The Importance of the First Psychotherapy Case in the Development of the Therapist's Professional Self as Viewed Through the Lens of Self Psychology

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As Viewed Through the Lens of Self Psychology

A DOCTORAL PAPER
PRESENTED TO THE FACULTY OF THE
GRADUATE SCHOOL OF PROFESSIONAL PSYCHOLOGY

IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE
DOCTOR OF PSYCHOLOGY

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JULY 10, 2014

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Abstract

This paper explores the gap in the literature between what is herein referred to as the “first psychotherapy case” and its impact on the development of the trainee psychotherapist’s professional self. The self psychology concepts of identity development, selfobject needs and fulfillment, narcissism, shame, countertransference, and structuralization are incorporated into the theoretical framework from which this developmental milestone is viewed. The theory’s emphasis on early experiences and the development of self highlight the distinctiveness of the first case for the therapist. The beginning psychotherapy case poses a unique context for selfobject experiences and the developing self, involving both the therapist’s presumably mature needs (assuming an existing cohesive nuclear self) and more infantile needs as the professional, peripheral self develops. As a result, the potential and important implications for the psychotherapist, the patient, training implications for the supervisor, and the ensuing treatment through termination are identified. The intent is to shed light on an area that is understudied thus far, and to begin a conversation as to why and how the impact of the first case on the psychotherapist should be examined. Implications, limitations, and ideas for future exploratory and qualitative research are also discussed.

Keywords: First psychotherapy case, self psychology, beginning psychotherapist, psychology trainee, professional self
The Importance of the First Psychotherapy Case

In the Development of the Therapist’s Professional Self

As Viewed Through the Lens of Self Psychology

“Everyone has to have a first treatment case.”

-Sank and Prout, 1978

The discipline of clinical psychology requires both academic course work and practicum experience to prepare a student to become a psychotherapist. Mastery of academic coursework is readily measured using standard metrics. The development of a therapist’s professional self, defined as the part of the self that “lends itself to be used in service of the patient and the therapy,” is not as easily measured (Yerushalmi, 1994, p. 3). Although academic training influences that development, early therapeutic encounters and supervision experiences are more impactful on the beginning psychotherapist.

Psychology trainees also bring with them certain expectations, sometimes in the form of assumptions or rigid ideas, about psychotherapy and how it is supposed to proceed. These expectations can come from a variety of popular culture sources, personal experiences, or by listening to their professors and supervisors, as they have little firsthand experience with which to gauge events that occur in psychotherapy (Wallace & Alonso, 2004). Initial therapeutic encounters come at a time when new therapists are establishing their values and may be questioning values held throughout their lives (Sank & Prout, 1978). In addition, beginning therapists feel a “legitimate sense of anxiety” when facing an intimidating variety of clinical challenges and responsibilities, while simultaneously knowing they will be evaluated (Teicholtz,
2007, p. 157). Countertransference, which refers to the personal reactions and experiences a therapist has when working with a patient, is often addressed in didactics and in theory, but remains “unsettling, at best, for the therapist and destructive, at worst, for the patient” when initially experienced (Sank & Prout, 1978, p. 638). Furthermore, in their international longitudinal study, Orlinsky and Ronnestad (1993) compared therapists with fewer than five years of practice to those with more experience, and found that those with less experience were more likely to describe themselves as disengaged and their therapeutic work as distressing.

A significant body of literature has been directed toward assessing the challenges beginning psychotherapists face during their psychotherapy training experiences (Brightman, 1984; Eckstein & Wallerstein, 1958; Glickhauf-Hughes & Mehlmann, 1995; Halewood & Tribe, 2003). However, there have not been studies that specifically show the impact of the first psychotherapy case upon the development of a therapist’s professional self.¹ This is an important subject to look at because the growth of the professional self, for the most part, begins during the interactions with the first psychotherapy case. The first case is a highly valuable time in the development of a therapist, and is an area of the literature that has not received the necessary empirical and theoretical attention.

The primary focus of this paper is to explore the impact of the first psychotherapy case on the therapist’s professional self through a particular theoretical framework, that of self

¹ The professional self is used here to refer a peripheral self identity, and not the primary or nuclear self, although it should be noted that the former is in many ways contingent on the latter. If one does not have a strong and healthy sense of self, it is unlikely the professional self will be organized in a cohesive manner.
The premise of this paper is that the first case experience between therapist and patient is a significant factor in shaping the therapist’s professional self. This new identity helps to define the psychotherapist that one becomes. The experiences of the first case are internalized, introducing the key elements needed for the developing professional self.

As noted, the impact of the first psychotherapy case experience on the therapist will be analyzed using principles of self psychology theory. Self psychology is widely accepted as central to updating psychoanalytic thought in a way that provides an integrated view of normal development, psychopathology, and the treatment process. In this paper I propose that one’s professional identity can emerge only through exchanges similar to those that served to create the initial sense of self during childhood. In using a self psychological perspective, it is my aim to highlight the similarities of early selfobject experiences and what is recapitulated in one’s first clinical case. Self psychology speaks to the fact that, at least initially, people learn and grow psychologically when they are faced with positive feelings about both themselves and significant others. It is suggested that these positive self feelings might contribute to increased cohesion and a stronger intrapsychic in the trainee psychotherapist, facilitating the development and strengthening of the self during this time in training (Teicholtz, 1999). Additionally, aspects of the developmental process as well as the therapeutic relationship, both of which are instrumental and fundamental in self psychology, are examined.

This paper takes a macro-level view, as it does not cover the specifics of any actual case and therefore is not exhaustive on specific ramifications on the developing professional self. However, a fictional set of individuals (clinical supervisor, trainee psychotherapist, and first psychotherapy case patient) will be used in some sections of the paper to illustrate the potential application of self psychology principles through hypothetical examples. In these examples, the
FIRST CASE AND PROFESSIONAL SELF VIA SELF PSYCHOLOGY

therapist will be named “Jane,” the patient “John,” and the clinical supervisor “Dr. Lisa.” This is not intended to be a case study, nor is its purpose to limit the scope in which the reader views this paper, as every case and every person is unique. Instead, by including this, it is my hope to illuminate some of the points and the intricacy of this theoretical lens.

This paper is not intended to address the theory or practice of supervision during initial therapy experiences, as many have addressed this in the literature (Lee, 2005; Ronnestad & Skovholt, 1993; Simon, 1989; Teicholtz, 2007). This omission should not be confused with a lack of importance of supervision for the development of the trainee’s professional self. Supervisors play an integral role during this time of development, and supervision demonstrably influences the experiences of the first psychotherapy case (Dodds, 1986; Gilbert & Evans, 2000; Simon 1989). Many of the selfobject functions of the developing psychotherapist are met during supervision of the first psychotherapy case. This subject has been addressed in the current models of self psychological supervision (Lee, 2005; Teicholtz, 2007; Wallace & Alonso, 1994). In fact, it has been argued that supervision is the primary source for selfobject experiences that aid in the development of the trainee’s professional self and as a result, supervisors are likely to be present for some or all of the factors discussed herein. However, the patient is also in the selfobject milieu of the psychotherapist and has an important, and often overlooked, role in the development of the trainee’s professional self. For the purposes of this paper, therefore, I will reserve my comments regarding supervision for the Implications for Training section.

