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MIRRORING AND IDEALIZING IN PSYCHOTHERAPY WITH SCHIZOPHRENIC PATIENTS

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ABSTRACT

MIRRORING AND IDEALIZING IN PSYCHOTHERAPY
WITH SCHIZOPHRENIC PATIENTS

By

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Mirroring and idealizing are continuous developmental processes that strengthen the self. In psychotherapy, the therapist is experienced as a potentially mirroring selfobject, and the patient idealizes the therapist (Kohut, 1971). Data from the Michigan State Project were used to assess these processes in psychotherapy. The hypotheses were that patient change was correlated with therapist mirroring, acceptance of the patient's idealizing statements, and insight into these needs.

Sixteen predominantly urban, Black, schizophrenic patients were given psychotherapy with and without medication over 20 months. Six graduate student therapists were supervised by 2 experienced therapists. For this study, raters were trained to identify the Kohutian constructs and rated each of the 16 patient's therapy, using one full audio-taped therapy session.

The results, from a multiple regression analysis, did not support the hypothesis: confirming (part of mirroring) was found to be negatively, significantly related to 20 month change ($p < .05$). Therapist's acknowledgement of the need to idealize tended towards significance ($p < .09$).

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Gratitude is extended to Dr. Bertram Karon for his generosity, insight, and support. I would like to thank Dr. John Hurley for his availability and foresight, and Dr. Gil DeRath for his suggestions and help. Thank you to my family for their encouragement. This is for Bennet Wolper.

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INTRODUCTION

Kohut (1971, 1977) developed a theory of how the self experienced a significant other as a selfobject -- a part of the self. The selfobject is used as a mirroring, empathic source, as a figure to idealize, and as a twin figure with which to form an identification. These three psychological functions, when they occur in the psychotherapy situation, are named the mirroring selfobject transference, the idealizing selfobject transference, and the twinship selfobject transference. The Kohutian model assumes that the therapist contains the patient's relational needs for mirroring, idealizing, and twinship.

The concept of mirroring began with Lacan (1936), who posited a "mirror-stage" in the first year of life, where the child recognized his/herself in the mirror. The mirror-looking was believed to supply a pleasing sense of identity and integration of body parts with the whole mirror image. Winnicott (1971) felt that the child's first mirror was the mother's eyes. The baby, when held and fed, saw his/her emotional state reflected in the mother's gaze (e.g., when a mother looks concerned when she sees that the baby is distressed or smiles back at a happy baby). A disturbed mother would fail to mirror the child, leaving the child feeling disapproved of or unrecognized. Roger's (1957) notion of accurate empathy is related to the mirroring concept in that both convey a sense of being understood. Roger's accurate empathy dimension accrued

considerable support in psychotherapy research (Bergin & Strupp, 1972; Rogers et al., 1967). Kohut expanded the concept of empathy to be specifying the subject of what was being mirrored. A parent might mirror only one aspect of a child's personality, resulting in overstimulation of one part of the child and understimulation of others (as exemplified by the empty-headed beauty or the awkward intellectual). Furthermore, Kohut believed that the empathy should extend to the child's "healthy narcissism." Kohut's idealizing concept sprang from the Freudian concept of the ego-ideal. The child needs a strong adult to identify with so that he/she feels protected. Kohut believed that a healthy parent idealizes the child which promotes a strong self; and the child, optimally, idealizes the adult, which helps the child to feel secure and whole.

Kohut's concepts have been elaborated with theory and case histories, but scientific investigations are needed to clarify their psychotherapeutic efficacy (Schwaber, 1981). The exploration of specific therapeutic interventions and their impact on psychological change seem to yield the most fruitful results in therapy research (Bergin & Strupp, 1972). Freud's notion of transference has a history of being considered as intrapsychic and then as interpersonal, and, presently, as intersubjective (Atwood & Stolorow, 1984). The intersubjective view of transference recognized that both the therapist and the patient relate to one another out of their own subjective experiences of the relationship despite the therapist's attempts at objectivity. Kohut's selfobject transference dimensions mapped the patient's mirroring and idealizing needs with the therapist's acceptance, rejection, or unawareness of those

needs. This study aimed to measure mirroring and idealizing processes in psychotherapy and to use them as predictors of patient change. Patient change was operationalized by independently performed ratings of Clinical Status Interviews (CSI) wherein a therapist, not connected with the researchers, conducted an interview to assess the patient's mental health at intervals throughout the 20-month treatment.

The hypotheses were:

I. Therapist's active mirroring (confirming, accepting, approving, and admiring will positively correlate with patient change from six and 20-month ratings.

II. Therapist's acknowledgement of the patient's mirroring need will positively correlate with patient change, from six and 20-month ratings.

III. Therapist's presentation of an idealized figure (power, calmness, and confidence) will positively correlate with patient change, from six and 20-month ratings.

IV. Therapist's acceptance of the patient's idealizing need will positively correlate with patient change, from six and 20-month ratings.

This investigation of mirroring and idealizing used psychotherapy sessions between psychoanalytically trained therapists and schizophrenic patients. Although Kohut intended his theory for narcissistic and other neurotically disordered patients, Stolorow and Lachman (1985) stated that Kohut's theory should apply to psychotic individuals. Raters were trained to understand and identify the constructs of mirroring and idealizing. After the training period (described in detail in the method

section), raters were given audio-taped psychotherapy sessions (one for each patient) in random groups of four until each of the three raters had scored all 16 tapes.

METHOD

The data of study were obtained courtesy of Professor Bertram Karon and the Michigan State Project (Karon & Vandenbos, 1981), which was conducted at the Detroit Psychiatric Institute during 1967 and 1968. The Michigan State Project's (MSP's) purpose was to assess the efficacy of psychotherapy without medication and with medication for schizophrenic patients, as compared to a hospital control group of routine care with medication. This study used 17 audio-taped psychotherapy sessions which were all of the psychotherapy data that remained intact from the project's total data that had originally included 24 psychotherapy patients. The sessions were first selected with the criteria that they not be the first or last two sessions, and that there were at least ten minutes of patient's speech; from this group, one tape was randomly selected to represent that patient's therapy. Of the ten participating therapists, two were experienced psychotherapists (over ten years of clinical experience with schizophrenics), and the eight others were either graduate students in clinical psychology graduate school or physicians doing their psychiatric residencies. Of the 16 patients, eight received psychotherapy with adjunctive psychotropic medication (Thorazine) and eight received psychotherapy with no medication.

