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A historical study of the "use-of-self" in clinical practice

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ABSTRACT

The purpose of this study was to examine the concept of the use-of-self in clinical practice through a historical lens, in order to clarify what is meant by the term, to illuminate the evolution of the concept, and to attempt to reconcile the perspectives of several theoretical approaches.

Seven theoretical approaches were examined, they are presented in five sections. The first section examines the Classical Psychoanalytic Theory of Sigmund Freud. The second section examines expansions on and departures from the classical position and includes contributions made by Carl Jung and Carl Rogers. The third section highlights three postclassical theories which exemplify a more nuanced understanding of the clinician's role in clinical practice. These include Kohut's Self Psychology, Relational Theory using the work of Mitchell, and Intersubjectivity, based on the work of Stolorow. The fourth section addresses the clinician's role in promoting social justice and includes the Social Constructionist perspective and Critical theory. The final section discusses the application of traditionally Buddhist concepts to western clinical practice and mindfully-informed practice.

The theories reviewed for this study reveal that the concept of use-of-self has undergone a notable shift in the past century. Despite ongoing investigation, the literature pertaining to the concept of use-of-self has consistently shown that the therapeutic relationship is the primary vehicle for client growth and change. Regardless of the clinician's theoretical approach, therapeutic growth and change always takes place in the living context of the relationship

between clinician and client. While foundational theories are instrumental to clinical practice in that they provide an organizing framework, the essential core of clinical practice is the clinician's use-of-self in the therapeutic relationship. And ultimately, each clinician must continuously pursue self-knowledge and build self-awareness, qualities which enhance the clinician's participation in the therapeutic relationship.

A HISTORICAL STUDY OF THE "USE-OF-SELF" IN CLINICAL PRACTICE

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CHAPTER I

Introduction

The Issue: Use-of-self

This thesis represents the culmination of a historical study of the "use-of-self" in clinical practice. For all psychotherapeutic modalities, the clinician's "self" is the primary tool used universally to promote therapeutic change. Although the concept of the use-of-self did not emerge in the academic literature until the second half of the last century, theoretical speculation in regards to the clinician's presence within the therapeutic relationship has been around since Sigmund Freud (1856-1939). Freud, a pioneer of clinical work, identified the importance of the clinician's use-of-self early in his career, however, he introduced the concept as the countertransference phenomenon. Since its emergence, use-of-self has remained a central concern for both theorists and practicing clinicians alike. However, due to the nearly impossible task of defining self, the concept has evolved over the last century and continues to be explored today.

Within the clinical context, *use-of-self* can be defined as the clinician's deliberate application of self within the therapeutic relationship. Due to the difficulty of pinpointing a definitive definition of self, for the purposes of this study, this researcher used the term *self* to refer to the personhood of the clinician. Through education and training, the clinician develops skills to effectively use the self as a tool in the processes of assessment and intervention.

Essentially, the self is the primary instrument used by the clinician to promote change, health, and empowerment, as well as foster subjective well-being.

Through education and training, the clinician acquires and cultivates personal qualities and skills that will support the effective use-of-self in practice. These include the recognition of the client's individuality and respect for the rights and dignity of each individual. In order to perceive the client's individuality, the clinician must develop knowledge and awareness of their own location within systems of oppression and be attuned to the impacts of oppressive systems on individual clients.

Empathy, or the ability to enter the experience of the client, is another skill that must be cultivated and refined for the effective use-of-self. Carl Jung's (1865-1961) investigation of the "wounded healer" suggests that many individuals are drawn to do clinical work through personal "wounds," or experiences that result in heightened empathetic awareness. In order to use empathy as a strength in practice, the clinician must develop and maintain a questioning attitude towards their motives and feelings in the work and in the therapeutic relationship. The ability to enter into the experience of others in order to benefit the client is dependent upon the clinician's ability to maintain a reflective stance, watching for evidence of inevitable "blind spots," which can impede the process of effective work.

While understanding the clinician's role in practice has received consistent attention since Freud, the concept continues to be a topic worthy of investigation, primarily because the definition of self continues to change. This researcher holds the opinion that as knowledge of the definition of self advances, what is understood about the use-of-self can be improved and applied towards the therapeutic relationship, ultimately benefiting both the client and the clinician.

Purpose of this Study

The purpose of this study was to examine the concept of the use-of-self in clinical practice through a historical lens. This researcher completed a review of the literature, with the intent to accomplish the following objectives: to clarify what is meant by the term use-of-self in clinical practice, to illuminate the evolution of the concept, and to reconcile the many theoretical approaches that have contributed to what is understood about the phenomenon in contemporary thought.

Need for this Study

Historically, in theory, training, and practice, much critical attention has been given to the person of the client. Placing emphasis on the client is a logical approach, as the client is the natural focus of any clinical encounter. However, due to the interpersonal nature of clinical work, it is widely understood that the clinician's primary instrument is the self. Therefore, it is reasonable to expect that the person of the clinician bears an inevitable influence on the work. For this reason, it is of utmost importance that the clinician thoroughly examine and deliberately apply the concept of use-of-self in order to most effectively use this instrument in service of the client.

Social work is unique in its approach to clinical work in that it considers the person in the context of environment. Clients are assessed, evaluated, and treated according to the clinician's understanding of the context of each individual's unique experience. While early psychological theories urged clinicians to practice from a neutral space, more contemporary theories recognize the inevitable impact of the clinician's context on their presence in the work.

In designing this study, this researcher expected that a historical examination of the concept of use-of-self would result in a significant contribution to their knowledge and

development of a professional self. Specifically, this research project has provided insight into how this researcher, a heterosexual, white, middle class, cis-gendered, able-bodied female can practice most effectively in a field that aims to serve oppressed and marginalized populations.

Contribution to the Field

The National Association of Social Workers (NASW) Code of Ethics directs social workers to "challenge social injustice" without supplying a solution for how to approach the task from within the system (NASW, 2008). Social workers do not exist outside or beyond the systems of oppression that create the conditions that call forth their attention and skills. Therefore, social workers committed to anti-oppressive work must be cognizant of their individual position within systems of oppression and must be vigilant in forging helping alliances, and empowering others, rather than unwittingly perpetuating oppression through service. An investigation of the concept of use-of-self represents a significant contribution to the understanding and application of non-oppressive social work practice.

Relevant Data

The concept of clinician use-of-self originates in the literature through Freud's theories of countertransference. Therefore, this research project began with Freud by examining the clinician's role as a neutral observer, a blank screen serving to elicit the patient's unconscious thoughts, feelings, and desires. Following Freud, this researcher pursued C.G. Jung's (1865-1961) contributions to the field by considering the concept of the wounded healer and the influence of the clinician's personal experiences on the development their therapeutic self. Heinz Kohut's (1913-1981) Self Psychology was reviewed for its contribution to knowledge of the clinician's role as an active empathetic presence. Research into Humanistic Psychology, the work of Carl Rogers (1902-1987), in particular, considered how the clinician's presence alone

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can be healing, however, the importance that the clinician's quality of presence communicate full attention and acceptant listening to the client. Later perspectives, such as Constructionist, Critical Theory, Intersubjectivity and Relational Theory were explored for their recognition of the influence of subjective experience on both the clinician and the client. Anti-oppressive practice, an important contribution to the field of social work, has its roots in these theories. Finally, Buddhist Psychology was reviewed for its contribution to methods of developing clinician insight and self-awareness, as well as for its influence on emerging research into the definition and understanding of self.

Methodology

This researcher completed a comprehensive investigation of the selected phenomenon using the Smith College Library Discover research tool. Search terms included: use-of-self, deliberate use-of-self, conscious use-of-self, intentional use-of-self and countertransference. The books and journal articles which comprise the body of research offered additional resources within their bibliographies. Further research utilized the following academic research tools: PsychInfo, PEP Archives, Worldcat, Proquest, the Smith College SSW Thesis Collection, and Google Scholar.