Additionally, this paper should not be understood as a full analysis of the potential impact of all self psychology principles on the trainee psychotherapist; rather, the elements that most pertain to the “first psychotherapy case” experience, as conceptualized by me, are presented to illustrate the importance of this time in the development of the therapist’s professional self. This
theoretical application sets the stage so that others can build upon this framework through future research and development of self psychology concepts as they pertain to the first psychotherapy case. It is intended that those contained in the selfobject milieu of the therapist’s first psychotherapy case, namely supervisors, can use this analysis as a guide to their understanding and interactions in order to help facilitate the growth of the budding professional self.
Definition of the First Psychotherapy Case

Initially, it may be helpful to clarify what constitutes a therapist’s “first psychotherapy case” as the term is used in this paper. This case may or may not be the first patient with whom the trainee sits in a therapy room; rather, the term reflects the initial case in which a therapist in training feels that she\(^2\) is conducting psychotherapy. Although I refer to a single case in this paper, the experience of the first psychotherapy case can take numerous forms, including a group of cases simultaneously. The experience of this first case goes far beyond the acquisition of therapy skills and the desensitization and demystification of the therapy process. Not only will the therapist learn to implement the therapeutic techniques and theoretical interventions of her supervisors and professors, but will begin to define herself as a therapist.

The therapist will carry the experience of treating her first patient throughout her professional career. The threshold that a graduate student crosses to become a psychotherapist is analogous to the change that occurs in a woman when she first becomes a mother. It is not just the role of caring for her first child and the application of parenting skills learned during and before her pregnancy that define motherhood, but more importantly, it is the experience of mothering that adds to the definition of her person. Similarly, the experiences of a psychotherapist during the first psychotherapy case add to the development of her professional self.

The first case experience and the resulting new identity as a therapist are integral in defining the professional self. The first psychotherapy case has a direct impact on how one sees

\(^2\) For clarity, and in keeping with the fictional individuals introduced above, the therapist in this paper will be referred to as “she” and the patient as “he.”
oneself as a therapist and how one relates professionally from that point forward. Because it is
the initial, and arguably one of the most challenging, milestones in one’s training, the
experiences of the first psychotherapy case are internalized, introducing the key elements needed
for the developing of the professional self. These elements are then coded in a way that is
idiosyncratic to the therapist, her views of the world and herself, and the ways in which she has
made sense of these experiences.

Elements of Self Psychology Used in this Paper

Self psychology focuses on early experiences and the development of a person’s psyche. Its
emphasis on both the patient’s and the therapist’s experience makes self psychology
particularly useful when looking at the significance of the first psychotherapy case. The aspects
of the theory highlighted in this paper are intended to help the reader understand the importance
of the process by which identities develop as viewed from a self psychological perspective, as
well as the magnitude of the first psychotherapy case. To illustrate these points, the following
concepts have been selected and expanded upon herein: the basic tenets of identity development;
selfobject needs and experiences, as well as the environment that is needed to adequately fulfill
these; the role of narcissism; the experience of shame; and countertransference. By no means do
the concepts discussed in this paper exhaust the comprehensive nature of the theory’s
contribution and conceptualization of psychological development.

How Identities Develop

According to self psychology, the core of the development of self is defined as the
maturation of a cohesive nuclear self. This self results from “optimal interactions” (Kohut &
Wolf, 1978, p. 413) and is “imbued with basic strivings for power and success, basic idealized
goals, and basic talents and skills” (Gardner, 1991, p. 44). A healthy sense of self develops
through emotional experiences that are nurturing and affirming, and that stem from the parents’ hopes and expectations of the child (Lessem, 2005). The theory “envision[s] the healthy self as providing its owner a sense of coherence, continuity, vitality and positive regard” (Lessem, 2005, p. 31). One’s sense of self is strengthened through positive emotionality, which contributes to feelings of self-worth; is continually undergoing expansion and growth; allows for feelings of richness via self-expression; and is capable of enhancement through a lifelong process of internalizing ideals and through relationships with an admired other (Teicholz, 1999).

Selfobject refers to an other or a representation of an other, which serves a narcissistic purpose for the person (Lessem, 2005). The term selfobject specifies a function, not necessarily a person: “The selfobject relationship refers to an intrapsychic experience and does not describe the interpersonal relationship between the self and other objects” (Wolf, 1988, p. 184). It is assumed that one is born with a need for “relatedness and connection for our psychological survival and growth”; by focusing on how one experiences one’s surroundings, it bridges the individual’s internal and external world, which is central to identity formation (Lessem, 2005, p. 6). According to Stolorow, Atwood, and Orange (1999, p. 383) it is the “felt responsiveness” of others that co-determines the organization of self experience.

A responsive early selfobject environment is the expected initial experience of the infant. This provides the basis for a confident expectation of appropriate selfobject responsiveness throughout life. One’s ability to experience selfobject responsiveness progresses with maturity, moving from an infantile or all-encompassing and urgent need to a stage in which others (likely a peer group) meet these needs, and then to the maintenance of a mature repertoire of “concrete-immediate” and “symbolic-distant” ways of meeting selfobject needs. And “though our selfobject experiences mature, there is no doubt that the archaic selfobject continues to exist” and
will reverberate in the unconscious and impart a sense of fullness and authenticity to all that we feel” (Kohut, 1980, p. 502).

In psychotherapy, meeting the patient’s selfobject needs is not a deliberate or technique-laden process. The only thing required is being alert to the selfobject relatedness of the patient towards the therapist and to what factors may be standing in the way of achieving this. A therapist must recognize that she is always contributing to her patient’s self state. Additionally, selfobject experiences are a completely “subjective, particularized, and idiosyncratic experience” (Lessem, 2005, p. 36).

The first psychotherapy case, like all subsequent cases, is about the patient’s need for attunement, growth in some part of himself, and survival, within the context of his own life and subjective struggles. For the new psychotherapist, this case is very much a narcissistic experience that functions toward building the professional self. While this may always be true, during the first psychotherapy case it is apt to have more saliency, whether or not all of the parties are aware of it. Although the relationship between the therapist and patient is an interpersonal one, in the first psychotherapy case, it is less about the patient and their presenting concerns, and more about the way in which the beginning psychotherapist experiences herself in the room with the patient. The therapist’s need for relatedness in the context of the professional self is crucial for the survival and growth of this burgeoning identity. Because the therapist, too, is having a self function fulfilled by the relationship, she is likely to internalize more of her experiences during this case and incorporate them into the way she conducts herself as a therapist.

**Narcissism**

Kohut challenged the classic psychoanalytic view of narcissism as a “manifestation of
infantile self-absorption that needs to be outgrown,” and purported instead that it was a “vital personal resource” that needs to be “nurtured through its maturation and transformation” (Lessem, 2005, p. 7). In addition to this shift in thinking, Kohut, in his development of self psychology, also strayed from Freudian theory by proposing that narcissism has its own developmental line and is not mutually exclusive with one’s ability to love another (object love) (Lessem, 2005).

