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Learning an empathic use of self :: a study of therapists-in-training.

Joan M. Copperman
University of Massachusetts Amherst

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LEARNING AN EMPATHIC USE OF SELF:
A STUDY OF
THERAPISTS-IN-TRAINING

A Master's Thesis Presented
by
JOAN M COPPERMAN

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

MASTER OF SCIENCE

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Psychology

LEARNING AN EMPATHIC USE OF SELF:

A STUDY OF

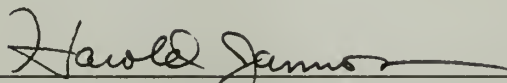
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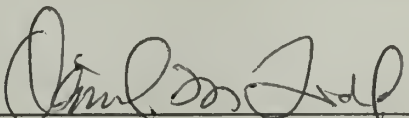
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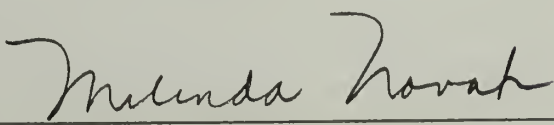
JOAN M. COPPERMAN

Approved as to style and content by:


Harold Jarmon, Chairperson


David Todd, Member


Howard Gadlin, Member


Melinda Novak, Chair
Department of Psychology

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Sometimes while discouraged, I could only muster enthusiasm with fantasies of writing these acknowledge-

ments, an act that symbolized completion! However, now that that time has come, I write them with some sadness because this marks the end of Hal Jarmon's involvement with my clinical training. Hal has brought to his involvement with students a breadth of vision and depth of wisdom that has encouraged me to approach these years of training as an opportunity to become as fully myself as possible. I thank him deeply for the permission that he models to be a manch despite enviromental opposition.

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CHAPTER I

INTRODUCTION

Overview

This study began as an investigation into the clinical trainee's experiences of projective identification. The literature on projective identification describes this phenomenon as a powerful and often frightening experience. Casement (1985) suggests that familiarity with the concept of projective identification could help clinicians understand certain aspects of countertransference. A familiarity with this concept would appear to be an important part of clinical training.

After gathering the data it became clear that trainees' experiences with projective identification were not clearly delineated from experiences with countertransference or empathy. The study has evolved into looking at how trainees learn to use their internal experience in the service of understanding their clients.

The data analysis examines the issues involved for trainees as they learn an empathic use of self. The salient themes include the following: learning to alternate between the observing and experiencing parts of the ego; learning to identify the origin of affect; and

problems in empathizing. The literature review section analyzes the concepts of empathy, projective identification and countertransference to provide a foundation for the discussion. Additional relevant literature will be examined in the discussion section.

Empathy

Over thirty years ago Theodore Reik (1937) bemoaned the lack of consensus about the concept of empathy:

I note with a certain envy that my difficulty in describing the process of psychological comprehension adequately does not exist for many psychologists. Faced with my problem, the expression 'empathy' readily occurs to their minds and flows from their pens. Indeed this expression sounds so full of meaning that people willingly overlook its ambiguity. To speak of empathy has on occasion been as senseless as to discuss sitting in a box without distinguishing whether one means a compartment in a theatre, the driver's seat or a big case. The word empathy sometimes means one thing, sometimes another, until now it does not mean anything. (pp. 356-357)

When he wrote this, Reik was making one of the first, if now little recognized contributions to the literature on empathy. This now voluminous literature abounds with sophisticated analyses of the psychological processes that underlie a therapist's empathic functioning, analyses that are varied and often contradictory.

Empathy exists outside the clinical setting but its more specific clinical usage departs significantly from how it is understood in everyday usage (Beres & Arlow, 1974; Berger, 1987; Schafer, 1959). Everyday usage has

blurred the essential neutrality of the empathic process (Basch, 1983b). Too often, empathy is understood as having positive feelings for another, "especially love, compassion, and sympathy, and particular forms of behavior, specifically indulgence, gratification, and infantilization" (Basch, p.122). Berger suggests that in everyday usage the essential neutrality of clinical empathy is lost due to the understanding that an empathic person could be described as: "sensitive to the needs and feelings of others;..tactful, altruistic, sympathetic, indulgent" (p. 5). Greenson (1960) also differentiates empathy from feelings such as sympathy, pity, or sorrow.

A clinician's empathic functioning denotes a special mode of perceiving the inner experience of a patient. It is an "emotional knowing" of the state of another, a sharing in or an experiencing of the other's feelings (Berger, 1987; Greenson, 1960). In a clinical setting not only the conscious state is shared but the unconscious experience as well. Schafer (1959) offers a definition that emphasizes that it is all levels of the patient's mind that is shared. He names the functioning of a therapist as "generative empathy" to distinguish a therapist's empathy from other forms:

Generative empathy may be defined as the inner experience of sharing in and comprehending the momentary psychological state of another person. Specifically, what is to be shared and comprehended is a hierarchic organization of

desires, feelings, thoughts, defenses, controls, superego pressures, capacities, self representations and representations of real and fantasied personal relationships. (p. 345)

Though subjectively empathy is seemingly simple, it is actually a complex psychological process (Buie, 1981) and too often taken for granted (Beres & Arlow, 1974). It is usually understood as occurring preconsciously and automatically (Schafer, 1959), and as involving both the therapist's conscious and unconscious reactions. Empathy is generally seen as involving affective responsiveness and cognitive mediations. A subjective sense of losing the boundaries between the self and one's object or a merging of the internal representations of self and other are often part of empathic activity (Beres & Arlow, 1974; Olinick, 1969; Schafer, 1959; Sandler & Rosenblatt, 1962); as is an ego regression on the part of the therapist (Fleiss, 1942; Issacharoff, 1984; Schafer, 1959; Olinick, 1969). Most of the literature about the mechanisms that underlie a therapist's empathic responsiveness reference these aspects. However, there are many explanations of the empathic process and there is little agreement about how empathy occurs. The following four bases of empathic functioning will be reviewed here: identification, affective resonance, a working model of the client, and inference. Buie, Basch (1983b) and Berger (1987) provide analyses of metapsychological considerations and disagreements,

questions and consensus amongst different views of empathic functioning. This study considers empathic functioning to be primarily based upon identification.

Identification

Fleiss (1942) is credited with having first conceptualized empathy as based upon a therapist's identification with a patient's repressed impulses. However, two earlier works presaged his contribution, works which possibly were overlooked since they did not adhere to the "classical" view that countertransference is a hindrance to treatment.

In 1926, embedded in a paper on the occult processes in psychoanalysis, Helene Deutsch offered some visionary yet neglected observations about the nature of both empathy and countertransference. She suggested that the formation of unconscious identifications with the patient's infantile wishes and impulses was the basis for a therapist's empathy: "...empathy is precisely the gift of being able to experience the object by means of an identification" (p. 137). It is only through analyzing his¹ affective response that the therapist is able to understand this response as an identification with his patient's material:

1. Regarding terminology: In keeping with the terminology of those I quote, a terminology that reflects both their reality and their bias, I will use the male pronoun in this section. In the discussion section, I will use the female pronoun to refer to the therapist, as this more accurately reflects my interview subjects.

The affective psychic content of the patient, which emerges from his unconscious, becomes transmuted into an inner experience of the analyst, and is recognized as belonging to the patient (i.e., to the external world) only in the course of subsequent intellectual work. (1926, p. 136)

Reik (1937) suggested a similar process of unconscious arousal in the therapist which made possible a deeper understanding of a patient. As an early proponent of the usefulness of such feelings, Reik argued that it was through attending to his inner affective response that a therapist is able to understand the unconscious communication from a patient:

The united or conflicting effect of the (patient's) words, gestures, and unconscious signals, which point to the existence of certain hidden impulses and ideas, will certainly not at first stimulate the observing analyst to psychological comprehension. Their first effect will rather be to rouse in himself unconsciously impulses and ideas with a like tendency. The unconscious reception of the signals will not at first result in their interpretation, but in the induction (in the analyst) of the hidden impulses and emotions that underlie them. (p. 193)

and

The observation of other people's suppressed and repressed impulses is only possible by the roundabout way of inner perception. In order to comprehend the unconscious of another person, we must, at least for a moment, change ourselves into and become that person. (p. 199)

Though he termed this process a "temporary introjection" he paralleled Fleiss's ideas on identification (Tansey & Burke, 1989).

Fleiss (1953) suggested that in empathic functioning, the therapist takes the patient into himself "in order to experience (the patient's) feelings" (p.280). He termed this process a "trial identification" and formulated empathy as:

a person who uses empathy on an object
introjects this object transiently, and
projects the introject again onto the object.
(1942, p.214)

Fleiss believed that this trial identification allowed for "introspection on an object that while external, has become internal for the moment" (1953, p. 280). He suggested that such a sequence of introjection, introspection and then (re)projection allowed for a particular type of reality testing: the scrutiny of the thoughts and feelings of the patient inside the therapist. This process allowed for the experiencing of the patient's feelings as one's own. Fleiss appears to limit the range of what is taken in to be only that of repressed impulses. Others broaden the range to include defenses against that impulse (Schafer, 1959; Beres & Arlow, 1974; Olinick, 1969).

Deutsch, Reik and Fleiss all write within a drive theory perspective; consequently, that which is identified with is conceptualized as infantile wishes and impulses, not internalized object relationships. In a groundbreaking work in which he argued that a therapist's countertransference is useful, Racker (1957)

conceptualized two types of identifications that occur with patients' internal representations. The first he termed a "concordant identification": the therapist's identification with the ego or conscious experience of the patient. Sandler (1987) has elaborated this as the therapist's identification with the patient's phantasy self representation of the moment. A "complementary identification" is the therapist's identification with the patient's internalized objects; or with the object representation in the patient's transference phantasy (Sandler). With few exceptions, (Beres & Arlow, 1974; Deutsch, 1926; Schafer, 1959; Tansey & Burke, 1989), empathy has been considered to consist of only concordant identifications.

Beres and Arlow (1974) developed the role that identification plays in the empathic process and termed it as a "transient identification." They suggested that there were

two distinguishing features to empathy: one, it is a transient identification; second, the empathizer preserves his separateness from the object. (p. 33)

The "transient identification" is experienced as "feeling with" the patient, or as sharing in the patient's affect. The resulting "sense of oneness" with the object must be "followed by a sense of separateness" which is able to occur when the therapist breaks off the transient identification and replaces "the thinking and feeling

with the patient" to "thinking about the patient" (p. 39). Thus, Beres and Arlow emphasize that empathy involves a cognitive component as well as a sharing of affect. The therapist must separate from the transient identification and switch from participation in the patient's affective state to trying to understand what has been unconsciously communicated. The therapist must use his affect as a cue to make this switch:

The affect experienced by the therapist we suggest is in the nature of a signal affect, a momentary identification with the patient which leads to the awareness, 'This is what my patient may be feeling. (p. 35)

Beres and Arlow suggest that narcissistic individuals face difficulties empathizing due to their desire to merge with their object for narcissistic gratification and consequent difficulties in maintaining a sense of separateness.

Objections have been raised to conceptualizing empathy as based upon identifications because such a use of identification departs from its usual usage as denoting a defense mechanism or as involved in the process of structuralization (Berger, 1987; Buie, 1981). Buie concludes that authors who consider identification as the basis for empathic functioning are using the term identification in a "nontechnical descriptive sense" (p. 29). Identification is used to imply the taking in of the object of empathic focus but a change in the empathizer that would be expected from a usual process of

identification does not occur. In contrast, Tansey and Burke (1989) say the identifications involved in empathy do change the empathizer and contribute to the formation of a special structure-the therapist's work ego.

Basch (1983b) agrees that the term identification is not used in the usual sense of internal structural change to be like another:

The identification that takes place in an empathic encounter is not with the other person per se, but with what he is experiencing. It is a matter of concluding that one's own affective state duplicates that of the other, the presumed similarity permitting one to identify one's own affective position as representative of the other's mental state at a particular moment. (p. 105)

Nonetheless, the use of the term identification highlights that there is an "involuntary, unconsciously mediated transformation within the analyst that is fundamental for the empathic experience" (Basch, p. 106).

Working Model

Greenson (1960) contends that empathy is not based upon an identification process. He offers the alternative view that empathy is based upon utilizing a "working model" of a patient. By "listening through" the working model the therapist attempts to experience the patient's feelings. Greenson describes a working model:

- a) All I know of the patient: experiences, modes of behavior, memories, fantasies, resistances, defences, dreams, associations, etc. All this is the skeleton and basic structure.
- b) I diminish the quantity of resistance.
(The working model of the patient within me is not merely a replica of the patient. If that

were so, the model would have the same resistances as the patient and would not supply me with clues. The model has resistances and defences similar in quality but less in degree.)

c) I add my conception of his potentials.

d) I add my theoretical knowledge and clinical experience.

e) In addition all my experiences with similar kinds of people and situations-real or fantasied. (p. 422)

Greenson suggests that since empathizing means to share in another's feelings, the analyst must actually "become involved in the emotional experiences of the patient" (p. 420). This necessitates a split in the therapist's ego functioning to allow for an oscillation between participating in and observing the emotional experience. At times of experiencing, the working model is shifted into the foreground and what is "peculiarly or uniquely" the therapist is de-emphasized and isolated. Greenson suggests that only those therapists who are secure in their sense of identity can tolerate the "temporary de-cathexis" of one's self image that is necessary for empathy.

Under successful empathic listening the patient's communications will produce what Greenson calls an "aha" experience:

I use the term 'aha' to epitomize that involuntary and pleasant sensation of suddenly grasping and understanding something hitherto obscure. (p. 421-422)

This experience serves the same purpose as a "signal affect" (Beres & Arlow, 1974) and alerts the therapist to

analyze what has occurred. Greenson specifies that these stages do not happen in a linear sequence but occur intermittently, automatically, quickly and preconsciously.

Affective Resonance

The interplay of affective responses and cognitive analysis of those responses has been emphasized thus far. Basch (1983b), in contrast, suggests a model for empathy that is primarily affective. He believes what others have termed trial or transient identifications should be understood as instances of "affective resonance." Affective resonance-the ability to be effected by another's affective display-stems from the emotional communion experienced between mother and infant. Affective resonance is a process by which the therapist generates in himself a similar affective state by virtue of an unconscious imitation of the facial and bodily expressions of the patient. A capacity for empathy is rooted in early infantile experiences of merger (Basch, 1983b; Ferreira, 1961; Olden, 1953).

Inference

Buie's (1981) view of empathy is rooted more in cognitive than affective processes although he does acknowledge the importance of the latter in some cases of affective communication. He concedes that early infantile experiences of affective communication may play a role in empathic functioning but argues that empathy is more a cognitive than affective process. Buie says that

empathy is an "ordinary" perceptual process involving inferential reasoning about the patient's inner state:

Empathy depends on sensory perception of behavioral cues from the object about his inner state. The empathizer compares these behavioral cues with one or more kinds of referents in his own mind which could be expressed by similar behavior. He then infers that the inner experience of the object qualitatively matches that associated with his referent. (p.305)

The processing of these cues is both conscious and unconscious. The therapist compares these perceived cues against internal referents and then draws inferences about the patient's inner experience. Buie identifies four categories of such internal referents.

Self-Experience Referents consist of memories available to the analyst from his own past and can be represented as "impulses, affects, body feelings and superego pressures" (p. 291). What others call temporary identifications could fit here though Buie specifies these referents have a low affective intensity.

Imagination Imitation Referents are created when no self-experience referents fit the patient's material.

Resonance Referents are the most likely to correspond to the actual inner state of the patient and could correspond with Basch's view of empathy. These occur when the strong affect experienced by the patient stimulates the same affect in the analyst. Buie says affect contagion is a natural response to strong emotions in others. The analyst's affective intensity exceeds

those felt through the self-experience referents. Conceptual Referents have the least affective arousal and are primarily cognitive. These abstract concepts represent the analysts general knowledge and are drawn from artistic, literary and mythological frameworks. There also exist specific conceptual referents which are "comprised of particular self and object representations as well as certain introjects." Included here also is a referent of an internal model of the patient (Greenson, 1960). Buie specifies that the empathic process is vulnerable to three limitations: the desire of a patient to not be empathized with; the therapist's inadequate referents; and the inherent uncertainty of the inferential process.

Schafer (1959) does not offer a model of the empathic process but in his discussion of how clinical empathy differs from other forms of empathy incorporates many of the above ideas. He stresses that empathy requires both affective and cognitive elements. Relying too heavily upon cognition prevents the kind of ego regression that is necessary for sharing in another's experience. Relying too exclusively upon affect results in "intolerable reactivity involving an illusion of identity, fusion of the ego with the object" (p. 349). Echoing Beres and Arlow (1974), Schafer stresses that the experienced affect is to serve as a signal for understanding the patient. Like Greenson (1960), Schafer

suggests that over time, "an internal image of the patient is built in the therapist's mind, an image based upon "partial introjections, emotional reactions, and revival of memories concerning oneself and the object" (p. 351).

Projective Identification

Projective identification is most simply defined as "unconscious projective fantasies in association with the evocation of congruent feelings in others" (Ogden, p. 1). Projective identification is about a person splitting off feelings or internal representations and producing in someone else emotions or experiences which resemble their own. What is important about this is the activation of feelings in others in addition to the projective activity. Projective identification addresses the phenomenon of how one person (the projector) uses another person (the recipient) to contain an unwanted or an endangered aspect of the self. In a clinical context, projective identification addresses the phenomenon of clients using their therapist to contain unwanted or less often, threatened parts of themselves.

Projective identification is most commonly thought of and learned as a primitive defense mechanism, which, along with splitting, is characteristic of individuals with an underlying borderline character organization. In this context, it is considered to be a primitive and pathological process. In contrast, while acknowledging

the reliance on projective identification as a defense mechanism utilized by borderlines, others (Grotstein, 1981; Horwitz, 1983; Langs, 1976; Malin & Grotstein, 1966; Ogden, 1982; Scarf, 1986) consider projective identification to occur at all levels of personality organization/functioning and to be a common dynamic in close relationships. Most importantly, some authors (Malin & Grotstein, 1966; Ogden, 1982; Bion, 1959) view a therapist's handling of a projective identification as the main source of change in psychotherapy.

Ogden (1982) delineates the following functions of projective identification, all of which can be part of a clinical encounter:

- 1) a type of defense by which one can distance oneself from an unwanted or internally endangered part of the self, while in fantasy keeping that aspect of the self alive in the recipient;
- 2) a mode of communication by which the projector makes himself understood by exerting pressure on the recipient to experience a set of feelings similar to his own;
- 3) a type of object-relatedness in which the projector experiences the recipient as separate enough to serve as a receptacle for parts of the self but sufficiently undifferentiated to maintain the illusion of literally sharing the projector's feeling;
- 4) a pathway for psychological change by which feelings similar to those which the projector is struggling with are processed by the recipient, thus allowing the projector to identify with the recipient's handling of the engendered feelings (pp. 36-37)

Significant confusion and controversy surround the topic of projective identification. Finell (1986), Meissner (1980) and Whipple (1986) are among those

critical of the concept. Projective identification has been used to explain various psychological phenomena; its meaning has changed over time; and it deals with both intrapsychic and interpersonal realms of experience, often without adequately differentiating between the two (Ogden, 1982; Horwitz, 1983). Both self and object representations can be projected and there are numerous motivations for projective identification: the wish to rid the self of unwanted self objects or wishes to dominate, devalue, control and fuse with the recipient (Horwitz, 1983). Finally, discussions of projective identification often do not adequately distinguish it from the concept of projection nor adequately distinguish between the projector and the recipient.

Distinctions drawn between projective identification and projection are inconsistent but two of the most common are relevant to the clinical encounter. The first concerns the degree of splitting that accompanies the projection (Grotstein, 1981). Ogden (1982) argues that the degree of splitting in projection is more complete, whereas in projective identification, the projector maintains a connection with what is projected. In projective identification:

...the projector subjectively experiences a feeling of oneness with the recipient with regard to the expelled feeling, idea or self-representation. By contrast, in projection the aspect of the self that is in fantasy expelled is disavowed and attributed to the recipient. The projector does not feel kinship with

recipient; on the contrary, the recipient is often experienced as foreign, strange, and frightening. (pp. 34-35)

Langs (1976) similarly argues that in projective identification the projector maintains a tie to what is projected. He says that in projective identification, the term identification is not being used in an incorporative direction but in an externalizing direction:

The term identification is applied in an unusual manner in the term projective identification; it refers to the subject's continued attachment to-identification with-the contents that he has externalized and to his efforts to evoke an identification in the object. (p. 277).

Consequently, a blurring of boundaries between the projector and recipient occur in projective identification but not in projection.

The second distinction drawn between projection and projective identification is that in the later, the recipient is affected and made to experience himself in accordance with what is projected; whereas in projection there is no impact upon the recipient. Ogden (1982) emphasizes the interpersonal aspects of this concept to highlight the effect on the recipient as a result of the interpersonal pressure which accompanies the projective activity.

One approach to distinguishing between projection and projective identification on the basis of their effect on the recipient is Horwitz's (1983) distinction

that directionally, projection is onto and does not necessarily penetrate the recipient. A projective identification, in contrast, sinks into the recipient and modifies the latter's self perception. In projection, all that is distorted is the perception of the projector.

Many distinguish projective identification from projection by the interaction that is part of projective identification (Finell, 1986; Gillman, 1980; Langs, 1976; Tansey & Burke, 1985; Ogden, 1982). Langs eloquently states this distinction by defining projection as the projector "intrapsychically attributing" whereas projective identification is an attempt to "interactionally place" (p.259) an aspect of the self into the recipient. The interaction element is also emphasized in Casement's description of projective identification as the

product of interactional pressures upon the analyst from the patient, which are unconsciously aiming to evoke in him the unbearable feeling state which the patient could not on her own yet contain within herself. (1985, p. 292)

Unlike projection which is solely the disavowal of fantasy or feeling on the client's part with no impact on the therapist, projective identification involves the therapist experiencing the client's feelings within him/herself. The therapist's feelings occur as a result

of the client's verbal and nonverbal behavior and are experienced as part of countertransference.

Another important distinction between projection and projective identification is that in the latter the client identifies with the therapist, whereas in projection the therapist is experienced by the client as alien or estranged. This is sometimes an important feature of projective identification in that the element of identifying with the therapist is an attempt to "master" what has been projected by seeing how the therapist deals with it.

Ogden delineates three phases to projective identification:

In the initial phase, the projector unconsciously fantasizes getting rid of an aspect of the self and putting that aspect into another person in a controlling way. Secondly, via the interpersonal interaction, the projector exerts pressure on the recipient to experience feelings that are congruent with the projection. Finally, the recipient psychologically processes the projection and makes a modified version of it available for reinternalization by the projector. (p. 36)

Ogden calls the second phase the induction phase. During this phase the recipient is pressured by the projector to experience himself in ways that correspond to the unconscious fantasies and to identify with what has been projected. Communication and a form of object relatedness are functions of this phase.

Ogden develops the third phase as being the process by which psychological change occurs. This is the phase

where the projection is processed by the recipient and given back to the projector for reinternalization. During this phase the recipient experiences himself in accordance with the unconscious fantasy but the feelings are modified due to having been introjected by a more integrated personality. Ogden asserts that due to the recipient's idiosyncratic personality the processing of any projection is incomplete, but to the extent that the projection is processed by the recipient and reinternalized by the projector, psychological growth in the projector results. Reinternalization can range according to the maturational level of the projector from introjection to identification, thus precipitating different degrees of change. As part of a therapeutic process, this phase can involve "offering" back the projection in the form of an interpretation. It can also involve behaving differently than the client in dealing with the projected feelings. Psychological growth is promoted by the therapist providing alternative ways of handling the feelings through making the modified projection available in the form of interpretations or interpersonal interaction.

