Countertransference Self-disclosure

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Introduction
The particular relational principles and concepts that influence my approach include aspects of the psychodynamic and humanistic traditions. I consider that many of the problems that clients present have their roots in earlier relationships, particularly with their primary caretakers. A variation of these difficulties is then perpetuated in their current relationships. Therefore, I believe a relationship has the potential for transforming their difficulties, creating a narrative with different meanings.

Furthermore, I see the mind as made up of relational schemas (Little, 2011) and that human development occurs within a “relational matrix” (Burke and Tansy, 1991, p. 370). My clinical focus is to attend to these schemas within the transference-countertransference relationship. The client and therapist begin to create a unique coupling that involves an engagement between two subjectivities. This engagement offers the opportunity for the client to meet the new object, work through the old object relationship, and reclaim the self.

I will here focus on the countertransference element of the transference-countertransference matrix and the application of the therapist’s use of countertransference self-disclosure from a relational perspective.

The debate about self-disclosure has evolved because of clinical and ethical concerns as well as deep rooted and contrasting philosophical differences about what helps clients. Those from a psychodynamic background might be more familiar with anonymity and the theoretical discouragement of certain aspects of self-disclosure, considering this to be an intrusion into the client’s internal world. Whilst for those from a humanistic tradition, self-disclosure may be part of the therapeutic frame and they may be more at ease with it. Perhaps the theoretical task is to find a balance between these two positions.

Countertransference is generally taken to mean the therapist’s total response to the client (Kernberg, 1965), and will include:

1. The client’s transference to the therapist of ego state relational units (Little, 2006), which may generate a reaction.
2. The reality of the client’s life and the therapist’s reactions, for example, a clinically depressed client may dishearten anybody.
3. The therapist’s own transference dispositions, as determined by his or her ego state relational units.
4. The reality of the therapist’s life that may influence how the therapist behaves with the client, e.g. suffering a cold and not wanting to see anybody.
Engagement in Relationship
Stark (1999) translates Mitchell’s (1988) delineation of his three psychotherapy models in the following way. The “drive conflict model” she describes as the enhancement of knowledge, in which the therapist responds interpretively, “the developmental-arrest” model as the provision of experience, in which the therapist responds empathically, and “the relational-conflict model” as the engagement in relationship, in which the therapist responds authentically. She suggests that the therapist is continuously shifting between these three modes of action.

In a relational-conflict model, and thus a relational transactional analysis model, (see Hargaden, (2011) for an exposition of the commonalities between these two) what occurs in the therapeutic dyad will take account of the total experience of both the therapist and client. This stance entails a further relational principle, which is the engagement in relationship.

Engagement in relationship, as outlined in the introduction, concerns helping the client to understand their impact on the therapist and also the therapist’s impact on the client. Engagement also entails the therapist being centred within his or her own experience. The therapist makes use of his or her countertransference, seen as an important source of information about both the therapist and client. The transference-countertransference matrix is seen as co-created within the therapeutic dyad and represents a unique coupling. A further ingredient is the need to be able to shift between being the old object of earlier relationship and the new object; between the repeated and needed relationship, to understand the nature of the present engagement. As Stark describes, the therapist will be “drawn into participating with the patient in her enactments and yet... preserve a perspective that enables her to have some understanding of what has been mutually enacted in the relationship” (p. 118). Self-disclosure of the therapist’s countertransference in the process of engagement is a significant therapeutic option.

Self-disclosure
It seems that, for some therapists, self disclosure has become equated with the relational approach. “There is a common misperception that to work relationally means to self-disclose relentlessly” (Wachtel, 2008, p. 245). Wachtel reminds us that in a relational orientation self-disclosure is permitted, not required.

As therapists, we cannot avoid revealing ourselves. The way we talk, our gender, our dress, the furnishings of our consulting rooms are all aspects of ourselves that we reveal. Further, the therapists’ interpretations are disclosures, since they demonstrate the existence of a different and separate mind. When the therapist sits opposite the client, in contrast to using the couch, disclosure of the therapist’s subjectivity is inevitable. The client will interpret the therapist’s behaviour and responses to their expressions and behaviour; as does the therapist. This process will be both conscious and unconscious.

