants described, intense personalities may chronically overwhelm each

other, difference may in fact be openly degraded, and, consistent with the writings of Miller (1981), family members may use each other in inappropriate ways to serve their own unmet needs. Furthermore, if families are the *only* available source of selfobject support, the client risks becoming mired in an early developmental stage; if home is the only safe place in the world, the child can never truly leave. Even without particular incidents which an outside observer might agree were clearly "traumatic," these individuals may experience chronic microaggressions, incidents in which they become aware of their difficulties in navigating the social, academic, or professional environment. In any milieu, even those who are not actively inimical to the gifted individual may stand by helplessly, failing to provide support, protection, or guidance. They may thus contribute to the individual's perception that no help is available (Miller, 2002; Miller & Guidry, 2001). With no model of how to be successful in the world without losing the self, no way to leave the situation, and no reliable assistance from a valued other, gifted clients may be at particular risk for the "no map, no exit, no help," experiences which Joseph (1995) has explained as characterizing trauma.

The therapist, then, becomes of paramount importance. According to this study, some gifted clients come into therapy to work on specific problems and develop better coping skills. For these clients, therapists who are perceived as being at least moderately intelligent and who are patient and curious in the process of developing their own accurate empathic understanding can be effective in serving the role of expert resource. However, many other gifted clients come into therapy in order to more fully understand themselves, in some cases seeking to heal deep-seated and long-standing feelings of pain and emptiness. In these cases, although the client may appear on the surface to be

extremely high-functioning, the therapist may unknowingly be taking on a monumental task: to repair a lifetime of inadequate selfobject support and chronic trauma.

In order to serve this role, therapists for gifted clients must pay careful attention to the accuracy of their own empathic understanding. If the client does not perceive that the therapist's empathy is *accurate*, as described above, then the therapist will also not be perceived as eligible to provide the necessary *mirroring* empathy. Similarly, if the client is able to present a false self successfully and to manipulate the therapeutic process, the therapist may lose eligibility in the client's eyes to serve as an accreditor.

Respondents in this study who experienced consistently inaccurate empathy or active degradation on the part of the therapist tended to find therapy ineffectual or even actively harmful to them. The disappointing or traumatic experiences they had had in other relationships were recapitulated within therapy. Therapists who were perceived as particularly intelligent but nevertheless unempathic and degrading were highly effective denouncers.

By contrast, respondents who found deep self-understanding in therapy all strongly valued the therapists' own high intelligence and the shared experiences they brought to the relationship. In their long-term therapeutic relationships, the role of the therapist was not just to help the client work through problems, but to serve as a role model and fellow-traveler, a person whom the client could see as being "like me." In that role, the gifted therapist was eligible to serve as accreditor or selfobject in a way that many bright-but-not-gifted therapists were not.

It is, of course, possible that some of the respondents' feelings of superiority and discomfort with associating with people whom they did not perceive as highly intelligent

may very well reflect unhealthy narcissism. Some of the reported disturbances in selfobject relations over the course of development could easily have resulted in the activation of narcissistic or other primitive defenses. Similarly to the respondents in this study, it is possible that therapists who encounter gifted clients within their own practices will observe these primitive defenses as well. However, it is important to recognize two things. First, even if aspects of characterological disorder *have* arisen for a client, a therapist would not competently respond simply by devaluing the client and openly confronting these defenses. Rather, skilled clinical practice in this realm would *emphasize* the need for accurate mirroring empathy and the gradual restoration of selfobject functions (Stark, 1999). Second, it is possible that a client who espouses giftedness as part of their identity and who reports being most comfortable when interacting with other similarly gifted individuals may, in fact, be telling a truth undistorted by primitive defenses. As the saying goes, "It isn't bragging if you can prove it." In those cases, as described by the respondents in this study, a therapist's dismissal of client experience and achievement may be seen as particularly harmful to the relationship. It is important for therapists to avoid drawing premature conclusions about the veracity and significance of client self-descriptions.

Unusual Events: The Question of Trust

Several individuals who redistributed the request for participants prefaced these with brief personal statements in which they vouched for me as the researcher. Upon inquiry, they explained that the members of the groups they were sending the request to were often wary of journalists, researchers, and other "outsiders." They had experienced both voyeuristic and exploitative motives, feeling that the public presentations of the

information they had provided were not congruent with the experiences they had shared. Although some journalists have portrayed the experiences of gifted individuals with compassion and a view of the whole person, high intelligence or precocious achievement is commonly portrayed in the media with a "freak-show" narrative, emphasizing the deviance of the individual and reinforcing the societal judgment of what constitutes "normal" behavior. At times, individuals have felt that their personal stories were used to promote political or educational views quite different from those they themselves supported. It is perhaps worth recalling that the word "geek," now commonly applied to gifted individuals who have high achievement in scientific or technological fields, originally described a carnival performer who violated societal norms, most notably by biting the heads off of chickens or snakes. Thus, it is perhaps not surprising that those who knew and wished to help in my research felt the need to assure their contacts that this research was being conducted by "one of us."

