

Finding an Authentic Voice

Use of Self: Essential Learning Processes for Relationship-based Work

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This article articulates and defines the *use of self* construct in relationship-based intervention in the infant and family field. A set of descriptors is introduced that can be used in supervision with trainees and new practitioners to help operationalize clinical processes and the concepts inherent in developing reflective practice skills. Particular emphasis is given to discussing Schön's distinction of *reflection in action* and *reflection on action*. Examples derived from supervision and consultation dialogues are given to illustrate opportunities for enhancing clinical process and reflective practice skills, and concepts that can confuse practitioners are discussed. It is suggested that the practitioner's greater understanding of, and comfort with, how internal experience impacts intervention in relationship-based work allows for the development of a unique and effective "authentic voice." **Key words:** *countertransference, infant mental health training, reflective supervision, relationship-based practice, self-awareness, transference, use of self*

FOR THOSE training and practicing in the infant-family field, there is a dual task: focusing on complex theoretical material and on the affective dynamics of use of self. This article explores the "use of self" construct in relationship-based work and articulates the associated processes and skills that must be mastered in training to work most effectively in the infant and family field. Articulating these processes and skills more clearly for training programs, supervisors, and trainees in infant-family practice creates better opportunities for mastery and the development of an "authentic voice." To this end, we first provide competency descriptors of the key processes involved in the development of use of self, including an elaboration and operationaliza-

tion of Schön's description of *reflection in action* and *reflection on action* (Schön, 1983). We then enumerate and illustrate skills inherent in these processes and provide examples of clinical supervision and consultation dialogues in which these are used. Finally, we address concepts relevant to the "use of self" construct that are confusing to beginning clinicians and interventionists and outline phases involved in developing an understanding of use of self.

We believe that an understanding of "use of self" serves to anchor and define the dynamics that underlie the process of change in clinical work. A working definition and a set of clear descriptors that identify components of use of self are important for both training and service programs to help trainees and staff develop ways of working in clinical encounters that encourage going beyond explicit content and knowledge about a situation to include an awareness and exploration of reactions and deeply held beliefs. Such explorations require careful attention to the feelings, values, and beliefs that are activated in one's self and others when working with clients, in the

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supervisory relationship, or in clinical case conferences.

Building from the work of Eggbeer and others and from our own supervision practices in service and training programs, we are defining *use of self* as the capacity to observe and be aware of one's own thoughts, feelings, and behaviors, as an important source of communication and information in a variety of clinical experiences (1994). This process of being aware of one's own internal experience and how that experience influences behavior include recognition of the judgments, wishes, intolerances, hot buttons, or fears that one brings or that become activated in clinical encounters. Our definition also includes an ability to be aware of and appreciate that the internal worlds of others are equally diverse and as individually unique as our own. In relationship-based intervention, the use of self becomes the vehicle through which information, knowledge, and support are given to a family. Thus, use of self is an active, dynamic, and often intersubjective process that implies full realization of one's own internal world, the other's internal world, and the importance of the rich interplay that links these 2 fields of experience.

The term *use of self* encompasses and expands upon the psychoanalytic concepts of transference and countertransference used in psychodynamic and psychoanalytic approaches to psychotherapy. There is a rich and extensive literature that describes the concepts of transference and countertransference in work with adults, children, and families (Sandler, 1976; Orange, 1994). However, the literature is often confusing for practitioners as different writers use terms in different ways and there is much debate about the concept within the literature (see Furman, 2002). From this literature, Bion's (1978) concept of containment has been incorporated into our thinking on use of self. Winnicott's article (1949) has also influenced our thinking in development of the use of self descriptors. It is a widely read article describing the ways in which working with very disturbed patients can affect the analyst. This article was a first

in that it described the similarities between the client analyst relationship and the mother-infant relationship. Winnicott's (1971) use of the space of play also has influenced our thinking about providing ample time and generous doses of curiosity to any clinical situation. We have also been influenced by the Kleinian concept of projective identification (Seligman, 1999). French's work (2000) on the concept of negative capability originally used by Keats and borrowed by Bion for use in the analytic world has been influential in helping us describe one aspect of use of self. However, since infant-family practice is inclusive of a wide array of early intervention, early childhood education, and mental health disciplines, an operational, more descriptive, and a far more accessible definition of the *use of self*, and examples of its application in home visiting work, is needed. In the world of infant-family practice, the term *use of self* first appeared in an article by Bertacchi and Coplon (1992). Their definition of *professional use of self* described the importance of self-awareness and the willingness to explore what a particular family scenario may bring up for the intervener. Fenichel (1992) included the article in a widely read and highly influential anthology entitled *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A Sourcebook*. Subsequent writers in the field of infant mental health have used the term extensively when writing about supervision, which they term a relationship for growth (Gilkerson & Shamoan-Shanok, 2000; Norman-Murich, 1996; Shamoan-Shanok, 1995).