Subjects

All MSP subjects were selected to fit the following criteria upon admission to the hospital: (a) diagnosis of schizophrenia; (b) onset of psychotic symptoms within 3 months prior to admission; (c) first admission to a mental hospital; (d) no history of electric shock therapy or insulin shock treatment, (e) no diagnosed organic brain damage, and (f) no history of substance abuse. A team, independent of the project, evaluated and randomly assigned patients to the three groups: psychoanalytic psychotherapy supervised by Dr. Karon, psychoanalytic psychotherapy with adjunctive medication supervised by Dr. Tierney (a Board certified psychiatrist with over ten years of treatment with schizophrenics) and a hospital comparison group of routine care with medication. The original MSP sample of 36 patients was reduced to 33 because of one patient's death, an additional patient diagnosed as brain damaged, and the last because of staff interference with treatment. Of the 17 patients in the two psychotherapy groups, one patient was excluded from this study because of staff interference towards the end of the 20 month treatment program. The 16 remaining patients were primarily poor, urban Blacks as illustrated in Table 1.

Table 1

Patients' Characteristics

SEX	Males = 7	Females = 9	
RACE	Blacks = 11	Whites = 5	
RELIGION	Catholics - 3	Protestants = 9	Agnostics = 4
EDUCATION	Grade K-6 = 1	Grade 7-9 = 2	Grade 10-11 = 8
	Grade 12 = 4	College = 1	
MEAN IQ = 80			

Therapists

The 10 therapists consisted of 7 males and 3 females. All were White; eight of the therapists were from the United States, one was from the Phillipines, and one was from Iran. Half of the therapists used an active psychoanalytic approach without medication, and half used a supportive, ego-analytic psychotherapy with medication.

Treatment

The patients averaged 70 psychotherapy sessions during their 20 month treatment program. Most of these therapy sessions took place within the first six months. The patients initially received therapy either three or five times a week; when they became outpatients the therapy sessions were reduced to approximately once per week. The sample of sessions used in this study consisted of one full audio-taped psychotherapy session selected randomly from the group of available sessions (as described above). The use of one taped session to represent

each patient's therapy is problematic because the session selected could misrepresent the total therapy experience. The author thought that the raters would make a more meaningful decision about the therapy dynamics based on one full session rather than fragments of many sessions, despite the representation problem. It seemed that a therapy session can be read as a meaningful story and that it would have been misleading to fragment the session at random points.

Outcome Measures of Treatment

MSP utilized several outcome measures to identify patient change. All patients were assessed on four occasions: at the onset of treatment, at 6 months, at 12 months, and at 20 months. The assessments consisted of the Thorndike-Galllup Vocabulary test, the Porteus Mazes, the Wechsler Adult Intelligence Scale, the Feldman-Drasgow Visual-Verbal Test, the Rorschach projective test, the Thematic Apperceptive Test, and Clinical Status Interviews. The CSI was chosen as the measure for patient change for several reasons. Most importantly, the CSI was selected because of its construct validity. A clinician's interview of a patient intended to assess their mental health seemed more related to meaningful change than did the intelligence tests or the projective tests which were designed to bring forth aspects of intellectual functioning and personality. The CSI also yielded the highest validity coefficients with regard to patients staying out of the hospital. The patient's ability to stay out of the mental hospital represented a practical index of mental health. Patient's ability to stay out of the hospital after psychotherapy treatment was also used as the criterion for health by Rogers in his psychotherapy study of 1957. The average correlation of the CSI to the

other assessments was .50. The CSI was a clinical interview given by an experienced psychiatrist who was not a member of the ward staff. The dimensions were: ability to take care of self, work performance, sexual adjustment, and social relationships; absence of delusions, hallucinations; gross distortion of reality; degree of freedom from anxiety and depression; amount and range of affect, life satisfaction, achievement of capabilities, and benign rather than destructive effect on others. The inter-judge reliability for the final quantification of the CSI was .79. Patient change, for this study, was measured by the six month ratings of the CSI and the 20 month ratings of the CSI, so that each patient had two outcome scores.

Operational Definition of Mirroring

The mirroring construct was approached in two ways: an active therapist attribute (confirming, accepting, approving, and admiring); and as a need (the need to be mirrored) of the patient for the therapist to acknowledge. There is some conflict in Kohut's work as to how to employ the mirroring function; as an active technique or as an area of need to be interpreted (Kohut, 1984). The study attempted to resolve this problem by including an active and an insight version of the constructs. The mirroring function was, in the active version, operationalized by four subscales: (1) confirming vs. non-confirming; (2) accepting vs. not-accepting; (3) admiring vs. shaming; and (4) approving vs. not-approving. The mirroring characteristics were constructed to form a hierarchy, with confirming meaning a basic sense of validating the patient's self; accepting meaning receptivity to the patient's communications; approving being a positive expression from the therapist;

and admiring meaning active support of the patient's grandiose and exhibitionistic strivings.

The insight version of mirroring construct was measured by subscale (8) and rated the acceptance vs. rejection by the therapist of the patient's need to be mirrored.

Operational Definition of Idealizing

The active idealizing construct was operationalized by three subscales representing therapist attributes of: (5) calm vs. anxious; (6) powerful vs. weak; and (7) confident vs. doubtful. The positive attributes on these three subscales (calm, powerful, and confident) theoretically formed an idealized therapist figure.

The insight version of the idealizing construct was measured by subscale (9) which measured the therapist's degree of acknowledgment and acceptance of the patient's idealizing statements and need.

All of the nine subscales were marked by 5 points with 3 standing for "neither" (see Appendix C for a copy of the subscales).