It is, of course, also important to recognize that I was asking people to talk about experiences that are typically not shared even with friends, much less with a complete stranger or a person who might very well see them again within the community. Although I took care not to ask about the content of therapy, in many cases it would not have been possible for respondents to make their stories clear without sharing some deeply private information. Mindful of this question of trust, I had taken several steps to help make potential informants feel comfortable.

I strongly emphasized the provisions of anonymity and confidentiality and assured respondents that I had thought through various potential loopholes or accidents carefully. I gave participants multiple methods to protect their anonymity and to control

the possibility that I might ask them additional questions that they did not wish to answer. When doing member checks or follow-up interviews, I again took care to emphasize my intention to understand them clearly rather than to uncover what they had chosen not to express.

By allowing participation in writing and doing most follow-ups through email or telephone conversations, I allowed participants to avoid face-to-face interactions. Suler (2004) described the "online disinhibition effect," in which the asynchronous and impersonal nature of online communication, as well as the relative minimization of visible status and authority markers, potentiates the presentation of aspects of self which are often kept hidden. In this situation, I intentionally used the opportunity to share without ever seeing me as a way to provide safety around possible feelings of vulnerability.

I had also taken care in the recruitment materials and questionnaire to present myself as a person who could be trusted, and a person who spoke the ordinary language of the gifted culture. Part of my choice to host the call for participants on my professional website, where I describe my own story and my professional philosophy, was so that those who wished to investigate me as an individual could do so easily and without feeling that they were violating boundaries in doing so. I have also been an active member of a number of online support boards and a presenter at gifted parent-oriented conferences for many years. A number of individuals, separately from their data, mentioned that they were willing to participate or to encourage others to do so specifically because they were aware of me as a member of the community and knew that I was open and genuine about my own self-presentation and my goals for the study.

With this trust established, participants were willing to share openly with me. The stories shared were complex and detailed, and often intensely angry, sad, or joyful. Participants had had awful or wonderful experiences, and many spoke passionately about their desire for their stories to be heard by the professional world. I have received many thank-you notes, from participants and from those who chose not to participate, for doing this research and taking on the role of ambassador between the cultural groups. One of the saddest of these letters was from a mother who acknowledged that she would not have time to respond to the questionnaire because she was too overwhelmed by the current need to deal with her son's psychological problems and his difficult interactions with the mental health system. I have been honored and humbled by the trust placed in me and hope that the result has accurately reflected the respondents' experience. Because I am aware that some of the respondents may in fact choose to read this, I hope that they will share with me any areas where I have erred, so that I may continue to improve the work.

There is much that is not known to the clinical world about the gifted community, but it appears that, when appropriate care is taken to facilitate the process and to maintain an attitude of respect and collaboration, the members of this culture are willing and even eager to cooperate with research.

Future Research

The limitations of this study, as described earlier in this chapter, suggest a number of directions for further research. Studies could specifically facilitate participation from underrepresented groups, look in detail at contemporaneous therapy experiences, probe

the countertransferential reactions of therapists working with highly intelligent clients, or methodically explore various facets of the cultural experience of being gifted.

Very few parents of gifted children reported on the quality of the working alliances they had experienced with therapists who were providing therapy to their children. Similarly, only a small number of experiences with child or adolescent therapy were described. Future studies, similar in structure to this one, could be aimed specifically at these subpopulations. Particular attention would need to be paid to developing questionnaires to probe the specific experiences of parents and adolescents. To elicit information from children and adolescents, even those who are highly verbal, would probably require an in-person interview methodology which would take both developmental maturity and developmental asynchrony into account. For example, interactive methods involving play and storytelling would be more likely to be appropriate for children. However, for all ages, but particularly for adolescents, it would be important to provide choices in how to tell their stories, so that respondents might feel that their maturity and competence were being adequately respected.