To further operationalize a working model of the use of self for infant-family practice, we have expanded and modified "use of self" descriptive items from Heffron's (2002) professional growth evaluation format, *Developing Competencies in Infant and Early Childhood Mental Health*. The evaluation was developed to guide trainee evaluations in a community-based infant and early childhood mental health-training program by helping supervisors and trainees in the program

structure and record reflective dialogues about processes and knowledge that trainees are engaged in mastering. The items are descriptors that elaborate a set of essential clinical abilities that are meant to be used interactively in supervision sessions to help the trainee or employee explore these essential areas of clinical process and learn to recognize them in the clinical sessions with families. Conversations between supervisors and trainees help create shared awareness, opportunities for self-examination, and increased understanding about working definitions of *use of self*. The initial review of these competency descriptors and periodic reassessment can be useful as an evaluation of professional growth for the trainee in this sometimes hard-to-define area. These periodic reassessments are good opportunities to anchor and illustrate the descriptors with examples from the trainee's own clinical experience. The continuing dialogue about the trainee's growth and development will hopefully set the stage for similar growth-enhancing dialogues with peers and mentors over the course of each participant's clinical career. Below we have listed the modified descriptors that we have found to be helpful in working with staff and trainees to encourage growth in the use of self. The 12 descriptors are grouped into 4 broader categories of clinical processes.

“USE OF SELF” DESCRIPTORS

Reflective practice

1. Awareness and ability to monitor and reflect on ways in which work with families can evoke past or present personal experiences of the clinician or the family on a conscious or unconscious level.
2. Ability to understand that the clinician's personal characteristics, clinical context, style, and professional role influence the interactive process with families through conscious and unconscious means.
3. Ability to observe individual behavior and the interactive exchange with oth-

ers, reflect on these dyadic and systems processes, and attribute relational meaning.

Translation of reflection into action

4. Ability to consider, observe, and monitor impact of interactions on the family and talk with the family about this in a way that is potentially meaningful for them.
5. Ability to use self-knowledge, and the ability to think about the client's experience to help formulate therapeutic responses.

Relationship awareness

6. Ability to understand and accept that each family is unique and will perceive the clinician and the intervention through the lens of their own experience.
7. Ability to create a feeling of reciprocity and comfort/friendliness with a family by allowing for normal everyday social interactions without losing a sense of purpose and safety about role and reason for involvement with the family.
8. Negative capability or the ability to tolerate strong affect and situations that are ambiguous realizing that these involve not knowing or not understanding behaviors and motivation.
9. Ability to recognize and think about experienced internal pressures that can “press” toward an emotional response and urges or wishes to act.

Internalized professional self

10. Ability to maintain professional boundaries in a variety of intervention/treatment settings such as home, child development center, or other community setting.
11. Ability to listen to the family and discover the things that are important to them about their child and themselves and then collaborate with the family on behalf of the child despite press of clinician's agenda.

12. Ability to set the frame for the work as focused on parent-child relationships in spite of multiple distractions.

OPERATIONALIZING USE OF SELF: REFLECTIVE PRACTICE IN ACTION AND ON ACTION

Putting the clinical processes described above into practice first requires the clinician to be able to reflect both in action and on action (Schön, 1983). Reflective practice involves using self-knowledge to reflect on affect, actions, and intentions, and to reflect on the process of formulating intervention strategies during moment-to-moment clinical decision making. *Reflection in action*, or the ongoing capacity to observe oneself and consider what is happening internally at any given moment, while simultaneously attending to what is happening between self and others, is the hallmark of interpersonal process and thus is important to many clinical disciplines. From a Piagetian point of view, one accommodates new information through reflection, creating new schemas that allow for an enlarged perspective. Schön (1983), in his work *The Reflective Practitioner, How Professionals Think in Action*, describes a professional's ability to experience surprise, puzzlement, or confusion in a situation that he finds uncertain or unique. Schön describes the ability to think in action as the capacity to reflect on the current situation and to recognize that prior understandings are implicit in our behavior. The following examples of reflection in action demonstrate the internal processes of infant mental health clinicians. In the first example, Jake is working with a new foster parent (Meg), who seems to be missing the cues of a recently placed 12-month-old (Billy). Jake's inner dialogue might be as follows:

"Boy is it frustrating to watch her ignore him when he is looking at that plate of crackers on the counter. She doesn't seem to notice what he wants. Maybe she would notice if he were more vocal in his signals, but Billy seems kind of frozen. I wonder what he went through when he was pulled from his last placement. I wonder if I should wait

to see what happens, or say something? I've heard she is a tough cookie and I don't want to get off on the wrong foot with her by saying the wrong thing. I wonder if she'll react to me differently because I'm a male? I guess I feel frozen too. I think I'll say something and see what happens." (Here Jake asks Meg some exploratory questions about how Billy is settling in to her home) Jake notices to himself, "These questions aren't going anywhere." Meg seems bored and these questions are not helping me to connect with her. Jake, noticing Meg's disengagement, asks her about his visit and how she feels he might be helpful to her and Billy. Meg replies, "I was a little surprised that you were a man, but I guess it would help if you could get some information for me about him. I don't have any real information about him." At this point Jake is able to extend questions to Meg that opens up a real dialogue that ends up being useful to both her and Billy.

