

Who's Showing Up? A Relational Approach to Supervision

Summer Session '09

Supervision of psychotherapy and assessment cases is a part of all clinical psychologists training. The experiences we have with our supervisors—usually more senior and experienced members of our field—can have a profound effect on our career development. Issues of shame and self-esteem, of disclosure and non-disclosure, of hope and trust, run throughout the supervisory relationship, as they do in the psychotherapy relationship. Both are, of course, relational activities (Alonso, 1985).

During the Psychoanalytic Case Conference at Fielding's Summer Session, Dr. Judith Schoenholtz-Read and advanced graduate student Jason Boothe offered us an extended, live demonstration of "relational supervision." More than a role-play, Judith and Jason engaged in real supervision of his work

with a suicidal woman in her forties with a history of sexual abuse, both as a child and ongoing as an adult, whom Jason had been seeing for a number of years.

J u d i t h grounded her work in a paper by Dr. Mary McKinny on



Dr. Judith Schoenholtz-Read

relational perspectives on supervision and "the supervisory triad" (McKinny, 2000). This approach attempts to move supervision from attention solely to the relationship between therapist and patient to include as well the relationship in supervision. What had been a 2-person model becomes a three-person model, and more. From this perspective, in supervision we need pay attention to the patient's world, the therapist's world, their intersubjective world (the space between them, in Ruthellen Josselson's phrase) and—in parallel fashion—the supervisor's world, the supervisee's world and their intersubjective experience. Not only is there a

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The impact of combat on Veterans: Reader Response

Our Spring '09 newsletter contained an article entitled, "War On A Sunny Afternoon," about teaching and learning at Fielding and the experience of combat Vets. A number of readers responded with thoughts of their own.

Working with Vets

Hello,
Thanks so much for keeping me on the distribution list. I've been working with Marine and Navy dependents where I'm now living near Camp Lejuene in NC. Reading about the seminar struck many chords. A long time ago I worked with Vietnam vets and knew personally how their responses seem contagious to those of us living with them.

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The Alonso Center is very pleased to announce that the Lazarus Family Foundation has made a \$10,000 gift to the Center to sponsor the Anne Alonso Memorial Symposium.

The first such symposium will take place during Fielding's 2010 Winter Session when the Center will sponsor an evening event:

Who's Showing Up? A Relational Approach to Supervision

Friday night
January 15th, 2010

This symposium will explore in more depth many of the themes touched upon in this article.

We are very grateful to the Lazarus Family Foundation and to Fielding graduate, Dr. James Lazarus.

We welcome suggestions about possible future Center offerings. Contact Dr. Sam Osherson with ideas and suggestions (sosherson@fielding.edu/617-354-1330). To discuss gifts and contributions to the Center contact either Dr. Sam Osherson or Anne Kratz, Director of Development (akratz@fielding.edu/805-898-2926).

We'd like to hear from you!

What would you like to see in the newsletter? What articles do you like? What are your questions about the Alonso Center at Fielding Graduate University? What would you like to know about individual or group psychotherapy, parenting, social issues, teaching or the School of Psychology?

Send us your questions and the faculty will provide answers in a subsequent newsletter (please specify if you would prefer an answer by personal e-mail or if you authorize publication of the question and answer in the newsletter).

Please send all questions to sosherson@fielding.edu

The Alonso Center
at the School of Psychology
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parallel process, there are parallel triads! There are emotional demands on both supervisor and supervisee in this way of working.

Mc Kinney says, “When relational theory is extended to supervision, it raises questions about what supervisor and supervisee can know, how authority is negotiated within the dyad, and how clinical expertise is understood to develop.” (McKinney, 2000, 567). The supervisor may be a potent presence in the therapy—but what kind of presence, exactly?

Judith began by asking Jason where he saw himself in relation to the patient, and what he wanted from the hour long supervision time together. Jason indicated that he was troubled about a familiar feeling in his work with the patient, his wish sometimes that the patient would not show up for their therapy sessions. He wanted to figure out his role is in whatever is going on and what is evoked in him and played out in the therapy.

As they talked, Jason revealed that some time ago, the patient had made a very real suicide threat that had left him very frightened for her safety and wondering what he had missed that led to this behavior. In addition, the patient had become more vocal about quitting therapy as her insurance was about to run out.

This led Judith to wonder, who was not showing up—the patient or Jason?

In response, Jason recalled that his thoughts about the patient not showing up began when he questioned whether he was a good-enough therapist. “Maybe this work isn’t for me,” Jason commented. He reflected on this and said that “maybe if I don’t show up, she’ll be ok and I won’t have to experience what happened with the suicide attempt. Logically, I don’t feel I missed anything, but there’s a little voice in me that said that if only I had found the right words, if only I can, something I can say will keep her from doing it, even just till next session.” Jason revealed

that he thought of death as the ultimate termination. He feared the patient will preempt things and kill herself.