A major weakness of this study is that the experiences were described in retrospect, often from a distance of many years. While clients were able to describe particular moments of high emotional valence for them, it is possible that these recollections do not adequately or accurately reflect the general course of their work, or even that memories have shifted significantly over time. Future research projects might involve the recruitment of current therapy clients who could provide contemporaneous accounts of their therapy experiences. This real-time methodology would also be more

amenable to being combined with quantitative measures of the alliance and of the effects of specific experiences on how the alliance was perceived.

Another weakness was that clients were able to report only on their own experiences. While the current data strongly suggest that countertransferential issues, such as feelings of competitiveness or intimidation, might affect the ability of some therapists to provide empathic understanding and collaborative therapy, client perception is a poor measure of therapist experience. A future study might recruit therapists who are aware of working with highly intelligent clients to explore their own internal experiences. However, because of the potentially shameful nature of countertransferential reactions, and because these reactions often remain below the level of consciousness, such methodology might not yield valuable information. A more potentially informative method might involve the recruitment of therapist-client dyads who could be observed and questioned directly. This method would enable the exploration of differences in client and therapist perception of the alliance. The real-time study of therapist-client interactions, however, would still require that therapists recognize that they were working with gifted clients in order to volunteer to participate. It would also create a situation which would encourage therapists to be highly empathic in order to look good to the researcher, even if their alliances with previous gifted clients had been perhaps more problematic.

This study, because of recruitment methods, tended to attract participants from the middle class who appeared to be relatively well-functioning at present. However, the research literature is clear that highly intelligent individuals are found in all racial groups, all ethnic groups, and all social and cultural strata. In my own clinical work, I have

encountered a number of individuals who appeared to be highly intelligent, yet whose clinical needs were understood by most helpers exclusively in terms of their chronic substance dependence, self-injurious behavior, or other significant psychological problem. They often came into conflict with staff and other clinicians because of their lack of patience with the simplistic and repetitive nature of the treatment they were required to participate in, their desire to take a leadership role within their own therapy, and the at-times overly complex or impertinent nature of the questions they asked. When I have sat with them myself, I could, as one respondent to this study described, "see it in their eyes." Yet I have often heard other clinicians comment in frustration that these clients were obviously bright and obviously committed to their own treatment, but "just weren't fitting in." In all cases, the clients were at risk of being involuntarily terminated from their treatment programs; some actually were. When direct intervention was provided in which intelligence was directly and empathically addressed as a facet of their experience, the clients experienced improved outcomes. It would be of great clinical interest to develop methods by which highly intelligent clients from disadvantaged backgrounds or with major mental illness could be nominated and identified, so that their experience of the therapeutic relationship could be explored. Information about how gifted clients might present in these environments, as well as guidance about how to work with them empathically and effectively, would be useful to clinicians whose work does not normally focus on issues of intelligence.

Finally, responses from this study tend to support the idea that giftedness can be construed as a culture. However, because the questionnaire did not address the topic directly, comprehensive information about the World, Members, Social Practices,

Language, and Choice Principles within the culture was elicited only in passing. In future studies, ethnographic information could certainly be gathered in a more systematic fashion, including directly from a variety of expert informants, and analyzed in terms of how these cultural features might relate to the conative and psychosocial findings common within the gifted population. This information could guide clinicians who are not themselves familiar with this cultural information and practice, increasing their capacity to correctly interpret typical behavior and to provide accurate empathy.

Conclusion: A Perhaps Uncomfortable Question

The generally accepted model of the development of social and cultural identity, as described in chapter 1, describes the need for individuals to come to accept various facets of their identity and to integrate each into a complex view of the self. This pattern of identity development is relevant not just for aspects of self which are generally seen as stigmatizing, but also those which are seen as largely positive. Giftedness, of course, is often experienced as both. Yet educators, therapists, and other authority figures all too often treat high intelligence as something that a healthy person hides not only from others, but from the self. A number of respondents in this study indicated that they felt that their giftedness could not be safely shared, not just in the larger social world, but also within the supposedly safe context of psychotherapy. Furthermore, giftedness is often regarded with intense skepticism, as something which must be objectively and repeatedly proven before it can be considered valid within a multidimensional view of self.

So the question becomes this: Is intelligence unspeakable? Is there any other personal characteristic or aspect of social identity about which a responsible therapist would routinely advise that it should be denied, ignored, and hidden? Has keeping

potentially shameful secrets in the closet, hidden not only from the world but from the self, been found to be beneficial for any other clinical population? When we treat giftedness as something so shameful that even we, the expert clinicians, cannot tolerate the exploration of the ways in which it affects the clients' lives and selves, we send a powerful message about the unacceptability of this dimension of human difference.

