The Therapist’s Journey: A Model of Professional Identity Development

“It takes a lot to constitute an analyst’s voice: part of it is and always was there, part of it is in an endless training and reshaping, part of it gets lost at times of crisis, part of it will never be found, or has never been there, and we always talk against the echo of what there is and what there is not.”

Gershon Molad

INTRODUCTION

Is it possible to be a good therapist and a flawed person, intimate and effective with clients but detached and distracted from one’s spouse, patient and understanding in the office but critical and hypersensitive at home? What is the relationship between the “unhealthy” aspects of oneself and therapeutic behavior, between the professional identity of the therapist and the Soul of the person? How does the cultivation of a professional identity over the span of training and practice assimilate these unhealthy aspects of self? To what extent does formal training protect, inhibit, or potentiate personal development? How do we discover, hold, understand, and learn to use the “unhealthy” aspects of ourselves when what is split off and dissociated by the individual is also devalued by the professional community?

Do I dare present my thoughts, my wounds to you in this time of economic uncertainty, hope, and confusion? How much am I willing to disclose? There is suspense at the border of every human encounter. The autobiography of a therapist is a story of pain and humiliation recast by efforts at recovery, and the trappings of success and self-deception that follow. Am I too CYNICAL? How much of this story needs to be told in a public forum? Shouldn’t we keep our private thoughts private? I am trying to balance the psychoanalytic narrative, the blank screen that has spoken with authority for so many decades and still commands attention. We design our techniques to master our suffering and to help. We are not heroes. We are not special. We are wounded-healers.

There is conference space and clinical or psychoanalytic space that Judy Vida and Gersh Molad (2002, 2005) write so eloquently about. They describe two conflicting existential dimensions of the therapist/analyst’s identity, illustrated in how analysts differentially talk to clients in therapy and
colleagues at meetings and conferences. Their writings describe the challenges that an analyst faces in trying to be authentic within the psychoanalytic group. They define “conference space” as the professional domains where analysts/therapists interact: seminars, conferences, and supervision. Conference space is dominated by performance and driven by fear and shame that compel the analyst/therapist to present a professional competent “false self” to colleagues. In conference space the analyst silences the personal, the vulnerable, the messy, “the missing parts,” so as not to be silenced by the group. Psychoanalytic space represents the idea of an optimal hoped for experience of mutuality and intimacy. It embodies the “autobiographical dialogue,” a conversation epitomized by attunement, openness, authentic communication, and mutuality. And there is OUR CHATTER, the unwritten, uncensored, undocumented messy stuff, the private, non-publicized conference where “hope and dread” dance in exile. I call this interstitial space a private-semi-private space that siphons off the dialogue of conference space. It includes not only what we think in private, but also what colleagues say during breaks, or at lunch. It is filled with gossip, complaints, admiration, angst, weariness, sexual excitement; it is the non-public, unstated, subversive unorganized that rubs threateningly against the conference. It also absorbs my internal monologue that seems so “unfit” for public dialogue.

Who am I and who are you? Who are we when we enter the consultation room and when we exit? Who are we in this room? Think imaginary door frames what Molad refers to as the illusory boundaries that define therapists behavior in different spaces. Think about what we need from the different others in our life. What voices compete in your mind as I talk? How will you receive me? And if I stumble? How will I receive myself? I don’t know who you are. Should it matter? We are the same and we are different. You are the Other, always present and unknowable, absent and strange, threatening, yet so integral to who I am. I can’t quite recognize you amidst the shadows cast by my defenses. I don’t know what you really think of me, and I have an aching desire to know. - Reassure me that I am OK - as if there is a final Truth, messianic like in its power to heal. And so, when I present a public thought, I am waiting to be made whole, when I make an interpretation, I am wanting to be recognized as warm, insightful, deep; I am waiting…still waiting to shine and conquer, to be accepted. And behind the scenes lurking are the lines from Emily Dickinson “This is my letter to the World/ That never wrote to Me.” This sentiment echoes through my life and seeps into spaces that I imagine are filled with love.
Who am I and how did I become a therapist and in particular a psychoanalytically oriented one? Why does anyone make this choice? (if it is a choice) The answers are buried in the details of my life, forgotten memories and dreams. It is difficult tease out the conscious and unconscious qualities of a lived identity, to render the complex relationship between who we are and how we imagine we are perceived. At the critical interfaces of experience, reflection, perception, and communication there is fear and shame, and disjunction, an ever-present instability and possibility for distortion, disclosure and concealment. Language at its best is like an unprepared understudy all too willing to do its part, but unlikely to do it well. The linguistic constructions that describe the self hold the self in traction as the individual moves through life.

I am suspicious of my retrieval words that stretch across time and create coherent narratives. Coherence is the refuge. Words, words, words: repression, projection, splitting, dissociation, id, ego, super-ego, self, subject, object; today’s words and yesterdays meanings, and yesterday’s words and today’s ghosts. Words have histories like patients, splintered loyalties, split across paradigms. Words slide across time like refugees. Paradigm shifts swallow words, etherize meanings, Id, ego, and s-ego are museum words. A generation ago they were alive. According to Derrida, (Sarap, 1993) “All words are open to question.” Words, theories, and stories, and allegiance to theory; identity and identity development; identity is a fiction constructed to deal with pain and ambiguity. Theories of identity development are collective narratives, stories we tell each other to ease our professional uncertainty and elevate our professional visibility. This is a story and a theory about the story and a story about a theory.