Judith then asked Jason to say what happens to him internally when he says that. He replied that, “I get angry. This is such difficult work. I’m supposed to be tolerant and helpful but I want to shake her.”

Listening to this exchange, I found myself wondering about moments when we think we are protecting our patients from painful material, but are actually protecting ourselves. If a supervisor shows up for the therapist, can the therapist show up for the patient? We often don’t show up for the patient because we fear we won’t be able to handle what we hear.

After a discussion of more of the case details, the supervision returned to the connection between therapist and patient, and between supervisor and supervisee. Jason talked about some of the patient’s disconnecting behaviors. Judith asked if Jason had spoken with the patient about *his* wish to disconnect from her. “Yes,” he replied.” At first she didn’t say much but over time she’s been able to talk about her wish to disconnect.” Jason reported several sessions in which the patient got very angry with him, saying she wanted more from him.

Judith asked Jason how he understands that request.

“That she wants more from me than I can articulate. I think my comment about wishing to disconnect terrified her and made her angry.”

Judith encouraged Jason to stay with that comment and see what comes up within himself, particularly his associations about when she leaves the therapy while not knowing if she’ll even show up the next time. “That seems to underline the whole therapy.”

“Is she safe?” Jason asked.

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“Let’s stay with her rage,” Judith encouraged. “You ask her, you get angry, I mean *she* gets angry. Oh, a slip there!” Judith acknowledged her slip, mixing up Jason and the patient. She wondered what Jason felt about her slip that *he’s* the angry one.

“I feel you want something from me and I can’t give it. I get so angry because I’m not sure what you want.”

Judith disclosed a similar feeling within herself. “I’m not sure either, but something is there,”

“I think....,” Jason responded. Judith encouraged him to stay with his feelings. “I don’t know, I just want some quiet.”

“OK, so let’s be quiet and stay with the feeling.”

After some silence, Jason responded, “I feel myself getting lost, not sure what to make of that. I feel you are frustrated and I want to placate you but I’m not sure what to say. If I don’t say anything, then I can’t be wrong. There are these moments I feel really insecure. Am I competent enough to be sitting in the room with this person I try to reassure myself that I’m not completely lost at times when I do feel completely lost.”

“What if we are lost together” Judith asked.

“I feel you can tolerate being lost and I can’t. I... I’m supposed to tolerate it because she can’t and I worry she’ll feel lost or take her life because there’s something I missed.”

“I’ve certainly been in that place and I’m getting that feeling sitting with you,” Judith replied, “that I have to be watching carefully, too. What’s it like to feel lost in here?”

“I can tolerate it because I know you’re not going to let me fail...”

“Fail?”

“By not keeping her alive.”

This very grounded, open discussion between Jason and Judith led into a discussion of the patient’s desperation and what it was like for Jason to sit with her desperation. Judith went back to “this idea of whether she’s going to show up”—and *who* is going to show up. Jason said he’d felt forced to show up for the supervision demonstration after he’d volunteered. He’d wished to retreat emotionally, just as he imagined his patient felt. He’d actually showed up more than he expected. That led to the insight that it is possible to show up even if one is confronted with overwhelming and scary feelings, patient and therapist alike. Jason left the session realizing that “it’s possible to show up even if I feel overwhelmed.”

The painful truth about the therapist’s dilemma is that we *can’t* keep someone alive who decides that they want to die. Perhaps we all weave fantasy to reality when we imagine that our supervisors have the magical powers to prevent the therapy from going awry (eg, not keeping the patient alive.) One thing that good supervision *can* do is to help us as therapists find the trust in ourselves and our supervisors to sit with overwhelming

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Student memories of positive and negative experiences in supervision

I recall the interest of my supervisor in my conceptualization of therapy and with the clinical tools I used. It was fulfilling to raise clinical interest in a career psychologist

Once I was surprised that my supervisor had clinical reservations about my adaptation to my practicum site due to the level of awareness necessary to maintain personal and professional safety. In hindsight, I’m pleased to know that I made the needed adjustments, but at the time it was less than a positive experience.

My supervisor one day gave me challenging feedback in a caring way. She told me that I needed to organize myself more effectively, talk better notes to remember what had happened in sessions,

and also be easier on myself so I could listen to my patients better. It was the first time a supervisor ever held me to a higher standard. It felt great that she wasn’t just telling me I was doing fine. I’m a good student and often I think I can just “get through.” This supervisor wasn’t letting me do that.

