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Self-esteem and the professional development of the beginning psychotherapist : a developmental model.

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SELF-ESTEEM AND THE PROFESSIONAL DEVELOPMENT OF
THE BEGINNING PSYCHOTHERAPIST--
A DEVELOPMENTAL MODEL

A Dissertation Presented

By

ALAN SHERMAN GOLDBERG

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

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School of Education

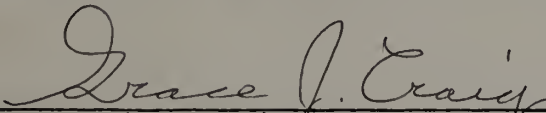
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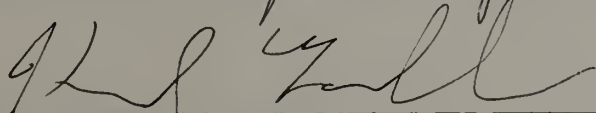
By

ALAN SHERMAN GOLDBERG


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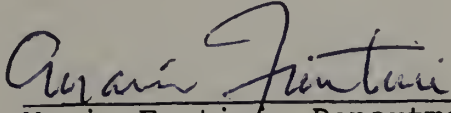
Grace Craig, Chairperson of Committee



Howard Gadlin, Member



David Schuman, Member



Mario Fantini, Department Head
Human Services,
Applied Behavioral Sciences

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This dissertation is dedicated to the memory of Doug Forsyth, my former chairperson, whose sudden and unexpected death has left so many of us deeply saddened. My appreciation and thanks to Grace Craig for assuming the chairpersonship at a difficult time and helping me reorganize and rewrite the introduction. In its final form, however, this dissertation is largely due to the unlimiting encouragement, good humor, clarity of thought, and hard work of David Schumann and Howard Gadlin. David's support and "crisis intervention" from the beginning of my comprehensives through the end of my dissertation defense was simply invaluable. Howard's long hours unselfishly spent, patience, and ability to help me organize my thoughts gave substance to this work. And finally, I'd like to thank my wife Renee for her support, encouragement, and patience.

PREFACE

It is my belief that dissertations are frequently pervaded by an autobiographical thread. One's particular choice of topics is often influenced by issues that are personally meaningful and sometimes conflictual. These issues and conflicts may be metaphorically expressed through the content of the thesis. Not uncommonly, the dissertation itself may be an individual's attempt to address and resolve these particular issues. Further, the process of dissertation writing represents an individual's final transition from student to professional, a step that is not without its psychological conflict.

My interest in the psychotherapeutic training process, self-esteem, and the beginner's professional development has evolved from my personal experiences in becoming a psychotherapist. This dissertation is my attempt to make sense of a seven year struggle with psychotherapy's complexity and ambiguity. Having attained both a secure professional identity and a comfortable level of clinical competence, I question the necessity of the emotional turmoil I endured in becoming a psychotherapist. Like most, if not all, neophytes I was preoccupied with my clinical adequacy and plagued with painful

self-doubts. Such self-consciousness and low self-esteem seemed to paralyze me at times and interfere with my psychotherapeutic performance and learning. On those rare occasions in the earlier part of training where I felt more comfortable with the process and my self, my clinical work seemed to be more effective.

I later began to wonder if a different training focus could have somehow mitigated the intensity of the confusion and low self-esteem that I and my fellow students seemed to experience. Specifically, I wondered if students who were better prepared for the inherent ambiguities and confusions of the psychotherapeutic training process might be less inclined to become immobilized by their inadequacies and self-doubts. If the neophyte could understand the learning of psychotherapy as a multi-staged, developmental process which predictably threatens self-esteem, then he/she might be better able to function therapeutically. I was unable, however, to find any existing training models which seemed to address either the beginner's experience or the training process in this way. This dissertation is in part an attempt to establish a more relevant and effective theoretical model for psychotherapy training.

ABSTRACT

SELF-ESTEEM AND THE PROFESSIONAL DEVELOPMENT OF THE
BEGINNING PSYCHOTHERAPIST--A DEVELOPMENTAL MODEL

February 1984

Alan Sherman Goldberg, B.S., University of Massachusetts

M.A.C.P., Antioch Graduate School

Ed.D., University of Massachusetts

Directed By: Grace Craig

This dissertation presents a developmental model for understanding the learning experiences of the neophyte psychotherapist as he/she struggles to attain a professional identity. Such a model is predicated on Mahler et. al.'s work on the separation-individuation process of early childhood and is roughly divided into three subphases: symbiosis; differentiation-practicing; and rapprochement. It is hypothesized that derivatives of the original separation-individuation process are reactivated for the neophyte therapist as he/she moves through the training process. The author thus attempts to establish an analogy between the development of the infant's self and the development of the neophyte therapist's "therapeutic self".

The core of the "therapeutic self" is said to

reside in the ability to use one's self empathically. The capacity for empathy is itself dependent on an individual's security with his/her sense of self. It is argued in this dissertation that the individual's self-esteem can be utilized to reflect such self security and therefore reflect the capacity for empathy.

Since the student in clinical training must learn to use his/her self empathically, and since such use entails exposure to psychological conflict and change, becoming a psychotherapist is an emotionally stressful process. The effects of such stress on the neophyte are exacerbated by the complexity and ambiguity of the training process, and the amount of time required for proficiency. Consequently, it is not unusual for the neophyte to be plagued with anxiety, self-doubts, and low self-esteem. Because these feelings diminish the effectiveness of supervision, and otherwise impair the student's learning and performance, it seems critical that psychotherapy training sensitively focus on, and work with these anxieties, self-doubts, and feelings of low self-esteem.

Because these feelings are a product of a developmental experience, both professionally and psychologically (learning to become a psychotherapist entails changes in the ego), it is argued that a developmental model of

training is the most sensible approach. This argument is made in relation to the confusing array of conflictual training paradigms that currently exist.

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C H A P T E R I

INTRODUCTION

The practice of psychotherapy is a complex and emotionally demanding endeavor since it involves the therapist's personality in a process of change.¹ Most psychotherapists agree that effective clinical intervention requires that the therapist empathically participate in the emotional climate produced by the client. Consequently, the therapist is exposed to a constant barrage of anxious energy from the client and must become comfortable with emotional responses of his/her own which ordinarily may be quite conflictual.² While the therapist's primary clinical tool is his/her use of empathy, it may paradoxically serve as a source of antitherapeutic defensive maneuvers.

Since the student in clinical training must learn to use his/her self empathically, and since such use entails exposure to psychological conflict and change, becoming a psychotherapist can be an emotionally stressful process. The effects of such stress on the neophyte are exacerbated by the complexity and ambiguity of the

psychotherapeutic training process, and the amount of time required for proficiency. Consequently it is not unusual for the neophyte to be plagued with anxiety, self-doubts, feelings of inadequacy, and low self-esteem.

Because these feelings diminish the effectiveness of supervision (Dodge 1982) and otherwise impair the neophyte's learning (Ralph 1980, Dodge 1982) and clinical performance (Bandura 1956, Ford 1963) it seems critical that psychotherapy training sensitively focus on, and work with the beginner's anxieties, feelings of inadequacy, and low self-esteem. The latter focus is especially important given the available empirical literature which supports the significance of self-esteem as a variable effecting a broad range of behaviors, including learning and performance (Coopersmith 1967, Brookover et al. 1963, Fitts 1972, Wylie 1978). Since learning to be a psychotherapist is a highly individualized process of growth, (Both personally and professionally), it seems sensible that a training model which closely utilizes the neophyte's everchanging, subjective experiences (anxieties, feelings of inadequacy, and low self-esteem) as a basis for educational intervention might be most efficient in producing competent psychotherapists.

We expect that such a model might explain the training process and the beginner's professional evolution in developmental terms. That is, the training process

might be said to consist of discrete, ordered stages with specific developmental tasks or milestones characteristic of each stage. The beginner's experience may then be clearly understood in relation to the particular developmental level reached and/or the particular developmental task to be mastered. Such a developmental perspective may not only clarify the process of training, but may make supervisory intervention more accurate and effective since it would be more closely geared to the student's experience and needs.

Certainly the idea of a developmental framework for viewing a process of growth and change is not novel to the field of psychology. Since Freud's theory of psychosexual development numerous developmental theories have emerged to explain the evolution of personality and behavior (Horney 1950, Sullivan 1953, Winnicott 1965, Erikson 1950, Mahler 1975, Kohut 1971 to name a few). Given the valuable contributions of these theories in advancing the practice of psychotherapy, and the close parallel between the latter and psychotherapy supervision, we might naturally expect to see existing models of training actively utilizing derivatives of these developmental theories.

A review of the literature on training in counseling and psychotherapy however, not only reveals a surprising lack of such a developmental perspective, but presents the reader with a confusing array of oftentimes

unrelated and conflictual training models.³ What is apparent is that educators do not yet have a universally acceptable and effective model for training psychotherapists.⁴ Because of a diversity of views as to what constitutes therapeutic effectiveness, training goals and emphases are arbitrarily based on available resources, on the interests and theoretical positions of faculty members, or on the needs of the immediate community.⁵

Traditional training programs have consisted of a set of courses based on the recommendations of a professional group, the state certification requirements, and an unspecified notion of the material a student should possess to enable him to function as a psychotherapist.⁶ These courses, although selected to meet APGA and APA standards, frequently offer uncoordinated training in theory, practice and research as discrete areas of the psychotherapist's functioning.⁷ Such a traditional didactic approach is referred to as a "transfer of training" model because its fundamental assumption is that the student's mastery of academic material--unsystematically acquired through lectures, textbooks, training tapes, and term papers will automatically transfer to how the neophyte will actually behave in the therapy session.

There are innumerable problems with this kind of training approach. First of all, it has never been satisfactorily demonstrated that didactic courses in

psychotherapy or more remotely related areas, are by themselves an effective means of training the psychotherapist.⁸ The didactic approach totally ignores the emotionally stressful, highly individualized nature of the training process. Consequently, there are no provisions for individual differences among students in this model. In addition, such an approach denies the true complexity of both the training experience and actual practice of psychotherapy in its implication that mastery of both is merely an intellectual achievement. Finally, the "transfer of training" model has been criticized for assuming that the transfer will automatically occur.⁹

A number of educators (Ivey 1971, Ivey et al. 1968, Carkhuff 1969, Traux and Carkhuff 1967, Brammer 1973, Hackney and Ivey 1973) advocate a different orientation towards training where the acquisition of specific therapy and counseling skills is the main focus. While skills acquisition is an important part of the psychotherapist's development, such a mechanistic, "engineering" type model oversimplifies and depersonalizes the training process. Becoming a psychotherapist entails involving one's self in a process of change which cannot be adequately explained by the mere learning of "effective" techniques. Similarly, successful performance as a psychotherapist (at least in most psychodynamic, humanistic, and existential approaches) requires that the

therapist utilize his/her self empathically in participating in the emotional climate of the therapeutic interaction. Perhaps the learning of these empathic techniques may be quite useful for those involved in more superficial counseling (i.e., vocational and/or guidance counselors). However, such a skills oriented approach to training fails to adequately prepare the beginner for the depth and breadth of psychotherapeutic work.

Another generally recognized model of training, the counseling/therapeutic model, has been thoroughly described in the literature (Boyd 1978, Hart 1978, Kurdius, Baker, and Thomas 1977). Focusing on the student's understanding and overcoming of personal and emotional concerns that prevent effective performance, this model views supervision as a form of therapy (Delaney 1972, Ekstein and Wallerstein 1958, Meuller and Kell 1972, Rogers 1956). Such a model is based on the assumption that the more psychotherapists are aware of, and understand their affective reactions to clients, the more helpful and effective they will be with these clients. While most programs may agree with this assumption in principle, only the psychoanalyst's training actually requires a personal analysis as an adjunct to formal supervision.

Given the emotionally stressful nature of psychotherapeutic training and practice, the

counseling/therapeutic model seems like a more appropriate one for facilitating professional development than the "transfer of training" and "engineering" models. While this particular training focus is indispensable to both the psychotherapist's growing awareness of his/her self and developing ability to utilize his/her self therapeutically, such a model is not without its complications. While supervision may walk a fine line between teaching and psychotherapy, it is not psychotherapy. Supervision may be an appropriate place to highlight interpersonal and/or intrapsychic impediments to effective clinical performance and learning but it is not necessarily an appropriate place to attempt to resolve these. Supervision based on this model deals primarily with the neophyte's countertransference distortions with the client and/or transference distortions with the supervisor (Fleming and Benedek 1966, Ekstein and Wallerstein 1958). In addition, there is no provision within this model for understanding these distortions in anything but a random, situationally specific manner (i.e., as related to a particular client's dynamics). Further, the neophyte's difficulties with the psychotherapeutic learning process and his/her struggles to attain a professional identity are not given adequate attention.

The task of conceptualizing a useful model for training becomes even more complex and confusing given the

lack of basic definitions for and distinctions among common terms which define these models.¹⁰ For example, the typical "practicum model" is considered by many to be the ultimate training vehicle within many programs." While the term "practicum" is often used to denote a fieldwork experience or an internship, there is no standard definition for it.¹² Bernstein and Lecomte (1976) highlight the confusion generated here.

Some programs use practicum as an arena for peer group supervision of actual counseling situations; others support professional consultation activities; practicum is sometimes identified with the learning of theories in seminars or study groups, or with skills training. Many programs seem to incorporate an arbitrary mixture of these elements; in total they are regarded as practicum.¹³

This same kind of confusion exists in the so-called "experiential model" of training because no common definition can be arrived at to adequately define the term "experiential." Carkhuff (1969) defines the word as the practice of learned skills and such a definition would overlap with our understanding of the typical practicum model. Brammer (1973) defines "experiential" learning as involving the doing of a task that results in learning. Rogers (1961) uses the term in a more general sense to explain the opposite of cognitive. Finally, in psychoanalytical training "experiential" is often used to indicate personal therapy. Consequently, what constitutes an

experiential model of training is quite unclear.

There have been numerous attempts to address the need for a more generally acceptable training model (Bernard 1979; Bernstein and Lecomte 1976; Jakubowski-Spector et al. 1971; Kohlberg 1975; Littrell et al. 1979; Martin et al. 1981; Ralph 1980 to name a few). Several have made important contributions in this area by providing a sound framework for integrating traditionally conflicting approaches. For example, Bernard's (1979) discrimination model combines didactic, counseling/therapeutic, and consultation models of training. In a similar manner Bernstein and Lecomte's (1976) integrative-competency based model defines and integrates four common elements in the psychotherapist's training (theory education; skills training; experiential activity; practicum experience), each of which represents separate models of training. However, both these models are limited in that they almost totally ignore the importance of the individual's experience within the learning process and the personal development which this entails.

Other models have attempted to address the criticism that training approaches do not make enough allowances for individual differences among trainees. For example, Bernard's 1979 model (above) stresses the importance of a flexible training approach which dictates that the supervisor shift his/her role (as teacher, therapist,

or consultant) depending upon the trainee's idiosyncratic difficulties. Similarly, Jakubowski-Spector et al.'s (1971) behavioral model directly focuses on the student's behaviors (thinking, feeling, and acting) as a basis for educational intervention.

While these models attempt to resolve the question of a more generally acceptable training paradigm for psychotherapists, and in a number of cases succeed in lessening some of the ambiguity around conflicting approaches, they nevertheless miss a critical point. Simply stated, training to be a psychotherapist is a two-fold developmental process. Not only does the student develop professionally by gradually moving through an as yet undefined sequence of stages from neophyte to mature psychotherapist, but such professional development also entails the potential for psychological development. The latter may be understood as the development of a therapeutic self, an ability to use one's personality (i.e., feelings, thinking, reactions) therapeutically. Because the evolution of a therapeutic self is a form of psychological development* it cannot be adequately explained by models of training which stress the learning of specific skills, techniques, or bodies of knowledge. Since tradi-

*According to Ralph (1980) the changes reported by psychotherapy trainees may be more accurately understood as facets of ego development—enduring changes about the self and others.

tional training approaches have barely focused on the importance of the trainee's psychological development, the latter has remained, for the most part, an unrealized potential. Further, even so-called models which claim to be more trainee and experience centered (i.e., experiential, practicum, and behavioral models) fail to consider the student's experience and feelings as part of a larger developmental process. Without such a perspective, educational intervention seems piecemeal and unrelated.

This is not to say that the need for a developmental framework has gone completely unrecognized. Kohlberg (1975) stressed the need for such a developmental approach to counselor education in stating that without this perspective training programs would become a "potpourri of approaches, a set of eclectic activities".¹⁴ Ralph (1980) asserted that a developmental perspective of the student's level of functioning was central to the teaching of psychotherapy. He recognized four developmental milestones in the process of learning psychotherapy:

- (1) Learning the role of the psychotherapist as a non-directive expert.
- (2) Adopting a patient-centered approach that is global, patient-centered, and concretely content centered.
- (3) A relationship-centered approach that involves the discovery of psychotherapy as an interpersonal process.

- (4) The development of a therapist-centered approach in which there is increasing awareness of the usefulness as well as the limitations that the therapist's own feelings impose.¹⁵

With these milestones, Ralph roughly traces out the development of the trainee's therapeutic self. While innovative and focused on the trainee's developmental experience, Ralph's schema is incomplete and too general. The beginner's experience within each stage and the specific training issues need to be expanded while movement from stage to stage needs to be more clearly delineated. While Ralph discusses the training process as one which entails psychological change within the neophyte, it is unclear what these changes are, how they take place, and what role the supervisor plays as facilitator.

Littrell et al. (1979) proposed a developmental framework which incorporates four existing training models, (counseling/therapeutic, teaching, consulting, and self-supervising), into a four stage developmental sequence. As the student progresses from stage to stage and attains a greater sense of competence and professional independence, the supervisor's role and training model changes accordingly: in Stage I the supervisor establishes a non-judgemental and supportive learning environment; in Stage II the supervisor utilizes both counseling/therapeutic and teaching models; in Stage III a consulting model is employed; and in Stage IV a self-

supervising model is utilized.¹⁶ Thus, there is decreasing supervisory control with increasing trainee professionalism until the self-supervising model is adopted in the final stage of the training process.

Of the training models considered, Littrell et al.'s presents both the clearest picture of training as a discrete developmental process, and the most sensible framework for organizing supervisory intervention. While this model considers training as a developmental process, professionally-speaking, there is little to no emphasis on the psychological development which psychotherapy training entails nor the effect of this development on the neophytes learning and performance. Since the personal, psychological growth which is inherent in the learning process is intricately interconnected with professional growth, the two must be considered together for an effective training paradigm. Further, because these two facets of growth entail changes in the neophyte's sense of self and self-esteem, which are hypothesized to play a critical role in learning and performance, such a two-fold developmental perspective of training seems important.

In summary, the literature on counseling and psychotherapy training presents the reader with a confusing array of oftentimes conflicting and unrelated training models. Numerous attempts have been made to remedy this situation and develop a more generally accep-

table training paradigm, while partially successful in eliminating some of the confusion, the majority of these attempts have fallen far short of the mark because they have failed to consider the two-fold developmental nature of psychotherapy training. That is, becoming a psychotherapist involves the neophyte in a process of both professional and personal, psychological growth. Any educational intervention which does not seriously consider the importance of these intertwined developmental processes to the neophyte's learning and clinical performance misses a critical aspect of training.

Since becoming a psychotherapist involves the formation of a therapeutic self, and aspects of ego development, it seems logical that a developmental model would be the most appropriate way of viewing training. While the need for such a framework has been recognized, the few developmental models that exist consider either professional (Littrell et al. 1979) or psychological (Ralph 1980) aspects of development, (and the latter only superficially), but not both. There is a need, therefore, for a comprehensive developmental model which effectively combines the neophyte's professional movement from supervisory control and dependence to independence with the accompanying psychological changes (self-changes) which such movement entails.

This dissertation attempts to address such a need

by proposing a developmental framework for psychotherapy training. The theoretical foundation for this model building, and for the dissertation in general is primarily psychoanalytical and neo-analytical in nature. We will predominantly utilize analytical, object-relations, and ego psychology principles to examine the various facets of the training process and the neophyte's clinical functioning. The rationale for such an approach is that the analytical orientation best lends itself to the study of self development and identity formation. It offers more depth, detail, and clarity about the process of early development than other, non-analytical modalities. Since we conceptualize the changes that a therapist-in-training undergoes as a form of self development (formation of a therapeutic self) it makes sense that we utilize an approach which will allow us to both examine and discuss the training process and beginner's experience in clear developmental terms.

Our rationale for using such a model of self development to examine the psychotherapist's professional evolution is further explained in the therapist's use of empathy as a clinical tool. Empathy entails a transient loss of self, a temporary blurring of the self boundaries in order to identify with the client, which is immediately followed by a regaining of this sense of self. Since the capacity for empathy is dependent upon an individual's

security with self and is initially established in the first three years of life, an early development perspective might help us examine the neophyte psychotherapist's struggle with using empathy clinically.

The proposed framework for our early development model is derived from Mahler et al.'s (1975) conceptualization of the separation-individuation process of early childhood. In separation-individuation, the child moves through a series of stages, starting from a state of psychological fusion with the mothering one, until gradually he/she develops a separate sense of self and identity. This process of movement from no-self and total dependence to the establishment of a sense of self and relative independence is utilized as a model for the neophyte psychotherapist's development of a therapeutic self and professional identity. Of the analytical writings, Mahler et al.'s (1975) work was chosen for the following reasons: First, it represents the most empirically accurate and detailed account to date of the first three years of the individual's psychological development; Second, the separation-individuation process clearly highlights the infant's key developmental issues and experience as he/she moves from dependence to independence; Third, because derivatives of the original separation-individuation process reverberate throughout the life cycle, Mahler et al.'s work can be quite useful

in helping us understand and discuss the process of professional identity formation. The method which we will employ to construct out developmental framework is by analogy. We will examine the neophyte's training experiences and growth as a rough parallel of Mahler's subphases of early development.

Because of the theoretical nature of this dissertation it seems appropriate here to caution the reader about its inherent limitations. In utilizing an analytical framework to organize our perceptions and thinking we have had to exclude numerous other conceptualizations of the subject matter and problem. Consequently, our understanding is naturally biased and limited, representing just one of many possible explanations. While our perceptions may be constricted by an analytical bias, it is this constriction which allows us to examine our subject matter in more depth than otherwise might be possible. An additional caution relates to the limitations inherent in any theoretical conceptualization. A theory of psychotherapy or personality development, for example, represents a particular individual's attempts to make sense out of observed phenomena. This can be helpful as long as the theory maker does not lose touch with his/her subject's reality and is able to maintain a flexibility which allows his/her observations to dictate his/her theoretical constructions, rather than the

reverse. In this dissertation we have attempted to maintain such a flexibility while presenting our theoretical notions.

This dissertation is organized in the following manner. In Chapter II, the process of psychodynamic psychotherapy is critically examined in order to provide a framework for a more detailed presentation of the psychotherapist's role and experiences. An empathic use of self, as the essence of this role, is closely detailed. This includes an in depth explanation of both the mechanics of empathy and empathic failure as well as a discussion of the capacity for empathy. A relationship between anxiety, empathic failure, and the psychotherapist's mistakes is then hypothesized. This chapter, along with the next, lays some of the groundwork for the importance of a developmental perspective of psychotherapy training.

In Chapter III the notion of self-esteem is introduced and discussed as a behaviorally significant variable. Because self-esteem has an important impact on learning and performance and is a product of early development we are interested in examining this variable in our training model. The antecedent conditions of self-esteem are then discussed. The current literature on self-esteem and behavioral performance is then examined in an attempt to establish how the therapist's self-esteem

effects his/her clinical performance. A relationship is hypothesized between the therapist's self-esteem, anxiety, and clinical errors. The chapter concludes with a discussion of the development of self-esteem in early childhood.

Chapter IV examines the experience of the neophyte therapist as he/she progresses through the process of psychotherapeutic training. Our developmental model is indirectly introduced in this examination and is based on Mahler et al.'s (1975) work on the separation-individuation phase of early childhood. Such a model proposes that the neophyte's training experiences may be best understood as a rough parallel of the original process of self-formation.

The concluding chapter of this dissertation attempts to further address the issue of unsystematized training for therapists by first examining in detail the components of good supervision. A framework for effective supervision is then presented which integrates the supervisor's skills and interventions into the neophyte's developmental model discussed in the previous chapter. This framework breaks down the process of training into symbiotic, differentiation-practicing, and rapprochement stages and offers guidelines for the supervisor's particular interventions.

