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PART II: SUPERVISION OF THERAPY: MODELS AND PARADIGMS

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The Development of Professional Identity in Psychotherapists: Six Stages in the Supervision Process

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ABSTRACT. It is our view that the processes which psychotherapists undergo as they both learn their craft and develop a sense of professional identity conform to the developmental sequelae which lead to individuation and identity formation in human beings in general. In this chapter we highlight parallels in the developmental processes and delineate guidelines for supervisory practice which they imply. We have identified six stages in the learning and supervisory processes of psychotherapists-in-training and of new professionals. We describe the new trainee's diffuse anxiety, excitement, and dependency on the supervisor in the earliest stages, his or her increasing sense of confidence, competence and autonomy as they emerge in the middle stages, and, his or her emergent stability as a

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psychotherapist and collegiality both with peers and senior staff during the last stage.

Part of the process of becoming a psychotherapist involves developing a sense of professional identity. Once this has been attained with some degree of coherence, the professional identity serves as a stable frame of reference from which psychotherapists make sense of their work and, to some extent, the fabric of their lives. This chapter offers a description of the phases through which beginning psychotherapists pass as they learn the craft of psychotherapy and develop their professional identities. The chapter's focus is on the course of this evolutionary process as it manifests itself in the supervision relationship. The point of view expressed reflects the psychodynamic bias of the authors.

Ekstein and Wallerstein (1953/1972) point out that the

> sense of professional identity is an essential attribute in a profession such as psychotherapy, and its acquisition must be considered one of the important training goals. Professional identity is a higher form, a later acquisition than the self concept. It is an extension of the self concept. (p. 66)

These authors describe the sense of professional identity as having both external and internal components. External features relate

> to being externally *identified* as a psychotherapist, to being accepted as such by the general public and by other professionals . . . (and to) being identified as what one wants to be. The internal side has to do with the process by means of which an identity is established, the *process* . . . of identification with the teachers of psychotherapy. (pp. 77-78)

It is our belief that the "Healer identity" is an integral aspect of the professional identity. The term "Healer identity" refers to the notion of faith-in-oneself-as-Healer. In his book *Persuasion and Healing,* Frank (1961/1972) discusses in some detail the nonmedical roots of the healing process. He emphasizes the idea that the faith of both patient and therapist in the power of the latter to heal can often be instrumental in effecting the curative process.

In contrast to traditional medical sources of healing, the psychotherapeutic process is an *invisible* curative agent. The therapist, therefore, cannot easily learn to believe in its power. He or she can only attain the condition of faith through repeated experiences of conducting the process and observing its effects. Therefore, regardless of whether a psychotherapist-in-training learns his or her craft from the vantage point of psychiatry, social work, or psychology, attainment of the "Healer identity" is a significant goal of the training process. This means that even though psychiatric residents embark upon their training as psychotherapists with an already established but rudimentary medical healer identity, it is only as they learn the art of conducting the invisible "talking cure" that they develop the "Healer identity" of which we speak.

We have made it our primary task to depict the various consecutive types of dyadic supervisory relationships which trainees and new professionals form as they learn to become psychotherapists. For purposes of simplicity, we have chosen to ignore the fact that trainees, particularly in clinical psychology and psychiatry, are likely to be involved in several different supervisory relationships at any given time. These relationships will, of course, each have a different character depending upon the personalities of the supervisor and the supervisee involved. It is our contention, however, that there are identifiable, normative types of relationships which most trainees and new professionals form with one supervisor or another during each stage of their development, and it is on these normative relationships and phases that we have focused our attention.

Although we describe a variety of stage-specific supervisory problems which are likely to arise in the normal course of events, we do not address the spectrum of difficulties posed by the trainee who is identified as a "problem student." The reason for the exclusion is that students in this category manifest behavior which represents, by definition, deviation from the norm, and it is our primary task here to describe the characteristics which fall within the parameters of the norm itself. In general, it seems that trainees who are resistant to forming trusting attachments, who are highly narcissistic, or who have severe difficulties dealing with authority figures, comprise the most frequently encountered group of supervisees regarded as problematic.

In our view, there are six stages in the early learning and supervisory processes. We have labeled these as follows:

Stage One: Excitement and Anticipatory Anxiety
Stage Two: Dependency and Identification

Stage Three: Activity and Continued Dependency
Stage Four: Exuberance and Taking Charge
Stage Five: Identity and Independence
Stage Six: Calm and Collegiality

We do not see the above as discrete stages which occur once and once only. Rather, we assume considerable overlap between phases as well as a return to any of these under new or difficult circumstances. We believe that retrograde motion is inherent to learning and developmental processes and do not consider it "regressive."