Organization

This thesis is organized into three chapters. Following the present chapter, which has introduced the concept and identified this researcher's questions and motivation for study of the phenomenon, the second chapter presents a review of the literature and represents the body of the study. The third and final chapter provides a discussion of the review of the literature through the evaluation and synthesis of the various theories. The discussion includes a report on this

researcher's evolved understanding of the concept, as well as their view on how it can be applied

to contemporary social work education, training, and practice.

CHAPTER II

Historical Themes: The Therapeutic Relationship

Introduction

The purpose of this study was to examine the concept of the use-of-self in clinical practice through a historical lens, with the intent to accomplish the following objectives: to clarify what is meant by the term use-of-self in clinical practice, to illuminate the evolution of the concept, and to reconcile the many theoretical approaches that have contributed to what is understood about the phenomenon in contemporary thought.

In this chapter the researcher will identify the theoretical works which have influenced the evolution of the concept. The chapter is divided into five sections. The first section will address theories of the clinician's role in the therapeutic relationship from the classical perspective, as established by Freud. The second section will address the contributions of theories that can be identified as expansions on and departures from the classical position: C.G. Jung, and Carl Rogers. The third section highlights postclassical theories that exemplify a more nuanced understanding of the role of self in clinical practice. Theories to be explored in this section will include self psychology, relational theory, and intersubjectivity. The fourth section will acknowledge the NASW Code of Ethics' call for social workers to challenge social injustice and will explore constructionist and critical theories in order to identify the origins of Anti-oppressive practice. The chapter's final section will discuss Buddhist psychology and its contributions to contemporary understanding of the therapeutic relationship, with particular

emphasis on emerging understanding of what comprises the self, as well as the clinician's ongoing pursuit of increased self-awareness.

I. The Classical Position: Sigmund Freud

Sigmund Freud (1856-1939), the founder of classical psychoanalysis and father of modern psychology, was an Austrian neurologist born in 1856. As a young man, Freud was profoundly influenced by the work of archaeologists, and later dedicated his life and career as a physician to unearthing the mysteries of the mind and the origins of human suffering. While Freud is perhaps best known for theories that address the inner dynamics of the mind, his contributions to the field of psychology extend to the therapeutic relationship as well.

Although he pursued his research within the bounds of science, Freud's clinical work was often deeply personal, as he was a physician profoundly moved by human suffering. Freud illuminated the influence of relational dynamics on human development and the formation of personality; elements which contribute significantly to psychological well-being. In his clinical work, Freud possessed a keen awareness of the patient's use of the therapeutic relationship, and as a consequence, gave much consideration to defining the clinician's role in this unique relationship.

Freud was the first physician to recognize the inherent therapeutic influence of the clinician/patient relationship. Through rigorous practice and research, Freud broke through the limits of established medical knowledge and revolutionized psychoanalysis, or, the "talking cure" (Breuer, Freud, Strachey, & Freud, 1955/2000, p. 30). Within the field of medicine, psychoanalysis represented a radical new method of addressing psychopathology and alleviating

the symptoms of human suffering, and it opened the doors to what would become a widely practiced and rapidly advancing discipline.

As a neurologist, Freud was trained to diagnose and treat illnesses originating in the mind. As such, Freud ascribed to the view of the clinical relationship as hierarchical, identifying the clinician as expert. Freud believed that training in the established principals of medicine, self-knowledge, and objectivity together permitted the clinician to view the patient from the position of trained expert, and supported a view of the patient as someone whose psychopathology rendered them "ill" and requiring treatment. Freud likened the role of the clinician to that of a surgeon, "who puts aside all his feelings, even human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible" (Freud, 1912/1981, p. 115).

Freud expanded this view of the hierarchical nature of the clinical relationship in his 1937 paper, "Analysis Terminable and Interminable." Here he discusses the importance of the clinician's state of health as being an essential element of therapy. Freud explains that the clinician must establish him/herself in a "superior position to that of his patient if he is to serve as a model for the latter in certain analytic situations and, in others, to act as his teacher" (Freud, 1937, p. 400). From the position of expert, the clinician is able to employ specific elements of the relationship to guide the patient toward health. Therefore, for Freud, the primary goal of psychoanalysis is to bring about the alleviation of the patient's symptoms and restore them to a state of mental health and well-being.

Central to his formulation of the specific mechanisms behind the effectiveness of clinical work is Freud's identification of the transference and countertransference phenomena. Transference and countertransference are relational dynamics that emerge organically within the

clinical relationship and generate the substance of the therapeutic exchange. For the purposes of this study, *transference* is defined as the phenomenon whereby the client brings to the therapeutic relationship, "feelings, wishes, and assumptions from past relationships" (Berzoff, Flanagan, & Hertz, 2011, p. 25). Conversely, *countertransference* is defined by McKenzie (2008), as the clinician's transference, and by Freud (1912/1981), as the influence the patient has on the unconscious feelings of the clinician. Due to their generative properties, Freud determined these relational dynamics to be the very core of the therapeutic process.

Transference, in particular, represented for Freud the most valuable material to arise out of the clinical relationship. Freud refined and solidified his theory of transference through his clinical work with Ida Bauer, aka "Dora" (Freud, 1905/1955). Freud's work with Dora marked the emergence of his view of transference as the guiding force behind the therapeutic process.

Freud's psychoanalytic treatment calls for the clinician to attend to the patient as the patient enters into a state of free association. Through free association, the patient naturally presents transference material, which Freud embraced as the very heart and substance of therapy. While the patient relaxes into flow of free association, the clinician listens for evidence of internal conflict and developmental arrest concealed in the patient's apparently ordinary musings. Freud believed that the patient's projected or displaced feelings toward the clinician offered potentially valuable insight into the patient's psychopathology, information which the clinician would use to inform therapeutic interventions.

Although Freud's method of psychoanalysis was structured within a patient-centered relationship, he was also acutely aware of the role of the clinician in the relationship. In developing psychoanalysis as a therapeutic modality, Freud acknowledged the potential impact

of the clinician's presence on the treatment and gave much thought to defining the clinician's role.

Just as Freud determined the patient's transference to be indispensable to the process of analysis, he designated the clinician's countertransference as a persistent obstacle to the work. Freud warned against inevitable feelings of countertransference, believing they presented a hazard to psychoanalytic treatment. Freud believed that countertransference could potentially contaminate the therapeutic field and impede the therapeutic process. Consequently, he advised clinicians to deliberately strive to remain relationally neutral, particularly in the presence of the patient's transference. Freud (1912/1981) instructed clinicians to employ "evenly suspended attention," in an effort to provide a neutral field for the patient's feelings of transference to emerge without interference (p.111).

Freud believed that a position of neutrality was essential to the clinician's role in therapeutic relationship, however, he stressed that this was an active position, one requiring continual effort and skilled attention. As a means of protecting the patient from unskillful responses to unbridled personal feelings, the clinician was directed to pursue self-analysis. Freud believed that through self-analysis, the clinician would develop self-knowledge, which would support the ability to remain neutral. Freud believed that with skilled attention, the clinician's natural and inevitable countertransference feelings could be kept in check, and outside the therapeutic relationship. In time, Freud's extensive research established the neutral relational field, deliberately structured and modulated by the clinician, as the optimum context for therapeutic change in cases of psychopathology.

II. Expansions on and Departures from the Classical Position

This section discusses the concept of use-of-self in the clinical relationship as understood by psychoanalyst C.G. Jung and the humanistic perspective of clinical psychologist Carl Rogers.