ENDNOTES

Chapter I

1. Ralph, Norbert B., "Learning Psychotherapy: A Developmental Perspective" in Psychiatry, Vol. 43, August 1980, p. 249.
2. Ford, E.S.C., "Being and Becoming a Psychotherapist: The Search for Identity," American Journal of Psychotherapy, Vol. 17, 1963, pp. 477-478.
3. Bernstein, Bianca L. and Conrad Lecomte, "An Integrative Competency Based Counselor Education Model," Counselor Education and Supervision, September 1976, pp. 26-28.
4. Jakubowski-Spector, Patricia, Richard Dustin, and Rickey L. George, "Toward Developing a Behavioral Counselor Education Model," Counselor Education and Supervision, Spring 1971, p. 242.
5. Bernstein and Lecomte, 1976, p. 27-28.
6. Jakubowski-Spector, et. al., 1971, p. 242.
7. Bernstein and Lecomte, 1976, p. 29.
8. Chessick, Richard D., How Psychotherapy Heals, (Science House Publishing Co., 1969, p. 161.
9. Jakubowski-Spector, et. al., 1971, p. 242.
10. Bernstein and Lecomte, 1976, p. 28.
11. Ibid.
12. Ibid.
13. Ibid.
14. Kohlberg, Lawrence, "Counseling and Counselor Education: A Developmental Approach," Counselor Education and Supervision, June 1975, p. 250.

15. Ralph, 1980, p. 244-245.

16. Littrell, John M., Nancy Lee-Borden, and John Lorenz, "A Developmental Framework for Counseling Supervision," Counselor Education and Supervision, December 1979, pp. 130-134.

C H A P T E R I I

EMPATHY AND THE PSYCHOTHERAPIST'S ROLE

An Introduction to the Practice of Psychotherapy

Psychotherapy can accurately be described as a process, an ongoing interpersonal interaction between two participants, a client and a therapist, who, meeting under prearranged circumstances and following a specific set of ground rules (i.e., time, place, length and periodicity of meetings, duration of treatment, fee, etc.) work together to reach a mutually agreed upon goal, the alleviation of the client's symptomatology or difficulties in living. It is the latter which has precipitated the client's originally seeking treatment, and is related to problems involving his/her self (i.e., impoverished level of self-esteem, non-functional ego boundaries, or failures of the ego's adaptive capacities).

Throughout this dissertation, as we examine the various aspects of the psychotherapeutic process and the therapist's professional development, we will be utilizing a psychoanalytically oriented framework. Based upon Freudian and Neo-Freudian principles, our framework

stresses the importance of early development (specifically the first three years) on behavior, personality, and self-formation. Inherent in our theoretical orientation is a belief in the critical role of the mother as a primary catalyst for the infant's psychological growth. In addition to drawing from Freud's basic psychoanalytical theories, we will utilize the neoanalytical works of Sullivan, Horney, Winnicott, Kohut, and Mahler to name a few. Various aspects of a Rogerian perspective will also be employed in several areas where they appear relatively compatible with the analytical train of thought, i.e., self-esteem development, pathology and change, and empathy.

Before proceeding with our description of the psychotherapeutic process and the therapist's role, a clarification of some of the terms utilized in this dissertation is appropriate here. In the classical and more recent psychoanalytical literature (i.e., ego psychology and object relations theory) there appears to be a great deal of confusion and overlap in the definition and utilization of the terms "self" and "ego." Frequently used interchangeably and synonymously in the earlier writings,¹ self and ego are currently discussed either separately, or, when they are considered together in the same theoretical work, their interrelationship is, at best, unclear. Without further commenting on these incon-

sistencies and confusions in the analytical theory, we will attempt to provide a rough framework for understanding the ego, self, and their interrelationship. Such a framework, which will be utilized throughout this dissertation, integrates theoretical notions of Hartmann (1958, 1964), Spitz (1959), and Jacobson (1964) among others.

Both Hartmann and Jacobson employ the notion of "self" to refer to the whole person of an individual, including his/her body and body parts as well as his/her psychic organization and its parts.² Thus, the self is used to represent the individual's unique, total personality, i.e., his/her psychophysiological Gestalt. The self is also employed to represent the developmental achievement of a state of psychophysiological oneness, that is, of a separate, fully functioning, and internally-regulated individual entity.³ Like Hartmann (1964), we will utilize the term 'ego' to represent a "substructure" of the individual's personality or self in a similar way that the terms 'id' and 'superego' represent other substructures.

The ego functions in important organizing and adaptive capacities which ultimately determine the psychic strength and structure of the self. In the newborn, these ego functions, i.e., perception, intention, object comprehension,* cognition, language, recall phenomena,

*Object as it is used here is in the psychoanalytical sense to designate the psychic representation of the infant's object of attachment, i.e., mother or father.

productivity, and motor development, are mere potentialities and totally dependent upon the environment, and especially interactions with the mother for their development.⁴ Early maternal failures result in a hampering of these potentialities, i.e., ego weaknesses, which in turn, will interfere with the development and structuralization of the self. The emergence of the fully functioning self is thus dependent upon the successful unfolding of the ego's apparatuses and functions. In the ego's mediations between the individual's intrapsychic world and the world of outer reality, it facilitates the resolution of physical and psychological frustrations and conflicts. An important component of the ego's adaptive capacities, the defense mechanisms, maintain the effective functioning of the ego and, ultimately, the psychological integrity of the self.

Self-concept, self-image, and self-representation are terms that are variously utilized to reflect the individual's psychic representation of his/her self. It is because of the self's uniquely reflexive nature, that is, an ability to be both subject, the "I," and object, the "me," of behavior, that we can speak of these self representations. An individual's sense of self refers to a psychological awareness of one's separateness and individuality. Inherent in this sense of self is a particular feeling component which reflects the individual's

degree of satisfaction or contentment with his/her self. We will utilize the term self-esteem to refer to this feeling component.

Returning to our discussion, the practice of psychotherapy, then, is one which concerns itself with disturbances in the self, which are a consequence of ego weaknesses. Manifest in low self-esteem or other distortions in the self, such ego weaknesses, when severe enough, can result in a complete breakdown of the individual's daily functioning. Ideally, within the psychotherapeutic context, the psychotherapist's training, life experience, clinical expertise, and personality enable him/her to help facilitate the resolution of the client's emotional difficulties and pain through a strengthening of the ego and thus restructuring of his/her impaired self. Within this role, the therapist functions as a catalyst in restimulating the natural processes of ego development, those having been arrested due to an early maternal failure.

In this context, psychological change entails a better realizing of one's innate potential and capabilities, these having been blocked, interfered with, or lost at some point during the individual's early psychological development. More specifically, such change entails a redevelopment or recovery of "lost" aspects of the personality, alienated parts of the self, particularly emotions, which, for defensive adaptive purposes, have

long been dissociated or obscured. Such a dissociation is a product of the ego's early adaptive attempts to resolve the problems of growing up, psychological and physical survival within the family matrix, and constitute a developmental arrest. To better understand the nature of psychotherapy, and especially the therapist's role within this interaction, the nature of the ego's adaptive responses to psychological stress must be examined in greater depth.

From an analytical perspective, the child's behaviors and personality characteristics that are anxiety-provoking or otherwise conflictual for the parents are deemed "bad" by them and may result in their anger, empathic failure and withdrawal of love. The consequences of such empathic failure and withdrawal of love for the child's developing ego and self are potentially devastating. As a threat to the child's ego, this parental response generates anxiety which, in turn, stimulates adaptive or defensive maneuvers. On the surface, the specific behaviors which elicited the anxiety-provoking parental withdrawal eventually become "bad," i.e., ego threatening, to the child and, for psychological and physical survival, the ego responds by "eliminating" these behaviors while exaggerating certain others.

In order to clearly illustrate the ego's adaptive responses to anxiety-provoking situations, and the nega-

tive ramifications of such adaptation for future development, we will utilize a rather extreme example in focusing on the developmental dynamics of borderline psychopathology. While most maternal failures are not so severe, nor ultimately as ego-impoverishing as those found in the borderline syndrome, this kind of example vividly illuminates the potential for psychological difficulties in the ego's adaptive responses. A mother who experiences as rejection her two year old's age appropriate attempts at separation, might be empathically unavailable, attacking, and withdrawing of her love when the child experiments with independent functioning. In addition, we might expect such a mother to respond with love and encouragement to her child's expressions of dependence and helplessness. Thus, for this child to avoid self threatening and ego impoverishing anxiety, and maintain maternal love, his/her ego adapts by avoiding "dangerous" independent strivings. Along with this avoidance, the child's ego must find a way to defend against its own rage and other anxiety-provoking affects generated by the mother's empathic failure and infantilizing behavior. Such adaptation, as we have said, ultimately has its price in terms of future development. While the two year old child's dependent behaviors and avoidance of attempts at separation temporarily maintain much needed supplies of maternal love and satisfaction of other needs, with later

maturation, these adaptive strategies of the ego become less and less effective, and finally symptomatic. He/she is not equipped psychologically to function as an adult, becoming overwhelmed with anxiety when faced with any situation requiring independent behavior. While physiologically an adult, psychologically this individual is a child, lacking the ego strength to cope on his/her own. Thus, the ego, and consequently, the self have been deprived of the opportunity to grow and develop and therefore, the individual cannot successfully adapt to an adult world. The ego, with its dependency seeking strategies and impoverished ego functions (in this example we would expect to see weak ego boundaries [i.e., a poor sense of self], significant distortions in reality testing, primitive and ineffective defense mechanisms, and disturbances in affect), is the essence of what such an individual brings with him/her to the therapeutic encounter, or any other relationship.

An understanding of the ego's "antiquated" adaptive attempts will help illuminate the psychotherapist's major goals within the therapeutic encounter. In general, a particular client's style of interacting is reflective of the individual's self and ego strength. The manner in which the client interacts with the therapist highlights the former's ego-adaptive strategies. As demonstrated in our example, such strategies have an interpersonal aim,

i.e., to maintain love, nurturance, and maternal acceptance, while avoiding feelings of abandonment and anxiety. That is, as in the past, they are designed to meet certain needs by eliciting specific behavioral responses from the social environment while avoiding others. Within the confines of the therapeutic encounter, the client will repeat, or transfer these same behavioral strategies onto the therapist in an attempt to establish a particular emotional climate and elicit certain responses from him/her. In the process, the client distorts some of the realistic aspects of the therapeutic relationship.

The tendency towards this distortion and "as if" behavior is referred to in the literature as the transference reaction. Utilizing our example of the infantilizing mother and overly dependent child, how can we understand the transference? Let us assume that, years later, this particular individual sought out psychotherapeutic treatment (a most likely occurrence given the nature and extent of his/her ego-impoverishing, developmental experiences with mother). We might expect to see this early conflict being "transferred" to, or played out in various ways within the therapy. For example, this client (assuming a female) might attempt to get the therapist to take care of her by presenting herself as fragile and totally incapable, or by asking for certain favors (i.e., to take over her finances, forego the therapy fee,

provide extra time within the sessions, or make all decisions for her). The transference is here manifest in the client's attempts to elicit infantilizing behavior from the therapist and in her presentation as helpless. Similarly, such a client, after contemplating or attempting an independent move (i.e., terminating therapy and returning to school, coming to a decision alone, getting a job, or expressing her anger at the therapist or others), may become overwhelmed with anxiety and fears of failing, critical attack, and retaliation by the therapist. Since early attempts at separation and individuation were met with this kind of unempathic assault by her mother, the client expects a similar response from the therapist when she attempts to individuate in one form or another.

The Psychotherapist's Role in the Process of Psychotherapy

Since one of the primary causes of the client's malfunctioning and pain is his/her ineffectual adaptive strategies, successful psychotherapeutic intervention necessarily must focus here, at the site of the original developmental arrest. Thus, the client's transference reactions play an important role in the overall curative process of treatment. Ideally, the therapeutic process sufficiently frees up the developmental arrest so that the client's ego is allowed to mature. Simplistically, this

process is facilitated by the therapist's focusing with the client upon the latter's transference distortions, highlighting their origins, dynamics, and maladaptive nature.

If the client is successful in eliciting the sought-after behaviors then the therapy is doomed to failure. If this were the case, then the client's self, with its inherent ego weaknesses, remains intact and unchallenged by reality, thus continuing in its malfunctioning. In our example, for the therapist to respond with caretaking, infantilizing behavior, which this particular client attempts to elicit, then he/she would merely be perpetuating the same conditions originally responsible for the developmental arrest. The client's conflict over separation-individuation would remain as his/her dependency is encouraged at the expense of his/her individuality. This particular client, being unable to cope with situations that demand independent functioning, will respond with overwhelming anxiety and fears of abandonment whenever help is not forthcoming. Further, when someone does come to the rescue, i.e., the therapist, this client will respond with regressive behavior, having had his/her dependency needs met, as well as with rage for having his/her needs to individuate frustrated. Thus, the early developmental conflict continues unchecked.

If, however, in this process, the therapist refuses to "dance the same old steps" and, instead, highlights the client's transference distortions while responding in a different, more therapeutic manner, then the client is faced with a new and powerful interpersonal experience. The repetitive experience of being unsuccessful in eliciting the hoped for response from the therapist, combined with a therapeutic examination of these maladaptive self-strategies, ultimately provides the client with an opportunity to work through the original developmental conflict. The working through process strengthens the client's ego and leads to more adaptive self-strategies. Psychotherapeutic change, then, i.e., a strengthening of the individual's ego and the development of more adaptive self-strategies, is facilitated by exposing the client to a different kind of interpersonal experience, a "corrective emotional experience" (Sullivan 1950).

The foundation for the "corrective emotional experience" and for psychotherapeutic change in general is the quality of the psychotherapeutic relationship. The determination of the quality, in turn, is primarily dependent on the personality of the therapist, a variable that has long been recognized as one of the most important to the psychotherapeutic process.⁵ The therapist is actually employing aspects of his/her personality or self to facilitate change within the client's self. Generally

speaking then, the therapist's use of self encompasses all that comprises the psychotherapist's role, and is the most critical task of one's clinical endeavor.

Sullivan (1949), in discussing the role of the psychiatrist and his/her effectiveness, elucidates this use of the self as "participant-observer."

"The expertness of the psychiatrist refers to his skill in participant-observation of, in contrast to the mere participating in the unfortunate patterns of his own and the patient's living."⁶

What Sullivan refers to here is the necessity for the therapist to be able to utilize his/her self to enter the emotional or psychological world of the client in order to better understand him/her, and yet still be able to return to his/her own sense of self. Thus, within the therapeutic relationship, the therapist's overall functioning as a "participant-observer" sums up the crucial role which he/she must adopt in the work. Participation-observation requires a balance that is difficult to maintain and when the therapist loses this balance, then he/she loses the clinical perspective necessary for effective intervention.

In our previous example in order for the therapist to genuinely understand the client's conflict and feelings, he/she must briefly "participate" in the helplessness and panic. If such participation leads to the therapist him/herself becoming overwhelmed with panic and helplessness, then he/she, having lost the emotional distance or perspective necessary for the "observer" role,

will be of no therapeutic help. In overparticipating, such a therapist is unable to help the client understand and alter her problematic behavior.

At the other extreme, if the therapist becomes too much the observer, or too cognitive, he/she will create too much interpersonal distance which will preclude any genuine understanding of the client. For the therapist to respond to our client's panic and helplessness with a detached stance, and an interpretation, for example, that the client is acting like a child because she wants the therapist to mother her, then it becomes clear that this clinician has no true feeling-sense for what the client is experiencing. His/her interpretation, while theroretically accurate represents a complete lack of understanding of the client's feelings and may engender hostility.

"Empathy"

A critical aspect of the therapist's role in using his/her self as participant-observer is a willingness to be exposed to the emotional climate generated by the client, and to the threat of change which this entails. It is such emotional participation which holds the key to an understanding of, and resolution of the client's psychological difficulties. That is, within the therapeutic encounter, the client's affect, behavior, and interactional style will catalyze particular emotional

reactions within the therapist. These reactions provide a diagnostic key to the client's communications and interpersonal difficulties since they provide the therapist with an emotional understanding of the client. Thus, when the therapist repetitively feels a pull within him/herself to take care of the client, or feels guilty and withholding during periods of silence within the session, or angry at the client's helplessness, or terrified by the client's rage, then these and other subjective reactions alert him/her to the client's feelings and conflicts around dependence-independence. Thus, the therapist needs to "emotionally know" the client, without which he/she cannot grasp the subtle and complicated feelings involved in the client's problematic behavior.

It is this "emotionally knowing," or experiencing of another's feelings that is meant by the term empathy. Few psychotherapists would deny that an empathic, intuitive understanding of their clients' communications is their most vital, if not indispensable tool in psychotherapy. It is through this capacity, "the capacity of the subject instinctively and intuitively to feel as the object does," that most therapists gain true entry into the client's life space.⁷ Heimann refers to the therapists' emotional response as an "instrument of research" into the clients' unconscious, and that for an analyst not to consult his/her feelings when working

ensures that their interventions will be inadequate.⁸ Leonard and Bernstein similarly refer to the therapists' use of self as an "instrument" which intuitively registers the quality of rapport in the therapeutic alliance and the intensity of resistance, source of anxiety, frustration tolerance, and the level of depression in the intrapsychic system of the client.⁹

Despite the widely acknowledged focal importance of empathic understanding to the psychotherapist's effective professional performance, comparatively little investigation and conceptualization of empathy can be found in the psychoanalytic literature. Beres and Arlow indicate that empathy, as a highly subjective and integral component of the psychotherapeutic work, is too easily taken for granted.¹⁰ As a consequence, it has remained a vague term lacking clear-cut criteria and an operational definition. In discussing the reasons for this, and the scarcity of documented reports on empathy, Beres and Arlow point to the self-revealing nature which this documentation entails.¹¹ The therapist/researcher, in examining his/her empathic response to the client's productions, must expose his/her inner processes for public scrutiny, a vulnerability very few have the courage or willingness to endure. The ability to tolerate such exposure and vulnerability by itself does not guarantee an accurate reporting of the empathic response. Because of the

idiosyncratic, highly subjective nature of empathy, clear documentation of this elusive feeling-type of experience remains almost nonexistent.

Halpern and Lesser (1960), in their discussion of empathy in infants, adults, and psychotherapists, utilize the working definition of this construct as the "imaginative transposing of oneself into the psychological frame of reference of another so that the other person's thinking, feeling, and acting are predictable."¹² In Greenson's (1960) definition of empathy, he offers a possible explanation as to why the other's behaviors are predictable. He defines empathy as a temporary sharing or experiencing of the feelings of another person in which one partakes of the quality and not the intensity of the feelings.¹³ As a preconscious phenomenon, empathy is to be differentiated from sympathy, since it doesn't contain the element of condolence, agreement, or pity essential for sympathy.¹⁴ Though imitation and mimicry also bear some resemblance to empathy, they are conscious phenomena and limited to the external behavioral characteristics of a person. While the imitator or mimic may temporarily look like and act like the other person, his/her actions function to merely replicate the observable, surface phenomena in this person, and do not allow for a deeper understanding of, or connection with him/her. Empathy, on the other hand, is more of a subjective, inner experience

of sharing in, and comprehending the momentary psychological state of another person. The shared experience is based to a great extent on remembered, corresponding affective states of one's own. Observing a client's life at any one point, we tentatively project onto him/her the feelings we once felt under similar circumstances and then test this projection by further observation.

Schaffer (1959) conceptualizes the nature of the therapist's empathic comprehension in terms of affective and cognitive components. The former consists of the re-creation of affect, i.e., becoming able to feel approximately as the other person does through a revival of past inner experiences of a similar nature.¹⁵ Such a re-creation of affect within the therapist is a product of his/her transient identification with the client. As it is experienced, the affect is in the nature of a "signal" (Beres and Arlow, 1960), a momentary identification with the client that leads to one of two kinds of awarenesses: first, the therapist may come to feel just like the client, as, for example, when a grieving client stimulates grief and sadness within the therapist; or second, when the affect which the therapist experiences corresponds precisely to the mood which the client has sought to stimulate in him/her, as, for example, the masochistic individual who tries to evoke criticism and attack, or the helplessly dependent individual who attempts to elicit

nurturance and caretaking behavior. Schaffer describes the latter or cognitive component of empathy as follows:

"empathy requires the free availability of memories supplemented by the sensing or judging of similarities that make past personal experience relevant to the current situation. It requires perceptual attention, or vigilance, to elusive cues, difficult to conceptualize, in motility, verbalization, affective expression, and tempo. It requires implicit, if not explicit, anticipations of future developments as well as causal "feels" or inferences as to what brings about a situation involving those affects being experienced by the object and the empathizer.¹⁶

As psychotherapists, then, without such an empathic understanding we would have no real basis for effective intervention. In order to better understand the critical function of empathy within the psychotherapeutic encounter, we will utilize an early development model of empathy within the mother-infant dyad. In the psychoanalytical perspective, the utilization of this parallel between the mother-infant and therapist-client relationships has illuminated and clarified important areas of theoretical and clinical work.

In his interpersonal theory of personality development, Sullivan (1953) first postulated the existence and importance of empathy between mother and infant as the primal mode of interpersonal communication.¹⁷ The mother, through her smell, voice, tonal, postural, and facial expressions, communicates to the infant either rejecting tensions and anxiety, or loving nurturance and security. In a similar way, the

infant communicates through its crying and fussing a feeling of "tenderness" in the mother which impels her to administer to the infant's needs.¹⁸

Winnicott (1960) expanded Sullivan's work with empathy in detailing the importance of the mother's empathy in personality development and the consequences of empathic failure in relation to later psychopathology. The mother, through her empathic responsiveness, creates a "holding environment" for the infant, buffering it from overwhelming, ego-impoverishing anxiety.¹⁹ Through her "good enough mothering," she allows the developing child to experience an "optimal level of frustration," enough to stimulate ego development without the child's being either overwhelmed from too much exposure, or infantilized from too little.²⁰

Kohut (1971, 1978), in his presentations on personality development, psychopathology, and the psychotherapeutic treatment of the narcissistic disorders, similarly emphasized the critical importance of parental empathic responsiveness. Like Winnicott, Kohut postulated that early empathic failure resulted in arrested development and was largely responsible for the more serious psychopathological disturbances, i.e., borderline and narcissistic disorders.²¹ He also drew a close parallel with the empathic processes between mother and child, and father and child, and those manifest in the

client-therapist relationship. Kohut highlighted in more detail than Winnicott the critical role that the therapist plays in undoing early empathic failure through his/her own empathic responsiveness. The therapist's consistency here, among other things, facilitates a process of "transmuting internalizations," or changing of the client's intrapsychic structure (inner objects) which, in turn, allows the once arrested process of psychological development to continue.²²

Generally speaking then, empathy is a form of "emotional knowing" of the other through a process of projecting one's self, feelings, and experiences. More specifically, empathy can be characterized by a two-part process, an understanding of which will illuminate both the psychotherapist's successful utilization of empathy, as well as empathic failures. First, empathy entails a transient or temporary identification with the other person.* Such an identification requires a temporary suspension of one's ego boundaries, and thus a temporary loss of self. Second, and immediately following this initial transient identification, the empathizer is able to regain, and thus thus to preserve his/her sense of separateness from the object.²³

*This is to be distinguished from identification as it is commonly understood in the psychoanalytic literature as an unconscious and permanent phenomenon primarily defensive in function.

An example of the two-part process inherent in empathy is clearly manifest when an empathic mother's response to her child's pain is compared with the corresponding behaviors of a non-empathic mother. In the first case when her child has been hurt, the empathic mother will react to his pain and anxiety, but will maintain her separate existence as a mother. That is, she will identify with her child and his hurt, though such identification remains transient and serves to mobilize behavior appropriate to the emergency. The non-empathic mother, on the other hand, may either narcissistically withdraw from the situation, or so completely identify with the child that she suffers along with him to the point where she shares the child's helplessness.

It is this two part process of empathy which allows us to understand and explain the mechanics of the therapist's participant-observer role. Such a flexible balance between the affective and cognitive is what Fenichel (1945) stressed in his use of the metaphor of Scylla and Charybdis in psychoanalytic technique.²⁴ As the most important clinical tool available to the psychotherapist, the ability to empathize is consequently considered to be one of the essential effective ingredients in psychotherapeutic treatment.²⁵ It is empathy that opens up the client's experience for examination and provides the therapist with the diagnostic cues needed for

accurate intervention.

From what has been said up to this point, empathy is a complex, affective and cognitive process which entails a temporary and partial loss of self, followed by a re-establishing of one's psychological separateness. Given empathy's crucial role in the therapist's effective functioning, the capacity for empathy or his/her ability to engage and disengage the self is of interest here. The capacity for empathy first begins to emerge in the Rapprochement aged child (18-20 to 24 months and beyond) with the growing awareness of her/his separateness and helplessness.²⁶ Mahler postulates that it is this initial experience with his/her own vulnerability that allows the child to begin to empathically understand these same feelings in other children.²⁷ The intrapsychic basis for this increased ability to tolerate a wider range and greater intensity of affect is the emergence of a stable, secure sense of self. It is during the next subphase of the Separation-Individuation process (termed by Mahler the Consolidation of Individuality and the Beginnings of Emotional Object Constancy), that this stability of self and self boundaries are attained.