Watching the mind of this trainee, we see he is observing and reflecting on the multiple perspectives of Meg, Billy, and himself. The trainee shows that he is willing to watch multiple screens of thought, behavior, and perception, have a quick internal dialogue about his own worries or perceptions, and make judgments about how to act or what to say. This kind of application of use of self broadens and enhances the intervention. In contrast, if Jake had simply applied his knowledge of development and acted on his frustration by directly instructing the foster mother, he would not have been taking into account the possibility of offending her, he would have missed an opportunity to assess the situation more fully, and he would not have taken into account the possible impact of gender difference.

Here is a second example of reflection in action in which a mental health clinician is working with a family whose baby is quite somber and withdrawn.

"This little guy is serious, but I think I see him beginning to get interested in me." At this point the clinician lowers her face for an impromptu game of peek-a-boo which elicits interest and delight from the infant. At this point a number of possibilities arise and the clinician thinks to herself. "This works, I wonder if I should ask the parents if he likes to play this with them, or if I should prompt them by asking them to take a turn. Maybe I should just keep it up or am I risking taking too

active a role and leaving the parents out?” Based on her knowledge of the family and the baby the clinician will make a decision of how to proceed having done a quick internal review of the possibilities.

It is hoped that this process of thinking in action, rather than just plowing ahead in the implementation of concrete knowledge, will allow an intervention to be more successful and to hold more meaning for the families and children involved. Being able to reflect in action is a complex and consciously acquired skill requiring simultaneous attention to self, other, and the joint interpersonal process. We suggest that training programs must provide opportunities for the development and enhancement of self-awareness and the ability to use this awareness in formulating specific interventions. Reflecting in action demands that the trainee be willing to develop the ability to consider several hypotheses simultaneously, that is, to watch multiple screens of thought, behavior, and perception, have a quick internal dialogue about his own worries or perceptions, and make judgments about how to act or what to do or say or what not to do or say.

In contrast to the *in vivo* nature of reflection in action, *reflection on action* is the opportunity to think *after the fact* during supervision, clinical case conferences, or in consultation about what has happened during a clinical encounter. This type of *reflecting on action* increases understanding so that future interventions are more effective. By reviewing material retrospectively, one can consider from a distance what happened including what conscious and unconscious thoughts might have influenced interventions, reactions, and behaviors.

Reflection on action allows for a 2-part process. The first part involves an internal process of reviewing what has happened through thinking, writing about what has happened, or, in some cases, reviewing video material. The second part is more interactive and relational, done with a supervisor or colleague, and helps sort out and explore the layers of meaning for the clinician, implications for interventions, and next sets of questions and behaviors to observe and explore. The devel-

opment of the use of self is embedded in processes with others such as supervision, clinical case conferences, and peer discussion that focus on thinking on actions that have already occurred and will continue to occur.

This type of *reflecting on action* increases understanding so that future interventions are more nuanced and effective. By reviewing material retrospectively with a reflective partner or partners, one can consider from a distance what happened including what conscious and unconscious thoughts might have influenced interventions, reactions, and behaviors. The term *parallel process* is used to describe the effect of a relationship upon other relationships. In supervision and consultation relationships, parallel process is also evident when one person is highly aware of himself or herself and able to use their presence in the relationship in a way that is intended to impact and strengthen the capacity for reflection of those with whom they are working. In teaching use of self and reflective practice in this process-oriented manner, the supervisor provides the trainee with opportunities for internalizing an active awareness of the dynamic interplay in relationships in clinical work. The sections below on key skills will use examples from supervision that capitalize on this notion of parallel process to teach clinical skills and understand key processes involved in use of self.

OPERATIONALIZING USE OF SELF: SKILLS DEVELOPMENT IN CLINICAL PROCESS

The “use of self” competencies as elaborated above (reflective practice, translation of reflection into action, relationship awareness, negative capability, and internalized professional sense) draw upon a specific set of key skills that help further define the nature of the clinical and interpersonal process when working with families. In our experience, the articulation and exploration of this skill set with trainees in the infant family field enhances their capacity for reflective practice. These skills are discussed below and elaborated with examples.

Perspective taking

Perspective taking is the capacity to see the point of view of another, for example, baby, child, spouse, or family member, including the ability to notice the context and, to fully explore a behavior or response of one's self or another from these potentially differing outlooks. Perspective taking is particularly relevant when things such as child-rearing practices, styles of behavior, and talking emanate from different sociocultural and economic milieus. Although perspective taking implies being able to understand a practice or behavior, it does not necessarily imply approval. Being able to understand without condoning a practice, especially when something may be dangerous for a child, is of key importance. It is only after the perspective of another is understood, including both their objective circumstances and subjective reality that the clinician can begin to introduce ideas and alternatives that may broaden or alter the client's viewpoint. In training clinicians to work in infant mental health and early intervention settings, supervisors and instructors can themselves use perspective taking to help build this capacity in trainees. The following dialogue between a supervisor and a trainee about a case that involves a woman's undocumented struggles with domestic violence illustrates the supervisor's work to help the trainee gain broader perspectives.

Supervisor: Do you have any idea why Adelina missed your session?

Trainee: I am not sure, I feel bad, she sure needs some help with the situation with Sergio. When I saw her last she told me she was still afraid of him, and that she wants to leave.

Supervisor: I wonder what it would be like for her to leave.

Trainee: She would get a lot of help in the shelter.

Supervisor: That's so, but what would it be like for her.