Naturally, the character of supervisory relationships can never be entirely determined or controlled by the student, who is, after all, only one member of the supervisory dyad. The supervisor has an equal role in shaping the supervisory experience. It is our bias that it is the supervisor's task to assess the professional developmental level of the trainee or new professional and provide learning conditions appropriate to that stage of development. We believe that the role of the supervisor is not only akin to that of the therapist, but also to that of the mother or primary parent.

Erikson (1950/1963; 1968) has discussed in detail the process through which human beings develop the sense of a stable self. In elaborating on Hartmann's (1938/1958) concept of the "average expectable environment," Erikson (1968) speaks to the importance of the parents providing "a whole sequence of 'expectable' environments" (p. 222) in order to facilitate experiences appropriate to the child's evolving needs and abilities. Winnicott's concept of the "holding environment" (1965-b) as managed by the "good enough mother" (1965-a) is a more subtle reworking of this theme. The idea that the course of the child's identity development is related to the adult's capacity to adapt to the changing needs and abilities of his or her child is similar conceptually to the notion that the course of a trainee's professional identity development is related to the supervisor's ability to adapt to the changing needs and capacities of the supervisee.[1] Wherever possible, therefore, we have described in

1. There are additional parallels between early parent-child relationships and supervisor-supervisee relationships. Throughout the course of this chapter, therefore, we often draw upon the language of the former to describe the latter. In so doing, we do not mean to imply either a one-to-one relationship between the internal development of the child and that of the adult psychotherapist-in-training, or a one-to-one relationship between the parent-child experience and the supervisor-supervisee experience. In the case of the former, the similarities relate primarily to interactional processes and not to psychic content. In the case of the latter, the similarities relate only to the pattern of the process and not to the intensity, longevity, or significance of the relationship.

general terms the supervisory tasks which correspond to each of the six stages which we have delineated.

It is impossible to predict exactly how long it will take a given trainee to achieve a cohesive professional identity. Our general assumption is that the process never takes less than four years and, in fact, frequently takes many years more. This means that people who study in any of the three most common types of psychotherapy training programs (psychology, social work, psychiatry) may reach some of the later stages toward the end of their training years but will not achieve Stage Six, the period of "Calm and Collegiality" until after completion of formal training.

Not everyone who initially sets out to become a psychotherapist actually manages to master the tasks of each of the six stages. Some therapists "get stuck" in one stage or another, most often, Stage Five, the period of "Identity and Independence." These therapists are easily recognized by the fact that they never again seek close supervision after completion of their formal training years.

We have found no significant reference in the literature to the parallels between the general course of human identity development and the specific course of professional identity development in psychotherapists. However, Fleming (1953), Grotjahn (1955), Gaoni and Neumann (1974) and Yogev (1982) do propose a variety of stages of growth and learning through which psychotherapists-in-training or new therapists pass en route to becoming professionals. The models they each offer are quite consistent with one another's in the way that they address the developmental progressions of both the therapist's skill with the patient and supervisor-supervisee relationships. In terms of the former, learning is seen to occur first, through defining the psychotherapeutic role; second, through learning to explore and understand what the patient's internal processes are and imply; and third, through discovering what the therapist's internal processes are and imply. In terms of the latter, the direction of growth is from initially viewing the supervisor as teacher, to, much later, relating to him or her as senior colleague.

STAGE ONE: EXCITEMENT AND ANTICIPATORY ANXIETY

The first phase begins when the psychotherapist-in-training initially becomes acquainted with the training agency in the capacity of student. It ends upon contact with either the first patient or informa-

tion about the first patient. Depending upon either the system to which the training agency subscribes, or the new trainee's degree of reluctance to speed up the process of patient assignment, the phase may be as brief as several hours or as long as several weeks or even months.

In general, this period is marked by the trainee's diffuse anxiety and excitement. These feelings are generated by the newness and awesomeness of the long-awaited professional opportunity to become a psychotherapist. The uncomfortable feelings are maintained because the trainee has no specific task on which to focus and bind the anxiety until he or she is assigned a patient. While all of us can recall this very brief but overwhelming prelude to becoming a psychotherapist-in-training, the phase is virtually without mention in the literature. We consider the omission remarkable. So many practicing clinicians attribute considerable significance to the beginning phase of a psychotherapy venture, yet almost no one has described the analogous moments of the supervisory relationship.