Further to the inevitable disclosures, we need to consider the therapist’s deliberate self-disclosure. My goal in exploring countertransference self-disclosure is to invite us to consider, what we might be disclosing, when and when not to disclose, and if we do, how we do and the motivation for it.
Self-disclosure of the Countertransference
According to Maroda (2004), focusing on and incorporating the revelation and analysis of the countertransference into psychotherapy technique, increases the opportunity that dynamic conflict will be resolved within the therapeutic dyad and enhances the here-&-now relationship.

Aron (1996) poses the question ‘When is it useful for an analyst deliberately to self-disclose?’ (p. 223) and provides various questions to consider. In summary, he invites us to think for which clients it might be useful, at what point and, under what conditions. He further invites the therapist to reflect on the ethics involved.

Therapeutic Frame and Method
The process and degree of countertransference self-disclosure that a therapist will allow him or herself, will be influenced by their therapeutic frame, and how boundaries are understood, as well as by the therapeutic method, in particular how the purpose of therapy is conceived and accomplished. Maintaining our therapeutic frame enables us to detect any erosion resulting from unconscious processes.

Gorkin (1987) offers the following arguments in favour of self-disclosure:
- Self-disclosures may confirm the patient’s sense of reality.
- They may help to establish the therapist’s honesty and genuineness.
- They show that the therapist is not so different from the patient, that the therapist too is human.
- Self-disclosures clarify the nature of the patient’s impact on the therapist.
- Self-disclosures may help to break through treatment impasses and deeply entrenched resistance.

On the other hand self-disclosures by the therapist should take account of the client’s process, their developmental level of functioning, the current state of the therapeutic relationship and the nature of the transference-countertransference matrix. In my view an aim of relational therapy is to deepen the transference-countertransference relationship. Self-disclosure may not be judicious if it forecloses on deepening that relationship, or is used defensively.

A Technical Choice Point
There may be a tension between self-disclosing, on the one hand, and staying with, and working with the client’s projections on the other. If I self-disclose I may disrupt the projections that the client needs me to understand, but self-disclosing may also facilitate a different process. This represents a technical choice point.

Clinical example I: Non-Disclosure. The countertransference response I had to a stoic man who was talking about his musical interests, was the ‘urgent’ desire to tell him I played guitar, as I knew he did. This was interesting because, at that point, his stoicism made it difficult for me to warm to him. Reflecting on this, led me to understand that he wanted to connect with me. At that point, I could have self-disclosed and told him of my interest in guitars. This may have enabled him to identify with me. Instead, I chose to talk of what I understood of his needs at that point, and how he probably wanted to connect with me. I offered him my
interpretation of my countertransference response. This man used projective identification extensively to 'rid' himself of his needs and maintain his self-reliance. I had received his projection and converted it into an aspect of myself that identified with him. In so doing I understood the communicative elements. The aspect of my countertransference process that was particularly 'mine' was the interest in guitars. What he projected was his need to connect. At an unconscious level, I had combined the two. His use of projective identification worked because an aspect of me identified with his projection: it is an interpersonal process.

Clinical example II: Countertransference Disclosure. In the case of a client who lacked awareness of her impact on others, my self-disclosure gave her an opportunity to receive feedback in the present moment. At the end, of a stormy session during which the client attacked me in a sadistic and persecutory manner; she asked me gleefully if I was angry with her. It was as if she would feel triumphant in having provoked me. I felt a pull to comply and say I was angry. However, I said, ‘No I don’t feel angry. I feel frightened and bullied.’ I felt we had a strong enough attachment to tolerate the disclosure. She was shocked by the feelings I disclosed. The client’s expectation of being faced with an angry person was familiar. The fear that I felt was the client’s disavowed feeling, which she had learnt to repress when faced with her bullying parent.