Self psychology notes a transitional period in development on the way to mature narcissism that is characterized by the grandiose self and the idealized parent imago. During this time, “the developing child has an exhibitionistic need for admiring, mirroring, and confirming responses to his or her innate sense of vigor, greatness, and perfection” (Gardner, 1991, p. 478). This dimension of the experience is known as the grandiose self. With the appropriate mirroring experiences, this initial expansiveness is likely to mature into “self-esteem, assertiveness, ambition, a healthy enjoyment of successes, and a pleasure in the pursuit of interests and activities” (Gardner, 1991, p. 478).

Additionally, it is during this time that a child has the need for closeness, approval, and support from an idealized source, which is referred to as the idealized parent imago (Gardner, 1991). When the child is “permitted to merge with the idealized calmness and strength” of caregiver self-objects, these idealizing needs are “transformed into ideals and values, idealized goals, and respect and admiration for others” (Gardner, 1991, p. 45). The transformation of the idealized parent imago is also essential in developing the capacity for people to soothe, comfort, and regulate themselves, “particularly in regard to affects and tension states” (Gardner, 1991, p. 45).

Unlike theorists before him, Kohut (1971) believed that “a positive sense of oneself adds
greatly to one’s ability to relate fully to others,” and “viewed narcissism as a motivating or development-driving force” (Lessem, 2005, p. 15). These traits can be considered crucial characteristics in a therapist; and when they come from successfully navigating the developmental process outlined above, it arguably elevates the ability of the therapist and sustains them as they sit in the room with the patient. The time of the first psychotherapy case is unique, as the therapist is still early in the development of her professional self, and so does not possess the ultimate flexibility and self-cohesion that accompanies mature narcissism. However, it can be assumed that the therapist does possess the beginnings of the healthily developing self based on her nuclear self. She is not likely contending with a lifelong pattern of misattunement or a fragmented sense of self. Therefore, the presentation of the development of narcissism in beginning psychotherapists should be considered distinctive, as it is a hybrid state that holds the trainee’s psychological makeup in tension between these two stages.

During the first psychotherapy case the therapist’s grandiose professional self is apt to be the most vulnerable, as it is impacted by her experience of not knowing enough and not feeling in control of her clinical work. The professional self is still in the process of forming at this time, and has not yet matured beyond the beginning stages of the grandiose self. Of the many factors that can affect the trainee’s grandiose professional self, some are dynamic and relate directly to the first psychotherapy case, and others are static and remain constant in the constitution of the person. Brightman (1984) looked at the development of trainee psychotherapists and proposed a model that helps to capture the unique challenges of their development over the course of training. The first part of this model is omniscience, which refers to the therapist’s need to know enough. This need is frustrated by the therapist’s lack of clinical experience and technical knowledge, and by the fact that omniscience is impossible. Due to anxieties about the first
psychotherapy case, a defensive move by the therapist may be to shift the focus onto the intellectual parts of the learning in order to mask feelings of incompetence (Rubin, 1989). For example, instead of sharing her subjective experience of John, Jane may choose to focus on the structure of the session, theoretical facts, her thoughts about the session, and/or diagnostic criteria when she is in supervision with Dr. Lisa. The pressure the beginning therapist feels to be viewed as competent (by self and others), particularly during the first psychotherapy case, sets self expectations that are difficult to meet.

The next stage in the model, benevolence, refers to the trainee’s idealized perception of therapists as “all-loving,” which in the first psychotherapy case may result in a denial of any extreme feelings of self-interest or hostility that are felt by the beginner psychotherapist (Brightman, 1984). This creates a tendency in the therapist to deny any negative countertransference to the extent it feels incongruent with the perception of the therapist’s role. In the third stage, the psychotherapist’s tendency towards control and power (which can be considered developmentally appropriate for the grandiose self) or need for omnipotence may further interfere with her ability to master her own affects and be effective in attending to the patient’s needs (Sharaf & Levinson, 1964). Jane may try to establish and exert her power in the relationship with John by formulating a treatment plan without involving or collaborating with him to get his feedback. By shifting the therapy according to her plan, Jane is no longer prioritizing John’s needs in the therapy.

Fortunately, “with adequate selfobject experience and the absence of traumatization, the grandiose idealizing poles of the self…develop from archaic to mature forms” (Lessem, 2005, p. 20). Specifically, the maturation of the grandiose-exhibitionist pole of the self results in “realistic ambitions, the energy for sustained pursuit of these ambitions, and the development of stable
self-esteem” in the psychotherapist (Lessem, 2005, p. 20). Additionally, when properly nurtured, the grandiose professional self ultimately will allow the capacity for attainment of realistic expectations and a stable sense of self-esteem for the therapist. At this stage the professional self will also be able to engage in self motivated passions and goals. These qualities are seemingly important for the developing professional self, as the first psychotherapy case serves as the starting line for the career of the therapist.

When selfobject needs are met, healthy narcissism develops, which is essential for the development of attributes such as flexibility, empathy, wisdom, and creativity. One never grows out of needing and/or having a selfobject milieu; in fact, at the time of the first psychotherapy case, the therapist is dependent on her selfobject milieu to help facilitate the growth of her professional self. Part of what makes narcissism healthy is based on accepting one’s dependence on and interdependence with one’s selfobject milieu and its function in building and sustaining a cohesive self state. It is through the maturation of selfobject needs that the psychotherapist’s selfobject needs can be met both symbolically (internalized representations) and concretely (interpersonal experiences) (Lessem, 2005).

**Shame**

In self psychology, shame refers to a painful feeling about one’s self in relation to one’s whole self. Shame and narcissism, as viewed from the perspective of self psychology, are interconnected and cannot be separated. “Shame is the affect at the very core of a derailed narcissistic experience” (Morrison & Stolorow, 1997, p. 65). What makes shame particularly painful is the notion that it is felt at the precise moment one is looking to be recognized and admired by another.

There are two principal sources of shame: erosive grandiosity, which is an intense
grandiosity that then impedes a sense of personal cohesion; and crushing narcissistic injury, which is the response to feeling ignored or hurt by an unresponsive, misattuned, or otherwise under-stimulating selfobject milieu (Lessem, 2005). If one does not get the response that one needs, feelings of uncertainty and deflation, as well as withdrawal from the “offending interpersonal environment,” are likely to ensue (Morrison, 1994 p. 24). In order to protect the misattuned other, one often copes by assuming one’s own unworthiness, likely creating unreachable ideals in order to facilitate this pattern, which only adds to the propensity to feel shame. For example, Jane may begin to feel an increasing amount of shame if her interventions and presence are repeatedly met with hostility or negativity, causing her to shy away or avoid talking about this in supervision with Dr. Lisa. If this persists and goes unnoticed, Jane may begin to integrate this into her professional self concept and make inaccurate reflections about herself and her abilities.

At the time of the first psychotherapy case, based on the high standards and idyllic view of therapy that may be held by the therapist, she is faced with confusion and possible feelings of unworthiness when charged with being responsible for another’s psychological well-being for the first time. Just as shame develops in a child who is longing and looking to have his specialness affirmed, the therapist may feel a similar vulnerability as she begins to engage in the therapy process with another who is feeling vulnerable as well. This may impede her from trying more advanced interventions (i.e., challenging the patient) because she wants positive feedback from the patient and not disagreement.