I have a wonderful, warm supervisor who frustrates me a lot because I feel that I start to present what happened during a therapy session and then he “hijacks” our time by giving me a long lecture on what is going on with the patient. He’s very smart, but I feel that he doesn’t allow me to get into any affect, or what my experience is. Maybe he is scared of doing that, but I feel we never address the dynamics between us.

A painful moment with a supervisor happened when he asked me, “why did it take you so long to be in a PhD program” As in: *what is wrong with you?*

It mattered a lot to me when one of my first supervisors complimented me, saying that I had a lot of good insights in the assessment case I was working on.

A very meaningful moment in supervision happened when I admitted to a counter transference issue that was embarrassing and getting feedback that was kind, thoughtful, and normalizing.

A painful moment happened when my supervisor suggested that a client was not a “good fit” for me. I felt like a failure.

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feelings so that we may be able to make the same thing happen in our work with patients. Supervision can provide us with the



visceral experience—the “implicit knowing”—of sitting with overwhelming feeling so that we may be able to bring that back into our therapeutic work.

The case conference ended with an engaged discussion among the group of students and Marge Cramer, April Fallon, Sherry

Hatcher, Ruthellen Josselson, Marilyn Freimuth, Stephen Ruffins, and Sam Osherson. The discussion ranged from the hold that suicide and suicide attempts can have on the therapy to theoretical questions about the point at which case formulation becomes an important part of relational supervision, as well as whether relational approaches lead to a bypassing of the aggressive impulses and violence present both in the therapy and in the patient’s life. *AC*

References

Alonso, A. *The Quiet Profession: Supervisors of Psychotherapy*, NY: MacMillan, 1985

McKinny, M “Relational Perspectives on the Supervisory Triad,” *Psychoanalytic Psychology*, Summer 2000, 17(30), 565-584



Letters... (continued from cover)

The studies of police families have illustrated this a great deal.

Thanks Again,
Joyce Williams

the power of ... 'sitting in the mud'
with someone
...to work with people who had
lost everything...

Listening to Vets

Hello:

I just wanted to let you know how interested, touched, and appreciative I was of your article on working with veterans.

I graduated with only an MA from HOD in 2002, after doing a thesis based on volunteer experiences in New York just after 9/11 so I am not really qualified to offer any comments, but this is an issue which is very close to my heart....I am sure that there will be far too many vets ending up on the streets of California. The vast increase in numbers of those surviving horrific head trauma, never mind catastrophic injury will soon be overwhelming, to their families and existing medical resources.

Earlier in my career, I had the incredible privilege of running a newly created hospice in a rural area. My big push was educating the community on issues of grief and loss. I could not count the number of parents I knew who lost children, mostly from accidents.

As a result of my work around sudden death, death from chronic illness, I found my avocation with issues of grief and loss. At that time, in the late 1980s, there was not the huge army of 'grief counselors' that now show up at every emergency. At a national

hospice conference I found a couple of inspired experts—Donna O'Toole who had developed a curriculum on grief and loss for public schools—K though 12—in North Carolina—and Dr. John Schneider who was finishing a book on the developmental issues of grief and loss. The two of them were pioneers in spreading the idea of how issues of grief permeate our lives—even success can trigger grief—the loss of striving for a goal when it is reached—and are best integrated when we can acknowledge that.

Schneider talked about the power of what he called 'sitting in the mud' with someone. He used the phrase after trying to work with people who had lost everything in mid-western floods. Talking was not what they wanted, needed or what worked. For me, it was a revelation but something I have experienced over and over again, heard from others working with the dying, the traumatized—after 9/11 some of the most effective 'counselors' were dogs who could go into schools and make a beeline for the child that nobody could reach. Others I have know who have experienced horrible losses—the loss of a child

More recently I went with a close friend to his Vietnam reunion. It had only been started within the last few years.

Like most vets, my parents and their peers who lived through 6 years of bombing and destruction in London during WWII, he did not talk about it. I encouraged him to go to the reunion and he invited me to the second one he attended. I was deeply touched and honored. Here are some things I learned and observed in the process.

1. That many of the men went to Vietnam individually, not in units or groups and finished their tours in the same way, so it took time for them to find their place in whatever unit they ended up in. The military has now learned that that was a bad idea.

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article...

2. While some of the stories of the way that vets were treated on their return has been discounted and dismissed; in fact it varied as the war went on and became more and more unpopular. At

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best there was a general disinterest in what they had done in the later years.

3. There were many men I heard about that did not come to the reunion and the consensus was that events in Iraq had triggered too many traumatic memories for them.