**Personal digression.** We all have stories (myths) describing how we believe we became interested in psychoanalysis and why we decided to become therapists. I discovered Freud accidentally as an anxious, self-conscious, insecure high school student coincidentally around the time of my parents divorce at age 15. My parents who were not readers had a copy of Ernest Jones (1953) biography of Freud. I read it. I liked that he was Jewish and that he had used cocaine. After reading *Interpretation of Dreams* (1900), I started a dream journal and spent more time writing down dreams, day residues and associations than living. After my parents divorce, I turned away from sports which had consumed 100% my childhood and slipped into the counter-culture of the 60’s. I hid in shadows, smoked marijuana,
experimented with LSD, maintained modest grades, suffered from lack of artistic and musical talent, and walked along the perimeters of every group or individual I met. Encountering Freud opened a door to the possibility of understanding my anxious insecurity. The ideas of Freud welcomed my anxious despair driven curiosity, my adolescent rebellious counter culture critical nature, my alienation from the norm, my not fitting in. It gave a desperately needed meaning to what had previously been unwelcome incomprehensible distress. I realized that I wasn’t the only screwed up person.

After emerging from the personal exile that followed my graduation from high school in 1969 and encompassed much of my undergraduate years, I eventually entered graduate school at the California School of Professional Psychology in 1977 at the Berkeley Campus. Those intervening years contained the sadness, wounds, disappointments, failures, and trials found in many conventional “coming of age” stories. I felt empty, inadequate, and doubtful that I could make something of myself. My journey left large emotional wounds that propelled me in the direction of becoming a psychologist. It was difficult to imagine another track. It was difficult to imagine. My parents and friends were worried about my ability to establish a career. Anticipating at least four more years of school was comforting. I hoped and needed to believe that I would find relief, security, and confidence in addition to a livelihood by becoming a psychologist. The therapy I received up to that point was at best minimally supportive. I entered graduate school with wounds too painful to communicate. I believed I was screwed up and more damaged than most of my classmates. I was scared of people and critical of my intelligence. I felt intense anxiety bordering on panic. I tiptoed around the edge my despair fearing that I could fall in and then the feelings would never stop.

I am a wounded-healer. I am deeply ambivalent about my woundedness however much I lean toward acceptance. This ambivalence influences my clinical work, my theory, my writing, and my ability to love beyond the best of my intentions. OH HOW THE UNCONSCIOUS twists the fibers of my being. My woundedness is embedded in my healing. I am proud of my healing self. I enjoy my job and this professional self, what Jody Messler Davies (2004) refers to as the “preferred vision of oneself.” It carries me forth. It expresses my better sides. It can be poetic, decisive, and insightful. My healing is embedded in my wounds. I accept these wounds as necessary, though not good. With family I can be reactive, impatient, and
irritable. I tuck away envious feelings tinged with paranoia about friends and colleagues who I see as more successful. I am still insecure, and at times contemptuous of my insecurities, frightened that my wounds will leak into my work, worried that I am too detached, emotionally restricted, and avoid the intimate stuff. I am afraid that my wounds will also leak into this presentation – ashamed that my wounds still smart after all these years. My woundedness creates the conditions for empathy as well as for splitting, omnipotence and devaluation.

Ancient voices surround this present moment. We speak, we treat, we theorize, and we live from the position of “wounded-healer.” The archetype of the “wounded healer” captures the dual, conflicted nature of the contemporary therapist’s identity while linking it to the spirit of healers of the past. Goldberg (1991) states, “In the oldest myths of healing, it is precisely because healers were vulnerable to wound and suffering that they had the power to heal.” The personal journey of the ancient healer involved transformation through suffering and exposure to the dark sides of the psyche. I use the term to express the precarious split between the wounded and healing parts of the therapist’s personality and the difficult struggle that therapists experience pursuing this journey of self discovery-acceptance in modern times. Precarious, because the split all too easily becomes an organization of identity through fear of vulnerability, through succumbing to the prevailing values that privilege strength and achievement.

Theoretical digression. Postmodern sensibility has stirred contemporary psychoanalytic writers to challenge, deconstruct traditional analytic concepts. It has been particularly critical of the idea of the Self as an isolated, autonomous, and knowable entity. If the self is neither isolated nor knowable, than how do we conceptualize the intersubjective or relational self? What are the implications for psychoanalytic theory, education, and treatment?

In Hope and Dread In Psychoanalysis, Stephen Mitchell described the relational self as an emergent relational process that consists of patterns of different self and object images “derived from different relational contexts” that changes over time. (Mitchell 1993) The relational self is a hybrid complex, a blending of internal-external qualities, that include the internal, contained world of dreams, feelings and thoughts as well as the external world, otherness, consisting of friends, enemies, children, significant others, therapeutic routines, parents, therapists, colleagues, clients,
supervisors, friends, and institutional affiliations etc. The relational self is constituted and buoyed by relational-contextual factors, self-objects encountered in job, friends, family, and routines that provide stability and cohesiveness.

The relational self is changeable, entangled in the world, more process than structure, a phenomenon whose stability is maintained by routines, tasks, and relationships, and challenged by change and novelty in the environment. We are so embedded in the world, so mystified by the assumption of authorship of our identity that we are unaware of how sensitive, dependent, and reactive we are to the world. This is especially true as our world becomes increasingly routinized.

The post-modern-conceptualization of the unknowable self has implications that are important to the subject of professional identity development, psychoanalytic education, and treatment.

First, the recognition that we can never feel whole, that there is an essential something missing and a limit to our understanding, is not knew or newsworthy. However, this central feature of human experience has yet to be integrated into professional training. It has a theoretical importance without personal implications. How one feels, how one copes with the feelings of emptiness, inadequacy and shame is critical to the process of becoming a therapist. This problem has been referred out to personal therapy to the detriment of our training. The classic-contemporary psychoanalytic tripartite model of training consisting of course work, supervised case work and personal analysis splits the analyst in training, splits the course work from the core therapeutic task of integrating diverse and contradictory aspects of the self.