Trainee: Odd, I guess, I wonder if what I presented sounded too good to be true, I

don't think they have these kind of services in Guatemala.

Trainee: I think she should be thinking about her kids right now.

Supervisor: I bet she is, but has she talked about what her family would say if she did this? We don't know much about her family of origin and what they expect of her.

Trainee: I haven't asked her that, but you think they would want her to be safe.

Supervisor: Yes, I imagine so, but I do wonder how Adelina sees this or what is keeping her. It might be worth exploring with her.

The trainee's curiosity was prompted by this discussion. Her supervisor had inquired extensively about the trainee's perspective about domestic violence and worries about these children. She had, as illustrated, also raised significant questions about missing pieces of information or understanding that could be missing from the sessions to date. In subsequent conversations with Adelina, the trainee discovered that Adelina was reluctant to leave her husband because he regularly sent money back to both of their families in a small town in Guatemala. By more fully understanding the emotional and economic realities and the core conflicts underlying Adelina's reluctance to leave an abusive husband, the trainee developed more empathy for Adelina's position and eventually was able to help the family navigate these troubled waters in a way that decreased the danger to Adelina and her children.

Learning to use background and foreground

Visualizing thought "in action" as occurring in either the foreground or the background of the mind is another helpful skill for trainees to develop as they work with clients. For example, in the background of a clinician's mind may be areas of curiosity and a developing set of questions that are being formulated, but are not ready to be asked. Some of these questions may be answered wordlessly as the clinician observes, listens, and begins to know the family and the situation.

Other questions may be moved to the foreground and asked at opportune moments when the parent has gained more comfort and trust with the clinician, or when an immediate crisis has passed. Some areas of curiosity or concern may prove to be unimportant while some may be issues such as fear of missing important cues, beliefs about the situation, and projections of personal beliefs or worries onto the client or the parent-child relationship that arise from the clinician. In the foreground, the clinician must remain attentive to both behavior and material that is presented, and must not let the background questions intrude on the ability to listen, empathize, and remain affectively attuned to present issues. It is helpful for clinicians to realize that clients also often have a set of background questions and concerns such as “Is this person to be trusted,” “If I say this will I seem a fool,” or “I wonder how long this will take.”

Recognizing, identifying, and learning to live with a “press”

A “press” refers to a kind of affective internal pressure that a person experiences in certain types of situations that can create an emotional response and a strong urge to act. An illustrative example of a universally felt “press” is what it feels like to be in the room with a crying infant. The child’s behavior functions to “press” the adult into an action (eg, to pick the child up). A press can be felt as a strong desire to have a parent see things our way or a desire for a child to be treated in a way that lines up with the clinician’s beliefs, cultural values, or even personal wishes. In clinical work with infants and young children, one is continually confronted with a variety of internal presses to do, act, and feel certain ways. At times these come from protective urges directed toward a child, particularly when the parent may not be doing what seems to be in the child’s interest. Other times a press is a by-product of training in a particular discipline (eg, children who are not talking should have speech therapy), a strongly held cultural belief (eg, children

must obey their parents), or a moral imperative that something should not happen (eg, a parent should not ignore a child’s distress). When the press is detected, discussed, and possibly understood, it can provide a key that can help unlock a child’s or parent’s experience. The press can also be useful in helping trainees clarify their own values, or explore differences in beliefs and expectations that they may have for a family with whom they are working. Unrecognized and unexamined, a press can be a dangerous pressure that can lead to clinical missteps and may prevent trainees from paying attention to the interactions occurring in front of them. Recognition of a press without exploration of implications of possible action can lead to interventions that are inappropriate or uninformed by parental interest, need, and readiness. This selection from a supervision transcript illustrates the supervisor’s attempts to help her trainee uncover an undiscovered press that is impacting on her work.

Supervisor: Tell me a little about what happened on the visit.

Trainee: Well, Angie was crying and Dad just ignored her for at least 10 minutes. I was dying, I had to fight myself not to pick her up.

Supervisor: How did you manage that?

Trainee: I knew if I picked her up, this would seem like taking over. So I asked a few questions about the crying.

Supervisor: How did those go?

Trainee: I think I was awkward. I asked him what he usually did when she cried like this, was my being here making it any different. He said no, and then I really wanted to tell him to just pick her up or I will.

Supervisor: What were you thinking when you heard her cry so long?

Trainee: Well, I was thinking about her, and I was thinking he must be so insensitive but it also made me remember my own child at that age and the agony I would go through when I was trying to get her to sleep through the night.

Supervisor: I wonder what dad would say if you asked him what it was like to listen to her cry.

In this case the trainee was aware of the press and how difficult it was to contain in the moment. She was able to use supervision to reflect on action and discuss the details of the session. The supervisors' recognition of the trainee's internal state around the child's crying, and her support of exploring this in more depth, is useful in helping her become even more able to consider possible interventions by using her own experience as a template.

