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ORIGINAL PAPER

Teaching the Use of Self Through the Process of Clinical Supervision

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Abstract In their efforts to learn the skills involved in the use of self, clinical social work supervisees are faced with the daunting task of integrating information coming not only from the patient but also from their own complex set of responses. The clinical supervisor serves a key role in guiding the trainee through this process. Grounded in contemporary psychodynamic theory, this paper discusses an approach to helping the supervisor model the use of self in the context of the supervisory relationship. A supervisory case example is used to illustrate.

Keywords Use of self · Clinical supervision · Countertransference · Psychodynamic theory

Among the greatest challenges for the novice clinical social worker is the process of learning to incorporate and make sense of the myriad information that is communicated and received throughout the course of even a single psychotherapy session. At a time in training when the student's emerging sense of professional identity is often quite fragile (Gill 2001), the task of sorting out the internal responses evoked by the patient from those emerging from one's own history, all while attempting to conceptualize case material through the lens of one's increasing font of academic knowledge, can seem insurmountable. Beginning therapists are learning to sort out the complex implications of issues such as race, gender, and perceived socio-economic status (both of the clinician and the patient). They are dealing with their responses to the material that the patient is presenting, especially when this material is experienced as taboo or otherwise provocative (e.g. issues of abuse). At the same time, they are learning to attend to the many levels of conscious and unconscious communication that are occurring throughout the treatment. Making therapeutic use of this material by means of well-conceived and well-crafted interventions can thus seem a Herculean task well beyond the grasp of the trainee. It falls in large measure to the clinical supervisor to accompany the neophyte therapist in the process of growth, discovery, and integration.

Grounded in contemporary psychodynamic theory, this paper will explore processes by which the supervisor can assist social work supervisees in incorporating the use of self into their practice. In addition to surveying briefly the history of the concepts of countertransference and use of self as well as their perceived role in therapeutic treatment since the time of Freud, it will consider the skills that we seek to develop in supervisees, and the role of the supervisor as teacher and model of use of self. In particular, it will consider ways in which the supervisor can model a stance of non-judgmental, reflective attention to one's internal responses in the clinical situation, and make use of these as a tool for understanding and intervening with patients. Existing models for educating trainees about the use of self will be reviewed. A detailed supervisory case example will be used to illustrate.

Historical Perspectives on Countertransference and the Use of Self

Beginning with Freud, much attention has been paid to the phenomenon of countertransference and its impact on the

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clinical situation. Freud (1910) first described countertransference as "a result of the patient's influence on his [i.e. the analyst's] unconscious feelings" (p. 144). Later, Freud (1912) used the image of the telephone to describe the nature of communication between the analyst and analysand, encouraging the analyst to be receptive to the patient's transmittal of unconscious material. Thus, it fell to the analyst to do all in his or her power to eliminate interference with this process. The classical tradition, then, encouraged awareness of the complex set of personal reactions and responses to the patient known as countertransference with a view to decreasing its influence in the therapeutic situation and facilitating the neutral stance of the therapist (Edwards and Bess 1998; Jacobs 1991; Racker 1988/1957; Thompson 1988/1956).

Beginning in the 1940s a shift was noticed in the way in which countertransference was viewed (Thompson 1988/1956). This shift involved a reconsideration of the nature and therapeutic value of countertransference. Increasingly, these internal responses came to be seen as a potentially valuable tool that the clinician might use to advance the clinical work with the patient. In his writing, for example, Tauber (1988/1954)) notes that an analyst may be so concerned with avoiding the possible impingement of countertransference that he or she may not be able to attend fully to the contents of the material that the patient is presenting. To remedy this, Tauber encourages the conservative and responsible use of the countertransference material as long as the analyst is willing to take responsibility for the effects of doing so in the treatment and not to react with defensiveness. In this way, he suggests, issues of resistance may be more easily worked through.

For her part, Thompson (1988/1956) adds that the analyst should be open to the patient pointing out what may be blind spots in the analyst's personality, and calls upon the analyst to respond in a non-defensive manner, thus encouraging the analyst's naturalness and spontaneity. She draws attention to the notion that the whole person of the analyst and the whole person of the patient exert a mutual influence upon each other.