Second, the boundaries of the self extend beyond the skin-contained self. Self-not self, the Buddhist idea of the interdependent nature of all things captures the quality of this ancient postmodern formulation. It is not what we think or feel at any given moment that defines the self, but the expanse of our lives that gives breath and depth to the various manifestations of self-being-in-the-world. The Self is refracted through the multiple interactions we have with others. Otherness in its multifaceted complexity embodies aspects of our selves. Self-understanding as process is neither exclusively introspective nor a dyadic, but is multi-interactive. We need others not only for recognition and validation, but also to find and learn about our displaced,
exiled selves. From this perspective transference is expansive and plural. To know more about myself I need my wife, my son, my daughter, my dog, my therapist, my patients and my friends and enemies, and an open heart. Clinical theory continues to value individual modes of treatment over family, group and couple.

Third, the self is highly context dependent. Different qualities and affect states are triggered in different situations. Our sense of personality continuity is more a function of context than internal structure. If you change context, then you change internal sense of self. I am different at home than I am in my office. We are different in our office than we are in conference. As we move through the different spaces of our lives, and pass through what Molad refers to as imaginary door frames, we assume different versions of self without recognizing the constituting and transformational function of context or the accommodative mechanisms of adjustment. Thus misperceptions and misattributions shadow one’s steps, Psychoanalytic developmental theory continues to minimize the ongoing influence of the environment on the individual.

Fourth, the prevailing cultural climate creates the signifying context of identity development that influences how we train our students and how we treat our patients and how we theorize. There is a generational transmission of values embedded in the policies, procedures, pedagogy, and ideology of graduate school and postgraduate institutes that draws from the cultural leixcon. The logic of splitting what Derrida refers to as logic of “binary oppositions” (Sarup, 1993) structures western thinking about the world. Split terms like strong/weak, stable/unstable, rational/ emotional, healthy/sick, and independent/dependent form the meaning units that frame the discourse on identity. These terms define the qualities of the ideal and shameful self, the thematic structures of self in relation to others, and are particularly relevant in our understanding of the construction of therapist/patient co-identities.

PROFESSIONAL IDENTITY DEVELOPMENT: THE FRAMEWORK

Three Attitudes Toward the Self

How one feels about oneself, in particular about the wounded aspects of self, is a central mediating variable in the development of one’s identity. Three predominant attitudes towards the self or modes of being co-exist in
varying degrees in each of us reflecting our conscious/unconscious orientation to the vulnerable-wounded-shameful parts of our personality: self-rejection, self-improvement, and self-acceptance. The interplay of these modes influence our openness to experience and capacity to learn and to change. At different points in time, and in different situations, one mode of being may be dominant, while the other modes are subordinate, latent, and emergent.

**Self-rejection** represents an attitude of hatred toward perceived personal shortcomings based on an inability to tolerate psychological pain. Shame toward our inadequacies can lead to efforts to obliterates conscious awareness of the pain through mechanisms such as denial, projection, externalization, omnipotent fantasy, drug use and acting out.

**Self-improvement** represents an attitude of conditional acceptance of the shameful parts of oneself that is based on the hope that one can change. Through self-reparative efforts one tries to repair the damaged parts of oneself. This mode while constructive and pragmatic is similar to self-rejection in its difficulty in accepting psychological pain and vulnerability as an intrinsic condition of being human. Its pragmatism is rooted in a magical if, then…world of possibility. If I read this book, attend this seminar, get supervised by this analyst, then… Underlying the mode of self-improvement is the fantasy in the perfectibility of the damaged self.

**Self-acceptance** reflects an attitude of compassion toward the shameful aspects of self. It involves coming to terms with one’s weaknesses and strengths and giving up any illusions of perfectibility. Self-acceptance is achieved through the breaking down of one’s defenses, and the omnipotent fantasies that cast the world a playground for self-improvement. Self-acceptance is achieved slowly and through cycles of experiencing disappointments, failures, and successes; struggling with self-rejection and self-improvement.

**The trajectory of identity development: The therapist’s journey**

It is a challenging and unique aspect of our profession to have one’s professional identity so intimately linked with one’s personal self. Becoming a therapist is a state of mind, a sensibility, a never-ending process of developing an identity, a solution to a deeply personal problem, as well as learning a body of knowledge, a set of techniques, and establishing a career.
The therapist’s identity is an amalgam of professional role, which grows around a personal amorphous core. The professional and the personal dimensions of self are variables in a complex equation describing the therapist’s identity, where the professional holds the “preferred (idealized) version of self and the personal holds the remains, including what is messy, wounded, inadequate, and unacceptable.

I am proposing a simple framework for understanding the trajectory of identity development in the therapist. Therapist’s develop from an initial experience of anxiety and insecurity through a phase of self-improvement, change, and identity consolidation that encompasses professional training and career building, to crisis that is ever present and holds the potential for growth via greater self-acceptance.

The initial phase leans heavily on the project of self-improvement. It is guided predominantly by the drive to repair the damaged self and is structured by the cognitive processes of skill building and affective, identificatory processes involved with the establishment of a professional identity.

The second phase is guided by the mode of self-acceptance. Carl Jung said in Modern Man in Search for a Soul, “The patient does not feel himself accepted, unless the very worst in him is accepted too.” This quote goes directly to the heart of the struggle for self-acceptance. To accept the worst, we need to learn to fail, face our failures, allow others to see this, and survive the experience. This movement toward vulnerability and openness is antithetical to western values that privilege achievement, power, stability that are the identity building blocks underlying professionalism.