Giftedness should not be the *only* aspect of self-definition in a mature individual, but neither should it be excluded from consideration. The results from this study suggest that many highly intelligent individuals are hungry for the opportunity to explore their lived experience, in its totality, within the therapeutic relationship. Rather than assuming that they will simply "make it on their own," we as professionals should listen empathically to their voices.

Provisional Clinical Guidelines

Therapists recognize that intelligence is a valid dimension of individual difference and that high intelligence occurs in individuals from all social, racial, ethnic, and economic groups.

Therapists understand that high intelligence may have diverse and pervasive effects, not solely on cognition and academic achievement, but on every aspect of the lived experience of gifted individuals.

As with other dimensions of human difference and cultural experience, therapists do not require a claim of high intelligence to be proven before it can be considered as a valid part of the therapeutic dialogue.

Therapists strive to become culturally competent with the gifted population. They educate themselves about the cognitive, conative, affective, behavioral, social, familial,

relational, academic, and occupational experiences commonly found in this population. They learn about how gender, ethnicity, low socioeconomic status, as well as concomitant learning disability or psychological disorder, can create additional risk for these individuals. They also educate themselves about the persistent mythology surrounding the educational and psychological needs of these individuals. They become aware of high intelligence as a source both of risk and of resilience.

Therapists understand that the various manifestations of high intelligence are not necessarily indicative of psychopathology. They also understand how high intelligence can serve to mask psychopathology.

Therapists learn about how social stigmatization can create psychological risks for this population. They also understand that the espousal of giftedness as part of an individual's social identity is not necessarily indicative of psychopathology, and may in fact reflect a positive step in social identity development. One role of therapy can be to support the continued process of development of the individual's identity as a gifted person.

Rather than assuming that these are "easy clients" with whom any therapist could be successful, therapists recognize that gifted clients bring a unique constellation of needs and challenges to the therapeutic relationship. They seek consultation or make referrals when appropriate.

Therapists maintain self-awareness regarding their personal attitudes about intelligence and gifted individuals, and consider how their feelings about their own and others' intelligence may affect their work with these clients. Therapists understand that

countertransferential responses such as intimidation, admiration, competition, envy, or resentment, all pose potential risks to the relationship.

Therapists are encouraged to consider whether their own personal capacities are sufficient to provide accurate and mirroring empathy to a highly intelligent client, as well as to keep up with a potentially rapid, intense, and complex course of therapy.

Therapists recognize that gifted clients typically present with the same broad range of psychological diagnoses found in the general population. Clients may not identify their intelligence explicitly as related to their problems, either because they are concerned about the reaction of the therapist, or because they have not yet explored the connection themselves. However, therapists understand that giftedness is likely to be intertwined with the problems the clients struggle with, and provide an open forum within therapy for supportive dialogue around this issue.

Therapists recognize that the normative progression of the development of the self may have been affected by the often poor fit between gifted individuals and their ecological systems. They understand the potentially important role a therapist can serve in repairing these traumatic experiences, as well as the risk that a therapist could cause further harm through failures of empathy.

In their therapeutic work with gifted clients, therapists are encouraged to manifest an attitude of openness to learning. Being willing to work hard at understanding can both facilitate the therapeutic dialogue and serve as an important demonstration of cultural sensitivity.

In conducting therapy with gifted clients, even with children and adolescents, therapists avoid taking a “one-up,” authoritarian, expert, or controlling stance. Rather,

they remain aware of the possibility that the client will prefer a collaborative and egalitarian relationship, in which both partners can be valuable sources of information and ideas, in which each can question the others, and in which the client's self-determination can be supported.

Therapists understand the gifted clients may not only challenge themselves in therapy, but may also wish to be challenged still further. However, they also understand the risks that perfectionism may bring to the relationship.

In considering therapeutic techniques and interventions, therapists take into account the fact that gifted clients may manifest different levels of development from what is typical for their ages, as well as that a client who is highly advanced in one domain may be age-typical or even immature in another.

Therapists pay careful and empathic attention to the balance between intellect and affect in therapy with gifted clients, recognizing both overintellectualization and emotional flooding as potential risks. They help clients learn to value and use all aspects of the self.

Therapists recognize that high levels of cognitive development may lead gifted clients to become frustrated with what they perceive as simplistic techniques or easy answers; they pay attention to whether a client may prefer more complexity and nuance. Postconventional and philosophical reasoning, as well as empathic and imaginational strengths, may be particularly valuable topics and resources for therapeutic exploration.