As in most, if not all, early developmental achievements, the role of the mother's emotional responsiveness and communication is crucial in facilitating the child's development of empathy. Halpern and Lesser (1960)

theorize that the amount and quality of pleasant and unpleasant emotional communication to the child probably affects his/her total empathic ability. They explain,

If the infant's most frequent somatic experiences through empathy have been pleasant (euphoria and a reduction of tensions) it may be expected that his use of empathy will be rewarded and he will tend to further develop this form of communicative reception. If, however, no reduction of tension or increased tension---the infant's tendency to empathize will be consequently extinguished. And, most important, the infant's learned empathic "attitude" will not be restricted to the reception of cues from the mothering one but will be applied, through stimulus generalization (transference) to all other persons. Theoretically, the infant's generalized "attitude" could range from complete openness to empathic communication to complete rejection of it.²⁸

The presence of a stable, secure sense of self seems to be a necessary prerequisite for empathic responsiveness. The ability to maintain one's ego boundaries when engaged in an interaction with another allows the individual to ultimately retain his/her separateness and sense of identity. Such a notion gets confirmation from Erikson's (1950) discussion of the requirements for intimacy. He stresses that the stability of one's ego boundaries, and thus one's sense of self at the culmination of adolescence provides the basis for intimacy of relationship in young adulthood.²⁹ Intimacy, in turn, is not possible without an empathic exchange between those involved. Therefore, an individual with a relatively secure sense of self will be more able to engage in the potentially self-threatening process of transient iden-

tification which is characteristic of empathy.

Greenson (1960) similarly discussed the capacity for empathy as a product of the individual's sense of security with his/her self. He states that the capacity for empathy is dependent upon one's ability to "modulate the cathexis (the amount of psychic energy invested in) of one's self-image."³⁰ The temporary decathexis of one's self image which is necessary for empathy will be readily undertaken only by those who are secure in their sense of identity."³¹ Accordingly, Greenson adds that those analysts with too restricted an identity, or with amorphous or multiple identities will probably be inhibited or unreliable empathizers.³²

Given that the capacity for empathy is related to the stability of one's sense of self or self-image, and that self-esteem is reflective of the individual's conscious and unconscious feelings about this self-image, it is reasonable to assume that self-esteem may be in some manner related to the individual's capacity for empathy. Halpern (1955) lends support for such a relationship in indicating that a person can empathize significantly better in personality areas where he/she is satisfied with his/her own behavior, as opposed to areas where he/she is dissatisfied. According to Halpern's reasoning, one might then assume that a therapist who was involved in a stable and satisfying heterosexual relationship would be more

successful in making an empathic connection with a client who was experiencing relationship problems than if he/she were him/herself involved in a similarly frustrating and problematic relationship.

While this line of reasoning implies a direct, linear relationship between self-esteem and the capacity for empathy, that those high in self-esteem are the best empathizers and, conversely, those low in self-esteem are the worst, other possibilities may exist. Since the basis for the empathic response is an ability to establish a transient identification with the client, and since most, if not all, clients in treatment suffer from low self-esteem of one kind or another, the therapist has to have experienced blows to his/her self-esteem in order to provide a foundation for the identification with the client. The therapist must be an individual who experientially understands pain and failure. Given this, a therapist without such an understanding may not be able to so easily empathize with his/her low self-esteem clients and, consequently, may not be as therapeutically effective. One may then hypothesize that while self-esteem facilitates empathy, it does so only if the particular individual has had enough experiences of low self-esteem to serve as a basis for the empathic understanding.

The notion of self-esteem is of interest to our examination of the performance of the beginning

psychotherapist and will be pursued in a later chapter. As the therapist's major clinical tool within the treatment, his/her use of self as a participant-observer, or empathic instrument, largely determines the success or failure of the therapeutic endeavor. In the remaining sections of this chapter, we will examine the various manifestations and dynamics of the therapist's failure in his/her clinical use of the self as participant-observer. Since the therapist's empathy has been given such a crucial role, we will attempt to understand clinical mistakes, the countertransference reaction, and antitherapeutic outcomes in terms of an empathic failure on the therapist's part.

"Empathic Failure and Anxiety"

As a result of exposure to the emotional climate generated by the client, the therapist's self is subjected to a constant barrage of probing and provocation from the anxious energy transferred by the client. Consequently, the therapist is confronted with, and must become comfortable experiencing, emotional responses of his/her own that ordinarily may be quite conflictual. For example, a clinician with painfully unresolved feelings related to loss will have these emotions stimulated by his/her empathic connection with a client whose parent has just died. Thus, while the therapist relies upon an empathic

use of self for his/her effectiveness and competence, it is, paradoxically, because of this empathic connection that the clinician becomes potentially vulnerable to overwhelming anxiety, countertransference feelings, and mistakes.

In order to better understand the dynamics of the clinician's empathic failure and the notion of countertransference, we must first consider the critical role played by anxiety in the psychotherapist's functioning. Since anxiety is said to be actively involved in empathic failure,³³ countertransference,³⁴ and clinical mistakes, we will also examine the various sources of anxiety within the therapeutic encounter. Anxiety has long been considered to be a powerful force in the shaping of behavior, and intricately involved in psychological dysfunction, as one of the primary causes, adjuncts, and/or consequents of psychopathology.³⁵

According to Sullivan (1953), anxiety preempts all other basic needs in the need-satisfaction cycle of the developing infant, temporarily shutting the infant down functionally and impairing normal development.³⁶

Winnicott (1965) talks of a similar role for anxiety in interrupting the normal process of development, prolonged and overwhelming anxiety being a source of ego impoverishment.³⁷

In the phenomenological school of thought it is a

theoretical and empirical given that anxiety distorts the individual's perceptual processes and narrows the available field of vision to the anxiety and its source. The consequents of this perceptual tunnel vision are a flattening or deadening of the perceptual field, and an elimination of the richness and the numbers of cues available for subsequent behavior. Consequently, there is a rigidity of behavior, with new behaviors becoming impossible.

As a clarifying note to this discussion, the varying nature of anxiety must be more clearly differentiated. What has been described above is, in general, considered to be pathological anxiety. This is to be differentiated from normal anxiety, which itself serves as a source of creativity, spontaneity, excitement and motivation to action in our lives. Pathological anxiety appears to have no adequate justification for it in relation to objective events in reality. There would be nothing pathological about a client's intense anxiety when it is related to his upcoming departure for combat duty in a war zone. In addition, pathological anxiety is unduly prolonged and exaggerated, and gives rise to defensive maneuvers which seriously interfere with the individual's daily functioning. For example, the individual who becomes overwhelmed with anxiety whenever she attempts to leave her house to go grocery shopping or meet

a friend, and ultimately is forced to remain inside in order to dissipate her fears, is experiencing pathological anxiety.

Anxiety has the potential to disrupt any interpersonal relationship, including the psychotherapeutic one. Since the therapist's empathic connection with the client exposes him/her to a great deal of anxiety, it is not uncommon for this anxiety to stimulate defensive maneuvers in the therapist. The consequences of the therapist's defensive mobilization in the service of anxiety reduction, empathic failure, will invariably undermine the treatment if left unchecked. With his/her most valuable tool impaired, the therapist has no way of accurately understanding the client and making therapeutic interventions. Empathic failure in psychotherapeutic treatment may destructively replicate the client's early developmental experiences.

Given that empathy consists of a two-part, sequential process, we may assume that empathic failure will be related to disturbances in either of these parts. This is essentially what Greenson (1960) posited in his exploration of the vicissitudes of empathy. That is, empathic failure is manifest either as an inhibition of, or as a loss of control of empathy.³⁸ According to Greenson, the inhibited empathizer is afraid to get involved with the client. He/she is unconsciously unwilling to leave the

isolation of the position of the uninvolved observer. Consequently, he/she does not establish a transient identification with the client, nor experience the signal affect discussed by Beres and Arlow (1972). Instead, the affect, impulses, or sensations of the client are defended against because of the anxiety and threat they pose the therapist. This type of therapist is phobic of his/her feelings, and/or fears that he/she will be unable to regain his/her sense of self as separate were he/she to temporarily relinquish it. Thus, because of an unwillingness to feel like the client, or in a complementary manner, he/she misses all the subtle, non-verbal communications and their meanings. The therapist who is unmoved by one client's genuine display of grief, or left unprovoked by another client's extremely provocative behavior, manifests this kind of empathic disturbance. Experiencing grief with the client or anger at the client, may be too anxiety provoking for the therapist to tolerate.

The uncontrolled empathizer, unlike the inhibited one, is able to establish the transient identification with the client. This temporary participation in the emotional climate of the client, however, leads to too intense an involvement for the therapist, and he/she loses a clinical perspective. The uncontrolled empathizer tends to overidentify with the client, and is susceptible to

either being overwhelmed by, and/or acting out of the consequent feelings. For example, with a severely depressed client, the therapist may go beyond the experiencing of the signal affects of depression and become completely overwhelmed by the client's hopelessness and self-disparagement. Working with such a client, this writer can vividly describe the above experience metaphorically as one of being slowly enveloped, as the client continued to speak, by an oozing blackness until both he and the client were emotionally inundated by the latter's depression. The therapist, at this point, wanted to immediately terminate what obviously appeared to be an ineffective treatment. In presenting this client to his supervisor in a manner that was heavy with feelings of self-disparagement, inadequacy, and hopelessness, this writer came to realize that he was acting out an overidentification with the client in both his own affects and wish to end the therapy.

"The Sources of Anxiety Within the Client-
Therapist Interaction"

In any empathic failure, anxiety from one source or another is most often an important precipitant. While these sources of anxiety are multidetermined, they can be roughly conceptualized to flow from three general areas. Since there is tremendous overlap between these areas, however, such a conceptualization does not represent real,

clear-cut distinctions, but rather an attempt to facilitate our discussion of the development and effect of anxiety within the therapist.

Utilizing Cohen's (1952) framework for understanding the anxiety-arousing sources within the client-therapist interaction, we can highlight the following areas: (1) situational factors--reality factors such as intercurrent events within the therapist's life (i.e., illness, deaths, divorce, etc.), and also social factors (i.e., need for success and recognition as a competent therapist); (2) unresolved neurotic problems of the therapist (i.e., developmentally determined conflicts around intimacy, loss, abandonment, etc.); and (3) communication of the client's anxiety to the therapist.³⁹

There are innumerable and varied situational factors which can potentially generate anxiety within the therapist. The outside, realistic events within the clinician's life will oftentimes be restimulated within the treatment by a client's particular life problems or psychological difficulties. For example, a therapist whose wife had recently left him will not uncommonly find this conflict and its attendant feelings emerging within the session with a client who is in the process of mourning a spouse's death. Similarly, a therapist facing serious financial problems will be especially sensitive to a client who is inconsistent in his payments, or one who

excitedly wants to discuss a recent and rather large inheritance. In these situations, outside events form the basis for the therapist's anxiety, and he/she is reminded of these events by the client. Such an anxiety-provoking reminder precipitates defensive maneuvers which are a potential distraction to his/her effective functioning.

Of the situational sources of anxiety, frustration of the need for public and private recognition of one's professional competence is probably one of the most ubiquitous and powerful. Clearly the need for recognition of one's professional competence, both by colleagues and clients alike, is not, by itself, an unreasonable nor a neurotic one. We live in a society where a high value is placed on successful performance and there is a realistic need both financially and emotionally for recognition of competence by one's colleagues. Further, the clinician has a need for creative accomplishment. This is manifest within the therapeutic encounter as an expectation to see favorable changes within the client. It would be impossible for a therapist to participate in a treatment situation where the goals are symptom reduction and conflict resolution without suffering frustration, self-doubts and anxiety when his/her best efforts result in no apparent progress. The anxiety generated from the frustration of these social needs, as anxiety from any source within the treatment, has the potential to disrupt

the therapist's effectiveness. After completing our discussion of the sources of anxiety within the therapeutic encounter, we will then examine how this anxiety functions to disrupt the therapist's performance.

The second general source of anxiety, the therapist's own unresolved neurotic problems or psychological difficulties, is discussed in the traditional psychoanalytical literature as the concept of countertransference. Previously we defined the transference reaction as a distortion by the client of the realistic aspects of the treatment situation, the therapist, his/her behavior, or some event within the therapy. This distortion can be understood in terms of the client's displacement of experiences, interpersonal styles of relating, thoughts, and feelings from his/her early development onto the present therapeutic encounter. Theoretically, the countertransference can be similarly understood as a transference reaction in reverse. Fromm-Reichmann (1950) discusses the therapist countertransference reactions, or "special sensitivities" to various client behaviors as probably due to pertinent experiences in the therapist's own childhood in which he/she had learned certain defensive operations in his/her struggle for survival.⁴⁰ These defensive maneuvers are then applied inappropriately, and in a generalized fashion, to later therapeutic, interpersonal contacts.

Countertransference is employed here in the more classical sense to indicate the existence of unresolved childhood conflicts now manifest in the therapist's neurotic difficulties with the client. For example, a therapist who, as a child, was adopted and who subsequently was never able to constructively resolve his fears of abandonment and loss demonstrates countertransference in his inappropriate expression of rage to a client's announcement that she has been thinking of ending the treatment. Similarly, the therapist who, as a young child, was frequently subjected to her father's seductive incestuously-tinged overtures, and to which she responded with passivity and guilt, will have a "special sensitivity" to respond in this manner, i.e., the countertransference, to seductive male clients.

These countertransference reactions are to be distinguished from, and not equated with, the therapist's other responses to the client. In a good deal of the literature on countertransference, the term's meaning has been considerably broadened beyond the therapist's distortions of the client to include a large proportion of the therapist's behavioral reactions within the session. For example, a therapist getting angry at a client's extremely provocative behavior, or a recently divorced therapist experiencing anxiety with a client's announcement of his sudden marital separation, would be considered manifesta-

tions of countertransference reactions by this broader definition. Cohen (1952) demonstrates this broader interpretation of countertransference in her discussion of anxiety,

When, in the patient-analyst relationship, anxiety is aroused in the analyst with the effect that communication between the two is interfered with by some alteration in the analyst's behavior, (verbal or otherwise), then countertransference is present.⁴¹

While anxiety may be present in the therapeutic interaction and potentially may have a disruptive effect on the communication between client and therapist, this does not necessarily mean that countertransference is present, in the classical sense (which is how it will be employed throughout this dissertation). As we have seen above, there are numerous, non-neurotic sources of anxiety within the therapeutic encounter, and to discuss these as countertransference manifestations confuses the term.

Communication of the client's anxiety to the therapist is the third general source of anxiety discussed by Cohen (situational factors and unresolved neurotic problems are the first two). This source of anxiety is a consequence of the empathic pathways of communication in existence within the treatment situation, and of the therapist's willingness to allow such an empathic connection. In this way he/she becomes susceptible to "catching" the client's anxiety. The therapist's susceptibility to empathically catching the client's anxiety is

further heightened by the existence of the other sources of anxiety mentioned above.

Such "affect contagion" (Donner and Schonfeld, 1975) is frequently seen in neophyte psychotherapists who become overwhelmed with anxiety because they feel that they haven't yet learned "what to do."⁴² As a situational source of anxiety, their lack of experience and training makes them susceptible to anxiety from clients who demand that their therapist "do something." Thus, a client who enters treatment in a panicked, anxiety-ridden state, and who is unable to provide himself with relief, will, in all probability, look to the therapist to "do something" since he, himself, cannot. For the neophyte, this client's panic and anxiety becomes contagious, and catalyzes an anxious search for the "right" technique or intervention.

If anxiety or any other intense affect stimulated in the therapist proves to be too stressful psychologically, he/she will automatically and usually unconsciously, mobilize defensive maneuvers which are geared towards the elimination of the source of distress. As a consequence of these defensive mobilizations, the therapist's empathic use of self is temporarily impaired. Repeated and prolonged disturbances in the therapist's empathy will lead to frequent clinical errors and, ultimately, to treatment failures. The present examination of the impact of anxiety and other intense affects

upon the therapist's performance will help us understand the nature and dynamics of his/her clinical mistakes.

In general, regardless of the source of the anxiety or other affects, when these feelings are of sufficient intensity, their potential effect upon the therapist is similar. Thus, a therapist who empathically catches a client's intense anxiety, and one whose neurotic conflicts are restimulated by the client's behavior, will both have a tendency to respond in a self-protective manner. Either therapist may attempt to diffuse his/her anxiety by becoming overly active within the session, changing the subject, attacking the client, ending before the allotted time, etc. Likewise, a therapist who has recently separated from her husband, a situational source of anxiety, may respond in a similar manner as the above therapists when her client attempts to talk about his/her own marital distress. In these situations, the therapist's interventions represent an empathic failure in that they are in the service of his/her own needs rather than those of the client.

Such interventions do not facilitate the exploration and resolution of the client's conflicts, which demand an approach to, rather than an avoidance of the anxiety provoking material. The therapist may collude with the client's own resistance to , and ambivalence about the psychotherapeutic exploration. For example, a client with

intense, unresolved anger at his parents, who experiences these feelings as intolerable because of the overwhelming guilt and anxiety they stimulate, will naturally be resistant to feeling, expressing, and exploring his anger. If this client's anger is similarly anxiety-provoking for the therapist then he/she will not uncommonly divert the client away "therapeutically" from the conflictual area (i.e., encourage him to discuss in detail a recent fishing trip).

"Empathy and Countertransference"

Since participant-observation is the therapist's key to effective intervention, his/her attempts to empathically utilize his/her self in this way make him/her vulnerable to overwhelming anxiety and countertransference reactions. Highlighting the interrelationship between empathy and countertransference will help clarify our discussion.

Through empathy a therapist may experience one of two kinds of emotional situations. By recalling past experience, he/she may come to feel similarly as the client. At other times the client, through his/her interpersonal style and behavior, may attempt to make the therapist feel and respond in a complementary manner to his/her own. In the first case, the therapist will emotionally relive, if only temporarily, a similarly charged

experience, for instance a tragic loss, prideful accomplishment, or traumatic rejection. In the second case, the therapist will experience a particular set of feelings which are "compatible" with the client's behaviors, and often mirror those characteristics of the client's parent(s). For example, a masochistic client, through his interpersonal style, may attempt to elicit the same kind of sadistic behavior that was characteristic of a particular parent during early childhood. Or, this situation may be reversed as the client, responding as his parent did, will attempt to elicit a masochistic response from the therapist.

What becomes clear is that as a consequence of the therapist's transient identifications, he/she will be exposed to a wide range of feelings, some emotionally charged than others. When the identification leads the therapist to feelings which are closely related to, or reminiscent of those associated with his/her own early developmental conflicts, the therapist becomes susceptible to the countertransference reaction. To continue our example, if this client responds to the therapist in a sadistic manner (as his parents once did) in an attempt to elicit a complementary masochistic response, such behavior could be problematic for the therapist whose developmental history included a sadistic parent who demanded passive acquiescence in exchange for his/her love.

When the therapist attempts to establish the transient identification, in this case allowing him/herself to feel as the client once felt at the hands of a sadistic parent, the emerging feelings of passivity and abuse may be "too close to home" and thus too anxiety-provoking to tolerate. The therapist may then respond to the client and his sadistic behaviors in a distorted manner, "as if" the client was, for the moment, the therapist's sadistic parent from the past. In this countertransference reaction the therapist may defensively attack the client or passively and guiltily withdraw into self-disparagement. Here the transient identification with the client stimulates an already existent, pathological identification within the therapist, to which the therapist responds with time-tested defensive maneuvers. In the process, as the realities of the therapeutic interaction are distorted, the therapist loses control of his/her empathic response as a consequence of an over-identification with the client.

The therapist's countertransference response can also be understood in terms of an inhibition of empathy, a failure to establish the transient identification. If the therapist's identification with the client proves to be too anxiety-provoking, it is not unusual for him/her to totally avoid an empathic connection with the client. In our example, the client's pull for masochistic or sadistic

behavior may be unsuccessful because the therapist may have walled him/herself off from this particular conflictual area. The countertransference, in this case the therapist's inclination to insulate him/herself from any emotional involvement with the client's sado-masochistic dynamics, can be understood as a potential for re-enactment of the therapist's early strategies of dealing with a sado-masochistic parent. As a child, the therapist may have divested him/herself emotionally from the parent as a means of adaptation and conflict resolution. As a consequence of this empathic inhibition, the therapist has no real sense of what the client's experience is like, and therefore no basis for accurate intervention.

The therapist's defensive maneuvers, which reflect various distortions of the current realities of the treatment situation and client's behavior, are manifestations of an empathic failure and lead to clinical errors. Countertransference is not only a consequence of empathic communication but is also a tendency towards empathic failure. The therapist, caught up in the countertransference, may fail to sensitively listen and respond to the client. As with any empathic failure, the countertransference, when left unchecked, will ultimately result in treatment failures.

In order to more clearly understand the notion of countertransference and its relationship to both empathy

and the therapist's mistakes, we will conceptualize it as a tendency or susceptibility towards perceiving and responding in a distorted and antiquated manner. What is important to emphasize in this conceptualization is that such a tendency towards perceptual and behavioral distortion is only that, a tendency. The therapist's unresolved childhood conflicts that get reactivated as a result of his/her participation in the emotional climate of the interaction do not necessarily lead him/her to action and empathic failure. If this were the case, then whenever the therapist experienced countertransference feelings, he/she would always and unknowingly be impelled to disrupt the therapeutic process with ill-timed and inappropriate interventions. This conceptualization of countertransference as solely a destructive influence on the therapist's performance, an affliction to be avoided at all costs, obscures the critically important role these therapist reactions play in the curative process of psychotherapy.⁴³

While the existence of countertransference feelings represents a potential for the therapist's distortions, defensive maneuvers, empathic failure, and consequently, mistakes, these feelings are also an important indication of the presence of a particular empathic communication from the client. That is, the therapist's countertransference, as a special type of empathic com-

munication is a powerful indicator that something valuable has been communicated by the client to the therapist, that this communication has registered, has been recorded, and has been reacted to by the therapist, albeit in the unconscious and as yet in a not quite understandable fashion.⁴⁴ The nature of the client's communications, according to Tauber and Green (1953), is a manifestation of their specific psychological difficulties.⁴⁵ They describe the therapist's countertransference reaction as an unconscious scanning response to the neurotic atmosphere created by the client. Since the client's pathology is manifest in his/her transference, it follows that the therapist's countertransference reaction is a "scanning response" to the client's transference.

If this is indeed the case, and the therapist's countertransference is an empathic registration of the client's transference, then we would expect that the therapist's countertransference might potentially provide him/her with valuable clues as to the client's psychological dysfunctioning, and thus be an invaluable guide to the therapist's interventions. This view is widely supported in the analytical literature. According to Heimann (1950), "the therapist's countertransference is not only part and parcel of the analytic relationship, but it is the client's creation, it is a part of the client's personality."⁴⁶ Consequently, she refers to the coun-

tertransference as one of the most important tools in the therapist's work, an "instrument of research into the patient's unconscious."⁴⁷ Little (1952) and A. Reich (1960) similarly view the countertransference reaction as an indispensable tool to the therapist's work which provides important diagnostic clues to the client's psychopathology. Reuch (1961) reiterates the countertransference's potential importance to the treatment, and like Heimann, views the client's transference as the triggering mechanism for the therapist's countertransference reaction.⁴⁸

An example of such a relationship between the therapist's countertransference and the client's transference will facilitate our discussion. A female client with a history of severe rejections from inadequate relationships with a distant father and a hypercritical, overcontrolling mother entered treatment with a male therapist. As a consequence of these early developmental experiences, this client suffered from intense feelings of worthlessness, inadequacy, and depression, along with a core feeling that she was responsible for all of life's rejections because of her "badness." As it emerged in an extended opening phase of treatment (approximately 6-8 months), the transference illuminated her developmental conflicts and inner sense of badness. These were specifically manifest in a hypercritical and relentless negating

of all of the therapist's attempts to establish a therapeutic relationship. Out of an expectation and fear of rejection, this client tightly controlled the sessions, refusing to acknowledge and examine these behaviors. In essence, this client attempted to render her therapist totally impotent in a manner similar to the one employed by her parents with her during early childhood.