The presence of narcissistic injuries, defined as “the damage experienced by an individual’s real self,” has been noted to be higher in trainee therapists than more experienced therapists (Halewood & Tribe, 2003, p. 88). At the time of the first psychotherapy case, when the
professional self is presumably the most underdeveloped, and the expectations and assumptions of what psychotherapy is are at a peak, the therapist is likely to hold more rigid beliefs and to invest oneself personally in the success of the therapy. Thus she is apt to take it upon herself when something does not go according to plan. The higher rates of narcissistic injury in beginning therapists were also found to be further accompanied by a degree of the following aspects: restriction of emotional affect; lack of understanding of the self; the presence of false self traits (in which therapists were more aware of how they present to others than they are of their own feelings); the need for mirroring and understanding; problems with setting boundaries; grandiosity; depression; and perfectionism (Halewood & Tribe, 2003).

As is normal in development, the beginnings of self awareness come with the comparison to and competition with others, as well as the formation of the capacity to shape ideals. During this process the therapist develops a picture of the “ideal professional self,” which is reflective of a sense of her potential perfection. Additionally, she will develop ideas about what constitutes professional failure and shortcomings (Lessem, 2005). Because of the newness of the professional self, and the lack of experience to strengthen and define this self, at the time of the first psychotherapy case the therapist is in the process of shaping her ideals. Throughout this case, when one (hopefully) has good enough attunement to meet one’s selfobject needs, one’s ideals about perfection and failure become less rigid and binary, as well as more realistic and fluid. When a healthy sense of self is fostered, feelings of shame become more temporary and manageable. Furthermore, this facilitates the therapist’s ability to take a more active role in the shaping of her professional self, by seeking out affirming experiences and “scanning [her] environments for potential sources of selfobject sustenance” (Lessem, 2005, p. 25). This allows
for the creative application of attributing to others the qualities and responses that one needs to meet one’s own selfobject needs.

**Selfobject Needs**

The notion of selfobject needs is also central to the theory of identity formation. Kohut (1971) defined these as innate developmental needs that must be met partially by another person or thing, as the fulfilling of the need is more important than who or what actually fulfills it. There are three specific selfobject needs that Kohut focused on: mirroring, idealizing, and twinship needs (Lessem, 2005). Over time, subsequent theorists have contributed their own understanding, conceptualizations, and additions to these ever evolving concepts; many additional selfobject needs have been proposed since the emergence of the theory, including the efficacy selfobject need proposed by Wolf (1988).

Caregivers most often meet the selfobject needs of children, and, as children mature, others within their selfobject milieu can begin to meet their needs as well. “Age-appropriate selfobject needs are the normally required selfobject experiences that fit the age-dependent requirements to sustain self-cohesion” (Wolf 1988, p. 56). Any “normally well-functioning adult will continue to have selfobject needs into adulthood, and therefore developmental manifestations of these should not be looked at as a developmental deficit” (Gilbert & Evans 2000, p. 66).

Supervisors, professors, peers, and patients all make up the selfobject milieu of the first psychotherapy case and facilitate the development of the therapist’s professional self. While this growth is linked to the strengthening of other parts of the self, a process that often occurs through supervision and accompanying learning, it is not the primary focus of the first psychotherapy case; it is only a byproduct. For the purpose of this paper, the critical aspect of the first case
selfobject milieu is the therapist’s experience of the patient in the room. The adequacy of the milieu in meeting the developmental needs during the first psychotherapy case will be decisive in determining the fate of the emerging self (Gardner, 1991), in a process analogous to that of childhood (albeit within a significantly different context, that of the psychotherapist as caretaker for the patient).

This first psychotherapy case for the budding psychotherapist is generally the primary therapy experience and becomes the representation of what therapy is in a larger sense. The professional self has yet to be solidly formed and rooted in many selfobject experiences, and therefore the patient’s response to the therapist and to the treatment greatly shapes how the therapist understands therapy, as well as the way in which she experience herself as a psychotherapist. The space in which the first therapy occurs is often one in which, developmentally, the therapist is still looking outside herself for evidence of her professional identity. Additionally, “the dependence on others [to meet one’s selfobject needs often] becomes salient during life transitions” (Banai, Mikulincer, & Shaver, 2005, p. 227), such as the first psychotherapy case, which can ultimately lead to a disruption in the organization of the self.

When considering the selfobject needs of the therapist during the first psychotherapy case, it is important to reflect on the entire developmental span of those needs, as their combination plays an integral role in the development of the professional self. Each therapist brings her own experiences and ways in which she has progressed up to this point. As a result, the therapist’s selfobject needs can span from primitive and infantile (in this paper the professional self as a peripheral self) to a well-developed (nuclear) self that will be sustained through the adult and mature experiences of the selfobject milieu. These varying levels of selfobject needs are all present during the first psychotherapy case.
Self psychology recognizes that, as providers, therapists have their own selfobject needs that are met through patient interaction and the therapeutic process. While this concept has been used to address sustainment of a professional self in more experienced psychotherapists, these needs serve a different function in the first psychotherapy case, as this experience initiates the development of the professional self. The first psychotherapy case is noteworthy because, while the professional self is being shaped by interactions with the patient, it is also being influenced by other factors, including the nuclear self (that is presumably relatively stable and matured) and interactions with supervisors. The first psychotherapy case becomes the blueprint with which one maps one’s experiences of the developing professional self, as one creates early memories of being a therapist.

In the early stages of development of the professional self, fulfillment of the therapist’s needs must more readily come from others. Given limited interactions from which to build the self, the therapist in training does not have the internal sense of self-as-professional to call upon in difficult patient situations. Although therapists in training do not approach their first case as a way to actively get their selfobject needs met, this does occur and influences their views of themselves as therapists. It has been recognized that supervision fulfills many of the selfobject functions of the developing psychotherapist. Much of supervision literature has focused on the selfobject needs of beginning therapists, and the models of self psychological supervision have been proposed to address these needs. However, this is not the only way in which these needs can be met, as there are others in the selfobject milieu of the therapist in training. It seems prudent, when examining the first psychotherapy case, to include the patient as an identified player in nurturing (in the broadest sense of the term) the budding professional self.
This is complicated by the fact that the patient is unaware that his presentation (holistically speaking) will impact the therapist to the extent that it actually does. The patient, unlike early caregivers, does not have the knowledge, responsibility, or wherewithal to actively work to meet the needs of the developing therapist and to provide her with the selfobject functions needed for the cohesion of her professional self.

Patients often come to therapy to fix ruptures in their own self experience in order to develop and sustain a healthier sense of self. As is the case in all psychotherapy cases, it is important that the patient’s care and wellbeing remain at the forefront of the therapy. If in the course of the therapist’s development, her selfobject needs exceed the parameters of appropriate therapeutic boundaries, it would be the role of the supervisor to address this. For example, if in reviewing Jane’s work with John, Dr. Lisa notes a pattern of Jane directing interventions towards affirming her own self (professional and/or personal) by pointing out her own accomplishments, being overly self disclosing and/or defensive, and not attuning to John and his needs, it would be imperative that Dr. Lisa attend to this in the clinical supervision. Under circumstances where developmental needs remain unmet, then an expansion of the therapist’s selfobject milieu through personal psychotherapy may be indicated in order to facilitate the growth of a cohesive professional self.