In the first example, in not disclosing my countertransference, and instead examining my experience of introjective identification, I could then understand what the client was unconsciously struggling with and attempting to communicate through projective identification. In the second example, in disclosing, the client had the experience of knowing how she was impacting on me, and from that she could then perhaps begin to know her own response of fear to her internal sadistic bully with which I was identifying.

Gabbard and Wilkinson (1994) suggest that one of the purposes of self disclosure is to inform the client of the “interpersonal and intrapsychic use that the patient is making of the therapist” (p.143). They further suggest that this form of self-disclosure can be defined as “clinical honesty” (p.143). This is echoed by Maroda, (2010), who describes addressing the need for “affective communication and personal feedback” (p.159), as one of the tasks in treating Borderline personalities. Gabbard and Wilkinson highlight that, in working with Borderline clients in particular, self-disclosure of the countertransference will have an influence on several areas of the therapeutic work, including; transference exploration, patient revelations and neutrality.

Technical Neutrality
Greenberg (1986) highlights the nature and importance of neutrality within a relational-conflict model. Within this, an important area for consideration is whether the therapist’s disclosure promotes or detracts from the therapist’s ability to maintain technical neutrality (Little, 2011). It is an attitude of mind, not a set of behaviours, entailing a non-judgemental stance which attempts to find a balance between engagement and observation as well as balancing an attitude and stance between being perceived as both the new object and the old object (Greenberg, 1986). The client will invite the therapist to repeat old experiences but will also long to be exposed to new experiences. At times, the therapist will seem more like someone
from the past and at times someone new. Technical neutrality involves acceptance of all parts of the client; not being invested in any one aspect over another. This enables the client to work through the old object relationship, find the new object and reclaim the self. Neutrality is measured by the client’s experience of the therapist as both the old and new object (Figure 1).

Technical neutrality is an aspect of the ‘therapeutically required relationship’ (Little, 2011) and represents that which it is appropriate for the therapist to provide, as opposed to that which was needed from the primary caretakers but was missing, insufficient or part of a traumatic experience. This will need to be understood and grieved. One way of understanding the ‘working through’ of these processes would be to consider this a mourning process.

![Diagram](image)

Figure 1
The Position of Technical Neutrality

Self-disclosure may impede or enhance neutrality and the working through process. For therapy to get underway the therapist will need to be seen as a good enough new object who offers containment, and for therapy to come to an end the therapist will probably need to be seen as the old object (Greenberg, 1986). The therapist might not interpret the existence of the bad/old object in the early phase of therapy so as to enable the client to settle in. A good enough relationship needs to be built before the client can bring any disavowed feelings directly into the therapy.

**Counter-therapeutic Self-disclosure**

The space between the therapist and client is a dynamic and changing expanse of conscious, non-conscious and unconscious processes (Summers, 2011, this volume), verbal and non-verbal communication. Self-disclosure may open up or close down this space and may be in the service of the “therapeutically required relationship” (Little, 2011), or a defensive manoeuvre by the therapist.

Newly practicing therapists from a humanistic tradition may have a tendency to self-disclose in order to anchor the therapy in the working alliance (Greenson, 1967). They may be uncomfortable with the client’s transference perception of them and try to impose what they see as reality, thereby discouraging the development of the
transference-countertransference relationship. Alternatively therapists may self-
disclose to gain approval from the client (Myers & Hayes, 2006, quoted in Maroda,
2010, p.109), as with the therapist who demonstrates to the abused client that they
do care for them, unlike their abusive parent. This projects the sadistic persecutory
object outside the consultancy room, so that the client can continue to be seen as a
victim and the therapist as the idealised perfect other.

There are benefits and costs to the therapeutic relationship as a result of the
therapist’s self-disclosure which need to be assessed individually. Self-disclosure by
the therapist needs to be a choice, and we need to be “attentive to the
consequences” (Wachtel, 2008, p. 247).