The therapist, quite appropriately, experienced feelings of frustration, anger, inadequacy, and impotence as the therapeutic work appeared to go nowhere. Despite clinical supervision and much support as to this client's level of difficulty, the therapist couldn't seem to shake his feelings of inadequacy and impotence. It was as if, no matter what he did with the client, his efforts had no impact on her. In the sessions, the therapist moved from a mechanical repetition of already failed interventions to a passive, depressive withdrawal from the client. Interestingly, the client, via her transference behavior, had given this therapist a core experience of hers which she frequently described in the sessions, "No matter what I say and do, I cannot have any impact on those around me, so what's the use." For the therapist, the feelings of inadequacy and impotence that were stimulated by his failure to reach the client, and which ultimately precipitated a passive withdrawal, were reminiscent for him of a developmental conflict with a hypercritical,

overcontrolling, and rigidly defended father. The therapist's response to this unavailable father was reactivated in his countertransferential response to the client.

In this example, the client's transference stimulated the therapist's countertransference. Because the therapist acted on his countertransference distortions of the treatment situation by giving up and passively withdrawing from the client, he missed the important message value of her empathic communications. He was, temporarily unable to use his feelings of hopelessness, inadequacy, and impotence, and their genetic associations (i.e., as related to experiences with an overcontrolling, hypercritical parent) as clues to understand the client's interpersonal style and developmental conflicts. Since the countertransference is a form of empathic communication, in order for it to be therapeutically useful, the therapist must be able to regain his/her sense of self once the transient identification with the client has been established. In this case, the therapist's transient identification led him to his own, anxiety-laden conflictual issues, an overidentification with the client, and the mobilization of antitherapeutic defensive maneuvers (i.e., withdrawal). Consequently, he was unable to regain his clinical perspective in the therapy, and the treatment became stalled.

It is what the therapist does subsequent to the countertransference feelings registering that determines whether the therapeutic encounter becomes growth promoting or regressive, destructive, and repetitious. The therapist must be able to sufficiently separate or disengage him/herself from the emotional interchange so that he/she may cognitively appraise and analyze his/her countertransferential feelings, their origins, and relationship to the client's transference. A failure to do this, like any empathic failure, will precipitate mistakes in the therapist's performance of his/her clinical tasks. Countertransference reactions are not harmful provided that they are carefully examined and analyzed. Just as the transference reactions are genuine aids to the client's and therapist's quest for understanding, and, just as the transference is harmful to the therapeutic enterprise when it remains unexamined and is permitted to lie fallow, so too are countertransference feelings a powerful tool in exploration and a potent instrument for uncovering inner states within the therapist which are damaging only if they are brushed aside or ignored.

It is not an uncommon conception that the therapist's errors are invariably related to his/her countertransference. From this view, when a therapist's intervention is mistimed or otherwise inaccurate, it is seen as a consequence of unconscious defensive processes

precipitated by the re-emergence of unresolved early childhood conflicts. In this conceptualization, both the mistakes of the beginner and the more experienced clinician are invariably manifestations of neurotic issues. According to A. Reich (1960), however, such a generalized explanation of the therapist's mistakes is reductionistic, inaccurate, and a "rampant misconception."⁴⁹ While countertransference is one source of empathic failure and treatment errors, not all clinical mistakes are countertransference based. As we previously pointed out there are other sources of anxiety within the therapeutic encounter which are equally capable of causing empathic failure and mistakes. Disturbances in empathy are an inherent part of countertransference based mistakes and considered by Greenson (1960) to be the decisive factor in the mistakes of the beginner. Since such disturbances in empathy disrupt the therapist's utilization of his/her clinical tool, empathic failure may be a more accurate and inclusive way of understanding the clinician's mistakes.

As an example, a therapist whose husband has recently left her will probably experience a great deal of anxiety-laden feelings with a male client who is actively struggling with a decision to leave his wife. Given the nature and extent of her own anxiety, it would not be unusual to see the clinician defensively steering her client away from this issue, or otherwise interfering with a

therapeutic working through of the client's dilemma. Because of her marital experience, the therapist may displace her feelings onto the client for wanting to leave, or she may, for therapeutically irrelevant reasons, attempt to dissuade him from leaving. In either case, the therapist's own issues interfere with her maintaining an empathic stance and, therefore, lead to antitherapeutic, defensive interventions. While a source of anxiety, empathic failure, and mistakes, the therapist's marital problems do not necessarily reflect countertransferential difficulties.

A neophyte psychotherapist who becomes overwhelmed with anxiety and clinically non-functional with his first exposure to a severely anxious, psychotic client will, because of loss of control of empathy, make numerous mistakes. His anxiety, the resultant defensive maneuvers, and mistakes may have absolutely no relationship to any early unresolved conflicts and, therefore, cannot accurately be referred to as a countertransferential reaction. On the other hand, a male therapist's antitherapeutic, critical attack in response to an overcontrolling and provocative female client's acting out, while representing an empathic failure on the therapist's part, can also be seen as a countertransferential problem because of his genetic tendency to respond in this manner to overcontrolling and provocative women. The therapist's unresolved developmen-

tal conflict with his mother, an exceptionally domineering and provocative individual, is restimulated by the client's interpersonal style.

There are other contributing factors to the therapist's impaired performance in addition to his/her empathic failure. For example, client qualities such as a lack of motivation, or an intense resistance towards treatment may have a significant negative impact on the success of the therapist's use of self as an empathic instrument, regardless of how empathically in tune the therapist may be. In relation to his/her role, however, the therapist's empathic failure appears to be a principal precipitant of his/her clinical mistakes. In the final part of this chapter, we will examine several specific manifestations of the therapist's errors and their relationship to empathic failure.

The therapist's errors are usually manifest in both faulty attitudes about the treatment and/or the client, as well as in various disturbances of technique. False assumptions concerning the scope and potency of therapy frequently generate problems within the treatment.⁵⁰ When the therapist entertains assumptions of omniscience concerning him/herself or the treatment, the client is given the messages that therapy is a panacea and that he/she is inferior to the clinician. The first of these messages sets the client up for disillusionment in

the therapist and treatment because of unrealistic expectations, and the second merely reinforces the ego-defects and disturbances in the self (i.e., self-esteem) which originally precipitated the client's seeking treatment. The therapist's omnipotence is reflective of a narcissistic overinvestment in his/her self, and interferes with his/her ability to empathically connect with the client. For the client, this experience of the therapist's empathic failure may, for example, replicate his/her early developmental experiences with a narcissistic mother who used him/her as a means to satisfy her own needs.

The therapist's problems with the goals of therapy serve as an additional source of conflict and empathic failure within the treatment, and thus, therapeutic mistakes. When goals are too abstract, or ambiguous the lack of direction will frustrate both parties involved and can potentially stimulate unrealistic expectations by the client. Further, if the goals are not in the client's best interests, and/or exceed the client's capabilities, destructive consequences will emerge. For example, if the therapist, to bolster his professional self-image, pushes the client too quickly into anxiety-provoking situations which the latter is not yet capable of tolerating, the client could easily be traumatized. This parallels the empathic failure manifest in the mother who prematurely

pushes her daughter to be on her own before the child is developmentally ready. On the other hand, unrealistically perfectionistic goals on the therapist's part may foster dependency in the client. Whether couched in the need for further therapeutic work, or other infantilizing behaviors on the therapist's part, the fostering of the client's dependency merely confirms his/her feelings of helplessness, inadequacy, and low self-esteem. The developmental prototype of this kind of empathic failure is seen in the overprotective, overinvolved mother who is unable to allow her child to experience age appropriate steps at separation.

A variation of this empathic failure is visible when the therapist mismatches his/her technique to the client's psychological difficulties. For example, when a therapist, because of a failure to accurately assess the nature and severity of the client's disturbance, applies uncovering techniques to a client with too little ego strength and defenses to tolerate the accompanying anxiety, severe damage could be done to this client. Likewise, for a therapist to employ ego supportive, defense-building techniques to a highly defended neurotic whose psychological problems are a consequence of his/her overdefendedness, rather than utilizing uncovering maneuvers which this type of client has the strength to tolerate, means that this client's psychological diffi-

culties will be exacerbated. This therapeutic mismatch is also visible in the clinician who adheres too rigidly to the theoretical prescriptions of one particular school of thought. When this happens, the client is fit into the therapist's Procrustean bed of theory, and his/her model of "normal" or standard behavior. Consequently, this therapist fails to see and respond to the client as a unique individual.

One additional manifestation of the therapist's empathic failure within the treatment situation is his/her misuse of interpretation. The overuse of interpretations can place an artificially high emphasis on insight and intellectual understanding at the expense of the individual's feelings, and utilization of life resources for energy, pleasure, and integrity of function.⁵¹ Further, predominantly transference-centered interpretations can distort or minimize the impact of reality factors in the client's life, and foster malfunctioning. For example, when a therapist interprets a client's reality-based anger, which is being directed at the clinician because of the latter's insensitivity, as "really" related to the client's father, and not the therapist, then the therapist is denying the client his/her reality and contributing to his/her emotional difficulty.

Such a reality-distorting interpretation by the therapist, along with his/her technical and theoretical

rigidity, while indications of empathic failure, are considered to be evidence of the therapist's insecurity.⁵² Thus, the therapist's faulty interpretation which denied his/her client's reality is a way for him/her to defend against the anxiety aroused by the client's angry expression. Empathic failure, in this case, is a product of the clinician's attempts to defend him/herself from intolerable affects.

In this chapter we highlighted the psychotherapist's empathic responsiveness as a critical aspect of his/her effective clinical performance. Empathy was discussed paradoxically as both a source of the therapist's successful interventions as well as his/her clinical errors. It was also hypothesized that regardless of the level of experience, the psychotherapist's mistakes can be best understood as some manifestation of an empathic failure. Since the capacity for empathy was said to be dependent on a secure sense of self, which in turn can be reflected in the individual's level of self-esteem, we hypothesized that the therapist's self-esteem may be related to his/her effective functioning. In the following chapter we will explore the construct of self-esteem and its relationship to the psychotherapist's performance.

ENDNOTES

Chapter II

1. Blanck, Gertrude and Rubin, Ego Psychology, Theory, and Practice (Columbia University Press, c.1974), pp. 21-22.
2. Hartmann, Heinz, Essays on Ego Psychology (International University Press, c.1964), pp. 127-129.
3. Ibid.
4. Blanck and Blanck, Ibid. pp. 28-29.
5. Hadley, Suzanne W. and Hands H. Staupp, "Contemporary Views of Negative Effects in Psychotherapy" in Archives of General Psychiatry, vol. 33, November 1976, p. 1295.
6. Sullivan, Harry Stack, "The Theory of Anxiety and the Nature of Psychotherapy" in Psychiatry, vol. 12, 1949, p. 12.
7. Halpern, Howard M. and Leona Lesser, "Empathy in Infants, Adults, and Psychotherapists" in Psychoanalysts and Psychoanalytic Review, vol. 47, 1960, p. 38.
8. Heimann, Paula, "On Countertransference" in International Journal of Psychoanalysis, vol. 31, 1950, p. 81-82.
9. Nadler, Raoul P., "Utilizing Reflected Countertransference" in Canadian Psychiatric Association Journal, vol. 21, 1976, p. 146.
10. Beres, David and Jacob A. Arlow, "Fantasy and Identification in Empathy" in Psychoanalytic Quarterly, vol. 43(1), 1974, p. 26-27.
11. Ibid.
12. Halpern and Lesser, Ibid., p. 33.

13. Greenson, Ralph R., "Empathy and its Vicissitudes" in International Journal of Psychoanalysis, vol. 41, 1960, p. 418.
14. Ibid.
15. Schafer, Roy, "Generative Empathy in the Treatment Situation," Psychoanalytic Quarterly, vol. 28, 1959, pp. 347-348.
16. Ibid.
17. Sullivan, Harry Stack, The Interpersonal Theory of Psychiatry (New York: W.W. Norton and Co., Inc., c.1953), pp. 41-42.
18. Ibid., pp. 39-40.
19. Winnicott, D. W., The Maturation Process and the Facilitating Environment (New York: International University Press, c.1965), p. 43-45.
20. Ibid., pp. 145-146.
21. Kohut, Heinz, The Analysis of the Self (New York: International University Press, c.1971), pp. 43-45.
22. Ibid., pp. 40-42.
23. Schafer, op.cit., pp. 343-345.
24. Ibid., p. 350.
25. Traux, Charles B., "Effective Ingredients in Psychotherapy," Journal of Counseling Psychology, vol. 10, no. 3, 1963, pp. 256-258.
26. Mahler, Margaret S., Fred Pine, and Anni Bergman, The Psychological Birth of the Human Infant (Basic Books, Inc., c. 1975), pp. 97-98.
27. Ibid.
28. Halpern and Lesser, op.cit., pp. 33-34.
29. Erikson, Erik H., Childhood and Society (New York: W. W. Norton & Co., Inc., c.1950), pp. 263-264.

30. Greenson, op.cit., p. 423.
31. Ibid.
32. Ibid.
33. Little, Margaret, "Countertransference and the Patient's Response to it," International Journal of Psychoanalysis, vol. 32, 1952, p. 38.
34. Cohen, Mabel Blake, "Countertransference and Anxiety," Psychiatry, vol. 15, 1952, pp. 231-235.
35. Wylie, Ruth C., The Self-Concept (University of Nebraska Press, c.1961), p. 203.
36. Sullivan, op. cit., pp. 43-44.
37. Winnicott, op.cit., p. 47.
38. Greenson, op.cit., pp. 419-420.
39. Cohen, op.cit., pp. 236-240.
40. Fromm-Reichman, Frieda, Principles of Intensive Psychotherapy (Chicago: University of Chicago Press, c. 1950), p. 5.
41. Cohen, op.cit., p. 235.
42. Donner, Lawrence and Jacob Schonfield, "Affect Contagion in Beginning Psychotherapists," Journal of Clinical Psychology, vol. 31(2), April 1975, pp. 332-339.
43. Singer, Erwin, Key Concepts in Psychotherapy (New York: Basic Books, Inc., c.1965), pp. 297-299.
44. Ibid., p. 298.
45. Ibid., p. 297-298.
46. Heimann, op.cit., p. 83.
47. Ibid., p. 81.
48. Ruesch, J., Therapeutic Communication (New York: W. W. Norton & Co., c.1961), p. 175.

49. Reich, Annie, "Further Remarks on Countertransference," International Journal of Psychoanalysis, vol. 41, 1960, p. 390.
50. Hadley, Suzanne W. and Hans H. Staupp, "Contemporary Views of Negative Effects in Psychotherapy," Archives of General Psychiatry, vol. 33, November 1976, p. 1297.
51. Ibid., p. 1298.
52. Ibid.

C H A P T E R I I I
SELF-ESTEEM--ITS DEVELOPMENT AND BEHAVIORAL
IMPORTANCE

"Self-Esteem and the Therapist's
Capacity for Empathy"

Since the psychotherapist's empathy is his/her most valuable clinical tool, it makes sense that the capacity for, and development of empathy within the neophyte are important considerations in the training of competent clinicians. We have previously said that the capacity for empathy is closely related to the individual's security with his/her sense of self.* Because the individual's sense of self is pervaded by an evaluative thread, i.e., that he/she feels a certain way as a consequence of his/her total self-awareness, perhaps we may utilize this self-evaluative awareness to reflect the degree of security manifested in the individual's sense of self. For the purposes of our discussion, we will refer to this self-evaluative awareness as self-esteem. In this chapter we will explore the notion of self-esteem and its hypothe-

*Sense of self is used here to refer to the individual's total awareness of who he/she is as a person, socially, physically, and psychologically, including his/her capabilities, character traits, and identity.

sized behavioral importance.

As it is defined here self-esteem is an evaluation which an individual makes and customarily maintains with regard to his/her self, that expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes him/herself to be capable, significant, successful, and worthwhile.¹ It is important to note here that an individual's high self-esteem does not simply connote only positive feelings for him/herself, but also a recognition and acceptance of his/her negative qualities. While the individual may not be aware of these self-evaluations, they are manifest in his/her voice, posture, gesture, and many aspects of his/her overall functioning.

Our hypothesis, then, is that self-esteem is a psychological concept which both captures the essence of, and reflects the individual's security with his/her sense of self. Given this assumption, it follows that the psychotherapist's capacity for empathy is in some way related to his/her self-esteem. Since his/her empathic connection with the client is dependent on an ability to experience oftentimes uncomfortable and threatening affects within him/herself, and since such affects may frequently evolve from his/her own similar problematic life experiences, the empathic psychotherapist must necessarily have emerged from these experiences with an

attitude of self-acceptance. This is not to imply that the therapist has resolved all of his neurotic conflicts. What is more important than the resolution of his/her own conflicts is that the therapist comes to understand these to be part of the human condition, and thus can accept the resultant emotions within him/herself without an attitude of disapproval or self-disparagement. The therapist with a comfortable level of self-esteem (whose self-evaluative awareness remains one of acceptance) is able to tolerate a wider variety of affects within him/herself and, therefore, is better able to empathize than his/her lower self-esteem counterpart.

In this dissertation we are particularly interested in exploring how the neophyte psychotherapist's self-esteem, as a reflection of the level of security with his/her sense of self, affects his/her clinical functioning. Because self-esteem is considered by many to be related with perception, learning, motivation, and other facets of behavior, we might expect to see the neophyte therapist's learning and performance affected by his/her self-evaluative attitudes. The notion that such self-evaluative attitudes are a product of early development has slowly evolved from a variety of theoretical and empirical works.

Theorists in sociology as well as in numerous and conflicting schools of psychology have alluded to the cri-

tical role of evaluative interaction in the development of the individual's sense of self. While they all may emphasize the important contribution of significant others, and especially the parents in these evaluative interactions, the theorists differ in their discussion of what these "others" contribute and the manner of the contribution. Cooley's (1922) discussion of the "looking glass self" emphasizes that the gauge of self-evaluation is a mirror image of the criteria employed by the important persons of our social world.² Mead (1934), in his examination of the socialization process, concludes that the individual develops self-attitudes which are consistent with those expressed by the significant others in his world.³ Internalizing their posture towards him/her, his/her self attitudes reflect the extent to which they value or devalue him/ her, i.e., reflected appraisals.⁴

Freud's (1933) tripartite schematization of the personality into id, ego, and superego offers the notion that the child's self-evaluative attitudes evolve from interactions with the parents.⁵ The superego, a product of parental identification and internalization, regulates these self-attributes by passing judgement on the child's behaviors, rewarding or punishing on a basis initially established by the parents. Rogers' (1951) client-centered theory of personality development similarly stresses the importance of such evaluative interactions

with significant others and the introjection of parental attitudes in the development of the individual's sense of self.⁶ Sullivan's (1953) focus on the interpersonal roots of the personality underscores the large evaluative component of interpersonal relationships and the impact of these evaluations on the developing personality. If these "other" evaluations are negative, anxiety is generated within the child which, in turn, stimulates defensive maneuvers as the child attempts to reestablish interpersonal security.⁷ Such defensive mobilization in the service of maintaining the self's security may prove to be ultimately destructive to the self's healthy development.

Horney (1950) also discusses anxiety in personality development and the ramifications of this anxiety on the child's feelings of self-confidence and security. As a consequence of parental psychopathology, the child is left with "basic anxiety," profound feelings of insecurity, isolation and apprehensiveness.⁸ To defend against such feelings the child forms an idealized image of his capacities which only temporarily bolsters his self-confidence. When the unrealistic demands of this idealized image cannot be achieved, the child's feelings of dissatisfaction, insecurity, and low self-confidence are increased. Adler (1956) similarly discusses the child's inferiority feelings and the parent's role in either ameliorating or exacerbating them. While such

inferiority feelings have their initial basis in what Adler calls "organ inferiorities," actual physical weaknesses or disabilities in early development, parental acceptance, support and encouragement during development can compensate for these organ inferiorities and lead to positive self-feelings.⁹

"The Antecedent Conditions of Self-Esteem"

In his work on the antecedent conditions of self-esteem, Coopersmith (1967) attempts to tie the above theoretical works together by developing a unitary concept, self-esteem, which captures the essence of these self-feelings of security, insecurity, inferiority, etc. Coopersmith's empirical examination of self-esteem is based on the theoretical notion that self-esteem is a behaviorally significant variable.¹⁰ He believes that the individual's self-esteem importantly interacts with numerous areas of the individual's functioning (i.e., conformist behavior and creative behavior can be empirically linked with the individual's level of self-esteem).¹¹ In his attempts to determine the antecedent conditions of self-esteem, Coopersmith isolates four variables which he feels are interrelated with the development of self-esteem: first and foremost is the amount of respectful, accepting, and concerned treatment that an individual receives from the significant others in his/her

life; second, the individual's history of success; third, the individual's values and aspirations significantly determine how these above successes will be perceived and interpreted; fourth, the individual's ability to defend against blows to his/her self-esteem.¹² Since we are interested in the development of the neophyte psychotherapist's self-esteem, as well as its impact on his/her clinical performance, and since we will be utilizing a parent-child developmental model to examine the neophyte's developing self-esteem in relation to his/her supervisor, Coopersmith's work is especially relevant here.

In his discussion of parental treatment as the most important antecedent condition, Coopersmith highlights four aspects of the parent's behavior which are specifically related to the child's developing self-esteem: these are parental acceptance; establishing and enforcing clear limits, providing respect and latitude for individual action within these limits, and the parent's own level of self-esteem.¹³ Coopersmith's findings indicate that while all of the above "parental conditions" may contribute to the development of self-esteem, not all are essential to the development of self-esteem in any given individual, nor is any single one of them sufficient to produce marked enhancement.¹⁴ He hypothesizes that combinations of these "parental

conditions" are required, more than one, but less than the four established in the study.¹⁵

The second principal contributing factor to the development of self-esteem noted by Coopersmith is the individual's experiences with success. His/her early successes and achievements form the basis for a sense of competency from mastery. Importantly, according to Coopersmith, the individual's determination of what is a success or an accomplishment is initially dependent on this significant other in his/her immediate interpersonal environment.¹⁶ If the parents devalue what a child perceives as an accomplishment, then the child will soon begin to question it him/herself.

The third major antecedent condition to the development of self-esteem relates to the individual's particular goals or aspirations. Coopersmith's findings indicate that individuals with high self-esteem set significantly higher goals for themselves than do persons with medium and low self-esteem.¹⁷ These individuals with high self-esteem seemingly expect more of themselves than do persons with less self-esteem and presumably maintain their esteem by meeting their expectations rather than lowering their standards. Those people with low self-esteem are as desirous of success as those with loftier esteem, but they are less likely to believe that such success will occur. The pessimism that results is an

expression of anticipated failure which in itself decreases motivation and probably contributes to the occurrence of such failure.¹⁸

The last variable of importance to the overall development of self-esteem is the individual's ability to deal with experiences of devaluation, failure, and other self-esteem threatening situations, i.e., loss, anxiety. To be able to successfully defend against blows to one's self-esteem without these defensive maneuvers interfering with one's effective functioning or reality testing is important to the development and maintenance of self-esteem. Such defenses represent the individual's ability to resist or reject devaluating stimuli and events, and thus permit him/her to maintain the conviction of being powerful, capable of dealing with adversity, and successful.¹⁹ Without such internal defensive support, the individual's self-esteem would be susceptible to continuous fluctuation.

"The Behavioral Importance of Self-Esteem"

In addition to Coopersmith's work, other theories and researchers have gathered data which further emphasize the behavioral importance of self-esteem. Since the neophyte psychotherapist's security with his/her sense of self (which we theorize is reflected in his/her level of self-esteem) determines his/her capacity for empathy, and

since this, in turn, largely determines his/her success and competence as a clinician, we might expect the neophyte's self-esteem to be an important variable in his/her successful or unsuccessful performance. In the following discussion we will briefly examine some of the theoretical and empirical studies which support the hypothesized importance of self-esteem in the performance of the beginning psychotherapist. While these studies do not directly deal with the psychotherapist nor his/her specific functioning, they nevertheless highlight behavioral areas which will have an important impact on his/her clinical performance and empathic use of self. As a final preface, the studies to be examined are by no means theoretically consistent, they instead represent a confusing array of unrelated theories. While their theoretical rationales may be conflicting, they share the assumption that self-esteem is a behaviorally significant variable.

We will begin our discussion by exploring the hypothesized relationship between self-esteem and anxiety. Our rationale for beginning here is based on the pervasive disruptive effect that anxiety has on the neophyte psychotherapist's performance and especially on his/her ability to empathize. In the previous chapter we highlighted the role of anxiety as an important precipitant of empathic failure within the psychotherapist. Without an

empathic connection to the client, the psychotherapist has no means of accurately understanding him/her and therefore no basis for effective intervention. Regardless of how skilled or experienced he/she may be, empathic failure within the psychotherapist invariably leads to clinical mistakes and disrupted treatment.