Analytical Psychology: C.G. Jung

Carl Gustav Jung (1865-1961), Swiss psychiatrist and psychoanalyst, stands besides Freud as a pioneer of modern psychology. Although born twenty years apart, Jung and Freud exhibited strong influence over one another and even collaborated professionally for several years before ultimately parting ways. Jung founded a new school of psychotherapy called analytical psychology and distinguished himself from Freud in his development of principles such as the collective unconscious, archetypes, and personality types (extroversion and introversion). Jung further distinguished himself from Freud in his understanding of the therapeutic process and the application of analytical principles.

Jung was originally drawn to the field of psychology through his interest in the occult, as it addressed mechanisms of the mind both seen and unseen, combining biological explanations with emotional and spiritual insight. Whereas Freud was preoccupied with curing individual psychopathology by detecting the driving forces of the unconscious, Jung was concerned with the task of *individuation*, or the psychological process of integrating the unconscious and conscious aspects of self, which could move the individual toward wholeness, or a more conscious and meaningful life. For Freud, psychoanalysis represented a cure for the mentally ill; for Jung, a path toward fulfillment of human potential, appropriate for any individual seeking a more integrated and purposeful life.

Unlike Freud, Jung did not view the clinician-patient relationship as hierarchical, nor the analyst as an objective outsider looking into the patient's suffering from an expert position. Jung

viewed the therapeutic relationship as a collaborative endeavor. He described analysis as a mutual dialogue between clinician and patient (Jung, 1935/1976). Whereas Freud experienced the role of clinician as expert observer, Jung located the clinician inside the analytic process, as a skilled and experienced companion to the patient seeking healing.

Freud's method of psychoanalysis was termed "reductive," that is, the aim was to uncover and extract psychic conflict (Jung, 1915 p. 386). In contrast, Jung's method was "constructive," the aim being to illuminate and integrate unconscious content (Jung, 1915, p. 387). Freud's approach required the clinician to assume the stance of a skilled surgeon; Jung's approach relied on the contributions of the patient's subjective wisdom to complement and join forces with the professional knowledge and personal experience of the clinician.

Jung applied the traditional mythical concept of the wounded healer to understanding the dynamic relationship between clinician and patient. He posited that each individual has internal wounds, as well as the innate capacity to heal and be transformed by them. For Jung, the clinician-patient relationship is unique in that it functions as a catalyst for the process of integration, a process Jung understood as one which held the potential to support both the clinician and patient in the task of becoming whole.

Jung believed that clinician and patient activated the role of "healer" in one another. When entering analysis, the patient projects their inner healer onto the clinician, and the clinician simultaneously projects their inner "wounded self" onto the patient. The primary task of the analysis is to utilize the patient's wound in service of individuation and integration. This is a continuous process in which projections are dissolved through recognition.

Jung put forth the idea that projections cease once they are made conscious. In other words, projections are no longer projections once they are recognized by the individual as

belonging to the individual (Jung 1936/1959). Once the individual becomes conscious of the content of the projections, it is available for contributions to increased self-knowledge and integration. In this way, analysis offers the individual the opportunity to retrieve material that was involuntarily displaced through projection (Jung, 1938/1959). In the case of the therapeutic relationship, the patient retrieves and experiences their own individual healing capacities.

Mental illness for Jung represented an imbalance of the conscious and unconscious forces in an individual. The individual, experiencing distress as a result of this imbalance, seeks treatment, believing the clinician holds the power to "cure." The patient initially experiences the clinician as a figure of power and authority because they have projected the qualities of healer onto the clinician. However, in time, the patient begins to recognize the projections as involuntary and unconscious, and the dependence on the clinician's power is gradually replaced by recognition of the patient's inherent strengths and healing potential.

Jung believed that the personality and attitude of the clinician are of paramount consequence (Jung, 1934/1964). Michalon (2001) notes that Jung also put forth the idea that it is ultimately the clinician's own wounds, which motivate their choice in career, and Nouwen (1972) argues that these wounds serve as a necessary bridge toward understanding the patient's experience. The analyst is to enter the therapeutic relationship and allow him/herself to be moved by the patient. Jung writes of this unique stance, "The doctor is effective only when he himself is affected. Only the wounded physician heals. But when the doctor wears his personality like a coat of armour, he has no effect" (Jung, 1963/1989, p. 134). Therefore, it is precisely those places where the clinician is personally touched by the relationship, that ultimately activate the patient's inner healer and support the process of therapeutic change.

In sum, the clinician's role in the therapeutic relationship is to assist the individual in discovering innate inner resources. Through ongoing personal analysis and professional training, the clinician learns to alternately confront unconscious material and support the budding capacities of integrated self-awareness.

Self-Directed Therapy: Carl Rogers

The field of psychology experienced a surge of new perspectives as a result of the Human Potential Movement of the 1960s and 1970s. The occurrence of this shift can be attributed to new and radical interpretations of the classical Freudian model. The changes which emerged in clinical practice during this period were significant because they represented a departure from the Freudian model which had served as the foundation for practice in preceding decades.

Carl Rogers (1902-1987), clinical psychologist and founder of humanistic psychology established himself as a central figure of the human potential movement. His belief in the inherent potential of the individual is clearly evident in Rogers' clinical work, as well as in the theories which grew out of his work. Rogers approached the therapeutic relationship with deep respect and concern for individual human experience. He stands out amongst his peers in his pursuit of empirical knowledge, and his contributions toward understanding the therapeutic relationship remain significant today.

Popular notions of the human potential movement are reflected in Rogers' approach to psychotherapy and in the principles of humanistic psychology. Humanistic psychology is a form of psychotherapy based on the notion of the individual's inherent capacity to heal him/herself. Rogers placed this principle at the core of his practice, and in doing so redefined the therapeutic relationship as a client-driven experience. While Freud viewed internal structures and conflicts as the natural governing forces of human experience, Rogers believed that all human beings

possess an innate tendency towards growth and health. Rogers believed that the clinician's role was to assist self-directed clients, rather than to cure passive patients.

Rogers held that like other living organisms, humans move naturally towards fulfilling their innate potential. However, Rogers maintained that several environmental conditions must be present in order for individuals to reach the highest potential of human experience: self-actualization. Rogers claimed that the extent to which an individual is able to move in the direction of self-actualization is dependent on the extent to which their environment provides the supportive qualities of genuineness, acceptance, and empathy.

For Rogers, self-actualization represented the individual's capacity to realize their highest potential, or to live in such a manner that he can "become his potentialities" (Rogers, 1961, p. 351). Rogers acknowledged self-actualization to be an ideal, but he considered movement towards self-actualization as natural given certain conditions. Conditions such as empathy and positive regard can be found in ordinary interpersonal relationships. However, due to the unmediated complexities of such relationships, it is the therapeutic relationship which provides the ideal context for growth.

The human potential movement viewed psychotherapy as a service not exclusively for those with identified psychopathology, but for anyone seeking a vehicle for personal growth. The clinician's role in non-directive therapy is to create the conditions that will enable the client to activate their innate healing capacity. Rather than curing the client, the clinician facilitated the growth process through an authentic interpersonal relationship. This was markedly different than the classical therapeutic relationship which was based on the skillful use of transference and countertransference. Rogers countered the classical position's view of the clinician as

embodying a blank screen, believing such impersonal aloofness could be detrimental to the client's growth (Rogers, 1957).

Rogers called for the use of genuineness, acceptance, and empathy to support the client's growth within the therapeutic relationship. By exhibiting these qualities, the clinician achieves a presence that communicates what Rogers termed unconditional positive regard (UPR) (Wachtel, 1986). In meeting the client with UPR, the clinician provides the space and a relationship context in which the client experiences the freedom to bring forth their whole self.

Therefore, for Rogers, the function of the clinician is to provide a space for the client to safely explore deep hidden feelings (D. C. Baldwin, 1987). In this way, the therapeutic relationship stands out as a unique space where the client can reveal closely held aspects of self and experience, those things they might be unable to freely share in the context of other interpersonal relationships.