Raters

The three raters consisted of two White male college seniors with psychology majors, and one Black female college graduate with counseling experience in a community clinic. The raters were trained by the author in three, 2 1/2-hour meetings during one month. The author told the raters that they were working on a project looking at how therapists with different training used various techniques that had unknown effects. The constructs were communicated by a training workbook (see Appendix B), and an audio-tape of the author and another student role playing the nine

concepts corresponding to the nine subscales (i.e., confirming, accepting, admiring, approving, insight into mirroring needs, calmness, powerfulness, confidence, insight into idealizing needs and their opposites). At the meetings, the raters discussed the subscales and practiced rating with clinical material. At the end of the third meeting, all raters were given four audio-tapes, selected randomly. After rating the first group of four tapes, the raters received the next group of four tapes until each rater had rated the same total sample of 16 tapes. It took the raters two months to complete the ratings. All three raters gave the exact same score for a patient on a subscale 68% of the time. the average inter-rater reliability coefficient was .62. All of the original subscale ratings were converted from the original sheets so that the "5" endpoint of each subscale represented the positive aspect of that subscale (i.e., in subscale 1, 5 = "confirming"). The reliability coefficients (alphas) for the nine subscales were: subscale 1 = .28, subscale 2 = .87, subscale 3 = .50, subscale 4 = .50, subscale 5 = .75, subscale 6 = .32, subscale 7 = .35, and subscale 9 = .45.

Data Analysis

High scores on the subscales were used, hypothetically, as predictors of patient change, using a multiple regression analysis. A Pearson product moment coefficient was also performed on each of the nine subscales independently, to assess their first-order correlations with patient change.

RESULTS

The data analysis employed the six and 20 month ratings of the CSI as the measure of patient change. The six month measure was selected because most of the intensive psychotherapy took place during the first six months of treatment, and the 20 month measure was selected because it was the last assessment time and would capture the full effects of the therapy. The six month evaluation outcome measure yielded no significant results (see Appendix F). The 20 month evaluation provided some useful information. The following table presents the nine subscales first-order correlations with change at 20 months. From these first-order correlations, it seemed that only the first mirroring subscale, confirming, tended towards significance ($p < .06$), then in a negative direction.

Table 3 illustrates the multiple regression analysis, using all nine subscales. From these results it seemed that the confirming subscale tended towards significance ($p < .09$) in the negative direction as predicted, and that the insight into idealizing subscale tended toward significance ($p < .08$), as hypothesized.

Table 2

Pearson Correlation of Therapist's Behavior with Patient Change (N = 16)

Scale	Pearson Coefficient	Significance
(1) Confirming	-.47	.06
(2) Accepting	-.21	.44
(3) Admiring	.18	.50
(4) Approving	.26	.33
(5) Calm	.13	.63
(6) Powerful	-.26	.33
(7) Confident	-.31	.24
(8) Insight-mirror	.15	.58
(9) Insight-ideal	.13	.62

Table 3

Relationship of Mirroring and Idealizing to Patient Change (N = 16)

Scale	Coefficient	S.E.	T	Significance
(1) Confirming	-1.36	.52	-2.06	.09
(2) Accepting	.88	.35	.98	.37
(3) Admiring	.32	.20	.90	.41
(4) Approving	.02	.26	.04	.97
(5) Calm	- .84	.18	-1.15	.29
(6) Powerful	- .50	.20	- .95	.38
(7) Confident	- .22	.12	- .66	.54
(8) Insight-mirror	- .09	.21	- .28	.79
(9) Insight-ideal	.98	.19	2.11	.08+
Multiple R .85	Adj. R Square .33			F = .24

The confirming (subscale 1) and insight into idealizing (subscale 9) scores were then entered as the two variables contrasted with patient change to form a final model, as illustrated by Table 4.

Table 4

Model of Confirming and Insight-Ideal Contribution to Patient Change

Scale	Beta Weight	S.E.	T.	Significance
(1) Confirming	-.68	.19	-2.75	.01*
(9) Insight-ideal	.44	.10	1.81	.09

Multiple R	.62	SS(Reg)	.46	SS(Res)	.75
R Square	.38	MS(Reg)	.23	MS(Res)	.06
Adj. R Square	.28	DF	2.13	Significance F =	.045*

* p = .05

From the multiple regression analysis model, above, the confirming subscale is significant in a negative direction. The insight into idealizing subscale tends towards being positively related to change. Together. these two variables significantly correlate with change (significant F = .05). Both of the two subscales together account for 20% of the variation in change scores.

DISCUSSION

The hypotheses of this study were not fully supported by the results. However, there are two aspects of the mirroring and idealizing processes that seemed to contribute to patient change in the sample. The confirming subscale (part of the mirroring measure) was found to be negatively related to change. The therapist's acceptance of patient's idealizing tended towards positive correlation with patient change. Approximately one third of the fluctuations in patient change at 20 months was accounted for by the two findings: the negative confirming finding and the acceptance of idealizing trend.

The six month therapy change measure did not correspond with any of the mirroring and idealizing subscales, but the 20 month therapy change measure yielded some relationships to the processes under study. This differential yield suggested that the effects of the therapist's management of mirroring and idealizing increase over time. Unlike a chemical reaction, the intersubjective relationship between patient and therapist may be thought of as an evolutionary process. Perhaps the 20 month results can be explained by the theory of introjection and identification. The patient may, gradually, feel connected to the therapist and may incorporate his/her therapeutic attitudes, as opposed to the patient immediately receiving help from the therapist. An unequivocal empirical answer does not exist for the question of when

patients change (from psychotherapy), and so this study's results are neither supported or contradicted by previous psychotherapy research. Because this study used archival data, the effects of the therapist's use of mirroring and idealizing dimensions of transference may have been less potent. Future research could employ therapists who were actually training in Kohutian technique to better measure the effect of the handling of mirroring and idealizing.