In Sullivan's (1953) discussion of the role of anxiety in personality development, he hypothesizes that anxiety is the individual's behavioral response to an actual or anticipated threat to his/her interpersonal security.²⁰ To protect his/her self from this threat, the individual establishes a defensive organization, the "self-system," which functions to avoid the impingement of anxiety. Similarly, Horney (1950), Winnicott (1963), Mahler et al (1975) discuss anxiety as a threat to the self's security which catalyzes a defensive reaction.

Since we hypothesize that self-esteem may be utilized to reflect the individual's security with his/her sense of self, a threat to this security may be manifest as a threat to the individual's self-esteem. In the empirical literature, such a threat to self-security is often conceptualized in terms of self-esteem. For example, Coopersmith (1967) states that if it is a threat that releases the anxiety, it is the individual's self-esteem that is being threatened.²¹ Fitts (1972) states that with a threat to the individual's self-esteem, neuro-

tic defense mechanisms are mobilized to prevent the experiencing of additional anxiety.²²

Rosenberg (1965) and Thompson (1972) point to a negative relationship between self-esteem and anxiety, i.e., low self-esteem is linked with high anxiety and high self-esteem is linked with low anxiety. While self-esteem may appear to be linearly and negatively related to anxiety, the nature of the relationship remains unclear. Whether low self-esteem leads to anxiety, or anxiety leads to a lowering of self-esteem is uncertain. Quite possibly a circular type of relationship may exist where low self-esteem generates anxiety or makes the individual more susceptible to anxiety and this, in turn, lowers self-esteem. Certainly low self-esteem does not necessarily mean that an individual will experience high anxiety or the reverse, that a high self-esteem individual experiences only low anxiety.

While anxiety may be considered to be a behavioral warning signal of an impending threat to the individual's security with his/her sense of self, what is less certain is whether the individual's self-esteem can always be utilized to accurately reflect or register this threat. Given that anxiety within the psychotherapist has been empirically associated with his/her mistakes and incompetence (Luborsky, 1952; Bandura, 1956; Bandura, Lipsker, and Miller, 1968), we may assume that the therapist's

self-esteem may be somehow related to his/her mistakes and therapeutic competence.

We know from the empirical literature that self-esteem is related to the performance of a number of behavioral tasks. For example, the hypothesized relationship between self-esteem and academic performance (as measured by academic achievement) has generated a good deal of supporting research (Borislow, 1962; Fink, 1962; Brookover, Thomas and Patterson, 1964; Glasser, 1969). Theoretically it is assumed that low self-esteem undermines an individual's motivation and persistence, serves as a source of distraction and interference, and creates a self-fulfilling expectation of failure. Conversely, the individual with higher self-esteem is said to be more confident in anticipating a positive outcome from his/her efforts, and thus more determined and willing to wholly invest his/her energies in the behavioral task at hand.

Given self-esteem's proposed relationship to academic performance, we suspect that a similar type of relationship may exist between the neophyte psychotherapist's level of self-esteem and his/her clinical performance. We do not, however, wish to imply here the existence of any relationship between academic performance, self-esteem, and therapeutic competence. Clearly an individual may be proficient academically and incompetent as a psychotherapist, and vice versa. While the proposed relationship

between self-esteem and clinical performance appears straightforward, we suspect its true nature may be far more complex.

We will attempt to clarify the nature of this relationship by examining several behavioral areas related to the psychotherapist's competent performance. We previously stated that experiences of success are an invaluable antecedent condition to the development of self-esteem. Experiences of success in goal delineated areas are expected to enhance the individual's self-esteem while failures are expected to deflate his/her self-esteem. (Success and failure are being subjectively defined here). While the relevant empirical literature (reviewed by Wylie, 1960, 1978) minimizes the effects of failure upon the individual's self-esteem, and thus does not support the hypothesized relationship, we question the accuracy of such experimental findings. Since the experimental failures were not in personally significant areas, their minimal effect upon the subject's self-esteem is understandable. If, however, a failure was in an important, self-selected activity (for example, a career choice), we suspect that the effect on the individual's self-esteem would be more significant.

For the psychotherapist, and especially the neophyte, the success or failure of a particular treatment may have important ramifications for his/her later thera-

peutic endeavors. Numerous mistakes, failed treatments, and other manifestations of incompetence may seriously impair the clinician's professional credibility with him/herself and others. In addition, the particular outcomes of his/her therapeutic efforts may affect the clinician's need to be recognized as competent and to be engaged in a meaningful life task. It is conceivable that repeated failures may threaten the therapist's self-esteem and interfere with is/her clinical performance.

A second behavioral area which we believe to be indispensable to the psychotherapist's effective performance and related to his/her self-esteem is discussed in the literature as conformist behavior. Conformist behavior, specifically a susceptibility to persuasion, entails a lack of conviction in one's own thoughts, feelings, and beliefs, and thus a tendency towards altering these in accordance with the corresponding thoughts, feelings, and beliefs expressed by others. Theoretically, it is assumed that the individual's level of self-esteem influences conformist behavior and makes him/her more susceptible to persuasion. Low self-esteem is said to undermine an individual's convictions in the face of difficulties, distress, or danger, resulting in conformity.²³ Compliance may be explained as a manifestation of the low self-esteem individual's defensive attempts to avoid displeasing others.

It is our contention that such conformist behavior is diametrically opposed to the psychotherapist's effective use of him/herself as an empathic instrument. In using one's self as a barometer to gauge the client's feelings, and style of relating, an inherent trust in one's own feelings and intuition is crucial. Without this trust or belief that what one is feeling is a realistic reflection of the interaction, and thus a partial creation of the client, successful psychotherapeutic intervention becomes impossible. Such confidence in one's intuitive response is the opposite of conformist behavior. The therapist who is able to navigate through highly charged, anxiety-laden interactions without defensively abandoning his/her intuitive response manifests this confidence.

The therapist who is unsure or fearful of his/her "gut reaction" will lack the self-confidence, conviction, and clarity necessary to employ this intuitive response as a tool in the treatment. Such a clinician will be inclined to avoid or devalue his/her feelings as an important source of clinical information under situations of stress. It is this tendency to avoid and devalue one's self-feelings under the stress of the therapeutic encounter which we relate to the literature's discussion of conformist behavior.

If self-esteem is indeed related to conformist behavior, we would expect to see the therapist's self-

esteem as an important factor in his/her empathic use of self. The empirical work reviewed (Wylie, 1961; Capbell, 1961; Coopersmith, 1967; Fitts, 1972) provides evidence for an inverse type of relationship between self-esteem and conformity. That is, those subjects* who possess a low level of self-esteem are more inclined to manifest conforming behaviors than their higher self-esteemed counterparts.

As an adjunct to this research, Coopersmith (1967) also demonstrated that high self-esteem is a critical factor in creativity. The creative individual is typed as a non-conformist, being more inclined to rely upon his/her own judgement in determining a course of action and relegating the opinions of others to a secondary position.²⁴ While the above research may point to an inverse type of relationship between self-esteem and conformity, the actual one is probably more complex. Accordingly, McGuire (1968) and Wylie (1979) theorize that self-esteem may interact with other related behaviors and personality variables in its influence on conformist behavior.

"Acceptance of others" is the final behavioral area we will examine that is both crucial to the therapist's successful performance and related to his/her self-esteem. Without the therapist's unconditional acceptance of the client, the therapeutic working alliance can-

*These studies did not involve psychotherapists.

not develop and treatment therefore cannot truly begin. The client who does not feel such acceptance from his/her therapist will be unwilling to invest the latter as a psychologically important person nor take the risks necessary for the ultimate success of the therapy. The basis for this "other" acceptance is an acceptance of one's self. If an individual does not like certain aspects of him/herself and invests a great deal of energy denying or otherwise defending against them, he/she will certainly be unable to tolerate similar behaviors in others. Eric Fromm (1947) states, "Love for others and love of ourselves are not alternatives. On the contrary, an attitude of love toward themselves will be found in all those who are capable of loving others."²⁵ Similarly, Horney (1950) makes the point that children who are not loved by their parents do not develop the capacity to love themselves or others.²⁶

The self-love and self-acceptance which we now discuss are aspects of the individual's security with his/her sense of self and reflective of his/her level of self-esteem. As we define self-esteem the very essence of this concept is captured by the notion of self-acceptance. We assume, therefore, that self-esteem is directly related to an individual's acceptance of others. According to Adler (1956), the neurotic person plagued by low self-esteem characteristically uses depreciation of others as

a means of raising his/her self-esteem by then comparing him/herself with the devalued other.²⁷ The psychotherapist with high self-esteem has a larger basis for identification with the client, and thus empathy, than his/her low self-esteem, less self-accepting counterpart. The empirical work (reviewed by Wylie, 1961,1979) which explores the relationship between self-esteem and acceptance of others generally supports the existence of the hypothesized linear relationship.

"The Development of Self-Esteem
in Early Childhood"

Since we are interested in the psychotherapist's development as a professional, and the impact of his/her self-esteem on clinical performance, a closer examination of self-esteem's developmental origins is appropriate here. Because self-esteem is considered to be a relatively stable, developmentally determined aspect of the personality, an exploration of its formation in early childhood will facilitate our understanding of the evolution of the neophyte's self-esteem as a professional.

When we refer to the individual's self-esteem, it is important to note that we are conceiving of it as a rather consistent personality variable which is woven like a thread through the fabric of the individual's entire personality, coloring, in some way, his/her behavior.

This core or basic level of self-esteem pervades the individual's varying feelings about him/her self and abilities (for example, high self-esteem as a student, low self-esteem as a professional), there is an underlying level of self-esteem which seems to affect these varying levels. While an individual's self-esteem may fluctuate, these fluctuations are considered transient phenomena in response to situational changes in the individual's environment. It is assumed that self-esteem will return to its customary core level when environmental conditions return to "normal."

The core or basic self-esteem has its developmental roots in the first three years of life during what Mahler, Bergeman and Pine (1975) refer to as the separation-individuation process. While Mahler and her colleagues do not systematically examine the notion of a core level of self-esteem, nor its origins, their discussion of the psychological birth of the individual will help provide us with a framework to explore and hypothesize about the development of self-esteem.

According to Mahler, et al., separation-individuation is a developmental process which involves the child's achievement of separate functioning in the presence of, and with the emotional availability of the mother.²⁸ Normal separation-individuation follows the child's movement from a psychological symbiotic union with

the mother, where the infant perceives no separation between the mother and him/herself, through various subphases in which separation is first experimented with and then gradually achieved. This developmental process begins around four to six months of age and, though it culminates in the third year of childhood, it is never truly finished since issues of separation-individuation are continually reactivated throughout life. In Mahler et al.'s framework, separation and individuation are conceived of as two complementary, intertwined developmental processes: separation consists of the child's emergence from the symbiotic fusion with the mother and individuation consists of those achievements marking the child's assumption of his/her own individual characteristics.²⁹

During the symbiotic period of development (birth - four or five months), prior to the start of separation-individuation, the infant's primary developmental task is the psychological investment of the mother in a dual unity.³⁰ The infant, at this time, behaves and functions as though he/she and mother were an omnipotent system within one common boundary.³¹ As a consequence of this state of non-differentiation, the infant experiences the satisfaction of his needs as emanating from within him/herself. It is because of the infant's inability to recognize the mother as a need satisfying person in her own right that the symbiotic period is often referred to

as a time of primary narcissism.

The infant's ability to invest the mother in an omnipotent dual unity, and thus establish a state of primary narcissism, is largely dependent upon the quality of the mother's caretaking behavior (Winnicott's "holding behavior"). Her empathic responses to the infant's needs provide him/her with a positive and satisfying experience of the world (as undifferentiated as it may be for him/her at this time), and the confident expectation that his/her distress will be alleviated. It is the resultant sense of undifferentiated omnipotence, or primary narcissism, from this symbiotic period that we believe to be a major part of the foundation upon which a core sense of self-esteem is built. The infant's experiences of satisfaction and tension reduction as a result of the mother's ministrations foster the later development of a sense of trust and confidence in her and the world. These experiences of benign expectation and trust in others eventually become manifest in a sense of trust in one's self.

While the symbiotic period may lay the foundation for the development of self-esteem, it is the child's experiences during the separation-individuation process that will importantly contribute to the emergence of a pervasive and long-lasting sense of self-esteem. The nature or quality of this core sense of self-esteem is largely dependent upon the outcome of the developmental

movement from psychological dependence characteristic of the symbiotic period, to a differentiated and stable sense of self characteristic of the final subphase of the separation-individuation process.

One of the major developmental tasks for the infant in this process is to gradually relinquish the belief in his/her parents and own omnipotence. Such an illusion must be replaced, instead, by a more realistic belief in the self with its inherent separateness and vulnerability. It is specifically the infant-toddler's psychological movement away from a belief in his/her own and mother's omnipotence, towards a more realistic appraisal of self and other, that has a significant impact on the shaping of his/her sense of self-esteem. The process of discovering that one's omnipotent beliefs are inconsistent with one's reality is, in the best of conditions, a severe narcissistic blow to the young child. If the separation-individuation is too abrupt, and the child is forced to face either his/her separateness and vulnerability or mother's faulty omnipotence before he/she is psychologically ready, then he/she will be left with a depleted sense of self-esteem.

The child's psychological readiness for this process of disillusionment is dependent on the developmental achievements of the symbiotic period and earlier subphases of separation-individuation, most importantly the prac-

ting subphase (seven - sixteen months). These achievements provide the child with a source for secondary narcissism* which will ultimately enable him/her to relinquish his/her omnipotence (primary narcissism). If the symbiotic period has been developmentally satisfactory for the young child he will enter differentiation (five to seven months), the first subphase of separation-individuation, with a sense of trust and confident expectation. During differentiation, the infant with such a sense of trust is able to begin to experiment with moving away from the mother.

If the symbiotic period has been unsatisfactory, then the child will not have been able to accumulate a sufficient reservoir of basic trust or normal narcissism which would provide him/her with a solid base from which to reach out confidently into the "other-than-mother" world.³² Such a child cannot easily invest him/herself in the process of separating because he/she is psychologically unready. It is during the practicing period when the child's expanding motor capacities significantly widen his/her world that the separation from mother and developmental achievements are most pronounced.³³ This aged child concentrates on practicing and mastering his/her own

* (Secondary narcissism entails a psychological investment in one's capacities, body, etc. which is more realistic than the omnipotence of primary narcissism and which acknowledges the existence of a separate, need satisfying person, i.e., mother).

skills and autonomous capacities, activities which Mahler et. al. believe may serve as the initial encouragement for the child's exchanging his/her magical omnipotence for pleasure in his/her own autonomy and his/her developing self-esteem.³⁴

Optimally, the child leaves the practicing subphase and enters rapprochement (sixteen - eighteen months to twenty-four months and beyond) having been freely able to invest him/herself in all his/her own separate functioning without much concern for the whereabouts of the mother. As a consequence of these practicing activities, which highlighted his/her physical separateness and increased cognitive development, the child slowly begins to realize that he/she is indeed a separate being from the mother. The rapprochement child begins to experience obstacles that lie in the way to his/her "world conquest."³⁵ This subphase marks the onset of the receding of both the child's magical omnipotence as well as his/her belief in mother's omnipotence. Consequently this subphase has important ramifications for the later emergence of self-esteem. With the growing awareness of powerlessness and vulnerability, the child makes increasing demands upon the mother as he/she ambivalently experiences the separation process. While pushing towards autonomy, he/she fears being left alone and longs for a return to his/her symbiotic omnipotence. It is dif-

difficult for the rapprochement child to feel both his/her dependence and need for autonomy. Mahler's discussion of this aged child's subphase specific behaviors of shadowing and darting away from the mother is applicable here.³⁶

The mother's patient and empathic response to her child's ambivalence as well as her availability to mirror the child's accomplishments are crucial to his/her exchanging magical omnipotence for a more realistic belief and confidence in his/her self, and to the development of self-esteem. It seems important to the rapprochement aged child that he/she can provide pleasure to the mother through his/her accomplishments.³⁷ Kohut's (1971) description of the gleam in the eye of the loving mother mirroring her pride in the child's achievements is pertinent here.³⁸ It is the child's experience of mother's affection coupled with his/her favorable experiences of success with mastery during this and the previous subphase which importantly contribute to the child's development of self-esteem.³⁹ The rapprochement aged child internalizes mother's affectionate response to his/her behavior taking in a sense of self-worth. The developmental process of internalization, a process of making part of oneself that which was formerly external, is adaptive in function and one way for the child to cope with or defend against the increasing vulnerability felt as his/her awareness of separateness grows. As internalizations proceed, so does

greater independence from the environment.⁴⁰ The child then comes to identify (a type of internalization) with mother's, and later father's, attitudes and behaviors, responding to him/herself in a manner that parallels theirs.

To sum up our discussion to this point, the key developmental ingredients which contribute to the formation of a core level of self-esteem are as follows: the quality of the symbiotic period and the relationship between mother and infant; the child's experiences of success with mastery and his/her psychological investment in his/her own functioning; the timing and nature of the child's movements through separation-individuation and psychological readiness for separation and the relinquishing of a belief in his/her own and mother's omnipotence; the nature of the mother's empathic response during rapprochement and her ability to mirror the child's accomplishments; and the child's internalization of, and identification with, maternal and paternal responses and figures.

The development of a core sense of self-esteem is clearly a complex and multidetermined process. As the child moves through the final subphase of separation-individuation, object constancy* (roughly the third year

*In Mahler's framework this subphase is called (consolidation of individuality and the beginnings of emotional object constancy."

of life and beyond), his/her sense of self (identity) and self-esteem reach a fragile stability. We hypothesize that it is at this point in life that the core level of self-esteem is first established. During this subphase (not a subphase in the same sense as the first three since it is open-ended at the older end), increased identification and internalization lead to the establishment of emotional object constancy, the maintenance of a constant, positively charged inner image of the mother which permits the child to function separately despite moderate degrees of tension and discomfort.⁴¹ This separate functioning includes the ability to maintain self-esteem in the absence of the mother. What is important to note here is that emotional object constancy, a unified sense of identity, and self-esteem maintenance, represent merely the beginnings of an ongoing developmental process. These so-called internal structures are by nature quite fragile at this point in time and, therefore, still susceptible to disruptions from environmental stress and later developmental conflicts. Further, the stability and quality of the internalized image of the mother and thus of self-esteem, still depend upon the actual mother-child relationship.⁴²

The establishment of a more stable core sense of self esteem is gradually achieved during the following oedipal developmental period (three - six years) with the

formation of the superego. A product of internalization of parental behaviors and prohibitions, the superego regulates the child's behavior in accordance with internalized ethical principles.⁴³ The superego thus regulates self-esteem by maintaining harmony between these internal moral codes and the child's activity. The superego additionally regulates self-esteem by either rewarding (enhancing self-esteem) or punishing (deflating self-esteem) the child's accomplishments and behaviors depending upon how they compare to an inner idealized image, the ego ideal.⁴⁴ Somewhere around the end of the oedipal period and beginning of latency (age seven) the child's pervasive sense of self-esteem becomes solidified.

In general, the developmentally determined level of self-esteem is rather resistant to more permanent alteration, though it may temporarily fluctuate with situational changes in the individual's life, i.e., loss of a job, falling in love, beginning in a new profession, completing a dissertation, etc. Such situational sources of self-esteem are both individually and culturally weighted in that both individual and cultural norms, goals, and expectations determine the influence of various environmental events. More permanent alteration in the nature of the individual's core sense of self-esteem is believed possible through long-term psychotherapeutic intervention, which, by its nature, seeks to change the

quality of the individual's internalized objects as well as the superego's functioning.

Given the hypothesized importance of the psychotherapist's self-esteem in his/her performance, we are particularly interested in examining the neophyte psychotherapist's self-esteem and its impact on his/her clinical functioning. Since entering a new profession is ordinarily a self-esteem stressing experience, we might expect to see a beginner's self-esteem subject to a great deal of fluctuation. If this is the case, then we might also expect to see the beginner's performance affected in some way by such fluctuation of his/her self-esteem. Since the practice of psychotherapy entails more self-threat than most professions, we might expect to see the stress on the training psychotherapist's self-esteem heightened. In the following chapter we will begin to explore the relationship between the neophyte psychotherapist's self-esteem and his/her clinical performance. To facilitate our discussion, we will first examine the neophyte's initial experiences and gradual development as a clinician. In the developmental perspective which we will offer, special focus will be on the neophyte's self-esteem and its evolution as he/she moves through the training process.

ENDNOTES

Chapter III

1. Coopersmith, Stanley, The Antecedents of Self-Esteem (W. H. Freeman & Co., c.1967), p. 5.
2. Cooley, Charles Horton, Human Nature and the Social Order (Charles Scribners Sons, c.1922), p. 184.
3. Mead, George Harbert, Mind, Self, and Society (Chicago: University of Chicago Press, c.1934), p. 259.
4. Ibid., p. 213.
5. Freud, Sigmund, New Introductory Lectures on Psychoanalysis (W. W. Norton & Co., Inc., c.1933), chapter 3.
6. Rogers, Carl R., Client-Centered Therapy (Houghton Mifflin Co., c.1951), p. 498.
7. Sullivan, Harry Stack, The Interpersonal Theory of Psychiatry (W. W. Norton & Co., Inc., c.1953), pp. 42-43.
8. Horney, Karen, Neurosis and Human Growth (W. W. Norton & Co., Inc., c. 1950), p. 18.
9. Adler, Alfred, Individual Psychology of Alfred Adler (New York: Basic Books, Inc., c.1956).
10. Coopersmith, op.cit., pp. 5-7; 22-23.
11. Ibid., pp. 52-54.
12. Ibid., p. 37.
13. Ibid., pp. 235-238.
14. Ibid., p. 240
15. Ibid.
16. Ibid., p. 243.

17. Ibid., p. 246.
18. Ibid.
19. Ibid., p. 248.
20. Sullivan, op.cit., pp. 42-43; 113-114.
21. Coopersmith, op.cit., p. 132.
22. Fitts, W. H., The Self-Concept and Psychopathology Dede Wallace Center Monograph (Nashville, Tennessee, c.1972, no. 4), p. 49.
23. Coopersmith, op.cit., p. 56.
24. Ibid., p. 59.
25. Fromm, Eric, Man For Himself (Rinehart Publishers, c.1947), p. 129.
26. Horney, op.cit., p. 18-21.
27. Adler, op.cit.
28. Mahler, Margaret S., Fred Pine and Anni Bergman, The Psychological Birth of the Human Infant (New York: Basic Books, Inc., c.1975), p. 3.
29. Ibid., p. 4.
30. Ibid., pp. 48-49.
31. Ibid., p. 44.
32. Ibid., p. 59.
33. Ibid., pp. 66-69.
34. Ibid., p. 74.
35. Ibid., p. 78.
36. Ibid., pp. 77-78.
37. Ibid., p. 90.

38. Kohut, Heinz, The Analysis of the Self (New York: International University Press, c.1971).
39. Mahler, et al., op.cit., pp.117-118.
40. Ibid., pp. 101-102.
41. Ibid., p. p. 109.
42. Ibid., p. 112
43. Hall, Calvin S., A Primer of Freudian Psychology (Mentor Books, World Publishing Co., c.1954), pp. 31-32.
44. Ibid., pp.33-34.

C H A P T E R I V

THE NEOPHYTE PSYCHOTHERAPIST'S SELF-ESTEEM: IT'S DEVELOPMENT AND IMPACT ON CLINICAL PERFORMANCE

The Experience of the Beginning Psychotherapist

As a beginner in any endeavor, an individual is naturally susceptible to feelings of inadequacy, anxiety, and incompetence as he/she struggles to attain a professional status. The making of mistakes is an integral part of this learning. The "naturalness" of these mistakes and feelings of incompetence as a necessary prerequisite to becoming a professional oftentimes escapes the beginner. Since professional development is usually in a field of great personal importance, the neophyte is often plagued with painful self-doubts and anxiety which threaten his/her self-esteem, and may generalize to other areas and behaviors within his/her life.

It is assumed that with more professional experience, training, and success, the beginner slowly develops into a "not-so-beginner" and his/her feelings of competence and self-esteem gradually rise. The amount of early successes depends in a large part on the chosen field, the difficulty in attaining mastery, and the

individual's inherent talent. Those that are more difficult, where success is not immediately forthcoming, present the neophyte with a more stressful and frustrating learning situation that can severely tax the individual's level of self-esteem.*

Given the behavioral significance of the latter, we might assume that the neophyte's special vulnerability to problems involving self-esteem would affect both his/her performance within their profession, as well as the learning process. In those professions where progress is naturally slow, we would expect to see this effect highlighted.

The practice of psychotherapy is one such profession where the learning process is long and emotionally charged. It is one in which the rewards are slow in coming and the neophyte's sense of self-esteem is subject to intense stress and rapid shifts. Learning and practicing psychotherapy generates anxieties which are almost unique among professional pursuits, thus posing additional problems for the beginner.¹ These anxieties and problems stem from several sources, the most important of which is the paradoxical nature of the psychotherapist's role.