Rogers believed that in order for the clinician to be able to provide a non-judgmental therapeutic space for the client, the clinician must pursue a "solid grounding in self" (McConnoughy, 1987). In order to hold UPR for the client, the clinician must be intimately familiar with their own negative feelings and attributes (Raskin, 1978). He noted that the clinician could not genuinely offer the client something they had not yet experienced toward themselves.

Rogers emphasized that the self he used in therapy did not include every aspect of his personal character. He stated that because he stressed UPR in therapy, many people did not recognize that he could be "very tenacious and tough, almost obstinate. I have often said that those who think I am always gentle should get into a fight with me, because they would find out quite differently" (M. Baldwin, 1987, p. 51). For Rogers, being keenly aware of one's thoughts,

feelings and spontaneous reactions to the client is not the same as sharing them with the client.

The clinician employs a conscious application of this personal information to the therapeutic

interaction. In this way, the therapeutic relationship offers a model of genuine acceptance, a

quality Rogers identified as central to the process of healing and self-actualization.

III. Postclassical Perspectives

This section highlights theories that exemplify a more nuanced understanding of the role of self

in clinical practice. Theories to be explored in this section will include Self Psychology,

Relational Theory, and Intersubjectivity.

Self Psychology: Heinz Kohut

Heinz Kohut (1913-1981) was an Austrian-born neurologist who developed self

psychology, one of the first branches of psychology to emerge on American soil. Kohut began

his career within the framework of classical psychoanalysis, however, he was clearly influenced

by object relations theorists, particularly in terms of their understanding of how the self develops

in relationship. Kohut established his own theories late in his career, and rather than viewing his

work as complete, he regarded it as representing just the beginning of a "yet incompletely

explored psychological field" (Kohut & Wolf, 1978, p. 424).

Kohut's nuanced understanding of the concept of self, including its development, as well

as its vulnerabilities, was central to the development of his clinical theories. Kohut detected

something missing in Freud's definition of normality as the ability to love and work (Erikson,

1950, p. 264). His role as a clinician offered him opportunities to witness variations in an

individual's ability not only to "be" human, but also to "feel" human. While an individual might

manage well enough in life as long as they possess the ability to love and work, Kohut

recognized that for those without a cohesive sense of self, life remains distressingly hollow.

Kohut believed that a cohesive sense of self generates inner vitality along with the

capacity for joyfulness. A cohesive sense of self also supports the capacity for pride in one's

qualities and abilities, and gives life purpose and meaning. In his practice, Kohut noted that

individuals in treatment often displayed symptoms of a common underlying pathology. Many

patients exhibited labile self-esteem, and a hypersensitivity to failures, slights, and

disappointments (Kohut & Wolf, 1978). He believed these characteristics represented a

"defective or weakened condition of the self," and his primary goal in treatment was to

rehabilitate the self-structure (Kohut & Wolf, 1978, p. 422).

By the end of his life, Kohut believed that all psychopathology was a result of a flawed

condition of the self and that "all these flaws in the self are due to disturbances of self-selfobject

relationships in childhood" (Kohut, 1984, p. 53). On the other hand, Kohut argued that the

development and maintenance of a cohesive sense of self is dependent on the availability of

suitable selfobjects, and on the ability of the individual to receive psychological nourishment

from them.

Kohut found that patients reactivated certain specific narcissistic needs in the therapeutic

relationship, which he termed narcissistic transferences. He determined that classical drive

theory did not adequately explain or address this common dynamic, and so rather than

investigating and interpreting the symptoms or transferences, Kohut turned his attention towards

the process of treatment. Kohut moved away from the classical stance of clinician as objective

interpreter and into a new position of unwavering empathic presence. This shift in the listening

perspective of the clinician is perhaps Kohut's most significant contribution to the field of psychology (Schwaber, 1983).

Kohut discovered that it was precisely the narcissistic transference that "made effective psychoanalytic treatment possible" (Kohut & Wolf, 1978, p. 413). Therefore, he believed that the clinician's efforts should be "concentrated on the task of keeping the old needs mobilized" (Kohut & Wolf, 1978, p. 423). In order to accomplish this task, the clinician should employ what Kohut called "empathic immersion and vicarious introspection" (Kohut, 1959). In this way, the clinician actively adopts a stance of "continual and open receptivity" to the patient's unique experience (Mitchell & Black, 1995, p. 156).

While clinical interpretation or education might cause the patient to further suppress unmet needs, an empathic presence can "gradually - and spontaneously" transform unmet needs "into normal self-assertiveness and normal devotion to ideals," both key aspects of inner vitality and a cohesive sense of self (Kohut & Wolf, 1978, p. 423).

For Kohut, the clinician's empathic presence was the primary tool used in therapeutic interventions. Kohut's therapeutic use of empathy, however, was a more nuanced expression of "feeling" for the patient. Kohut stated that this approach, "allowed me to perceive meanings, or the significance of meanings, I had formerly not consciously perceived" (Kohut, 1979, p. 3). The empathic presence required the clinician to be attuned to the patient's narcissistic transference and to meet the patient's needs, as well as remain present and understanding when the patient experienced empathic failure. The clinician's effective use of empathic presence resulted in the patient feeling genuinely seen and understood by another person. This experience within the therapeutic relationship would ideally be internalized by the patient and employed in other interpersonal relationships (Dewane, 2006, p. 550).

Relational Theory: Stephen A. Mitchell

Clinical psychologist and psychoanalyst Stephen A. Mitchell (1946-2000) founded the psychoanalytic perspective identified as relational. Originally established by Mitchell and co-author Jay Greenberg in 1983, relational theory has since been expanded upon and revised by subsequent theorists and clinicians. However, it remains a foundational perspective and its influence can be found in a range of contemporary theories and practice models.

Relational theory is fairly radical in terms of the clinician's use-of-self in the therapeutic dyad, however, the principles of relational theory grew naturally out of the earlier work of object relations theory and self psychology. Relational theory is unique in its assumption of the path to therapeutic change. Segal (2013) notes that "change occurs neither through insight about fixed internal structures nor through the experience of receiving empathy, but through a process of supportive, respectful, mutually-reciprocal meaning-making" (p. 377). Relational theory is also noteworthy for its contributions toward exploring aspects of the therapeutic relationship, particularly in terms of the clinician's subjectivity, self-disclosure, authenticity, and spontaneity.

The relational view of the clinician stands directly opposite Freud's idea of the clinician as a blank screen. While Freud encouraged the clinician to remain objective in order to avoid contaminating the therapeutic field, relational theory recognizes that it is not only impossible for the clinician to remain objective, nor is it useful. Relational clinicians inhabit a subjective perspective deliberately and use this perspective to inform the clinical encounter.

The clinician is seen as a participant observer, as a skilled professional who works collaboratively with the client to pursue therapeutic change. Relational theory posits that much of the work takes place within the therapeutic relationship itself. What transpires between the clinician and client is unique in each therapeutic dyad and is the result of two individual

subjective realities. Enactments are inevitable and serve as material to be explored, understood and integrated by the clinician and client together over time. It is essential for such material "to be experienced within in the analytic relationship before they can be integrated and reframed in a perspective that enriches rather than destroys a relationship" (Mitchell, 1990, p. 540).

Analytic interpretation takes on new meaning in relational theory. Rather than being a skill employed by the clinician, it becomes a collaborative effort between the clinician and client. Therefore, the clinician's individual goal is not to root out conflicts and offer interpretations, but rather "to help the patient reappropriate the aspects of his self-experience and affective life that have been cast aside under the pressure of anxiety, guilt, and shame" (Wachtel, 2008, p. 220). Together, the clinician and client investigate the relational material which arises naturally out of the therapeutic relationship.