Others agree that the successful handling of a patient's projective identification is the basis for change in psychotherapy. Bion (1959) posits as the single most important form of interaction between patient and therapist, the containment and processing of

projective identifications in the more integrated personality of the therapist. He emphasizes the importance of the therapist remaining open to the patient's projective identification, in some ways for similar reasons that a mother remaining open to an infant's projective identification is necessary for normal development: "projective identification makes it possible for him to investigate his own feelings in a personality powerful enough to contain them" (p. 314). In subscribing to the view that therapeutic change involves structural change in the ego (Leowald, 1960), Malin and Grotstein (1966) suggest that

(P)rojective identification helps explain the development of these higher levels of ego integration....We suggest, moreover, that this method of projecting one's inner psychic contents into external objects and then perceiving the response of these external objects and introjecting this response on a new level of integration is the way in which the human organism grows psychically, nurtured by his environment....The essence of the therapeutic process is through modification of internal object relationships within the ego, and this is largely brought about by projective identification (p. 28).

Ogden concurs:

The idea that there is something therapeutic about the therapist's containment of the patient's projective identification is based upon an interpersonal conception of individual psychological growth: one learns from (in fantasy, 'takes in qualities') another person on the basis of interactions in which the projector ultimately takes back (reinternalizes) an aspect of himself that has been integrated and slightly modified by the recipient. (1982, p.40)

Kernberg (1965) also asserts that the modification of a patient's complementary projective identification may "provide a cornerstone of the work with a particular patient" (p. 48).

A patient is able to grow from how the therapist contains and deals with a projective identification because often what is projected is unbearable and intolerable to the patient. It is for this reason that it has been projected. In this light the importance of the therapist's containing and tolerating the experience becomes apparent. Casement (1985) suggests that patients perceive when the therapist cannot tolerate the feelings either. The patient experiences the therapist as "thrown off balance" and "the sense that these feelings are unmanageable is traumatically confirmed" (p. 82). A therapist's management of a patient's projective identification helps the patient see that another being has been able to tolerate the experience. It is stressed that along with reinternalizing the projection, the patient also takes in some of the therapist's capacity to tolerate the feelings. (Casement; Malin & Grotstein, 1966). A failure of containment confirms the patient's worse fears.

Additional importance in therapy of projective identification is in making available to the therapist

through his own experience data about the internal world of the patient that would not otherwise be understandable:

The therapist who has to some extent allowed himself to be molded by this interpersonal pressure and is able to observe these changes in himself has access to a very rich source of data about the patient's internal world-the induced set of thoughts and feelings-which are experientially alive, vivid, and immediate. (Ogden, 1982, p. 4)

A third implication for the therapeutic relationship is the use of projective identification for understanding counter-transference. Through understanding a countertransference reaction in response to a projective identification, previously hidden aspects of the transference can be illuminated. Ogden (1982) sees countertransference reactions as resulting from both "concordant" and "complementary" identifications. Others (Finell, 1986; Horwitz, 1983) delineate the countertransference reactions that result from a patient's projective identification as only complementary identifications in that the therapist unconscious reaction complements the patient's conscious experience. Sandler (1987) associates the view that projective identification consists of concordant identifications with Bion's (1967) notions of the therapist as a container.

It is important to consider how an understanding of projective identification helps a therapist to understand

his countertransference reactions. A common theme runs through the literature that a projective identification produces a feeling that one is not being oneself (Grinberg, 1962), or is acting out of character (Gilmore & Krantz, 1985) or playing a part in another's fantasy (Ogden, 1982). Often this is a judgement that is reached retrospectively since the therapist's unconscious participation often precedes his recognition.

The issue of countertransference reactions as a result of a projective identification illuminates a problematic implication of this concept. Finell (1986) Meissner (1980) and Whipple (1986) object to the blurring of boundaries between self and other implied in the description that the therapist receives a projected part object of a client. Ogden suggests that the threat this poses is one reason the concept has been resisted. While a defensive stance of maintaining a rigid view of impenetrable and fixed boundaries precludes an appreciation of this concept, the question being raised of what mental content belongs to the patient and what to the therapist is an important one. Ogden suggests that

When the therapist suspects that he has developed an intensely held, but highly limited view of himself and the patient that is in an important sense shared by the patient, he is very likely serving as an object of the patient's projective identification. (p. 73)

Empathy and Projective Identification

Empathy and projective identification have usually been considered to be very different mechanisms occurring at different times in the therapeutic process. Projective identification is usually associated with intense negative affect and countertransference disruptions. Empathy, on the other hand, is often associated with positive countertransference:

The empathic experience...as it is traditionally defined, is characterized in the therapist by feelings of harmony and closeness with his patient, as well as by the experience of positive self-regard for performing a job well. (Tansey & Burke, 1989, p. 56)

An alternative view is presented by Tansey and Burke. They argue that these concepts do not refer to different realms of experience but that such a distinction arose in part due to the theoretical framework out of which each concept developed. The concept of empathy was developed by ego psychologists and is understood as an intrapsychic process within the therapist, whereas projective identification grew out of a relational perspective. They assert that there is "a fundamental sameness between what is typically referred to as the processing of a projective identification and the objective scrutiny of an empathic trial identification" (p. 63).

According to Tansey and Burke, both empathy and projective identification involve projective activity by the client:

We propose that in the process of a therapist's achieving empathic contact with his patient, some degree of projective identification from the patient is virtually always involved... (An) empathic trial identification does not spring full blown in the mind of a therapist. In addition to the therapist's receptivity, the achievement of empathic contact always involves the interpersonal "sending power" of the patient such that the induced trial identification is the outcome of a radically mutual interactive process.
(p. 62)

Additionally, both empathy and projective identification involve an identification on the part of the therapist. This is consistent with others who view empathy as based upon trial identifications. However, like some others (Beres & Arlow, 1974; Deutsch, 1926; Schafer, 1959), Tansey and Burke broaden empathy to include complementary as well as concordant identifications: the therapist identifies with the patient's phantasied object representations as well as with phantasized self representations (Sandler, 1987). They concur with those who understand projective identification to involve the client's interactional pressure on the therapist to form an identification with the projected contents.

Tansey and Burke's concern is not with a metapsychological rearrangement of terms but with how therapist's handle and utilize countertransference. They see empathy and projective identification as interrelated aspects of countertransference and feel that projective

identification provides an important pathway to empathic receptiveness that is often overlooked. They suggest that empathy and projective identification have been differentiated by four characteristics:

the intense versus mild impact on the therapist, the intrapsychic versus interpersonal nature of the process; pathology versus normality; and the therapist's degree of conscious control over versus unconscious reactivity to the experience. (p. 61)

Having recast empathy as more of an interpersonal process than an intrapsychic one, they also question the other distinctions drawn between empathy and projective identification:

In attempting to examine how a patient communicates with a therapist and influences him to respond in one way or another, the decision about the degree of coerciveness, disruptiveness, intensity, or psychopathology involved is essentially arbitrary. We have concluded that much is to be gained from recognizing the commonality between the easily, quickly, and preconsciously processed 'flash' experience of empathy and the much more difficult, at times even tumultuous, processing of an exceedingly uncomfortable projective identification that involves considerable time and conscious energy. (pp. 63-64)

Countertransference

For the purposes of this study countertransference is viewed as the totality of the therapist's emotional reactions to the client, and includes both the conscious and unconscious reactions of the therapist; the "'real' as well as the neurotically 'distorted'" (Tansey & Burke, 1989, p. 10). This "totalist" perspective contrasts with a "classical" view of countertransference which defines

countertransference as the therapist's pathological and unconscious reaction to the client's transference.

Two factors motivate such an adherence to a totalist view of countertransference. Foremost is the belief that the therapeutic process involves a relationship between two people, both of whom contribute to the emotional climate which is created. According to Kernberg (1965),

A totalist concept of countertransference does justice to the conception of the analytic situation as an interaction process in which past and present of both participants, as well as their mutual reactions to their past and present fuse into a unique emotional position involving both of them. (p. 41)

The second factor is the belief that countertransference represents an extremely useful investigatory tool into the client's emotional life. A therapist's unconscious perception of a client, such perception being manifested by countertransference reactions, is potentially much more attuned to the client's unconscious than a therapist's conscious reasoning (Heimann, 1950; Reik, 1937). A classical view of countertransference implies that such reactions are wrong and to be overcome. Such a view fosters a "phobic attitude" on the part of the therapist towards his own emotional reactions, an attitude that limits understanding the client.

When the analyst feels that his emotional reaction is an important technical instrument for understanding and helping the patient, the analyst feels freer to face his positive and negative emotions evoked in the transference

situation, has less need to block these reactions, and can utilize them for his analytic work. (Kernberg, 1965, p. 40)

Considering countertransference reactions as useful mitigates against the possibility that such reactions will be acted upon or discharged out of a wish to not acknowledge them.

Tansey and Burke (1989) argue that the once intensely debated distinction between a classical and totalist view has evolved to a generally held view that the therapist's experience is "potentially-though not necessarily useful" (p. 34). They suggest that the convergence of these formally divergent views has resulted from two factors: a more sophisticated understanding of empathy as central to the therapeutic process; and to the development of the concept of projective identification and the role it plays in psychotherapeutic change. New schools in psychoanalytic theory that emphasized the interpersonal nature of the therapeutic process as well as the increasing popularity of an object relational framework facilitated both these changes.

Tansey and Burke suggest that the classical-totalist debate has evolved into an increasing focus upon classifying the source of therapists' reactions. Whether therapists should have reactions is debated less than how to understand and use these reactions. Attempts exist to classify the therapist's reactions along a continuum:

therapists' reactions range from being a "reflection of the patient's internal world and a response to the interactional pressures" (p. 35) to reactions stimulated in the patient's presence but which "emanate predominantly from the therapist's essentially private concerns" (p. 35). Lakovics (1983) offers one such classification of the sources of countertransference:

TOTAL COUNTER- TRANSFERENCE	SOURCE	TIME	TREATMENT
Concordant Identifi- cation	Originates in the patient but is experienced by the therapist.	Develops from patient's pre- sent self experience.	If recog- nized and understood, can be ex- tremely use- ful in treat- ment, if un- recognized, can become a hindrance.
Comple- mentary Identifi- cation	Same	Develops from patient's past experiences of early objects.	Same
Inter- actional Reactions	Originates from the interaction and personality characteristics of the therapist.	Develops from current here/ now exper- iences of therapy.	May be a hin- drance and sometimes useful de- pending on whether they are under- stood, incor- porated, and used with therapeutic interven- tions in mind.

Life Events	Originates from the therapist's life experiences outside of therapy.	Develops from current thera- pist life experiences	May be use- ful or may be a hindrance.
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Institu-
tional
Counter-
transference

Classical Counter- transference	Originates in the therapist.	Develops from therapists past (neurotic) conflicts.	Hindrance
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CHAPTER II

METHODS

Subjects

Interview subjects were ten students enrolled in the Clinical Psychology Program at the University of Massachusetts at Amherst. All students seeing clients at the training clinic within the psychology department were contacted (see Appendix A) and invited to participate in the study. Subjects were informed that the study would investigate experiences with projective identification of therapists-in-training and that familiarity with the concept of projective identification was not necessary for participation in the study. There was only one criterion for participation: subjects should either currently be in or have received psychodynamic supervision in the past. It was emphasized that one's chosen orientation need not be psychodynamic. This criterion was established due to my assumption that experiences with projective identification would be most likely to occur and be noticed in treatments that were non-directive.

Of the approximately 20 students contacted, 15 responded. Of these 15, one declined to participate due to lack of time. Three trainees were not invited to

participate because they did not satisfy the criterion. This left 11 respondents. The original number desired for participation was 10 trainees with the hope that these 10 would represent a range of experience. Since only two men responded, the decision was made to interview both men. A decision was made to eliminate one respondent from the level of experience most heavily represented. The eliminated respondent was randomly chosen. The final 10 subjects represented the following levels of experience: (1) 2 trainees with 3-4 years of seeing clients; (2) 5 trainees with 2-3 years of seeing clients; (1) 3 trainees with less than a year of seeing clients. There were two men and 8 women. Of the 10 trainees interviewed, six considered their orientation to be primarily psychodynamic; one trainee combined psychodynamic with a systems orientation, one with behaviorism. Four trainees expressed that they either did not have an orientation or were still finding one.

Many of the ideas in this thesis are explored along developmental lines. The pseudonyms and levels of experience of the interview subjects are as follows:

<u>3-4 years of experience</u>	<u>2-3 years of experience</u>	<u>less than one year of experience</u>
Rebecca	Wendy	Dorothy
Sharon	Sara	Peter
	Michael	Isadora
	Jane	
	Elizabeth	

Setting

The Psychological Services Center (PSC) is the training clinic run by the Clinical Psychology Program at the University of Massachusetts. The program offers exposure to psychodynamic, behavioral and family systems orientations and PSC teams reflect one of these three orientations or a blending within a more eclectic framework. Teams are composed of one faculty member, a teaching assistant, (T.A.), who is an advanced trainee, and five to seven trainees. Trainees usually carry a caseload of three clients and receive an hour of supervision a week from both the faculty leader and the T.A. Additionally, most teams utilize peer supervision within a case presentation format.

PSC participation is required the first two years of training and is optional thereafter; many advance trainees opt to continue with ongoing clients in long term treatment. Trainees start seeing clients either the summer after their first year or the beginning of their second year. During the first year participation on teams consists of observation of therapy sessions and team discussions.

Interview

The interview was semi-structured in format (see Appendix B). Interview questions were aimed at eliciting discussion of two types of clinical experiences: (1) those involving strong emotions on the part of the

therapist; (2) those where the therapist had experience him/herself in a similar way to how their clients experienced themselves. This approach was taken to explore clinical experiences which might have involved projective identification but were not defined as such. The last part of the interview asked directly about experiences with projective identification.

The interviews took place in March and April of 1988. Most interviews lasted approximately one and one half hours. The interviews with the two most advanced trainees lasted two and one half hours. Participants were assured of their confidentiality and that of their clients and were asked to sign an informed consent (Appendix C).

Analysis of Data

My first step in the data analysis was to make verbatim transcripts of each interview. I then spent several weeks familiarizing myself with these transcripts by reading and rereading them. It became evident that trainees experiences with projective identification were not clearly distinguished from experiences with empathy and other sources of counter-transference. Additionally, important themes related to the general process of learning psychotherapy emerged from my initial analysis of the data. These themes included: (1) The differentiation of the origin of affect; (2) Issues about empathy and the loss of boundaries; (3) Trainees own

experiences in therapy or personal growth apart from therapy; (4) Identifying with clients; and (5) Reactions to how emotionally involving clinical work was.

At this point in the analysis the experiences of these trainees gave a vivid picture of some components of clinical training but there was no framework for the discussion. I decided to return to the literature to search for a more comprehensive understanding of what it was that I was looking at. I immersed myself in the literature on empathy. I found particularly helpful analyses of the communication of affect in the clinical setting and discussions of how therapists use their own emotional reactions. In reading the literature on psychotherapy training, I realized much of the data illuminated issues related to trainees' developing abilities to use their inner experience in understanding their clients. The final organization of the data examines how trainees learn an empathic use of self in their clinical work. While I have developed a theoretical framework to understand my interview data, I have presented the data in such a way that allows the subjects to speak for themselves and invites the reader to interact with the trainees' words and thoughts.

CHAPTER III

THE THERAPEUTIC USE OF SELF

Introduction

The concepts of countertransference, empathy and projective identification provide a foundation for exploring the meaning of a therapist's inner subjective experience. Attunement to one's inner experience is considered by some to be their most reliable source of data about a client: it is a widely held belief that "the experience of the therapist while he is in interaction with the patient plays a central role in psychoanalytic understanding of the therapeutic process" (Berger, 1987, p. 39).

The examination of one's own inner experience to understand a client's involves the therapeutic use of one's personality: the use of one's self. A therapist's use of herself as an "instrument to observe the psychological life" (Basch, 1983b) of her patient is the main instrument of investigation in psychoanalytically informed psychotherapy. A therapist's affective responses, fantasies, associations and somatic experiences (Thompson, 1980) are all means for understanding what is being communicated by one's patient. While it is an empathic "use of self" that is

widely considered to be the essence of the psychodynamic therapist's role (Goldberg, 1984; Berger, 1987), the receiving and processing of clients' projective identifications has also been considered by some to be part of an empathic use of self (Tansey & Burke, 1989).

In part, a therapist's use of self involves entering into the emotional world of the client: a critical aspect of the use of self is "a willingness to be exposed to the emotional climate generated by the client and the threat of change this entails" (Goldberg, 1984, p. 35). Additionally however, a therapeutic use of self consists of alternating between such emotional involvement and a reflection upon what this emotional experience means. Descriptions of this process are found in Sullivan's discussion of the term, "participant-observer"; the oscillation between the observing and experiencing parts of the therapist's ego (Jarmon, in press, Schafer, 1959); and the observing and experiencing functions of the therapist's work ego (Olinick, 1973). In an early writing, Deutsch (1926) maintained that a therapist had to master both positions of being an observer and a participant in order to oscillate between emotional involvement and distant objectivity. Reik (1937) asserted that as a participant in the emotional interchange the therapist is a part of what is observed. Goldberg (1984) emphasized that the therapist must enter

the client's world but then return to her own self to maintain the clinical perspective required for effective intervention.

The importance of this balance is illuminated by the comments of an advanced trainee. Sharon's comments illustrate why it is not enough to participate in the client's experience without reflecting on its meaning.

I think it could become empathy if I wanted to let it happen that way, I mean if I wanted-I think it becomes empathy when you put consciousness into what's happened to you. You can lose yourself and become disorganized by what somebody is doing to you without it being empathic, it only becomes empathic when you recognize what the feelings are in relation to that person and that these feelings that you're having are like them...You could imagine two hysterical people together, and how they could get themselves worked up to tizzy-not therapist and client, but like they're firing off of each other. They're catalysts, but they are not necessarily empathizing. They're definitely mushing boundaries. But a therapist and client, I could imagine having a hysterical client and sort of getting caught up in that upward spiral and that swirl and at the same time keeping an eye on it and saying: 'Oh, this is a little breathless, this is what that feels like, this must be what it felt like to her when she had to take her driver's test, it felt like this!' That's when it becomes empathy.

To learn to be an effective participant-observer in the clinical interaction is an arduous developmental process and represents a "complex, cognitive and affective achievement" (Goldberg, 1984, p. 145). Trainees must learn first that their internal experience is a potential source of information and not to be feared or eliminated. Exposing oneself to the emotional

climate generated by a client can be a threatening adventure for many reasons, some of which will be highlighted throughout this thesis. It is especially threatening before one learns that one's inner experience is an important part of the therapeutic encounter.

This chapter will explore the experiences of therapists-in-training in learning to become participant-observers in the clinical encounter. It will explore first how trainees react to realizing that the work involves such intense emotional participation. Learning to observe what is experienced will be explored in the section on the observing self.

The Literature on the Development of a Therapeutic Use of Self

Given the centrality of the use of self in the clinical encounter, surprisingly little is written about the development of this ability in therapists-in-training. Although much of the literature explicates a therapist's use of self in its empathic and analyzing functions, little is said about the developmental vicissitudes of learning to use one's internal responses as an instrument of therapeutic investigation and understanding.

In an interview study conducted on supervisors and therapists-in-training, Ralph (1980) suggests that therapists progress through the following four "milestones" in learning to be therapists:

- 1) Learning the role of the psychotherapist as a nondirective 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.

The therapeutic use of self could be seen as corresponding to the last stage in this developmental scheme. Ralph suggests that understanding that one's affective and cognitive responses are clinically useful represents the highest developmental achievement of a "therapist centered" approach. He says this learning is facilitated when trainees have a conceptual understanding of why their feelings and reactions are useful. This developmental step is achieved when a therapist learns to trust her reactions as a "source of information rather than as an unwanted and anxiety provoking intrusion" (p. 246). The comments by Sara, a trainee in her 3rd year, underscore the developmental nature of this achievement. She bemoaned how she still felt unable to use her inner experience.

Will I ever? I think that's a weakness. I don't use my feelings enough. Sometimes it's easier not to. I think I'm just learning now to notice myself in the therapy room, instead of just focussing on the client. I'm just starting to notice what's going on with me at

the time. Which for the first year I didn't do hardly ever. And didn't want to either!

Sara's comments also illustrate Ralph's assertion that "for many students the ability to use their own feelings, reactions and intuitions in a more spontaneous way is connected with being more comfortable in the role of therapist" (p. 247).

The third milestone identified by Ralph lays the foundation for understanding the importance of one's inner experience:

A third conceptual milestone for trainees is the discovery of what is perhaps the core of dynamically oriented psychotherapy-psychotherapy as an interpersonal process involving the feelings and reactions of both therapist and patient. It represents a movement from a more concrete approach that focuses on the content of the hour, what the patient said and did, to a relationship-centered approach that focuses on the metacontent of the hour-that is, the feelings and emotions developed in the patient-therapist relationship which generated that content. (p. 246)

Therapists in training must learn that their inner experience is a source of information about their client. They must learn to attend to and use their emotional reactions in the service of understanding their clients.

Sharaf and Levinson (1964) describe some developmental difficulties that are inherent in the therapeutic use of self. They propose that clinical training is characterized by a quest for omnipotence. Given that therapists-in-training are individuals with

the highly developed intellectual abilities necessary to enter competitive training programs, trainees must now develop their emotional sides and become more open to the experiential aspect of clinical involvement. In describing the change from valuing intellectual insight and conceptual knowledge to valuing an emotional way of knowing, they say that therapists-in-training, in their quest for omnipotence, move from a desire for omniscience to a desire for "omniscience." They suggest that trainees, "new to the world of affective interchange" in the clinical setting, long for the apparent "omniscience" of more experienced practitioners who demonstrate an "emotional elasticity" and "range of gut responses."

Marguelis (1984) elaborates on the issue that therapists-in-training, having succeeded at intellectual accomplishments, must now learn to value emotional involvement. In reflecting upon his own seminal training experiences, he recalls how he was challenged to "put aside his knowledge" in order to learn to listen to patients. As an experienced and senior clinician, he has grown to appreciate a supervisor's admonition that knowledge not be used defensively against the pain that "could not be borne" (p. 1031). He recalls that his supervisor questioned whether he and his highly intellectually accomplished peers "could stand to listen" (p. 1031) to their patients.

Changing from an intellectual to the experience near approach necessary in the clinical endeavor requires that one be able to tolerate uncertainty. Bion (1959) writes of the importance of not knowing to allow for the emergence of the not yet known. In order for both therapist and client to learn about the client, the therapist must tolerate uncertainty and the anxiety from "forestalling closure" (Goldberg, 1984) on what is understood about the patient's experience. Thompson (1980) borrows from Winnicott (1971) and stresses that the ability to use one's inner experience is enhanced by an ability to sit with "muddle." Not knowing and sitting with muddle often have to be learned by therapists-in-training.

A therapeutic use of self demands an emotional involvement that can challenge experienced clinicians. As beginning therapists, the scariness, intensity and demands of such emotional involvement is that much more challenging: therapists-in-training are still developing the skills needed to make use of this involvement. Before trainees gain appreciation that their inner experience is useful, emotional involvement is seen as even more problematic. As we turn to the experiences of therapists in training, we will see therapists grappling with the emotional demands of the work in learning the use of self.

The Experience of the Emotional Intensity of the Work

The emotional intensity of the work came as a surprise to virtually every therapist-in-training interviewed. Throughout the interviews trainees described how challenging and emotionally demanding clinical training is. Therapists spoke often of feeling affectively overwhelmed and of doubting themselves. For instance, Dorothy conveyed her surprise that the work was so emotionally intense. Her views of her early experiences are colored by her work with Tina, a borderline client, with whom the work was especially evocative:

I never really expected to feel any of these kinds of-it's like being on a roller coaster. That's what it feels like a lot of times. I didn't expect that at all. None of it. So this is all somewhat unusual in terms of what I would have predicted a priori...I didn't think that it would have that depth...I don't feel out of control any more but at the beginning-kind of out of control or just so unaware-not in the sense of crazy out of control but so unaware of what's going on-like 'What the fuck is this? I don't understand this!