Beginning therapists are filled with anxiety, shame, and existential self-doubting questions triggered by the challenge of doing therapy, and driven by a deeper sense of defectiveness. Am I good enough, smart enough, healthy enough, perceptive enough, sensitive enough capable enough, tough enough to be a therapist? The wish to become a therapist is often linked to the conscious desire to change and repair oneself. There is often a childhood history of psychological trauma and subsequent psychological vulnerability that predispose individuals to become therapists. (Goldberg, 1991, Dryden, 1989,)
Beginning therapists deal with their anxiety and vulnerability in multiple ways that mobilize self-rejection, self-change and self-acceptance modes of being. However, professional training, what we learn in graduate schools and post graduate institutes, is guided predominantly by the principle of self-improvement that values achievement, competence, mastery, composure, and assertiveness whose split off relatives, failure, emotionality, vulnerability, and passivity are devalued. These feelings are problematized and excluded from mutual inquiry. The personal markers of self-improvement are feelings of increased confidence that are linked to mastering intervention techniques, theory, and ultimately grounded in the consolidation of a professional identity that confers stability and authority.

Our theoretical orientation colors and contours the foundation for our professional identity. It is the glue that holds us together and binds us to each other and separates us from each other. We communicate much of our identity through this theoretical insignia. Our theoretical orientation announces us to our colleagues and to our clients. Becoming a relational analyst, a contemporary Freudian, a Kleinian or a Jungian consolidates the vulnerable self as an integral something.

What’s in a name but the exclusion of something feared. The polarization of difference into distinct theoretical ideologies subverts thinking to the logic of splitting that overvalues certain qualities and devalues other qualities. Otherness comes to embody a difference that is threatening. Kleinians are dark, authoritative, and rigid. Relationalists are too personal, permissive, and self-indulgent. Who we are relationally is less determined by who we think we are than what we are afraid of becoming.

Our professional identity can protect, constrain, and or potentiate the development of the self. It can harbor a fragile ideal self, while masking the more troubled shameful aspects of identity. It can also be the vehicle to transport the troubled self forward into challenging encounters that lead to authentic growth. If the relationship between work and personal life, between ideal and shameful self is reciprocal, one grows and develops. My mistakes and excesses increase my compassion for not only clients but also for my family and myself. What I say to my clients, I apply to myself. The efforts that my clients make can be inspiring. While we have the chance to work through our conflicts through the process of becoming and being a therapist, and many of us do, under pressure from internal and or external sources, the personal and the professional can become split into distinct and
complimentary self states, where the professional embodies the idealized version of self and the personal holds the unhealthy, shameful aspects of self. The professional/personal split is sustained through the daily activities of being a therapist, reinforced by the structure of the therapeutic relationship, and serves to bolster the therapist’s “preferred version” of self.

**The Journey: Starting out.** During graduate school and later in my post doc, (the late 70’s and early 80’s) I aspired to become a competent analytically oriented therapist. I was self-consciously constructing my psychoanalytic identity. I measured my progress against the analytic ideals of the day: abstinence, anonymity, neutrality, and the well-timed, and tactfully titrated correct interpretation. I strongly identified with and envied supervisors who seemed to embody these qualities. I could not measure up. The challenges of learning psychotherapy were immense. I longed to achieve that state of sturdy calmness and be able to convey that authoritative confidence that I associated with psychological health and professionalism, and believed was needed as a condition of doing effective therapy.

As a beginning therapist, I felt uncomfortable inhabiting the professional role. I felt awkward not answering personal questions that client’s asked me. I felt restricted by what I thought I should and shouldn’t say to clients, and threatened by supervisor’s towering expectations. I worked under the belief that it was bad technique, which meant I was a bad therapist to gratify clients, engage in small talk or answer questions directly. My analytic supervisors taught that the only valid activity was interpretation or inquiry leading to interpretation. I believed that my difficulties following these prescriptions represented my personal deficiency. I kept this deficiency hidden from supervisors and friends. I felt inadequate with colleagues and supervisors. I wrote volumes of process notes, never mentioning that most of my process was preoccupied with what I didn’t know, what I wanted to but was afraid to say, and how deeply uncomfortable and inadequate I felt in the room with each and every client. I was bleeding throughout my internships, a little less during my post doc. Nobody noticed or commented on the mess, as I consciously polished my professional analytically oriented false self. I never talked in supervision or case conferences about how inept and anxious I felt. I was never asked how I felt in supervision.
Everything personal and messy, the dangerous intimacy of the moment, was formalized and depersonalized through the constructs of transference and countertransference. Countertransference has at least two aspects: it is a critically important way of recognizing personal distortions; it can also assume an as if character that distills an unsettling feeling to a point of being tolerated. Talented analytic supervisors stayed on the surface of my false self. There seemed to be a conspiracy of false selves, an unstated policy that prohibited direct open discussion of vulnerability. It was a time for achievement and the show of competence. I only spoke about these feelings in therapy, which was a partial sanctuary for my self-doubts that seemed far removed from the rigors of graduate school and internship. I worked hard to correct my personal deficiencies while hoping that nobody would notice them. For years I felt inadequate and uncomfortable doing therapy. I secretly harbored it as a conviction that something was wrong with me. I hoped that with time, with more therapy and supervision I would get better and become the therapist that I wished I could be.