In decades since, the emergence of the relational, interpersonal, and self-psychological traditions has contributed further to our understanding of the meaning and role of countertransference in psychotherapy. In these views, the internal experience of the therapist is seen less as a hindrance and more as an integral part of the therapeutic process. This inner dynamic serves not only to help the therapist understand the unconscious communication of the patient, but also to craft interventions that utilize and build upon the therapeutic relationship. It is this relationship and the interface of the subjectivities of therapist and patient that is seen as central to the helping, healing process (Brown and Miller 2002). The whole self thus becomes the instrument or tool of the therapist (Thompson 1988/1956). In this view, not only is it undesirable to eliminate the impact of the clinician's subjectivity from treatment, it is downright impossible (Lewis 1991). This has important implications for the supervisory relationship as a key place where beginning clinicians learn to make use of their self in their work.

Cultivating the Supervisee's Use of Self Through Supervision

Various methods have been proposed for teaching the use of self to students of psychotherapy. Edwards and Bess (1998) focus their attention on the central importance of self-awareness on the part of the therapist as a way of integrating personal and professional selves (Reupert 2007, 2008). To this end they advocate a three-pronged approach to the exploration of the self. First, they suggest, the therapist must make an inventory of the self. This includes a self-examination of personality traits that contribute to her identity as a therapist. They encourage reflection on questions such as what one enjoys about being a therapist and a consideration of the role that this plays in the therapeutic work. Secondly, they call for the development of self-knowledge. This especially concerns beliefs and attitudes on the part of the therapist about the nature of life's problems and how they are best solved. Finally, the authors point to the need for an acceptance of risks to the self. That is to say, therapists must remain open to self-discovery with all the challenges that accompany it. Only in this way, they suggest, can therapists hope to understand their patients better.

For his part, Lewis (1991) has developed a modular training program for therapists that includes one section devoted the development of use of self. This module contains various elements. Lewis begins with the consideration of the impact the therapist makes upon a patient by virtue of factors such as appearance, size, movement, posture, office setting, among others. Furthermore, he suggests that students will benefit from as much insight as possible into their interpersonal style and how this impacts others. Thirdly, growth in the use of self demands attention to the therapist's developing feelings (including sexual feelings) about the patient. Finally, Lewis utilizes an exercise in which trainees discuss and elaborate fantasies about themselves and their patient as a way of uncovering underlying countertransference.

Glickauf-Hughes (1997) describes a model of supervision in which supervisees are taught in both didactic and experiential ways how to manage patients' use of primitive defenses such as splitting, projection and projective identification and their impact on the clinical situation. Citing

the work of Bion (1962) on containment, Glickauf-Hughes notes that therapy provides a new opportunity for patients to have their difficult feelings and behaviors effectively contained thereby allowing for the possibility of an interpersonal dynamic with the therapist that is different from the one to which they have become accustomed. In order for this kind of containment to occur, therapists must be able to acknowledge, sit with, and wonder about their experience of a range of affective states that are often difficult to tolerate, particularly in the clinical context. Examples of such states might include anger, shame, incompetence, boredom, and sexual arousal.

These considerations highlight in a particular way the issue of personal psychotherapy as an element of training in clinical practice. Personal psychotherapy has long been considered to be of great benefit to the developing psychotherapist, not only to prevent unresolved personal issues from adversely affecting the treatment as discussed previously, but in fact to free up areas of the therapist's personality for greater use in the therapeutic relationship (Thompson 1988/1956; Wolstein 1988/1959). Edwards and Bess (1998) suggest that personal psychotherapy affords the student the opportunity to have a therapist who may be a model for practice, provides a first-hand understanding of the therapeutic process, and facilitates the integration of one's personality with one's professional learning. In keeping with the perspective presented here, personal psychotherapy can provide new clinicians with a safe space in which to grow in comfort with the exploration of a wide range of emotional experiences as they deepen their self-awareness.

Still, the narcissistic vulnerability to which new therapists are subject can make the practice of attending to the many internal and external aspects of treatment seem extremely daunting. Psychotherapy trainees of any discipline who are trying on an unfamiliar role are commonly preoccupied with issues of competence such as following the rules, doing things correctly and well, understanding the patient's presenting problem, and using effective techniques and interventions. Thus, they may find it quite difficult to listen deeply to their internal responses in the ways that have been suggested. An example serves to illustrate.

Ms. K was a second year social work student placed in an outpatient mental health clinic. Eager to learn, she nonetheless expressed normal doubts about her ability since she had never before conducted individual psychotherapy with patients. She felt full of questions on issues ranging from the initial orchestration of the formalities of a session to the complex work of assessment, diagnosis, and intervention. Her supervisor, while providing needed answers to her task-oriented questions, reassured her that he would be there to support her, and encouraged her to be patient with herself and to allow the process to unfold. In this way he attempted to shore up her vulnerable sense of self as a student and emerging professional.