One of Dorothy's reactions was to question whether she could handle the work. She described having fantasies of saying "Uncle, I've had enough, I didn't want to do this anyway!" Looking back on these times Dorothy felt:

It's scary to think that I could have had those feelings; that I just wanted to quit; that I just didn't want to do this...It was scary to see that I could just fall apart like that. Or move to the fantasy of saying 'I just have to get out of-just throwing my books down and

having a temper tantrum. ...I was in for more than I had bargained for...So that's why it's scary-can I do it?

Early in her training Dorothy had been shaken from receiving her client's projective identifications. Unable to identify how she could be made to feel so intensely, Dorothy felt out of control. She characterized herself as experiencing extreme emotions:

But the scariest one was-well I think all of them combined on a bad day that it would be so overwhelming that I would think about quitting: 'I made a mistake; I shouldn't do this; see, I can't do this-I get so involved in it!' That was the scariest part of it all...I would be so fucking angry. Or just so fucking confused. Extreme forms of emotions.

While much of Dorothy's reaction reflects her experiences with Tina, she feels that doing psychodynamic therapy requires a greater emotional involvement than she expected. She contrasted her training experiences with previous work:

I think just the nature of this kind of therapy. In behavioral therapy I would have never gotten involved in these kinds of issues...Because it's really getting into some of the deep issues, it requires the person really being deep and I think you have to dig in deeper than that. It's not something that I knew was going to happen...I think it's draining. I think it's given me an appreciation for how difficult it is for people to go through some of these things.

Peter also recounted feeling that he just could not tolerate how anxious he had sometimes felt in the beginning. He recounted with amusement his reaction before seeing a client who had ragefully stormed out of their previous session.

I had a panic attack. I never had anything close to that in the past. I felt 'I can't do this-I'm leaving-I'm going to Brazil! I can not be in the room with this woman for 50 minutes.' I was shaking. I had heard about panic attacks before but never came close to it before.

Can One Be Competent if the Work is So Emotional?

Doubts arose not only about tolerating the intensity of the work but also about what it meant that one was so reactive. These doubts seemed to arise because of lack of recognition that one's emotional responses are useful and integral to the work. One expression that these concerns took was whether one could be competent given the intensity of the reactions. Elizabeth was one of several therapists who questioned this. She described her reaction to a number of affectively laden sessions:

I've felt sometimes after a session just very full of emotion, sometimes able to identify them, sometimes not. In a way that I'm not use to feeling after a session. It happened several times in a row. Having it happen to that extent was strange, and a little disturbing: 'How am I going to be a good therapist if after a session I feel like this?'

Peter expressed a similar concern upon his realization that clinical work was so emotionally evocative. He thought this made it more complicated than he had originally envisioned. In response, Peter felt:

Incompetent. It seems like it's really hard to do-almost impossible. On one hand I thought: 'Ok, this is hard stuff, it's going to take a long time and a lot of work to be good at this'...But on the other hand wondering if it's a challenge that's just too big and wondering if I was ever going to get good at it.

Emotional Involvement Was Seen As Indicating Personal Weakness

Another form that self doubt seemed to take was in therapists' concerns that their emotional reactivity indicated personal weaknesses or psychological problems that made them unsuited to the work. For instance, Dorothy felt that

it was such a weakness that I could be feeling this way. Like god, I thought I was stronger than this; I should be able to take this more.

Sharon was another therapist who experienced her reactivity as diagnostic that she was unsuited to the work. Like Dorothy, she had worked with a disturbed client early in training and found herself experiencing her client's "craziness." Consequently, she had sustained similar feelings of surprise, fear and self doubt:

I was initially frightened by it, and I thought it meant that I was crazy, and that it meant that I was a bad-that I shouldn't be a therapist because I could be so easily swayed by the wind in the room...It's a useful tool to let that happen to you-it took me longer to realize it as that rather than simply understanding what was going on. That interim phase was when I was still a little thrown by the fact that I was so vulnerable to it. Also medical school syndrome: That I had everything in the book and here was proof...Yeh, it made me feel like I was crazy, or that there was barely concealed craziness. But I look at that now differently too. I'm not so sure that that's wrong, but I think it's fairly true of everyone. And it just depends on how strong the defense systems are. So I'm not as threatened by the fact that that might be true as I used to be...(But) what I felt at that time was that I was indeed crazy; I had been hiding it from everybody and had a great front,

and all it took was one client to prove that my front was useless! I wasn't sure if I was borderline or what, but I knew it was way down developmentally!

Sharon alluded to how letting herself be affected by the emotional climate in the room, or in her words, letting herself be swayed by the wind in the room, is a useful tool. She did not yet feel that she has it under her control to the degree that she would like.

In contrast, Rebecca, the most advanced therapist interviewed, had grown to be more comfortable with the emotional intensity of the work. She felt that working with countertransference was one of the most interesting aspects of the work and articulated clearly her developmental process with learning to use her self in the room. She said in the beginning she had been "buffeted" by having countertransference reactions that she had not known how to understand or use. Like other trainees, the beginning period had engendered considerable distress. She summarized her process of learning to tolerate the emotional intensity of the work:

Starting off just feeling all these things, even in the beginning not even being aware of them except to feel some discomfort or to just feel bad about myself for having those kinds of feelings. Giving me all sorts of self doubts about "Can I do this work because I'm so reactive?" Having to go home and think about clients, thinking I don't want to have to take these problems home with me. So starting off it feels like a really hard kind of thing...It made me wonder if I wanted to do this kind of work, basically. Because, it was early enough that I didn't know this was part of the work: 'Maybe there was something wrong with me-maybe

I'm not cut out for this. Because I don't think this happens to everybody because look at me; I'm crawling into bed-Therapists don't usually do this. I've known therapists who seemed a lot more at ease.' So I would doubt myself and my ability, thinking it was more my problem rather than it was an inherent part of the work. Within that step would be: 'God, maybe this is part of the work! Do I want to do it?! It's happening every time! And it seems like some other people around me are doing this too! Ahh!' (Then) came this kind of resignation: 'This is part of it.' But let me think. It took a long time until I could almost not care about having feelings...So going through: like at first, not wanting to have these feelings, then resignation that part of being a therapist means having strong feelings, then there was a lot of judgements on those feelings, like 'Oh my god, I'm hating my client', maybe this is saying so and so about my client but it's also saying I have this-I don't want to know that or it forced me to look at myself and-ooh, I don't want to know that I have this.' Then there was a real excitement, like 'Ooh, I had this countertransference reaction', or 'Oh, I can have this range of feelings'; this sort of high on myself about it. It was really exciting to feel something really strongly and even more exciting to be able to do something with it. And then it's sort of developed into this 'all in a day's work' kind of attitude. Like I don't feel the same kind of guilt I used to feel when I'd get angry, or feel like it was wrong or right in this major excited way. There's just a lot more tolerance and acceptance. It's not like it's a blah now, because that has a negative connotation. But just an acceptance that the same way that a carpenter uses a saw, this is what I use. And I don't go home with this stuff anymore. Except when things are very intense.

Mourning The Realization That The Work Is So Involving

Rebecca's summary highlights additional issues in learning that clinical work is so emotionally evocative. She felt ambivalent that emotional involvement is part of the work because she feared that being a therapist would

mean being emotionally overwhelmed much of the time. She questioned whether she wanted to be a therapist, followed by an almost depressive resignation to the realization that clinical work involves such a use of self.

Dorothy also expressed a type of mourning upon her realization that clinical work is so emotionally evocative. At first she resisted her emerging understanding that how she felt was an inherent part of the work:

But I guess the other thing that bothered me was: 'Do I have to do this in order for it to work? Is this a necessary requirement?' Going through all of that-'Isn't there another way.' So I guess there was kind of a depression and frustration and a bunch of different things combined: 'This is self torture!'

Like Rebecca, Dorothy has come to understand that her emotional responsiveness is a clinical "tool," but she remains ambivalent that her emotional involvement is necessary. Her appreciation of this necessity helps her to remain open despite occasional desires to not feel her clients' pain. She said:

You've got to open yourself to those types of things or it's not going to be effective. So on a shitty day you can't think 'I don't want to feel ambivalent, I don't want to feel angry, I just want an easy day!' Because then you're not going to get anything done.

Michael also spoke of his ambivalence:

It's complicated because there's still some lingering feeling of I don't want to feel these things so maybe I don't want to be a therapist. It's mixed. Because the feelings can be quite painful...I think part and parcel

of this work is not to control what I'm feeling-I mean certainly not to the extreme, but I think it would be very possible for me to go into most sessions and cut off my feelings altogether. But I wouldn't be doing very good work. So part of the way I understand it is letting myself feel it and that may be painful.

Wendy also spoke of sometimes having to make an effort to be open to feeling. Even outside her clinical work she often feels out of touch with her own feelings and admitted that

One of the reasons I wanted to do psychodynamic work was because of the emphasis on my feelings as part of the work-so for no other reason I would have to figure out what I feel.

She also struggles to remain in touch and connected with clients at times when she might prefer not to feel.

Sometimes it's an effort on my part to be open to the person-where I need to consciously make an effort to be open. And then I can feel that. Then I'm open to feeling those feelings. But other times I've noticed that I'm closed-either because I'm feeling shitty, and when I feel shitty-I don't feel like connecting with people. And I've noticed that happening in therapy, where I've just not made as much effort to be there-and my questions are different, my interactions are different and I feel less empathic. And other times when I'm feeling differently, and feeling more like connecting, I can feel bad in a session but I feel like I'm much more there with the person in a different way. And I don't know-I don't really understand it very well. But it has to do with having an openness to that connection so be willing to feel maybe in some ways it has to do with that. And I don't always want to feel I think.

Finding A Balance

Dorothy and Michael are both struggling to find a balance with how involved they allow themselves to get in the emotional climate of therapy. In their ambivalence

about feeling their clients' pain, they know they risk maintaining too much interpersonal distance to develop an emotional understanding of their clients. They worry that their motivation is one of self protection.

Sharon also questioned what it meant that she was less receptive to entering the emotional climate in the room than she had been in the beginning. Like Dorothy, she had been overwhelmed in the beginning. In time she realized that she "could pull (her)self together and go on with (her) life" and "came to understand that it wasn't as terrifying as it seemed to be at first." Like Rebecca and Dorothy, Sharon came to see the affective intensity as part of the work and to feel less overwhelmed. However, Sharon did not share Rebecca's confidence that her ability to tolerate the intensity was entirely positive. She feared it was defensive:

I might be less responsive to it now-I would have the capability to be less responsive...I'm not sure it's good. I feel like I've become much more inured to what we're doing. And I'm not sure that I'm all there in the way that I was in the beginning: Body and soul, heart and mind. I'm not nearly as present.

Interviewer: I would imagine that you have developed the capacity to turn it off and on with greater facility.

Sharon: Right, but I might keep it off more than I should. I'm just speculating...I would say that for me that issue of being open to it or not is really where my work as a therapist is right now. At the end of a session, or when I'm reviewing a transcript or in supervision, the degree to which I allowed myself to feel what they were or weren't feeling is what I tend to focus on...what I'm trying to do is be aware of my feelings.

Perhaps Sharon's susceptibility to "being swayed by the wind in the room" motivates her to "keep it off more than (she) should." At this point in her clinical development she focuses on trying to be open to the affect without becoming overwhelmed. In the beginning this balance seemed impossible:

I was just scared that I was going to be on a roller coaster; that this profession was just going to be hair raising. I mean it's one thing to have a nutty client-it's another thing if you have 4 suicidal clients. Who wants to be feeling suicidal times 4. You know?

Sharon's emphasis on remaining open to her feelings suggests a belief that this is a necessary component of effective clinical work. Sharon would agree with Rebecca's assessment that her ability to emotionally resonate with her clients is a "tool, like a carpenter's saw."

Perhaps Sharon, Michael and Dorothy are being defensive in their desire to not feel and are distancing themselves from emotional interactions. Perhaps they are taking too distant a stance and are unwilling to become involved out of fear of their feelings. However, a balance between participating and keeping one's emotional distance in order to make use of what one experiences is necessary for effective clinical work. Perhaps they are developing the skills to become effective participant-observers, thereby not becoming so enmeshed that they lose their ability to reflect on the process. As will be

discussed shortly, part of the necessary skills is the ability to switch to the position of the observing self. Elizabeth's comments suggest that at times she finds that balance:

I can feel with them if I'm really with them. Those feelings come together and I'm just really there. It doesn't mean I can't think about the process at the same time, but kind of not backing away from feeling, or at least not too much. I mean I don't want to get totally absorbed in their emotions because then I wouldn't be helpful either.

Giving Up Control

Another concern that emerged in the interviews about being emotionally involved with one's clients were feelings about giving up control. Comments by Dorothy illustrate that part of her difficulty had been that she had felt out of control of the process. In response to how she experiences herself in the room Dorothy said:

I feel much more vulnerable...It's kind of scary to not know where these things are coming from sometimes. To question what the fuck is going on here, as opposed to a style where you're much more confrontive and in a sense, much more controlling of the particular emotions and the directions that things are going to go in. Basically the client is doing that in this type of therapy; the client is doing that so you're going along with the flow.

Feeling vulnerable meant not knowing what she was going to be made to feel. Dorothy had to learn to give up control and to willingly follow where her clients took her.

Isadora also struggled with giving up control and feeling vulnerable. In response to a question about

identifying with or feeling like her client, Isadora said:

I frame it in my mind as a positive thing and something I would like more of. But at the same time it's a little risky and scary but it's worth it to me.

Interviewer: What's scary or risky about it?

Isadora: Well, it's out of control. It's more vulnerable. Because you're less certain; less certain about where your feelings will go; you're more involved and less removed.

Dorothy dealt with her anxiety during this initial period by trying to maintain control of the process. Over time she has grown more comfortable and has learned to accept the emotional impact of being with her clients. She has seen this change most dramatically in her work with Tina:

Probably in the third session with Tina, I went in ready to defend myself, just really feeling shut down: 'I'm not going to let her do this to me, I'm going to be in control'-that kind of stuff. Now, I've just learned to relax before I go in and say 'She's going to bring in what she brings in and it's stuff I need to see and it's stuff we need to talk about.' So I just have a different attitude about it now. Not that she's trying to harm me, she's trying to get me to help her.

Dorothy's struggle to tolerate the intensity of the work emanated primarily from her work with Tina. Perhaps Dorothy's work with a disturbed client so early in training sensitized her to issues of intense affect. In developing a recognition that Tina's intense impact was her way of dramatizing her need for help, Dorothy has learned that her internal responses are helpful and not

something to be feared. According to Tansey and Burke (1989), there are some clients, and perhaps Tina is one, with whom even experienced clinicians would be challenged in their ability to manage the feelings aroused in the work. They state:

It is sometimes with great effort that the therapist is able to maintain, if not neutrality, at least equanimity in the face of interactional pressure.
(p. 104)

As a beginner, Dorothy was doubly challenged. As Brightman (1984) says:

Feelings of helplessness and/or fears of loss of control (in both trainees and patients) can mobilize strivings after an ironclad sense of total control over the clinical field in order to dispel the attendant anxiety. (p. 299)

Judging Oneself

Participating in the emotional climate of clinical work involves confronting one's beliefs about the meaning of the feelings that are aroused. One component of meaning has been illustrated by what trainees thought the feelings illuminated about themselves. For instance, Rebecca and Dorothy thought the feelings indicated personal weakness and Sharon thought the feelings indicated she was crazy. An additional level of meaning entails one's judgements about the goodness or badness of specific feelings; part of tolerating the affect is not being constrained by beliefs about the unacceptability of certain feelings. Rebecca spoke of arriving at the

position where her feelings conveyed information and she no longer felt compelled to judge herself for having them.

It took a long time until I could almost not care about having feelings. Which sounds so weird, but that's where I feel I'm getting to now. I notice this from conversations with other people-'so what if you hate that, so what if.' That seems like a very important place to get. It's not as cold as it sounds.

Interviewer: Almost like they are information as opposed to being truth in themselves?

Rebecca: Yeh, and that it doesn't say anything about-not that it doesn't say anything about me but that it isn't a judgement call. Which for a while it felt that way.

This took a while in her training:

I also think I was more closed out of uncertainty and embarrassment-not wanting my supervisor to know or not wanting me to know. Now I don't care-or not that I don't care but that it's a good sign. Just as I've learned that it's not only ok but that's what it is. I just sort of let myself experience things.

Rebecca's openness results in part from the value that she places upon understanding her counter-transference:

I also think I'm prone to countertransference reactions because I think that that's a good thing to have. So as long as I think that I kind of give myself permission to look for them. Because I think I can make use of them.

According to her, Rebecca works primarily within a transference-countertransference paradigm. She accepts the emotional impact upon her because she wants to make use of her internal response as a clinical tool.

The Intersection of the Work with One's Private Emotional Life

Before turning to the topic of the observing self, a final consideration is relevant to how trainees grapple with the emotional intensity of the work; namely, how the emotional demands of clinical work intersect with trainees private emotional lives and/or their experiences in therapy. It is a partially held belief in the field that therapists should have been in treatment themselves. If therapists must learn to use their feelings clinically, then a therapist's familiarity with her own emotional life is important. Therapists need to be familiar with their internal conflicts and problems in relationships and should be able to tolerate a wide range of affect. There were no questions in the interview about trainees's receiving therapy but information was volunteered by four out of the 10 therapists-in-training.

Everyone who talked about the intersection of their clinical development with their own therapy described how therapy had been helpful for their clinical work. Three trainees spoke of therapy as helping them become more open. Rebecca described becoming comfortable with how emotionally evocative the work is and said that therapy was part of her process of becoming more open to feelings:

I think I've gotten more and more open as time's gone on. I started out much less open, partly-some of that coincides with my own

therapy and what's become more available to me of myself, can now be touched on by other people.

Michael and Isadora also spoke of their own therapy as helping them become more open, especially at times of experiencing themselves as similar to their clients in ways that might feel uncomfortable or anxiety provoking. Isadora valued these experiences:

I value it and I trust it more that it's ok and it's not going to lead me someplace I can't handle. It's a value system too. To sort of explore to the depths of what you can know about yourself and thereby enrich your life. Not just live in the mundane.

Another helpful aspect of being in therapy was expressed by Isadora and Elizabeth who talked about their own therapy in the context of how their own emotional struggles contributed to their ability to understand and empathize with their clients. Isadora said:

Like when my client questions do I understand her. She says I think you can sympathize but you can't empathize. And I guess I think because I've struggled through a lot-that is the root of my empathy, even though it may not be these exact issues, I've done a lot of work and that's hard and I think I know what the pain is of this kind of work. And that comes from therapy but it comes from just living too.

Elizabeth expressed similar thoughts in the context of having had a very difficult year emotionally:

I'm having to face my own feelings in a way that I never used to. Through all of this (an emotional crisis) and my own work in therapy. I'm letting myself feel more than I used to and that certainly has an impact in therapy. In terms of being able to feel with a client. And I think that that's going to stay. I mean my

experiences where I've gone through certain things will stay also, but I think the more important one is my ability to really be there with feelings that are hard and allow myself to feel them when it's appropriate to.

Elizabeth and Isadora were both talking about general life experiences rather than therapy itself. Elizabeth spoke of the difference her own emotional work has made in her clinical work:

I'm able to understand a lot more now than I ever did all the things my clients go through. There was something that I could be there with them and hear but I was very removed- I was really there with my clients first year but not really emotionally involved. I would have strong emotion because I screwed up, rather than because there was a strong feeling together, although that happened sometimes too. This year I've been much more connected at a very emotional level.

Elizabeth sometimes experienced difficulty keeping her own emotional work separate from her clinical work. Despite these problems, Elizabeth recognized the positive impact on her development in that her emotional vulnerability made her pay closer attention to her responses in the room:

I think that most of it was from just knowing that I've got a responsibility to these people and no matter what I'm going through I've got to work it out in a way that I can be effective with my clients and not let this get in the way with them. Whenever I would have a reaction in therapy or after or whatever-something about a client that I didn't understand to a level that I was comfortable with-then it was kind of a crisis-oh no, what's happening, I have to understand this, something's going on here and I would talk about it in my own therapy or my supervisor and I would ponder over it, and through that process it's gotten more important in general aside from when it's a big problem.

Elizabeth admitted that it was very confusing to be reaching the point in her development as a therapist where she is beginning to pay attention to her feelings in the therapeutic encounter at such a tumultuous time in her own emotional life. But it is exciting as well: "This year has been a powerhouse for my therapy."

It has been a "powerhouse" for Elizabeth's use of herself as a therapist because her own experience in therapy have given her access to her feelings, and difficult emotional times have made it even more imperative that she understand her inner experience as a clinician.

It is seen in these comments that becoming more comfortable with affective responsiveness involves learning that it is not a negative reflection on oneself to have feelings and that such feelings are part of the work. A conceptual understanding of countertransference and how feelings are useful helps; additional understandings based on other sources will be explored in later chapters. The next section will identify another crucial input: the role of supervision in directing trainees attention to their own reactions and what can be learned from these reactions. We turn to the topic of the observing self and the importance of the balance between experiencing and thinking about that experience.

The Observing Self

Few therapists-in-training actually referred to an observing self; however, in virtually every interview there were references to experiences which suggested an inchoate understanding of a dividing line between an experiencing self and an observing self. For instance, Isadora could not identify how her client pulls for her to be mothering but she could observe herself behaving in such a way. And Peter felt that "a lot of the time I get so sucked into the interaction that I stop thinking about it as I should be as the therapist." The awareness of a duality emerged most clearly from Sharon:

What I want to be able to do as a therapist is be able to be in two places at once. I want to be able to be in them-or have them in me, and understand what's going on; and I also want to be able to be a fly on the wall and keep a sort of working observer that can interrupt it or slow it down or head it in a different direction or whatever, in order to be most helpful. I'm not good at that yet. What I tend to do-it's like there's two different puddles and I tend to jump back and forth between them-I'm either the fly on the wall or I'm lost in their stuff. I think that working those two simultaneously is what makes therapists good therapists.

In her description of jumping between two puddles, Sharon says that her experience of this duality is not one of integration but is an either-or position. I think perhaps in her work Sharon actually operates from a more integrated position than her account suggests. In fact, in her reflections on how she might work differently as a

more advanced therapist with Karen, the client who had made her feel so crazy, she expressed her growing awareness of the possibility of integrating these two positions:

I think that she didn't see me as a discrete bounded person. Who she was just kind of filled up the whole room and incorporated me into it. I think I had a choice, I think I could have put a wall around myself, could have pushed myself back away from it, and maybe I would do that to a greater degree now, or more selectively now as a therapist, but this was brand new to me. I was eager to do it right and to be there with her. So I just fell into it, time after time...(Now) I think I would be much better able to observe what she was doing and how what she was doing was having an impact on me without losing my sense of my observing self. What would happen to me would be that I would lose my sense of the observing self-I would have no consciousness of time, I was caught up in her world.

In describing the "roller coaster ride" that her client, Tina, took her on, Dorothy spoke of how she has learned to move from a participating to an observing position:

If I just start having a really strong emotion. I try to partial out countertransference, but a lot of the time I really don't understand why I'm feeling so angry or so incompetent. When it's just something that's so salient or intense and I don't understand it-that's kind of how I know it's coming. But also now I don't get scared-I kind of know the limits now and I know that eventually it's going to end. I kind of just now try to relax, when I can I put myself in an observing position and try to process what's going on. And I do make process comments now which is helpful and which I couldn't do before because I couldn't remove myself at all.

Sometimes Dorothy's observing self takes a very literal form:

(S)ort of looking at myself from over there and thinking, (Dorothy), why are you doing all this talking-it's not something you typically do.

and

(I) just temporarily forget where I am. It's like everything goes gray and I really have to come back-It's like I'm just really somewhere else. It's all kind of a scary feeling. Going up and down with this person. I'm sort of there but not there-I'm sort of where she's at. So I really have to think about seeing myself sitting where I'm sitting and coming back to that.