As we have previously said, therapeutic effec-

* (At this point, self-esteem may sound identical to self-confidence. While there is considerable overlap in meaning between the two and behaviorally they may appear the same, self-esteem entails a self-acceptance of both good and bad qualities which is not necessarily implied in self-confidence).

tiveness and competence significantly depend upon the clinician's ability to empathically use his/her self. Because his/her use of self routinely exposes the psychotherapist to a great deal of anxiety, he/she is susceptible to anti-therapeutic maneuvers and mistakes. This situation is especially troublesome for the neophyte whose inexperience generates additional anxiety and has a direct impact on his/her self-esteem.

An additional source of stress for the neophyte's self-esteem stems from the fact that psychotherapy, as a profession, does not so easily lend itself to understanding nor mastery. The process is intricately complex, ambiguous, and at times so idiosyncratic that it may be contradictory. These difficulties are reflected in Chessick's (1969) comments on the nature of the psychotherapy training endeavor:

"The gloomy fact must be faced that anyone attempting to undertake the teaching of psychotherapy, whether by individual supervision or by seminar, is setting out on almost totally uncharted waters with little but instinct to guide him."²

Furthermore, learning psychotherapy is intimately interconnected to the neophyte psychotherapist's personality which further complicates and intensifies the learning process. The learning process exposes the student to highly charged emotional experiences and demands continual self-scrutiny. The learning process entails, in varying degrees and form, a transformation of the entire

self. Freud's (1905) comments about his work with Dora are appropriate here:

"No one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast, and seeks to wrestle with them, can expect to come through the struggle unscathed."³

The nature of the psychotherapeutic profession and learning process, then, confronts the neophyte with a self-threatening and, therefore, self-esteem stressing experience. Since we believe that self-esteem is an important variable in behavior, we expect that the neophyte's self-esteem will significantly affect his/her abilities to learn the role of, and perform as a psychotherapist.

Because the stress on the beginner's self-esteem gradually changes as he/she progresses through training, an understanding of the neophyte's professional evolution will elucidate our examination of his/her self-esteem and its effect upon clinical performance.

According to Ralph (1980), the literature on teaching and learning psychotherapy, despite its richness, gives few descriptions of the process of learning psychotherapy and the subjective experience of the neophyte as he/she moves through this process.⁴ The classical texts on training (Ekstein and Wallterstein, 1971; Benedek and Fleming, 1966; Tarachow, 1963; Rogers, 1951, 1959; Traux and Carkhuff, 1967), examine how the learning process is affected by transference and coun-

tertransference phenomena (1971, 1966) and describe some of the desired outcomes of the learning process (1951, 1959, 1967). However, they provide little information on the developmental experience involved in learning psychotherapy. Since we know that the learning inherent in psychotherapy training goes beyond a cognitive level to involve one's self in a process of change (Ralph, 1980 describes the changes that neophyte psychotherapists report as facets of ego development, i.e., enduring changes in schemas about the self and others,⁵) it seems reasonable to assume that a developmental perspective might be a useful way to conceptualize the learning process.

"A Developmental Model of the Neophyte
Psychotherapist's Experience in the
Learning Process"

It is a contention of this dissertation that such a developmental perspective, which we will formulate in this chapter, will facilitate the training experiences for both supervisor and supervisee. Ralph (1980) believes that such a developmental understanding of the level of functioning of the student-therapist is central in the teaching of psychotherapy, occurring intuitively among good teachers.⁶

In establishing a developmental framework from which to view the experiences of the "growing" pro-

fessional we will be utilizing as an analogy Mahler, Pine, and Bergman's (1975) work on the psychological birth of the human infant. The rationale underlying such a choice is based on the significant contributions of their work to our understanding of early development, psychopathological development, and the theory and practice of psychotherapy. In their longitudinal studies of early childhood, Mahler and her colleagues have established a particularly insightful and useful framework for viewing the child's intrapsychic movement from dependence to independence. Separation-individuation, as the process is referred to, entails the child's achievement of separate functioning in the presence of, and with the emotional availability of the mother.⁷

Mahler points out that like any intrapsychic process, separation-individuation reverberates throughout the life cycle, always remaining active as new phases of the life cycle manifest new derivatives of the earliest processes still at work.⁸ For example, derivatives of the original separation-individuation process can be seen in adolescence as the teenager gradually moves away from his/her family and attempts to establish an identity of his/her own. Similarly, events like leaving home to enter college and, later, graduating and entering a profession, are in themselves processes of separation-individuation and therefore evoke intrapsychic derivatives of the early

childhood process. Thus, feelings of helplessness, dependence, and fear may accompany a student as he/she first assumes a professional role, and while these feelings are certainly not identical to the child's helplessness, dependence, and fear as he/she begins to separate from the mother, they are, nevertheless, related.

The essence of the psychotherapeutic training process involves the development within the neophyte of a therapeutic self. The nature of this development entails the neophyte's entrance into an interpersonal (supervisory) relationship with an as yet unformed therapeutic self and, gradually, as a consequence of this relationship, the therapeutic self emerges. Because of the analogous nature of this developmental process to the one inherent in early childhood (in early childhood, the infant's self gradually emerges out of his relationship with the mothering one), we hypothesize that it will personally re-evoke fragments of issues from the neophyte's own development. What is important to keep in mind throughout the ensuing discussion is that our emphasis is mainly on the neophyte's professional development and not on the specific intrapsychic issues related to his/her early development.

Because individual supervision constitutes the heart of the neophyte's training, the clinical supervisor becomes an emotionally significant person to the trainee.

Since the goal of supervision is to teach what is therapeutic, and this in itself consists of using one's self as an empathic instrument, then learning the therapeutic role necessarily requires a focus on and a careful examination of one's feelings, motives, emotional response patterns, and interpersonal conflicts. In many ways, then, the supervisory process walks a fine line between teaching and personal psychotherapy.

As we formulate our early development-training analogy, we will alternately highlight the various stages of Mahler et al.'s separation-individuation process with the corresponding experiences of the beginning therapist as he/she moves through the learning process. It is important to note here that what we are offering is a plausible explanation of the psychotherapist's professional development and not a factual account.

In the symbiotic phase, a forerunner of the separation-individuation process, the infant is said to be in a state of psychological fusion or oneness with the mother in which he/she behaves and functions as though he/she and mother were an omnipotent system--a dual unity with one common boundary.⁹ Thus, symbiosis describes a state of undifferentiation in which the "I" is not yet differentiated from the "not I."¹⁰ The child's rudimentary ego is non-functional at this time and unequipped for its later adaptive purposes. Therefore, the child is

totally dependent upon the mother as an "auxiliary ego" (Winnicott, 1951). The mother's "holding behavior" (Winnicott) is said to be the symbiotic organizer (Mahler) of psychological birth.¹¹ The mother's psychological and physiological ministrations provide the foundation for healthy ego development by buffering the rudimentary ego from disruptive experiences and anxiety. Maternal failure at this stage results in the infant's ego being overwhelmed and seriously weakened. The cathexis, or psychological investment of the mother is considered to be the principal psychological achievement of the symbiotic phase.¹²

For the neophyte psychotherapist, his/her initial clinical experiences are quite often terrifying and anxiety-provoking. Professionally speaking, he/she has, at best, a rudimentary sense of self. The beginner's "professional ego" is virtually nonexistent and nonfunctional, and as a consequence, he/she often has difficulty tolerating the anxiety and painful affects that are an inherent part of the therapeutic encounter. Lacking a functional "professional ego," the neophyte is frequently coerced to mobilize his/her defenses both within the treatment and the supervision.

Not uncommonly, one manifestation of this defensive mobilization is an activation of the compensatory defense of feeling omnipotent. In this case the neophyte

may wholeheartedly adopt the expert, all-knowing role, providing advice, insights, behavioral prescriptions, etc. Such striving for omnipotence is a regularly observed theme in psychiatric training and can be understood as a defensive manifestation of underlying feelings of inadequacy, low self-esteem, and sensitivity to criticism.¹³ Such an individual defends against a basic sense of inferiority by projecting the "inferior" parts of the self onto others who are then devalued. For the neophyte psychotherapist, then, the quest for omnipotence is primarily a product of his/her feelings of helplessness, inadequacy, and impotence.

While this quest for omnipotence may be directly reflected in the neophyte's assuming an "all-knowing" role, such is the exception rather than the rule. To defensively deny the intense feelings of inadequacy, lack of theoretical and practical knowledge, self-doubts, and low self-esteem so characteristic of this developmental stage entails a great deal of reality distortion. Rather, the striving for omnipotence and/or other adaptations to the painful experiences of beginning are manifest in different ways. More often than not, in the face of such overwhelming evidence of professional inadequacies, the neophyte may turn to a particular supervisor and "cathect" or invest him/her with the omnipotent knowledge and qualities which they so painfully lack. Simultaneous to this

idealizing is a distortion of the realistic feelings germane to beginning psychotherapeutic training. That is, in viewing one's supervisor as omniscient, there may be an exaggeration of the beginner's realistic modesty into a sense of emptiness, of being devoid of knowledge.¹⁴ To fill this void and allay an acute sense of incompetence, the beginner looks to his/her supervisor-mentor who appears to offer what he/she perceives as lacking in his/her self.

Identification with a supervisor/mentor is not in itself a negative occurrence. On the contrary, the supervisor as a role model provides the beginner with invaluable learning experiences. Where this identification with and idealizing of a supervisor becomes a source of interference for the neophyte's development is when the beginner overemphasizes his/her inadequacies and lack of knowledge. In viewing the other as all-knowing, the neophyte may come to distrust his/her own instincts and feelings. Since the therapist's primary treatment tool for both diagnosis and intervention is an empathic use for self, a persistent mistrust of one's self and feelings, in deference to the "knowledge" of a supervisor, can only adversely affect the neophyte's learning and performance. At the other extreme, a strong resistance to, or total rejection of supervisory interventions may deprive the neophyte from learning that his/her feelings may sometimes

impel him/her to antitherapeutic maneuvers within the psychotherapeutic encounter.

The role of the first supervisor is extremely crucial to the neophyte's professional development and sense of self as a clinician. The supervisor's "holding behavior," how he/she handles the neophyte's inexperience, anxieties, inadequacy concerns, self-esteem, and tendency to idealize, enables the latter to slowly begin to tolerate the flood of affects not uncommon to the therapeutic encounter. For the beginner, the supervisor functions as an auxiliary ego, in Winnicott's sense, attempting to prevent him/her from becoming too overwhelmed by the learning experience. It is most probably the supervisor's "holding behavior" which enables the neophyte to relinquish the expert role* and begin to tolerate the anxiety inherent in utilizing an open-ended approach within the therapeutic encounter. The adoption of an open-ended (i.e., less structured) approach is considered by Ralph (1980) to be the first developmental milestone for the beginning psychotherapist.¹⁵

For the infant, in early development, the symbiotic period is followed by the first subphase of the separation-individuation process, a time when the infant begins tentative experimentation with moving away from the

*[Expert role is used here to imply its stereotypical meaning, exaggerated professionalism, providing advice, having all the answers, always being in control, etc.].

mother. Characteristic of this differentiation subphase is the emergence of a transitional object (Winnicott, 1953), or temporary maternal substitute expressed in the infant's insistent preference for an object, i.e., blanket, teddy bear, etc., which is lasting, soft, pliable and warm to the touch.¹⁶ Similarly, one sees the emergence of transitional behavior, where the mother's preferred soothing or stimulating pattern is taken over by the infant in his/her own way.¹⁷ Both transitional objects and behavior temporarily allay the anxiety of being without mother by keeping her psychological representation always present. As part of the initial experimentation with moving away from the mother one observes a pattern of comparative scanning, of checking the familiar, mother, with the unfamiliar or other-than-mother.¹⁸ This "checking-back" pattern, the beginnings of an ability to discriminate, is considered by Mahler to be the most important normal pattern of cognitive and emotional development.¹⁹

In response to the comparative scanning and contact with the other-than-mother-world, at around eight months of age, a behavioral reaction in the infant is observed which ranges from curiosity and wonderment to apprehension and intense anxiety.²⁰ The intensity of the so-called "stranger-anxiety" or "8-month anxiety" is mostly dependent on the quality of the previous symbiotic

phase and the mother's holding behavior. In children for whom these were optimal, curiosity and wonderment are the predominant elements of their inspection of strangers. By contrast, among those children whose symbiotic period was less than optimal and did not instill in them a sense of basic trust, abrupt and intense stranger reactions are visible.²¹ According to Mahler et al., disturbances during the symbiotic period and in the mother's holding behavior (i.e., maternal intrusiveness) may be manifest in premature or delayed differentiation.²²

Just as the infant can be observed to make tentative forays away from the mother on the road towards separation-individuation, so too can a similar process be observed in the neophyte psychotherapist's professional development. Early on in the neophyte's experience, he/she most commonly adopts the supervisor's theoretical orientation, style, techniques, and mannerisms. This modeling of the supervisor is, in the beginning, quite undifferentiated in relation to the neophyte's sense of self, personality style. The supervisor is introjected whole and indiscriminately as the neophyte attempts to assume the role of psychotherapist. Such a massive identification with the supervisor functions in a parallel manner as the infant's transitional behavior and objects. It allows the neophyte some sense of professional self and security in the absence of the supervisor. Such

"transitional behavior," (i.e., taping sessions and obsessively studying or transcribing them, taking copious notes during or after the therapeutic and supervisory sessions, trying to concretely operationalize the supervisor's instructions), are all means for the neophyte psychotherapist to bind his/her anxiety and deal with the reality of his/her clinical inexperience, dependence, and helplessness. It is also important to note that some of these behaviors are quite helpful to the neophyte's professional development.

As we mentioned earlier, the neophyte's relinquishing of the expert role and adopting an open-ended approach is a first developmental milestone. Letting go of the expert role with its inherent control and structure is simultaneously a source of relief and additional anxiety for the novice. The relief stems from a sense that one does not have to take responsibility for all that happens in the interview, and that one does not have to demonstrate an expertise that is, in reality, nonexistent. The open-ended approach to the interview frees the neophyte to listen more carefully to, and experience the interaction with the client. The latter interaction may then expose the therapist to additional anxiety. Without the therapist's active structuring, both participants will be exposed to more anxiety-provoking experiences as the client is allowed, or sometimes

coerced, to experience emotionally conflictual feelings. A student quoted in Ralph's (1980) essay on the therapist's development describes the issues of the neophyte making this developmental step.

"I began to realize that what I began to do when I got anxious over a silence in the hour or over a question I had difficulty answering, was to structure things immediately with the patient. I couldn't tolerate a little anxiety coming to the fore. I learned to sit back and tolerate some anxiety and to be a little less active and allow things to come out of the other person."²³

One likely consequence of the neophyte's anxiety from "not knowing" is a search within one's self for something clear and concrete to grab hold of. It is as if the neophyte desperately seeks the right answers or correct solution to the psychotherapy puzzle. He/she may potentially solve this puzzle by adopting (in an undifferentiated and concrete fashion that is reflective of the neophyte's own conceptual development in this area,²⁴), his/her supervisor's theoretical orientation.

In the face of psychotherapy's ambiguity, uncertainty, complexity, and confusion, a theory to call one's own keeps the neophyte from being completely overwhelmed. A theory is initially turned to for its promise of understanding, and for its role in allaying the neophyte's fear of real contact with the client. The greater the beginner's uncertainty, confusion, and anxiety about doing therapy, the more tenaciously he/she will cling to his/her theoretical orientation. Such a

theoretical orientation appears to embody a solution to the painful identity crisis with which the neophyte struggles. One will be a Rogerian, a Jungian, or Freudian, since each is the only "true way" of practicing psychotherapy. With such an identity, one now has a "modus operandi," a guide to illuminate the dark and unknown recesses of this journey called professional development as a therapist. It is important to note here that the adoption of a theoretical rationale is an integral part of the psychotherapist's professional development and not necessarily defensive in function. Regardless of the therapist's level of experience, a sound theoretical base is an indispensable adjunct of successful treatment.

During the neophyte's "differentiation" period, in addition to developing a strong identification with the supervisor, he/she begins to make the discovery, if at first only intellectually, that there are other oftentimes conflicting theoretical approaches and therapeutic modalities which are equally as effective as the one prescribed by the supervisor. This discovery potentially can signal the beginning of the neophyte's development of his/her own style of psychotherapy. Having gained some exposure and experience with varying therapeutic modalities, the neophyte begins to select pieces from each which personally make sense while discarding those that do not.

The neophyte, then, engages in a comparative scanning of other modalities, ultimately "checking back" to the familiar territory of the supervisor. It is important to note here that we are stretching our analogy quite a bit in this discussion. The infant "checks back" because his/her sense of self and relationship with mother are possibly threatened. For the neophyte psychotherapist, however, it is probably only his/her professional sense of self that is being threatened, since he/she already has a fully developed self, and not necessarily his/her relationship with the supervisor. This is not to imply that the neophyte's discovery of differences between him/herself and supervisor is uneventful. Depending on the particular supervisor, a recognition of difference may indeed threaten the supervisory relationship.

Given the neophyte's initial overwhelming preoccupation with his/her adequacy, and the potentially debilitating anxiety this may engender, the importance of the first theoretical orientation adopted as a "security blanket" cannot be overemphasized. With the subsequent exposure to other contradictory modalities, it is quite common for the neophyte to experience such exposure as an anxiety-provoking threat to his/her security and professional sense of self. It is as if the neophyte's comparative scanning has the potential to be a stimulus for a type of "stranger reaction" or "stranger anxiety."

Whether the neophyte responds to his/her discovery of the "other than supervisor world" with either curiosity, wonderment, enthusiasm, and openness, or apprehension, anxiety, and defensive mobilizations is dependent on his/her supervisor and the latter's "holding behavior." The supervisor's position in dealing with his/her supervisee's beginning professional differentiation may be analogous to the mother's position as her differentiating infant makes his/her first tentative steps away from her.

The supervisor who is relatively secure in his/her personal and professional sense of self, has an open realistic view of the psychotherapy profession, is an empathically in tune and sensitive teacher, and whose self-esteem is not pathologically tied into the trainee's development will encourage the latter to develop his/her own style and orientation. Such a supervisor will prepare the trainee for exposure to conflicting modalities and be able to tolerate the latter's development as a separate and equally competent individual. As this trainee moves through the training process, he/she will be less threatened by, and more open to, contradictory therapeutic approaches. These will be more readily embraced as a natural and important part of the learning process rather than avoided as a source of debilitating anxiety.

Some supervisors, however, profess a one-sidedness and rigidity in their teaching which is ultimately

destructive to the training of competent, empathic clinicians. Such supervisors rigidly believe that their orientation and style of treatment is far superior to all others and invest a great deal of time and energy defending their position through critical attacks on the "competition." For these individuals, conflicting modalities are a dangerous threat to their personal and professional identity and self-esteem and, consequently, have to be negated. This onesidedness is manifest in their supervision where they may intrusively attempt to produce little more than puppets or clones of themselves at the trainee's expense. This kind of supervisor fails to recognize the separateness and individuality of the trainee in a similar manner that some mothers fail to recognize the separateness and individuality of their infants.

In the trainee with this quality of first supervisory experience, whose professional self-esteem and sense of self have been handled in a less than optimal way, it is not unusual to see an anxiety-laden response when he/she is exposed to conflicting therapeutic modalities. The anxiety inherent in acknowledging the efficacy of the "competition" cannot be tolerated and is avoided with a rigid adherence to the supervisor's particular orientation. Less than optimal supervisory "holding environments" may, conversely, produce a prema-

ture differentiation or separation from the supervisor and a neophyte who goes through the remainder of training as overly independent, defended, and resistant to further supervisory intervention.

According to Mahler et al., after the differentiation subphase, the child makes further steps away from the mother. This is a time designated the practicing period when the child's expanding motor development widens his/her world and contributes to his/her first steps to an awareness of separateness.²⁵ Practicing is a time when the infant's narcissism and sense of omnipotence are at their peaks.²⁶ The child seems intoxicated with his/her own faculties and with the greatness of his/her own world.²⁷ During this period the infant seems less concerned with the mother's whereabouts and relatively impervious to knocks and falls as he/she concentrates on practicing and mastering skills and autonomous capacities.²⁸ During this subphase, which lasts from approximately 7 to 16 months, the infant maintains illusions of grandeur and union with the mother.

It is these illusions of union with the mother, and the narcissistic belief in one's own and one's parent's omnipotence which the infant must gradually relinquish and replace with his/her own autonomous functioning. It is during the subsequent period of rapprochement that the child begins to anxiously discover

that he/she is not only separate from the mother and must cope on his/her own, but, being quite small and helpless, may not be up to the task. Rapprochement is marked by an increase in separation anxiety and an increased need for mother to share his/her new skills. The child's previous imperviousness to knocks and falls dissipates as he/she begins to experience some of the obstacles which lie in the way of his/her "world conquest."²⁹ As the infant begins to realize his/her separateness and helplessness he/she tries to employ mechanisms to resist and undo them.

Two characteristic patterns of the toddler's behavior during this subphase indicate his/her ambivalence about this newly discovered separateness. The child may frequently "shadow" the mother, incessantly watching and following her every move.³⁰ These behaviors may alternate with the child's "darting away" from mother with the expectation of being chased and swept into her arms.³¹ Such "shadowing" and "darting away" indicate both a wish for reunion with the mother and a fear of reengulfment by her.³²

During rapprochement the child's source of pleasure shifts from his/her focus on an active exploration of the inanimate world and his/her own functioning so characteristic of the previous practicing period to social interaction. Thus an awareness of other children's separate existence, their being similar, yet

different from one's own self, and a growing attachment to the father as a love object are observed during rapprochement.³³ Further, the later part of this period is characterized by a widening of the toddler's emotional range and the beginning of empathy.³⁴ With the child's growing awareness of separateness and vulnerability, he/she seems more capable to respond empathically. Finally, manifestations of higher level ego identification with the attitudes of others, versus non-differentiated introjections, or mirroring tendencies characteristic of earlier periods, can be observed during rapprochement.³⁵

The conflict of this subphase between the desire to be separate, grand, and omnipotent on the one hand, and to have mother magically fulfill all wishes on the other, while denying her aid as coming from the outside, culminates in the rapprochement crisis.³⁶ The relinquishing of his/her delusions of grandeur and union, the developmental task of the rapprochement crisis, is critically dependent on the mother's emotional availability. During this time the mother must be able to sensitively handle the child's rapidly alternating desire to push her away, and to cling to her, a behavioral sequence described by Mahler as "ambitendency."³⁷ Maternal disturbances here result in exaggerations in the amount of stage-appropriate separation-anxiety, shadowing, and daring away behavior.³⁸ Uncertainty as to the mother's availability

diverts the child's emotional energies away from the developmental tasks at hand.

In continuing our analogy with the neophyte psychotherapist, his/her "practicing period" is manifest in an idealism, enthusiasm, and naivete about the therapeutic process in general, and the supervisor, and his/her therapeutic modality. After the initial anxiety-provoking trauma of the first few client contacts, the neophyte's indiscriminate adoption or introjection of the supervisor's theoretical orientation and therapeutic style enable him/her to begin the quest for omnipotence so characteristic of early training. Most people involved in the training of novice psychotherapists have noticed that at this time the beginner's belief in the efficacy of psychotherapy as a panacea is at its height, along with a belief in the supervisor's omniscience.³⁹ With psychotherapy promising to cure all, and the supervisor viewed as all-knowing, the neophyte enthusiastically sets out to learn and practice the right way. Mistakes or problematic situations in treatment, while emotionally painful, can be easily resolved with the supervisor. The comfort in this knowledge enables the neophyte to concentrate on the client's presentation and be somewhat less preoccupied with issues of his/her own adequacy.

As a rough parallel with the infant's shift in focus outward from mother to an exploration of the world

of inanimate objects, the neophyte's entire focus within the therapeutic encounter during this point in his/her professional development shifts outward from a self-consciousness to a client consciousness. That is, the neophyte, in his/her early attempts to be the expert, is quite often preoccupied with his/her performance, effectiveness, likeability, etc. This preoccupation with self, a type of professional narcissism, precludes truly effective intervention since it distracts the neophyte from listening to the client. When the beginner is able to relinquish the expert role, he/she is then able to focus more on what the client is saying or feeling.