The task of the new trainee's supervisor at this stage is similar to that of the newborn's parent: to provide "enough security so that the baby will be free to explore the new world on his own without feeling that he is neglected or abandoned" (Kaplan, 1978, p. 63). While the specifics of the successful holding environment will vary depending upon the personalities of the supervisor and the supervisee, the essential element consists of the supervisor's accurate empathy regarding the trainee's anxieties and vulnerabilities.

STAGE TWO: DEPENDENCY AND IDENTIFICATION

The second stage begins as soon as the trainee is assigned a case. It ends with the trainee's first realization that he or she has had a significant impact on a given patient. Most often, this impact is experienced by the novice as having a personal rather than a professional, or healing, character. Interruptions in the treatment, whether brought about by the novice's illness, vacation, of field placement termination typically provide an opportunity for the trainee to notice the extent to which a patient has come to feel attached to or to rely on the new therapist. The patient's tears, rage, or regression all attest to the fact that at least one member of the trainee-patient dyad believes that the former is actually a therapist. Stage Two, by definition, precedes this discovery.

The trainee's lack of confidence, skill, and knowledge about what psychotherapeutic work actually entails typically leads to a high degree of dependency on the supervisor as well as to idealization of the latter's skills and understanding. Although the consistent characteristic of the supervisee's relationship with the supervisor during this stage is the dependency of the former on the latter, the visible form this may take can range anywhere from outright submission to the supervisor, to healthy, trusting dependency, to casual rejection of the supervisor's help, to a chronically rigid, counterdependent mode. Commonly, however, supervisees emulate their favorite supervisor's perceived therapeutic styles and attitudes about clinical matters, as well as, on occasion, their body postures and personal mannerisms (Barnat, 1973).

Most often, trainees seek instruction from their supervisors about how to manage specific patient behaviors such as: not appearing for, cancelling, or coming late to scheduled appointments; making numerous between-session telephone calls to the therapist; asking personal questions of the therapist; demanding concrete advice; or appearing in an intoxicated state at appointment times. In addition, trainees want to know how to respond to a patient's excessive tearfulness, psychotic productions, rage reactions, suicidal ideation, gross acting out between sessions, and difficulty separating from the therapist at the end of sessions. Questions about managing the first phone call to the patient, introducing oneself, and handling the patient's attempts at conversation in the hallway or waiting room are all of concern to the trainee during this period. Students exert considerable pressure on their supervisors to play the role of author of a *How to Perform Case Management* text while they are in this stage of the learning process.

The most fundamental question trainees have during this phase, however, is "What exactly is my job with these patients?" New trainees are easily distracted by the often complex and anxiety-provoking reality issues with which their patients present. They find it difficult to either grasp the nature of the internal problem which stymies the patient or, if they do understand it, stay fixed in their focus on the internal element. Alternately, students may perceive the "therapeutic task as being limited to a kind of detective game, at a distance from the patient, a matter of discovering dynamics and genetics, of describing pathology without doing something about it" (Fleming, 1967, p. 420).

Trainees do not usually ask their supervisors all of the questions

which occur to them: some are simply too painful to articulate. Perhaps the most salient of these is: "Do I have what it takes to perform this work successfully?" Supervisees in this phase are frequently plagued by the self-doubts and ambivalent feelings which reflect both the inchoate nature of their professional identities and the minimal degree of skill they as yet have amassed with which to perform their work. Supervisors can help address the "affirmation hunger" (Barnat, 1974, p. 190) of the novice by conveying through attitude and manner a sense of warmth and acceptance. This idea is consistent with the observations of other writers that professionals who are benevolent and supportive make the best supervisors for students who are in the earliest phases of their training (Chessick, 1971; Rosenbaum, 1953).

Just as trainees do not ask their supervisors all of the questions which occur to them, neither do they tell their supervisors about all that transpires in the interactions which they have with their patients. Beginning therapists tend to disguise much of what they do with their patients when reporting to supervisors for fear of either looking silly or, alternately, not looking good enough. Although psychotherapy supervision is always fraught with potential for creating narcissistic wounds in the supervisee, at no other developmental stage are supervisees more consistently vulnerable than they are when just entering the field.

Trainees frequently express interest in understanding their patient's diagnoses, dynamics and interpersonal styles. Early on, they rarely ask for and do not seem able to digest lengthy supervisory discourses or probings regarding transference, countertransference, and more general theoretical matters (N. Kaslow and Friedman, 1984). When trainees do mention countertransference, it is usually in the form of a confessional regarding the presence of unacceptable hostile or sexual feelings about a patient. It is a rare beginner who is not disturbed by such feelings from time to time or who is able to grasp immediately, without some coaching, the extent to which such feelings provide valuable clinical information about the patient rather than solely about the therapist.