During this period of heightened vulnerability, therapists need the confirming, understanding gaze of their professors, supervisors, and therapists. We need to be invited, coaxed, warmly nudged to open up and to disclose how we feel about ourselves and how we feel about the experience of becoming a therapist. It takes a lot to constitute an authentic voice. It involves breaking through a wall of fear encircled by a shrine of shame. One struggles repeatedly against one’s prescriptions and prohibitions, and against the expectations and standards of the group. Without an invitation to disclose and a model for disclosure that is valued, we dare not reveal too much for fear of judgment. To the extent that graduate training, professional organizations and post graduate institutes embody the rules of conference space, the expectations to perform and achieve, it supports the internal splitting of the self into professional and personal/private domains. Conference space does not provide a safe environment for breakdowns. At best there exists an unsteady tension, an unspoken don’t ask won’t tell relationship between the dominant professional culture and the shameful aspects of oneself. To disclose neediness, fragility, vulnerability, weakness, defectiveness and incompetence in a competitive environment is personally and professionally risky. It is much easier to accommodate to convention.

As a consequence of splitting, the messy, vulnerable, inadequate parts of our personality become stigmatized and excluded. One grows within the
space allotted by the parameters of self-improvement, of making better and stronger. There is an arc of tension between the therapist’s effort to grow and develop and the defensive maneuvers that shadows these movements. The confidence that accrues from professional success often conceals a persistent sense of defectiveness. Our ability to “heal” others belies our reluctance to be vulnerable. Our exercising our ideal self reduces the pressure to work on our actual self. The dedication to work and over-work becomes a perilous journey of self-deception. We hide our defective self in the attic, while we present our “preferred version of self” in the office, at meetings and conferences. We construct our lives in such a way to spend less and less time in the attic. We begin to believe in the reality of our ideal self. The more we believe in our ideal self, the less we can tolerate our failings and the more hideous our actual self feels.

What doesn’t get expressed publicly grows in secrecy under the requirements of conformity and festers according to the laws of the unconscious. Interstitial space flourishes like a tropical rain forest. It is an underground world of unexpressed thoughts, a parallel universe of insurgent feelings that seep into gossip, private obsessions, and seed the solitary musings of conferences, and the casual remarks exchanged between colleagues in hallways. This marginalized world of discourse, a wasteland of discarded, seemingly unimportant shameful aspects of self constitute an unwritten yet invaluable narrative that is unacknowledged by training programs. It is manifest in our personal lives, our relationship to our children, our significant others and our parents.

However, these silenced voices also haunt clinical space like a ghost. The more intimate voice of clinical space lacks the textured vulnerability of its exiled selves. We hesitate to speak our minds. We don’t trust our bodies. There is an air of duplicity in the clinic. We are afraid of the ghosts. We feel like imposters when they are present but not acknowledged. We move hesitantly into life space feeling relief when we return untraumatized. We move into clinical space sometimes fleeing life space and grab hold of the anchor of thinking that we are more together than our clients. Our experience is haunted by the silence in sessions and the spaces created by decisions not to say things that would compromise our authority and risk the image of our composure and mental health.

**Personal Digression.** Each day when I go to work I somehow adjust my neediness, my worries, my impatience, and my armored, reflexive
character-driven reactions so they do not play a significant role in my professional psyche. While doing psychotherapy, I am usually able to experience my optimal idealized version of self: a self that is capable of deep listening, patience, creative problem solving, empathy and occasional playfulness. Something transformative happens before I walk into the waiting room to meet a client. It is a mode of self-repair embedded in my daily routine that adeptly assuages narcissistic wounds with no side visible side effects. It feels good to be on top of one’s game, especially if I am depressed because of a fight that I had with my wife. It is easy take refuge in the reality of my professional self and breath in the assertion “I am good.” It is like having a talisman, an affirming self-object that just happens to be my job.

It is all too easy to not recognize the important contribution that clients make to this feeling of wellbeing. The one client who frequently starts a session perplexed as to why he is feeling irritable and leaves the session with the benefits my insight. The dependent client who has placed me on a pedestal and repeatedly acknowledges my skills and compassion. Client idealizations enhance my self-esteem, and support the split in functioning between my ideal and shameful self. I look forward to working with these clients without necessarily recognizing my dependence on their high regard.

In the language of Self Psychology, our self-object needs are intimately tied to the psychotherapeutic situation. Hoffman (1998) states that the asymmetrical structure of therapy fosters what he describes as “regard for the analyst.” (p83) “The analyst is in a position that is likely to promote the most tolerant, understanding, and generous aspects of his personality.” According to Bacal and Thomson (1996), “The analyst is usually no more aware that these routines may embody self-object needs than he is of the air he breathes.” They state, “the most common self-object need of the therapist is for mirroring of his function according to whatsoever way he conceives this function. If he conceives of it as a caring attitude he needs to be affirmed for this. If he conceives this function in terms of cognitive understanding, he needs affirmation for this.” They suggest, “That this need may reflect an inadequate working through of the “darker” or “nastier” sides of the analyst in his own analysis.”

However difficult our job is (which we tend to acknowledge all too readily), it is far easier to function optimally in the office than at home. It is easier to be a therapist to a patient then a therapist to one’s sick self or needy wife.
Working effectively within certain parameters reinforces my belief in my idealized self at the expense of my plodding, needy, inadequate self. However ineffective I might be or feel at work, I don’t scream at my clients or pout when they don’t listen to me. I might act out around the corners, but this doesn’t lead to major outbursts. Sometimes I am able to help others in ways that I can’t help myself. Sometimes my off camera behavior is appalling. I would be mortified if a client or a colleague was a fly on the interior walls of my life. The shadow cast by the expectations of my ideal self darkens the shame of being so ineptly human. If only my clients knew…