As Ms. K began treating her first patients, her supervisor noted that her process recordings were peppered with self-recriminations about the "badness" of her reactions to her patients. Statements such as, "I'm feeling like I want to take care of the patient, and I know that is really bad," were common. The supervisor asked her what she believed was bad about her feelings. Ms. K. stated that she believed she had to maintain a neutral and distant stance in order to help her patients. The supervisor clarified that this belief was grounded in a particular theoretical system and suggested that her countertransference might in fact be helpful in her work. He encouraged Ms. K to suspend judgment of her reactions and suggested an observation of the material that emerged both from the patient and herself, taking all of this as information that would help her to understand her patient better. This would serve as a framework for the interpretation of future countertransference reactions.

Bion (1970) exhorted the analyst to come to the session without memory, desire, or understanding. Trained in eastern traditions of philosophy, Bion believed that such a stance created the condition for the possibility of openness on the part of the therapist. If the supervisee can be encouraged to begin from a stance of non-judgment, both of the patient and of herself, the kind of observation and active wondering that the use of self demands may be facilitated. Having thus cleared away much of the static that can result from expectable initial self-consciousness and doubt, the student can be guided to consider and make use of her self experience in a more integrated way with the patient and to translate this experience into effective interventions.

The Supervisor as a Model of the Use of Self

As already noted, the task of guiding the beginning clinical social worker in the development of the use of self falls largely to the clinical supervisor. What, then, are the attitudes and tasks that this requires of the supervisor? Like the novice or experienced therapist, the supervisor may be encouraged to follow the advice of Bion (1970) by approaching the work of supervision without memory, desire, or understanding. Thus, while the supervisee is being encouraged to attend not only to the accuracy of assessment, understandings, interpretations and other interventions, but also to the role of countertransference in the weaving of the therapeutic relationship, so too must the supervisor attend not only to the work of teaching (i.e. the transmittal of information) and skill development, but to the impact of countertransference reactions on the supervisory relationship itself (Kindler 1998).

Furthermore, several authors discuss the mutual interaction or influence of the supervisor, the supervisee, and the patient in the context of supervision. Here too, the supervisor serves as a model for the use of self. Strean (2000), for example, notes that attention to one's own countertransference with the supervisee can be useful in working through difficulties in the student's clinical work inasmuch as these difficulties often get unconsciously enacted in the supervisory relationship. He recommends judicious suspension of the anonymity of the supervisor so as to facilitate the student's work. The student is likewise assisted in the development of the use of self when the supervisor acts as a model in this way. For example, Knox et al. (2008) found that supervisors' self-disclosure of their reactions to supervisees' patients helped normalize supervisees' feelings, served as a teaching tool, and strengthened the alliance between supervisor and supervisee.

In her method of teaching students to deal with patients' use of primitive defenses, Glickauf-Hughes (1997) notes that due to their primitive nature and the complexity of dealing with them, such defenses may be enacted by students in the supervisory relationship. This may serve as an unconscious way of communicating to the supervisor what is happening in the treatment (Bromberg 1982). Furthermore, this parallel process offers the supervisee the opportunity to experience the containment of these difficult dynamics by the supervisor. Other examples of students' manifestation of their efforts to manage patient's primitive defenses might include rejecting the supervisor's attempts to help, feeling dejected because of a patient's devaluation of them, expressing intense anger towards the patient, and wishing to terminate the therapy precipitously. Glickauf-Hughes recommends a variety of techniques for dealing with this including various combinations of teaching, clarification, modeling, and role playing.

Kindler (1998) discusses supervision from a self-psychological perspective. Borrowing from Fosshage's (1995) thinking regarding the analyst's experience of listening from a variety of positions, Kindler applies this construct to the supervisory relationship. In addition to her stance as supervisor, she may also take the position of the supervisee as well as the patient. Furthermore, the supervisor may listen from the perspective of empathy (e.g. from the patient's perspective) or from an other-centered perspective (e.g. as someone in relationship to the patient). By taking this stance, the supervisor may more effectively listen and understand not only the patient's internal process, but the dynamic process between the supervisee and the patient. This facilitates not only the treatment but the development of the supervisee as well. Confirmation of this development may be seen in the supervisee's increased capacity for self-righting, the expansion of self-awareness, and symbolic reorganization.

Kindler goes on to emphasize the importance of the supervisor's empathic listening to the supervisee, even if this seems to preempt the discussion of patient material. This activity is viewed as not only modeling the process of self-psychologically-oriented treatment, but also serving self-cohesion and vitality functions for the supervisee thus enabling her to focus more adeptly on the subjectivity of the patient. Likewise, consistent with a self-psychological orientation, he recommends a close and non-defensive attention to the supervisee's experience of the supervisor to promote feelings of safety and the growth of the supervisory relationship.

