CHAPTER THREE: THERAPIST SELF-DISCLOSURE AND THEORETICAL ORIENTATION.

3.1. Introduction.

As evidenced throughout the previous chapter the empirical and quantitative research has failed to account for the processional and contextual embeddedness of therapist self-disclosure. Many variables co-exist to determine the nature of the therapeutic relationship within which the self-disclosure occurs, and these have unfortunately been by-passed.

One of these variables is the therapist's theoretical orientation. This orientation is the therapist's guiding force, and it is within this orientation that he or she defines his or her role within the therapeutic situation. The definition of this role circumscribes the degree and nature of the therapist's participation.

The literature on psychotherapy is voluminous. Berg and Derlega (1987) cite Goldfried (1980) who stated that there are over one hundred approaches to psychotherapy. For purposes of this study, the researcher has selected the humanistic-existential and psychoanalytic traditions for detailed discussion. Reasons for inclusion of these traditions are the following.

Firstly, both the humanistic-existential and psychoanalytic schools of thought essentialize or conceptualize and implement the therapeutic relationship for growth and healing.

Secondly, justification for exclusive focus on these two traditions comes from authors who polarize these two modes of

thinking when discussing and considering therapist self-disclosure.

Curtis (1981) and Cornett (1991), for instance, contrast these two approaches where psychoanalytic thought mainly contraindicates therapist self-disclosure and where humanistic thought indicates it. However, emerging trends within the psychoanalytic orientation depolarize these two traditions to a certain extent. This depolarization concerns, firstly, the humanizing of the psychoanalytic relationship, and secondly, the use of therapist self-disclosure. These approaches will be discussed extensively in this chapter.

As outlined by Cornett (1991), humanistic and existential approaches to psychotherapy place much emphasis on the therapist's authenticity (Jourard, 1971), genuineness (Truax and Carkhuff, 1967) cited in Curtis (1981), congruence (Rogers, 1961), and transparency (Jourard, 1971). These terms are often used synonymously with the term therapist self-disclosure. It will be pointed out that these attitudes need not necessarily imply the use of self-disclosure. They often imply the use of self which is private. However, the philosophical assumptions on which these therapies are based allow for therapist self-disclosure, and there is not much internal argument or questioning concerning this. The philosophical assumptions on which these theories rest will briefly be outlined. This will also help to clarify the terms that are used synonymously with self-disclosure.

In strong contrast to the existential and humanistic traditions the psychoanalytic frames of reference do not give a unified view as to the analyst's stance within the therapeutic relationship. As Mitchell (1993: 5) has succinctly stated: "... psychoanalysis appears to be more

diffuse and divided than any other comparable intellectual or professional discipline".

The literature that is gathering as regards **countertransference disclosure** specifically requires detailed discussion. The newer trends within psychoanalytic thinking have expanded the concept of countertransference to include an objective or common element which refers to the therapist's encounter experience that may be disclosed to become part of the analyzable clinical data. This developing trend within psychoanalytic theorizing and practice forms an essential part of this chapter and will be clarified in a later section.

There has been much growth and change within psychoanalytic circles and these developments bear directly on the therapeutic relationship and dialogue, and ultimately on the increased use of therapist self-disclosure (Rosie, 1980). For this reason the nature of the therapeutic relationship from within a psychoanalytic perspective requires a more detailed and comprehensive examination.

One could commence with an overview of the role of therapist self-disclosure within the existential-humanistic tradition and then proceed to the role- and place of therapist self-disclosure within the psychodynamic tradition.

3.2. An existential-humanistic view of therapist self-disclosure.

3.2.1. Introduction and philosophical assumptions.

May (1986-87: 49) has noted that there is no special school of therapy to be put in a category of "existential". In his view, existential refers to an attitude toward human beings

and a set of presuppositions about these human beings. For this reason and because humanistic psychology is built on these same fundamental premises, which will address themselves in the next few paragraphs, the word "existential" has not been awarded separate status for purposes of this study.

Yalom (1980) has pointed to fundamental differences between the American Humanistic and the European Existentialists, where the existentialists emphasize human limitations and the tragic dimensions of existence, and where the humanists are more expansive, optimistic and hedonistic, emphasizing self-actualization rather than life meaning. "Whereas the Europeans are more likely to discuss limits, acceptance, anxiety, life meaning, apartness, and isolation, the American existentialists focus on potential, awareness, peak experiences, self-realization, I-Thou, and encounter" (Norcross, 1987: 62).