As with Sharon, Dorothy's ability to "bring herself back" increased with experience:

Now that I've seen it, especially in Tina's case, I've seen it so many times. I realize things aren't going to fuck up if I say one thing wrong, or if I expose my feelings too much. There aren't the same fears associated with performance so much. And now I have a better sense of what it's going to be like to be on a roller coaster. I can put it out there and look at it. I wasn't able to do that at the beginning because it was so foreign. That helps an awful lot. And after the session I think about where to go in the future, and what was said in the last session, so just general processing abilities helped a lot.

Dorothy did not elaborate on what these processing abilities were. The shift from the experiencing self to the observing self is one important ability and will be elaborated in the next chapter. Once that shift is made the therapist must analyze what has made her feel as she has. She must think about what it is that she has experienced, review what has transpired between herself

and her client, think about how her feelings surfaced, and consider the ongoing therapeutic context or other issues that could be contributing to her feelings. The therapist must ask herself such questions as what am I experiencing, how did I come to feel this way, what purpose might it serve for my client for me to feel this way, and what of my own might I be contributing? (Tansey & Burke, 1989). The therapist must sublimate and scrutinize her feelings, thereby becoming "neutral" (Thompson, 1980) and "objective about (her) subjective experience" (Tansey & Burke, p. 87). These are the functions of the observing self. This analyzing function is an act of sophistication made possible by both experience and theoretical knowledge. Comments by Michael illustrated his use of his observing self:

I tend to do an exploration of where they (feelings) come from for me, and then how they fit in for my client. Kind of functionally, what they mean for my client, or what they do for my client, and then I just try to think about the intersection of those two. Also in terms of why are those feelings salient for my client at this time. As part of that, are there particular reasons that they're salient for me.

Rebecca spoke of asking herself similar questions. She described that at first this could happen only after a session. She would come out of a session and ask herself what she had felt and consider why she might have felt such a way. She summarized how she became more able

to analyze these questions in the moment and to integrate the experiencing and observing functions.

(T)hen I could look backwards. Like how might this be there, how might these kinds of feelings fit in with what's going on. But again, it was out of the session. And I still really didn't know what to do with it. Then the next piece of that is what can this tell me about the person...So I would use it like that-not really do too much with it but have it inform me. And the way that that gets refined is so interesting to me. Next to kind of try to think on my feet a little more, first of all to be able to be both self aware and listening at the same time in a session is really hard, but kind of practising that. Some of it comes from realizing you don't have to listen to every word the person says and hang onto the details of the content. So it kind of gives you permission to say-'well, what am i feeling right now', to move your attention in a little bit. So I would try to pay attention to what I was feeling in the room, and I would go through some of that checklist in my mind.

Rebecca illuminates here a key to a successful use of the self which is stepping back from the content and looking at the feelings that are engendered as a function of the content. This moves echoes the milestone described by Ralph (1980) of moving beyond a client and content centered approach to therapy. He says:

It represents a movement from a more concrete approach that focuses on the content of the hour, what the patient said and did, to a relationship centered approach that focuses on the metacontent of the hour-that is, the feelings and emotions developed in the patient-therapist relationship which generated that content. (p. 246)

Sharon also recognized the need to step back from content:

What I'm trying to do is be aware of my feelings. It's like I go through this triage system-am I having feelings or am I not. And often I think I'm not but I am, and it's really after the fact that I realize I am. So then, ok, I am having feelings, then it's-are these feelings because the person wants me to feel how they felt in a similar situation so they're doing to me the same thing somebody did to them?; or are these feelings the feelings that they feel right now? And those are two very different things. So I try to make a decision which is going on. Often I get caught up in the content and lose the sense of the feelings, and often the content isn't important, but that's where my struggle is right now-to let go of the content stuff and just pay attention to what's washing over me or coming through me.

Instead of content, Rebecca tries to focus on the process of the session. This focus involves an awareness of herself from which could be inferred the use of her observing self:

To me, reflecting on the process means paying attention to my experience, and if I'm not doing that, then I'm not aware of my experience and I'm just kind of there. I might be being too chatty, or too much aligned, or too engaged in content, or bored, or daydreaming. (It also means paying attention to) what's going on between the two of us...(and) turning my thoughts to myself and asking why I'm reacting as I am.

The awareness of the use of an observing self showed developmental differences across levels of training but the developmental process within the individual emerged more strongly. Elizabeth expressed most clearly how an awareness of herself and her internal process had dramatically developed during the course of the past

year. She attributed this largely to the role that supervision has played in bringing her attention to herself.

(M)y supervisor throughout the whole year has been asking me how did you feel? And I would say-I don't know, I don't remember. So apparently at the beginning of the year this wasn't happening...But it also took me time to get to the point where I am right now so it's a gradual process-so I've noticed there's been a big change with that. Where now it's very relevant to me-how am I feeling ,obviously thinking as well...I mean his asking me kept telling me it was something that I should be noticing...So I think that he really was instrumental with my starting to look at it myself without his having to ask about it. So that has changed because of that process of his helping me and me learning to do it myself.

Ralph (1980) maintains that supervision plays "the crucial role in directing the trainee's attention" (p. 247) to the therapeutic relationship and their own responses.

Though Elizabeth is the only trainee to highlight the role of supervision in teaching her the importance of self awareness and observation, her comments illuminate the crucial role of supervision. The fact that only Elizabeth mentioned supervision is in part due to the lack of questions pertaining to supervision. There were also no questions about the topic of the observing self which might have elicited mention of supervision. Those who write about supervision emphasize the importance of supervision in this developmental achievement.

Issacharoff (1984) notes that through supervision, the

trainee learns to shift from the experiencing to the observing self. Bromberg (1984) suggests that supervision serves the purpose of helping a therapist develop what he called a third ear by listening to a session as an outside observer. Jarmon (in press) suggests that the "supervisee learns to scan the field of therapeutic interaction, identifying with each participant, but identifying also with a third position, the observer, from which to observe the field as a whole." As Elizabeth testified, at a most basic level, the supervisor's attention to the internal responses of the supervisee (and what is consequently learned about the client), educates the trainee as to the importance of this.

A supervisor also serves as an auxiliary observing self. Sharon alluded to the use of an auxiliary observing self in suggesting that her beginning experiences with Karen might not have been so extreme if there had been someone observing behind the mirror:

It's like she took me on a train ride with her. We'd walk into a session, and I had a choice whether to pay attention to her, to listen to her and try to follow her or not to. And if I had chosen not to, I don't think any of this would have happen. Or if someone had been observing behind the mirror, I don't think it would have felt quite the same to me.

It is interesting to speculate why having someone observing would have enabled Sharon to feel differently. Supervision plays a role in holding and

containing the anxiety to allow trainees to reflect on their experiences in the clinical context. Had there been another person behind the mirror Sharon could have aligned herself with that person and contained some of her anxiety, using that alliance to build the wall around her that she felt she lacked. Sharon's as yet fledgling ability to separate herself from the interaction in the room did not provide sufficient distance and objectivity needed to further her understanding of her client. Yet she could imagine projecting herself as an observer into a third person!

Perhaps having an observer would have bolstered her observing ego for other reasons. Given a choice of regressing with her client or defending against the regression, Sharon might have used an observer to move toward an adaptive non-regressive position, a move beginning therapists would be likely to prefer. The role of regression in the therapeutic encounter will be explored in later chapters.

In addition to experiences in supervision, I believe the ability to use the observing self increases as therapists-in-training come to understand the nature of their internal experience, and from the development of what could be called the work ego of a therapist. These topics will be explored in the next chapter.

CHAPTER IV

LEARNING TO WORK WITH AFFECT

The Nature of Identifications in the Empathic Process

The concept of neutrality is frequently used to characterize the background against which therapists evaluate changes in their inner experience. Basch (1983a) proposes that neutrality involves the therapist's "controlling (their) affective needs and emotional predilections so as to maintain an even-handed attitude towards the content" (p. 697). He suggests that neutrality depends on the ability to regard affective reactions as objects of scientific scrutiny. Scientific scrutiny includes an evaluation of the idiosyncratic and personal sources of any reaction. King (1978) emphasizes the importance of neutrality in asserting that "if the analyst is to remain free to use his own affects to understand his patient's unconscious conflicts, he must maintain an attitude of neutrality or non attachment" (p. 334). One's affective responses must be utilized as sources of information about the therapeutic interaction.

Changes in the therapist's inner experience are identified against a baseline of neutrality. When these changes reach a level of intensity different from a "neutral self" in interaction with the client, they

indicate that a trial identification has occurred; be it through empathy or projective identification (Tansey and Burke, 1989):

The therapist has an identificatory experience characterized by particular self experience and associated affective states...His affective reaction to the particular self experience elicited by the immediate interaction optimally is a 'signal affect' (p. 81)

It is through the "signal affect" (Beres & Arlow, 1974) that the therapist is alerted to shift from experiencing with the client to thinking about what has been experienced and what the meaning is: to shift from an experiencing to an observing position. Through a conscious or preconscious (Schafer, 1959) sense of being influenced emotionally, the therapist is alerted to use her subjectivity to examine what she can learn about her client's feelings. Schafer illuminates that in this context, "affect functions here as a signal within the ego for renewed reality testing (or scientific scrutiny) rather than an intensification of defenses" (p. 347). Opinion is strong that this trial identification must be partial and short lived in order to be useful and not create countertransference complications. Herein lies a significant developmental step: learning to use one's reactions as 'signal affects' that an identification has taken place, thus indicating the need to shift from an experiencing to an observing position.

Shifting from the experiencing to the observing position has been discussed with regard to individual clinical interactions. However, the recognition of the necessity of making this shift is a developmental achievement for a therapist-in-training. Issacharoff (1984) suggests that one role of supervision is to assist the trainee in learning to shift from transient identifications to self observing. Comments in the previous chapter illustrate that such supervisory interventions help the trainee realize how important this shift is in therapeutic conduct.

The understanding that a therapist's inner experience is responsive and vulnerable to the vicissitudes of the client's experience reinforces the importance of making this shift. Beginning therapists often experience their internal reactions not as information about their clients but as information only about themselves. Tansey and Burke (1989) pinpoint this confusion for therapists:

(V)iewing the self experience as reality rather than as a powerful source of understanding regarding both what is happening in the therapeutic interaction and why the patient may need him to feel this way.

However, to effectively process emotional communications, a therapist must

recognize his emotional response to the patient, not as a surface "reality", but as a signal affect, containing potentially valuable underlying meanings, which can alert the therapist to the fact that an identification experience has in fact occurred. (p. 84)

Tansey and Burke consider this distinction necessary in utilizing any emotional communication from a patient. Making such a distinction facilitates the shift from an experiencing to an observing position.

Lakowics (1983) suggests that learning to view one's inner response as information about the client rather than as a "surface reality" becomes possible once the trainee understands the concept of identification as "something which (he) feels but cannot consciously distinguish as originating in the patient" (p. 252). It is through understanding the nature of identification in the clinical interaction that the trainee comes to understand "the concept of therapeutic intervention through empathic responsiveness" (p. 253). Issacharoff (1984) describes such identifications as "unconscious but not deeply rooted" (p. 94).

Tansey and Burke suggest that the shift to the observing position and the realization that the induced affect is a powerful source of information is composed of two separate stages: "containment" of the affective experience and "separating" from it. Containing consists of tolerating and maintaining in consciousness the thoughts, feelings or impulses that are experienced. This can be difficult for even experienced therapists because affects that need to be contained are often difficult to tolerate or can activate a therapist's "unanalyzed" conflicts. Tansey and Burke suggest that a

failure in containment is accompanied by defensive operation with which the therapist blocks from conscious awareness those aspects of his modified self experience which he cannot tolerate. (p. 85)

Alternatively, they suggest that failure in containment can result in the therapist acting in accord with what is stirred up, thereby discharging it from consciousness.

While containing clients' induced states remains a challenge for therapists throughout their clinical life, tolerating the experience is only one of the difficulties for beginning therapists. Beginning therapists are often not aware of the utility of containing their clients' painful feelings. Furthermore, many trainees are no more attuned to their own inner states than the clients they attempt to treat: they must become more fluent at reading their inner experiences just as their clients must.

After containment, Tansey and Burke suggest that the therapist then must establish "a sense of separateness" from the experience in order to examine the identification and its related affects. They cite three crucial insights (in addition to personality stability and analytic ability) that provide the necessary psychological distance from the identificatory experience.

- 1) The therapist must strive to suspend potential superego criticism and be able to experience himself in a temporarily unfavorable light.

2) The therapist realizes that his current self-experience, however uncomfortable, does not constitute an unmanageable threat to self-esteem when viewed in relation to a predominance of positive self-representations.

3) The therapist understands that the introjective identification (trial identification) is temporary. (p. 87)

All of these insights are especially difficult for beginning therapists.

Tansey and Burke describe the failure to psychologically separate from induced experiences. Unlike a failure in containment, the therapist is able to hold in consciousness the view of himself that has been generated. He does not defensively either block or act it out. However, the experience is taken as accurate rather than as information that could help him understand the world of his client; the change in experience is taken as an "enduring actuality rather than as a temporary and induced identification signally something important about the client" (p. 88). The therapist is unable to pull back enough from the material to observe this change; to be "objective about his subjective experience" (p. 87). The identification is then not short lived or partial (Reich 1950) but prolonged and seen as part of the therapist's self.

Basch (1983b) speaks similarly of the necessity to separate from one's reactions to be able to understand them:

To be empathic an individual must be able to separate himself sufficiently from his feelings and emotions so that instead of simply reacting to them he can establish their genesis and the significance they have in the context in which they are experienced. (p. 119)

Tansey and Burke present two alternative consequences from the failure to gain sufficient separateness from an identification. The therapist may sustain problems in retaining conscious awareness of the induced experience. "At the opposite extreme, the therapist may remain all too aware of the induced feeling with no perspective on its underlying meaning" (p. 87). Tansey and Burke are writing about challenges and failures at all levels of clinical development but their insights are particularly helpful in illuminating difficulties for beginning therapists in learning to use their inner experience.

Jarmon (in press) also directs attention to the problem of therapists becoming "overidentified with one or more of the patients' significant objects":

Identifications become a problem when no longer transient. They take hold of the therapist and impede her capacity to both retain a sense of her therapeutic self and to respond empathically to her patient.

Especially for the beginning therapist who would have only a rudimentary "therapeutic self", the propensity for identifications to be prolonged is exaggerated. Lakovics (1983) adds that when a transient identification stimulates an inner conflict of the therapist it is

especially hard to recognize the "identification as being outside oneself" (p. 255). To the extent that beginning therapists suffer from "medical school syndrome" as well as not yet having explored their inner conflicts, they are prone to overidentifying and failing to understand the source of their experience. As will be discussed shortly, it is the therapist's responsibility to separate out how her conflicts contribute to any subjective response to a client. However, the focus here is upon the difficulty of recognizing that identifications and the resulting affects created in the clinical encounter can be used to understand clients rather than taken as "surface realities" in themselves. Lakovics addresses this problem in the beginning therapist:

The problem of differentiating those responses whose source is the patient's pathology from responses which are a lack of knowledge, personal difficulties (whether neurotic or otherwise) and/or supervisor related can be insurmountable. (p. 252)

He says the key is learning to differentiate feelings and reactions "which originate from the patient and therapist as a consequence of the therapeutic relationship" from those "which originate from the therapist's private personal past" (p. 252).

Allowing oneself to be taken over by transient identifications can endanger the necessary balance between the experiencing and observing positions. One can get drawn into either the participating or the

observing side at the expense of the other. Thus far this discussion has emphasized the loss of the ability to observe due to a lack of awareness that an identification has occurred. Tansey and Burke call this an "overcooked" identification. Insufficient scrutiny is applied to the change in experience and a "laissez faire" position is taken in relation to the interactional pressure. They suggest a significant risk results for reenacting in the clinical relationship traumatic relationships the client is recreating through the transference. Greenson (1960) termed as "uncontrolled empathizers" those therapists who overidentify with clients and lose their clinical perspective through too intense an involvement. Such therapists are vulnerable to being overwhelmed or to acting out. In a similar vein, Schafer (1959) suggests when a therapist fails to sufficiently separate from the experience the affect is acted out rather than used as a signal for inspection. Instead of using her counter-transference to understand the client's experience, the therapist is pulled by her inner experience into a non-analytic and potentially traumatizing interaction.

The opposite extreme is of too much interpersonal distance which can foreclose on an emotional understanding of a client. An "intellectually distant state" (Berger 1987, p. 38) results in an inability to make use of or be open to experiencing transient

identifications. Greenson (1960) suggests that these "phobic empathizers" are "unconsciously unwilling to leave the position of the uninvolved observer" out of fear of the feelings or a fear of being "unable to regain a sense of self" after the identification is experienced.

Tansey and Burke say the identifications that result in this position are "undercooked identifications." They suggest that sometimes due to the potency of both the interactional pressure and of what is being transmitted, a therapist will be overly rigid or controlling, as if anticipating an attempt to influence her to a degree that she unconsciously wishes to avoid. Depending on the dynamic involved and the intensity with which it is being transmitted, therapists vary in how open they are to the impact of any particular interaction. A therapist's tolerance for various trial identifications is correlated with her tolerance for potentially difficult internal experiences.

The nature and intensity of the interactional communication being processed vis-a-vis the therapist's capacity to tolerate the transitory modification of his self experience largely determines the degree of awareness in the therapist of the identification experience. (1989, p. 82)

It seems an easy assumption to make that as a beginning therapist, one's ability to tolerate these modifications in self experience is limited. Especially when these self experiences involve feelings of

helplessness, incompetency or failure, beginning therapists might defensively over or underidentify with these changes in inner experience.

As training progresses, there is an increased ability to make the shift from experiencing the identification to observing and thinking about what has transpired. The shift grows smoother as the trainee "gains experience and is more able to tolerate and accept them (identifications) as a necessary and useful (albeit often disturbing) part of the psychoanalytic process" (Issacharoff, 1984, p. 94). Through supervision on how to analyze one's internal experience a trainee is shown the usefulness of such a shift. This shift is also facilitated by an increased understanding of the nature of identifications (Lakovics, 1983) and how to separate from and use them. Additionally, it would appear that this shift becomes more possible as the trainee develops what has been called a work ego (Olinick, 1969), a second self (Schafer 1983), or a therapeutic self (Goldberg, 1984; Jarmon, in press); which along with neutrality, serves as a base from which to observe changes in inner experiences. Making this shift is reinforced by the fact that "a feeling of relief is associated with regaining the observing position" (Issacharoff, 1984, p. 95). Finally, learning how the concept of identification explicates how feelings and fantasies imagined as one's

own "are not only expected but originate within the patient" is relieving for a trainee (Lakovics, p. 253).

The danger always exists of attributing all reactions to one's client without examination of one's personal contribution. Tansey and Burke characterize the "totalist" view of countertransference as potentially using the patient's unconscious as the royal road to one's own. It is incumbent upon a therapist to separate out her private contribution to countertransference. A therapist must review what has transpired and how her feelings surfaced, examine her working model of the client, consider the therapeutic context as well as her own proclivities to determine possible connections between her experience and that of her client (Tansey & Burke, 1989). Tansey and Burke summarize criteria for establishing along a continuum the extent to which an identification is reflective of the patient's internal world and a response to the interactional pressure, or to which it may have been stimulated in the patient's presence but "emanate predominantly from the therapist's essentially private concerns" (p. 35):

- 1) the degree of the therapist's consciousness (or lack thereof)
- 2) the degree of control over the intensity of the experience
- 3) the degree of separateness or differentiation of ego boundaries maintained by the therapist
- 4) the type of introjection involved

5) whether the identification is concordant or complementary

They stress that any conclusion about the meaning of one's subjective response must be clinically validated through the client's response to subsequent interventions. They also stress that any subjective response of the therapist is a unique compromise of her own personality with the affect and role relationship (Sandler, 1976) that the client is trying to induce, albeit at times unconsciously.

The attempt to understand a therapist's inner experience as either a purely personal response (the classical view of countertransference) or as totally induced by a client is fanciful. Most clinical interactions strong enough to induce a response in the therapist will contain a mixture of all of the possible sources of affect:

Unfortunately, the therapist's inner thoughts contain mixture of messages, and the sources of the messages are not easy to distinguish. Some stem from vibrations in harmony with elements in the patient, others originate from the therapist-as a separate individual or as an individual interacting with the patient. (Berger 1987, p. 28)

The impossibility of clearly separating out the source of one's affect relates to attempts to distinguish between empathy and projective identification. Though empathy is often conceptualized in terms of only concordant identifications and as sharing in the conscious ego state of the client, it is to be understood

as sharing and comprehending a complex hierarchy of drives, defenses, and internal structures (Schafer, 1959); sharing in a psychological state which is much more than just concordant identifications. Efforts to delineate empathy and projective identification in a clinical encounter involve both subjectivity and therapists' unique sensitivities: "decisions about coerciveness, disruptiveness, intensity, psychopathology (are) essentially arbitrary" (Tansey & Burke, p.63). This is the complicated realm of the voluntary and unconscious transmission of affect.

Along these lines, Berger's thoughts about the differences between empathy and countertransference apply to the differences between empathy and projective identification:

To attempt to be overly exact would be to overreach, and the end result would be a reified inaccurate description of a complex dynamic process. (1987, p. 40)

An additional hurdle in attempting to identify the origin of one's affect is the complicated nature of affect. "One of the peculiarities of affect is that they are felt by others and they induce or are expected to induce in others identical or opposing affects" (Rycroft, 1968, in King, 1978). The interpersonal communication of affect is both a subtle and complex process. It ranges from primarily verbal modes with a relatively high degree of separation between subject and object to more

"primitive modes such as affect contagion where a strong affect in an individual stimulates the same affect in another" (Furer, 1967, p. 279; Stern, 1985). As Berger says:

The roots of emotional experience are inextricably intertwined. Compounded by complexity of emotions, their subliminal nature and the blurring of boundaries between self and object that occurs at archaic levels of experience. (p. 35)

Therapists come to feel what their clients feel. This occurs through both projective processes on the parts of clients and through empathic resonance. Empathy most commonly refers to resonance with a client's conscious experience and the delineation between empathy and projective identification is probably easier when the identification is complementary. However, despite important differences between these concepts, the literature on empathy abounds with statements that imply that the origin of the therapist's affect is in her patient. Empathy is defined thus: "sample of the patient's inner state" (Fenichel, 1953), sampling feelings of another, sharing in the affect, experientially knowing another's state (Berger, 1987), sharing in what is understood to exist in another (Schafer, 1959). Both empathy and projective identification produce feelings within the therapist that could be understood as originating in the client.

Through coming to understand the transient nature of identification and how affect is communicated, therapists-in-training learn to use their internal responses as information about their clients. This involves learning to recognize, contain, separate from and observe what is felt. Crucial to this is learning that what is experienced might have its origins in one's clients. If therapists miss this contribution to their experience, they lose a powerful vehicle for understanding their clients, and worse, risk a countertransferential reenactment of a client's previous relationships.

The above discussion highlights a fundamental question about the origin of the affect that therapists experience in the clinical situation. It was not possible to evaluate through a research interview the origin of the affect which therapists-in-training experience in their clinical work. This assessment is accomplished in the ongoing context of supervision. It was possible however, to explore the thoughts of therapists-in-training as they were beginning to understand that what they experience is related to what their clients experience, even if unconsciously. This is one of the first steps in beginning therapists learning to make use of the concept of trial identifications and the signal affects which are induced by these identifications.

The Differentiation of the Origin of Affect

This section explores trainees' views about where their feelings come from in the clinical encounter. The following example illustrates what is meant by the problem of the differentiation of the origin of affect.