Learning to inhibit actions

Learning to inhibit one's actions in the moment includes the ability to reflect, consult, and collaborate before responding with an intervention. Taking something someone says too literally without ample exploration can lead to premature and erroneous judgment about motivation or capacities. Trainees in infant-family practice often must work with supervisors to become wary of reflexive or unthinking responses to situations or comments made by parents (Heffron, 1999). Slowing down and valuing the process of listening, inquiring about details, and observing without completing a plan, making a judgment, or springing full bore into action about a resource need is important. Learning not to act is related to the concepts of negative capability (see French, 2000) and the press, but equally often pressure to act can come externally from the client, from other organizations, or from colleagues. Helping a client explore implications of actions or choices, for example, by making statements from the perspective of the baby or young child can be helpful. We have come to use the term *hydroplaning* to describe rapid action without reflection whether caused by an internal press or pressure from the outside. The image of a sleek speedboat zipping over the surface of the water helps clinicians understand the need to slow down, understand, reflect, and promote parental reflection when possi-

ble. This example is drawn from a transcript of a supervision session.

Supervisee: I felt so scared about the parents' statements about wanting to leave the child so she could join her boyfriend that I found told her very directly how this would hurt the baby.

Supervisor: There was something in her statement that seems to have scared you. What did you say after you stated that leaving would hurt the baby?

Supervisee: I just went on about that and how he would remember it forever. I realize that I was so very anxious.

Supervisor: How did the parent react?

Supervisee: She looked kind of stunned, I know this was the wrong thing to say.

Supervisor: What would help you slow down when you feel anxious the next time?

Supervisee: I think if I could remember to be at least as curious as I am anxious, then I could remember not to fast forward to a conclusion.

Holding the tension

Holding the tension is the ability to tolerate and hold conflicting ideas, notions, anxieties, or presses felt by a client and work consciously to help the client think about these without pushing for a particular outcome. Holding the tension is a form of press but the important distinction is that the clinician who holds the tension is able to inhibit action, is aware of, and can tolerate, the multiple pressures, and can maintain this state of suspended action while seeking understanding. Supervisors often hold the tension of their trainees that, in turn, helps these trainees tolerate the extraordinary urges that they often feel.

Trainee: Edna is supposed to take the baby in for his ophthalmology follow-up, but she keeps canceling the appointment. I feel very annoyed with her. This baby could just go blind.

Supervisor: Have you asked her about this?

Trainee: She has a different excuse every time.

Supervisor: I wonder what she is struggling with?

Trainee: I don't know, but as I think about it she was horrified the first time she went. I know she wants the best for the baby, but the exam is a difficult procedure.

Supervisor: I wonder if this is the strain she is feeling, I want the best for my baby, but in order to get it I have to do something that seems to hurt him.

Trainee: I haven't talked about that, I wonder how I could bring it up.

Supervisor: What would it be like to do that?

Trainee: I guess I could ask her.

Supervisor: What might make this hard?

Trainee: Just wanting to get it done, but knowing I may need to let her talk it through even though it seems like it shouldn't be necessary.

Reframing a parent's interpretation/representation of the child

Reframing means offering a different view or idea of a child's actions or exploring a parent's attributions about the child to suggest a more positive or developmentally appropriate meaning. This often involves wondering about the origins of the meanings attributed—Is it a projection with origins in the parents' past? Is it a lack of understanding about a developmental phase or a particular situation? Is it a cultural belief? Is it a deeply held representation shaped over time? Here is an example of a supervisor using reframing in a supervision session. The trainee is working as a mental health consultant in an Early Head Start setting and has been struggling with how to respond to a parent who is worried about her child becoming spoiled in the group program.

Trainee: The mom just doesn't get that she is so lucky to have Cahill in a classroom where the teachers are so attentive.

Supervisor: I can see how this would be frustrating for you since he is in such a wonderful classroom, but could it be that mom is worrying that will demand the same level of responsiveness from her?

Trainee: I am not sure.

Supervisor: I wonder what we could do to explore this with her in a way that wouldn't be threatening?

Use of somatic observations as an avenue to discussion of countertransference

Using one's self in clinical encounters includes developing an awareness of one's own physiological responses, changes in mood, and as well an ability to observe these changes in others and learn to inquire about them as appropriate. These changes in physiological states, awareness, and responses are often a way into the world of complex responses that help inform clinical work. For example, a trainee commented to her supervisor that she always seemed to want an ice cream after a session with a particularly depressed mother whose child was part of an early intervention program. She had casually mentioned that she had gotten some ice cream after one session that had made her late for another appointment. The supervisor asked her to describe the sensations she had after the sessions and with some prompting the trainee was telling her about the discomfort she experienced relating to the children in the home who seemed to be hungry for attention. Unaware that she had used the term *hungry*, the supervisor paused and restated the word as a question, "hungry?" and waited. The trainee said to her somewhat defensively, I don't mean they are hungry, she feeds them and they look healthy, but guess I can't stand them being hungry in that other way and so I feed myself. As they continued to talk, the trainee stated her distress in bringing up the children's "hunger" to a mother who herself seemed hungry for her attention. Together they worked to find a way to acknowledge the hunger of all parties in a way that would not make the mother feel criticized.