There are times when I leave the office and feel deeply satisfied with myself. However, at the end of a difficult day I can feel so tired and burdened that I am incapable of patience or thoughtfulness. Absorbing another’s pain is hard mental labor. Walking up the stairs to my home, I hope that my house is quiet and that my family will not need me. My optimal self depleted by its labor shadows me, making its presence known as an afterthought to the less than optimal fumbling of my frazzled self. I need consideration; I need to be comforted. I walk into the house and my wife doesn’t look up from the laptop. At this moment, my frazzled self has difficulty communicating these needs. My wife seems intensely involved in her work. I don’t want to disturb her. I am afraid of conflict. I feel resentful. I am ready for a fight. I withdraw on cue and scowl, slam a cupboard and mutter. I am not able to enlist the aid my optimal reflective self. In contrast to the ease with which this happens at work, in the actual world, the process requires a procedure equivalent to psychosurgery. In contrast to the intensity of impasse present in my marriage, it seems infrequent in my therapeutic relationships. However, the most common therapeutic impasse goes unnoticed and is the outcome of the influence of the mutual positive co-transference. Its presence is subtle and can be detected when therapy is moving too smoothly. The patient is working diligently and the therapist is feeling effective and really good.

Case illustration. We have all had difficult cases where we have made mistakes, where we have been pushed into a corner and acted outside our preferred versions of self. I’ve chosen this case because it illustrates how our beliefs about who we are and our theories about what we do can unwittingly create conditions for impasses with our clients. He was a therapist in training who came for counseling to fulfill her graduate school requirement. She was never comfortable in her role as client. I was never
comfortable in my role as not her therapist. Early into our work, she brought me a paper that she had written that critiqued the frame. In this paper she stated that the frame was established and maintained for the comfort of the therapist at the expense of the client. It was a mechanism used to manage the needs of the client based on what the therapist could tolerate. She claimed that the therapist’s narcissistic insistence on maintaining the frame encouraged the client’s accommodation, and accentuated the compliance of the false self. She felt that the needs of the true self, especially the regressive needs, cried out against the rigidity of the frame, particularly the compulsive commitment to ending sessions on time. While the client is invited to open her heart, she must abruptly stop at the end of the hour. This rigid adherence to the frame posed a grave threat to the client who might need more flexibility in order to grow. My client felt this rigidity to be harsh, insensitive and potentially re-traumatizing.

She was articulate and pleasant, friendly on the surface, and yet intent on not becoming my client, at least on my terms. She was neither demanding nor argumentative. She would casually minimize the value therapy, frequently remind me of ways in which she obtained therapy from friends, alternative healers, while complain that she wasn’t getting anything out of our therapy. She made her co-payment at the start of each session with a certain ambiguous acknowledgement that left me feeling unmistakably paid. There was often anxiety floating in the office creating a background of suspense and discomfit. She was inclined to chat about events in her life as many patients do. Her chatting triggered in me a disinclination to listen, an anxiety about my role, and an insistence on acting more like the therapist, which meant steering questions to focus on problems. The more I acted like a therapist, the more she resisted acting like a client. We became locked in an impasse. Efforts to talk about the impasse only deepened it. I was too afraid and unsteady to address the difficulty as our impasse. We sustained a tense and uncomfortable relationship for 11 sessions, until she decided to find another therapist. I was wounded, but relieved when she terminated therapy.

The case presented difficulties for me. I felt uncomfortable being with her. I viewed her statements about the inequality of the frame as defensive. While she never explicitly asked or demanded that I modify my approach, her Being insisted on what I unthinkingly felt to be a major demand. Although I felt ineffective when working with her, I blamed her for these feelings.. I thought about her personality inconsistencies as evidence of
underlying problems of dependence and trust. Viewing her psychological disturbances in terms of resistance invalidated her need. I presented this case to a consultation group and received support and confirmation of my formulations. The group agreed that she indeed was a difficult and resistant patient.

In retrospect I came to understand that she did not want to be in therapy with me because I failed to be the therapist that she needed. I was unwilling to meet her on her terms and accept her wish not to be the patient that I needed her to be. I didn’t want to bend. I expected her (needed her) to talk about problems in therapy, and not to chat. Her chatting disqualified me. My reluctance to chat disqualified her. My difficulty in addressing this impasse was a mutually determined difficulty that I failed to address as such because I didn’t recognize it as a mutual impasse. I thought of it in terms of resistance and felt it was our job to understand her resistance. This approach merely strengthened the impasse.

On a more general level my un-self-reflective response to this impasse reflected my blind spot, palpably felt by her. I don’t necessarily see my smile or sneer as I look into another’s eyes. I don’t always hear the anger in my voice, even after it is pointed out to me. And I didn’t see that my need to maintain my therapeutic stance was insensitive and possibly hurtful. While I can never know myself without an Other, I often don’t recognize myself in another’s description.

How does one reconcile interpersonal ambiguity, contradictions, and complementarity? How does one make sense of the inside outside discrepancies and utilize these differences as a source of information when they seem so threatening. In the spirit of Winnicott’s 1971 essay where he differentiated object use from object relating, I suggest that in order to see oneself and recognize the impact one has on another, especially in the heat of a conflict, whether it is a patient or significant other, one needs to break through one’s omnipotence and “surrender” to the perspective of the other. Without this surrender, self-awareness and clinical insight is defensively encrusted in convictions emboldened by idealizations and devaluation.

**SELF- ACCEPTANCE**

The therapist’s journey is never-ending. Over the course of training and through much of our professional career most of us exist predominantly in
the mode of self-improvement. This mode of being has its benefits and its limit. The experience of achievement, mastery, and success provide only the training wheels for our journey. At the limit, wishing to change something deep within one’s character can be equivalent to the wish to be another person. Actively wanting to change and not accepting oneself can lead to tyranny of the false self.