A client is 20 minutes late for a session which she spends talking about her abusive boyfriend. The therapist feels angry during the session. The therapist's anger contains different information depending upon where she thinks it originated. Is the therapist reacting angrily to her client's lateness? Perhaps the client's lateness was not able to be avoided and the therapist would have been angry with the client regardless of the content of the session. In this case the anger is a response to an event but originates in the therapist. In another scenario the lateness might have been an expression of the client's anger towards the therapist, thus the anger originated in the client. Is the therapist feeling angry because the client told about excruciatingly painful experiences without any apparent affect, leaving the therapist to supply the affect that the client is defending against; here too, the origin would be in the client. Is the therapist identifying with her client's anger at her boyfriend? Perhaps the client was late, knowing this would anger her therapist, and together with provocation and affectless recounting

of stories about her abuse could produce the anger in the therapist that the client could not tolerate in herself? More contextual information would be needed to make sense of the session. However, each explanation suggests a different view of the client-therapist relationship for the therapist's consideration.

To be consistent with the language of the data, I will use the phrase 'the therapist is feeling the client's feelings.' This is problematic for one can only experience one's own feelings. However, affect can be understood as having its origin within the client but affecting a resonance within the therapist through processes such as projective identification, trial identification, affect contagion and empathy. Buie (1981) describes a moment of "empathic resonance":

This was not a sadness of his own and it was not sympathy. Experientially, it seemed to be her sadness which he felt. (p. 301)

The differentiation of the origin of affect within an interpersonal context is a complex process.

Sharon and Michael are two therapists-in-training whose comments illustrate the problem. This is Sharon:

It took me awhile to learn that often when I was feeling something in the room, that it was the client's feelings that I was feeling. I mean I felt that it was my feelings, and I didn't understand why I was having these feelings.

Although Sharon is not always sure whose feelings she is experiencing, she is clear that at times it is her

clients'. In contrast, Michael is just beginning to consider that his tendency to "feel too much of what the client is feeling" results in part because of his client. He is grappling with an emerging sense that he feels his clients' feelings.

I have thought of it (his feeling too much) as coming from me but I think I need to think of it-I'm beginning to think of it as coming a lot from the client.

Developmental Differences

Much of the differences among therapists-in-training in thinking about whose feelings they were experiencing related to their level of training. In her 4th year, Sharon conveys a surety that Michael, a 2nd year student, does not express. Two therapists in their first year of seeing clients could not imagine experiencing feelings whose origins were in their clients. For example, in considering whether he ever felt uncertain about whose feelings he was experiencing Peter said: "I always feel like they're my feelings." Isadora expressed a similar viewpoint:

It's always felt like my feelings, even the anxiety-I felt like I was anxious, and the most I can say is that discussing it it felt like those feelings were there because of the interaction between us but they still felt like mine. I've never felt like this is a feeling that's totally new to me and I don't know where it's from...I'm not uncertain whether it's me or someone else, I might be uncertain about what I'm feeling, but my confusion isn't about if it's somebody else's feelings.

Such categorical statements were not made by more experienced therapists. Sharon described her work with

Karen, a psychotic client with whom she had first considered the question of whose feelings she was experiencing:

I think of working with Karen, and just feeling like something was plopped-like Monty Python where they open your head and take out your brain and put someone else's in. (It) was just a feeling that this wasn't me, like in one ear and out the other, the image of going through you-that I was a vesicle or a vehicle.

Another experienced trainee, Jane, described a similar process of her client "giving" her feelings to her:

(I) think her sense of helplessness was so powerful. It wasn't something that she had enough ego strength to tolerate in that intensity so in some ways she was giving that to me to sort of hold for her.

Jane explained that she was very susceptible to being given or to taking on her clients' feelings. Her grasp of this has changed during her training:

(I)'d say that as I've developed as a therapist, that I've become more aware of the fact that they are not my feelings that I'm feeling. I've taken on someone else's feelings but there's much more of a conscious awareness of who those feelings belong to.

Rebecca was also sure that at times her affect originated in her clients. She described how she felt listening to a client's emotionless account of how she had never grieved the death of her father:

Meanwhile I was-I felt myself tearing up, felt this incredible loss, felt myself thinking about my own father. Just felt really upset and sad, and sad for her. And I felt like I was grieving for her father, 35 years ago. And this person who I had never met and didn't know too much about and she had no connection

with that at all. But apparently somewhere she did because that just wasn't mine.

The distinction between experiencing one's own feelings or one's clients is often not clear even for advanced trainees. The process of differentiation is illustrated by Rebecca's account of her work with

a classic narcissistic personality disorder, not in the sense that she's egocentric or anything like that, but just in the sense of the emptiness, the absolute inability to connect...a number of times we would sit in a session, and she would talk about her work, her week and this and that, and she would leave and I would feel so dead, and so, not just that I would be tired, because that was always a part of it because I would be bored, but that I would just leave there feeling drained-absolutely empty, I couldn't go on, I would lose my enthusiasm for everything, felt like nothing mattered. And the next week she would come in and talk about what a great session that had been, how great she had felt, because she had sorted out how to handle some problem. And I just would have been for days feeling like nothing mattered, absolutely sapped, boredom, discouraged, not even-didn't have enough emotion to feel discouraged, I was just blah. And after that happened several times I began to think about that this isn't mine, this is her, and I'm holding onto all this so she can go off feeling good. But I don't want this anymore.

How did Rebecca come to realize these were her client's feelings?

(B)ecause it was different-there's times when I have felt drained, and I felt that because my client has taken a lot from me, but this was different, she wasn't taking anything from me, there was no connection, so it's not like she's using me in some way or depleting me, it just felt like she was infusing her own empty space into me to not have to deal with the anxiety of that on her own.

These developmental changes reflect more than how this question is talked about. All three of the above advanced trainees spoke of earlier periods in training when they would not have conceptualized it as experiencing feelings which originated in their clients. Part of the developmental change is exposure to concepts which explicate the mechanisms by which therapists experience their clients' feelings. As Rebecca's comments illustrate, the examination of one's feelings in the context of what is known about the client may lead one to conclude that the feelings originate within the client. Part of the change is an intellectual process but experiential learning is also required. Such learning is influenced by the kind of clients one has worked with as well as one's experiences in supervision.

Feeling What Clients Feel

Despite developmental and experiential differences in how they viewed the origin of affect in the clinical context, most trainees in this study thought that the feelings that were evoked in them were in part co-determined by their clients feelings. For instance, in reference to her sad feelings in relation to a client with whom she was terminating, Isadora said: "those are my feelings-not just hers, but I think I was feeling part of her feelings for her."

It was apparent in the comments of other trainees that they also thought they experienced their client's

affect. Michael described his work with a client in play therapy who would create a shadow of his hand with a flashlight and bring it down from the ceiling to strangle Michael:

There's an 11 year old boy who I'm seeing now who plays out a lot of scenes that are just filled with terror, and I see very little indication that he experiences it. I think he quickly turns it around to being a superman. That's the way he copes with it and I don't think he experiences it and I sometimes experience it.

Sharon understood herself to be "feeling feelings that these people were feeling deep down, but were so defended against that they weren't aware of." She commented that this often happens with one client in particular:

I have a client who doesn't feel feelings, and she's better now than she was 2 1/2 years ago, but she really has consciously trained herself not to have feelings because that was the way she wanted to get through life. And I tend to have two reactions to that. One is to get frustrated and angry at her, like to the point where I want to shake her, but the other is to feel the feelings that I think she should be feeling.

Sharon sees this happening in one of two ways:

I bet that a lot of what she does is give me a lot of her split off-I think that anger is her split off piece of her that she's given me. That she's really not able to have it and experience it, but she either makes me angry by how she acts or she'll describe situations where she should be feeling angry and she isn't, and I become angry in place of her, and in both places I become the repository of the anger that she can't have.

Sara also experienced herself as feeling what a client could not feel:

A woman who had been through so much-incest. She just seemed so tensed up and removed from any feelings about it. She could verbalize-'I feel this I feel that', but she was really a blank screen emotionally. And I felt like dying on the spot, and really felt upset, I wanted to cry, got teary. And she felt she couldn't do that because it would all just come out and never stop coming out. So I felt that I was feeling what she knew she couldn't feel.

Trainees' conclusions about whether they felt what their clients felt appeared to be unrelated to considerations about the origin of their affect. As Isadora's comments illustrate, she was comfortable saying that she experienced her client's feelings but still maintained that all her feelings originated in herself. Sharon, Michael and Sara have also said they felt their clients' feelings yet each held a different view about where their affect originated.

Considerations Beyond Empathy

Sara was just beginning to struggle with her sense that part of what she experienced originated in her clients. In speaking about whether she felt penetrated by a client's particularly vivid descriptions of paternal sexual abuse, Sara said:

I didn't feel it was like a pipeline or anything like that. But I definitely felt like this was in some ways part of her. I mean empathy only goes so far, and I thought this must be some little teeny bit of how she must-underneath it all-underneath this robot mode, really feel. So in that sense they would penetrate me.

The power of these experiences is suggested by the evocativeness of Sara's language. When I asked whether

she ever felt confused about whose feelings she might be experiencing, she replied:

Yeh. Sometime's I didn't know if it was her or me or both. As a person I'd like to think that I would feel bad for someone that that happened to, but sometime's it was a little strong. And when that happened I would feel like this must be coming from her, when I would feel-I sort of feel like I know I'm a nice person but I'm not that nice-like those kinds of thoughts. That's when I would feel this isn't just me, it's coming from her.

In suggesting that "empathy only goes so far," Sara senses that there is something else that would explain her experience. Her struggle to conceptualize how part of what she felt originated in her client is similar to that of trainees who were not familiar with the concept of projective identification and had not learned in supervision that clients could induce their therapists to experience their feelings.

It is not only through projective identification that therapists come to feel their clients' feelings. In the interviews trainees defined empathy only in terms of concordant identifications. They drew a clearer distinction between empathy and projective identification than those that appear in the literature where empathy is considered a more inclusive concept. One reason for this is that the concept of projective identification is often explained by reference to the unconscious desire on the client's part to have an impact on the therapist; whereas empathy is understood as arising voluntary from a

therapist's effort to understand. This distinction can be seen in trainees references to clients "giving their feelings to them."

Jane viewed the differentiation of her clients' feelings from her own as central to clinical work. She felt that a delineation around empathy is very important for clinical reasons.

Part of being close to someone is being able to experience their feelings in some way or to feel like you know what they're feeling in a very deep way. Whose feelings belong to who become much more blurred in close intimate relationships, and that's sort of the nature of it. In terms of doing clinical work there are certain kinds of boundaries and a much clearer sense of how you use those feelings in terms of being a therapist. I think projective identification adds a lot to that domain. If I'm in an intimate relationship I'm not quite as concerned with whose feelings are whose and what those feelings mean or any of those types of things. As far as being a therapist and working with a client, those issues are very important in terms of the kind of work that you do.

As can be seen and will be elaborated later, Jane attributes her ability to make this distinction in large part to her experiential understanding of the concept of projective identification.

In contrast, Wendy did not find it meaningful to attempt to distinguish the origin of her feelings.

Once that I figure out that I'm feeling something, I usually don't question whether it's mine or someone else's. Like if I'm with someone sad and we're both sad-or when talking to someone who is sad-if I start feeling sad I'm aware of starting to feel sad but I never question whether it's my sadness or theirs.

That's where the empathy issue comes in for me- I just feel clear that I'm feeling sad with them...I don't really have the concept that I'm feeling somebody else's feelings in the way that's almost disembodied-it's almost-I might use the idea that I'm feeling bored because this person is bored and I'm picking up their boredom, so more in an empathy sense I think...

Isadora also did not find it meaningful to consider that the origin of her affect could be in her client. She did not find the concept of projective identification significant nor had it been stressed in supervision that what she experienced might originate in her client. In considering the idea that her feelings did not come from her, she said:

That's a hard question. Do they come from me? I mean why does a feeling occur. A feeling occurs for me usually because either a thought or an external event. So as I said, if the feeling occurs during or after a session, to me it's been initiated by the interaction with that person but it triggers a feeling that is not foreign to me, and exists in me generally...(For instance) I wasn't feeling particularly rejected in my life at that time but I have in the past, so it was more-this exists so now here's another experience of something I've already experienced. It's because of this client that it's occurring at this moment.

It is possible that neither Wendy nor Isadora have had experiences where part of what they felt had origins in their clients. Neither of them seemed to have considered the potential for an empathic resonance with their clients' feelings.

Jane and Rebecca expressed a contrasting view. Jane felt that it was often on an unconscious level that she

"took on" or resonated with her clients' feelings.

Rebecca said:

To me it's a projective identification when the client just isn't angry at all, is not experiencing the anger and I'm experiencing it really strongly, and there's nothing that they've said that's pissed me off...It's one thing if somebody's just bad mouthing somebody or if somebody's-it's even different if somebody's being obnoxious in some way or pushing one of my buttons. But if somebody's just talking and I can't understand why I'm enraged then it's just something-it's like unconscious to unconscious instead of just going through any conscious channels. Again that's just my own way of seeing it.

Michael had a viewpoint that seemed to be between those of Isadora and Wendy and those of Rebecca and Jane. He at one point had referred to himself as "catching his client's feelings", echoing what Jane and Rebecca had said. At times he sounded more like Isadora and Wendy:

I think of it in just kind of a vague way as a function of the interaction, that I come to feel what he was feeling. But I don't yet have the concept of him giving it to me."

The Impact Of Supervision

Supervision can be seen as playing a pivotal role in Michael's transition as evidenced in the following exchange about whose feelings it is that he experiences:

Interviewer: Have you ever felt confused about whose feelings you were experiencing?

Michael: No. I'm so quick to assume that they're mine that I haven't. And then it's kind of wrenched out of me that they're not all mine.

Interviewer: Wrenched out in a session or in supervision?

Michael: Mostly in supervision. Although that's shifted-a lot of the supervision happens

inside my head now. So it can happen like that. But I don't often feel confused. I might feel confused about the session but not whose it is.

Interviewer: Although you used to feel confused, right?

Michael: No, I used to be sure it was mine...

Interviewer: So through the process of supervision you've become aware that they might not be your own.

Michael: Right.

Michael has begun to internalize his supervision.

Rebecca and Sharon also spoke of their processes of internal supervision. Rebecca described her steps in learning to differentiate whose feelings she was experiencing:

I would have all these feelings and I would leave and go to supervision, or sit down and think "Alright. I have this strong feeling. Is there any reason that I should have had this feeling?" So in a really structured way but outside of the session, asking myself where did that come from? Is it something they did that made me feel that way, or did something happen in my life recently that I'm feeling this way that triggered it off, or is it something that's absolutely unexplainable...(N)ow if I get this feeling that's inexplicable, I can kind of relate it to something that's going on in the person's unconscious. Before I could do that, before I had enough of an access into unconscious stuff, if it was absolutely unexplainable, then I could start to think of it as projective identification and then I could look backwards. Like how might this be there, how might these kind of feelings fit in with what's going on. ...Then the next piece of that is what can this tell me about the person...So like if I had these tremendously angry feelings, I'd come out and go through this list. So if there was nothing they were saying that was making me angry, so then I would say ok, maybe it's something they're putting into me. Then narrowing it, saying maybe they're making me experience the fact that there's a really angry aggressive part of him.

Rebecca's description of her internal supervision focuses on when she might be the recipient of her client's projective identification. Her emphasis is upon the unconscious communication between her clients and herself. In contrast, Sharon's process of internal supervision includes interactional as well as unconscious processes by which she might come to feel her clients' feelings.

I try to pay attention to my feelings, and when I'm having feelings, I try to make a distinction between whether the client is doing something and I'm feeling something in response to it, and what I'm feeling is indeed what they are feeling, and so they're doing whatever they need to do to give me their same feelings, or they're doing something to me, and what I'm feeling is a clue to me of what they're feeling. It's like if you're angry at me and shout at me and make me feel bad, either you want me to know what it's like to feel bad, or you want me to be aware of your anger. And those are two very different things. And so as a therapist, when I'm feeling something, what I'm always trying to figure out is which of those two things it is, that's going to be useful to me as a therapist. And if you make the wrong guess it's hopeless. Because if you're angry and make me feel hurt and I start talking to you about how hurt you must feel, and what you're really feeling is angry, then we're really off base. And similarly, I tend to do the opposite actually-someone gets angry at me and I feel hurt and say 'gee, I can tell you're feeling really angry,' and they say 'no I'm not angry,' and I'm missing the point that what's going on is that they're very hurt.

The Differentiation Of Affect Which Is Similar To One's Own

The differentiation of the origin of affect is especially difficult when it involves separating out clients' feelings which are similar to one's own.

Michael spoke of how he always seemed to be able to "find a link" between his own issues and his clients' feelings. Supervision has focussed on separating out how much is his feeling and how much is his clients'. He reported that with Nathan, his own issues made him prone to confuse the origin of his affect.

At the end of the sessions when I felt so terrible, I think I was feeling his feeling of having failed and therefore he wouldn't come back. And his feeling was having failed and I didn't want him anymore and actually that was my feeling that he didn't want me anymore. And there were a few of those times where it was very clear to me later that I hadn't done anything so terrible in the session...But I was really distraught at times-the intensity of my feelings was really amazing to me.

Interviewer: How was it resolved?

Michael: I think through realizing it. Realizing that I hadn't done anything so terrible. And realizing that the degree to which it was an issue that was important to him. The issue of feeling like he had failed, feeling abandoned.

Interviewer: And so it sounds like a combination of supervision and reviewing who Nathan is helped you realize.

Michael: Yeh. Also somewhat reviewing who I am. I think there are personal issues that made me more prone to identifying. That really helped to resolve it a lot actually. To realize what those were.

Interviewer: So it sounds consistent with the work of separating out-

Michael: Him and me.

Isadora also struggled with the apparent similarity between her feelings and those of her clients. This meant to Isadora then, that what she felt originated entirely in herself. She spoke of various feelings she experienced with her clients, feelings of rejection,

nurturance and vagueness, and in considering whether her clients had produced these feelings in her she said:

That's a hard one. I think-yes they've produced them at that time but all those feelings exist in me. I think a lot of feelings are produced in people. I don't feel as vague as S, I'd say that's the one that sticks out as being the least part of me in any way, I mean, mothering, and feeling rejected are part of me so it's hard to say they were created by them. But I think that the fact that it happened at those times was due to them.

Work With More Disturbed Clients As A Context For Considerations About The Origin Of Affect

Perhaps it is in experiencing alien feelings that trainees begin to consider that they can have feelings which originate in clients. It was through experiencing unfamiliar feelings that Jane first thought about her clients "giving" their feelings to her:

The first time it came up was with this borderline client in supervision. I was just so frustrated and I didn't have any way to explain those types of feelings. Feelings of anger. And those are feelings that I don't experience very often. It was very striking for me to be feeling those types of intense emotions. And my supervisor and I discussed the whole concept of projective identification and how it fit it. And it just provided me with a framework to think about my experience and thinking about my client and myself and how it fit together. So the first experience of finding that concept useful was in the context of having feelings that I didn't usually have. And that was a clue that something was going .

Trainees who had worked with borderline clients found meaningful the idea that they could experience feelings which originated in their clients. In reflecting on the concept of projective identification Jane said:

I think this concept become's more vivid off certain types of clients. I wouldn't feel as comfortable if I hadn't been working with a borderline client. Something about that type of client provides context for thinking about the question of whose feelings.

Another advanced trainee spoke of her work with borderline clients at a suicidal crisis center to illustrate her conviction that she could be made to experience her clients' feelings:

It's interesting, but projective identification happens constantly when I see the clients at 'ES.' It happens all the time and it's entirely projective identification. They're great at it. It happens at one shot deals often. These people come in and I'll sit and have a session with them-45 minute evaluation-it's always with borderlines, and they infuse me with all their anxiety and they leave feeling better. And it's the most incredible experience. You can watch it happen, and you can't stop it because they're too good at it. But they'll come in and say 'I'm gonna cut, I'm gonna cut, I did some cutting'. And they won't tell you that they feel better, but they'll go and hang out and by the end of it I'm filled with incredible anxiety...maximum anxiety, and I can feel it rising as I sit with them, I just feel it going up and up, and I know what they're doing but they're great at it. I don't know how they do it, but they're great at it.

If working with borderline clients provides a context for considering oneself to be experiencing another's feelings, then it is not only developmental change that explains different views among trainees about the origin of their affect. This is corroborated by Dorothy and Sharon, both of whom in their first year of seeing clients grappled with this question due to seeing seriously disturbed clients. It is interesting that in

reflecting on their initial reactions to clinical work, both Sharon and Dorothy spoke of fearing that being a clinician meant being on an emotional "roller coaster."

Sharon spoke of her early work with Karen:

My first client was very crazy-it was a client that would not have been assigned to me as my first client if people had realized how crazy she was. And she used to decompensate during the session, and she would start talking nonsense. She would talk at a rapid fire clip for 50 minutes in such a way that the only way that I could say anything was to say-'wait, excuse me, Karen!' (waving hand) and the stuff that she said often wouldn't make any sense. She'd start a sentence and stop in midstream and start talking about something else. And everything would be tangential. And I used to come out of that room feeling crazy, I literally felt crazy. And a couple of times I had to go and track down my supervisor and say 'I don't know what to do with this-I really feel nuts.' So anything after that has been much easier for me to deal with. But it was also an interesting trial by fire because it taught me about that phenomenon, so I don't think I'm surprised or upset when it happens to me now and it never happens to the same degree. Interviewer: The phenomena of?

Sharon: Of feeling like they put their stuff into me.

How did this become meaningful?

I remember my supervisor making it clear that basically what I was feeling was Karen's feeling. She was conveying it to me in this way because she didn't have any other way of conveying it rather than that I was crazy. Which it felt like. Rather it was that I was experiencing her craziness.

Sharon effectively conveyed how crazy she had been made to feel in her work with Karen. She was relieved to learn that her "craziness" could be explained. In discussing how the concept of identification is an

"excellent vehicle" for teaching trainees to form interventions on the basis of "empathic responsiveness," Lakowics (1983) sheds light on how important it would be for Sharon to know it was her client's craziness:

Without a conscious recognition of the varieties of identifications, it is not possible to respond empathically on a consistent and prolonged basis to patients with serious and complex psychopathology. (p. 253)

The intensity of Sharon's experience was echoed by Dorothy in her descriptions of her early work with Tina. For Dorothy, the alien nature of what she felt was in the intensity of the feelings.

(I) would have such incredible emotions about things. I would leave the room so angry-I would leave the room and my neck would be beet beet red. And I would feel like I had no control over getting that angry. I don't think it was just a countertransference problem. I would be so fucking angry. Or just so fucking confused. Extreme forms of emotions. Sometimes she would give it to me big times, but other times it was hard to understand why I would be feeling such extreme emotions.

After the first session:

I ended up calling my supervisor. I was seeing her on Fridays, and at one point I called saying 'I don't know what went on but I was so angry I almost couldn't contain-what is going on?' I was upset the whole weekend. I woke up in the middle of the night-that kind of upset. Just really taken aback by what had gone on. And I couldn't understand why I was continuing to feel that way. I just couldn't shake it so I ended up calling him and talking about it. That made it more manageable.

Since some of what Dorothy experienced was related to competence and failure, as a beginning therapist it was hard to differentiate whose feelings these were:

At the beginning it was difficult to realize these feelings were coming from the client rather than from me because I was so nervous about beginning therapy. But after a while I realized it was consistent and it was powerful enough and after talking about it in supervision, I saw that it was coming from them. I could see differences between the three clients and that's how I knew it wasn't just me reacting in a particular way to particular things.

I asked Dorothy if she ever felt confused about whose feelings she was experiencing?