For the beginner, what this client-centered approach (not to imply Rogerian) entails is a rather narrow focus on what the client is saying, doing, or feeling. In other words, this approach is more concrete in that it focuses mainly on the verbal or behavior content of the hour to the virtual exclusion of other, more covert levels of communication. As far as the neophyte is concerned, at this stage of his/her development, the content of the session is not only what is important, but is all that he/she is aware of. According to Ralph (1980), the adoption of such a client-centered approach along with the neophyte's first theoretical rationale comprise a second developmental milestone in training.⁴⁰

In continuing our early development parallel,

there comes a point in the beginner's training, towards the end of the first, or during the second supervisory experience or later, when the neophyte's idealism about the therapy process and belief in the supervisor's omnipotence slowly begins to fade. There are a number of experiences which simultaneously may contribute to this. With the introduction to a new supervisor who espouses a differing theoretical orientation and supervisory style than the first, the neophyte's professional sense of self and belief system may be seriously challenged. Not only must the neophyte make the adjustment to a new relationship, which in itself entails a fair amount of emotional stress, but also, he/she must become comfortable with a different way of viewing the psychotherapeutic process. (Conceivably the latter would remain true even if both supervisors adhered to the same theoretical base. For example, in the psychoanalytical school numerous variations exist.) Being asked to conceptualize in an unfamiliar way, where adherence to "old, time-tested" ways are seemingly no longer applicable is an anxiety-provoking experience for the neophyte. Further, the dawning awareness that one particular theory may be just as helpful as the next, even though both may be contradictory, is equally unsettling and confusing.

With the emergence of such contradictions is the growing sense that a theoretical orientation is merely an

abstraction and cannot be truly depended upon to resolve all the problems of human behavior, nor rescue an anxious neophyte from a particularly stressful therapeutic encounter. This is especially true of the earliest theoretical orientations adopted by the beginner since they have only limited basis in clinical experience. (There is a great difference between an organic or natural growth towards a theoretical framework evolving out of one's own experience and thought, and a flight into a theoretical structure stemming from the wish to stop the frustration and agony of uncertainty.) Further, at a time when the neophyte begins to feel more vulnerable about his/her professional adequacy, and thus more dependent on his/her supervisor, the latter's omnipotence appears to fade. With more experience the neophyte painfully realizes that the supervisor, like his/her theories, is fallible and does not have all the answers. For the neophyte these discoveries mark a beginning realization of the depth and complexity of the psychotherapeutic process.

The emergent anxieties from exposure to conflicting modalities, the supervisor's "shortcomings," and the growing awareness of the complexity and unpredictability of the therapeutic process shatter any illusions of omnipotence or grandeur which the neophyte might have entertained and underscore his/her professional inexperience and powerlessness. Relinquishing the futile

quest for omnipotence, to become as all-knowing as one's supervisor, entails a facing of one's clinical helplessness and ignorance. This is a type of "rapprochement crisis" for the beginner as he/she sees the extent of his/her professional separateness and inadequacies.

It is important to keep in mind that when we discuss this particular developmental crossroad of psychotherapy training as a type of rapprochement crisis, we are clearly overstating our analogy. While it is quite conceivable that the neophyte therapist may respond to his/her growing awareness of professional separateness and inadequacy in a parallel manner as the emergent toddler, i.e., with attempts to resist and undo his/her sense of helplessness by stepping up his/her efforts to enlist the supervisor's aid, Mahler's developmental metaphor does not entirely fit here. While it is not uncommon to notice the neophyte rigidly "shadowing" the supervisor's theoretical style, trying to reproduce exactly his/her suggested interventions, such behavior is more appropriately characteristic of the opening stage of training.

In resolving this later training "crisis," we might expect to see the neophyte "shadowing" the supervisor in an ego syntonic, less concrete and dependent way. That is, the neophyte may attempt to become his/her own version of the supervisor by integrating his/her own per-

sonality into the treatment rather than mechanically reproducing the supervisor's behaviors. We might say that at this point in training the neophyte's identification with his/her supervisor(s) is of a higher order, developmentally, than when he/she first began training. The neophyte has embarked on an ongoing process of discrimination in which he/she integrates various aspects of the supervisor, his/her style, theoretical orientation, etc., which are compatible with his/her personality (ego syntonic) while discarding those aspects which are incompatible (ego alien). Such an integration process parallels the ego identifications which Mahler discusses as utilized by the rapprochement aged child to cope with his/her growing sense of separateness.

Simultaneous to his/her growing awareness of professional separateness, the neophyte makes the discovery (with the supervisor's aid) that psychotherapy is an interpersonal process involving the feelings and reactions of both the therapist and client. According to Ralph (1980), this third conceptual milestone (viewing the interview with an open-ended approach as the first; adopting a theoretical orientation and client-centered approach as the second), a relationship-centered approach, focuses on the metacontent of the hour--that is, the feelings and emotions developed in the client-therapist relationship which generated that content.⁴¹ The meta-

level of communication herein discussed is largely unconscious and beyond critical examination. The neophyte's discovery of this more covert mode of communication marks the attainment of an important stage in his/her development.⁴²

With the establishment of this new perspective, a great deal of the unknown and mystery about the therapeutic process slowly begins to dissipate. Equipped with a potent tool for understanding, the neophyte is able to make some sense out of interactions and situations which previously defied clarity. Thus, the acquisition of a relationship perspective, by providing the neophyte with a source for additional and accurate diagnostic information, enhances his/her clinical acumen and effectiveness. This in turn serves as a source of personal and professional self-esteem, enabling the neophyte to begin to view him/herself as a more competent clinician.

Just as the mother's emotional availability is crucial for a healthy resolution of the rapprochement crisis, the supervisor's attitudes towards the neophyte have an important impact on the latter's growing sense of professional self. It is crucial that the supervisor at this stage foster the neophyte's independence and reliance on his/her self as an empathic instrument. It is important that the supervisor does not feed the neophyte's need for an omnipotent identification, but instead

encourages the beginner to experience differing modalities and supervisory styles.

The main task of the fourth subphase in Mahler's schema, the consolidation of individuality and the beginning of emotional object constancy, is twofold: (1) the achievement of a definite, in certain aspects lifelong, individuality, and (2) the attainment of a certain degree of object constancy⁴³ ("object" in the psychoanalytical sense refers to something through which drive gratification is achieved). The establishment of such object constancy depends upon the gradual internalization of a constant, positively cathected, inner image of the mother which permits the child to function separately despite moderate degrees of tension and discomfort.⁴⁴ The fourth subphase is further characterized by the unfolding of complex cognitive functions, i.e., verbal communication, fantasy, and reality testing.⁴⁵ It is an open-ended phase in that these developmental tasks, attaining a sense of object constancy and a unified self-image, represent merely the beginnings of an ongoing developmental process.⁴⁶

For the neophyte, the attainment of a healthy professional identity and sense of self is also an open-ended, ongoing process. The ability to therapeutically use one's self empathically is a complex, cognitive and affective achievement that gradually evolves with cli-

nical experience and training. Its development is stimulated by the neophyte's growing professional independence and his/her emerging understanding of the therapeutic encounter as "therapist-centered" in Ralph's (1980) sense. That is, the therapist comes to realize the clinical usefulness of his/her affective and cognitive responses to the client. Thus, a refining, or honing of the empathic use-of-self occurs as the young therapist begins to trust more and more his/her feeling reactions within the clinical hour. Supervisory intervention, while still important, becomes less of a necessity as the neophyte is able to function effectively and independently in the therapeutic role. The therapist, at this point, is better able to tolerate the ambiguities, uncertainties, and affective involvement of the therapeutic process without becoming overwhelmed and defensively mobilized. Success or failure of treatment, while important to the young therapist, is less frequently utilized as a measure of his/her therapeutic competence as it was during the previous stages. Thus the therapist gradually evolves a relatively stable sense of professional self and self-esteem.

ENDNOTES

Chapter IV

1. Ford, E. S. C., "Being and Becoming a Psychotherapist: The Search for Identity," American Journal of Psychotherapy, vol. 17, 1963, pp. 477-478.
2. Chessick, Richard D., How Psychotherapy Heals (Science House, c.1969), p. 163.
3. Freud, Sigmund, Dora: An Analysis of a Case of Hysteria (Collier Books, c.1905).
4. Ralph, Norbert B., "Learning Psychotherapy: A Developmental Perspective," Psychiatry, vol. 43, August 1980, p. 244.
5. Ibid., p. 249.
6. Ibid., p. 243.
7. Mahler, Margaret, Fred Pine, and Anni Bergman, The Psychological Birth of the Human Infant (New York: Basic Books, Inc., c.1975), p. 3.
8. Ibid.
9. Ibid., p. 44.
10. Ibid.
11. Ibid., p. 49.
12. Ibid., p. 48.
13. Sharaf, Myron R. and Daniel J. Levinson, "The Quest for Omnipotence in Professional Training," Psychiatry, vol. 37, 1964, p. 135.
14. Ibid., p. 136.
15. Ralph, op.cit., p. 245.

16. Mahler, et al., op.cit., pp. 54-55.
17. Ibid., p. 55.
18. Ibid., pp. 55-56.
19. Ibid., p. 55.
20. Ibid., pp. 55-56.
21. Ibid., p. 58.
22. Ibid., pp. 58-60.
23. Ralph, op.cit., p. 245.
25. Mahler, et al., op.cit., p. 66.
26. Ibid., p. 71.
27. Ibid.
28. Ibid.
29. Ibid., p. 78.
30. Ibid., pp. 77-80.
31. Ibid.
32. Ibid.
33. Ibid., p. 91.
34. Ibid., pp. 97-98.
35. Ibid., p. 98.
36. Ibid., p. 95.
37. Ibid.
38. Ibid., p. 97.
39. Ford, op.cit., pp. 477-478.
40. Ralph, op.cit., pp. 245-246.

41. Ibid., pp. 246-247.
42. Ibid.
43. Mahler, et al., op.cit., p. 109.
44. Ibid.
45. Ibid., p. 117.
46. Ibid., p. 118.

C H A P T E R V

CONCLUSION

In establishing our analogy between the development of the neophyte psychotherapist's therapeutic self and the infant's psychological self, we said that anxiety had the potential to interfere with both developmental processes. While the impact of anxiety on the neophyte psychotherapist is less disruptive psychologically than for the infant, it nevertheless has important ramifications for his/her professional development and functioning. Anxiety within the neophyte potentially leads to defensive mobilizations and, consequently, empathic failure. Such a failure of the therapeutic self naturally results in inappropriate and ill-timed interventions, and thus, in the therapist's mistakes.

Bandura (1956, and 1960 with Lipsher and Miller) provides evidence for a "significant negative relationship" between the beginning therapist's anxiety level and ratings of psychotherapeutic competence.¹ Anxious therapists were rated to be less competent and more inclined to utilize defensive responses, and thus make mistakes in avoiding an anxiety-provoking interaction than therapists who were of low anxiety.² Since a minimal

therapeutic condition necessary for the resolution of a client's conflicts involves the client being allowed to express these conflictual feelings within the therapeutic encounter, the therapist's anxiety-motivated avoidance of the client's expression is antitherapeutic.

Given the hypothesized relationship between anxiety and psychotherapeutic competence, it is fair to say that both an understanding and sensitive handling of the neophyte's anxiety are important prerequisites to the development of competent professionals. This is especially true since the neophyte's empathic use of self potentially entails exposure to a wide range of anxiety-provoking affects. A major source of anxiety and, therefore, clinical mistakes is a product of the beginner's struggle for a professional identity. Developmentally speaking, the neophyte lacks a professional sense of self and, consequently, he/she is quite susceptible to anxiety generated from issues of adequacy and competency. In an attempt to overcompensate for these feelings of anxiety and incompetence, the neophyte may try to prove him/herself to both client and supervisor. Buckley, Karasy, and Charles (1979) claim that the most prevalent mistakes of the neophyte are related to his/her professional identity formation and self-esteem.³ The authors comment that the beginners in their study seemed to be frequently preoccupied with impressing clients and

obtaining reassurance about their competence and skill from them.⁴ As a consequence of their struggle with establishing their own professional identity and attempting to enhance their own personal professional self-esteem, these therapists for example made premature or inappropriate interventions, overused intellectualization, or avoided necessary confrontations with the client.⁵

"The Teaching of Psychotherapy"

We have tried to demonstrate that the training of competent psychotherapists, in addition to providing the necessary academic and theoretical base, entails the accomplishment of two interrelated tasks: one, facilitating the development of a professional identity and self-esteem; two, expanding the trainee's therapeutic self-awareness (the latter has been previously discussed in Chapter I and II as the therapeutic self, or the capacity to empathically use one's self). The success of these tasks is primarily dependent on the particular "holding environment" (in Winnicott's sense) of the training program and its supervision.* We assume that an effective training program will help decrease the neophyte's anxiety and increase the neophyte's tolerance for anxiety) and there-

*Just as the mothering ones "holding" (emotionally and physically) of the infant facilitates ego development by protecting it from overwhelming anxiety, so too can the program will help decrease the neophyte's anxiety.

fore reduce the frequency of clinical mistakes.

If self-esteem, tolerance for anxiety, and therapeutic self-awareness are such critical factors in competent performance, then we might expect to see most psychotherapy training programs focusing on the development of these factors within the neophyte. We have argued that such development is best facilitated by a close scrutiny of the beginner's experience as he/she progresses through the training process. However, an examination of the literature on the teaching and learning of psychotherapy (Chapter I) reveals the lack of such a developmental and subjective focus on the beginner. Not only are these specifics of training competent psychotherapists unclear, but, as we discovered, there is confusion even around general approaches to the training.

While not specifically mentioned in Chapter I, the difficulties inherent in training clinical psychologists will be briefly considered here as a review of the problematic nature of the psychotherapist's training. The question of the most appropriate and efficient model for the training and education of psychologists has been a difficult one for the field. Initial attempts to answer this question resulted in the Boulder Conference of 1949. A product of the conference's efforts to develop a more formally specified pattern of graduate training in clinical psychology, the "Boulder Model" emphasized

training in research methodology, the basis of psychology as a scientific discipline; in concepts and skills in individual diagnosis and therapy; a one year clinical internship program; and research competence skills as exemplified by a doctoral dissertation.⁶ The concept embodied in this pattern of training was called the scientist-professional model.⁷ Such a model endeavors to train researchers, academicians, as well as psychotherapists and, according to Havens and Dimond (1970), is commonly manifest in today's training programs.

The specific coursework required of a clinical psychology student usually consists of studies in experimental, social, and biological psychology, perception, learning, motivation, personality, statistics and research methodology, psychopathology, early childhood development, and courses more directly geared to psychotherapeutic treatment. A curriculum design, however, is typically based on haphazard factors such as the interests and inclinations of existing faculty, the current fads in the field, the texts on the market, the educational philosophy of the Chairman, and the recommendations and/or dictates of the APA.⁸ Since there is, at present, no unifying theory within clinical psychology, most training programs have focused heavily upon content, such as theories and research, in their educational endeavors.⁹ Certainly these are important facets of

training, however, taken alone they tell the student little about what clinicians actually do or should do and may even lead to confusion rather than clarification.¹⁰ Because it has never been satisfactorily demonstrated that didactic courses in psychotherapy can really help teach a person how to do psychotherapy, the efficiency of the clinical component of these programs in developing competent psychotherapists is seriously questioned. Since a large number of people who enter clinical psychology programs do so in order to become licensed practitioners, and not necessarily researchers or academicians, the skills which they most want to learn may not be best taught. It is only more recently that graduate education has begun to consider a professional training paradigm, (Vail Conference, APA, 1973), in which the training is more directly oriented towards professional practice.¹¹

However, even within this model, too little attention is focused on the dual developmental tracks (professional and psychological--Chapter I) inherent in the psychotherapist's training experience. Consequently, the trainee's potential for learning and psychological growth as a therapist is not realized. As we have attempted to demonstrate, the adjuncts to training (i.e., skills acquisition, coursework, practicum experiences, etc.) have been mistakenly considered to be the major focus of training inadvertently relegating the

neophyte's developmental experiences to an unimportant status.

"The Role of Individual Supervision"

While formal theoretical training plays a role in the development of competent clinicians, most professionals involved in the training process (as well as students) consider the supervised clinical work to be the heart of the neophyte's professional development.¹²

According to Chessick, individual supervision is potentially the best teaching modality, depending on the supervisor.¹³ We have supported this belief because individual supervision is one of the few modalities* in which the neophyte's professional self-esteem and identity, therapeutic self, and anxiety tolerance may be directly and constructively developed. Supervision, in fact, may be the only component of a training program which has the access and ability to sensitively utilize these aspects of the neophyte's subjective experience of the learning process.

From the available literature on the teaching and learning of psychotherapy, however, it has become apparent that supervision does not directly focus on the neophyte's developmental experiences, i.e., his/her struggles for a

*Personal psychotherapy and/or psychoanalysis is a second modality, but, except for the education of psychoanalysts, it is not normally a training requirement.

professional identity and self-esteem, anxiety tolerance, and growth of the therapeutic self. One of the most influential works in this area, Ekstein and Wallérstein's The Teaching and Learning of Psychotherapy (1971), presents a model that describes how the learning process is affected by transference and countertransference phenomena, not only in the therapist-client relationship, but also in the therapist-supervisor relationship.¹⁴ While the authors attempt to understand the interpersonal distortions in learning psychotherapy, they do not utilize the immediate experience of learning from the student's perspective. For example, a preoccupation with his/her therapeutic inadequacy is a painfully realistic experience for the beginner and does not necessarily represent a transference or countertransference distortion. Nevertheless, such a preoccupation may have as equally a disruptive effect on the neophyte's performance as any transference or countertransference issue. Fleming and Benedek (1964), and Doehrman (1976) similarly offer psychoanalytical perspectives of learning psychotherapy which mainly focus on the parallel process between the neophyte's clinical work and his/her supervision. However, these authors only indirectly address the issues of the trainee's professional identity formation, anxiety tolerance, and development of the therapeutic self.

From the theoretical perspective of client-

centered psychotherapy a number of authors describe some of the desired outcomes of learning psychotherapy but do not give us a sense of the development it entails nor the specific focus of the supervision. For example, Traux and Carkhuff (1976), Rogers (1965 and 1967), and Carkhuff (1969) describe the characteristics of a successful therapist. However, they do not explicate the developmental stages that the student goes through to acquire these characteristics. While the client-centered approach to supervision "non-directively" encourages the trainee to develop a "genuine or congruent" stance (we equate this with the neophyte becoming aware of, and accepting of feelings that arise in the therapeutic encounter--an important prerequisite to utilizing one's self therapeutically), it remains unspecified how the supervisor works with the neophyte's anxiety, struggle for a professional identity, and emerging therapeutic self.

"The Nature of Effective Supervision"

Because supervision is such an idiosyncratic process its quality and efficacy may vary widely, even within the same training program. It seems reasonable to assume, therefore, that the success of a particular program is largely dependent on the ability of its supervisors. According to Chesseeck (1971), however, supervisors are often chosen more because of their availability or reputa-

tion as therapists rather than for their supervisory ability.¹⁶ Given the unsystematic nature in which clinical supervisors are selected, what we have considered to be the crucial factors in the training of competent psychotherapists have often been overlooked or underemphasized in supervision.

This brings us to the central problem which this dissertation has attempted to highlight, that is, because of the largely irrelevant focus of today's graduate training programs and the haphazard way in which supervisors are selected, much of the neophyte's clinical training is left to chance. Consequently, an ordinarily difficult training process becomes even more so, and the neophyte is left to struggle more intensely. This situation is unnecessary, since models presently exist in the field which would facilitate supervision and training. Since we have argued that the psychotherapeutic training process leads to significant changes in the neophyte's personality and sense of self,* it makes sense that models of personality development may provide important guidelines for more effective training and supervision.

Since supervision has been presented as the most critical part of training, it makes sense that the selection of more competent supervisors might be a logical

* (According to Ralph (1980), the changes that trainees report seem to be facets of ego development.)

first step towards improving the quality of a training program. Because individual supervision was said to walk a fine line between teaching and psychotherapy, it seems reasonable to assume that there would be some overlap between the qualities of a good therapist and those of a good supervisor. Clinical skills, an ability to empathically use one's self, an attitude of acceptance or unconditional positive regard, and an openness or honesty all contribute to the effectiveness of both therapist and supervisor. The clinical supervisor, like any good teacher, additionally must have an understanding of the learning process and a special sensitivity to the student's experience of this process. In the same way that successful psychotherapy is dependent on a clinician's developmental understanding of the client and his/her psychological level of functioning, successful supervision is largely dependent on the supervisor's possessing a developmental understanding of the training process and the student's particular level of functioning. According to Ralph (1980), a developmental understanding of the student's level of functioning is central in the teaching of psychotherapy and occurs intuitively among good teachers.¹⁷

We have similarly argued that such a developmental understanding is a crucial aspect of effective supervision providing the supervisor with an accurate basis for his/her interventions. However, it is just such a develop-

mental perspective which we found to be lacking in most supervision. As we have seen, the supervisor's interventions are traditionally geared to the client's particular behaviors and dynamics and, secondarily to the therapist's own involvement with these dynamics. Rarely are the trainee's developmental level (professionally speaking) and experiences considered as significant factors in his/her learning and performance. In the proposed model, effective supervision considers the client's specific dynamics in relation to the trainee's level of development.

For example, in the model which we present, the stages of training are roughly broken into symbiotic, differentiation-practicing and rapprochement after Mahler et al.'s (1975) separation-individuation process of early childhood. If a trainee from the symbiotic stage is given a controlling, highly defended client who continually challenges his/her authority we might expect that this trainee may variously experience anger, impotence, frustration, and feelings of inadequacy. While this client may evoke similar feelings in a rapprochement level trainee, supervisory intervention must necessarily be different in both cases.

In the first case, the supervisor must primarily focus on the stage specific vulnerabilities of the "symbiotic" trainee (i.e., inexperience, self-doubts,

feelings of inadequacy, low self-esteem, etc.) in preparing his/her supervisory strategy. The client's interpersonal style and dynamics cannot be adequately understood and dealt with until these particular developmental issues are addressed. Supervisory intervention at this point would be predominantly supportive, anxiety-binding, non-confrontative, and self-esteem enhancing.

In the second case, with a more advanced trainee, the supervisor must adjust his/her strategy to take into account the student's growing independence, reliance on self, and ability to better tolerate anxiety and confrontation. While this particular client may assault the trainee's self-esteem and feelings of competence, the latter's response is handled somewhat differently because there are different developmental issues inherent in the rapprochement phase. For example, a growing awareness of both the complexity of the psychotherapeutic process and the limitations of theory in providing answers (both characteristic of this phase) leaves the neophyte confused, self-doubting, and inclined to seek outside assistance for the "right" answers. Recognizing these issues, the supervisor encourages the neophyte to rely upon his/her self while discouraging this search for the all-knowing supervisor. The supervisor must help the trainee deal with both the client's particular dynamics and the stage specific developmental issues which are fre-

quently evoked by these dynamics.

While Ralph (1980) stressed that such a developmental understanding of the student occurs intuitively among good teachers, it is our contention that the training of psychotherapists should not be left to intuition alone. There are a number of additional skills and characteristics necessary for effective supervision, most of which can be taught. Supervision, therefore, like psychotherapy, requires specialized training. In the following discussion, we will begin to address the nature of this training by delineating what we consider to be the essential ingredients of a good supervisor. Such a supervisor creates a special kind of learning atmosphere or "holding environment" for the student. While the particular ingredients of this holding environment are important by themselves, they must be selectively utilized within a developmental framework of the student's level of functioning to be most effective. We will, therefore, conclude this discussion by offering such a developmental framework for the conducting of supervision. In addition to Mahler et al.'s (1975) separation-individuation process (Chapter IV), this framework is based on Coopersmith's (1967) work on the antecedent conditions of self-esteem (Chapter III).

An effective supervisor, like any good teacher, needs both a strong theoretical and experiential

background. The former is developed in a similar manner as the theoretical training of the psychotherapist from coursework and readings in the basic principles of psychology, normal and abnormal behavior, personality development, and the various modalities of psychotherapeutic assessment and intervention, to name just a few. In addition, the supervisor must also have a solid theoretical understanding of the supervisory process and its functioning. The necessary experiential background is derived from several years each of closely supervised clinical and supervisory work.

The supervisor's theoretical and experiential knowledge may only be valuable as a teaching tool in relation to his/her ability to convey such knowledge. The supervisor must be able to accurately assess the student's conceptual level of development since the information which he/she imparts must be consistent with the student's ability to comprehend and utilize this information. Content which is too complex and prematurely introduced will stimulate anxiety and confusion within the neophyte, interfering with learning and performance. The supervisor's ability to relate his/her knowledge in a sensitive, non-threatening manner also has an important impact on whether the student is able to utilize this information. In his/her entire presentation, the supervisor must create an atmosphere of trust and safety so that the

neophyte feels comfortable being open and vulnerable during the learning process.