It is important that supervisors remember that trainees so often feel overwhelmed by the demands of early clinical work. Who among us does not recall the exhaustion we felt in the earliest turning phases after seeing only two or possibly three patients in the course of an afternoon. Because trainees at this stage tend to feel so emotionally drained and confused by their direct contacts with patients, the most helpful general service that the supervisor can perform is to demonstrate that there are ways of organizing and, equally important, anticipating those experiences which initially feel so chaotic to the novice. The organizing and anticipatory roles of the supervisor are basically holding functions.

It is also essential at this stage and during the one which immediately follows it that supervisors handpick patients for their students in order to screen out those who present major management problems or "hopeless" treatment prognoses. Complex management cases are to be avoided because they too quickly overwhelm and drain the novice, while "hopeless" cases impede the growth of the trainee's faith in the therapeutic process. This latter issue should not be taken lightly. It is highly unusual for a trainee to enter the field with a firmly entrenched belief in the efficacy of psychotherapy. It is therefore very much the task of supervisors and teachers to nurture the growth of the trainee's faith in the power of the healing process.

STAGE THREE: ACTIVITY AND CONTINUED DEPENDENCY

The third phase of development may begin within several months or years after a trainee has been treating patients in psychotherapy. It is initiated by the trainee's first realization that he or she is actually being taken seriously by his or her patients, who develop faith in the "Healer" long before the "Healer" himself or herself does (assuming that the latter is a beginning-level trainee). The patients' reactions gradually convince the therapist that the latter is neither an imposter nor a fraud. Thus, the impact which the reactions of patients have on the evolving self-concept of the therapist parallels the impact which the reactions of significant others have on the child's evolving sense of self-definition (Winnicott, 1967/1971).

The direction of growth for the supervisee during Stage Three is from passivity and dependency to a more active, less dependent mode. It is a shift from being done to, to doing. This shift can be observed both in the student's supervisory relationship and in the student's therapeutic work with his or her patients: the trainee at this stage generally vacillates between being a reactor to both the patient and the supervisor and being a more active participator in each relationship.

One of the consequences of the trainee's increased activity level is a concomitant elevation in his or her sense of professional responsibility for therapeutic actions and decisions. It will be recalled that at the end of the prior stage, the novice became aware for the first time that he or she was really having an impact on patients. Now, with that awareness in mind, the new therapist fluctuates between gross overestimation of his or her therapeutic power and equally inaccurate underestimation of it. The omnipotence feelings are accompanied by considered guilt and anxiety regarding therapeutic decisions which may have to be made. A trainee at this stage, for example, may feel overwhelmed by the consequences of choosing to seek hospitalization for a decompensating young adult who may, forever after, bear the stigma of having been a "mental patient" as a direct result of this treatment decision.

Trainees frequently try to cope with the omnipotence anxieties of this stage by discussing treatment problems and strategies with an assortment of supervisors, faculty members, peers, and significant others. The primary aim of such discussions is to "spill" affect. This behavior on the part of the novice is not to be confused with the more ideationally motivated requests for consultation with colleagues and senior staff which appear at later stages of professonal development. The most helpful stance that the supervisor can assume at these points is to acknowledge the difficulty and weightiness of the new therapist's responsibilities without overstating the case and escalating the trainee's anxiety level.

Supervision continues to be characterized by its patient-focus during this phase. Although less dependent on the supervisor than before, the average trainee remains dependent enough so that the tone of the relationship is still likely to be an overtly compliant one. Unlike the diffuse anxiety which characteristized the trainee during the previous stage, anxiety is now experienced episodically, during times of crisis. It is at these moments that the supervisee is likely to slip back into the more dependent mode of the prior stage.

Trainees continue to ask questions about management, but in addition, may make beginning efforts to learn about and integrate psychotherapy theory as it relates to practice. The intensity of the student's quest for understanding, however, is rarely matched by the extent to which he or she is able to integrate the answers. Theoretical exchanges during supervision primarily serve the purpose of providing the trainee with a stage upon which to practice voicing the nouns and verbs of the profession's language. The ability to converse in a sophisticated way is not yet possible. For instance, one might hear trainees at this level say the following: "There was so much splitting going on!" or, "The patient is using so many defenses!" This is the period during which students typically diagnose anyone they know, or have ever known. Beginning piecemeal use of the psychotherapy argot is made with great gusto and is, in fact, an extremely important part of both the learning and professional indoctrination processes. However, the new words and ideas as yet have little impact on the trainee's psychotherapeutic work.