The development of a healthy self is the outcome of specific tensions within the self structure. Each of the selfobject needs (tensions)—mirroring, idealizing, twinship, and efficacy needs—plays an important role in the development of an individual’s nuclear self. Similarly, when met by the experiences of the first psychotherapy case, they aid in the development of the therapist’s professional self.
Mirroring Need

The selfobject need of mirroring refers to the function of responding to the child’s need to be admired, understood, and validated (Lessem, 2005). This is done through distinguishing and matching the child’s internal states, which “mirrors back to the child a sense of self-worth and value” (Baker & Baker, 1987, p.3). This praise must be age appropriate and genuine in order to aid in building a cohesive sense of self. Conversely, if a child is responded to with undue criticism or indifference, the “result will be considerable vulnerability in the structure of self,” which could lead to low self worth and lack of personal value (Lessem, 2005, p. 39). Those who do not get their mirroring selfobject needs met, including the psychotherapist at the time of the first psychotherapy case, may try to overcompensate by striving for perfection, in order to overcome the perceived inadequacy within themselves.

In a mirroring transference, the patient looks to the therapist for a validating and confirming response that is akin to what he would have received from his caregiver. The prototypical way the mirroring transference is elicited from a caregiver occurs when a child shows the parent a newly mastered skill. For the therapist in training, building and demonstration of professional skills begin to merge during the first psychotherapy case. The response from her selfobject milieu is important. For example, when thinking specifically about the patient as a source of selfobject nurturance, if he responds to the therapist with interest or excitement about the therapist’s contribution in therapy, this will likely serve the same function of strengthening her self, just as it does in childhood when the child receives positive and attuned mirroring. Conversely, when the mirroring need for the developing professional self is not adequately met, a lack of efficacy ensues. A negative experience, such as feeling ineffective during the first psychotherapy case, will likely be detrimental to the building and cohesion of the professional
self. Again, in the case of John, if his narcissist needs do not allow for or reflect back the presence of Jane in the room, it would likely have an impact on Jane. And if, despite her best efforts to engage with him, Jane is unable to foster a solid therapeutic alliance with John, she may begin to infer that the lack of John’s response is due to a deficit in her own ability to be therapeutic. When this level of misattunement occurs, the positive affects that lead to strong self-esteem are split off, and the unintegrated affect states become “the source of enduring inner conflict because they are experienced as threats to both the [psychotherapist’s] established psychological organization and the maintenance of vitally needed ties” (Lessem, 2005, p. 41).

**Idealizing Need**

The idealizing selfobject need refers to the need to experience oneself as a part of, or linked to, an admired other. This allows one to feel protected and soothed in difficult and/or novel times. It provides one with the security of knowing that there is a capable, potent person who can be looked up to and who will respond when needed. When a child feels extremely disappointed with the idealized caregiver, it can lead to a diminished sense of safety, which can impede the ability to manage aggression, fear, and anxiety. It may also lead to a longing to be connected and a sense of emptiness within the individual. When there has been an adequate idealizing experience of a revered other, the child’s belief in the caregiver can morph into internalized goals, values, and strengths. These serve an organizing function for ambitions and self-strivings (Lessem, 2005). “The mature adult is secure in the knowledge that his or her imperfect family and friends are available in times of difficulty…the individual’s internal capacities to provide self-soothing increase, the intensity of the idealizing need diminishes” (Lessem, 2005, p. 49). An idealizing transference can emerge in the therapy room when the
therapist is perceived by the patient as powerful and has the ability to soothe and heal (Lessem, 2005).

A significant portion of the idealizing selfobject experience of the psychotherapist can and will likely occur in an effective supervisory relationship. Additionally, the idealizing need may be met through professors, seasoned clinicians and/or figureheads of the psychological theory with which the therapist aligns herself. For example, if, despite some apparent flaws, Dr. Lisa is able to mirror back in supervision the aspects of therapy with which Jane is doing well, Jane will feel safe and calm in the presence of Dr. Lisa and better be able to learn and correct her mistakes in the future. It is important to keep in mind that, although the examples provided here touch on many important idealizing selfobjects, in some cases they may not capture the whole experience of idealizing in this first case.

During the first psychotherapy case, due to the therapist’s own (natural) regression and countertransference, the patient may be put inadvertently into the position of being an “object representation of an idealized other” (Flanagan, 2011, p. 172) for his psychotherapist. That is, the therapist may relate to her patient as a novel other in her life, in a new, intimately attached and vitalizing relationship. The trainee therapist may link herself in some way to the patient because he is a “significant other” who is “experienced as non-autonomous parts of the [therapist’s] self” (Banai, Mikulincer, & Shaver, 2005, p. 227) during the initial stages of experiential learning. As is true for all individuals with regard to their early selfobject needs, the therapist’s professional self needs others to fulfill a self-enhancing function that she cannot provide for herself.

The therapist may also idealize the patient because the patient in return idealizes her. In order to facilitate growth, one needs to “see strength and wonder outside of the self, in others, in order to merge with their growth-enhancing qualities” (Flanagan, 2011, p. 172). Furthermore, the
therapist may feel soothed by a responsive patient who is able to incorporate the therapist into his self experience, reflecting back to the novice therapist a projection of the clinician she wants to be, rather than clinician she realistically is at this point in her training. The opposite is also possible; a patient might actively devalue the psychotherapist, which would presumably lead to the failure of the idealizing need being met, and could negatively impact the therapist. If, due to his dysregulated self-states, early childhood experience, and/or pathology, John is critical and harsh during therapy, Jane could experience the same, causing increased negative feelings that accompany the disappointment of this selfobject need. This early experience will then be incorporated into the developing professional self of Jane, and shape how she sees herself as therapeutic.

Additionally, as mentioned previously, while the therapist’s nuclear self may be healthy and considered in the mature state, the professional self is still developing. This potentially could put the therapist (subconsciously) in a bind, as the idealizing needs of one self do not match up with the other self. On the one hand, the nuclear self may be secure in the knowledge that her support network is available in times of difficulty; however, the therapist may not be able to relate to this newer part of herself. Therefore, when pulled to have her needs met, the ordinarily good enough nuclear selfobject milieu no longer may be adequate. The reliance on both the nuclear and peripheral selfobject milieus also may be strained by the therapist’s lack of experience with the practical, legal, and ethical constraints of therapy. This may cause an increased sense of anxiety in the psychotherapist. If the therapist is able to recognize her affective state and respond accordingly, it will allow for the strengthening of the professional self. At that point, she would then be better able to understand herself and therefore more genuine in the therapy room, which further facilitates the growth of the professional self. This
may not come easily; according to Rubin (1989), the hardest task of the psychotherapist is staying open to patient and self.

**Twinship Need**

Twinship, or alter ego selfobject need, refers to the need to feel “essential alikeness from the moment of birth to the moment of death” (Kohut, 1984, p. 194). Twinship fosters a sense of belonging and affiliation to others, and, throughout development, the individual demonstrates phase-specific versions of this need. Twinship experiences begin with a more merged quality and move towards differentiation, increasing tolerance for more differences and individuality. As an adult, twinship can be associated with the sense of belonging or through an affiliation with an organized group (e.g., graduate students, psychologists, adherents to a theoretical orientation). This has been suggested by other self psychologists to be the underpinning and a “necessary component” of all selfobject experiences, and is viewed as a “dimension of the selfobject experiences” (Eisenstein, 1988 in Lessem, 2005, p. 53).