Within the classical framework, self-disclosure was strongly discouraged. In relational theory, self-disclosure is viewed as a potentially useful or potentially harmful therapeutic tool. When used skillfully, self-disclosure can illuminate therapeutic content and support new depths of understanding for both the client and clinician. However, used without skill, self-disclosure can cause harm to the client or to the therapeutic relationship. It can be experienced by the client as a boundary violation, and may even be oppressive as a result of power dynamics between the clinician and client. While self-disclosure is not prohibited in relational work, it is a tool to be used with great care, and concern for the benefit of the client.

Relational theory invites the clinician to participate in the therapeutic relationship in a new way. Emphasis is on the process of the therapeutic work, and authentic and spontaneous interactions between the clinician and client are the focus of the process and, therefore, encouraged (Goldstein, Miehls, & Ringel, 2009). Early followers of Freud, such as Salvador

Firenze, experimented with clinician authenticity and spontaneity. Firenzi was particularly interested in patient gratification, and much of his work crossed relational boundaries that went against Freud's analytical structure. Relational theory brought the spontaneity and authenticity of the clinician into the therapeutic encounter in a new way. It also offers the clinician permission to use these relational elements to create a context in which the client may witness the clinician "'break out' of their traditional role and make a more spontaneous intervention" (Colman, 2013, p. 473).

Recognizing that the therapeutic dyad is reminiscent of early developmental dyads, the use of these elements play an important role in supporting bidirectional communication, which ultimately promotes self-knowledge and understanding for both the client and clinician. Aron (1996) states that the use of these principles in clinical work creates the possibility for "a profound clinical encounter, an interpersonal engagement, an intersubjective dialogue, a relational integration, a meeting of minds" (as cited in Colman, 2013, p. 473).

Intersubjectivity: Robert D. Stolorow

Intersubjectivity has its roots in Kohut's self psychology and was originally introduced into the theoretical literature by Robert D. Stolorow and George E. Atwood in the 1970s. Since then, intersubjectivity has been interpreted and expanded upon by others such as Benjamin (1998) and (2006). For the purposes of this study, the notion of intersubjectivity as proposed by authors Stolorow and Atwood (1992) will be employed: *intersubjectivity* is the "psychological field formed by interacting worlds of experience" (p. 3). In other words, it takes place in the context of relationships.

Freud's theories were based on a view of the individual mind as independent and isolated and psychopathology as the result of conflicting drives and repressed emotions. Classical

psychoanalysis, therefore, was based on a one-person psychology. The clinical work that developed out of object relations and self psychology was based on the understanding of the individual in relation to others, or a two-person psychology. On the other hand, Stolorow (1997) has proposed that intersubjectivity is a "no-person psychology" in that it reveals individual psychology to be a confluence of one's inner experience and relationships with others (p. 867). In other words, the individual's inner and external experiences are interdependent and mutually constitute the formation and functioning of one another.

Intersubjectivity acknowledges both the internal psychic and emotional experiences of the individual, as well as the relational context in which these experiences take root and develop. Previously discussed theories address internal conflicts and past relationships, however, author Bergson (1910/1960) argues that intersubjectivity holds that internal and external, as well as past and future are present and relevant in the present context of the therapeutic relationship (as cited in Stolorow, Orange, & Atwood, 2001). Stolorow points out that the intersubjective approach attends to both developmental and contextual concerns, a significant departure from classical perspective in particular.

In order to work on multiple levels, the clinician must employ acute sensitivity and rigorous attention to the many contexts of the individual's experience. Each individual brings rich developmental, relational, and cultural histories, and continues to occupy these, as well as others (Orange, Atwood, & Stolorow, 1997). Therefore, it is imperative for the clinician to maintain an open awareness of the individual's many contexts, while also engaging with the client in an authentic and spontaneous manner.

In contrast to object relations theory, which describes patterns of relating, intersubjectivity grew out of Kohut's theories of self psychology. Just as Kohut defined the

tripolar self, intersubjectivity seeks to describe and illuminate the worlds of shared experience (Stolorow, Atwood, & Ross, 1978). While self psychology defines how the clinician might attend to the various selfobject needs and vulnerabilities of the individual, intersubjectivity is a form of psychotherapy that strengthens and enriches the self-awareness of both the clinician and client through the therapeutic dialogue (Stolorow & Atwood, 1992, p. 22).

The therapeutic relationship then, takes the form of a present ever-evolving interpersonal relationship, and may encompass a wide spectrum of relational dynamics. Born through the interacting subjectivities of the clinician and client are what authors Stolorow, Atwood & Brandchaft (1994) describe as the effects of reciprocal mutual influence, colliding organizing principles, conjunctions and disjunctions, attunements and malattunements (pp. ix-x).

The specific therapeutic techniques employed by the clinician are unspecified by Stolorow. The theory is intended to provide a relational scaffolding on which the individual clinician applies their chosen theory or approach. Intersubjectivity asks only that the clinician's chosen style and technique remain intentional, and that the meaning and impact of these elements are investigated and reflected upon in the therapeutic dialogue (Stolorow et al., 1994, p. 209).

Finally, while the intersubjective approach calls for the clinician to "meet" the client in the relationship, it does not diminish the authority of the clinician. Intersubjectivity acknowledges the inherent asymmetry in the analytic dyad and preserves the definition of a therapeutic relationship as one between a clinician and client, rather than one between two participants, as the language of intersubjectivity might suggest (Stolorow et al., 1994, p. 209).

IV. The Clinical Social Worker's Role in Promoting Social Justice

Although many clinical social workers do not participate directly in macro work, social workers practice under a professional code of ethics that requires all clinicians to promote social justice through their work. The NASW Code of Ethics mandates that clinicians address "issues of poverty, unemployment, discrimination, and other forms of social injustice" (NASW, 2008, p. 5). Therefore, regardless of a clinician's professional focus, they must recognize their role as advocate and change agent, and practice in a manner which acknowledges and addresses all forms of oppression.

Social Constructionist Perspective

The postmodern social constructionist perspective (SC) provides a framework for social workers committed to addressing oppression and promoting social justice. Michel Foucault's (1926-1984) writings on the development and maintenance of knowledge and power in society are highly relevant to this discussion, as he identified all helping disciplines as potential vehicles for social regulation (Foucault, 1979).

For the purposes of this project, *construct* will be defined as: a concept or phenomenon created by society. Humans use constructs to make sense of the world and experience. However, while each individual experiences and lives within constructs of their own understanding, all constructs emerge out of social engagement and are therefore, "the result of an active, cooperative enterprise of persons in relationship" (K.J. Gergen, 1985, p. 267). Foucault suggests that the ideas and narratives created by or ascribed to individuals and communities are not fixed, rather, they are flexible, due to their relational and co-constructed nature. So while individuals employ constructs to make sense of themselves and their experience, the constructs

themselves are generated from multiple viewpoints and approaches to knowledge (Foucault, 1969/1972).

From a SC perspective, no one individual's reality is more or less real than another's, however, within the social meaning-making process, the dominant perspective is routinely privileged. Foucault identified this process as the manner in which the beliefs of the dominant group attain varying degrees of social importance and become accepted as conventional "truth" (Foucault, 1969/1972). As the dominant perspective achieves the place of truth, non-dominant perspectives become marginalized. Multiple forms of social oppression are the result of this truth-making process. Historically, the marginalization of non-dominant perspectives has resulted in the various forms of social oppression identified by the NASW code of ethics.

Marginalized individuals may experience this oppression consciously or unconsciously, however, the effects of marginalization and oppression cannot be separated from an individual's life experiences and psychological make-up.

SC offers a useful framework for clinicians, because change becomes possible only through awareness. Rather than holding one truth as a foundation for their practice, social workers who employ the SC framework have the opportunity to employ more flexible "tools of comprehension and relating, ways of describing and explaining that may or may not be useful under varying conditions" (K.J. Gergen, 2011, p. 343).