4. The reunion had, to my observation, some brilliant aspects. There were some large events, a barbecue, a memorial service with an inspired chaplain, a vet himself, at which they honored those who had passed away since the last reunion, an honoring of widows, including one widow who was married for just a year before her husband was killed. She never married again and was clearly fragile both physically and emotionally.

The most inspired part for me was the way each unit within this particular infantry division was given its own room in the hotel with tables and chairs and was open from 8 am till 2 am the next morning. There were always drinks and snacks there. Some sat quietly listening, while others talked and reminisced. People would drift in and out, sit at the tables, talk in larger groups, smaller groups, look at photo albums that some of the vets had brought. One man rarely spoke, just listened—he was the only survivor of his unit.

On the second night, one guy showed several carousels of slides—of villages, perilous bridges over raging rivers, camps or shots of a large group, with this comment, “I’m the only guy in that bunch that never got hit (killed) ...was that dumb luck or am I the smart one?.....here, Kathryn, that’s the love of your life. Not much comfort I know.” That was to the tiny fragile widow—the only African American woman I saw. Her husband was a big strapping man, obviously in his prime. It was her first reunion and touching to see the affection with which they all treated her, considering the tenor of the times when they served.

At various times, there was an unspoken consensus amongst the women to leave the men alone and we would all quietly leave

“I’m the only guy in that bunch that never got hit (killed) ...was that dumb luck or am I the smart one?”

the room. At different times all the women shared some thoughts with me. Despite the many long-term marriages and apparent success the common issue was the unbridgeable distance that all the wives experienced with their husbands. Some had tried therapy, at the VA and privately but it seemed to be something they had learned was just a permanent factor. They were still coming to terms with that. My friend had the same issue. He has few friends and does not want to have a close relationship with anyone, though he does have a good one with his only child, a son. His greatest satisfaction is visiting a couple of families of men in his unit who never came back from Vietnam.

One man at the reunion told me that the best therapy he had—his wife separately confirmed this—was not at the VA where he found the groups were too big—but an informal one put together by a psychiatrist who was not a vet at which he and a young English major graduate encouraged the men to write... about anything.... he said it had made a huge difference to him.

A few months later, I met my friend’s brother-in-law who was also a vet. The two of them have never talked together about Vietnam. My friend says it is clear his brother-in-law does not want to. The brother-in-law and I went for a dog walk one day. He told me that he had deliberately chosen since returning from Vietnam to never make friends with anyone. It was too painful to lose people and he had lost too many over there and did not want to go through that pain again. He just volunteered this information. I did not ask any questions but think I am quite good at listening of putting myself in a place of just being there with

...talking directly about the experience is not always the most therapeutic method.

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Letters...

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someone. My friend said that is the most the guy has ever said to anyone about his experience.

My thanks for the Alonso newsletter in general. Fielding is an amazing institution.

Best wishes,
Kate Wright

...moved by others stories to think about their own experiences...

There is a resource I have since found that I have found many vets really respond to: It is a very slim volume, *Veteran and Families' Guide to Recovering from PTSD* put together by a psychiatric nurse practitioner, Stephanie Laite Lanham, and includes the writings and poems of a lot of vets as well. She has worked with vets from WWII to Iraq and Afghanistan. She self published it and you can get it from the Purple Heart Foundation but I have found it quicker to buy it direct from Stephanie. I buy several at a time and give them away and am delighted at how it seems to strike a chord with so many vets.

My point is that talking directly about the experience is not always the most therapeutic method. Sometimes the trust you referred to can be established by just 'sitting in the mud' with someone or helping them find their own outlet. What I saw at the reunion was a lot of communication expressed without words of just knowing you were with a lot of people who shared your experience. Just by listening to stories of the earlier reunions, it is clearly a very therapeutic event in and of itself.

It is also true, based on some extensive recent research I have done on WWII, that so many of those who went through that, including professional journalists, were too shocked, appalled, traumatized by what they had seen that they were not ready to re-visit any of it for quite a few years. I know we can do some damage, however good our intentions, by pushing people to talk when they are not emotionally ready to do so.

Veterans Education Project

The article interested me greatly. The Veterans Education Project here in Western Massachusetts is using that kind of personal narrative or storytelling approach in its work, training our veterans and military family members to use their stories to make the abstract concepts and impersonal facts and statistics real, to put a human face on the issues. And, as you experienced in your seminar, those in the room who are veterans, or with loved ones or friends are veterans, are moved by others stories to think about their own experiences and relationships in new ways, and to share their own stories and insights. It's very exciting and magical when that happens, isn't it?