The supervisor's mirroring acceptance of the passive and active modes of the trainee's work and level of understanding enhances the trainee's self-perceptions and self-esteem. This parallels the process which occurs under optimal conditions between mother and child when the mother's "mirroring admiration . . . paints proud edges on the baby's body" (Kaplan, 1978, p.144). The basic ways in which the supervisor can convey acceptance are by limiting and focusing criticisms, setting limits judiciously, and by being predictable in affective tone from supervision session to supervision session, as well as in response to the psychotherapeutic work under scrutiny.

When the supervisor is attentive to and accepting of the trainee's needs, supervision tends to be a positive experience for the student. The supervisor, however, may or may not find this early phase of supervision to be particularly rewarding or stimulating. While it is of great value for the student's development that he or she be free to problem-solve, experiment, and make mistakes, it can be quite frustrating for some supervisors to sit back and watch this often messy and initially ineffective *modus operandi.* The supervisor's experience at this point may duplicate the mixture of pleasure and frustration felt by many parents as they watch their children's early attempts to feed themselves. Typically, food intake is painfully slow and relatively ineffectual. Because the process seems highly inefficient, it may be maddening for the parent when the child rejects help. However, as all parents know, children do eventually learn to feed themselves no matter what the degree of parental involvement has been.

Supervisors who are either unable or unwilling to perform early holding functions may create problems for their supervisees by either demanding premature movement from passivity to activity or by impeding increased activity levels as they emerge. One of the authors (NK) had the following supervisory experience during this

phase of her training, when the shift from passivity to activity was prominent and the need for acceptance was primary. During the course of a family therapy practicum in which she and her supervisor were regularly doing cotherapy, NK realized that she was ready to become more active in the treatment. Prior to a family therapy session, she indicated to her supervisor that she wanted to be more active during the forthcoming interview hour. The supervisor responded by saying, "You can talk for the first five minutes and I won't interrupt as long as you don't say anything stupid." This may at first glance seem to be an extreme response from a supervisor. We include it, however, because we feel that it clearly conveys the power which supervisors can exert, particularly those who enjoy the idealizing dependency of their students, to retard the emergence of higher levels of autonomous functioning.

STAGE FOUR: EXUBERANCE AND TAKING CHARGE

The fourth phase of development is ushered in by the trainee's realization that he or she really *is* a therapist. Previously, the trainee has observed patients improve, as many do, and has even felt instrumental in the process in some cases. What the trainee has not experienced until this turning point, however, is a basic sense of himself or herself as "Healer." Intrinsic to this aspect of the self-concept is the trainee's awareness that his or her own psychotherapeutic armamentarium is in large measure responsible for the treatment "cures" which he or she effects. It is at this stage, therefore, that trainees can be heard to exclaim with enthusiasm, "Hey! Psychotherapy really works!"

Trainees now feel more in command professionally because they know more about the treatment process, what their job is, and how likely it is that they will be able to facilitate certain changes in a given patient. The trainee's greater treatment effectiveness has come about partly in response to the amount of patient contact which he or she has accrued. But in addition, a variety of other factors have led up to this new development. By the time this phase begins, most psychotherapists-in-training have entered into personal psychotherapy, where they have accumulated perceptions about the phenomenology of being a patient as well as about the scope and pace of the treatment process (N. Kaslow & Friedman, 1984). They have also spent several years reading the literature of the field and discussing it both in class and in supervision. What happens during

this phase is that all of these experiences begin to gel. One visible consequence is that trainees are now able to substantively grasp connections between psychotherapy theory and practice.

It is usually during this phase of development that the student begins to identify more personally with one theoretical orientation or another. This has not occurred before in a meaningful way (from the supervisor's point of view) because the trainee still lacked both a sufficient knowledge base of the theory in question and any stable sense of his or her own psychotherapeutic style. Now, during a time of relative security, the trainee is better able to explore and experiment with novel points of view, for it is possible to envision adding them to an existing framework of thought and behavior. When multiple theories and techniques are presented to trainees in earlier phases of their education, they lack the organizing rubric into which to fit the diverse ideas.

Supervision during this stage ceases to be primarily patient-focused. The trainee is secure enough to be ready to handle the increased anxiety which countertransference exploration engenders. He or she is also better equipped to engage in theoretical discussions with supervisors. Whereas before, trainees placed a higher premium on having supervisors who were warm and empathic, regardless of their capacities to engage with ideas in an intellectually stimulating way, they now evidence a greater preference for supervisors who are intelligent and knowledgeable about both the literature and direct practice. The supportive style which was the *sine qua non* of good supervision during the early years or months, has become a desirable but insufficient characteristic of good supervision (Rosenbaum, 1953).