One might expect that as a consequence of his/her theoretical and experiential background the supervisor ideally has developed a sense of competence, confidence, and professional self-esteem. These qualities have an important role in both how the supervisor handles the neophyte's feelings of incompetence, inadequacy and low self-esteem, and whether the beginner feels protected. A competent, confident, high self-esteem supervisor is a better role model for the neophyte and more able to effectively deal with his/her performance anxiety and low self-esteem than a supervisor who is less sure of his/her capabilities. Since the supervisor's modeling within the teaching relationship is a critical part of the teaching, the effective supervisor will demonstrate how to handle clinical problems; both in the way he/she discusses the neophytes' clients and in the manner that he/she interacts with the neophyte.

An important aspect of this modeling behavior is a non-judgemental acceptance of the neophyte as a learner. The supervisor must understand the naturalness and importance of the student's mistakes in the overall learning process and must communicate this understanding both verbally and non-verbally. The supervisor must let the student know that he/she is expected to make mistakes and

that these will serve as an invaluable source of growth. This is just one of the ways in which the supervisor functions as a type of "auxillary ego" in helping the student manage the anxieties and stress inherent in training. This particular supervisory function must be present for successful supervision to take place. As an important aspect of this management, the effective supervisor helps facilitate situations in which the neophyte can experience clinical successes, the latter playing a critical role in the neophyte's development of professional self-esteem. A basic way in which this is accomplished is in the supervisor's selection of appropriate clients for the student. A caseload with particularly disturbed or otherwise problematic clients may prove too conflictual for the beginner and leave him/her feeling ineffectual and overly discouraged.

The effective supervisor functions as a type of "auxiliary ego" for the neophyte in a number of other important ways. First of all, he/she provides the neophyte with a clear structure for how the supervision and psychotherapy will be conducted. Such a structure is multifaceted and generally consists of establishing basic groundrules (i.e., the time, frequency, duration, and setting for supervision; the establishment and definition of clear and realistic goals for both supervisor and supervisee; and the delineation of both supervisor's and

student's responsibilities within the learning and therapeutic settings). The supervisor's clarity around this structure provides the neophyte with a model for how he/she should conduct the psychotherapy. As a critical adjunct to this structure, the supervisor will not only allow for, but encourage individual expression within the established limits. This is done by building into the supervision a mechanism for questions, the expression of negative feelings, and the exploration of conflicting views. A periodic process of mutual evaluation also encourages the neophyte's self-expression and contributes to his/her feeling respected and accepted by the supervisor. Inherent in this structure and in the manner in which he/she conducts the supervision, the supervisor also attempts to instill a sense of ethics and responsibility within the neophyte. This entails modeling and teaching about clients' rights, confidentiality, and the maintenance of a professional stance.

In his/her role as "auxiliary ego," the effective supervisor also helps train the neophyte's therapeutic self. In fact, we have attempted to demonstrate that it is a consequence of the supervisor's functioning as an "auxiliary ego" that the neophyte's therapeutic self slowly emerges. In the process, the supervisor encourages the student to examine his/her reactions to the client and him/herself as important sources of clinical infor-

mation. In this way the supervisor focuses on the development of the student's observing ego. This is just one way in which the supervisor encourages the student to utilize his/her personality and interpersonal style in the treatment.

Because some of his/her reactions to both the client and supervisor frequently reflect problematic areas in the student's life, the supervisor's role as a teacher oftentimes may become blurred with his/her role as a psychotherapist. Since these problematic areas need to be identified in the process of training the student's observing ego, some of the supervisor's interventions may border on psychotherapy. We have argued, however, that effective supervision does not entail the supervisor functioning as the neophyte's therapist. Therefore, the supervisor must be able to maintain as clear boundaries as are possible in this regard, pointing out potential areas for psychotherapeutic exploration without becoming involved in the exploration itself.

"A Developmental Framework for Supervision"

This concludes our discussion of the supervisor's qualities, skills, and interventions which are inherent in good supervision. What is most essential here, however, is not merely that the supervisor possess these qualities and skills, but that he/she is able to carefully select

which particular ones are most appropriate given the neophyte's level of professional development. Thus, the supervisor must not utilize his/her interventions at random, but instead, sensitively gear them to the ever-changing needs of the student. This sensitivity is largely dependent on the supervisor's developmental understanding of the process of supervision. In the following section we will present a framework which will provide the supervisor with such a developmental understanding and therefore, a general guideline for conducting effective supervision with a beginning psychotherapist. The framework derives from the developmental analogy (established in Chapter IV), between the psychotherapeutic training process and Mahler et al.'s (1975) separation-individuation process of early childhood. It consists of the symbiotic, differentiation-practicing, and rapprochement stages.

In our presentation of these stages we will highlight the particular supervisory qualities, skills, and interventions mentioned above which we feel are most important in each stage. In our model, it is crucial to keep in mind, however, that a number of these supervisory interventions and tasks overlap between stages. To better understand the supervisor's role and interventions throughout the learning process, we discussed (Chapter IV, v) his/her developing an "optimal holding environment" for

the neophyte. We have said that the essence of this supervisory "holding" is a sensitive and gradual shifting of interventions to meet the student's everchanging needs. The model which we now present reflects the specifics of this "optimal holding."

We will refer to the neophyte's earliest experiences as a psychotherapist and in supervision as comprising the symbiotic period. In the analogous symbiotic period of early childhood we discussed, (Chapter IV), the infant's lacking a psychological self and his/her consequent dependence on the mothering one's function as an "auxiliary ego." The mothering one's nurturant behavior and management of the infant's anxiety were said to be critical to his/her healthy development. Similarly, we may understand the supervisor's primary role during the symbiotic period as that of "auxiliary ego." Because the neophyte is so easily overwhelmed by his/her feelings of low self-esteem, incompetence, anxiety, and confusion during this stage, it is crucial that the supervisor gear his/her interventions towards helping the beginner manage these feelings.

As in all stages, the supervisor must first accurately assess the neophyte's conceptual level of understanding so that he/she may then select the appropriate kinds of interventions which the beginner can best utilize. The supervisor's auxiliary ego function

during the symbiotic period must include the establishment of a trusting, acceptant, and non-judgemental learning alliance. He/she further helps to manage the neophyte's anxiety by establishing a clear structure (with all that this entails) for the supervision and delineating the specific ground rules for both the supervision and the neophyte's treatment. During this symbiotic period it is also critical that the supervisor select appropriate cases for the neophyte in order to facilitate the latter's experiencing of some success. Since experiences with failure and mistakes are an integral part of learning and especially prevalent during this early stage of training, the supervisor must gear his/her interventions towards helping the neophyte learn from, rather than punish him/herself for these mistakes. Finally, the supervisor's modeling during this period provides the neophyte with a basis for identification with a professional and a way to temporarily allay some of the early anxieties and confusions.

In Mahler et al.'s model, the symbiotic period is first followed by the differentiation, and then by the practicing periods. During this time the infant tentatively began to function separately from the mother. Less easily overwhelmed with anxiety, the infant practiced his/her newly discovered and ever-widening abilities. The symbiotic holding environment must gradually shift to both

allow for, and encourage the infant's separation from the mother and independent functioning. In a similar way we may understand the supervisor's role during the differentiation-practicing period of psychotherapy training as one which supports and gradually encourages the neophyte's experimentation with independent functioning.

After assessing the trainee's conceptual level of understanding, the supervisor must address a growing sophistication and independence in the student. He/she must therefore provide more complex theoretical and clinical information, helping the student integrate the two. While theoretical modalities which conflicted with the supervisor's would have proven too anxiety-provoking and confusing for the student during the previous phase, their introduction in this phase stimulates professional development. The supervisor must therefore support and encourage the student's experimentation with broadening his/her theoretical perspective and being different from the supervisor. In his/her selection of cases for the student, the supervisor must recognize the former's need for more challenge and his/her greater ability to constructively utilize mistakes and failures. While supervisory intervention was predominantly supportive in nature during the previous phase, the supervisor must recognize the student's need for, and ability to utilize

more critical kinds of feedback during differentiation-practicing.

As the student takes more risks within the clinical encounter and is exposed to more anxiety-provoking situations, his/her problematic personal issues frequently emerge within the supervision. During this period, therefore, the supervisor must be prepared to maintain clear boundaries between the neophyte's supervision and his/her personal psychotherapy, and recommend the latter, if necessary. The supervisor's modeling which was important in the symbiotic phase because it provided the neophyte with general guidelines for how to be a therapist is now more narrowly geared towards helping the student deal with specific clinical problems. While the supervisor encourages the neophyte to use his/her own resources and therapeutic self, he/she also realizes that at this point in the student's development, such a therapeutic self is still weakly formed.

In Mahler et al.'s model, after a period of intoxication with the greatness of his/her own functioning, the child gradually and painfully began to realize his/her separateness, powerlessness, and vulnerability. The dawning realization that his/her sense of omnipotence was merely an illusion shattered the child's confidence and sent him/her ambivalently back to the mothering one. During the period of rapprochement the

child alternatively struggled with dependence and independence making these conflicting demands on the mothering one. His/her sensitive handling of the child's "ambitendency," his/her emotional availability and gentle encouragement towards independence were said to be critical to the child's ultimate development of a healthy sense of self and identity. In a parallel manner, the neophyte goes through a type of rapprochement crisis, a renewed period of disillusionment, anxiety, and confusion with the process of psychotherapy. The essence of this rapprochement crisis is a growing awareness that the process of therapy is far more complex than initially believed, that theories cannot be relied on to provide all the answers, and, instead, one must rely on one's use of self as a therapeutic instrument. The supervisor's interventions during this rapprochement period must directly address these particular issues and sensitively support and encourage the student's reliance on self.

The theoretical and clinical information which the supervisor imparts during this period must underline the ambiguities and uncertainties that are inherent in the treatment process as well as the limitations of theory. In his/her presentation, the supervisor models that one theory or clinician does not have all the answers. The supervisor must gently discourage the student's idealization and blind identification with him/her by presenting

him/herself as having limitations, yet at the same time as being able to tolerate the ambiguities and pain of the therapeutic process. During this period the supervisor must again actively manage the neophyte's increased anxiety and renewed fears of failure, and encourage the student to make more use of his/her self to provide the accurate answers. Supervision during rapprochement importantly must train the neophyte's observing ego and empathic use of self, and discourage the searching for outside remedies.

Just as Mahler et al.'s final developmental stage in which the child was said to attain a stable identity and sense of self is open-ended at the older end, so too is the "final" stage in the trainee's professional development. In essence, professional development is not a static process and ideally an end point is never reached. Additional training and supervision gradually sharpen the developing clinician's therapeutic self. While the components of the supervisory "holding environment" which we have named are important when supervising a more advanced therapist, they are not nearly as critical as during the first three stages. During later development the supervisor's role becomes that of a type of troubleshooter, helping the now seasoned therapist see the specific area(s) where he/she is stuck with a particular client. The supervisor's role here is more parallel to

how supervision was discussed in the current literature, as focusing on issues of the therapist's countertransference.

It is our contention that the utilization of such a developmental framework for understanding the supervisory process and neophyte's needs will make an important contribution to the supervisor's overall effectiveness. The utilization of this kind of model entails close work with the neophyte's self-esteem. Since our literature review has led us to believe that self-esteem is a critical variable in learning and performance, and specifically in the psychotherapist's empathic use of self (his/her most valuable clinical tool), it seems reasonable to assume that supervision which sensitively gears itself to the fostering of the neophyte's self-esteem can be expected to facilitate the development of more competent psychotherapists.

ENDNOTES

Conclusion

1. Bandura. Albert, "Psychotherapist's Anxiety Level, Self-Insight, and Psychotherapeutic Competence," Journal of Abnormal Social Psychology, vol. 52, 1956, pp. 333, 336.
2. Ibid., p. 336.
3. Buckley, Peter, Toksoz B. Karasu, and Edward Charles, Psychiatry, vol. 136, no. 12, December 1979, p. 1579.
4. Ibid., p. 1579.
5. Ibid.
6. Nelson, Constance B., "Clinical Psychology: Historical Review," International Encyclopedia of Psychiatry, Psychology, Psychoanalysis, and Neurology, ed. Benjamin B. Wolman, vol. 3 (Aescularius Publishers, Inc., c.1977), p. 177.
7. Ibid.
8. Havens, Ronald A. and Richard E. Dimond, "A Proposed Education and Training Model for Clinical Psychologists," Teaching of Psychology, vol. 5, no. 1, February 1978, p. 4.
9. Ibid.
10. Ibid.
11. Ibid., p. 3.
12. Chessick, Richard D., How Psychotherapy Heals (Science House Pub., c.1969), p. 161.
13. Ibid.
14. Ekstein, R. and R. Wallerstein, The Teaching and Learning of Psychotherapy (New York: International Universities Press, c.1972).

15. Ibid.
16. Chessick, op.cit., p. 161.
17. Ralph, Norbert B., "Learning Psychotherapy: A Developmental Perspective," Psychiatry, vol. 43, August 1980, p. 243.

BIBLIOGRAPHY

- Abramowitz, Stephen, Lawrence Weitz, and Charles James. "Supervisor Self-Concept and Self-Concept Deterioration Among Psychotherapy Trainees." Journal of Clinical Psychology, vol. 30, no. 3 (July 1974):300-302.
- Adler, Alfred. The Practice and Theory of Individual Psychology. New York: Harcourt Publishers, c.1927. The Individual Psychology of Alfred Adler. New York: Basic Books, Inc., c.1956.
- Arlow, Jacob. "The Supervisory Situation." Journal of American Psychoanalytic Association, vol. 11 (1963): 576-594.
- Bandura, Albert. "Psychotherapist's Anxiety Level, Self-Insight, and Psychotherapeutic Competence." Journal of Abnormal Psychology, vol. 52 (1956):333-337.
- Bandura, Albert, David Lipsher and Paula Miller. "Psychotherapist's Approach-Avoidance Reactions to Patients' Expressions of Hostility." Journal of Counseling Psychology, vol. 24, no. 1 (1960):1-8.
- Beres, David and Jacob Arlow. "Fantasy and Identification in Empathy." Psychoanalytical Quarterly, vol. 43, no. 1 (1974):26-50.
- Bergin, Allen. "The Effects of Psychotherapy: Negative Results Revisited." Journal of Counseling Psychology, vol. 10, no. 3 (1963):244-249.
- Bernard, Janine M. "Supervisor Training: A Discrimination Model," Counselor Education and Supervision, September, 1979, pp. 60-68.
- Bernstein, Bianca L. and Conrad Lecomte. "An Integrative Competency-Based Counselor Education Model," Counselor Education and Supervision, September 1976, pp. 26-36.
- Blanck, Gertrude and Rubin Blanck. Ego Psychology, Theory, and Practice. New York: Columbia University Press, c.1974.

- Boyd, J. Counselor Supervision, Muncie, Ind.: Accelerated Development Press. c. 1978.
- Brammer, L. The Helping Relationship, Process and Skills, Englewood Cliffs, N.J., Prentice-Hall Pubs. c.1973.
- Buckley, Peter, Toksoz Karasu and Edward Charles. "Common Mistakes in Psychotherapy." American Journal of Psychiatry, vol. 136, no. 12 (December 1979):1578-1580.
- Cameron, Norman. Personality Development and Psychopathology. Boston: Houghton Mifflin Publishers, c.1963.
- Carkhuff, R.R. Helping and Human Relations (2 Vols.) New York: Holt, Rinehart, and Winston, c.1969.
- Chessick, Richard D. How Psychotherapy Heals. Science House Publishers, c.1964.
- Cohen, Mabel Blake. "Countertransference and Anxiety." Psychiatry, vol. 15 (1952):231-143.
- Combs, Arthur. "Intelligence from a Perceptual Point of View." In The Self, In Growth, Teaching, and Learning. Edited by Don Hamachek. Prentice Hall, Inc., c.1965.
- Cooley, Charles Horton. Human Nature and the Social Order. New York: Charles Scribners and Sons, Inc., c.1922.
- Coopersmith, Stanley. The Antecedents of Self-Esteem. W. H. Freeman and Company, c.1967.
- Cutler, Richard. "Countertransference Effects in Psychotherapy." Journal of Consulting Psychology, vol. 22, no. 5 (1958):349-356.
- Dodge, Jacqueline. "Reducing Supervisee Anxiety: A Cognitive-Behavioral Approach," Counselor Education and Supervision, September 1982.
- Dunner, Lawrence and Jacob Schonfield. "Affect Contagion in Beginning Psychotherapists." Journal of Clinical Psychology, vol. 31, no. 2 (April 1975):332-334.

- Ekstein, R. and R. S. Wallerstein. The Teaching and Learning of Psychotherapy. New York: Basic Books, Inc., 1958.
- Erikson, Erik H. Childhood and Society. W. W. Norton Company, Inc., c.1950.
- Fitts, William H. "The Self-Concept and Psychopathology." Dede Wallace Center Monography No. 4, Nashville, Tennessee, c.1972. "The Self-Concept and Performance." Dede Wallace Center Monograph No. 5, Nashville, Tennessee, c.1972.
- Fleming, J. and T. Benedek. Psychoanalytic Supervision. Grune and Stratton, c.1966.
- Ford, E. S. C. "Being and Becoming a Psychotherapist: The Search for Identity." American Journal of Psychotherapy, vol. 17 (1963):472-482.
- Freud, Sigmund. Dora: An Analysis of a Case of Hysteria. Collier Books, c.1905,1963. A General Introduction to Psychoanalysis. New York: Garden City Publishers, c.1924.
- Fromm, Eric. Man For Himself. Rinehart Publishers, c.1947.
- Fromm-Reichman, Frieda. Principles of Intensive Psychotherapy. Chicago: University of Chicago Press, c.1950.
- Goin, Marcia and Frank Kline. "Countertransference: A Neglected Subject in Clinical Supervision." American Journal of Psychiatry, vol. 133, no. 1 (January 1976): 41-44.
- Greenson, Ralph. "Empathy and its Vicissitudes." International Journal of Psychoanalysis, vol. 41 (1960): 418-424.
- Hadley, Suzanne W. and Hans Strupp. "Contemporary Views of Negative Effects in Psychotherapy." Archives of General Psychiatry, vol. 33 (November 1976):1291-1302.
- Hall, Calvin S. A Primer of Freudian Psychology. Mentor Books, c.1954.

- Halpern, Howard and Leona Lesser. "Empathy in Infants, Adults, and Psychotherapists." Psychoanalysis and Psychoanalysis Review, vol. 47 (1960):32-42.
- Hart, G.M. Models of Supervision. Paper presented at the Annual Meeting of the American Personnel and Guidance Association, Washington, D.C. March 1975.
- Hartmann, Heinz. Essays on Ego Psychology. New York: International University Press, c.1964.
- Havens, Ronald and Richard Dimond. "A Proposed Education and Training Model for Clinical Psychologists." Teaching of Psychology, vol. 5, no. 1 (February 1978): 3-10.
- Heimann, Paula. "On Countertransference." International Journal of Psychoanalysis, vol. 31 (1950):81-84.
- Horney, Karen. Neurosis and Human Growth. New York: W. W. Norton Publishing Company, c.1950.
- Ivey, A.E. Microcounseling: Innovation in Interview Training. Charles C. Thomas Pub., Springfield, Illinois, c.1971.
- Ivey, A.E., C.J. Normington, C.D. Miller, with Morrill, and R.F. Haase. "Microcounseling and Attending Behavior: An Approach to Prepracticum Counselor Training," Journal of Counseling Psychology, 1968, 15(5) pp. 1-12.
- Jacobs, Theodore. "Posture, Gesture, and Movement in the Analyst: Clues to Interpretation and Countertransference." Journal of American Psychoanalytic Association, vol. 21 (1973):77-92.
- Jakubowski-Spector, Patricia, Richard Dustin, and Rickey L. George. "Toward Developing A Behavioral Counselor Education Model," Counselor Education and Supervision, Spring 1971, pp. 242-250.
- James, William. Principles of Psychology, 2 vols. New York: Holt, Rinehart and Winston, Inc., c.1890.
- Klagsbru, S. "In earch of an Identity." Archives of General Psychiatry, vol. 16 (March 1967):286-289.

- Kohlberg, Lawrence. "Counseling and Counselor Education: A Developmental Approach," Counselor Education and Supervision, June 1975, pp. 250-256.
- Kohut, Heinz. The Analysis of the Self. New York: International University Press, c.1971. The Restoration of the Self. New York: International University Press, c.1978.
- Langs, Robert J. The Technique of Psychoanalytic Psychotherapy, vols. 1 and 2. New York: Jason Aronson, c.1974.
- Little, Margaret. "Countertransference and the Patient's Response to it." International Journal of Psychoanalysis, vol. 32 (1952):32-40.
- Littrell, John M., Nancy Lee-Bordin, and John Lorenz. "A Developmental Framework for Counseling Supervision," Counselor Education and Supervision, December 1979, pp. 129-136.
- Lower, Richard. "Countertransference Resistances in the Supervisory Situation." American Journal of Psychiatry, vol. 129, no. 2 (August 1972): 70-74.
- Mahler, Margaret, Fred Pine, and Anni Bergman. The Psychological Birth of the Human Infant. New York: Basic Books, c.1975.
- Marks, Malcolm. "Conscious/Unconscious Selection of the Psychotherapist's Theoretical Orientation." Psychotherapy: Theory, Research and Practice, vol. 15, no. 4 (Winter 1978):354-58.
- Martin, Jack, Bryan Hiebert, and Ronald Marx. "Instructional Supervision in Counselor Training," Counselor Education and Supervision, March 1981, pp. 193-202.
- Mead, George Herbert. Mind, Self, and Society. Chicago: University of Chicago Press, c.1934.
- Nadler, Raoul. "Utilizing Reflected Countertransference." Canadian Psychiatric Association Journal, vol. 21 (1976):145-150.
- Nelson, Constance B. "Clinical Psychology as a Profession." In International Encyclopedia of

Psychiatry, Psychology, Psychoanalysis and Neurology, vol. 3. Edited by Benjamin Wolman. Aesculapius Publishers, Inc., c.1977.

- Perlman, Gerald. "Change in Self- and Ideal Self-Concept Congruence of Beginning Psychotherapists." Journal of Clinical Psychology, vol. 28, no. 3 (July 1972):404-408.
- Ralph, Norbert. "Learning Psychotherapy: A Developmental Perspective." Psychiatry, vol. 43 (August 1980):243-250.
- Reich, Annie. "On Countertransference." International Journal of Psychoanalysis, vol. 32 (1951):25-31. "Further Remarks on Countertransference." International Journal of Psychoanalysis, vol. 41 (1960):339-395.
- Reusch, J. Therapeutic Communication. New York: W. W. Norton Company, 1961.
- Rogers, Carl R. Client-Centered Therapy. Boston: Houghton Mifflin Company, 1951.
- Rosenberg, Morris. Society and the Adolescent Self-Image. Princeton: Princeton University Press, 1965.
- Schafer, Roy. "Generative Empathy in the Treatment Situation." Psychoanalytic Quarterly, vol. 28 (1959): 342-371.
- Scheflen, A. E. "The Significance of Posture in Communication Systems." Psychiatry, vol. 18 (1955): 135-146.
- Sharaf, M. R. and D. J. Levinson. "The Quest for Omnipotence in Professional Training." Psychiatry, vol.27 (May 1964):135-149.
- Singer, Erwin. Key Concepts in Psychotherapy. New York: Basic Books, Inc., 1965.
- Sullivan, Harry Stack. "The Meaning of Anxiety in Psychiatry and in Life." Psychiatry, vol. 11 (1948):1-13. "The Theory of Anxiety and the Nature of Psychotherapy." Psychiatry, vol. 12 (1949):3-12. The Interpersonal Theory of Psychiatry. New York: W. W. Norton, Inc., c.1953.

- Tarachon, Sidney. An Introduction to Psychotherapy. New York: International Universities Press, Inc., c.1963.
- Tauber, E. S. and M. R. Green. Prelogical Experience. New York: Basic Books, Inc., c.1959.
- Traux, Charles. "Effective Ingredient in Psychotherapy: An Approach to Unraveling the Patient-Therapist Interaction." Journal of Counseling Psychology, vol. 10, no. 3 (1963):256-263.
- Traux, C. and R. Carkhuff. Toward Effective Counseling and Psychotherapy, Training and Practice. Chicago: Aldine, c.1967.
- Wheelis, Allen. "The Vocational Hazards of Psychoanalysis." International Journal of Psychoanalysis, vol. 37 (1956):171-184.
- Winnicott, D. W. The Maturation Processes and the Facilitating Environment. New York: International University Press, c.1965.
- Wylie, Ruth. The Self-Concept. Lincoln, Nebraska: University of Nebraska Press, c.1961.
- Wylie, Ruth. The Self-Concept, Vol. II. Lincoln, Nebraska: University of Nebraska Press, c.1978.