Therapists consider whether psychoeducational reading, bibliotherapy, therapeutic writing, or other uses of written language may be useful adjuncts to therapy with highly intelligent clients.

Therapists develop familiarity with community resources which are available to provide educational, occupational, psychological, and social support for highly intelligent individuals at all stages of the lifespan.

Having themselves become knowledgeable about the complexities of working in therapy with gifted clients, therapists support the education of their professional colleagues on this topic through training, supervision, consultation, and continuing education.

APPENDICES: LIST OF APPENDICES

A Email Recruiting Letter

B Informed Consent Form

C Questionnaire

APPENDIX A: EMAIL RECRUITING LETTER

Request for Research Participation: Cheetahs on the Couch

I am a doctoral student in clinical psychology, and an educational therapist specializing in work with people who are gifted and twice-exceptional. For my research project, I am doing an exploratory study about the quality of the working relationships gifted clients experience in psychotherapy. My goal is to help therapists better understand how to work with these clients.

If you consider yourself cognitively gifted and have ever been in individual or family psychotherapy, whether for reasons related to your intelligence or not, I am interested in hearing your story about your experience of the therapeutic relationship. You can share your story by filling out an open-ended questionnaire, and some participants will also be selected for telephone or video-chat interviews.

Children and adolescents can participate, with permission of a parent, but must be able to provide their own first-person narratives.

All responses will be treated as confidential.

Only responses received by 31 March 2010 will be included in the doctoral project. However, I will continue to collect data until 31 January 2011, to enrich the data set for possible future publications. As a thank-you, participants responding by 31 March will be eligible to receive one of three $25 Amazon.com gift certificates in a random drawing.

For more detailed information and an informed consent form, or if you have any other questions, please contact me directly, or visit the following URL:

http://www.davincilearning.org/sketchbook/research.html

Feel free to forward this letter to individuals or groups who would be interested in participating, or suggest places where I might post it myself. (Please do not spam, and respect the guidelines of any mailing list or forum where you post it. Please do not forward this as a chain letter.)

Thank you very much!

-- Aimee Yermish

doctoral student, clinical psychology

Massachusetts School of Professional Psychology

educational therapist

da Vinci Learning Center

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APPENDIX B: INFORMED CONSENT INFORMATION

Welcome! This is an exploratory survey about the quality of the working relationships gifted clients experience in psychotherapy. It is being conducted by Aimee Yermish, a doctoral student in clinical psychology at the Massachusetts School of Professional Psychology. I am also an educational therapist specializing in work with people who are gifted and twice-exceptional. The study has been approved by the MSPP Human Research Committee. Responses for the current study will be gathered until 31 March 2010. Responses can be submitted after that date, until 31 January 2011, to enrich the data set for possible future publications.

What are you doing?

Research has shown that the quality of the working alliance between a client and a therapist is crucial for the progress of therapy. The alliance includes feeling that your therapist understands you, is honest about him/herself, is nonjudgmental, and can come to some basic agreement with you about what the problem is and what you will do about it together. It is also important that you and the therapist deal with problems in the relationship as they come up.

Little research has been done on how gifted clients experience the therapeutic relationship. In this study, I will ask you to describe how you have experienced the working alliance in your own therapy, and how your experience might have affected the course of your therapy. My goal is to help therapists better understand how to work effectively with clients like you.

Will you protect my privacy?

Yes. All responses will be treated as confidential. You do not have to give your full name, location, or any other personally identifying information. All identifying information that you provide as part of the contact process will be removed from the data set. All data will be maintained in password-protected files, with the computer under lock and key at all times. Any stories or quotes from the data used for illustrative purposes in research reports will be carefully anonymized to protect your privacy.

Any contact information you provide will be kept in a separate password-protected file and will be used only for the purpose(s) you designate. It will not be considered part of the study data, and will not be disclosed to anyone else.

Because of the open-ended nature of the questions, it is possible (although highly unlikely) that some of what you choose to disclose may *not* be able to be kept confidential. If I suspect that a child, elderly, or disabled person is in danger of abuse or neglect, I am legally required in all 50 states of the USA to promptly inform local authorities. Additionally, if a person is actively suicidal or homicidal, I am required to take action to help keep him or her safe.

How long will this take?

To answer the questions will typically take about an hour, although the length of time you spend is up to you. You are free to answer in as much or as little depth as you like, to leave out any questions you do not wish to answer, to stop participating in the study at any time, or to withdraw part or all of the data you have already given. There will be no negative consequences for your choice to withdraw.