Yeh. I went through that a while ago. Especially at the beginning it was very confusing. I didn't know what projective identifications were, I had no experience with this kind of therapy at all. Supervision helped enormously. That's probably the biggest factor. In terms of my borderline, I had observed some one with a borderline client over the summer, and just remembering some what the therapist had talked about in terms of her feelings. So I was a little prepared that that could be there but I was like-'not me!; That's not going to happen to me.' So when it started to happen in repetitive ways, and it started to happen in different ways, although I knew I didn't feel competent, that wasn't the only thing that was going on. With Tina, I specifically felt incompetent but I didn't feel that way with R, so something's going on with them-I'm not having the same reactions of feeling incompetent, since that was my biggest concern. So I think just seeing different clients, and having a chance to talk about it in supervision, and fitting together what I had heard from others about how clients made them feel.

It is largely through her work with Tina that Dorothy became comfortable with the idea that she might experience her client's feelings.

I feel the anger was the biggest one. I definitely think-she was feeling very angry, I

wasn't feeling angry for any reason. The stuff she was talking about didn't make me angry, It was the way that she presented it...I think the way she produced the feelings in me, I think the anger was a defense against her fear of loss, and the way she made me feel angry was to make me feel as vulnerable and almost at loss as she was. Like 'I'm not good at anything I'm doing and you're not good at therapy.' So she basically attacked me as her therapist. But it was more than just the words, it was the whole interaction. There was a lot of body language. I didn't even realize how angry I was until she called my attention to it, so it really had a very strong effect on me.

Dorothy would agree with Jane that it is something about working with more disturbed clients which makes the concept of projective identification meaningful:

We talked about it (projective identification) a little bit last summer-although at the time it didn't really make sense to me because I didn't have anything to hang onto it. Although I was observing another student who was seeing a borderline client, and there were times when I was just observing and I'd end up feeling things I didn't expect to feel. So I guess I was prepared a little in observing. And I can recall this therapist saying things I now say in the room-like this person's clenching their fists and like holding onto their chair-like you kind of hang onto yourself. I have the same experiences a lot of the times-like 'ok, here it comes.' So I say the same things I remember her saying and it's really funny. But I don't think there could have been anything to prepare for being in the room.

What does Dorothy think about this now?

I think you've got to take them in-really not as your own, but you've got to take it in and digest it in a way that's not always comfortable. Especially if they're not particularly good feelings. I think that's a requirement. I think that's necessary in therapy.

The accounts of Jane, Dorothy and Sharon illustrate how experiences of conscious recognition and examination enabled them to understand that their affect could originate in their clients. Perhaps this possibility is so unimaginable to some trainees that they must experience it before it becomes meaningful. Wendy described her struggle with the concept of projective identification as follows:

(I)n supervision sometimes we talk about things in the way that sounds more like projective identification like: 'You were feeling that person's anger.' I'll think about it in that way...sometimes after the fact I'll think about my interactions and my feelings in that way, but typically I don't...I don't feel them as those they're somebody else's feelings. I feel them as if they're my own feelings that are connected to what's going on...later I might think about them in a different way...It doesn't feel real in terms of a gut level at this point. It feels like it's more intellectual. It's a way of thinking about it and sometimes it leads me to a better understanding.

Wendy's grasp of projective identification is largely intellectual at this point. She has not had the dramatic and intrusive experience described by Dorothy and Sharon nor the containment of alien feelings described by Jane. Perhaps she has been the recipient of projective identifications but they have been understood as her own affect. The concept of projective identification sounds psychotic to her; Dorothy and Sharon would say that, indeed, it feels psychotic! Wendy expressed her confusion:

It just doesn't sort of-I can't connect with it on a gut level that these feelings aren't mine. It just feels really psychotic-that these are somebody else's feelings that are somehow in my body. And I guess I have enough trouble recognizing my own feelings and what I'm feeling that I don't want to have to deal with recognizing and then deciding is it mine or somebody else's.

Peter also was perplexed by the concept:

When I first heard about projective identification, I thought 'whooo, this is the twilight zone! I don't go for this, how is it possible given the laws of nature!'

Experiential learning is sometimes necessary to complement theoretical exposure.

Peter's and Wendy's reservations echo objections in the literature about the concept of projective identification (Finell, 1986; Whipple, 1986). Rebecca's comments illuminate some reasons why this is a difficult concept. Her reflections speak to Wendy and Peter's concerns:

(I)t's scary to think that someone else might be able to put something into you. Not only put something into you but your unconscious. Something that's so scary that it's absolutely unbearable. That people have that kind of power, or that you can feel that people can have that kind of power...(I)t's a magical concept and I think that's anxiety producing...(T)alking about putting feelings into somebody else and making them act it out. I mean, that's magic. And I think if you see the use of projective identification as having it's roots or beginning in a pre-verbal time, it is magical-because that's a magical time, that's a primary process time. And that's scary, that's the time before words do much good. And that's scary too because we're so good at putting things into words, good at intellectualizing, and we try to diffuse things with words. Some of my thinking comes from (an

article about) when words are useless, when words are unpredictable. And that's scary, because that's what we do-we say that by putting it into words it will be ok, and with projective identification you're talking about something that until we manage to do something with words, which is the way we make it, I think, acceptable to the client, we're talking about one of those early experiences that are unmanageable, and who wants that.

The Differentiation Of The Origin Of Affect Makes The Work More Manageable

Dorothy's evolution illustrates what seems to be an important feature of the differentiation of the origin of affect: the work becomes more manageable. Rebecca agreed:

I think that's one of the things that I've thought about the most, because projective identification and countertransference is one of the most interesting parts of doing therapy. And I've sort of come up with my own sense of development about that. To me there's kind of been this general sense of not recognizing it, and not doing anything about it, and just being kind of buffeted. And it makes being a therapist so hard-I used to go home-I mean that's a big part of taking clients home with you for me.

Rebecca feels that resonating with clients' projective identifications is part of the larger challenge of learning to work with countertransference. In contrast, Jane felt her own difficulty was limited to experiences with projective identifications. She agreed that an increased ability to recognize when her feelings are coming from her clients makes the work more manageable.

What I think happens as a result of experiencing this a lot is that I have a much greater ability to make that conscious more

quickly and to feel like these aren't my feelings that I'm having. Which I think makes the work much easier because I think the experience of holding someone's feelings when they're not yours can be very disturbing at times if you don't realize that they're not yours...so I think that gives you a lot more confidence to enter into that kind of process-I think that if I had to contain my clients feelings and think that they were my own I couldn't do it. It's ok briefly but otherwise it's just too draining on a very personal kind of level so I think that some of what I'm describing has to do with knowing that you don't have to-that you may experience that briefly but it's not going to be an extensive long term process.

Jane expressed more confidence than other trainees in her ability to differentiate her feelings from those of her clients. Dorothy wants to maintain susceptibility to "taking on" clients' feelings but wants to process them more quickly.

(I) like feeling susceptible-not that it's going to overcome me but that I need to really figure it out. To figure out what it means for them and to figure out if it really is my own or theirs. So the trick to me is not to give up my susceptibility but to give up the weight that that carries, or how bogged down in it I can get. It doesn't scare me the way that it used to, now it's just part and parcel. It's more fun to me.

Rebecca also wanted to become more adept at recognizing when she was the recipient of a projective identification:

I think what I'm shooting for, I'm trying not be judgemental, but in thinking about how I want to develop, it's not by becoming less open to them because I don't want to be closed off, but it's in becoming quicker to identify them, and so not having them-being able to have it almost as immediately as possible, at least the identification part of it, because that's where

the problems come in, so I want to be open to it but be able to use it more immediately. So I think I'm pretty open but sometimes it takes me too long.

Rebecca is alluding to the potential of "identifying with the projection" which then makes it more difficult to recognize that the source of one's affect is in the client.

Rebecca, Jane and Dorothy have been talking about differentiating their clients' feelings from their own in those circumstances when they are the recipient of a clients' projective identification. The potential for identifying with the projection is an important topic in the literature on projective identification. The literature on trial identification discussed in the previous section suggests an equally important potential for a prolonged identification during empathy. Under such circumstances, the therapist loses sight of the origin of her affect.

Rebecca took the problem of the differentiation between her feelings and those of her clients further. She had an expanded notion of the range of interactions in which she experiences her client's affect. She discussed how she has grown more adept at separating her clinical work from her personal life:

They weren't really my feelings and they weren't really a part of my life outside of therapy. They were part of my interaction with that person in the room.

The Work Ego

Rebecca's realization that feelings arising from clinical work are not actually part of her life brings to mind Schafer's (1983) concept of a therapist's "second self." Schafer says that a therapist develops a "second self" which he defines simply as "how the analyst functions as an analyst." He maintains that the second self functions differently than how the analyst functions as a person outside of the clinical context; individuals who are to some degree interpersonally impaired, be it unempathic, grandiose, etc., are able to function successfully as analysts due to the structure of the second self. Schafer holds that this second self has the capacity to regress in service of the clinical interaction and likens this regression to Kris' (1952) idea of the regression that happens as part of creativity.

Olinick (1973) presents a similar formulation of the work ego as simply the analyst at work. The work ego is defined in terms of functions such as the experiencing or observing functions: the concept implies a personality of traits, motivations and talent of the analyst at work. As early as 1942, Fliess maintained that an analyst must develop a work ego; and that this structure must have a "special relationship to the id, the environment and to the superego" because of the "constant oscillation between fantasy and logical scrutiny" (p. 221). He says

that part of the ability to be empathic rests upon the relaxation of the superego's guard on the activity of the work ego and a willingness to regress.

Little is said about the development of this second self or work ego during training but it seems that the ability to be empathic and to realize that an identification has occurred would be facilitated by and would facilitate the development of this structure. Brightman (1984) implies that part of a therapist's development is the establishment of a secure professional self not excessively vulnerable to threats to self esteem. He says that an inverse relationship exists between "the professional self's vulnerability/grandiosity and a capacity for accurately perceiving the other" (p. 312) or being empathic. Ralph (1980), in his description of the milestones that trainees progress through in the use of self does not elaborate but says that ego development is a part of the process:

The changes that trainees report seem to be a facet of ego development-that is enduring changes in schemas about the self and others. (p. 249)

The concept of a work ego that has similar qualities to the ego suggests that it could be formed through a similar developmental process. Schafer's (1968) scheme that ego structuralization happens through a sequence of incorporation, introjection, and finally identification

could apply to the concept of a work ego. Some have applied these ideas to the development of a therapist's self as a function of supervision. Ford (1963) suggests that supervisors are introjected and used as auxiliary ego supports. This introject undergoes changes until it is either incorporated (identified with) or rejected. Jarmon (in press) also suggests that the supervisor functions in something of an auxiliary fashion. He compares the supervisory relationship to the holding function of the mother-infant dyad. The supervisor creates enough of a safe "holding" environment to allow the supervisee to develop a clinical self by being able to separate her experience from those of her patients: "Her supervisor's task was to help her see the whole relationship she had taken in and to differentiate her experience from the patients." He sees this as a parallel to early development: "in the context of a safe holding environment, the infant can begin to differentiate between self and other, i.e. to develop its own identity." As "the self develops in part as a function of its identification with others," Jarmon sees that mutual identifications between supervisor and supervisee contribute to the development of the supervisee's therapeutic self through enhancing the supervisee's ability to identify with and separate from the patient's experience.

Tansey and Burke (1989) examine how the clinical encounter impacts on the development of a work ego. They term as "interactional introjects" the therapist's "introjection of the treatment process with each individual patient" (p. 51). They suggest that a therapist's "work-ego" is the sum of these interactional introjects. Interactional introjects consist of "working models" (Greenson, 1960) of both the patient and of the therapist in interaction; the latter model being the "different self experiences highlighted with different patients" (Tansey & Burke, p. 91). The work ego is then conceptualized as an "enduring representation of the self consolidated over time from images of self in interaction with patients" (p. 51). As in Schafer's schema, the various interactional introjects over time influence and shape more enduring identifications and influence the "self of the therapist in terms of ego functioning" (p. 51). Supervision would help the therapist become aware of these changes in self experience.

The comments of Wendy illustrate these points. She describes becoming aware of differences in her self experience. She is developing a frame of reference for her work ego.

I feel like I'm in a dawning understanding. I feel I'm still really at the point where I get surprised, where I'm noticing differences. I'll notice this felt good, or this session felt shitty. Or I feel like I can joke with this person. Or more typically finding myself

doing something and realizing later- 'God that felt different,' or 'I'm feeling more comfortable.'

Wendy's developing frame of reference would facilitate her scrutiny of her inner experience to understand how she is being impacted by her client.

This chapter has explored the impact of trial identifications on the inner experience of therapists and the thoughts of therapists-in-training on the origin of their affect in clinical work. Differences among therapists-in-training varied due to level of training. Both theoretical and experiential learning had an impact on trainees' perceptions of the origins of their feelings.

CHAPTER V

DIFFICULTIES IN EMPATHIZING

Introduction

Learning to use the self as an instrument of therapeutic investigation is a complicated and challenging developmental process. Thus far I have discussed a number of issues for therapists-in-training in learning an empathic use of self. These issues have included: (1) the oscillation and balance between the observing and experiencing positions; (2) the impact of trial identifications upon inner experience and how to use the resulting affect; and (3) the intersubjective communication of affect. This chapter will explore how empathic functioning is affected in the treatment of clients who are working on issues also salient in the therapist's life and the loss of boundaries during empathic moments.

Working with Similar Issues

The previous chapters have explored the processes of therapists-in-training learning to recognize that affect evoked in clinical interactions, though experienced as one's own, can be understood as originating in one's client. This perspective on the intersubjective communication of affect serves as a vehicle for enhancing

one's understanding of the therapeutic interaction. Supervision can help trainees learn to shift from an experiencing to an observing position. This shift and the recognition that an identification has occurred makes it possible for the therapist to think about the meaning of her inner experience and therefore that of her client's. The ability to make this shift is enhanced by the knowledge that affective responses can be used in the clinical situation. The development of a work ego also strengthens the ability to make this shift.

A trainee's task of separating from an experience induced by her client becomes particularly difficult when such a way of experiencing herself is one which, for historical reasons, the trainee is accustomed to. This occurs in the context of treating clients who are perceived as similar to oneself and/or who are working on issues important in the therapist's own life. When working with such clients, the task of separating from an identification is especially difficult in that the identifications can evoke representations that reflect one's own.

Lakowics (1983) suggests that both concordant and complementary identifications can stimulate a therapist's own conflicts and/or unconscious defenses against these conflicts. He suggests that stimulation of the therapist's conflicts can "prevent the therapist from recognizing that the identification is coming from

outside himself" (p. 251). Along these lines, Basch (1983a) says that a therapist can unconsciously defend against affective responses due to not being able to tolerate in a client what is defended against in oneself. Goldberg (1984) suggests if a therapist is too anxious about an issue, an insufficient openness to trial identifications can result. Alternatively, Tansey and Burke (1989) formulate that transient identifications can be intensified by the activation of the therapist's historical introjects. Olinick (1969) suggests that at the moment of a transient identification, the therapist has the same conflict as the client. When this conflict is familiar to a therapist, the transient identification would be particularly potent. Jarmon (in press) suggests that identifications will be stronger when a client is important to a therapist. Finally, Berger (1987) suggests that a therapist may be drawn into a prolonged identification when operating from an overly sympathetic state such that may happen when clients are perceived as similar to oneself.

Comments from Michael illustrate these points. He felt he identified with his client, Nathan, because they struggled with similar issues despite generational differences.

(T)here were certain dynamics that he had that I think I share. That perhaps made me identify with him more strongly and empathize more strongly than with others or in a different way. It really pushed the identifications."

Failure was a salient issue both for Michael and this client. Michael had experienced Nathan's feelings of failure as his own. He felt it was partly his identification with Nathan that led him, in his words, to "(catch)" Nathan's feelings of failure. As a result, Michael experienced an intensification of feelings that he felt already prone to having.

These formulations suggest that when treating clients who are perceived as similar to oneself or who are working on similar issues, trainees will face particular and perhaps intensified challenges to neutrality as well as to their sense of themselves as therapists. These challenges will be explored in the following section.

Increased Investment In The Work

The feeling of increased investment emerged from the challenge of working with clients with whom one identified. Both Sara and Wendy felt more emotionally involved in their work with clients who had similar issues. In speaking of Joanne, a client whom she perceived as similar to herself, Sara said: "in some ways it made me really want to help the person more...it definitely made me feel more connected to her."

For Wendy however, the increased investment had problematic consequences. Wendy sometimes wished that her client would change because she identified with him and wanted him to experience the resolution she had found in her own life.

Our work in general had been frustrating for me. Because of my investment in him. And in some ways my identification with some aspects of his stuff. Or more invested than I might be with other clients. And that was what was frustrating-his resistance. I think that to the extent that I identify with at least some aspects of his issues makes it a little more intense. And adds some intensity to the frustration and the protectiveness.

Questions About One's Role As Therapist

Wendy sometimes questioned her capacity to be a therapist when her clients worked on issues that were important in her life. At other times she felt especially gratified because she could use her past experience to help her clients. She recognized that when the issue was not yet resolved it could be problematic.

(I)f i can use it-either to make some connection or if I can use it to help me understand it better-to help a question that's useful or point out something in the process, then I really like that. I feel good. It feels kind of scary but good. I feel like it's useful. Like I was able to use something that I've worked out for myself and it felt really good to be able to be useful. On the other hand, when I can't do anything with it, when I feel like shit, this is the same thing I'm struggling with I have nothing useful to say, tell me when you figure it out', then it feels really awful. Then I feel insecure and question why am I being a therapist and I feel very grateful for supervision.

When Sara identified closely with her client Joanne, she also questioned her role as therapist.

The client was somebody who reminded me of myself in a lot of ways. The issues weren't identical, but she did remind me of myself in some ways. We're similar in the ways she thought about certain things, how she dealt with certain things, some of her problems. And the feeling was 'oh god, I don't know if I can help this person, I'm doing the same things she

does-I still do them.' I think in some ways I handle them better but at that age I did the same thing and I don't know if I can help this person who is so much like I am, or seems to be so much like I am. So the feelings were we're too much alike, like we're soul sisters sort of thing.

Sara and Wendy questioned their role because they were no more resolved on issues than were their clients. Halpern and Lesser (1960) write that therapists are better able to empathize in areas of life where they feel satisfaction. Therapists are less defensive when working on resolved issues than on active areas of conflict. Sara and Wendy are concerned that their conflicts impede the help they can offer as therapists. When confronted with a client with a conflict similar to their own, they relinquish the view that they may still know enough about the workings of conflict, defense, development, transference and countertransference to serve as guides in their clients' self exploration. Their tenuous sense of separateness and potential for objectivity is threatened. In order to avoid this threat one can imagine that some therapists might invoke a kind of splitting defense that is characterized by an us vs them perspective vis a vis their clients (Rausch, 1986).

The Constraints Of The Therapeutic Role

Sara's reaction to Joanne of feeling so much like her-feeling "soul sisters sort of thing"-resulted in her wishing to forsake the therapeutic relationship:

I sort of wish we had met at a different place and time and could be friends. God, I wish I was X number of years younger or her older, or this weren't the conditions of knowing each other. I felt I could help her more if I was her friend versus her therapist. It was an odd feeling.

The exploration of Sara's wish to befriend her client would undoubtedly yield meaningful material about how Sara experiences herself differently as a friend than as a therapist. This was not pursued in the interview. Her comments emphasize the extent to which the therapeutic role can be experienced as constraining. Sara seems to wish for the freer expression of a personal relationship with Joanne but it is not clear why she feels she could be of more help to her as a friend. The clinical relationship requires interpersonal behavior significantly different from that of a friendship: A therapist "requires of himself the subjugation of usual modes of human interaction-an abstinence imposed by the demands of the method" (Marguelis, 1984 p. 1030). As new therapists, not having yet internalized these new interactions and lacking a well-developed work ego, trainees miss social ways of interacting. Their yearning for a familiar code of interpersonal behavior seems to be most acute with clients whom are perceive as similar and able to be imagined as a friend.

One constraint of clinical work is having to refrain from overt shows of affection or nurturance. Therapeutic giving is primarily through interpretation and empathy,

not physical contact and self disclosure. This constraint could be particularly problematic when working with clients with similar issues. Peter described his experience of having to hold back in his work with a family where the mother struggled with health problems similar to those his mother suffers from.

(The) mother is begging-calling for emotional support from her son. All he really had to do is get up and hug her. He wasn't giving her any emotional support. And I was feeling like I really wanted to and was holding myself back hoping that son would do it...I knew I had to maintain my neutrality-especially with the team behind mirror!

Peter seems to be "feeling for" his client rather than "feeling with" her, or with her son (King, p. 337). He felt pulled by the mother's need for support and had to struggle not to act in a sympathetic way toward her. Because of his strong personalized response to the mother Peter is unable to appreciate how the son experiences the mother's communications. Because Peter is listening as if it was he in the son's situation he is not able to experience what he had told me he knew to be the son's resentfulness and anger. Peter obfuscated his alliance with the son when his own feelings took precedence. His neutrality is compromised but because he recognizes the feelings as his own personalized countertransference, he does not commit the mistake of "assuming or insisting that the (client) must of necessity feel what (he) might

experience given his situation" (Basch, 1983b, p. 114-115). Peter managed to maintain a neutral stance behaviorally despite his loss of emotional neutrality. He does not seem to recognize that it is sympathy he felt for the mother, not an empathic alliance with her or with her son. Goldberg (1980) suggests that:

Compassion or sympathy in psychotherapy is like politeness: it is a natural part of interpersonal harmony but probably has nothing to do with psychotherapy...Unfortunately it has addictive properties and can become an indulgence, and become a substitute for treatment. (p. 239)

Giving advice or problem solving are other deviations from a therapeutic role which might be pulled for most acutely by clients with similar issues. Sharon was one trainee who had experienced this pull.

When I'm unsure or uncertain of something-my tendency is to jump into the middle of it-I'm very problem solving oriented, I try to figure it out, solve it.

Sharon felt most tempted in these directions with Susan, a client whose family is unusual and Sharon believed, remarkably similar to her own. Sharon had learned to problem solve as a way to cope with the same dilemma Susan was currently facing. Her identification with Susan exacerbated her problem solving efforts:

So I have to bite my tongue to force myself from telling her how to do it. And I can't not do it; it's a joke in supervision now. Every time it comes up I have to put in at least a little tidbit of an idea!: 'Have you considered (doing such and such)?!' And depending on how strong I am in the session I do it less. Sometimes I'll really push it. It's like I can't not do it. I can say to myself, she's not you, for whatever reason that

you were able to do this she's not able to do this, she's not ready, you've brought it up enough times to know that this is not the course she's going to take.' But then there's this other little voice that says, 'But she would be so happy, it would be perfect. Let's see, she could (do such and such).' It's like I become her at that point, or she becomes me, or something. We aren't two separate people.

Difficulty Maintaining a Sense of Separateness

Sharon saw parallels in Susan's life and her own.

In perceiving these similarities she runs the risk of projecting her personality and needs onto Susan. She was aware of this:

I think it's more narcissistic stuff. I think I know what the answer is if she would only do it. And also her as a reflection of me: this worked for me so obviously it would work for her. We're alike in certain ways in this particular issue so she should be my little clone and it would work.

Sharon's struggle to keep herself cognizant of differences between herself and her client are admirable. Her difficulties can be used to illustrate important pitfalls experienced when treating clients with whom one perceives similarities. Perhaps many trainees are not conscious of the risks that Sharon sees.

I get confused about what's their stuff and what's my stuff. I worry about if how I'm conceptualizing what's going on for them is really because I'm superimposing my own issues onto them or not. And I think I understand them, but then I worry that that's really very facile, and that I may not understand at all but just that there are a lot of similarities.

Sharon illustrated the need to continuously "put oneself aside and attempt to doubt what seems obvious and clear" in order to perceive the client (Marguelis, 1984).

The line between empathy and the projection of one's own conflicts on to a client is often difficult to distinguish (Berger, 1987; Ferreira, 1961). "To project one's attitude onto a patient may serve as an unconscious defense against unacceptable conflicts and may interfere with an accurate understanding of the patient" (Berger, p. 31). This can result in a therapist's failure to perceive the differences between himself and his client.