The confirming/disconfirming axis of mirroring brought the one significant finding. Confirming was negatively related to change which was in the opposite direction, as hypothesized. This indicates that a questioning, challenging approach is helpful, in psychotherapy, for the patient. One possible explanation for the strength of the negative finding ($p = .016$) is that schizophrenic subjects were used. Confirming the unhealthy, distorted persons of the psychotic individual may have failed to motivate the patient to reorganize their way of relating to self and others. If the therapist tells the patient that everything about him/her and their world is fine, why would the patient undergo the (often painful) experience of change? The author believes that the negative confirming finding suggested a need for a modification of Kohut's mirroring theory, but the use of schizophrenic patients might have enlarged the negative effect of confirming. If schizophrenia is the result of a pathogenic parent (Karon & Vandenbos, 1981), then the confirming therapist may be felt as repeating the trauma of encouraging the patient's insanity. The schizophrenia may serve as a defense that must be confronted in a climate of acceptance of the patient's healthy self. It is interesting that, in the overall multiple regression

analysis, all the mirroring subscales had positive valences (accepting, admiring, approving) with the exception of confirming. Few conclusions can be drawn about the other mirroring components because of their failure to reach statistical significance, but this indicated that the therapist's mirroring must be directed towards the patient's inner-experience and, conversely, that the unhealthy, distorted expressions should be challenged and questioned. This study found that high confirming communications from the therapist hurt the patient's growth process. Confirming may have resulted in a kind of collusion with the patient's psychosis, which may serve as a screen to protect the patient from getting close to others. The therapist may have to confront the patient's bizarre gestures and thinking to reach the deep core of the self that may be available for alliance with the therapist. The need for adequate mirroring (documented by Kohut) may be accompanied by a need for confrontation of destructive personality organization. Psychotics have more pathology than neurotic personalities, and this may account for Kohut's lack of incorporating confrontation into his theory of how psychoanalysis can benefit the patient. The most controversial aspect of Kohut's mirroring theory, that people need praise and admiration requires further empirical investigation. The aforementioned change in Kohut's model of therapeutic mirroring would specify that the mirroring be directed at the healthy representations generated by the patient and towards their need for appreciation and admiration. Some challenging by the therapist may be needed to oppose the patient's resistance and continuation of old object-relational patterns.

The results of the study revealed a trend commensurate with the hypothesis that the therapist who acknowledged the patient's idealizing benefited the therapy. Emery (1987) stressed that the therapist's understanding of the patient's mirroring and idealizing selfobject transference needs was more important than actually mirroring the patient or providing them with a strong, idealizable role model. According to Kohut, idealizing stemmed from the self's hunger for an omnipotent figure to identify with and, hence, strengthen the self (Wolf, 1984). Klein (1956) stressed that the idealizing process was an important precursor to the search for a good object, and that it protected the child from the bad object which stimulated persecutory anxiety. Obviously many schizophrenic individuals have fragmented selves which may be related to a breakdown in the idealizing process. The delusional system, in psychosis, might provide evidence for the existence of a different idealizing process than occurs in more healthy persons. Delusions of grandeur (as in feeling oneself to be God or in communication with God) manifest idealizing but on to a non-human being; the delusional person idealizes mythic or historical heroes, but not living people in their world. A healthy relationship with a person who can contain the idealizing activity (and the person's ideals) protects the person from dissolution. The delusional form of idealization fails to provide the interpersonal security and growth that the healthy idealization achieves. Another problem with the schizophrenic's idealizing comes out in paranoid imagery where the persecutor is endowed with grandiose, powerful traits but is malevolent. The relational need for idealizing a strong, good person may be awakened when the therapist acknowledged the need and

restores it to an interpersonal configuration rather than a fantasied relationship. In terms of Kohut's original model, the therapist's insight into the need to idealize may play a role in therapeutic growth.

This study has demonstrated that Kohut's principles can be communicated and measured in the context of psychotherapy research. Future research might isolate each of the different aspects of idealizing and mirroring as they work for psychotherapy with relatively healthy, neurotic, and psychotic patients. The study also brought out the possibility of changes in the Kohutian model where mirroring would be supplemented with some limited challenging attitudes on the part of the therapist. Kohut (1971) thought that the mirroring and idealizing transferences should operate only in normal and neurotic patients. This study's findings indicated that the construct's generalization to and efficacy with schizophrenic patients remains a productive area for further investigation. More clinical and research studies are needed to explore the relationship of mirroring and idealizing processes in psychotherapy. Additional research may help to reformulate Kohut's theory.

APPENDIX A

INSTRUCTIONAL TAPE FOR RATERS

APPENDIX A

INSTRUCTIONAL TAPE FOR RATERS

This tape will present dialogues between a therapist and a patient. After the patient's statement, two alternative responses illustrating the mirroring and idealizing concepts, will be given from the therapist.

Patient: "Over the weekend, I thought, I miss you like crazy, then I'd think I miss you like poison."
ACCEPTING RESPONSE - Therapist: "Sometimes you miss me but other times, you feel angry...must be a relief not to be here all the time."
NOT ACCEPTING RESPONSE - Therapist: "Is that your bad voice speaking?"

Patient: "That reminds me. I was in school and my teacher, Mr. Finney, taught me to play piano, he was really nice. After my father dies, I wanted to kill myself...I called him up, asking him to meet me and talk. He couldn't, said he was busy. So I turned on the stove, and tried to burn my hand. I wanted to watch it burn. I had to go to the hospital."
CONFIRMING RESPONSE - Therapist: "When your teacher was too busy for you, it must have made you very angry. You burned yourself when maybe you wanted to hurt him."
DISCONFIRMING RESPONSE - Therapist: "Sounds like you become self-destructive when your needs don't get met immediately."

Patient: "This psychic told me that in a past life I was a man; a farmer and very strong. I feel like that sometimes, people have mistaken me for a man."

APPROVING RESPONSE - Therapist: "You enjoy your strength."

DISAPPROVING RESPONSE - Therapist: "What makes you want to be a man? Do you feel confused?"

Patient: "I'm thinking about my buildings. During the sixties I was an architect in New York City. I designed the Guggenheim museum, got paid a lot for it."

ADMIRING RESPONSE - Therapist: "That's a lovely building, I'm impressed."

ASHAMED RESPONSE - Therapist: "That's quite impossible, I'm afraid because even if you had been an architect, you were hospitalized for much of that time that you say you built that."

Patient: "Over the weekend, I spent some time with my ex and my kids. They really don't care about me, they spent all their time with their friends. I watched the basketball game on TV, and I kept thinking that you reminded me of Larry Bird. You always make the baskets, and seem to make sense out of things for me."

POWERFUL RESPONSE - therapist: "So you think in contrast to your family, I'm able to care for you."