Tageson (1982:10) has referred to "humanistic-existential" psychology as a not remarkably cohesive group labelled as humanists, personalists, phenomenologists, and existentialists. To add to this diversity, Norcross (1987: 61) has distinguished between existential-analytic and existential-humanistic. Existential analysis is seen as a compromise between psychoanalysis and existentialism, and the existential-humanistic approach is "closely allied with the third force of psychology". Philips (1981-82) has also pointed to the diversity of opinion regarding the variation amongst practitioners and theoreticians within existential thinking.

However, despite the variation discussed above, what is relevant for purposes of this study is that existential and humanistic thinking are built on the same fundamental

phenomenological tenets. Together they oppose the original conceptualizations of transference which has been the pivotal point in psychoanalytic thinking. These conceptualizations have circumscribed the nature of the analyst's stance and participation within the therapeutic dyad. It is precisely in this regard that the existential-humanistic theorists are fundamentally different to the mainstream psychoanalysts.

The departure from the orthodox conceptualization about transference has had radical implications for the relationship between therapist and patient, and specifically the nature and degree of the therapist's participation within the psychotherapeutic situation.

This departure can briefly be portrayed in the following way. According to Aanstoos (1994), beginning in the 1960's, one branch of psychologists adopted the label **humanistic**, in order to distinguish themselves from psychology as it had been traditionally established. DeCarvalho (1994) includes in this branch, the growth hypotheses of Maslow and Rogers, the personality theory of Allport, and the existential and phenomenological psychologies of May and Bugental.

This movement is frequently referred to as the "third force" (Davidson, 1994: 24; Wertz, 1994: 344), and includes **phenomenological**, **existential** and **humanistic** psychologists. Varghese and Franzcp (1988), Giorgi (1994), McConnaughty (1987), Sterba (1975) cited in Weiner (1983), and Yalom (1980) to cite a few, have described the sentiments of this movement.

Giorgi (1994) has referred to the third force as a protest movement against the state of the art conceptualizations and practices of psychology. According to Giorgi (ibid), the protest made by May, Rogers and Maslow was that psychology

was missing the heart of the matter. The human being, the human person, the very core of psychology that made everything else viable was not being addressed.

The influence of existentialism on psychology can best be understood as a reaction to, firstly, the mechanistic view of human behaviour and motivation as advocated in behaviorism and secondly, to the ideological metapsychology of psychoanalysis and psychoanalytically derived schools of thought (Tageson, 1982; Varghese and Franzcp, 1988). In this regard, Lowenstein (1993) has stated that humanistic psychotherapy is influenced by both psychoanalytic and behaviouristic approaches to treatment, but disagrees with both. It sees behaviour*sim* as underestimating the complexity of the individual personality, and psychoanalysis as faking a pessimistic view of the human potential for development. Johnson (1971: 1) has been outspoken in this regard:

> I am a psychologist. Yet I hate psychology. I owe it no allegiance. It has only abused me and those values most important to me. ... So do I hate psychiatry and social sciences other than psychology. Each is dominated by reductive systems which destroy the existential reality of man.

Tageson (1982: 11) captures the essence of this argument in the following way: (This movement) ... "is groping toward a broader, open-at-the-top perspective toward the science of human experience and behaviour". In the same way, Phillips (1981-82) has discussed the phenomenological approach which attempts an unbiased, presuppositionless grasp of the patient's subjective, phenomenal world.

Focusing specifically on therapist self-disclosure, it is

interesting to note that paralleled by the humanizing of the therapeutic relationship is the changing role of therapist (Gendlin, 1994) and the increased **awareness** of the therapist as a real person. This has profound implications for the use of self-disclosure by the therapist. In this regard Curtis (1981: 500) has stated that the use of therapist self-disclosure emerged under this influence of the humanistic-existential psychology movement, that is "third force" psychology.

It was also during this time that Jourard (1968, 1971) formulated and researched his ideas on self-disclosure. Originally researching self-disclosure within various dyadic relationships, Jourard (1971) also focused on therapist self-disclosure and urged therapists to be more authentic.