Use of gentle inquiry in promoting use of self

Gentle inquiry is a style of asking questions in a manner that helps the trainee or learner

carefully examine his or her own thinking and actions with a minimum of defensive reaction. The objective of gentle inquiry is to explore the trainee's thinking about a situation or concern to work toward an understanding of multiple possible views, multiple possible meanings, and useful questions. For the inquiry to be truly gentle and to promote a process of mutual discovery, rather than to be a pedagogical act, the supervisor must be careful to remain open to the dialogue, must not be too certain about the desirability of any given answer, and must remain open to the material that the trainee comes up with in their response. When the supervisee responds, the supervisor must truly remain open to what is said and be cautious about beginning internal formulations before understanding the remarks. Gentle inquiry becomes a way to guide a learner into looking at responses that may provoke hesitation because of lack of knowledge about what was "right to do," shame, fear, or concern about a deeply held cultural belief. Gentle inquiry involves finding questions that are at the right level, and then continuing with the line of thought and inquiry at a pace that can be tolerated and does not overwhelm particularly if the questioning stirs up feelings or past memories. Below is an example of an exchange between a trainee and a supervisor that illustrates a sequence of questions using gentle inquiry.

Supervisor: As I listen to you telling me about Anna's difficulties getting the baby to sleep, I'm wondering if you have worked before with somebody asking for this kind of help?

Brenda: No, but I have struggled through this with my own children.

Supervisor: (Noting the word *struggle*, but deciding not to highlight it) Do you think that is affecting the way you are working with Anna about these issues?

Brenda: (Carefully and with some sarcasm) I'm not sure really, but I find myself feeling a little annoyed with her. She really has no tolerance for crying so she just may be forced to be sleep deprived for years.

Supervisor: Do you have any idea why it is so hard for her to tolerate the crying?

Brenda: I have some ideas, but I haven't asked her.

Supervisor: I wonder what it would be like to have that conversation with her?

Brenda: Well, I realize I am a little reluctant I guess.

Supervisor: What are your ideas about why it might be hard for you to bring it up?

Brenda: I think she might be getting different advice from different people.

Supervisor: If you are right, I wonder what that would be like for her?

Brenda: Well, I keep thinking about myself. I had my husband and my older sister who kept telling me over and over what to do.

Supervisor: Could it be that you are worried about re-creating that feeling of too much advice for Anna?

Brenda: That might be it; I want to bring it up in more detail, but I don't want to be a pest.

In this incident the supervisor, through gentle inquiry, helps Brenda discover how her own memories of early motherhood are stopping her from becoming more active with a parent who is actively seeking help. In this example, Brenda increases her self-knowledge through rediscovery of memories that are setting up a sense of hesitancy in her intervention with Anna and her family. She is helped to notice her reluctance, to consider the meaning of it, and to practice finding her voice so that she can take advantage of the next opportunity for effective intervention.

Deploying feelings to highlight concerns

Deploying feelings involves the ability over time to become aware of one's own feelings and when it seems appropriate to use them effectively to influence an intervention. In the supervision vignette below, the supervisor deploys her own feelings while helping the trainee plan to do so with a client.

Supervisor: I am not quite sure about what I am going to say, but I have been

somewhat worried about this father's difficulties to plan for what this baby needs.

Trainee: Do you think I have been missing something?

Supervisor: I don't know, but I get the feeling Dad is still so depressed he finds it hard to carry on.

Trainee: I have been doing all I can.

Supervisor: I know you have been working hard, but I wonder if it might be time to talk again about the possibility of medication for this dad?

As this discussion went on, the trainee felt more comfortable about acknowledging her worry as well as some annoyance with the father. When this was examined, she decided to explore the Dad's depression again taking focus off the tasks she had been attempting to achieve that were related to the household and the baby's welfare. In doing this, she chose an approach similar to the one the supervisor had used. She became tentative, voiced her own uncertain wondering about the situation, and then raised the possibility of talking about the Dad's day-to-day feelings of sadness.

PHASES IN LEARNING THE USE OF SELF AND REFLECTIVE PROCESS

Development of use of self often begins with a first phase characterized by some confusion about the concepts and skills, and a heightened and somewhat uncomfortable self-consciousness about interventions used in clinical encounters. The second phase begins an awareness of moments where use of self or reflective process skills might be used, but often is accompanied by an inability to translate the feelings or thoughts into interventions. A third phase is a preoccupation and struggle with finding words to express feelings or at times moments of self-discovery prompted by supervisory or consultation questions. This phase often includes copious note taking during supervision sessions, and considerable worry about the lens of one's own experience intruding into the

clinical process. With practice, trainees become more aware of feelings and more comfortable with them, but often struggle with what to bring up with clients and, if so, how to say it. With time and continued exploration, trainees move toward a fourth phase that involves more active awareness of use of self, a deepening of their own awareness and awareness of others, and more ease in using this awareness to remain attuned to the parent while constructing meaningful interventions. The phases we have outlined are not linear. As clinicians move through and back and forth in these phases, they gain more confidence, more awareness, a set of skills that will be helpful for them throughout a clinical career, and a clinical voice that is authentic and their own.

Concepts that confuse

In our experience training and supervising in the multidisciplinary world of infant and family practice, we have identified a number of concepts related to the use of self that frequently confound new practitioners, and can affect their work. Creating opportunities to identify, name, and discuss these concepts with others promotes better understanding of process-oriented work, use of self, and reflective practice. Here are several examples of such potentially confusing concepts drawn.