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...so many of those who went through that were too shocked, appalled, traumatized by what they had seen that they were not ready to re-visit any of it for quite a few years

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Vietnam memories

Dear Sam:

Your article on veterans stimulated a lot of memories. I'd like to relate one soldier's story to you. My return from Vietnam was not an easy one. The TET offensive had started about two weeks

I was just 22 when I completed my time in Vietnam. I had spent most of the year in ...the Central Highlands.

before I left. Because of this, just prior to my return I had spent my nights fighting in Landing Zones, most of whose names I have forgotten. I also spent my days trying to do engineering work. The combination of combat at night and bureaucracy in the day also left me totally exhausted.

For the last several months in Vietnam I had dreamed of coming home to cold Connecticut, getting into my car, driving to warm Florida, buying a hamburger and a milk shake, and walking to the beach. I dreamt that I was no longer an officer and in charge of a group of men whose lives depended on my decisions.

I was just 22 when I completed my time in Vietnam. I had spent most of the year in and near An Khe in the Central Highlands. I had been a platoon leader first and then company commander of a combat engineer company, the 511th Panel Bridge Company. I was proud of what I did. The night before I left I made a big show of handing in my flack jacked, pistol, and rifle. That night we were attacked and there I was, going back to supply to pull out all my combat equipment again. As we headed out to the green line I watched the mortars going over our heads, hitting the marines behind us in middle of the camp. The whole image was surreal. Then, fittingly, the next morning the unit commander refused to free up transportation for me to get out of there. Fortunately I held a number of markers and my way to Qui Nhon and then Cam Ranh Bay was greased by people outside the battalion.

Many of the people who had been with me on the plane coming over were on the one returning. I do remember the whole flight to Vietnam being very noisy. The return flight, however, was as quiet as the proverbial undiscovered tomb. I asked one of the attendants about it, and she said that it was always that quiet on the return.

I wish I could do justice to the emotions going through me at that time. With the TET offensive I was convinced that God has let me live some 360 days over there just to do me in at the end. I was emotionally and physically exhausted. Within 48 hours of being in combat I was sitting in a commercial plane trying to contemplate the fact that I would probably live a full life, and that unlike so many of those poor people I saw, my turn did not come. Then began the, "Why me and not them." I knew I did not have the warm, loving family of so many. I did not have a wife and children depending on me. I had been away from home in college and then the early military. I believed that my family would have barely missed me. As I was pondering these thoughts, I slowly drifted off to sleep, awakening for stops in Japan (purchased some Japanese lighters for my relatives) and Anchorage (the first touch of American soil was the ice on the tarmac, and I almost flipped). I do remember a customs agent wanting to know everything I had purchased in Vietnam (all from the PX). He was irritated at the fact that I had not made out the long list, and I was irritated at his being irritated at me and not leaving me alone. Finally he just got up and walked away. All I could think of is that I get my butt shot at for a year so some idiot can hassle me coming back.

Little did I know.

Finally we arrived in Seattle. There we passed through an incredibly efficient line where they made sure that we had money and tickets and anything else we needed. We took taxis to the

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I was sitting in a commercial plane trying to contemplate the fact that I would probably live a full life ...Then began the, "Why me and not them."

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commercial airport. I thought I was going to die. I had not been in a land vehicle going over 10-15 mph for a year, and the taxi was going 65. I was petrified of what would happen if the truck in front of us were to hit a mine. (It took me weeks to get up to speed, as it were, on the highways.)

I flew to San Francisco on my way home, where my eyes were really opened. I had left February of 1967, just before the hippy era, and returned after its commencement. I remember seeing someone at the airport wearing long hair and what looked like a 6-foot colored handkerchief with sandals. Curious, I thought. Then this young girl with blonde hair and a red dress came up to me. She smiled, and then spat on my chest. Though stunned, I thought this was rather curious too. I had no idea of the anti-Vietnam sentiment that had developed since I left. Also, I have heard this story from so many other people that I think she made a life of spitting on GIs. What a waste of a life, and what a crippled mind. Then I took off for New York.

I arrived in New York at about 11 PM and called my parents to get the best way home. I had forgotten about the International Date Line crossing, and they let me know first that they were not expecting me till the next day. I was asked to get to Grand Central Station and they would meet me there. I did, and later they did. The station was empty, which seemed very fitting, and we had a little celebration with a shot of rye. All I remember of the trip home was how cold it was and how much snow there was. I was coming from the heat of Vietnam to the cold of Connecticut, though I did not know in how many ways that was true.

I do not know why this sticks in my mind. I had thought that the one minor advantage of being in the TET Offensive was that being awake all night in Vietnam might help my biological clock on the other side of the world. No way. For the first few days I needed a light on to sleep.

The morning I arrived home my brother called and announced that he had dropped out of college. For two weeks the only days

I had no idea of the anti-Vietnam sentiment that had developed since I left.