From a related school of thought, Brown and Miller (2002) add an intersubjective nuance to the discussion by viewing the supervisory process as a triadic intersubjective matrix. While akin to Fosshage's (1995) notion of multiple perspectives, Brown and Miller see the supervisory relationship as the "point of interaction" (p. 814) of three unconscious processes. By viewing the supervisory experience as a "space for listening" the authors seek to attend to the unconscious communication between supervisor, supervisee, and patient. Such a perspective does not come without its perils, according to the authors. Attending to the confluence of unconscious processes in this way runs the risk of blurring the line between supervision and the supervisee's personal treatment—a hazard not uncommonly encountered in the supervisory relationship. Likewise, supervision in this vein depends upon the willingness of both supervisor and supervisee to foster an atmosphere of self-disclosure in which material such as dreams as well as their personal reactions in the process are laid bare. The authors acknowledge that this may be difficult especially for the beginning student who is in a more vulnerable position.

Calling upon Mitchell's (1998) notion of the relational matrix, Ganzer (2007) applies a relational perspective to the structure of supervision. She states that a relationally oriented supervision is built not on the hierarchical stance of the supervisor vis a vis the supervisee, but on the mutual influence of the supervisor, the supervisee and the patient. This relational matrix, she suggests, is constructed from the intrapsychic, interpersonal, environmental, and organizational characteristics of all those involved.

Clinical Example

Ms. K brought the case of Victoria to supervision. Ms. K had begun treatment with Victoria approximately 4 weeks earlier. A single woman in her early twenties, Victoria was accompanied to the clinic by her mother and the two began to describe issues of poor self-esteem, a history of learning difficulties, social awkwardness, irritability, and loneliness.

Her mother reported frustration with Victoria, stating that she just wanted her to get married, and stop being such a problem. Significantly overweight, Victoria reported a great deal of self-consciousness about her appearance and detailed her envy of her reportedly beautiful and popular sisters. She had never been in a romantic relationship, and though she longed for this experience she stated that she did not know how she would ever find a man who would love her. She stated that she felt verbally abused by her father and brother who called her names and related traumatic incidents of verbal abuse by teachers when she was in grade school. She noted that these experiences continued to disturb her.

Though Victoria stated that she wanted therapy, Ms. K reported that she experienced her as apathetic and complaining during the sessions and wondered what to make of this. Ms. K went on to explore further with her supervisor an incident with Victoria that had occurred the day before supervision. Victoria had arrived for her session over two hours late. When Ms. K was informed by the receptionist that Victoria had arrived she was surprised, having supposed that Victoria would not come at all. She informed the secretary that she would be down shortly to speak with Victoria. Ms. K came to the supervisor's office for advice on how to proceed. While she had availability in her schedule she did not know if she should see Victoria. She stated that she had learned in Social Work Practice class to reinforce the importance of coming on time to session, and she was concerned about the possibility of encouraging the behavior of arriving late. While acknowledging this, the supervisor reminded Ms. K that it was still unclear why Victoria had come late. Together they decided that, when she went to speak with Victoria, Ms. K would inquire about the reason for the lateness and assess whether or not Victoria was in any kind of crisis. If Victoria was in crisis, she would be seen. If she simply had not come on time, Ms. K would reschedule the session.

Ms. K told the supervisor that when she went downstairs, she greeted Victoria in a friendly manner. She noted that Victoria did not appear to be in any distress. Ms. K called Victoria to the side and quietly noted that she was two hours late for her appointment. Ms. K asked Victoria if she was alright and assessed her for any sign of crisis. When Victoria stated that everything was fine Ms. K told her that they would need to reschedule the appointment. At that, Victoria began to yell loudly at Ms. K, asking her why she hadn't said so in the first place. Ms. K felt confused and asked what Victoria meant. Victoria responded in the same loud tone that Ms. K should have just told the secretary that she was not going to see her instead of making her sit there and wait. When Ms. K replied that she wanted to come down and speak with Victoria personally, Victoria yelled that all Ms. K was doing was wasting Victoria's time. With that she stormed out of the clinic as other patients looked on from a nearby waiting area. No follow up appointment was made. Ms. K stated that she was unsure what to do next.