By this time, the trainee is more clearly in charge of his or her psychotherapeutic work, both as case manager and as psychotherapist. Optimally, the supervisor, in response, has relinquished the more controlling role he or she had formerly played and has begun to act more like a consultant to the therapist. Because the trainee has finally begun to organize, plan, and execute the treatments he or she is conducting, these treatments take on a far more authentic cast than they have previously had. Trainees now tend to be more warmly, maturely, and genuinely related to their patients than they were before. Simultaneously, they are less intensely bonded with their supervisors.

The shift away from more dependent relations with the supervisor speaks to the solidifying professional identity of the new psychotherapist. During prior stages, the trainee responded to the supervisor in

a manner which primarily reflected compliance (or, of course, non-compliance in the more negativistic student). By Stage Four, the supervisee begins to genuinely identify with his or her teachers as "Healers." This identification process is the forerunner of internalization.

Sometimes it happens that a supervisor is more interested in directing the course of a treatment than the trainee may wish. The trainee is now so invested in experimenting with and inventing the treatments he or she conducts that unsolicited supervisory advice is likely to be either resented or ignored or both. It is not a matter of a trainee's wish not to have counsel regarding patient care, but, instead, a manifestation of the increasing need to shape the terms of the supervisory and treatment relationships. The supervisor is less frequently viewed by the student as someone who is there to evaluate the student or to protect the best interests of the patient (regardless of the reality of the situation from the point of view of the supervisor), and more frequently seen by the student as a consultant who will provide help when needed. The trainee is very much preoccupied with making his or her own discoveries in a progressively independent fashion, and overinvolvement or overcontrol on the part of the supervisor is a deflating experience for the trainee which robs him or her of the creative joys of this stage.

STAGE FIVE: IDENTITY AND INDEPENDENCE

This is the period of professional adolescence. It is most notable for the rejecting and/or devaluing attitudes which the new therapist may direct toward the supervisor. Arrival at this stage signals the emergence of the trainee's or junior staff member's new capacity to begin to envision survival without the full support of the supervisor. For most new therapists, this stage lasts for several years. It is analogous in both spirit and process to adolescent separation phenomena vis-a-vis the parents.

Major disagreements with authority figures have previously been avoided by the average trainee or new staff member because dependency needs were acute enough to muffle direct expressions of difference or anger. During this stage, however, supervisee-initiated power struggles of one sort or another can be normative. At the more subtle end of the spectrum, the supervisee may withhold a great deal of information from the supervisor about the course of

various treatment cases. The motive is the supervisee's wish to feel and be more independent as a clinician; the wish to avoid looking silly, which had been the primary impetus for withholding during earlier developmental phases, is no longer the operative motive. When Stage Five is reached by a new therapist who is employed on a full-time basis in the community, a form which the struggle for independence may take might be the creation of a *sub rosa* peer supervision group composed primarily of staff members who are at the same developmental stage. While such groups meet numerous needs, the element relevant to Stage Five in the developmental process is the extent to which these groups arise in reaction to or in rebellion against the agency's or institution's formal supervision process. It is important to keep in mind, however, that just as all adolescents do not experience intense turmoil as they go through their teenage and young adult years (Offer & Offer, 1975), neither do all new therapists behave in the foregoing ways. Our view is that when and if such behavior emerges, it is best recognized as phase-appropriate.

It is important to understand that the supervisee's behavior at this stage represents a developmental achievement despite the negativistic phenomena with which a supervisor may be confronted. During earlier phases, many supervisees engage in a form of passive non-compliance whereby they pay lip-service to the wisdom of supervisory suggestions but then do not implement them in treatment. The trainee's non-compliance at these times is in large measure due to either confusion about or fear of making the suggested interventions. Now, during the present stage, the issue is quite different. The supervisee is more measured in evaluating the accuracy and quality of the supervisor's advice and may believe, in the end, that he or she knows best how to handle the treatment problems in question. The central developmental given of this phase is the fact that the supervisee now has a firmly internalized clinical frame of reference on which he or she routinely bases treatment decisions. As a result, supervisory feedback can no longer have the dramatic impact which it once had. In the main, this is a function of the increasingly cohesive nature of the professional identity which is forming.