I could there was someone at the post office in Washington Connecticut who actually had a pin with my name stuck in the right place in a map of Vietnam. My eyes misted over when I saw that. Some cared, and then there were the others.

My grandfather had fought in WWI, and my uncle in the Pacific in WWII. My father served, but never left the states. My uncle and grandfather, like me, had seen some heavy combat, yet never talked about it. My uncle was the only one who knew exactly where I was in Vietnam and what actions were going on where. He never shared this with anyone. I found out by accident later. I had the feeling that I joined their club, that the combat had somehow altered my perspective on life in much the same way as it had theirs.

To this day I am enamored of the songs of WWII, those of Vera Lynne and the McGuire Sisters, who showed a missing of the men who went to war and a desire for their return. It was 1988, over 20 years later, when the mother who had lost a son over there put her arms around me and said, "Welcome home." I was surprised by the emotion that swept over me, and I realized that I had never been welcomed home before.

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...for me it was great to know that it was not just all in my mind. For all the past year in Vietnam, when I'd not actually be getting shot at I was in fear of getting shot at.

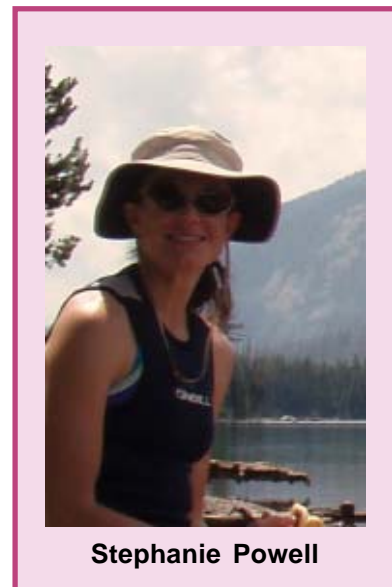
The Mother-Tongue: Intersubjective Dialogues with Bilingual Patients

Stephanie Powell

Stephanie Powell is a graduate student at the Fielding Graduate University. She lives in Boise, Idaho.

Many psychotherapists take for granted the context in which the patient and therapist share language of origin. Yet there is a strong likelihood that at some point in their careers, therapists will engage in a therapeutic relationship with a patient for whom English is not the first language. Although psychotherapy is often thought of as the talking cure, Aragno and Schlachet (1996) point out that many psychological theories do not address "...the language in which the talking should be done" (p. 23).

Because many bilinguals speak fluent English, therapists rarely consider the need to conduct therapy in another language. Aragno & Schlachet (1996) provide an argument against this assumption. They offer a case example in which a young, Spanish-English bilingual spoke perfect English, but lengthy efforts in treatment produced unsatisfactory change. Both patient and therapist were stumped by the lack of progress, and experimented with integrating the Spanish language into therapy. They discovered that language switching helped anchor treatment, and provided an avenue for meaningful change in the patient's life.