WEAK RESPONSE - Therapist: "Well I do my best, but, you know, I'm not perfect...nobody is."

Patient: "I'm in so much pain and I feel crazy, do you think I'll ever get better?"

CONFIDENT RESPONSE - Therapist: "You're wondering if I believe in your ability to get well."

DOUBTFUL RESPONSE - Therapist: "I don't know if you will or you won't."

Patient: "Dr., I need to use your phone, I'm worried that my cab won't come, can I use your office phone?"

CALM RESPONSE - Therapist: "Well there's a telephone in the lobby that should work, our time is up for today."

ANXIOUS RESPONSE - Therapist: "Well my next appointment will be here any time now. I guess if it will only take a moment you can use the phone."

APPENDIX B

TRAINING WORKBOOK FOR RATERS

APPENDIX B

TRAINING WORKBOOK FOR RATERS

Purpose

The purpose of this study is to see how therapists employ certain techniques. The techniques will be examined for how they relate with different approaches to doing therapy. You will be listening to audio-taped psychotherapy sessions. The patients are adult schizophrenic individuals who have been temporarily hospitalized and were receiving treatment. This workbook should help to teach you the techniques that need to be identified in the tapes. Please read the workbook carefully. When you begin to rate the tapes, you will want to know and be comfortable with identification of the techniques.

Mirroring

Mirroring is the act of reflecting back to the person what he/she really meant to convey. This can be a complex process because:

(a) The person may intend to say something but have trouble expressing the idea clearly.

(b) The person may be ashamed to tell the message and will, consequently, disguise the message.

(c) The person may not be clear about what they feel or think.

(d) The person may reveal a message that they are unaware of.

Sometimes the listener must probe for more information before reflecting back, to the speaker, what they meant. Probing for information is not mirroring. Probing may be a good lead-in to a mirroring statement. For example:

Speaker: "I don't know what it is, but I don't feel well today."

Listener: (PROBE) "You mean you don't feel well physically?"

Speaker: "Yes, that too, but I feel kind of bad. My friend from out of town left today."

Listener: (MIRROR) "So, you're feeling a little down and blue."

Speaker: "Yeah, that's it."

The listener has accurately mirrored the speaker's state of being, but not without some sorting through of the situation. A lot of the trick of mirroring is not the kind of response made (people mirror one another often), but the extent to which they are able to do it with all aspects of the speaker's presentation. Good mirrorers can figure out (with the help of questions) the message in almost any statement. Sometimes the speaker may say something that makes no sense or is distasteful to the listener. The listener who mirrors tries to extract the underlying purpose of the expression. The only way to check with the speaker to see if he/she was understood is to ask or wait for a validation from the speaker. Listeners who insist that their interpretation is correct are often not mirroring. Occasionally a person may resist hearing back what they said, but usually the speaker will respond positively to an adequate mirroring statement. The speaker is always the authority on their subjective experience. Being mirrored is a pleasant experience.

Part of mirroring in the therapeutic setting, is allowing the speaker (or patient) to direct the topics brought up in the session. If the listener (or therapist) changes the subject from what the speaker has brought up, then he/she is probably not mirroring. The following is an example of a speaker failing to mirror the listener's topic of conversation:

Speaker: "My brother asked me to go to the bar with him over the weekend, and I told him I wouldn't go. Usually we have a few drinks and somehow end up in an argument that ruins the rest of the weekend for me."

Listener: (NOT MIRRORING) "Let's get back to the issue of you, what's going on with you and your feelings towards me." Here is an alternative mirroring response to the speaker:

Listener: (MIRRORING) "Sounds like you've wised up to your brother and you are protecting yourself."

Again there are some exceptions to this rule that mirroring means staying with the issues that the speaker puts forward. For instance a patient may avoid exploring some information because it might cause anxiety, fear, or sadness, and the therapist may direct the patient to that topic; not really mirroring the patient but not failing to mirror either. If the therapist confronts the patient with new material before the patient has signaled some readiness, then the therapist is attempting to mirror (perhaps) but is not doing it as well as if the patient had introduced the topic him/herself.

Another facet of mirroring is that the mirroring statement tends to reflect the whole message rather than only a part of the message. If the listener focuses on an unimportant detail of the speaker's communication,

the listener may feel misunderstood. An example of successful mirroring the whole over the part follows:

Speaker: "I finally enrolled in school. I'm starting next week at Howell Community College."

Listener: (MIRRORING) "Really, that's great. What classes are you taking?"

Here is another response to the speaker's statement that illustrates not mirroring by focusing on the part instead of the whole:

Listener: (NOT MIRRORING) "Howell? Why did you choose a school so far away from the city, where you might have problems commuting?"

It is important when evaluating the mirroring skills of the listener to check if they responded to the speaker's attempts to appear in a good light. positively value their self, and to see if they respond to the speaker's attempts at accomplishing personal goals. With schizophrenic individuals this task is complicated by the schizophrenic's use of magical thinking and delusion. Consider the content of schizophrenic fantasy/delusion to see if it contains an attempt to brag or appear important as its underlying intent. Many therapists concentrate on deflating the delusion and pointing out reality. This is fine therapy but it is not a mirroring tactic. The therapist may understand the meaning of the delusion and mirror that back to the patient (which is a mirroring tactic). An example of mirroring a delusion:

Patient: "The President of the United States has a job for me. I've worked for the Secret Service before."

Therapist: (MIRRORING) "You seem to want a good job that's worthy of your talents."

A therapist may respond in a variety of ways to a patient's delusions and hallucinations. Your job is to figure out how able he/she is in mirroring the patient overall.

A different approach to mirroring is to respond to the listener's need to be mirrored. This approach to empathy is aimed at giving the patient insight into his/her interpersonal motives. There will be a separate scale for active mirroring and for pointing out the need to be mirrored (called the insight mirror scale). It is important to identify whether the therapist helps the patient gain insight into need states. The therapist may supply the insight comment after the patient asks for approval in some way. An example of recognizing the speaker's need to be mirrored:

Patient: "Last night I spoke to my wife and told her that we should go out more. You know I don't usually take her out to dinner or a show. Do you take your wife out a lot?"