Therapist self-disclosure may be experienced as intrusive or abusive, and too much
for the client to tolerate. At times, we may feel under pressure from the client, or from
our theories to disclose. If we feel obliged, we are probably caught up in something
that needs understanding. If we feel under pressure from our theories, then they, are
an object that may be tyrannizing us in that moment. We need to think carefully and
choose whether to disclose.

If the countertransference contains split off, expelled, elements of the client’s psyche,
it may be more therapeutic to contain these elements until they are understood.
Carpy (1989) suggests that if the therapist is able to ‘tolerate’ the projected feelings
that are the basis of the countertransference, this “by itself can help the patient, and
produce psychic change.” (p.289). By tolerate, he means, “the ability to allow oneself
to experience the patient’s projections in their full force, and yet be able to avoid
acting them out in a gross way” (p.289).

Clinical example III. I will now describe an invitation to self-disclose that the therapist
believed could lead to a reinforcing rather than to a growthful experience. A
depressed young man had spoken of something he was wrestling with at work. The
therapist commented that he seemed caught between a rock and a hard place, and
seemed unable to make a choice between two options. She noticed that she didn’t
feel involved as he spoke, as if he was holding her at arm’s length. Toward the end
of the session, the client asked if she was angry with him because he couldn’t make
up his mind. The idea that the therapist might be angry with him left him anxious and
he sought reassurance before leaving the session.

The therapist did not feel angry with him, but she was aware that if she answered the
question with a ‘yes’ or ‘no’ that would keep them in his script (Berne, 1972). The
therapist thought that his fear of her anger, needed to be addressed. A ‘yes’ would
only have confirmed the client’s beliefs. A ‘no’ may have given him temporary
reassurance, (“she’s not angry this time.”), but left the fear intact. In this example, the
therapist is actively engaged in the relationship and is able to hold in mind the
meanings implied in the request for disclosure and the impact of this request.

If a client perceives the therapist to feel a particular way, and the therapist does not
feel that way, the therapist should consider what in his or her behaviour served to
trigger the client’s perception. The client is probably interpreting some aspect of the
therapist’s behaviour.
Self-disclosure in the Context of Separateness

With some clients, the clinical task is to support their individuation and separation (Mahler, Pine & Bergman, 1975). Self-disclosure can serve as well as hinder this developmental goal. Many clients struggle with being separate in relationship and some will try to merge with the therapist to avoid separateness. A request from a client to the therapist to disclose their feelings, thoughts, or fantasies may be an attempt to merge and close the ‘gap’; an attempt by the client to enter the therapist’s mind. It is important to explore carefully a request for the therapist to disclose their feelings and thoughts. Similarly the therapist’s self-disclosure may also be a strategy to close the ‘gap’ to avoid something potentially uncomfortable.

Clinical example IV. A client, who was depressed and distressed, asked me if I thought he was borderline. This was an idea he had picked up from his partner. He asked in an anxious manner, and I felt obliged to answer. A thought I had in the moment was; he wants to know what is in my mind in order to close the gap between us. I responded by saying ‘You want a diagnosis rather than have an experience with me.’ Then I went on to say, ‘If I said yes, how might you feel? And if I said no, how would you feel?’ He was silent for a few moments, during which time he became tearful, and said, ‘I want to know who I am.’ This represented his core issue.

Conclusion

In conclusion, I believe we cannot avoid disclosing, or revealing ourselves. However, it is often a choice to decide in what way and when to disclose our countertransference. We need to bear in mind certain questions when considering disclosure:

1. Would self-disclosure represent a repeated traumatic relationship for the client?
2. Would it enhance or interfere with the ‘therapeutically required relationship’?
3. Is disclosure a defence, avoiding something?
4. Is there something behind the request or my impulse to disclose?

If the therapist considers that self-disclosure is a feature of their therapeutic approach, then whatever style they adopt, or whether they disclose with a particular client, needs to be a considered choice. I agree with Aron (1996) that whether or not we disclose, our position needs to be open to reflection and comment by both client and therapist, a position aligned to the relational principle of engagement.

References
Berne, E. (1972). What do you say after you have said hello? Andre Deutsch.