Regardless of skill, training, or awareness, clinicians practice with a relationship to power and privilege in a way that has the potential to be empowering or disempowering for their clients. SC provides a framework for clinicians to identify and explore their own location within social constructs and the identity they hold as a result of such constructs. Clinicians are asked to "interrogate" meanings, and to question their relationship to such meanings. As a result, the SC

framework can prepare clinicians to more sensitively inhabit and employ their privilege, and, ideally, enable them to practice in a manner that is empowering for clients.

The SC perspective does not require clinicians to focus their professional skills and resources on actively dismantling oppressive constructs. Informed by the SC framework, clinicians understand that "all knowledge, including small or grand narratives, can be valued and vulnerable to critique so that the potential is present for dominant beliefs and practices to be challenged and alternative narratives constructed" (Walker, 2001, p. 36). This is pertinent to practice because such an approach offers one way of addressing the oppressing effects of social meaning-making processes in the context of the therapeutic relationship.

The SC framework enables clinicians to actively promote social justice within and through the therapeutic relationship. In recognizing that no one individual can hold all knowledge or complete understanding, the clinician is able to approach each interaction and relationship from a stance of "informed not-knowing," and in doing so forms a therapeutic collaboration with clients that has the potential to become a form of resistance (Laird, 1998, p. 2). In this way, the clinician allows the client to inhabit the role of expert and the clinician takes up the task of joining them in their efforts to understand and free themselves from problematic patterns and experiences. Foucault identifies such micro-level exchanges to be an exercise of power a personal form of resistance to dominance (Foucault, 1969/1972).

When clinicians recognize that no one individual can hold all knowledge or complete understanding, they are able to practice in a manner that offers space for new understanding and the possibility of empowerment. When clinicians practice with less moral certitude and allow their personally held positions to be questioned and challenged, they discover opportunities to

"grow beyond the strictures" of their previously held worldview (M. Gergen, 2010, p. 263).

Such an approach creates the context for the client to potentially experience something similar.

Critical Theory

Many clinicians practice with the intent to challenge oppression and social injustice. A critical view of the profession, however, recognizes the potential for social work to contribute to and affirm the very oppression it seeks to challenge. Critical theory examines social work from this perspective and seeks methods of practice that work towards emancipating both clients and clinicians from the oppressive bonds of the dominant culture. Critical theory introduces the possibility of a more critically conscious form of practice, work that contributes to dismantling forms of oppression, rather than supporting the societal structures and institutions that maintain them.

Critically informed social work recognizes that social problems are the result of various forms of oppression, and that individuals live within, as well as participate in, complex social structures. Social work as a profession is located within this system. It is, therefore, of critical importance that clinicians reflect on what role the profession plays in the system, and how might one choose to practice in a manner that reflects the profession's intended purposes (Mullaly, 2007).

Critical theory proposes that a potential for social change exists in the relationship between individual insight and social change, and suggests that change is possible through actions taken by individuals who consciously reflect on their motives and needs (Dean & Fenby, 1989, p. 53). Critical social workers can begin by examining their position within systems.

Within the therapeutic relationship, clinicians are able to offer clients information regarding the influence of social structures in the formation of private troubles, thereby inviting the client to explore new perspectives (Mullaly, 2007).

Critical social work brings systemic issues into the therapeutic relationship in order to emancipate people from oppression. Critical social workers actively recognize and acknowledge the ways in which oppressive systems contribute to individual problems. In doing so, critical clinicians will often take a radical position, surrendering allegiance to the profession, when the profession supports oppression.

Authors Herz and Johansson (2011) remind us that social workers are trained in viewing the client within their individual context. However, a critical stance requires the clinician to also give consideration to the potential impact of their own context, or positionality, on the therapeutic relationship. Further, Herz and Johansson suggest that the clinician must also carefully consider the impact of various modalities on each individual client (Herz & Johansson, 2011).

While the critical clinician commits him/herself to continually developing knowledge and insight, clinicians will not seek to achieve the role of expert. Gadamer (1992), proposes that in theory, a critical clinician will be, "radically undogmatic; who, because of the many experiences he has had and the knowledge he has drawn from them, is particularly well-equipped to have new experiences and to learn from them" (as cited in Rossiter 1997, p. 33). In this way the clinician is present with the client in a manner that seeks to understand, rather than identify and interpret.

The critically oriented clinician understands that their individual perspective is only one of many, and that it is the product of their social location and person experiences. In this way,

they are alert to the potential for their own perspective to create unintentional exercise in power, which can have oppressive consequences for the client. A clinician who recognizes the partial nature of their perspective, will work in a manner that deliberately seeks to bring forth and privilege the client's perspective (Rossiter, 1997, p. 35).

Sakamoto (2005) directs attention to Freire's (1997) important description of the inherently oppressive nature of helping professions. While Freire's critique was specifically aimed at the relationship between teacher and student, it is a common reference used to illustrate the potentially oppressive nature of the clinical relationship. Freire reflects on the motivation of the helper, and states that any helping enterprise begins "with the egoistic interests of the oppressors and makes of the oppressed the objects of its humanitarianism, itself maintains and embodies oppression" (as cited in Sakamoto, p. 439). Freire's work illustrates the self-perpetuating nature of the power difference inherent in such helping relationships. Therefore, clinicians must utilize the inherent authority granted by possession of knowledge and position in a manner that does not re-inscribe the oppressive system it seeks to dismantle (Sakamoto, 2005, p 439).

On an individual level, clinicians committed to participating in critical social work can practice *reflexivity*. Reflexivity can be understood as the ability to continuously examine one's self in relation to others, and more specifically in terms of identity markers such as race, class, gender, sexual orientation, and ability. Reflexivity is a position one embodies and can be "accomplished through careful consideration of the self" (Miehls & Moffatt, 2000, p. 343). Smith (1997) argues that reflexivity is an essential component to knowing one's self, because the "self is situated within existential and psycho-social reality and cannot be abstracted from that reality" (as cited in Miehls & Moffatt, 2000, p. 342).

Reflexivity can be a valuable tool in social work practice. While many clinicians may wish to remain on terra firma, working with clients from the perspective of an experienced and skilled clinician, others may venture out beyond perceived certainties, and choose to work with clients in a way that allows them to be continuously challenged and changed. Ideally, a reflexive clinician will be in a position to meet the client in their world, as it is experienced by them, and is conscious of the potential influence of preconceived beliefs of what the client's world may, or should, be like. With skillful use of reflexivity, the clinician might be able to take in the client's experience in a way that brings them as close to the client's experience as is possible from the perspective of an outsider.

How the clinician chooses to employ the insight, knowledge, and understanding gained from such an experience is where reflexivity becomes a powerful tool in the work. Rather than simply reflecting on the new information and allowing it to settle into the landscape of the self, the clinician can allow him/herself to be challenged and changed by the information, and as a result, can impact his client's life in a way that is more true to the client's particular situation. Reflexivity invites clinicians to recognize that they are likely "oblivious to the worlds within worlds that existed just beyond the edge of their awareness and yet were present in their very midst" (Harris, 1993, p. 1711).

The average clinician is likely to possess a general understanding of the elements that shape their client's world and development. However, it is only through the client's expression and daily experience that the clinician can fully come to know these elements in terms of what they mean for each particular client. A therapeutic collaboration with the client enables the clinician to become more aware of the "worlds within worlds," which would ultimately enable the clinician to approach the work more closely attuned to the client's needs.

A reflexive practice challenges clinicians to practice with less certainty and perhaps a greater degree of discomfort. However, reflexivity is one way clinicians can help clients discover ways of being in the world that acknowledge their unique experience while taking into account the structures of oppression that may not always be seen or identified. Reflexivity invites clinicians to hold skills and knowledge in such a way that does not limit the potential for unique and radical ways of sitting with clients.