Speaker: (INSIGHT INTO NEED) "Seems like you want me to know that you are trying to improve your relationship with your wife. It's hard to know, for you, if you're doing the right thing."

In the active version of mirroring, the mirroring response will be rated on 4 axes. This breakdown of the components of mirroring should help you to focus. When rating the therapist's mirroring ability with each patient, these four dimensions will be assessed:

1. CONFIRMING----------DISCONFIRMING
2. ACCEPTING----------NOT ACCEPTING
3. APPROVING----------NOT APPROVING
4. ADMIRING----------NOT ADMIRING

These four components of mirroring can be thought of as a hierarchy beginning with a rather mild, global confirming attitude and ending with the strong, specific approving attitude. It is assumed that each therapist may evidence any combination of these mirroring behaviors. The confirming/disconfirming axis means that the therapist may confirm (validate) the patient's self as-is, or they may take a more confrontative, questioning (disconfirming) stance. The accepting/not accepting axis relates to the therapist's benign evaluation of the patient's statements, needs, and goals or (at the other end of this scale) the rejection of those statements, needs, and goals. The axis of approving/not approving should measure the therapist's favorable comments about the patient's statements or actions. This axis is meant to identify positive approaches from the therapist rather than the milder, more neutral axes of confirming and accepting. Finally the admiring/ashamed axis should be used to measure the therapist's pleasure in the patient's skills, and in the patient's self-love - their grandiosity.

In addition to scoring the four qualitative aspects of mirroring, you will need to mark an intensity number for each axis with the endpoints representing the words described (points 1 and 5). Points 2 and 4 will represent "somewhat" the quality on the half of the subscale and "3" will represent "neither" which means that the therapist's behavior did not fall on either end of the axes.

Idealizing

The therapist may want to create, in the patient, a feeling that the therapist is strong and can take good care of the patient. There are

different ways to help a person to feel safe. The qualities that I am mean by this are the presentation of confidence, power, and calmness. Confidence, here, means that the therapist feels confident in his/her abilities and in the therapeutic process - that the patient will probably get better. By power, I mean that the therapist communicates that he/she is strong and can hold up in the face of the patient's anger, anxiety, and neediness. Calmness means being able to soothe the patient and provide a general sense of even temperedness. The concepts are fairly self-explanatory. If the therapist seems comfortable with their role, then that is a sign that the therapist is fulfilling this "ideal" image.

Here is an example of a powerful therapist:

Therapist: "You seem angry with me."

Patient: "I don't see how I'm getting better, I feel terrible, and maybe you're hurting me...I don't know about whether I'll be here next time."

Therapist: "If you leave, I'll still be here next week."

Here is an example of the weak therapist's response:

Therapist: "Do you really think I'm hurting you? That's different from the way I see it."

The powerful therapist handles the patient's anger with an overriding sense of certainty in him/herself and seems unafraid of the patient's threat to leave therapy. The weak therapist may be doing ok, but it is through a weaker approach.

The confident versus doubtful therapist axis is based on the therapist's confidence in him/herself as a therapist and about the patient's capacity to change. An example of the confident therapist is:

Patient: "I feel very depressed lately. Thought I was getting better but the last few nights I can't sleep and I cry a lot."
Therapist: (CONFIDENT) "Well, I think it's important that you can let yourself feel your sadness."

An example of an alternative response that is doubtful is:
Therapist: (DOUBTFUL) "Really, maybe there is something that you're not telling me that I could help you with. It sounds bad for you."

The calm therapist is soothing and does not withdraw from material that is shocking or disturbing. The following is an example of the calm therapist:
Patient: "When I was in Vietnam, some of my buddies and I would smoke dope and take pills. I blacked out a lot; maybe I have brain damage.
Therapist: (CALMING) "Uh-huh, I understand that a lot of people in your position took drugs. Unless you notice some drop in your abilities and memory, you're probably ok, but it should like it was frightening."

The response of an anxious therapist to this might be:
Therapist: (ANXIOUS) "That sounds very serious; it might explain your mood swings; why don't we get a brain scan assessment."

The calm therapist is not placid or, necessarily, understated but is reassuring, and not ruffled by topics that arouse anxiety in the patient. In other words, the calm therapist purposely does not mirror the patient's frightened affect.

In the insight-idealizing subscale, you will be looking for the therapist's attention to the patient's need to idealize the therapist. This means that the therapist can point out that the patient wants to see the therapist as perfect. If the therapist seems uncomfortable with the

patient's idealization, then he/she will score low on this subscale. The patient may praise the therapist in an unrealistic way. If the therapist rejects the patient's praise, the therapist should receive a low score on acceptance of idealizing. If the therapist interprets the patient's disappointments with authority figures (i.e., parents, bosses, other staff members in the hospital), then he/she is probably going to score high on acceptance of idealizing; since the therapist recognized the need for the patient to find people to direct his idealizing towards.

APPENDIX C

RATER'S SCORING SHEET

APPENDIX C

RATER'S SCORING SHEET

Circle the number that best describes this tape on each scale.

1. 1----------2----------3----------4----------5
(confirming) (neither) (disconfirming)

2. 1----------2----------3----------4----------5
(not accepting) (neither) (accepting)

3. 1----------2----------3----------4----------5
(admiring) (neither) (ashamed)

4. 1----------2----------3----------4----------5
(approving) (neither) (not approving)

5. 1----------2----------3----------4----------5
(anxious) (neither) (calm)

6. 1----------2----------3----------4----------5
(powerful) (neither) (weak)

7. 1----------2----------3----------4----------5
(doubtful) (neither) (confident)

8. 1----------2----------3----------4----------5
(points out (neither) (ignores mirroring needs)

9. 1----------2----------3----------4----------5
(ignores or rejects idealization) (neither) (accepts idealization)

APPENDIX D

DESCRIPTIVE STATISTICS OF SUBSCALES

APPENDIX D

DESCRIPTIVE STATISTICS OF SUBSCALES

Scale	Mean	Standard Deviation
CONFIRMING	4.78	0.53
ACCEPTING	4.51	0.80
ADMIRING	3.33	0.73
APPROVING	4.14	1.02
CALM	3.98	1.41
POWERFUL	3.73	1.15
CONFIDENT	4.17	1.11
INSIGHT/MIRROR	4.02	0.82
INSIGHT/DEAL	3.54	1.03