A hallmark of this period is that the new therapist is typically quite conscious of the areas in which his or her professional or personal strengths either exceed, or seem to exceed, those of the supervisor. For example, he or she may be acutely aware of having a greater capacity to tolerate a patient's periods of silence or rage than

a given supervisor has. It is not until the next phase of professional development that the supervisee will be able to comfortably accept the differential skill levels of senior staff and feel open to learning from them again despite their deficiencies. To this extent, the current developmental phase is notable for the pervasive quality of adolescent-like devaluation of less-than-perfect authority figures.

This is the phase during which the supervisee is most invested in both minimizing the impact of the supervisor and maximizing his or her own sense of professional autonomy. Some supervisors feel quite comfortable with their role during this phase, but many find it painful to either experience the loss of supervisory control or accept the more limited parameters of the teaching arena. The developmental needs of the supervisee at this point require that the supervisor support the new therapist's autonomy moves while still remaining available as a helper. The supervisor's task is complicated by the fact that he or she must create a setting which, on the one hand, allows for the supervisee's freedom of functioning, and on the other, implicitly acknowledges that it is the supervisor who carries final responsibility for the treatments which the supervisee conducts.

One of the authors (DF) had the following positive experience with a supervisor during her predoctoral internship year, when she was beginning to work through the developmental crises of Stage Five. Several months before the end of that year, DF was assigned to a supervisor whose dominant theoretical orientation was one in which DF had little interest. After several unproductive supervisory hours, DF told the supervisor that her relative dissatisfaction with the supervision process was a function of her disinterest in the supervisor's theoretical point of view. Some discussion followed, after which the supervisor quite calmly suggested a modification of the supervisory contract. He proposed that the clinical case in question be discussed on an intermittent or, "as needed" basis only. DF experienced this plan as both implicitly supporting her individuation needs and affirming her faith in her growing clinical competence.

STAGE SIX: CALM AND COLLEGIALITY

This phase is characterized both by the therapist's sense of calm and stability and by his or her feelings of collegiality with peers, senior staff, and supervisors. The sense of professional identity is by

now so firmly established that risk-taking has become an integral part of the therapeutic style rather than a notable deviation from it. Therapists at this stage are more likely to re-examine and challenge psychotherapy "truths" than they were before and to increasingly personalize their own styles of treatment, rather than strive to emulate models to which they have been exposed. Because they have relatively stable and secure technical and theoretical bases from which they conduct treatment, therapists now feel more motivated to explore treatment modalities and issues which had prior been of less interest.

One of the reasons that the predominant mood of the new therapist is one of calm, is that self-doubts about competency issues are less intense than they have ever been: the affective highs and lows of earlier stages are considerably muted. Furthermore, the absence of the intensive monitoring and evaluation by supervisors which pervaded the training years inspires an increased sense of autonomy in the new professional, who realizes that he or she has become a trusted member of the professional community. The therapist's professional self-acceptance and the implicit affirmation of colleagues and administrators fosters independent functioning rather than the dependent style which was the *sine qua non* of the training years.

The level of integration of the therapist's professional identity is reflected in the way in which he or she views colleagues. Whereas in the early years, therapeutic expertise was presumed to lie primarily in the domain of senior professionals, there is now an awareness and acceptance of the fact that peers too are a valuable source of ideas, experiences and information. The peer supervision groups which proliferate during this stage arise out of a spirit of genuine respect among colleagues and are no longer tinged with conspiratorial feelings of rebellion against formal agency supervisors, as they were during the prior stage.

By the time therapists achieve this level of professional development, they may be involved in any or all of three different types of supervisory experiences. The first type is most similar to supervision relationships established during the training years. In this case, the therapist, now employed by an agency or institution, is likely to be subject to a form of supervision which addresses administrative as well as clinical matters. The supervisee is expected to conduct the treatments of his or her patients according to treatment plans established in concert with the agency-appointed supervisor, who carries both legal and agency-related responsibility for

the conduct of the cases. The supervisor in this setting may also be responsible for formally evaluating the therapist's performance in order to determine salary increases and promotional possibilities.

Both the second and third types of supervisory relationships likely to be established by a new therapist are, in contrast to the above, voluntary in nature. The second type also takes place in the context of an agency or institution and involves the obtaining of ongoing supervision by a junior clinician from a senior clinician who is affiliated with the same facility. In this form of supervision, however, the junior member of the dyad is not obliged to act in compliance with the views of the supervisor, who is neither legally nor administratively responsible for the course or outcome of the treatments being conducted, and is not a participant in official evaluations of the supervisee. The third form of supervision is similar to the second, except that: one, the supervisor is not affiliated with the same facility that the supervisee is; or two, neither supervisor nor supervisee are affiliated with an agency of any type.