If you give consent and provide contact information, I may contact you to help me understand your responses. I may also contact you for an in-depth telephone or video-chat interview, which will last approximately one hour and be scheduled at your convenience.

What's in it for me?

Besides the warm-and-fuzzy feeling I hope you will get from contributing to this much-neglected area of the field, you will also be entered into a random drawing for one of three $25 gift certificates to Amazon.com.

Who can participate?

In order to be part of this study, you must meet *both* of the following criteria:

* be identified as *cognitively gifted*. Typical means of formal identification include IQ tests, talent search results, participation in gifted programs, grade-skipping, subject acceleration, early participation in college courses, membership in high-IQ clubs, and so on. However, there are many different ways in which high intelligence may manifest, both in and out of school. Many very smart people, especially those from minority or underprivileged backgrounds, and those whose talents manifest in domains that are not traditionally tested, have never been formally identified or served. The aim of this study is to be inclusionary; if you think of yourself as gifted, if your teachers thought of you as gifted, if everyone in your family thinks you are gifted, or if you think everyone *else* in your family is gifted, you probably qualify.

* currently be, or in the past have been, even briefly, a *client in individual or family psychotherapy* (including family therapy where someone else (e.g., your child)

was the "person with the problem"). Issues related to your intelligence do not have to have been part of why you were in therapy.

Children or adolescents (under age 18 at present) may participate, but must be capable of providing their own firsthand narratives. Adults should not discuss questions or responses with children or adolescent respondents. If a child's report must be dictated to a caregiver, *please indicate this fact clearly on the response.* Children and adolescents should report only on *past* therapeutic relationships, not on current therapy.

Are you being straight with me?

No deception is involved in this study.

What are the risks?

The study involves no more than minimal risk to you (i.e., the level of risk encountered in everyday life). Because I am asking you to describe your experiences in therapy, you may find that it brings up intense or unpleasant memories.

What if I have more questions?

If you have any further questions about this study or about the rights of participants, if you wish to lodge a complaint or a concern, or if you wish to be informed when results of this research are published, you may contact the principal investigator:

Aimee Yermish

aimee@davincilearning.org

978-461-4815

30 Carriage Ln

Stow, MA 01775

You may also contact this project's faculty chair, Dr. Wynn Schwartz (wynn_schwartz@mspp.edu), or the Human Subjects Committee (hrc@mspp.edu) at the Massachusetts School of Professional Psychology (www.mspp.edu, 617-327-6777).

I'd love to help out! How do I get started?

Go to the next page, where you will provide your informed consent and begin responding to questions. When you are finished, please save the file and send it back to me at aimee@davincilearning.org

Thank you very much!

APPENDIX C: QUESTIONNAIRE

Questionnaire: Cheetahs on the Couch

Thank you very much for agreeing to participate in this research! Your participation will help psychotherapists better understand the perspectives of their gifted clients, as well as how their own behavior can better contribute to the success of therapy.

I know, this looks like a lot of questions. **I am not expecting you to answer all of them**. Please don't get perfectionistic on this. They are intended as generating questions only: they're to help you understand the kind of information I'm interested in and to help stimulate your memory, not to require you to answer in excruciating detail.

As mentioned in the informed consent form, you are free to answer as many of the questions you choose, at whatever length you choose, and to omit any questions you do not wish to answer for any reason.

The purpose of the present study is not to collect data to be counted and analyzed statistically, but to gather *stories* of real personal experience. So just tell me what you want me – or other therapists – to know.

Please understand all pronouns to refer to either gender.

Please note!

I cannot use your data if you do not fill this part out and include it with your response:

If you are 18 years of age or older, have read all of the statements on the informed consent form, and freely consent to participate in the study, please mark the "I agree" box below.

[ ] I am an adult, and I agree to participate

If you are 17 years of age or younger today, have read all of the statements on the informed consent form, and wish to participate in this study, you must ***also*** receive the consent of your parent or legal guardian. ***Both*** of the boxes below must be checked or I will not be able to use your data.

[ ] I am under 18 years of age, and I agree to participate

[ ] I am the legal guardian of this person under 18, and I consent on his/her behalf

Thank you very much!

Optional: Contact information

Remember that I am not requiring names, addresses or other personally identifiable information. Any such information you have provided at any point (including the return address if you send this questionnaire by email or hard copy) will be removed.

If you do not enter contact information here, I will not have any way of contacting you.

If you are willing to provide me with any contact information, you must enter it here, and you must choose what purposes I can use it for.