Many scholars continue to contribute to the literature on twinship because it is considered to be an “unfinished aspect of Kohut’s attempt to conceptualize the narcissistic transference” (Togashi, 2009, p. 22). It is viewed as the most important and essential selfobject phenomenon among recent self psychologists, many of whom regard the twinship selfobject environment as the “most primal source of humanization” (Togashi, 2009, p. 22). Finding oneself in the other and vice versa constitutes the most essential facets of humanization. Martinez (2006) hypothesizes that this new dimension of twinship is a “mature form of selfobject experience on the developmental trajectory of the twinship selfobject” (Togashi, 2009, p. 35). That is, twinship needs can be seen as a continuum, spanning all levels of self (from undifferentiated to mature and selective reciprocal affirmations of being like another).
In line with this developmental approach, it is likely that at the time of the first psychotherapy case the psychotherapist’s need for twinship is both undifferentiated and reciprocal in nature. This creates a split (not in the pathological sense) between the nuclear and peripheral self, making the way in which the therapist’s self coalesces unique and contingent on the context of the first psychotherapy case. While idealization is primarily met through other avenues such as supervision, twinship with the patient is essential because the therapist needs to learn how to find herself in her patients.

Supervision literature points to the fact that supervision facilitates the primary utilization of the twinship selfobject need. “The supervisor’s primary task is viewing the therapist’s work from the therapist’s point of view” (Lee, 2005, p. 14). Throughout the supervisory process, the supervisor and the therapist recognize their commonality and work together. This allows the trainee to “recognize their talents and acquire skills...[and come] to see themselves as therapists among therapists, a member of the professional community” (Mitchell, 2009, p. 12).

When a twinship transference emerges in psychotherapy, the patient wants to be like the therapist, in the sense of feeling what the therapist is feeling. It can also happen in the reverse, with the therapist wanting to experience—or, in fact, experiencing—what the patient is feeling. This may be more prominent in the first psychotherapy case as a patient talks about some part of the self that is underdeveloped or even traumatized. Additionally, this may be more likely to occur early on because the therapist is trying to develop her identity in relation to the patient, as opposed to with the patient. As a result, feelings of anxiety, depression, and alikeness may be present for the therapist as the patient seeks a twinship transference because he needs to feel connected to another. During the first psychotherapy case, the psychotherapist’s ability to connect with the patient through the formation of an intimate (therapeutic) relationship is
necessary in gratifying this need and fostering a sense of connection. When the psychotherapist is able to have this primary psychotherapy experience, she will better be able to communicate her empathy and subjective experience of the patient to the patient, which can in turn facilitate her own psychological growth.

**Efficacy Need**

Wolf suggested an additional selfobject need necessary for the development of a cohesive and healthy self. The efficacy selfobject need, according to Wolf (1988), is the need to experience oneself as “capable of affecting others and our environment in a manner that evokes” the selfobject experiences needed to build and sustain a cohesive self (Means, 2000, p. 63). The efficacy need, unlike the other selfobject needs mentioned above, reverses the dynamic in the selfobject relationship, in that it makes the self the actor acting upon the selfobject. “The essence of this phenomenon is the self’s experience of being an effective agent,” and is likely as influential and important for the developing self as the other selfobject needs (Wolf, 1988, p. 60). Feeling effectual, and that one can elicit a response, is an important part in differentiating one’s self through, first, the realization that one is bestowed with this power, and second, exercising the power. Although this is not considered to be one of the primary needs by all self psychologists, the efficacy selfobject need is still viewed as foundational in the theory and is used in the context of this paper to capture an aspect of the first psychotherapy case that may otherwise not be seen.

The efficacy selfobject need is related to the “intrinsic motivation to achieve mastery” (Gabbard, 2005, p. 52). This need touches on one of the most fundamental aspects of the first psychotherapy case, which includes both the unconscious and conscious needs of the psychotherapist in establishing and proving that she is able to be effective in her new role.
Having not had (much, if any) prior experience at the time of the first psychotherapy case, the selfobject experience of the psychotherapist is of central importance in determining her approach to the patient. The contribution of the therapist to the construction of the patient’s psyche is contained in her sense of success with, and impact on, the patient. This can come in many forms, and may be contained in some of the other theoretical concepts herein. When Jane elicits a response from John through reflecting back to him his experience, she can, in essence, feel effective as a therapist. This selfobject experience will allow the therapist to have access to evidence that she is achieving success in the broadest terms. Furthermore, this type of experiential learning creates modifications and new structuralization in the configuration of the developing professional self.

**Structuralization**

When selfobject needs are adequately met, it allows for the crystallization of the self within the matrix of a particular selfobject environment through a process of psychological structure formation. These selfobject experiences are internalized through the transmuting internalization process, which is the result of what Kohut termed optimal frustration. These are frustrations of the need for selfobject responsiveness that occur on a small scale and are often times corrected by an attuned caregiver (Lessem, 2005, p. 81).

It is inevitable that even the most aware and empathic selfobject milieu will not always be able to perfectly meet the psychotherapist’s professional selfobject needs. It is these times of disconnect that ultimately contribute to the internalizing of selfobject functions, so that the therapist is better able to self-soothe and manage her emotional responses during the first psychotherapy case. Structuralization in these instances occurs through repairing ruptures, which is done by a therapist’s ability to empathically attune to a patient’s selfobject experiences.
However, there are other self psychologists who see it differently. Terman (1988) believes that it is not about frustration, but rather satisfaction, that is often crucial in allowing for new structuralization. Structuralization in this case is “the process of acquiring structures or themes of experience” (Atwood & Stolorow, 1984, p. 33). In therapy, this transformation occurs when the therapist has empathically attuned to the patient and has fulfilled the patient’s selfobject needs. During the first psychotherapy case, the psychotherapist is obtaining new self structures simply by experiencing the process. This is occurring both through the satisfaction and frustration of her selfobject needs and experiences and leads to the process of gradual replacement of the selfobjects and their functions by the forming professional self and its functions.

The structuralizing of the experience of an effective therapeutic relationship is just as important for the patient as it is for the therapist during the first psychotherapy case. While the structuralization of the professional self is facilitated in part by supervision, and can be viewed as one of the underlying goals of this relationship, the firsthand experience of rupture and repair in therapy is a necessary component for the therapist in the structuralization of her professional self. Increasing cohesion and growth of the professional self can only come from sitting with a patient, and because the first case constitutes the “early experience” that self psychology emphasizes, this concept is central in supporting the importance of this developmental milestone. Just as a psychotherapist becomes an internal presence to a patient, the first patient becomes an internal presence to the therapist, becoming integrated into the functioning of the psychotherapist. The new structure helps to diminish the sense of vulnerability and will be of great benefit to the psychotherapist in helping to organize her professional self. These new emerging themes enable the therapist to more easily seek assistance and support from others in
her selfobject milieu when she is feeling overwhelmed, and enable her to more fully accept and benefit from the subsequent support she receives.