APPENDIX E

LITERATURE REVIEW

APPENDIX E

LITERATURE REVIEW

Rank (1923) was one of the first psychoanalysts to stress the management of the relationship to the patient, as opposed to interpretation of unconscious material. Rank felt that the therapeutic cure was buried in the actual relationship between therapist and patient. The American interest in Rank resulted in "relationship therapy" (Taft, 1933). The goal of relationship therapy was to help the person to experience their inner self. Although this school of therapy (originated at the Pennsylvania School of Social Work) was not far from Freud's notion of transference, the phenomenology of the relationship began to take precedence over the "blank screen" management of the patient. Comments from the analysand about the analyst were here understood as not just projections; the analyst took some responsibility for his/her effects. The experiential dimension of therapy was evolved by Rogers with client-centered therapy during the 1950's. Much of Roger's elaboration upon the empathic process in therapy parallels object-relations theory, especially that of Kohut. Kahn (1985) has also compared Rogers and Kohut. According to Kahn, Rogers and Kohut both focus on empathy as the key condition for psychological growth. Rogers and Kohut realized that people depend on others to function empathically so that they are, at times, experienced as one. Kahn noted that the two

theorists held divergent conceptions of the personality. Kohut's self is based on the traditional conflict model whereas Rogers conceptualized the self as congruent and whole when given unconditional acceptance. Ultimately, Rogers and Kohut described similar processes, but Kohut looked at where the empathy was directed. Too much empathy for one area of personality could overstimulate the self in one aspect and understimulate the rest of the self.

Rogers' (1957) therapeutic triad of accurate empathy, unconditional positive regard, and congruence formed the "necessary and sufficient" conditions for change. The therapist entered the client's subjective world and became "another self" for the client (Rogers, 1951). The therapist's ability to understand the client in a warm, accepting atmosphere was the curative action. Rogers tested his therapeutic conditions with schizophrenic, neurotic, and healthy individuals (Rogers et al., 1967). The Wisconsin Project found that therapists high on the three conditions (empathy, warmth, and congruence) helped schizophrenic patients stay out of the hospital. Accurate empathy of the therapists also correlated with reduction in the schizophrenia subscale on the MMPI. Later empirical research on Rogerian conditions for therapy met with mixed results (Meltzoff & Kornreich, 1970). Yet Bergin and Strupp (1972) concluded that even with difficult patients, empathy, warmth and respect facilitated change. In tracing the movement of therapy process from interpersonal to intersubjective, Rogers' concepts are still therapist traits, independent of the patient (Garfield, 1980).

The interpersonal theory of therapy began in the United States with Sullivan (1953) and in Europe with Klein. Fairbairn, Guntrip, and

Winnicott. While Rogers felt transference to be a somewhat annoying artifact of therapy (Rogers, 1951), the object-relations theorists saw that in the transference were the hopes and fears of a new healing relationship. The transference was a "creative illusion" (Cannon, 1968) that motivates the patient and must be used along with the real reactions of the patient to the therapist's persona.

Kohut defined three essential types of transferences. The mirroring, idealizing, and twinship transferences were the basis of Kohut's relational needs for a strong self. The self's need for a mirroring other and an idealized figure can be seen as Kohut's version of Freud's sexual and aggressive drives. Kohut's sense of the person's fundamental needs emphasize subjective rather than biological expressions.

Interest in the mirror as an actual and metaphorical experience started with Lacan in the thirties (Lacan, 1977). Lacan noted that somewhere between six and 18 months, the infant first recognized his/her self in the mirror. The child during this "mirror-stage" played in front of the mirror and exerted control over its body. The mirror afforded the child a sense of identification with the whole self and with mastery over the body.

Winnicott expanded on Lacan's mirror stage by placing the origin of the mirror to the mother's face (Winnicott, 1971). Ideally, the mother performs a mirroring function by giving back to the infant what he/she communicated; a preverbal sense of being understood. The mother must adapt herself as an object to be used by her child. the mother is a "holding environment." Winnicott stressed that the baby's feeling of

omnipotence must not be interfered with by the mother in her handling of the child. Kohut's proposal of the selfobject is anticipated in Winnicott's description of the good (enough) mother. The caretaker must give priority to the baby's needs over their own. The mirror role of the mother provides the child with approval and recognition. The child's identity is grounded in communications with the parent. Later experience with the actual mirror image is colored by historical experience with looking into the mother's eyes. Winnicott added dimensions of early object relationships to Lacan's theory of identity formation in the mirror-stage.

Winnicott (1971) found that the unresponsive or overly moody parent failed to mirror the child. The failure to mirror produced a defensive or withdrawn child. Winnicott observed that the child who had not been adequately mirrored treated actual mirrors with fear or with preoccupation with physical beauty. Miller (1981) indicated that an unmirrored child embarks on a life-long search for a mirroring other.

With reference to the process of psychotherapy, Winnicott touched on the mirror role of the therapist. The therapist must give to the patient what he/she puts forth to the therapist. The mirroring therapist helps the patient feel real and accepted. Patients feel angry when their therapist has failed to empathize (Winnicott, 1955). Again Winnicott, like Rank and Rogers, felt that the therapist's communications helped or hurt the patient.

The end of Lacan's mirror-stage, age 18 months, became the focus of attention for the American object-relations theorists, Kohut and Kernberg. The developmental stage of narcissism was conceptualized as

taking place between 18 months and 8 years (Wolf, 1984). Kernberg and Kohut worked to classify and explain the narcissistic self-disorders they encountered in clinical practice. Kernberg (1975), guided by his integration of Fairbairn's relational model and Freud's drive model, found that intersubjective experience influenced internal psychic structure. Kernberg approached character development from the mechanisms of introjection, projection, and splitting. Kohut (1984) rejected the concept of drive and build his theories around the idea of the self and its relational needs.

The difference between Kernberg and Kohut is that Kernberg viewed the self as besieged by libidinal forces and, consequently, potential dangerous. Kohut saw the self as inherently self regulating. Aggression and perversion are considered by Kohut to be a kind of last hope to repair a damaged self and not as manifestations of libidinal drive. Kohut tended to look for the whole self's message in any symbolic act, whereas Kernberg found the self as an orchestration of superego, ego, and id.