V. Contemporary Perspectives

This chapter's final section will discuss Buddhist psychology and its contributions to contemporary understanding of the therapeutic relationship. Of particular interest to this discussion, is the influence of Buddhism on emerging understanding of the concept which human beings experience as self. Consideration will also be directed towards the impact of Buddhist concepts on clinical practice.

Buddhist Psychology

Buddhism was originally brought to western attention in the 1960s and 1970s, however, in the last decade, interest in Buddhist concepts such as emptiness, mindfulness, and presence have experienced a resurgence in both in popular culture, as well as in the psychological literature. For the purposes of this discussion, *mindfulness* will be defined as the deliberate cultivation of attention to experience. Traditionally developed from a form of Buddhist meditation directed toward developing insight, "Vipassana," or insight meditation, western adaptations of Buddhism have taken various forms, the majority of which aim toward witnessing the mind and its processes without judgment. For the purposes of this discussion, *acceptance*

will be defined as "active nonjudgmental embracing of experience in the here and now" (Hayes, 2004, p. 656).

Although Buddhist psychology is based on the principals of a system of ancient philosophical and spiritual thought, current research supports the validity of many of the concepts promoted in Buddhist texts. Presently, much attention has been given to examining these principals in order to provide scientific validation for them. His Holiness the Dalai Lama, the spiritual leader of Tibetan people and a prominent figure in the Buddhist tradition, supports this investigation. Taking a unique stance for a spiritual leader, His Holiness has stated that concepts that do not stand up to scientific scrutiny will be abandoned by the Buddhist system (MLI, 2014).

In terms of western psychology, Buddhist concepts have had a direct influence on the establishment of recent "third wave" modalities such as Mindfulness-Based Stress Reduction (MBSR), Dialectic Behavioral Therapy (DBT), Acceptance and Commitment Therapy (ACT), and Mindfulness-Based Cognitive Therapy (MBCT). Perhaps as a consequence of current interest in Evidence Based Practice (EBP), these popular modalities have received wide attention in the literature and are empirically supported (Hayes, 2004).

The aforementioned modalities are commonly used to treat stress, anxiety, and depression, as well as other prevalent western pathologies. Buddhist psychology argues that much of what humans identify as suffering, is actually the result of habitual self-protection, or the individual's efforts to protect the sense of a core stable self. In fact, some western perspectives support this view. Conversations regarding the establishment of diagnostic categories for the DSM resulted in several perspectives, one being that all psychopathology is in one way or another, the result of resistance to unpleasant experiences (Hayes, Wilson, Gifford,

Follette, & Strosahl, 1996). From a Buddhist standpoint, many common defenses are simply an individual's efforts to protect the sense of a core stable self.

Buddhist psychology, however, argues that all efforts toward self-protection not only lead to further suffering, but will in fact, result in closing the individual off to a whole realm of experience (Donner, 2010). Mindfulness-informed practice supports the clinician's ability to identify what the client might be resisting, and work with them to gently build awareness of, and tolerance for, discomfort (Hayes, 2004).

As with many forms of therapeutic practice, clinicians who use mindfulness-informed modalities are encouraged to cultivate a mindfulness practice of their own (Hayes, 2004). The therapeutic relationship is commonly recognized as the determining factor of successful treatment, and the relationship is dependent on the ongoing development of the clinician. In the case of mindfulness-informed modalities, clinicians practice mindfulness in order to develop self-awareness, which has been noted by Sommers-Flanagan and Sommers-Flanagan (2009) to be essential for effective clinical practice (as cited in Gockel, 2010, p. 258).

Through personal practice, the clinician is able to develop increased self-awareness and a new understanding of self. With practice, the clinician begins to discover the "true" nature of self, which, according to Buddhism, is simply, "a series of thoughts, emotions, and bodily sensations" (Donner, 2010, p. 223). From a Buddhist perspective, the experience of a core stable self is the result of the individual attaching meaning to and identifying with such transient phenomena. The Buddhist perspective holds that all phenomena are empty, that is, all phenomena are mutually co-arising and therefore have no independent reality. Phenomena take form, however, and it is form that humans interpret to be the core stable self (Donner, 2010).

Through practice, the clinician increases the ability to decenter from experience of a solid self and is able to dis-indentify from these phenomena. In this way, the clinician is able to witness in real-time the construction routinely experienced as self, which enables them to move beyond identification with phenomena. Rather than habitually reacting to transient phenomena, the clinician becomes a witness to experience, and has the opportunity to develop insight, recognizing the ever-changing and constructed nature of all phenomena. With mindfulness, the clinician is able to shift into the perspective of witness without denying a sense of personal reality or day-to-day sense of self (Donner, 2010).

Just as Buddhist psychology stresses the impact of the mind's ability to create a notion of the self, it also provides instruction for developing the ability to recognize and witness this process. Self-awareness and freedom are the result of this process of discernment (Donner, 2010).

Magid (n.d) reports that building self-awareness results in a new relationship to one's overall self concept, and rather than resulting in a psychological experience of emptiness or no self, the individual recognizes an expanded sense of self, or what feels to be a "larger container that can hold reality as it is without adding more suffering to self and others" (as cited in Donner, 2010, p. 218).

Mindfulness practice offers many benefits, both for practicing clinicians, as well as for their clients. The clinician's increased awareness of their own experience and real-time reactions, increases their ability to be more present and available to the client, and gives them the ability to transmute these same skills and qualities to the client. As clinicians develop acceptance of experience in the here-and-now, they develop the willingness to "welcome and explore" emotional content as it arises (Gockel, Cain, Malove & James, 2013, p. 39). Fulton

(2005) states that the clinician's increasing ability creates the space for "a fuller range of expression" and quality of attention which on its own can be therapeutic for clients (as cited in Gockel, 2010, p. 256). Finally, mindfulness increases the clinician's ability to nurture similar qualities in their clients, and to offer a model of affect tolerance within the therapeutic relationship.

In effect, the clinician models a witnessing and curious presence, and works with the client to increase awareness of habitual relational patterns, as well as the capacity to intentionally enact more conscious responses. Describing the effect of the clinician's mindfulness practice on the therapeutic relationship, Gockel (2010) reiterates the findings of Speeth (1982) in stating that clinicians "become increasingly open, available, and flexible in their emotional responses to clients" (Gockel, 2010, p. 259). Habitual behaviors and impulsive responses are addressed because the clinician has the capacity to "participate with awareness" and is able to recognize what triggers particular actions (Linehan, 1993, p. 63).

Mindfulness develops an increasing capacity to accept painful negative emotions without acting in reaction to them (Welch, Rizvi, & Dimidjian, 2006). Furthermore, mindfulness training increases the ability to tolerate affect and experience without reflexive judgment. Clinicians are able to notice thoughts, feelings, and sensations without following the phenomena any further. Mindfulness increases the ability to sit with and tolerate all that arises. In practice, both the clinician and client benefit from the clinician's ability to be present with painful emotions and experiences. As the clinician develops their capacity to sit with and hold difficulties, the client begins to develop a similar capacity to sit with and hold these things on their own.

From a stance of mindfulness, the clinician is able to experience a radical openness to the therapeutic process itself. Clinicians will practice in a manner that allows theory and knowledge

to inform their practice, however, they are able to hold these things lightly. Although the clinician possesses training and knowledge that separates them from the client, the clinician does not inhabit the role of expert or objective authority. Rather, the clinician embraces an attitude of inquiry, and views the therapeutic process as an exploratory. Similar to critical practice, the mindful clinician inhabits a stance of unknowing and approaches the therapeutic relationship with curiosity. The mindfully informed clinician is tentative and, "it is this quality of attention supported by compassion that fosters the ability to look at experience as it is, beyond the concepts we build around it" (Gockel, 2010, p. 249).