You can provide partial information if you choose.

I will separate this information from your questionnaire responses, and keep it in a separate password-protected file, to protect against any accidental disclosures.

I will not disclose your contact information to anyone else.

Contact information:

Name:

Address:

City:

State:

Zip:

Country if not USA:

Phone:

Email:

By checking these boxes, you are giving consent for me to use the above contact information **only** for the following purposes (choose as many as apply):

[ ] contact you if I have brief follow-up questions

[ ] contact you for an in-depth telephone or video-chat interview

[ ] enter you in the random drawing for one of three $25 gift certificates to Amazon.com

[ ] inform you if this research is published

Code name:

If you'd like to make up an alias for yourself for me to use if I quote or paraphrase any of your responses, let me know here (if not, I'll make one up for you):

If you want to report on more than one relationship with a therapist, please either make it very clear which therapist you're referring to when, or fill it out once for each relationship, using the same code name for yourself on each.

Basic things I need to know before we get started:

What country did you live in when the therapy took place?

With which racial or ethnic group(s) do you identify?

What gender are you?

How old are you now?

How old were you when you entered therapy?

How frequently did you see your therapist?

How long did the therapy last?

Whose choice was it for you to go into therapy (yours? if not, whose?)

Why was therapy ended?

More about you

Upon what basis do you identify as gifted? Check all that apply.

[ ] Cognitive (IQ) test results

[ ] Achievement test results

[ ] Talent search qualification

[ ] Identified for gifted programming, honors track, subject acceleration, cluster grouping, or other gifted services at school

[ ] Skipped one or more grades in school

[ ] Entered college or participated in college courses early

[ ] Identified as twice-exceptional

[ ] Hit many developmental or academic milestones early and continued to high levels of achievement

[ ] Accepted for membership in high-IQ clubs (e.g., Mensa)

[ ] Biological relatives are gifted

[ ] Have been frequently spoken of as gifted by others

[ ] Other: _____

More basics

What was the professional title of your therapist (social worker, marriage and family therapist, school counselor, psychologist, etc), or his level of education (master's, doctorate)? If you don't remember, giving me the place you saw him (school, hospital, outpatient clinic, private practice, etc, will give me a general idea.

What modality of therapy were you in: individual therapy, family therapy, or something else?

If family, which other family members attended with you, and who was officially identified as "the one with the problem"?

What kind of therapy was this? (play, psychodynamic, cognitive-behavioral, supportive, behavioral, psychoeducational, humanistic, etc) If you don't know, what were the kinds of things you did with your therapist?

Definitions

Let me start by helping you understand what I am interested in. The therapeutic working alliance is a very important part of psychotherapy. We can think of it as being facilitated by:

empathy, the feeling that the therapist understands you and your experience

unconditional positive regard, the feeling that the therapist is nonjudgmentally accepting of you as a person, even if she does not always agree with you

congruence, the feeling that the therapist is being open and honest about his feelings

basic agreement on the nature of the problem and what it would be like if that problem were solved

basic agreement on what you will do together about the problem

repair of ruptures, collaborative negotiation of disagreements or hurt feelings as they happen. Therapists have to be very aware of their own feelings in order to do this well.

I'm not going to tell you what it's like to be gifted: I suspect you have your own experience of that pretty well in hand.

What Now?

Before you do anything else, **just tell me your story, as you remember it**. Make it as long or as short as you like. I'd like to hear:

* the nuts and bolts of when and why you went into therapy
* what your experience of the therapeutic working alliance was like
* how you felt your giftedness might have affected that experience (or not)
* if there were problems, what they were, what you did about them, how the therapist responded, and what the outcome was.

Once you have done that, if you're willing, go ahead and read the questions below, which are a more in-depth look at each of these topics. You don't have to answer any of them, and I certainly don't expect you to answer all of them. But if reading them makes you want to elaborate on something you've written above, or reminds you of something you forgot to tell me about, go ahead and add it. (I'd prefer if if you left the original story unedited; I will understand that whatever you write below should take priority.)

Empathy

Did you feel that your therapist understood you and your experiences? (If not, what was he missing?) For instance, did he understand…

… your motivations, values, intentions, or desires?

… your knowledge, understanding, the distinctions you were making in the world, or your insight into your own personal or social circumstances?

… the skills and competence you had, your ability to actually do the things you wanted to do?

… the significance of your actions, what your behaviors meant to you?

If he did not understand, what did he say or do (or fail to say or do) that showed you that he did not understand?