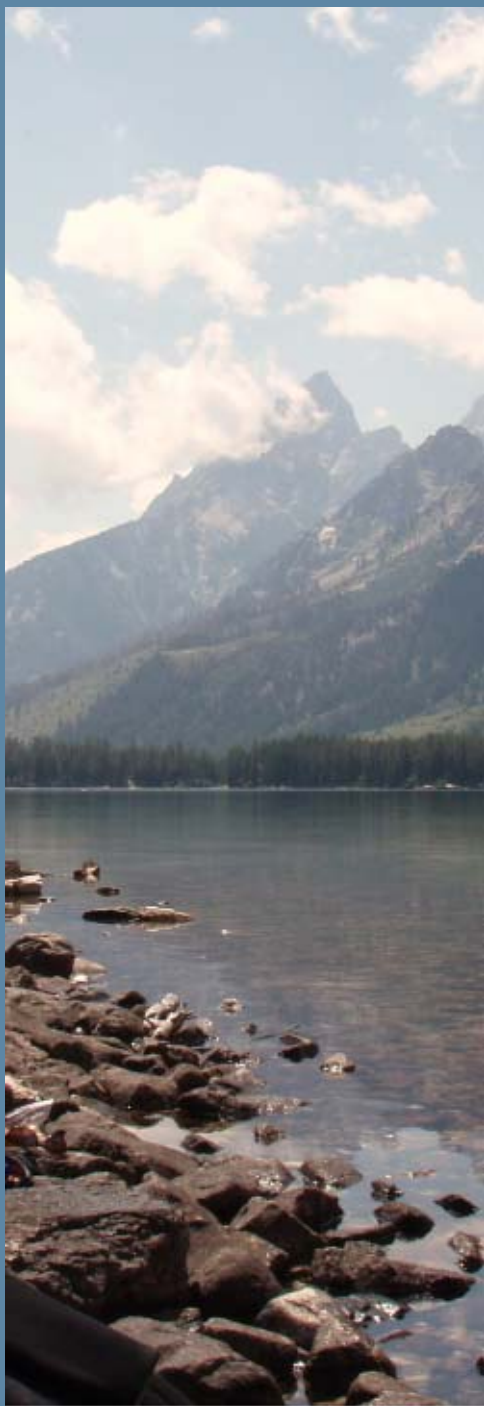
Stephanie Powell

From a psychoanalytic perspective, language is considered a mental representation because it resides in the brain as an abstract pattern with an array of cognitive and emotional components (Santiago-Rivera & Altarriba, 2002). Because the role of language is critical to treatment, the question that arises is whether meaningful change can occur if the therapist and client do not speak the same mother tongue. That is, the language in which early relational experiences were encoded.

The influential, unconscious role of language was acknowledged by early psychoanalysts. Buxbaum (1949) proposed that the mannerisms of speech among foreign language speakers often revealed implicit material aside from verbal expression. Observations of bilingual patients suggested a tendency for some patients to unconsciously choose a particular language to ward off anxiety or avoid painful emotions associated with a particular experience (Krapf, 1955). Contemporary research however, has disputed these earlier claims, revealing that certain memories may not necessarily be retrievable in a bilingual individual's

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...how to
communicate in a
way that captures
lived experience...



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second language, "...not because they are repressed, but rather because they are rendered inaccessible, having originally been encoded in another language" (Santiago-Rivera & Altarriba, 2002, p. 34). Marcos (1994) agrees that words in bilingual's second language have less meaning and emotion associated with them. No matter how proficient a person is in the second language, certain memories cannot be recoded. Aragno and Schlachet (1996) note case studies where words learned in a client's first language triggered emotionally-laden memories of experiences, but had no significant meaning in the English language, or in cases where English was learned in later stages of development.

Differences in Bilingual Language Systems

It should be noted that bilingual individuals do not fit neatly into one category, and possess key differences in second language acquisition. Irvin and Osgood (as cited in Santiago-Rivera & Altarriba, 2002) note that a compound bilingual is an individual who learns two languages simultaneously at a young age. This results in a memory system that can be accessed and expressed both languages. By contrast, a coordinate bilingual is an individual who acquires a second language later in life resulting in the development of "...two independent language systems, each with its own meaning, experiences, and words" (p. 31).

The notion of independent meaning systems has particular implications for therapeutic change, and brings to light the importance of considering a coordinate bilingual's language systems in the therapeutic context. Specifically, the independent meaning and emotional memories stored within each language.

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Words learned in one's first language are encoded and stored at a deeper level of semantic representation than the same words in the second language. This includes emotional associations and sensory meanings with attachment figures (Javier, 1995). This might explain why one's language of origin is considered the "mother tongue". In short, therapy conducted in a coordinate bilingual's second language is unlikely to activate a broader range of emotions that might be necessary for meaningful change because emotional experiences and foundations of meaning with attachment figures are deeply connected to one's language of origin (Aragno & Schlachet, 1996).

For example, in Schwanberg's (2006) study of post traumatic stress disorder (PTSD) symptoms among Spanish-English coordinate bilinguals, it was revealed that traumatic memories were described differently depending on the language in which they were spoken. When participants described traumatic memories in Spanish, symptoms reflected greater frequency and intensity than when described in English. This study supports earlier findings that emotional memory is more accessible and retrievable in the language of origin.

What's a Monolingual Therapist to Do?

So what is to be done about this? Should therapists learn to speak in a tongue they don't speak? The answer perhaps depends on the cocooned meaning of communication between therapist and bilingual patient. Although psychotherapy primarily consists of verbal exchanges, Stern (1985) points out that spoken language can be a double-edged

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word because personal meanings cannot always be captured and expressed through explicit language alone. Taking Stern's premise into consideration, perhaps the crucial component to consider in therapy is how to communicate in a way that captures lived experience of the bilingual patient. This task requires attuning to the patient's internal world through nonverbal, emotional dialogue.

Aragno and Schlachet (1996) have recommended allowing patients the opportunity to select a language wherein ideas and emotion can be expressed most accurately. They explain that unstructured use of the first language provides access to early emotional meanings and is a valuable therapeutic tool for restoring and integrating self representations. Santiago-Rivera and Altarriba (2002) agree that this process opens the doors to reliving, experiencing, and integrating the therapeutic experience in its fullest sense. Although therapists may not verbally comprehend the patient's language, they can attune to the experience in a way that the patient feels known.