**Countertransference**

Just as “the concept of selfobject transference implies selfobject need,” the same can be assumed about countertransference (Lessem, 2005, p. 133). When these needs are met, it allows for the selfobject experience needed for growth. As selfobject transferences emerge in the therapy for a patient, countertransferences can be stirred up in the psychotherapist as well. Countertransference is considered to be a powerful and useful “diagnostic and therapeutic tool” in treatment, and is codetermined by the therapist and the patient (Lessem, 2005, p. 147).

For example, in the more archaic mirroring transference, the therapist receives little recognition or acknowledgment by the patient for being an individual or for being separate from the patient. This experience of not being responded to as an individual can lead to specific countertransference reactions, which are dependent on the therapist’s own makeup and narcissistic vulnerabilities (Kohut, 1984). This can be further complicated in the first psychotherapy case by the increased narcissistic vulnerability of the therapist as she conducts therapy for the first time. With increased vulnerabilities, increased countertransference reactions are likely to occur—yet the literature suggests that students are often taught to conceal these feelings, and are generally interpersonally adept to do so (Ronnestad & Skovholt, 1993). If the therapist is unable to recognize this process as it is occurring, she will likely be unable to respond in a way that facilitates the therapy in service of the patient and minimizes her negative countertransference reactions.

Wolf (1979) first introduced the idea that the therapist, like the patient, brings into the therapy dyad selfobject needs that are bidirectional between therapist and the patient. He
noted the psychotherapists’ countertransference is indispensable to their empathy for their patients’ subjective experiences. Empathy provides a framework to understand the development of the self and also serves as a guide for therapeutic action. It is a way of understanding and knowing the patient, whereas the communication of that understanding is known as empathetic attunement (Lessem, 2005). This core self psychology concept is known as vicarious introspection, which is described as therapists’ ability to tap into their own subjective experiences in order to understand their patients’ experiences. Kohut shifted from defining empathy as observation to the subjective aspects that contribute to a connection between two people (Teicholz, 1999).

Wolf (1988) also suggested using the term of selfobject countertransferences to denote the counterpart in the therapist of the selfobject transferences of the patient. Bacal and Thompson (1996) built on Wolfe's thinking with their view of countertransference by asserting that both therapist and patient are sustained by the experience of the other's responsiveness. The therapist ordinarily has a variety of expectations of the patient, both conscious and unconscious, many of which embody selfobject needs that are usually responded to by the patient in the course of therapy. Additionally, the therapist’s own dynamics and selfobject needs impact the way in which she is able to attune to and work with patients. Kohut (1959) argued “introspection and empathy are the essential constituents” (p. 465) and that the limits of therapy are defined by “the potential limits of introspection and empathy” (482). In other words, in order to be truly empathic, it is necessary for the psychotherapist to find something in herself or her experiences that “affectively resonates with what a patient describes” (Buirski & Kottler, 2007).

During the first psychotherapy case, countertransference reactions are likely to be greater and more present in the therapy because the beginning therapist possesses less of a self to
aid in contextualizing them, as compared to a more veteran psychotherapist. This is due to the still developing professional self at the time of the first psychotherapy case and the process of actively (consciously and unconsciously) seeking out others to help meet selfobject needs. While developmentally appropriate for a self in an earlier stage of growth (i.e., the professional self), the psychotherapist is likely to dismiss or pathologize her countertransference and feelings that go along with the longing for selfobject attunement.

The growth of the professional self is linked to the strengthening of other parts of the self. The ongoing selfobject needs into adulthood can be understood in the trainee psychotherapist when looking at the development of her professional self. Kohut (1978) emphasized that, for psychological health, a person’s peripheral self (in this case the budding professional self) and the nuclear self need to be connected in at least one sector. Experiential learning is parallel with Kohut’s view that “significant, lasting changes take place in the nuclear rather than the peripheral self” (Lee 2005, p. 8). Because experiential learning creates modifications and new structuralization in the professional configuration of the nuclear self, the first psychotherapy case is the primary experience in allowing for this change of self.

When both the patient and the therapist are having their selfobject needs met, a harmony is produced within the context of therapy, allowing the psychotherapist to experience syntonic emotions for the patient. Conversely, when the therapist’s selfobject needs are not being met, she may experience disrupted self-states and painful emotions that disturb her ability to attune to the patient and her therapeutic effectiveness. When the professional self is still developing, and because of the fragility and newness of the self, these early experiences will greatly shape the way the psychotherapist then relates to the professional (i.e., therapy) environment, and how she organizes this experience will in turn shape her professional self. As documented in the self
psychology literature, the self, while still in the early developmental stages and taking form, is gathering sustenance from outside sources in order to define and shape this future self. This process leaves the therapist at the mercy of others, including the patient and the environment of the first psychotherapy case, for adequate and fulfilling selfobject experiences.

When diminished attunement is present in the therapist, it can take the form of disinterest or dissociation. Often the therapist experiences these types of disruptions when the patient is experiencing something similar. As a result, the psychotherapist may experience shame or feelings of inadequacy, anger, and disappointment in herself (Lessem, 2005). When these negative affects are felt as a part of the selfobject experiences, a healthy and cohesive sense of self does not develop. What results is, in part, unique to the individual; however, low self-esteem, anxiety, anger (self psychology refers to this as narcissistic rage), inflexibility, and intolerance for affect or mistakes are common responses. In conjunction with what self psychology says about the importance of early experiences in shaping the self, experiencing diminished attunement in one’s initial experiences will have great impact on the budding therapist’s sense of security and safety in the therapy room. During the time of the first psychotherapy case, the therapist is more likely to internalize these feelings and to take them as reflections of herself, rather than of the other. The resulting negative affects can impact the way she experiences herself as a professional, and the potential disorganization felt in that moment will be internalized and incorporated into the self.

In order to mitigate this experience, Bacal and Thompson (1996) advocate that the psychotherapist have an accepting attitude towards the “psychological legitimacy” (p. 30) of her selfobject needs stirred up by and/or felt in relation to the patient. The therapist’s functioning is enhanced as a result of the ability to open herself up to the recognition and awareness of these
needs within her. If the psychotherapist is unable to do so and feels compelled to protect herself from the shame-based awareness of her own needs in relation to the patient, she will not likely be able to resonate empathically, nor will she be equipped to optimally respond to the selfobject needs of the patient (Lessem, 2005).

**Termination of the First Psychotherapy Case**

It is important to consider the termination of the first psychotherapy case, as this case serves such a primary function in defining the psychotherapist’s professional self. It shapes her ideals and beliefs about herself as a psychotherapist, and about the general process of therapy.