From an alternative angle, Tansey and Burke (1989) assume that therapists use a range of introjects from their own life experiences as "potential models for the identifications stimulated by the therapeutic interaction" (p. 55). It is important that "identifications based on introjects established independently of the therapeutic process be scrutinized closely for the degree of correspondence" with a client (p. 55). The therapist's self awareness is vital here. In the above illustrations, Sharon sensed that she was not responding empathically but was seeing herself in her client.

Sara at first also experienced difficulty keeping herself separate from her client, Joanne, with whom she felt so identified.

(I)nitially it was overwhelming. As time went on I felt more able to use the feelings because I could see-we aren't the same person, we're not going to be the same person and I can be helpful in spite of this weird sort of

connectedness that I feel. I feel it's harder this way than in other cases.

The ability to be empathic is founded upon a psychological sense of separateness (Schafer, 1959). Empathic experiences do seem to involve moments of "illusory merger" (Buie, 1981, p. 286) as will be explored in the next section. However, these moments are sudden, transient and more uncanny than what Sara and Sharon have described. The chronic lack of separation they experienced stemmed from failing to distinguish their clients' mental states from their own. They were each vaguely aware of this and described their struggle to see their clients distinctly. Sara said:

Some of the time I wish I didn't have them,
(the feelings) because I felt I could be more
objective and therapist like.

Sharon saw this as a problem most likely to occur when she worked with people with similar issues. She questioned whether she understood them or whether she was only understanding herself:

(I)t engages me in a way that I think prevents me from being as objective as I would like to be. As a consequence I'm not really sure about whether what we're talking about is really my stuff or their stuff. I would say that it's a feeling of the boundaries going down, and their stuff and my stuff getting mushed up together, and me not being sure of what it is I'm looking at.

Sara also felt concerned that what she was responding to in Joanne were her own feelings. In discussing whether she ever felt confused whose feelings she experienced, Sara said:

Sometimes, and when I do I don't say anything. But the more I've seen her, the more I've seen the differences. It's less cloudy in terms of which are hers or mine. But mine do get muddled in there and it's hard to differentiate sometimes.

Clients Doing The Therapist's Own Work

Elizabeth worried about inducing her clients to work on her own issues. She had gone through an emotional crisis during the year and found that all three of her clients in the same week would work on issues that were of concern to her.

The thing that has been most upsetting to me lately is that the things in my therapy that I've started backing away from and haven't wanted to do because it's too hard, have been things with my clients. And they've been doing it and having these great...that she would suddenly have this great breakthrough and I would think: "That's what I'm suppose to be doing-that's exactly what I should be saying, that's exactly what I need'...that part of my strong feeling for them and part of my strong identification with this person is that she's doing my therapy for me. It was horrible to realize that that was going on. The work with her has been very good and it's certainly what she needs to be doing, but to realize that I was doing that and that that's part of why I was feeling so strongly and identifying with her-that was really hard.

Elizabeth realized that her identification with her clients stemmed from the fact that they were doing her emotional work. Apparently unaware that some consider a strong identification a departure from neutrality, the identification itself was not of concern to Elizabeth.

Sara also wondered whether the connection she felt with Joanne emanated from her sense that Joanne could be of help to her. This in turn made her want to help Joanne more:

In some ways it made me really want to help the person more, maybe part of that was a way of helping myself which may seem inappropriate.

Peter expressed concerns about how his work with the family with an ill mother activated conflicts about his own mother:

I realize I have this big countertransference issue that I have to deal with. So that's what I often feel. I feel like I need to help-to do something for this poor suffering person (the mother). I have to say 'ok, how much of this is coming from my need to help my mother.' So the feeling I get is one of concern to make sure that I'm doing what's best for the client, rather than what's going to help me the most.

Thompson (1980) addresses circumstances such as these when the therapist's conflicts are stimulated by the work with a patient:

In such circumstances it is clear that the patient and analyst have engaged in a relationship which is likely to change both of them. The analyst is forced to face aspects of his instinctual life, defence or self-structure (e.g. narcissistic vulnerabilities) which he now must master or master anew by a fresh piece of self-analysis. (p. 187)

Sharon explored additional ways that therapists can be drawn into helping themselves when treating clients with similar issues. She experienced herself as wanting to be a better mother to Susan than is Susan's mother.

I think there's a part of me that wants to be generous with her, and wants to give her something, and wants to be different from her mother, and her mother is saying (such and such), and I'm wanting to be the good mother as opposed to the evil mother-because I hate her mother-she definitely triggers that in me, I hate her mother. So I want to give to her as a good mother would instead of what her mother is doing.

Since Susan faced similar problems with her mother as Sharon had with hers, perhaps rather than hating Susan's mother, Sharon is actually hating her own; she does not know Susan's mother and has no relationship with her. Sharon also considered that in her identification with Susan, she was wanting to be a better mother to herself through her generosity to her client.

Activation Of The Therapist's Conflicts

Many trainees considered the possibility that treating clients with similar issues could be a source of personal growth. For most, this was because being confronted with their own issues through their client's work made it necessary to work on themselves. Wendy appreciated the value in this work but recognized the risk of confusion between herself and her client. She discussed her concern in terms of "taking on" or introjecting aspects of her client.

There's ways in which people whose issues are similar to mine are the most interesting and exciting because there's the most potential of growth to me. So it's challenging but also exciting and attractive. Yet with respect to this issue of taking on it's the scariest because that's where I would be the most vulnerable. I mean I don't know how much I'm thinking about this because we're talking about it or how much I thought about it at the time, but I'm thinking well of course it wouldn't be just any issue but would be things I'm more vulnerable to taking on.

Wendy recalled an experience in which she identified with a client's hand washing compulsion:

(It) reminded me in some ways-I also used to be more concerned with cleanliness and germs...so I noticed I felt very uncomfortable about it and I mentioned it to my supervisor. And then eventually stopped doing it....I think it played into my own stuff in some ways. ...I guess it hit an old button and I didn't think about it and then sometime like a week later I found myself doing this a lot and made the connection.

Sara reported a similar experience of finding herself acting in ways she had in the past and related it to the contact with Joanne. In contrast to Wendy's identification with her client's compulsive symptom, Sara felt a more general identification with Joanne.

She's one of those people that is very conscious of food, weight and physical appearance. Sometime I am and sometimes I'm not. When the case began that was an issue for her but I was in a 'It's not important to me mode.' As the case went on, I found myself doing just what she does with food, and worrying more about weight and all that stuff. But the thing is, the thing that was funny was that I knew it. It was like 'Alright, I'm letting myself do this because I do these things anyway, so I'm just going to let myself do it again.'...Part of it was what was going on with me personally anyway. But also, I was like, 'Well, this is how she gets control in her life, and that's how I've always in some ways gotten control in my life so-since things are out of control I'm going to get control back and I'll use her way which was always my way too.' Which I might not have done if it hadn't been something we were talking about because it had been so long since I did something like that.

For both Wendy and Sara, old defensive maneuvers were reactivated with their clients. A transient identification "hit too close to home" and "stimulated a pathological identification" (Goldberg, 1984, p. 63).

This created difficulty for Sara and Wendy in maintaining the psychological boundaries between themselves and their clients. Sara made a conscious decision to act like her client, but Wendy had experienced her clients' effect as "insidious." Wendy's experience was more disturbing and influenced how she felt about becoming a therapist:

I noticed it, and I didn't like it because it was disturbing. It was intrusive. I didn't want to be doing this and it was disturbing that this client could insinuate-effect my life. So that made it disturbing also...(B)y insidious I mean less conscious. It's one thing to kind of feel bummed out or angry or something else and saying that being with this person made me sad or whatever, because that's sort of part of the game. Or even to say 'Gosh, I really like this about this client and decide to try to be more like them. But to find myself being like a person unconsciously, especially when it's something that I don't even want to be, that's what was disturbing. It's the unconsciousness of it that I meant by it's insidiousness...(I)t's disturbing in the sense that I like to think I'm captain of my ship. And if I'm washing hands because of this-what else, maybe I'm going to start having other issues this person has. Just the sense of being out of control...(I)f this could happen what else could happen.

Defensive Moves

One final point about the challenges of treating people with similar conflicts emerged in the interviews. We have seen how working with such clients can stimulate a therapist's own conflicts, often resulting in increased and prolonged identifications. Alternatively, therapists collude with clients to avoid overlapping conflictual areas. Cohen (1952) suggests that when a therapist's neurotic conflicts are restimulated, five self protective

maneuvers are often undertaken: 1) an increase in activity; 2) a change of subject; 3) attacking the client; 4) ending before the allotted time; or 5) colluding with the client's resistance or ambivalence about exploring the conflictual materials. Goldberg (1984) suggests that defensive maneuvers on the therapist's part impede the use of self. An inhibition of empathy can result if the therapist has "walled himself off" from similar conflicts within himself. Finally, Basch (1983a) suggests that a therapist will interfere with what a client is saying or doing if, due to an inability to deal with similar conflicts, he unconsciously defends against his own affective responses to the material.

Several therapists were aware of such defensiveness with clients. Michael was aware that his own conflicts sometimes interfered with his ability to use himself:

The way it seems to happen is that something doesn't fit in a session, something feels blocked...And some of those cases, when I really dig down, and part of it I do myself, part in supervision, part in my own therapy, I can come to something often...I didn't react to the situation the way I could have or was the most helpful, why is that? I start on that. And often times it's because of a personal vulnerability on the issue or similar types of issues.

Sara said in talking about strong feelings experienced as a therapist:

(O)ccasionally in a session feeling overwhelmed because things hit too close to home. So not saying anything, or sometimes skirting an issue because it hit too close to home.

This section has focused on the problems therapists-in-training encounter when they treat clients who are working on similar issues to their own and with whom they are identified. Therapists, clients and therapies can also benefit when therapist and client's issues overlap. The potential for the therapist's empathy may be increased. Basch (1983b) suggests that the more similar are the client and therapist in biological, cultural or psychological features, the greater will be the therapist's unconscious perception of "unspoken or disguised affective communications." Despite the difficulties in her work with Joanne, Sara felt that their similarities had indeed, helped her to understand Joanne better:

I feel like I'm being a good therapist, basically that I understand better in some ways what the person is going through.

About Empathy and Issues of Boundaries

Throughout the interviews trainees spoke of difficulty with being present and empathic with clients. Sometimes this was because of having a bad day, sometimes because feelings associated with a particular issue or circumstance were difficult to empathize with, and sometimes because it was characteristically difficult for a trainee. For instance, Wendy, in thinking about how she comes to feel empathic responded: "That's a good question. I think that's a really important question for me anyway, because I don't always." The difficulty of

being empathic was also demonstrated in trainees' assessments that empathic moments were special. Michael said that feeling empathic is "one of the high points of doing this work. It feels good. It feels like at that time I'm really understanding ...touching and being touched."

Many difficulties in empathizing have been explored in the preceding chapters and include ambivalence about being emotionally involved, the difficulty of differentiating the origin of one's affect, and the challenge posed by working on clients' issues that are also salient in one's own life.

Even apart from working with clients with similar issues, difficulties in maintaining a sense of separateness can be inherent in empathic functioning. On one hand, clinical empathy involves a degree of psychological separation between therapist and client: "Empathy carries recognition and protection of the objects separateness and individuality" (Schafer, 1959, p. 353). On the other, empathic moments also involve moments without boundaries: empathy involves a temporary loss of one's psychological boundaries and is preconsciously experienced as merger or fusion with a client:

Every moment of empathy appears to depend on merger. Merging seems to be the chief factor in the most primitive, infantile forms of empathy. On the highest level of empathy, the level I have elsewhere termed generative

empathy, merging is included as one component along with others (sameness and likeness) of a more articulated and sophisticated kind. (Schafer, 1968, p. 153)

Even those critical of models which emphasize the role of merger or fusion as the basis of empathy agree that empathic moments include feelings that are experienced as fusion. Buie (1981), who maintains such models are inadequate because they "treat the phenomenon of merger or fusion literally" (p. 285), concedes that empathic moments involve the experience of "illusory merger" which "depends on a state of nondifferentiation of self from object" (p. 286):

The subjective experience of merging can be located as one part of a person's internal reactions to perceptions of another person, and this part of his internal reaction involves the illusory sense that self and object are fused. (p. 285)

Buie suggests this is possible through a "temporary suspension of attention cathexis of the physical and psychological boundaries of self and other" (p. 266).

Others also argue that the nature of the identificatory process of empathy involves a sense of fusion. Beres and Arlow (1974) describe the therapist's experience of transient identification as feeling at one with the client. Sandler and Rosenblatt (1962) suggest that the nature of empathic identification is a "momentary fusion of self and object representations" (p. 137).

Empathic functioning can also evoke a sense of fusion when the cognitive component is minimized. Empathy requires a cognitive transformation of that which is affectively experienced (Basch, 1983b; Schafer, 1959; Stern, 1985), a transformation involving the observing self of the therapist:

Affect operating with too little cognition would not achieve comprehension of another's experience; it would lead to confusing or intolerable reactivity involving an illusions of identity, fusion of the ego with the object. (Schafer, p. 349)

Comments by Sharon dramatically illustrate Schafer's statements. She offered an analogy to describe how affect operating without cognition results not in empathy but a feeling of embededness in another's feelings:

I guess it means getting swept up-the analogy I could make is-there are students on campus and they're rioting and they're running through the building and you're standing in the hallway. And they run past you and you wind up getting caught in the crowd and without even thinking about it or making a conscious decision you're running with the crowd too. It's that kind of a feeling, and so the way to avoid that is to go behind a closed door so they end up running by.

But for empathy a cognitive component is necessary. A previously used example from Sharon illustrates this point.

I think it could become empathy if I wanted to let it happen that way, I mean if I wanted-I think it becomes empathy when you put consciousness into what's happened to you. You can lose yourself and become disorganized by what somebody is doing to you without it being empathic, it only becomes empathic when you recognize what the feelings are in relation to

that person and that these feelings that you're having are like them...You could imagine two hysterical people together, and how they could get themselves worked up to tizzy-not therapist and client, but like they're firing off of each other. They're catalysts but they are not necessarily empathizing. They're definitely mushing boundaries. But a therapist and client, I could imagine having a hysterical client and sort of getting caught up in that upward spiral and that swirl and at the same time keeping an eye on it and saying-'Oh, this is a little breathless, this is what that feels like, this must be what it felt like to her when she had to take her driver's test, it felt like this.' That's when it becomes empathy.

Sharon has emphasized the necessity of the cognitive element to transform what is experienced into empathic understanding. In contrast, it seems that as beginning therapists the cognitive element is sometimes considered the entry into empathy. Two therapists spoke of having feelings they thought their clients should be having.

Peter described the following experience:

So the son is in a situation that's somewhat similar to mine, except mine is worse...I have a lot of the same concerns that that the son has. So sometimes in a session I feel things for the mother that I think that the son should be feeling, or sometimes I think this is what he is feeling, or sometimes I say how come he's not feeling this.

To ask "how come he's not feeling this" could be considered a cognitive approach to empathy without the affective resonance within. Such an approach is found in the multitude of explanations about empathic functioning. Buie (1981) stresses the need for inferential reasoning without the affective resonance so often stressed by others. Empathy can be arrived at

through imagining the feelings that should be present but were not, much as Peter has described. Greenson (1960) however, says this type of comparison or inferential thinking does not "provide the potentially intimate correspondence with the patient's subjective experience" (p. 90).

While an inferential approach to empathy certainly has its place both in the literature and the clinical encounter, such understanding would seem more vulnerable to a therapist's projective and defensive errors than an understanding informed by affective resonance. Furthermore, it removes a therapist from the more intense moment with a client. Empathy is often described as a more immediate involvement of the therapist; as "moments of uncommon and instantaneous intuneness with inner thoughts or images" (Berger, 1987, p. 19).

The special sharing in empathic moments is captured by Jane's comments:

I just have the sense sometimes that there's a very deep level of understanding-of connection-of sharing something that is really very special in a lot of different kinds of ways. I think during those times as a therapist I'm much more in touch with the feeling of being in the moment with a client. That there's a lot less of a distance. Empathy means having less distance in a relationship than you might have had before you've reached that kind of empathy.

Several trainees echoed similar thoughts of how empathic moments feels special and contain a connectedness that is not normally felt. Perhaps this

connectedness is how trainees are conceptualizing the moments of uncanny closeness which is written about (Basch, 1983b; Berger, 1987; Buie, 1981). Part of that connectedness is experiencing a softening of boundaries to allow a depth of contact rarely tolerated except in moments of intimacy. Sharon attributed these special moments of connection that others have mentioned to a softening of boundaries.

I think that in terms of sort of really hard definition of boundary issues-no, I don't think I really lose a sense of who I am and I don't become sort of psychotically disoriented. But in terms of a sort of soft definition-I think yes, there's some moments or some minutes when I really feel connected in a way that I don't normally with people and I don't normally out in my day to day life.

Sharon described her openness to this kind of experience as letting herself be taken for a ride by her client. This implies a giving up of control and letting her "experiencing self" follow the clients lead. Sometimes she does not want to let her barriers down and therefore cannot empathize:

I decide I'm going to go on a train ride with the person. They're going to take me somewhere-like in the side car of a motorcycle. That's really what it's like, it's like going on a trip, a journey, and sometimes-some days I'm just not willing to go. And that's when I'm interfering with what their process is...Sometimes I'm not open or don't want to let my barriers down in the same way, and that's when I think I'm not being as good a therapist.

Sharon felt that the extent to which she can tolerate that experience is directly correlated with how good a therapist she will be:

I have to say that I think the degree to which you can tolerate that is the degree to which you'll be a good therapist. For me anyway, my sense is that that is my working tool. And being able to know someone else's reality is what will enable me to be able to help them....I've come to realize that in fact it's sort of a gift. I don't think that I-and I would guess not many other people either-could be a very good therapist without having that. It's necessary but not sufficient in that you have to be able to make use of it as a tool. And so that's sort of where my development is at now. I've definitely come to accept it and appreciate it and be grateful for it, but now it's like I have to rein it in-learn how to control it, learn when to let it be there and when not to, or how to let it be there and to be a fly on the wall at the same time.

Sharon feels that due to personal characteristics she is susceptible to "getting swept up in the crowd." In the metaphor of a train ride she described herself as a good tourist because she is not invested in her own view.

I don't think it's something that I choose to do or something that I really even have control over-if you think of it as a skill, it's not like I've practised it, or decided I wanted to learn it and then went out and learned it. It's much more like it's something that I've become aware of and hopefully I'll be able to make better use of...so I tend to think of it more as just having to do with personal characteristics.

While she is susceptible to taking on others' feelings she is also quick to defend against it:

I think I'm relatively susceptible to doing it and also have a pretty quick defensive reaction to letting it happen. So a lot of times in order to maintain my boundaries, I get sort of cold and withdrawn. That's an overstatement, but I get cool and a little distant as a way of not letting myself take that on...to keep myself from feeling like I might be losing control of myself in relation to other people and their stuff.

Rebecca also spoke of needing to allow the type of closeness that enables clients to use a therapist as they might need to. In answering how she tried to remain open to receiving her clients' projective identifications she said:

Not being afraid I think is one way. Having it be ok to have that type of relationship. Really not being afraid. And being empathic, I think that's what keeps you open. It's the anxiety that blocks that. If you don't want to be that close or deal with those kinds of things, I think it prevents those from happening.

Sharon's fear of "losing (her)self in relation to other people and their stuff" reflects the blurring of boundaries that can happen when one tries to be empathically receptive. It has been suggested that empathic activity can be threatening to the therapist's mental health in that "one's narcissistic striving is in danger through the introjection (during empathy) because there is an identification with the object" (Fliess, 1942, p. 216). In empathic functioning, "the subject temporarily gives up his own ego for that of the object" (Olden, 1953, p. 112-113). An empathic transient

identification is considered to require a "temporary suspension of one's ego boundaries and thus a temporary loss of self" (Goldberg, 1984, p. 42).

Several trainees discussed boundary issues in their clinical experiences; however, they typically believed these experiences were due to clients' projective identifications, not to empathic receptiveness. Empathy also involves shifting boundaries to entail "a partial or temporary loss of self and the reestablishment of one's psychological separateness. (Goldberg, 1984, p. 42). Perhaps the fact that most trainees assumed that a blurring of boundaries occurs only with clients' projective identifications reflects the traditionally drawn distinction between empathy and projective identification (Tansey & Burke, 1989). Projective identification is associated with countertransference disruptions and negative affect while empathy is assumed to be under the therapist's control, not disruptive, not associated with difficulties of containing the material and finally, not threatening to a sense of self. This is an incomplete view of the empathic process and assumes too clear a delineation of the origin of affect.

Jane was willing to tolerate a blurring of boundaries in her clinical work. She specified that the ability to tolerate a blurring of boundaries depends on the ability to reestablish them. She was one respondent who limited this to experiences with projective identification:

I think it has to do with your understanding of boundaries in relationships, and being willing to tolerate a certain blurriness, knowing that you have enough skill to be able to bring those boundaries back. So ignoring them isn't so terrifying because you know that your clients' feelings aren't your own. But during the unconscious time that this process is happening, being willing to open yourself up because you know that you have the ego strength later on to be able to do that kind of separating out.

Sharon also learned that her ability to resonate with her clients' feelings was made safe by her ability to reestablish her psychological autonomy. Earlier in training she thought that her susceptibility to her clients inducing feelings in her meant that she was crazy:

I don't feel that way-actually I do still feel that way but I think it's true for everybody, and I don't feel that I'm labeled somehow. I think that we all have that potential and capability, and the test is not whether you can feel those feelings but whether you can pull yourself together again and go on with your life, and I could do that so over time I came to understand that it wasn't as terrifying as it seemed to be at first.

Greenson (1960) posits that behind some "phobic therapists" inability to empathize is such a fear that they will be unable to regain their sense of self.

Before Sharon learned that she could pull herself back she had interpreted these experiences as indicating she was psychologically unsuited for the work. As already mentioned, she had diagnosed herself vaguely as having a disturbance of the self since she had regressed so severely. Greenson (1960) describes why the temporary

loss of self that occurs during empathy could very well be experienced as a self disturbance. He states that "all that is peculiarly or uniquely" the therapist's is relegated to the background through a "temporary decathexis of one's self image."

Sharon experienced this as losing herself:

I think there are two aspects to the unsettlingness of it. The first is that their stuff is very unsettling-these are very unhappy people, and when you get a taste of it you get a sense of how unhappy they are. But the second piece is that when they're in you, you're not as much in you and that's really terrifying. It's sort of a vision of the bodysnatchers. It's very odd to feel that you can be that easily taken over and that you can be that vulnerable or susceptible to losing-don't know what to call it-losing the full sense of myself as a discrete bounded entity.

Sharon's work with her first client Karen, who was psychotic, laid the basis for thinking about these issues. Sharon's experience had involved a regression to a psychotic level of organization. She had to pull herself back from a loss of boundaries and also from a primary process level of thinking. Schafer (1959) writes that empathy involves a regression of the ego to a place of momentary "intrapsychic fusion of self-image and object image" and also must allow for an "adaptive employment of the primary process" (p. 359):

Regression may be resisted not only out of fear of the content but more importantly, out of anxiety that one may not find one's way back from the less stable stages of organization to higher and more stable organization. The resistance arises from the fear of losing

reality and ego boundaries, and being engulfed in archaic fantasy, defenses, diffuse impulse, and affect. (Schafer, p. 354)

Sharon's experience illustrates many of these points.