If he understood you, was he consistently able to show you that he understood in a way that left you feeling appreciated and safe within the relationship? If not, what happened?

If there was a problem, did you raise the issue directly? Why or why not? If you did, what was the response?

Unconditional positive regard

Did you feel that your therapist was able to accept you as a person without judging you? If not, did you feel judged because of some aspect of…

… your motivations or values?

… your knowledge or understanding?

… your skills and competence?

… your actions?

… what your actions meant to you?

… the things that happened to you?

Did you feel that there was something she expected you to want, to understand, to be able to do to, or to actually do? If so, what was it?

What did she say or do (or fail to say or do) that led you to this conclusion?

If there was a problem, did you raise the issue directly? Why or why not? If you did, what was the response?

Congruence

Did you feel that your therapist was generally being honest about himself and his own perspectives?

What did he say or do (or fail to say or do) that showed you that he was (or was not) being straight with you?

If there was a problem, did you raise the issue directly? Why or why not? If you did, what was the response?

Client Honesty

Did you feel that you were able to be honest with your therapist? If not, what aspect of your motivation, knowledge of your individual or social world, competence, or the meaning of your behaviors did you feel that you had to conceal?

What did she do or say that suggested that you needed to be careful about this topic?

What did you do?

Do you feel you were effective in keeping your secret?

Did you later decide to go ahead and talk about it? Why or why not?

If you chose to disclose, or if you let something slip, how did they react? Did it change your understanding of the relationship?

Goals

Did you feel that you and your therapist were able to come to some kind of basic agreement about what the problem was, or what changes in your life would be helpful? If not, what was your perspective, and what was the therapist's perspective?

What did he say or do that led you to believe that you were in disagreement?

Did you raise the issue directly? Why or why not? If you did, what was the response?

Were you ever able to come to an agreement? How did you accomplish that? If not, what happened?

Tasks

Did you feel that you and your therapist were able to come to some kind of basic agreement about what you were going to do about the problem together, or how the two of you should actually work together in therapy? If not, what was your perspective, and what was the therapist's perspective?

What did she say or do that led you to believe that you were in disagreement?

Did you raise the issue directly? Why or why not? If you did, what was the response?

Were you ever able to come to agreement? How did you accomplish that? If not, what happened?

Repair of Ruptures

Were there particular moments in which you felt a real failure of an otherwise-pretty-good alliance between you and your therapist? If so, what happened? What did you do? What did the therapist do?

If these incidents occurred, did they change your perception of your relationship with the therapist? In what way?

If these incidents occurred, did they have any effect on your choice of how long to continue in therapy? If so, what?

If these incidents occurred, did they have any effect on how deeply you chose to engage in therapy? If so, what?

If these incidents occurred, did they have any effect on how effective therapy was for you? If so, what?

Issues Specific to Giftedness

Was your giftedness, or aspects of your individual or social experience that you related to being smart, part of why you entered therapy? If so, what aspects?

Do you feel that intelligence was not part of the problem, but intertwined with it in an important way? If so, in what way?

Alternatively, do you feel that giftedness was not related to your problem?

Did your therapist seem knowledgeable about giftedness? How did he demonstrate this understanding? Did he describe himself as a specialist in gifted issues? (You can use a real name if you wish -- I will protect the clinician's privacy by not including it in any writing I do about this research.)

Did you talk explicitly in therapy about giftedness, or experiences you felt were related to your high ability level? Did your therapist? Who brought it up?

How well did you feel that your therapist understood how you experienced being highly intelligent, or how giftedness might have interacted with the problem that led you into therapy? What did he do or say that led you to believe this?

If you felt the therapist was missing something, did he seem to realize this fact? What did he do or say that led you to believe this?

Did you try to explain or address these issues? Why or why not? What was the outcome?

Management of Countertransference

Did you perceive your therapist as probably being highly intelligent herself?

How do you think your therapist felt about *your* intelligence or achievement? What did she do or say that led you to believe this?

How do you think your therapist felt about *her own* intelligence or achievement? What did she do or say that led you to believe this?

If there was something which concerned you, what was your internal response? What did you actually do? What was the outcome?

Overall

Did your feelings about how well your therapist was allied with you affect your choice of how long to stay in therapy, or how deeply to engage in the process? If so, how?

Do you think that these feelings affected how effective therapy was for you? If so, how?

Try this: give three or five adjectives describing what your relationship with your therapist was really like, and give four or six adjectives describing how you would have liked that relationship to be.

Thank you again for participating in this research!

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