The stranglehold of neutrality

Trainees have often learned in prior educational and training settings that professionalism involves neutrality. While this is true, trainees often become confused and believe that part of their task in training is to eliminate their own biases, blind spots, strong feelings, and internal pressures. Hearing from a trusted supervisor that these phenomena are normal and expected and that the task is not to eliminate these feelings and beliefs, but rather to get to know and understand them in one's self can create relief and a willingness to explore these issues more deeply and without shame and guilt. Exploration of, and comfort with, one's own internal workings leads to a greater clinical acumen as well as self-knowledge that

can be accessed in an arena of difficulty for the clinician.

Boundaries, scope of practice, and limits

All clinical training involves knowledge of professional roles and limits. These professional boundaries are often mutually understood by the client and clinician and reinforced by the “frame” in which the clinical session occurs—the clinic that is attended, the therapy room, the routines and procedures that accompany the visit. However, most infant-family practice settings require at least some in-home or community-based work, where the “frame” of the office is left behind and the professional clinical framework must be held and created by the clinician in the more personal setting of the client’s home. If this clinical frame is rigid and applied in a uniform way to all out-of-office situations, the clinician may have a hard time navigating unexpected situations that require bending to meet social practices and expectations of different cultures and crisis situations. Some simple examples of these boundary issues might include what to do when offered food on home visits or whether or not to take shoes off in a household where this appears to be the norm. More complicated situations can occur, as when an unknown adult suddenly appears in the middle of a session and the clinician becomes confused about whether to stop in order to protect the family’s confidentiality, or to ask if the family wants to have this person present while the family talks about a difficult concern. Home-based and community work also raise boundary concerns related to scope of practice. For example, as a therapist, what do you do when the parent asks you a health question? For clinicians providing preventive intervention services, how do you handle a severely depressed parent who is not willing to accept your referral to a mental health clinician? Through supervision dialogues, trainees can be encouraged to engage in “use of self” processes to reflect on complex boundary issues and develop more skill in responding to

situations in which there is not always a clear and ready answer.

The notion of interpretation (building insight) versus attunement (being with)

The amount of knowledge about what will help children learn and grow has led to the idea that the role of infant-family practitioner is to educate and enlighten families. Current emphasis on school readiness and program accountability have accentuated the impulse to educate and enlighten. This approach is tempting; because it builds on cognitive-behavioral modalities that stress helping others reach insights through a logical and thoughtful process that help clarify thinking step by step. Some clinicians may be drawn to interventions that involve analyzing what clients have said and delivering interpretations that will create insight in the parent about what is best for a child. Both of these approaches can be helpful, but should not overshadow the importance of attunement to a family’s needs through careful listening, respectful responses, and thorough attention to development of understanding about a family’s ways of being and hopes for their baby, themselves, and their family. This focus on attunement and understanding rather than on changing the family is more likely to result in positive outcomes such as increases in parents’ reflective capacities and their ability to work with and trust others just as parents who are attuned are more likely to have children who are responsive and reflective.

“Supportive” approaches

The notion of support is crucial to the work of infant-family practitioners but this concept is often misconstrued to mean a kind of unconditional positive regard for a parent enacted as unmitigated niceness. Too often, “supportive” is distorted to mean not providing important information, feedback, or dialogue, because it would be unkind to bring up a topic that could potentially anger the client, cause discomfort, violate cultural norms of either the client or the clinician, or simply name a situation that is unchangeable, such

as a child's diagnosis. The role of the infant mental health clinician, early interventionist, or other intervener is to develop a trusting relationship that allows for a dialogue with parents about their needs and their goals. In the course of this dialogue, the clinician should question, explore, and expand thinking by bringing in new information, their own responses or reflected-upon ideas, and, together with parents, construct a collaborative approach toward identifying needs and goals, and worrisome areas that are affecting a child or family. Supervisors should be vigilant about the trainee's distortion of supportive approaches and evidence of unmitigated niceness, desire to please clients, fear of client responses, or worry about communicating in an open way. Demonstration of the supervisors' ability to raise difficult subjects, explore their own worries of offending the trainee, and their caring and connected explorations will provide a model of strong supportive communication that can help trainees overcome tendencies toward support without substance or unconditional positive regard as a defense against strong affect, potential conflict, or discomfort.

Strength-based work

Strength-based work in infant-family practice settings has been a welcome contrast to some earlier approaches that stressed assessment of problems. Undoubtedly it is very powerful to recognize parental strengths and point them out as a way of building a parent's sense of competence and confidence. However, there have been some misinterpretations of strength-based work. Strength-based work does not mean countering a parent's own statement of concerns or problems with a recital of their strengths or encouragement to look on the bright side of things. When parents talk about their worries, an approach that includes sensitive listening, exploration of these issues, toleration of strong affect, and an ability to hold the tension as parents move through times of frustration and worry are critical.