Regardless of which of these three types of supervisory relationships the clinician is engaged in, supervisors at this stage tend to be less idealized than they were during the early years of training and, equally, are less likely to be devalued as they were during the new therapist's prior developmental stage. Instead, supervisors are more accurately seen by new professionals to be as they really are: more experienced clinicians who have both personal and professional strengths and weaknesses. This is an instance in which the lines of personal identity development and professional identity development converge for the new therapist.

The narcissistic vulnerability which was so prominent during the training years and which to a large extent hindered the learning process, has by now receded into the background in most cases. A very significant result of this shift is that the new professional now comes to the supervisory relationship with a keen investment in making that relationship work. The therapist knows roughly what it is that he or she is looking for from the supervisor as well as what the strengths of the supervisor are. A fair amount of effort may be expended by the therapist to create and sustain the conditions which will enable the supervisor to be of use. This is very different from the conditions which prevailed during the early stages of traineeship. Those years were dominated by the novice's anxiety, passivity, dependency, and defensive wishes to elude the supervisor. Equally, the current picture is in contrast to later stages of training

and/or early years of professional employment. Characteristic of those years were the new therapist's struggles to define himself or herself, achieve autonomous functioning, and, simultaneously, delimit the impact of the supervisor. Now, during Stage Six, these goals have been achieved, at least in a rudimentary way. Fears of the supervisor as the mother-of-fusion-and-engulfment have been minimized so that it is possible for the therapist, for perhaps the first time, to actively seek out and create the learning situations in which he or she thrives.

In the context of these supervisory conditions, countertransference becomes a prominent focus for both self-examination and supervisory interchange. Over the course of the training and early practice years, a perceptible shift in the therapist's view of the significance of countertransference has taken place. In the early stages, countertransference reactions in response to the patient were typically assumed to reveal defects in the trainee's character as well as weaknesses in his or her capacity for emotional control. The primary wish of the trainee was to exercise the ego-alien feelings. During later stages of professional development, however, countertransference reactions to the patient are viewed in a qualitatively different fashion. They are now seen as providing valuable cues about the patient's internal states and interpersonal relationships as well as about the therapist's. The therapist is both more interested in and more free to examine in a reflective and open manner his or her reactions to a given patient or to the therapeutic relationship. When this kind of self-scrutiny takes place, the supervision process may appear to be indistinguishable from the psychotherapeutic process.

SUMMARY

We have described a sequence of stages through which psychotherapists pass as they each develop their own sense of professional identity. We have not assumed that learning or identity development end here. However, we have chosen to come to rest at this plateau for two reasons. The first is that by the time the new professional reaches the period of "Calm and Collegiality," supervisory relationships no longer have the formative impact which they had in earlier years and therefore assume a qualitatively different character. The second reason is that the average psychotherapist undergoes a major transformation at about this time, when he or she

begins supervising the next generation of psychotherapists. The shift in professional self-concept which is brought about by this role change is an extremely complex one, similar in nature to that which a new parent experiences, and therefore, in our view, it exceeds the scope of this paper.

The course of professional identity development which we have outlined is in harmony with Erikson's (1950) identity scheme as well as with the separation-individuation model of Mahler and her colleagues (Mahler, Pine, and Bergman, 1975). Erikson's ideas are echoed by our view of the trainee's movement from phases of industry and mastery, to adolescent-like rebellion, to identity consolidation. Erikson's supposition, as well as ours, is that the path which identity development follows leads to an individual's increased "sense of inner unity, and an increase in the capacity 'to do well' " according to one's own standards and "the standards of those who are significant to one" (Erikson, 1968, p. 92).

At the same time, our understanding of the separation and individuation processes which trainees enact with their supervisors echoes the stage-theory proposed by Mahler and her colleagues to this extent: the supervisee's growth proceeds from phases of bonding and attachment, to efforts at differentiation, to signs of rapprochement crisis, to achievement of separation-individuation proper. Individuation in this sense "refers to the taking on of those characteristics which mark the person as a person in his own right; . . . . the child individuates largely by taking into himself characteristics of significant others in his life from whom he has differentiated" (Pine, 1979, p. 226). It is our view that these similarities between the specific course of the psychotherapist's professional identity development and that of his or her personal identity development, help the psychotherapist-in-training to acquire "large portions of his own personal identity and self-concept collaterally with his acquisition of professional and therapeutic role and identity" (Ford, 1963, p. 476).

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