Kohut elaborated on the journey of selfhood. Injury to the self that occurred during the narcissistic stage resulted in a narcissistic personality disorder. Kohut (1977) felt that a successful handling of this developmental stage left the person with a residue of "healthy narcissism." This fundamental narcissism accounted for the adult's capacity for initiative and zest. Yet the early appearance of narcissism had to be nurtured by the social environment. The other is perceived as a facilitator of self control or as an impediment to smooth functioning, with all the shades of gray in between helping and hurting. Kohut used

the term selfobject to describe the child's significant other(s). The parents are narcissistically cathected by the child.

There are three selfobject roles in the Kohutian framework that serve interrelated needs (Kohut, 1971, 1977; Wolf, 1984): (1) the mirroring selfobject that confirms the child's sense of greatness and perfection; (2) the idealized selfobject that serves as a source of calm and omnipotence with which the child can identify and feel safe; (3) the twinship selfobject that provides a sense of sameness between child and adult; often based on common gender identity.

The mirroring selfobject is needed to respond to the child's self exaggeration of perfection and grandiosity. Kohut (1971, 1977) sets the mirror transference (in childhood) as the stage for mobilization of the self. The larger than life sense of self helps to strengthen the child's self. The mirroring function of the parent is expressed by the saying that the child is the "apple of the (parent's) eye."

The idealized selfobject supplements the sense of security because the idealized parent is large enough to contain the child with his/her sense of grandiosity. The idealized selfobject is comparable to Winnicott's holding environment, and to Kernberg's soothing, holding introject. The idealized selfobject is also a reservoir for the self's goals and ideals.

The twinship selfobject addressed the need for connectedness between child and parent. The parent who tells their child that the child is a "chip off the old block" is expressing this twinship process (Kohut, 1984). The ego ideal is activated through the parent's confirmation of the child's positive resemblance to the parent.

In the natural evolution of the healthy self, there was the presence of an adequate selfobject environment that met the child's needs. The self, though, benefited from "optimal frustration" (Kohut, 1971, 1977) from the parents. When the parent failed to empathize, the child begins an internal process of "transmuting internalizations" wherein the psychological functions of the selfobject are taken over and cultivated inside the self. Gradually the child acquires the acceptance, confirmation, strength, and calm that was once gotten solely from the parents. The transmuting internalization process is similar to when a romantic liaison has ended. Each member of the couple may act in ways that resemble their lost partner. This chameleon-like gesture is related to Winnicott's transitional object theory where a toy may replace the absent parent. Transmuting internalization may be characterized as a transitional identity where the self recreates what was obtained from the other.

In pathological development, the self remained fragile and uncohesive because the selfobject needs went unmet. the adult may hunger for mirroring, idealized figures, and a twin figure. The parents can fail the child by not giving enough empathy or by overstimulation of the grandiose, exhibitionistic acts and goals of the child. If a specific capacity was celebrated to the exclusion of others, the child experienced the parents as not really being behind them but as selfishly interested in that one talent. The adult who had been overwhelmed with attention in one area may be conflicted about that skill, or may be deficient in other areas of life. When selfobject needs were not provided, the adult may be

frightened of their own neediness and avoid intimacy (Kohut & Wolf, 1978).

In psychotherapy it is assumed that the patient will experience all of the selfobject transferences (e.g., mirroring, idealizing, and twinship). Kohut (1979) in his case study "The Two Analyses of Mr. Z" interpreted Mr. Z's narcissistic demands (displayed through hypochondriacal symptoms) as unhealthy defense mechanisms. A second analysis with the patient, using the new theory, resulted in Kohut's mirroring of his need to show off. Kohut's acceptance of Mr. Z's narcissism helped Mr. Z to directly express his demands rather than to disguise them in body complaints. Kohut recognized unfulfilled yearning for an idealized parent in the patient that had been developmental frustrated by the father. Kohut's second analysis led to profound change in the patient.

Kohut believed that his conception of the analytic cure differed from others in that it focused on the scope of empathy rather than on the kind of empathy. For example acting-out behavior in therapy was interpreted as an attempt to empower the self (Kohut, 1984). As Karon (1981) stated about work with schizophrenic patients, the therapist must be felt as nonpunitive. In the Kohutian model of therapy the analyst is invested in finding the ways in which the self comes to feel strong. Unlike Rogers, Kohut used the transference response as a guide to needed empathic experience. Like Rogers, the therapist and patient function as a unit (Schwaber, 1981) rather than in a confrontational posture with the analyst reminding the patient of reality. The therapist provided some facilitating conditions whereby the narrative of the patient unfolded

(Stolorow & Atwood, 1984) in the presence of a powerful and confirming audience.

This literature review has attempted to show the development of Kohut's concepts of mirroring and idealization as they related to their application in psychotherapy.

APPENDIX F

SUBSCALE CORRELATIONS WITH 6 MONTH CHANGE

APPENDIX F

SUBSCALE CORRELATIONS WITH 6 MONTH CHANGE

Table 5

6 Month Change Correlated With Subscales (N=16)

Scale	Pearson Coefficient	Significance
(1) Confirming	.17	.53
(2) Accepting	.31	.25
(3) Admiring	.06	.83
(4) Approving	.31	.25
(5) Calm	.34	.20
(6) Powerful	-.26	.32
(7) Confident	-.32	.23
(8) Insight-mirror	.21	.44
(9) Insight-ideal	.11	.71

Table 6

Multiple Regression Analysis: Subscales with 6 Month Change

Scale	Beta Weight	S.E.	T.	Significance
(1) Confirming	-.41	.71	-.56	.59
(2) Accepting	.40	.48	.83	.44
(3) Admiring	-.33	.27	-1.25	.26
(4) Approving	-.06	.35	- .17	.87
(5) Calm	.05	.24	.23	.83
(6) Powerful	-.08	.27	-.31	.77
(7) Confident	-.05	.16	-.31	.77
(8) Insight-mirror	.14	.29	.48	.65
(9) Insight-ideal	-.01	.25	-.04	.97

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