Self-acceptance, coming out is a process not a singular event. Over time, we inevitably experience challenges, setbacks, personal crises, and failures. These experiences can lead to a feeling of malaise, self-doubt, and renewed questioning of our therapeutic skills. We can become cynical, disillusioned, apathetic, and more entrenched. We can make changes in accordance with the principles of self-improvement, making efforts to revitalize ourself by seeking additional training and or pursuing personal therapy. Alternatively, this dilemma can represent a turning point, a moment of eruptive and disruptive significance.

Self-acceptance involves breaking free from both past and present constraints, shaking things up in order to discover the possible variations of who we are. These constraints and blinders have become seamlessly identified with our professional identity and the daily routines that structure our work. The process of breaking out from the constraints exerted on the self entails examining the unexamined and is equivalent to how Winnicott (1971, p91) described the process of discovering external reality. He stated, “destruction plays its part in making the reality…This destructive activity is the patient’s attempt to place the analyst outside the area of omnipotent control, that is, out in the world.” We discover the possible realities through the destruction of the omnipotent fantasy of the other. To approximate an understanding of reality we have to sift through idealizations and devaluations, suspend our convictions in order to allow otherness to break through. Otherness is recognized through the affective mist of projections and the distinct discomfit that is felt when absorbing “Difference.”

Similarly, to discover the realities of the self we have to place ourself outside the protective shell of omnipotence and expose ourself to the influence of the other. The reality of self is discovered again and again in the shadows cast by others: therapists, clients, and significant others. In this sense self-acceptance is intimate and relational. Without this surrender to
the other, self-awareness is defensively encrusted in convictions emboldened by idealizations and or devaluations.

Wanting to change and the wish to be changed express active and passive strivings, dialectical dimensions intricately complimenting each other. The wish to be changed, the willingness to be influenced by another, to be taken care of, cradled, nurtured, interpreted, recognized, and transformed is buried deeply within one’s history. Bollas (1987) speaks about the adult’s pursuit of the “transformation object” and wish for change as resting on the first transformational object relation between the infant ego and the mother. He states, (1987, p 14) “Thus in adult life, the quest is not to possess the object; rather the object is pursued in order to surrender to it as a medium that alters the self.” This notion of surrender echoes Ghent description of surrender as representing an essential “force towards growth.”

Oftentimes it is only later, sometimes much later, that one comes to recognize that some very real growth took place in the context of the suffering and that one ultimately emerged the richer for the experience. How to account for this paradoxical situation? I believe that a most important ingredient is the wisdom and equanimity, and even creativity, that accrue from the confrontation with one’s narcissistic sense of omnipotence in which the feeling of helplessness is dealt with by a deep sense of transformative acceptance. It is not difficult to see that an act of meaningful surrender has occurred. (Ghent, 1990)

Psychological growth teeters on the edge of surrender. This desire, felt as helplessness, is often spurned, defended against, transmogrified into its opposite, and forgotten as its alter shapes efforts to master the universe. Accepting helplessness and dependence is critical to allowing oneself to be helped and healed. Wanting to be changed but unwilling to be influenced by others creates an illusion of effort in the service of defensiveness. Change and acceptance, dual challenges blend the double risk of letting another inside while letting the self out.

The Journey: Coming out. After I completed my postdoctoral program, I worked as a child psychologist in a community mental health clinic in the Watts area of Los Angeles. I was on my own for the first time, a fledgling therapist, working with troubled children in an impoverished community. I remember the feeling of freedom and excitement as I ventured out from the
excess of supervision in my post-doctoral program. I realized that I needed to work with these kids in a different manner; abstinence and neutrality were not options. Playing basketball, giving treats and hugs seemed more effective than words. I recognized how much my efforts to measure up to my idealization of an analytic therapist hurt me and required that I leave my personality at the threshold of the consultation room. I had become too stiff, detached, serious, and withholding. Far removed from the influence of my supervisors, I questioned the rigidity and orthodoxy that characterized psychoanalytic practice, and was critical of the constraints it placed on doing psychotherapy. This led to a lengthy troubling transitional phase in my professional development.

Disillusioned and ambivalent, I neither rebelled nor abandoned the psychoanalytic doctrine. I was doing my job: conscientious, enthusiastic at times, and committed to my clients. Yet, as I matured, my enthusiasm waned. I worked diligently, eventually leaving agency work and putting my energies into the development of a private practice and building a family. On the surface I espoused psychoanalytic beliefs, while in the office I practiced my unique conflicted brand of cognitive-behavioral-supportive-exploratory psychotherapy. In my head I felt inept and disloyal to my analytic ideals. Not being able to deal with the transference was my undoing. I harbored the conviction that if I were somehow better equipped I would be able to practice analytically. I envied friends from graduate school who had gone on to institutes to become analysts. I seemed to be plodding along, on the surface developing a successful private practice. I balanced unsteadily between self-complacency and self-doubt, working to change and wishing to be changed. Ultimately and sadly, I wanted to be somebody else. Perhaps therapy, time, and happenstance would work their miracles.

My exile from psychoanalysis joined ranks with insecurity and a series of personal crises that over time lead me back to psychoanalysis. Several critical events that occurred within a four year period deeply affected me. In 1995 my younger sister, just shy of forty, was diagnosed with leukemia. Within two years of the diagnosis, she died from complications of a bone marrow transplant that I was the donor. Her illness was a catastrophe for our family. My mother could not cope with her illness nor her death. I couldn’t cope with my mother.
After my sister’s death I wrote the following: It began with a quote from Dante’s *Divine Comedy*. “Midway in the journey of our life, I found myself in a dark wood, for the straight way was lost.” “I am back after spending some unexpected time in the woods, otherwise known as a mid-life crisis. I was surprised by what I found: old stuff, identity structures teetering, dark feelings with an empty-hurting core that had no end in sight, my former reconstructed, exquisitely fragile adolescent self. I was stunned to find such wounds, preserved fossil-like seemingly untouched by achievement, psychotherapy and everything else. It is not every day that I get lost in the woods. It took multiple shocks, wake up calls to push me so far off the path, to make me feel so intensely as if ghosts had materialized. Questions dislodged my center. Where was my growth? Was this grey, empty core the real me? Was this a setback or a final reckoning? The misery sucked.