When considering the potential impact the termination of the first psychotherapy case may have on the therapist, “the essential factors to be kept in mind are: the extent to which the therapist retains in the eyes of the patient the selfobject functions, or the extent to which the patient concretizes the functions and embodies them in the therapist” (Palombo, 1982, p. 24). Similarly, if the psychotherapist assigns the functions to the patient, rather than the experience of the first case, this may cause distress to the psychotherapist at the end of the treatment. The occurrence of this negative affect may further increase if the first psychotherapy case is terminated early, and “if the functions [of the first psychotherapy case] were not transmutingly internalized sufficiently for them to function as stable, enduring structures” (Palombo, 1982, p. 24). Conversely, if the therapy has come to a natural conclusion, the psychotherapist may have feelings of pride, a sense of achievement and accomplishment, joy, and relief (Palombo, 1982). It is also possible that both may occur in the termination of the first psychotherapy case due to the distinctive context of the discrepancy between the self states of the psychotherapist. Even if adequate structuralization, internalization, and maturation processes occur, the ending of the first psychotherapy case may be perceived as a loss of a selfobject experience for the psychotherapist,
even though it provided her with the fundamental experience of mastery, growth, and professional stability.

**Implications for Training**

It is essential for supervisors to recognize the significance of this first psychotherapy case in order to best help their supervisees. The importance of the first psychotherapy case is more than a matter of clocking hours in the therapy room or desensitizing to one’s anxieties: The experience is transcendent and leads to the development of the professional self. When supervisors are able to comprehend the power of the first case and its impact in forming the professional identity, they will be able to more appropriately address their supervisees, ultimately improving patient care.

The participation, contribution, and importance of supervisors throughout the process of the first psychotherapy case is necessary to the success of the therapist. In the example case of Jane and John, Dr. Lisa’s role in helping to facilitate and manage challenges allows her to be seen as a dependable and predictable presence throughout the course of the first psychotherapy case. If Dr. Lisa is able to adequately attune to Jane’s experience and meet the selfobject needs of her budding professional self, the ruptures that may occur (without adequate repair) can be ameliorated or put into perspective, ultimately facilitating Jane’s development. This would also serve to help John, as Jane can tolerate and reflect back to him more confidently and accurately her experience of him. When a healthy professional self is developed, the therapist is able to draw from her own inner strength and sense of self to guide interventions to facilitate the personal growth and cohesion of her patient. When this is not available due to lack of experiences (as is the case during the first psychotherapy case), the therapist’s countertransference is more likely to be unbounded because there is not a strong therapist self to
contextualize it. Therefore it is important that the supervisor of the first psychotherapy case work to emphasize the continuity between the nuclear self and the professional self of the beginning therapist to minimize disruptions. Given that the supervisor can provide a good enough or an appropriately responsive environment and adequate constitutional endowment, the formation and consolidation of the professional self during the first psychotherapy case will begin to emerge.

In the supervisory relationship, there is a parallel process of selfobject needs being met by supervisor to budding therapist and the therapist to patient, therefore making modeling a helpful supervisory intervention during this stage in the professional self development. If the therapist’s selfobject needs are not being sufficiently met through the supervisory relationship, it may be suggested she seek individual therapy in order to supplement her selfobject milieu to sufficiently meet her needs. Though the patient is included in this paper as an integral part of the therapist’s selfobject milieu, it is ultimately not the patient’s duty to meet the selfobject needs of his psychotherapist. No matter how ideal the patient is, there is a limit to his ability to applaud the therapist on her various therapeutic milestones as a budding clinician. The patient’s own needs to be mirrored, idealized, or have twinship should always take precedence. If this were not the case, it would be the supervisor’s responsibility to ensure quality patient care.

Though this paper uses self psychology as the theoretical framework through which to view the first psychotherapy case, supervisors, regardless of theoretical orientation, may find it helpful to bear in mind the transformative power and impact this case has on one’s professional identity and training. An initial goal of supervision, no matter the theoretical grounding from which it is derived, is to create a collaborative relationship based in trust. This allows for free exploration and curiosity of both the supervisee’s and the patient’s experiences (Teicholtz,
Supervisors can also work to shore up a trainee, who may then better be able to try a new intervention or to face the patient with a more confident stance.

Although varying theories may explain the importance of the first psychotherapy case differently and may not focus on the same factors, supervisors are encouraged to think through their own theory and perspective on this developmental process. For example, a behaviorist may draw a parallel between Wolf’s efficacy need and a Skinnerian understanding of self-esteem as deriving from having skills, with skills being reliably reinforced behaviors. In facilitating a sense of efficacy, supervisors may attempt to show the trainee what she does that works, and what she does that does not work, just as self psychology would say that empathy and responsiveness can aid the therapist in her ability to be able to talk about professional experiences that have caused confusion, shame, or embarrassment.

**Conclusion**

The first psychotherapy case, defined as the initial case in which a trainee experiences herself as a therapist, is always a memorable time. Regardless of whether it is rewarding or traumatic, the first case is an important milestone in every psychotherapist’s development. The experience of the first psychotherapy case has an impact on the therapist’s career and is integral to the formation of the professional self.

Self psychology has been utilized as a theoretical and therapeutic framework to explore the importance of this developmental milestone. The theory evolved from psychoanalysis, with its primary focus on the “self” as a construct. Furthermore, it emphasizes one’s early experiences, through proposed selfobject needs, and one’s subjective experience of early caregivers. The theoretical framework of self psychology serves as a useful lens through which to view the initially-acquired experiences that occur in the first psychotherapy case, as well.
The facets of self psychology discussed in this paper speak to how an identity (in this case, the professional self) develops. Good enough experiences through which one’s selfobject needs are met early on in the development of the professional self are provided by those that make up the therapist’s selfobject milieu. When adequate selfobject experiences are available to a therapist in a way that allows for them to be internalized, this process lays the foundation for and promotes the development and structuralization of a vital professional self through the maturation of narcissism. Conversely, when these experiences are absent or somehow insufficient, particularly at key developmental junctures such as the first psychotherapy case, a sense of shame, a lack of cohesion and self-confidence, as well as a sense of anxiety and rigidity pervade the self.

Therefore, it is useful for supervisors, a fundamental component in the selfobject milieu of the first psychotherapy case, to consider the selfobject functions of this case from the point of view of the therapist in training. As there are many feelings that may accompany the first psychotherapy case, the supervisory relationship can either mitigate or exacerbate these affective states, depending on the approach and the dyad. Given the power differentials and the vulnerability of this time in training, the onus is on the supervisor to keep the relationship safe in order for the environment to be conducive to the cohesive development of self. By being mindful of how threatening the first psychotherapy case experience may be for the therapist, the supervisor can then aid in the normalization and validation of the process, which is essential to strengthening the professional self. This process can further be facilitated through empathy that allows for affective integration on the part of the therapist. Empathic listening and responsiveness will allow the fledgling therapist to be more open to exploring the parts of her professional self about which she does not feel confident (Teicholtz, 2007).
Future exploratory research might study the first psychotherapy case and explore what factors are predominant in the formation of the trainee’s professional self during this time. Qualitative research would help to understand what exact properties of the developing self are similar to those of the earlier developmental process, the participating psychotherapists’ perspective on the first psychotherapy case, and the meaning that is being assigned to this time in training. Additionally, although a hypothetical case example was included to illustrate potential impact, case studies of real first psychotherapy cases would aid in illuminating the uniqueness of this time and could shed light on other considerations that may be significant during this stage in the development. Any future research or attention in these areas will lead to a better understanding of the impact of the first psychotherapy case on the psychotherapist, with important implications for the supervisors and others in the therapist’s selfobject milieu.
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