When the supervisor asked Ms. K how she felt about what had transpired she reported confusion and anger. The confusion, she said, related to her sense that Victoria's outburst had come out of nowhere. The anger related to her embarrassment at having been yelled at in view of the receptionist and patients in the waiting room. Furthermore, she admitted that, in her anger, she felt "turned off" to the idea of working with Victoria and somewhat pleased at the prospect of not seeing her again. The supervisor validated Ms. K's reactions both verbally and non-verbally, empathizing with both how confusing and embarrassing it must have been for her. He then asked Ms. K if she felt able to sit with those feelings and her memory of the interaction. Perhaps she and the supervisor could wonder about this together. What else did she think and feel about her exchange with Victoria? What else might have been going on?

As she processed her experience with the supervisor, Ms. K stated that it seemed like Victoria was telling her she was a bad therapist and was therefore rejecting her by storming out of the clinic. She spoke about feeling embarrassed and thought that she had perhaps not handled the situation well. Maybe this was why Victoria was leaving treatment. For his part, the supervisor was aware of having another feeling about the interaction between Ms. K and Victoria. He shared with Ms. K his sense of irritation. Victoria seemed not to have taken into account the value of Ms. K's time, he said, but then proceeded to accuse Ms. K of wasting her time. This led Ms. K to identify more with her own sense of irritation, which she had initially named but then abandoned to focus on her sense of embarrassment and inadequacy. The supervisor interpreted these latter feelings as understandable and likely related to her insecurity as a beginner, and added that they may in fact cloud some of her deeper reactions. The supervisor further noted that, if properly contained and dealt with, difficult countertransferential reactions, like irritation, can sometimes be a great source of insight and can open new pathways for therapeutic progress.

As they continued the supervisory session, the supervisor encouraged Ms. K to sit with and be curious about her own sense of irritation or annoyance. This led Ms. K to make a number of associations to Victoria's mother and to descriptions of the dynamics between the two as well as to Victoria's home life in general. The supervisor asked Ms. K to describe these. What emerged was a pattern of unstable, shifting affects in Victoria's relationships that evoked in her the very sense of emptiness and inadequacy she sought to remedy through therapy. As the supervisory dialogue continued, and the supervisor further modeled a

wondering stance, Ms. K grew more comfortable articulating and exploring her feelings and associations to what transpired with Victoria the day before. Having shared his sense of irritation, the supervisor facilitated Ms. K's identification and acceptance of her own anger, as well as her desire to end her therapeutic relationship with Victoria—not an easy thing for a new supervisee to admit to her supervisor.

However, this in turn helped Ms. K identify on an experiential as well as intellectual level a pattern whereby Victoria thwarted the development of healthy relationships. The supervisor encouraged Ms. K to think more deeply about the origins and implications of this pattern. Ms. K began to see that this aspect of Victoria's interpersonal behavior was born of repeated experiences of traumatic rejection that led to a narcissistically depleted self. In a self-protective but interpersonally frustrating way, Victoria evoked the very rejection she feared. However, she did so in such a manner as to walk away with some sense of control. At this point Ms. K said she was aware of experiencing even more empathy for Victoria and felt free to reach out genuinely to Victoria while allowing her the freedom to leave treatment if she chose to. With a minimum of effort, Ms. K was able to reconnect with Victoria and her treatment continued. Ms. K's increased understanding of and empathy for Victoria helped her not only to facilitate the repair of their relationship but to form a strong working alliance with her. Together, they began to examine the dynamics of Victoria's relationships and how they could be improved.

This clinical and supervisory experience helped Ms. K to grow in a number of ways. On a procedural level, she gained a clearer understanding of the way in which patient lateness was handled in the mental health clinic to which she was assigned. Furthermore, she benefitted from the experience of working through a conflictual encounter with her patient. Perhaps most significantly, however, she grew in her ability to explore her affective response to her patient and to wonder about the nature and meaning of that response. Further development of this skill will contribute to her growing confidence and effectiveness as a clinician.

Conclusion

The development of the use of self demands cooperative effort on the part of both the social work supervisee and the clinical supervisor. For the supervisee, this means the fostering of self-awareness with its attendant risks, the willingness to explore countertransferential experiences on all levels, the capacity for insight, and the ability to tolerate uncertainty and to suspend judgment both of the self and the patient in order to listen with evenly suspended attention. For the supervisor, this means the ability to model self-awareness and the vulnerability that comes with the appropriate sharing of one's feelings and thoughts, and the ability to listen carefully and non-judgmentally not only to one's own countertransference, but to the experiences of the patient and supervisee alike. Having assisted the supervisee in the identification and exploration of his or her experience of the patient, the supervisor is then able to help the supervisee translate that insight into clinically useful interventions that will advance the treatment. In this way, the supervisor is in a unique position to assist in the integration of the new clinician's personal and professional identities, and the honing of the finest of therapeutic instruments—the supervisee's very self.

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