Within three years of my sister’s death, my mother died of lung cancer and I mysteriously contracted endocarditis, a bacterial infection of my aortic valve. Over a period of months the diagnosis of my condition eluded physicians and I became increasingly sicker. When I was finally diagnosed, I was immediately hospitalized and within days underwent open heart surgery to replace my crippled aortic valve.

Several months after my surgery, I wrote the following: “My physical recovery was incredibly painful but progressed smoothly. Each day I became stronger, and felt less pain and fear. The physical recovery ennobled me. When I ventured back into society, I was showered with compliments from people who saw me. I told my story to welcoming ears a thousand times. I was a wounded hero who survived a life threatening illness. I felt compassion for the suffering of others, and deep gratitude to so many people for their thoughts, prayers and help. I felt life and love burning in my being. Psychological adjustment was not so simple. Returning to normality presented an unexpected challenge that my Olympian achievements had not prepared me for. I assumed that when you are given a second chance, it is big time news and should have a major effect on one’s life. I hoped that my psychological change would be at least as reparative to my soul as the surgery was to my heart. All would be well: I would be at peace. I would accept myself and become the person that I had always wished to become. After I had physically recovered from surgery, I found myself inhabiting the same familiar psychological space as before. My old self had been loyally waiting for me.”
These events changed the circumstances of my life that took years to crystallize into understanding. I didn’t realize how deeply affected I had been by these tragedies. I had been practicing for 15 + years, teaching, and supervising therapists in training. Over time I had become tired, unmotivated and depleted. My illness was a decisive wake up call. After recovering from the surgery, I slowed down out of necessity. I became more attentive to my personal and professional needs.

The process of coming out has no endpoint, no ritual ceremony, but consists of a series of setbacks that leads to encounters between ideal and shameful self, between self and others. In the mode of self-improvement, we strive to avoid setbacks. In the mode of self-acceptance we move against the grain, always against the grain. Still fearful of others, overly protective of my “preferred version” of self, I attended my first International Federation for Psychoanalytic Education (IFPE) conference in 2004. Three years prior I had re-established my connection to psychoanalysis and became a student in the Psychoanalytic Psychotherapy program of ICP. Two years prior to that I had returned to personal therapy.

At the start of the conference, I was introduced to Judy Vida who in turn introduced me to Gershon Molad. I had been reading their collaborative papers, and they were the reason I was at the conference. To my surprise they had read and enjoyed an article (2003, 2004) I wrote that employed their concepts of clinic and conference space. On hearing their interest I was swept away like a teenager meeting his hero. For a moment I was the person that I wished to be: important, a writer recognized by other important writers! Then the unpleasant implications of what I actually believed myself to be crushed this dream-like moment. This personal clash of selves happened to occur in public at the start of a conference where the sponsoring organization was committed to the values of “psychoanalytic space.”

I can’t be myself in this room with these people when I am feeling so insecure. I am an exile within a group of exiles, who have transcended their shame and isolation. They are smart, some eloquent and wise, some plain and simple. As I listened to the symphonic crescendo of internal voices, I felt worse and worse. Do I dare speak? The pressure of the conflict is more intense than usual. I expect more of myself. Conference
space is benevolent. The invitation to be myself is halted by a precipice of fear constructed over years of living. I test the waters with a short comment in one presentation. I interact with attendees in the halls in between meetings in what I labeled as interstitial space, a private-semi-private passing moment of intimacy where individuals seem more comfortable and honest. Interstitial space siphons off the worst of me and aborts the authentic dialogue of conference space.

Typically when I attend conferences, or present at workshops, I exist in interstitial space. I have become aware of not only the protective character of interstitial space, but also its adaptive function. Molad (2001) talks about the “illusion of the door frame” that demarcates conference from clinic space, that marks the “arrested development of the analyst.” I view the door frame as a personal boundary, a necessary feature of relational topography that marks the multiple passageways within life. The quality of the boundary will be different for different people and different for the same person in different settings. How one utilizes interstitial space will also vary. It can function as a sanctuary from the group, a productive work place or a subversive playground.

I would have preferred to end this anecdote and talk triumphantly describing how I mastered my anxiety and proceeded to speak out at the conference. By the end of the second day I was exhausted and disappointed in myself. I have struggled with this conflict long before I had constructs such as clinic and conference space to reference my distress. I was feeling so alienated and upset with myself that I considered not returning for the final day, a wish so unwelcome that I was as disturbed by its presence as I was distressed in the conference. I tried to reduce the stress by reducing my expectations of myself. However, I could not let myself off the hook. It was a conflict I could not avoid. I did return. I participated more during last set of meetings while keeping my pain private. Too little and too late was my feeling. During the final wrap up, as others shared their experience of the conference, I didn’t share my struggle that still burned inside. Only later as I drove home, in the lonely comfort of my car, was I able to process this experience.

Self-acceptance entails a compassionate understanding of one’s limitations and strengths. With this compassion one feels comfortable enough to show one’s colors. Self-acceptance is the bottom line. After years of therapy, of battling internal demons, taking risks, going against the grain, becoming
more assertive, and less guilty I find that the demons and the guilt are still present along side my achievements and efforts. I cannot banish my demons who like monsters in a child’s dream still haunt me. After all that I have changed, I am still myself.

References