(It) didn't happen all the time-but there were times when the way that she was in the room sort of scrambled my reality. It altered my perception. It dissolved the boundary between me and her in such a way that I didn't have-I no longer had my own personal perspective on the world, and it's like we were knit together. Not that I knew everything that had gone on with her, or in fact if I had gone into the grocery store I would have suddenly seen the grocery store the way she saw it, but it certainly gave me a feeling of what the flavor of her life must be like, even if it only lasted for 10 or 15 minutes. I experienced the confusion and the terror, and the disorientation that I think she was living with all of her waking moments. And I wasn't me at that time...(I)f I had to do anything I was very scrambled. For a few minutes it would be very hard for me to recover my own sense of self...It's like she took me on a train ride with her. We'd walk into a session, and I had a choice whether to pay attention to her, to listen to her and try to follow her or not to. If I had chosen not to, I don't think any of this would have happened or if someone had been observing behind the mirror. I don't think it would have felt quite the same to me. But the choice that I would make was that I would listen to her. And once I started listening to her; her way of seeing the world; how she perceived it; how she strung her thoughts together was totally different than mine. It wasn't just that it was different-it was that it was different and totally disordered, totally illogical, and so I wound up in that world.

Interviewer: Can you say more about your sense that your boundaries were no longer discrete?

Sharon: Well I think there were several things to that. I don't think she had a sense of me as a separate person. It took about six months for us to be able to have what would be considered to be a normal conversational style of interacting. It took about that long for

her to ever ask me a direct question, or for her to use my name, and I think that she didn't see me as a discrete bounded person. And who she was just kind of filled up the whole room and incorporated me into it. And again I think I had a choice, I think I could have put a wall around myself, could have pushed myself back away from it, and maybe I would do that to a greater degree now, or more selectively now as a therapist, but this was brand new to me. I was eager to do it right and to be there with her. And so I just fell into it, time after time.

Sharon felt that now with more experience she would be better able to observe what her client was doing and its impact upon her. She would be more able to be a fly on the wall and not lose her sense of her observing self. She felt that what happened with Karen happens with less disturbed clients also but to a lesser degree.

Dorothy's description of her work with Tina also conveyed the sensation of losing her sense of being an integrated self. She feels that it was hard to remain intact as she responded to Tina's fragmentation:

Interviewer: You said how sometimes you feel like you're losing your identity. Can you say more about that?

Dorothy: It feels like I'm on this roller coaster ride-sometimes I'll actually-not lose consciousness but almost? Like the room gets kind of-the background kind of blends in with everything else and I just temporarily forget where I am. It's like everything goes gray and I really have to come back. It's like I'm just really somewhere else. It's all kind of a scary feeling. Going up and down with this person. I'm sort of there but not there-I'm sort of where she's at. So I really have to think about seeing myself sitting where I'm sitting and coming back to that. Because she's changing who she is so much, I just get so pulled into where she's at at that point that I'm not at where I was before. The first

time it happened it was really kind of scary, but now I'm getting more accustomed to it. I can come back to where I am more easily. Because I do need to do that to figure out the process. But it can switch from her screaming and yelling at me to being very depressed, or childlike and wanting me to be nurturing. So trying to be there in those different capacities. Being pulled to be in those different capacities, I just have-I just get so involved in it or something that it's hard to remain intact myself at that point. It's a funny feeling.

Interviewer: It's hard to remain intact because you're responding to her fragmentation?

Dorothy: Yeh, also I'm just so out there that I sort of have to pick things up. I can imagine how hard it is for her to do that if I have a hard time going through it with her. To just kind of put things together and come back. I can imagine how that must feel for her. I never have that experience with other clients. It's weird...it's really like being in there with four different people some of the time. So no wonder I feel confused, and feel at times like I lose my identity because she's projecting so much stuff.

Dorothy's description echoes thoughts of Searles (1979) as he explores the role of symbiosis in identity development. He maintains that a symbiotic level of identity is a therapist's "most reliable source of data" about a client and happens through the projective and introjective processes of empathy.

A symbiosis-based identity serves as one's most sensitive and reliable organ for perceiving the world, not merely by mirroring a world set at some distance, but through processes of introjection and projection, literally sampling, literally mingling with in manageable increments-the world through which, moment by changing moment, we move. (p. 70)

Dorothy, Jane, Rebecca and Sharon's description of their boundaries being blurred or let down evoke Ogden's

(1982) description of the type of object relatedness that is created as a result of a client's projective identifications:

The projector experiences the recipient as separate enough to serve as a receptacle for parts of the self but sufficiently undifferentiated to maintain the illusion of literally sharing the projector's feeling (p.36)

Dorothy and Jane both imagined that their clients did experience this type of semi-differentiated relationship as a result of having induced their feelings in their therapists. Dorothy sensed that Tina feels closer to her and described there being "almost a fusion part" to their relationship at those times. Jane described how she thinks her client viewed her as a result of inducing her own anger in Jane:

I would think connected in a way that they usually aren't. There's something about that process that has to do with that kind of intimacy, that connection or understanding, particularly in an unconscious kind of way. So in some sense I think it heightened that sense of connection.

Jane, Dorothy and Rebecca have discussed boundary issues only in relation to experiences with clients' projective identifications. Sharon experiences boundary issues as relevant to other interactions as well. She compared her experiences of losing her boundaries with Karen to her work with other clients:

I think it's definitely there with these other clients, but it's much more bounded, much more limited. It doesn't happen for a whole

session, or doesn't happen every session or if it does, it's just a piece of a session.

Sharon would probably attribute this to her "susceptibility to taking on", a "personal characteristic" that she has learned to consider a gift. To the extent that each therapist-in-training has a different cohesiveness of self, a different defensive style and a different propensity towards or fear of connectedness she may be right. However, Sharon's thoughts about the relevance of boundary issues to all levels of clinical experience is supported in both the empathy literature (Beres & Arlow, 1974; Buie, 1981; Goldberg, 1984; Greenson, 1960; Schafer, 1959) and by those who consider projective identification to be a part of the empathic process (Tansey & Burke, 1989).

CHAPTER VI

CONCLUSION

An empathic use of self is widely believed to be a psychoanalytically oriented therapist's main instrument of investigation in the clinical encounter. A use of one's inner experience to understand that of one's client utilizes emotional communications from a client that are not available to more conscious reception.

Little attention is given to the developmental vicissitudes of therapists-in-training learning such an empathic use of self. A first step is appreciating that internal emotional resonance is a useful realm of information and does not indicate weakness or lack of suitability for clinical work. Ambivalence must be faced that the emotional involvement of clinical work is often more than was anticipated. Trainees sometimes feel regretful that clinical involvement can be so consuming and demanding. As clinical skills develop, the emotional intensity of the work becomes more manageable.

Understanding the nature of identifications in the clinical encounter helps trainees learn to tolerate the intensity of the work. Trainees then are able to appreciate that changes in their inner experience often originate outside of themselves from identification with

a client's affect. This in turn enables trainees to evaluate their induced feeling state, not as a surface or enduring reality, but as information about a client. Therapists must contain and sufficiently separate from these induced feeling states in order to appreciate the meaning of them. Therapists who believe induced feeling states represent reality are at risk of acting out these states, thus reenacting what a client has created in the transference and induced countertransference.

Separating from an induced state is facilitated when trainees learn to view changes in inner experience as a signal to separate from the affect and examine its sources and meaning. The scrutiny of induced affect involves questions such as: why am I feeling this way, what caused it, and what purpose might it play for my client for me to feel such a way. Information about one's client as well as theoretical exposure are brought into focus for analyzing what has been experienced. Such analyzing is a function of the observing self of the therapist; an oscillation and balance between experiencing with the client and analyzing from the position of the observing self constitutes the basis for an empathic use of self.

Supervision is of enormous significance in both its educative and holding capacities. Supervisory interventions bring a trainee's awareness to what she might be feeling. Such interventions model making the

shift to the observing self. The exploration of what can be learned through analyzing a trainee's inner experience demonstrates the use of the observing self.

Additionally, supervision helps contain a trainee's anxiety, thus enabling her to contain and separate from induced states.

In this study, trainees understanding and skills increased across levels of clinical development. More advanced trainees most clearly appreciated that one's affect is useful and reviewed how disrupted they had been by early intense experiences before recognizing its usefulness. Developmental changes were also seen in trainees' increased awareness that feeling states could be induced in them by clients. Both theoretical exposure and supervision had an impact on trainees' development. However, such developmental differences did not hold up under one condition, namely, working with disturbed clients who induced feeling states that trainees felt were alien or unfamiliar. Regardless of level of training, feelings of intense rage or experiences of momentary psychotic decompensation were made tolerable for trainees only upon understanding that they had been induced by a client. Trainees who faced such difficulties early in training were especially challenged. An additional change that did not hold up across levels of experience was in the awareness of the need to utilize an observing self. While there were

differences related to developmental level, changes within the individual trainee were more apparent.

Trainees empathic functioning appeared especially vulnerable when trainees worked with clients who were working on issues salient in the trainees own life or who were perceived as similar. Trainees felt an increased investment in this work which sometimes threatened their objectivity and sense of themselves as therapists. Trainees found it difficult to separate their own issues from their clients' issues and sometimes failed to distinguish their clients' mental states from their own. Trainees also experienced a reactivation of old conflicts and defenses when working with clients who utilized such defenses to deal with similar conflicts.

A trainee's ability to use herself empathically is facilitated by and facilitates the development of a work ego or a therapeutic self. Such ego development is part of the profound psychological changes that are part of clinical training: Psychotherapy involves a "therapeutic use of self" and the learning of psychotherapy requires a "transformation of self" (Sharaf & Levinson, 1984). I believe part of this transformation lies in a trainee's experience of her psychological boundaries.

Empathy requires an interpenetration of boundaries between therapists and clients. Empathic functioning involves moments of psychic merger with clients and sometimes a regression to symbiotic levels of relatedness

and psychic organization. As a trainee learns that she can reconstitute herself and pull back from this merger to reestablish her sense of identity, these experiences becomes less threatening. Perhaps one of the most profound transformations of clinical development involves a redefinition of self and other boundaries as boundaries become both more firm and flexible. This has not only to do with clinical skills, it has to do with changes at a very basic level of personality.

The requirements of empathy are almost universally seen as involving an individual with a secure sense of self or one confident in their ability to maintain their ego boundaries. Goldberg (1984) suggests that the presence of a secure sense of self seems to be a prerequisite for empathic responsiveness and that the quality of the therapy depends upon the therapist's personality. Similarly, Berger (1987) says that "the development of the self has to be cohesive and elastic enough to tolerate the requirements of empathy" (p. 30). Too rigid ego boundaries prevent empathic resonance and individuals with too permeable ego boundaries will experience difficulty in reestablishing their autonomy.

A therapist's degree of autonomy effects her empathic functioning (Greenson, 1960). A therapist with too amorphous an identity will be unable to maintain sufficient boundaries. Such an "uncontrolled empathizer" will overidentify. "Phobic empathizers," with too

restricted an identity, will maintain too intellectual a stance out of their fear that they will be unable to reestablish their sense of autonomy.

It is a given that trainees enter clinical training with varying degrees of intact, rigid or permeable boundaries. Some will start with hyperpermeable boundaries and as a response to the threat of the loss of autonomy, might alternate between being uncontrolled empathizers and withdrawing defensively. Others will begin with rigid boundaries and will have to learn to allow their boundaries to become more permeable. Part of clinical training is establishing firm but flexible boundaries, able to be permeable but strong enough to allow the reestablishment of psychological autonomy. The crucial role of personal therapy in this process is obvious.

Unfortunately, a professional choice to be a psychotherapist does not ensure that one has such a secure and flexible sense of self. Greenson (1960) and Olinick (1959) both suggest that behind many therapists professional choice are rescue fantasies and unconscious reparative efforts originally developed in a relationship with a depressed mother. Miller (1981) describes depressed as well as narcissistic parents forming the types of relationships with their children that later motivate the professional choice of psychotherapy. She asserts that children treated as narcissistic objects by

their parents develop "acutely tuned antennae" to the unconscious needs of others and a weak subjective sense of self.

Miller suggests that such people have heightened abilities to empathize, however, I think empathy here means being responsive to the needs of others and is not being used in a more specific clinical sense. It is possible that such empathizers have difficulty not being too sympathetic and indulgent with clients. The historical imperative of making a depressed mother feel better or maintaining the self esteem of a narcissistic parent could make difficult therapeutic interventions that aim at helping people confront their dysphoric and disowned aspects.

Miller describes such people as having a poor sense of self and weaker ego boundaries; these qualities would affect the empathic functioning of such therapists since empathy requires a separation between self and object. Such people often have a self image that they are very empathic out of their experiences of being used narcissistically by others. I question whether this self image is problematic in that a clinical use of empathy departs significantly from the usage implied here of an acute and indulgent sensitivity to the needs of others. Several trainees expressed the belief that their empathic functioning came naturally and implied that this ability was one reason for choosing this field. I suspect that

these potentially different views of empathy are problematic in obscuring a trainees understanding of the need and ability to maintain a separateness from their clients.

Perhaps the choice of therapy represents, for the individuals described by Miller, an attempt to work through these issues. We have seen how becoming a therapist involves learning how to use oneself empathically. Perhaps for some therapists, relationships with clients provide opportunities to meet again the needs of others, but this time voluntarily. As a therapist, the caretaking of clients allows for a maintenance of boundaries that need not negate the trainees sense of self as did the earlier caretaking relationships. However, allowing one's clients to use one as they need to, exposes such trainees to the risks of displacing their own needs and rage onto their clients. Brightman (1984) suggests that only after emotional healing of narcissistic wounds has occurred can such therapists be effective.

Kernberg (1965) suggests that people who become therapists to reenact reparative wishes towards their parents are used to "doing" in relationships. Previous experiences can make it hard for trainees to learn that the most effective use of themselves with clients is not an active doing, but to just be with them. As therapists, too much doing, in the form of being overly

interpretive prevents clients from developing their own subjective sense of self. The previously adaptive overuse of intellectualization and knowing in order to be able to control, leaves such trainees impatient with "not knowing." "Not knowing" is a state which is crucial for effective clinical work. Ogden (1978) paints a picture of a similar type of parental relationship. He formulates such narcissistic usage as a parent projectively identifying into a child. Such children, then, might become therapists out of a compulsion to master being the recipient of projective identifications. Perhaps even more than other therapists, those with weak ego boundaries will be engaged in a perpetual internal sorting out task.

To consider empathy as involving firm but flexible boundaries raises a final consideration. Recent scientific advances have called into question the traditional separation of self and object of a positivistic scientific paradigm. Earlier conceptions of human nature did not so clearly delineate the individual as an autonomous isolated unit. Such a delineation allows for the splitting and projection that contribute to both international conflict and to the travesties visited upon the environment. Empathy is the basis for cooperation and mutual subjectivity and a view of empathy that includes an interpenetration of psyches suggests that we are all more a part of each other than we feel.

APPENDIX A
CONTACT LETTER

Dear

I am writing to invite you to be a participant in my masters thesis research. I am investigating the experiences of therapists-in-training with projective identification. Controversy and confusion surround the concept of projective identification-it need not be a meaningful concept to you for your participation in this study. The only criteria that I have set is that I need for you to either currently be in psychodynamic supervision or to have received psychodynamic supervision in the past. This does not need to be your chosen orientation nor do you need to consider yourself versed in psychoanalytic theory.

I would like to interview you twice for approximately two hours each time. The first interview will take place during March or early April; the second interview to happen in May. In addition to the interviews I would like you to read a statement about projective identification that I have prepared. Your confidentiality as well as that of your clients and supervisors will be protected.

I hope you will consider participating. Please return the bottom of this sheet by March () if you are interested or have any questions and I will contact you.

Sincerely

Joan Copperman

To: Joan C.

Name: _____ Phone Number: _____

- ☐ Would like to participate
☐ I have some questions before deciding to participate

Please check one:

- ☐ In first year of seeing clients
☐ In between these two
☐ Last year before internship or post internship

APPENDIX B

INTERVIEW

I want to start with explaining how this interview is structured. As you know, I'm interested in our experiences with projective identification. As I said in my letter to you, the concept of projective identification does not need to be meaningful to you for your participation in my study. I'll be asking you questions about your clinical experience without including in our discussion the concept of projective identification. However, you should feel free to bring the concept in. At the end of today's interview I'll be giving you something I've written about projective identification that I'd like you to read before the next interview. And I would find it helpful to know now if projective identification is a meaningful concept to you? OK. Any questions? Alright, let's get started.

1. What year in your training are you? How long have you been seeing clients? Which types of teams have you been on and what type of supervision have you had?
2. At this point in your training, how would you describe your theoretical orientation, if you have one?

I'd like now to focus our discussion on some of your experiences with clients. These could be experiences either in a particular session or could describe a general dynamic with a client. It will probably be hard to remember at first, so take your time. Most people have found it helpful to take a minute to review their clinical experiences to organize their thoughts. I'd like you to think about one or two cases in which you experienced fairly strong feelings. However, you need not limit your answers to these cases and some of the questions may not relate to your experience.

3. In thinking about these cases, can you tell me about one or two experiences when you felt very strong feelings, how you dealt with them, and what you thought about having these intense feelings.
4. How did you use these feelings to inform you about your client or the therapy?

For the rest of the questions, you don't need to limit your answers to these cases.

5. Can you tell me about any experiences of having feelings, thoughts or images of yourself, either during or after a session or when thinking about a client, that resemble the feelings thoughts or images that your client holds of themselves, perhaps unconsciously?

Have you ever felt left with feelings after a session that you think might be what your client felt, or in general feels?

Have you ever felt like your client produced these in you?

Have you ever felt confused about whose feelings thoughts or images you were experiencing?

6. If you think about a client, or clients, who have had particular difficulty with certain feelings, have there been times when you found yourself feeling those feelings when your client wasn't?

Other than these experiences, can you tell me about any experiences in which it seemed you felt your clients feelings more strongly than they seemed to be?

7. Can you tell me about experiences of a client treating you or playing out a role with you that others have played with them, so that you're now being treated as they were treated?

8. Could you tell me about experiences-either in a particular session or to a general dynamic with a client, when you felt reactions or feelings of a different content or quality than you're used to?

How about feelings where you felt like they really didn't come from you?

9. Have you ever had any clients working on issues you felt you needed to work on? Did this intensify your own feelings, and if so, how did this happen? Do you think your client contributed to this in some way?

10. Can you tell me about ever feeling so involved in the relationship with a client or with your experiences in a session that you lose your sense of what you generally accept as real?

11. There are ways that a relationship with a client resembles a relationship with a supervisor. Other than the more readily apparent structural parallels, such as meeting an hour a week, and talking to someone who hopefully is helpful to you, are there ways that your relationship with a supervisor has resembled your relationship with the supervised client-for instance, Can you tell me about ever feeling or behaving in supervision like the supervised client feels or behaves?

12. What's your fantasy of how your supervisor feels towards you that might be similar to how you feel towards your client?

13. In general, how susceptible are you to taking on other peoples' feelings? How about confusing others' feelings for your own?

14. How do you respond to feelings of identifying with a client, or even feeling like the client seems to feel? (i.e., scared of, open towards, critical of, confused, threatened, gratified, wished it happened more often)

When this involves experiencing yourself in ways that make you feel judgemental or anxious, how is this for you? How open do you think you are to these experiences? (working model of self, uncom. self representations)

15. What is your sense of how you come to have feelings of empathy for your clients. What is this like for you?

To be asked if this information has not already emerged:

16. Can you tell me about how you tend to work with clients; for instance very active, or non-directive; and what you're trying to facilitate or accomplish by being this way? (silences)

Questions 17 through 24 to be asked if enough time: if not, go to question #25

17. Can you briefly describe a few clients that you've seen that stand out in your mind and tell me what it is or was like to be in the room with them.

18. Could you describe each of these clients as an animal, or give me a list of adjectives to describe them. How would each client describe themselves. What's your sense of where the concordance comes from?

19. Have you ever felt so involved in the relationship with a client or with your experiences in a session that you lose your ability to step back and reflect on the process?

How about ever feeling particularly cut off from a client? Did this related to issues your client was working on? Do you think your client felt this way also?

20. How do you use your inner process to inform you about your clients or about the process of a session? For instance, if you're anxious, how do you interpret this?

21. Do you feel like a client has ever felt your feelings, or experienced themselves in ways that reflected you or came from you more than them?

22. Could you tell me about experiences of feeling like a client has induced you to treat them a certain way or play out a role with them, such as victimizer, seducer, a role that someone in their past has played?

What's your sense of how they got you to play out that role?

23. Have you ever felt that your client is trying to or has managed to provoke feelings in you that some significant person in his/her past or present has felt. Can you tell me about this experience? How did you come to realize it was a feeling that this significant other person had experienced? (this question is trying to get at "complementary identification" not transference)

24. Could you tell me about experiences-either in a particular session or to a general dynamic with a client when you felt reactions or feelings that were more intense than the situation seemed to merit?

25. Is projective identification a meaningful concept for you?

If no, end interview.

26. What exposure have you had to the concept of projective identification? (e.g. through reading, classes, supervision) How has this concept become meaningful to you?

Has projective identification been identified or discussed either in supervision or on a clinic team?

27. Do you feel like you have been the recipient of a client's PI?

If not, go to question #41.

28. Can you describe what happened, beginning with the interaction with the client. Please talk about how you felt and how it was resolved.

(Any or all of questions 29 through 40 might be answered by this)

29. What helped you to see this (i.e., understanding the concept, supervision, repeated nature of the experience)

30. What about this client contributed to your realization that this was happening (i.e., history, verbal/nonverbal behavior, relationship patterns, issues)
31. In terms of how you felt, can you compare this with your normal or usual way of feeling. Was this difference helpful in figuring out what was happening? Did this experience relate to issues that you feel you could look at in yourself?
32. How did this experience add to your understanding of your client.
33. Were you able to use this experience to informed an interpretation or in any other way in the therapy? How?
34. How did it help the progress in therapy; the relationship with this client.
35. What's your sense of how your client viewed you or felt about you during this time?
36. Did this experience appear in your relationship with your supervisor?
37. How did this experience affect your feelings or your behavior towards this client? How did you feel towards your client after this experience with projective identification?
38. How did this experience affect your feelings about becoming a therapist?; on your identity as a clinician?
39. How open or vulnerable to clients' projective identifications do you think you are?
40. How has this concept been helpful for you in understanding your clinical experiences?
41. What do you think about the concept of projective identification?

Ok. These are all the questions I'd like to ask you today. Give subject Appendix C.

Subjects for whom interview ended at #25: This is something I've written about projective identification. I've tried to present what I think are the most important aspects of projective identification. I'd like you to read this twice-the first time as soon after this interview as possible; the second time close to the second interview. At the second interview we'll talk

more about projective identification, especially any questions or comments about this statement. Of course, we can talk before then if you like.

Subjects for whom projective identification was a meaningful concept: Even though you're familiar with the concept of projective identification, because it is a concept that is used in so many ways with much confusion, I'd like you to read this statement that I have written about it. Before we start the second interview we can talk about similarities and differences in our understandings of the term. Ok? I'd like you to read this twice--the first time as soon after this interview as possible; the second time close to the second interview. Of course, we can talk before then if you like.

APPENDIX C

INFORMED CONSENT FORM

This project will explore the experiences with projective identification of therapists-in-training. My participation in this study is not dependent upon a familiarity with the concept of projective identification.

My participation in this study will consist of: 1) taking part in two 2 hour interviews; 2) reading a statement about projective identification prepared by Joan Copperman, the principle investigator. I understand that I will be asked to describe aspects of my clients, the therapeutic relationship and the supervisory relationship, as well as my thoughts and feelings about my experiences.

I also understand that I may ask questions of the investigator at any point during the interviews and that I may refuse to answer any question asked of me. I understand that I may end participation in the study at any point and that I will not be penalized in any way.

I understand that all interviews will be audiotaped and then structured notes or verbatim transcripts will be made from the tapes. All of the information I provide in this study concerning my clients, my supervisor and myself will be kept completely confidential. If information I provide is used for publication, my name and all other identifying information will be altered.

I have read and understand the nature of this project and what is required of me. I am willing to participate as a subject in this research study.

Signature

Date

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