Cultural sensitivity and competency

These important topics are beyond the scope of this article and yet very closely linked to the development of use of self. As supervisors work with trainees, it is important to introduce expanded notions of cultural sensitivity and competence that include awareness of one's own cultural values and beliefs, socioeconomic situation, adaptation, acculturation, and sameness or difference from family of origin. Lieberman (1990) elaborated on the idea that each family is a culture of one and that curiosity and exploration are at the heart of cultural sensitivity. In addition to self-awareness and the willingness to explore cultural issues with families, clinicians need to recognize that cultural matching does not imply sameness, and must realize that vast differences exist within racial, cultural, and socioeconomic groups. In the same way, while learning about cultures is always helpful, such knowledge cannot substitute for appreciation of this family's experience of the complexity associated with migration, adaptation, regional differences, personal and family history, and intermarriage. Clinicians often need help learning to observe, ask questions, tolerate different child-rearing values, and finding effective ways to intervene in settings where values, practices, and understanding may be different. Because of understandable tensions and deeply held feelings that are often present when discussion of race, culture, and socioeconomic difference are undertaken, it is essential that "use of self" skills are used in supervision and consultation in training settings to address sociocultural topics so that trainees emerge more prepared to handle the inevitable situations that will encounter in a thoughtful manner.

SUMMARY

Our goal in writing this article has been to elaborate and operationalize the "use of self" construct so that it can be understood and applied broadly in the infant and family

field. A set of descriptors is introduced that facilitate critical analysis of its components and descriptions of related clinical skills. Undoubtedly, there are additional skills and cautions that could be added that would fit into this conceptualization. We feel that mastering the skills inherent in the descriptors of use of self is a basic step in the development of an authentic voice as a clinician. We have used examples from supervision and consultation dialogues, as we believe that trainees master use of self and related skills through their own experience of these clinical processes. We realize that learning use of self is a highly individualized process. Clinicians have vastly different experiences, personal inclinations, and prior training that make individu-

alization necessary within overall training, supervisory, and consultation settings. Yet, our experience has shown that a carefully structured discussion about the elements of use of self coupled with consistent application of the process in all elements of the training program helps trainees progress in areas that may be unfamiliar or difficult for them. By developing multiple opportunities for individuals to reflect on action in training and service programs, we can build the capacity to deploy the construct of use of self and assist clinicians to more fully develop the capacity to reflect in action in the day-to-day world of families and children. We feel that this capacity is essential for the development of an authentic voice as a clinician.

REFERENCES

- Bertacchi, J., & Coplon, J. (1992). The professional use of self in prevention. In E. Fenichel (Ed.), *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A sourcebook* (pp. 84-90). Washington, DC: Zero to Three.
- Bion, W. R. (1978). *Four discussions with W. R. Bion*. Strath Tay, Perthshire: Clunie.
- Eggbeer, L., Fenichel, E., Pawl, J. H., Shanok, R. S., & Williamson, D. E. (1994, October). Training the trainers: Innovative strategies for teaching relationship concepts and skills to infant/family professionals. *Infants and Young Children*, 7(2), 53-61.
- Fenichel, E. S. (Ed.). (1992). *Learning through supervision and mentorship to support the development of infants, toddlers and their families: A sourcebook*. Washington, DC: Zero to Three.
- French, R. (2000). Negative capability, dispersal and the containment of emotion. *Bristol Business School Teaching and Research Review*, (3). Retrieved November 1, 2003, from <http://www.u.w.e.ac.uk/ebs/trr/ls3-covt.html>
- Furman, E. (2002, June). On the concepts transference and countertransference and their use in child analysis. *Child Analysis: Clinical, Theoretical and Applied*, 13, 113-188.
- Gilkerson, L., & Shahmoon-Shanok, R. (2000). Relationships for growth: Cultivating reflective practice in infant, toddler, and preschool programs. In J. D. Osofsky & H. E. Fitzgerald (Eds.), *WAIMH handbook of infant mental health: Vol. 2. Early intervention, evaluation, and assessment* (pp. 3-32). New York: John Wiley.
- Heffron, M. C. (1999, August/September). Balance in jeopardy. Reflexive reactions vs. reflective responses in infant family practice. *Zero to Three*, 14, 15-17.
- Heffron, M. C. (2002). *Developing competencies in infant and early childhood mental health*. Oakland, CA: Children's Hospital and Research Center.
- Lieberman, A. (1990, April). Culturally sensitive intervention with children and families. *Child and Adolescent Social Work*, 7(2), 101-170.
- Norman-Murch, T. (1996). Reflective supervision as a vehicle for individual and organizational development. *Zero to Three*, 14, 16-20.
- Orange, D. (1997). Countertransference, empathy and the hermeneutic circle. In R. D. Stolorow, G. Atwood, & B. Brandchaft. (Eds.), *The intersubjective perspective* (pp. 177-186). Northvale, NJ: J. Aronson.
- Sandler, J. (1976). Countertransference and role responsiveness. *International Review of Psycho-Analysis*, 3, 34-47.
- Schön, D. (1983). *The reflective practitioner: How professionals think in action*. London: Temple Smith.
- Seligman, S. (1999). Integrating Kleinian theory and intersubjective infant research observing projective identification. *Psychoanalytic Dialogues*, 9(2), 129-159.
- Shamoon-Shanok, R., Gilkerson, L., Eggbeer, L., & Fenichel, E. (1995). *Reflective supervision: A relationship for learning, a discussion guide*. Washington, DC: Zero to Three.
- Winnicott, D. W. (1949). Hate in the countertransference. *International Journal of Psychoanalysis*, 3, 69-74.
- Winnicott, D. W. (1971). *Playing and reality*. London: Tavistock.