A case study in which language substitution was used as a treatment strategy has been noted by Pitta, Marcos, and Alpert (as cited in Santiago-Rivera & Altarriba, 2002). They provided an example of a Spanish-English bilingual who sought treatment with an English speaking therapist. The first few sessions were strategically conducted in Spanish which allowed the patient to

...words learned in a client's first language triggered emotionally-laden memories

openly discuss her difficulties and build trust with the therapist. As treatment progressed, English was substituted for Spanish. Pitta et al. suggested this strategy allowed the client a flexible context in which to experience and formulate meaning underlying affect.

Can a Therapist "Know" Without Understanding the Language?

It has often been suggested that the therapeutic relationship shares developmental characteristics with the parent-child dyad (Bowlby, 1988; Lyons-Ruth, 1999; Wallin, 2007). Lyons-Ruth (1999) points out that humans possess unique features of

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References

- Ameel, E., Malt, B. C., Storms, G., & Van Assche, F. (2009). Semantic convergence in the bilingual lexicon. *Journal of Memory and Language, 60*, 270-290.
- Aragno, A., & Schlachet, P. J. (1996). Accessibility of early experience through the language of origin: A theoretical integration. *Psychoanalytic Psychology, 13*(1), 23-34.
- Bowlby, J. (1988). *A secure base*. London: Routledge
- Buxbaum, E. (1949). The role of second language in the formation of ego and superego. *Psychoanalytic Quarterly, 18*, 279-289.
- Javier, R. (1995). Vicissitudes of autobiographical memories in a bilingual analysis. *Psychoanalytic Psychology, 12*(3), 429-438.
- Krapf, E. (1955). The choice of language in polygot psychoanalysis. *Psychoanalytic Quarterly, 24*, 343-357.
- Lyons-Ruth, K. (1999). The two-person unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational organization. *Psychoanalytic Inquiry, 19*(4), 576-617.
- Marcos, L. R. (1994). The psychiatric examination of Hispanics: Across the language barrier. In R. Malgady & O. Rodriguez (Eds.), *Theoretical and conceptual issues in Hispanic mental health* (pp. 143-153). Malbar, FL: Krieger.
- Santiago Rivera, A. L., & Altarriba, J. (2002). The role of language in therapy with the Spanish-English bilingual client. *Professional Psychology: Research and Practice, 33*, 30-38.
- Schwanberg, J. S. (2006). *Does language of retrieval affect the remembering of trauma?* (Doctoral dissertation, Fielding Graduate University, 2007).
- Stern, D. B. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.
- Wallin, D. J. (2007). *Attachment in psychotherapy*. New York: Guilford Press.

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affective communication which emerge early in infancy. In essence, this form of communication is perhaps the genuine mother tongue of human communication (i.e., the “implicit mother-tongue”). As such, the implicit mother tongue provides an avenue for attunement, and has potential to transcend the barriers of verbal communication between therapists and bilingual patients.

To illustrate this process, I draw parallels between implicit relational knowing and the notion of semantic convergence between languages. Implicit relational knowing involves not necessarily what is said, but how we feel and behave in interpersonal relationships. It is a culmination of implicit memories that provides a formula for being with oneself and others (Lyons-Ruth, 1999; Wallin, 2007). In the psycholinguistic realm, semantic convergence refers to a process when individuals who speak different languages interact in a way that influences each other over time. Eventually, elements of the two language systems (i.e., semantics, syntax, and phonology) become integrated into new patterns of similarities and form a new language that is different from either language as spoken by monolinguals (Ameel, Malt, Storms, & Van Assche, 2009). The basic premise of semantic convergence is that representation of language

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systems (whether bilingual or monolingual) is not isolated, and therefore, subject to relational influence. The degree of convergence is determined by the frequency of input from both languages.

Comparing semantic convergence to implicit relational knowing suggests that a type of convergence occurs between therapist and patient at the affect level of representation. With repeated exposure, new emotional meaning will be coconstructed between therapist and patient. In other words, emotional expression in the patient’s mother tongue will likely activate similar affect in the therapist outside the context of verbal comprehension. Over time, reactivation of emotional communication will converge in the meaning of felt security that becomes encoded in the emotional memory of both patient and therapist.

Although there are unique challenges in working with bilingual patients, therapists must be willing to provide the type of care necessary to foster transformation. Intersubjective awareness and implicit relational dialogue provide for the convergence of languages, and coconstruction of meaningful experience in the therapeutic context. As the bilingual patient grows and develops over time, the therapist can adapt in accordance with the patient’s evolving needs and interests, thereby increasing felt security and transcending the language barrier. A

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