The ability to inhabit the witness position decreases the experience of "direct entanglement" and this results in a sense of "profound well-being," and along with a committed practice, the possibility of "liberation from all suffering" (Virtbauer, 2011, p. 69). Liberation might be described as affect tolerance, which has been noted to be essential to the resolution of many common western disorders such as anxiety, trauma, and addiction (Roemer & Orsillo, 2009). In other words, enlightenment, or liberation, is available in the day-to-day here-and-now of human experience. Rather than some final goal or destination, liberation is simply freedom from the bonds of self-structured identification with ever-changing phenomena.

VI. Conclusion

This chapter examines the evolution of the concept of use-of-self in clinical practice from the conception of the concept in the classical psychoanalytic perspective of Sigmund Freud to the contemporary perspective of Buddhist psychology. The following chapter will will discuss the findings and their implications for professional social work.

CHAPTER III

Discussion

The purpose of this study was to examine the concept of the use-of-self in clinical practice through a historical lens, with the intent to accomplish the following objectives: to clarify what is meant by the term use-of-self in clinical practice, to illuminate the evolution of the concept, and to reconcile the many theoretical approaches that have contributed to what is understood about the phenomenon in contemporary thought.

Findings and Discussion

Amongst the helping professions, clinical practice is unique in that the clinician's principal tool is the self. Therefore, it is not surprising that the concept of use-of-self has received consistent attention by theorists and clinicians alike, beginning with Freud. Freud identified the countertransference phenomenon and put forth his findings in terms of its use in clinical practice. Freud's efforts established an investigative trend that continues today. Use-of-self in practice remains a central theme in research as the complexities of the clinician's position and role in the therapeutic relationship continue to be discovered.

The theories reviewed for this study reveal that the concept of use-of-self has undergone a notable shift in the past century. Freud determined that the clinician should practice as an objective and expert observer, offering interpretations to patients for the purpose of discerning the roots of pathology and alleviating symptoms. Jung considered the relationship between clinician and patient interdependent, and maintained that both individuals would be transformed

in the therapeutic process. The work of Rogers and Kohut encourage the clinician to be relationally present, an original approach which ultimately lead to the more subjective engagement of the clinician in relational and intersubjective practice. Critical theory and constructionist theory acknowledge the potential for helping professions to reinforce the same oppressive systems they claim to address, and suggest methods to promote more effective practice in the face of the complex nature of the work. Finally, concepts of Buddhist psychology have been widely adopted by western psychology in order to inform more mindful practice.

To summarize, use-of-self can be viewed from two general perspectives. The first, following Freud, suggests that psychopathology has predominantly intrapsychic origins and that the clinician inhabits an expert and objective position. From this perspective, the clinician should strive to remain neutral in order to avoid contaminating the patient's affective material. The second perspective views one's interpersonal biography as a significant contributor to psychopathology, and places emphasis on the interpersonal properties of the clinical relationship. Today, clinicians from each perspective continue to grapple with the question of how to participate most effectively in the therapeutic relationship.

Despite ongoing investigation, the literature pertaining to the concept of use-of-self has consistently shown that the therapeutic relationship is the primary vehicle for client growth and change (D. C. Baldwin, 1987; M. Baldwin, 1987; Fiedler, 1950; McConnaughy, 1987). In other words, the specific modality or techniques used by the clinician are less important than the relationship that occurs between the clinician and client. Expert clinicians across different schools have been shown to utilize the therapeutic relationship (Fiedler, 1950). Effective therapeutic change can be attributed to the quality and strength of the therapeutic relationship.

Therefore, while foundational theories are instrumental to clinical practice in that they provide an organizing framework, the essential core of clinical practice is the clinician's use-of-self in the therapeutic relationship. Regardless of the clinician's theoretical approach, therapeutic growth and change always takes place in the living context of the relationship between clinician and client.

In the spirit of several theories represented in this study, this researcher would like to offer a teaching attributed to Huineng, the Sixth Patriarch in the Zen lineage. It is said that Huineng likened Zen teachings to a finger pointing at the moon. The teachings are the finger directing us to the moon's location. However, the teachings do not represent true knowledge or understanding (Singh, 2010). Similarly, clinical theory is useful in that it can provide direction and a framework for practice. However, due to the living context and naturally evolving nature of clinical practice, theory can inform a clinician's use-of-self in practice, but can also act as a hindrance if taken in as reified truth.

Ultimately, each clinician must continuously pursue self-knowledge and build self-awareness, qualities which enhance the clinician's participation in the therapeutic relationship. The practice of self-awareness is instrumental in the formation of a professional identity, and contributes to a more deliberate, skillful, and effective use-of-self in clinical practice.

Contribution to Professional Social Work Practice, Policy, and Education

Through the process of completing this research project, this researcher has developed a new level of insight into how she might practice most effectively in a field that aims to serve oppressed and marginalized populations. Both personally and professionally, a significant level of identity privilege has informed this researcher's lived experience. Research into the various approaches to the clinician's use-of-self has refined this researcher's understanding of several

prominent theories and reinforced their commitment toward participating in socially conscious practice.

　　As this researcher enters the field as a new clinician and develops their own unique approach, it is their hope to maintain a stance of open curiosity, mindful that what is known about human psychology and relationships is constantly reflected upon, questioned, and revised. What remains constant, however, is agreement upon the power of the therapeutic relationship in effecting change. It is the hope of this researcher that they will be able to approach their practice with the awareness and acknowledgement of differences in privilege, power, and the lived experience of the individual, while remaining open to the aspects of affective experience which are in many ways, universal.

　　A historical review of the concept of the clinician's use-of-self supports the more contemporary perspectives such as relational and intersubjective practice. This review can inform the content of social work curricula, by highlighting the importance of developing clinician self-awareness in order to support a more effective application of theoretical understanding and practice skills. This study supports the inclusion of self-reflective material in clinical programs, activities which ultimately train clinicians to prioritize client context and tailor the clinical use-of-self to each individual.

　　This project has the potential to have indirect effects on policy, in that it speaks to the importance of anti-oppressive clinical practice. While much attention is given to training social workers to practice as agents of change on the macro level, less attention is given to practical application of anti-oppressive clinical theories. This study was intended to acknowledge the personal and social implications of clinical social work practice, and suggest that these aspects can coexist and inform one another.

Limitations of this study

Certainly time was the most constraining limitation of this study. In embarking on a review of the literature, this researcher discovered that the most informative descriptions of the clinician's use-of-self were to be found in the primary texts and literature of each theoretical base. This being so, it was impossible to do a comprehensive review of the literature for the purposes of this study.

Time also limited the number of theoretical perspectives this researcher was able to survey. Originally, this researcher hoped to include object relations, systems theory, as well as the implications of Martin Buber's philosophy of dialogical existence and the principles of neuroscience that reveal the biochemical workings of relationships, including the pathways of empathy and mirror neurons. The time available to this researcher resulted in only a brief survey of relevant theories and research.

An additional limitation of this study was the researcher's limited experience in the role of clinician, as well as client. While much can be gathered from the literature, certainly the researcher's experience in the field had an influence on how the information was collected, reviewed, and interpreted.

Finally, this researcher began the process of investigating her social location fairly recently. Therefore, it is likely that the researcher's social location and identity privilege resulted in unintentional, but discernable bias at times.

Recommendations for Future Research

This clinician is particularly interested in future research into the development of a professional identity. In particular, this researcher would like to explore the ways in which education and training the use-of-self practices of new clinicians. In a field where the self is the

tool, how are clinicians gaining the knowledge and experience to inform effective use-of-self? Is

the clinician's use-of-self something that evolves over the span of their career, or is it an aspect of

the professional identity that is solidified early on. If so, are field supervisors universally

invested in identifying and informing the development of students' use-of-self? Which aspects of

the clinician's education and training are most influential in establishing a clinician's unique

approach toward use-of-self? In the future, this researcher would like to conduct qualitative

interviews in order to obtain first person accounts of use-of-self in clinical practice.

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