The third force has called for radical transformations and reformulations of the nature of the "working" and "analyzable" data in psychotherapy, and this has had profound implications for the therapist's stance and role within this relationship. It now becomes necessary to discuss the nature of the therapeutic relationship within existential-humanistic thinking.

In summary, it can be stated that all of the above-mentioned movements whether they be labelled existential, phenomenological, or humanistic, have as common denominator their origin in the protest against orthodoxy, and their growth towards a "humanizing" of the therapeutic relationship.

This has far-reaching implications for the therapist's stance and participation within the therapeutic dyad. For purposes of this study, one can speak of the existential-humanistic psychotherapeutic relationship, as these movements taken

together share similar sentiments in terms of the fundamental nature of the therapeutic relationship.

3.2.2. The nature of the therapeutic relationship.

Tageson (1982) has described the most general characteristic of the humanistic movement its **person-centered approach** to individuals and their behaviour. He further awards Carl Rogers the status of the most radical proponent of this stance in the sphere of practical application to therapy. According to Mahrer and Fairweather (1993), Carl Rogers' approach was initially known as *nondirective therapy*, and then more popularly as *client-centered therapy*.

Gendlin (1994) has summarized how radically Rogers changed the role and stance of therapist. Therapists were advised not to impose interpretations. The patient was no longer to be a passive object of "treatment", and the name "patient" was changed to "client". He eliminated the medical model and took the new term from the field of law, because the lawyer is an expert and advocate but not a decision-maker concerning the client's life. Clients were invited to delve deeply into their own experience, and the therapist was to **listen** and share every nuance of this experience. Rogers further eliminated diagnosis, the patient's history, note-taking, and clinical distance.

In Carl Rogers' (1971: 9) own words, as cited by Gendlin (1994):

> Client-centered therapy has seen the unique, subjective, inner person as the honoured and valued core of human life. In taking this perspective the client-centered orientation has taken a stance that is in opposition to

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In Carl Rogers' (1971: 9) own words, as cited by Gendlin (1994):

> Client-centered therapy has seen the unique, subjective, inner person as the honoured and valued core of human life. In taking this perspective the client-centered orientation has taken a stance that is in opposition to

the major trend of American psychology - a trend that I see as viewing human life through a mechanistic, atomistic, deterministic scientism.

Accompanied by the awareness of man's essential need for a deep human relationship is a reasoning that client-centered therapy provides a relationship which implies and necessitates a greater use of the self of the therapist, of the therapist's feelings, and a greater stress on **genuineness.** This implies that the therapist openly be, or allow to awareness the feelings and attitudes flowing within him without front or facade, but without imposing the views, values, or interpretations of the therapist on the client.

It is important to note that Rogers (1971) as cited by Gendlin (1994) stressed that this does not carry with it the implication that the therapist impose his or her views, values, or interpretations on the client.

To facilitate this type of relationship, Rogers (1957) cited in Vanaershot (1990) postulated three therapist conditions to be essential for successful therapeutic change. Rice (1974) echoing these formulated them as guidelines for therapist participation. These include that the therapist be **congruent** in the relationship, that he experience **unconditional positive regard** for the client, and that he **communicate** to the client quite explicitly an **empathic understanding** of his internal frame of reference.

When discussing each of these concepts, compelling questions about therapist self-disclosure arise. To answer these questions, a section has been reserved and devoted to a discussion of therapist self-disclosure within the existential-humanistic psychotherapeutic relationship.

Before discussing these concepts, the primary point of departure for an existential-humanistic relationship, namely the shift from orthodox conceptions of transference to a "humanized" relationship needs to be discussed in more intricate detail.

3.2.2.1. The shift from transference to encounter.

Philips (1981-82) has accurately portrayed the shift from transference to encounter within existential-humanistic thinking. He has justified the analytic stance in terms of its rationale. This has to do with Freud's view of neurosis and the treatment required to deal with it. In this instance, as the treatment unfolds, it centres almost exclusively on the work with the transference.

If the work of therapy is centred on the analysis of the transference, then everything must be done by the therapist to facilitate its development in the therapy. This then justifies Freud's prescriptions to analysts to keep their personalities out of the therapy and in the background. In this instance, the transference relationship and the real relationship are theoretically irreconcilable.

Existentialist theoreticians and practitioners have a different concept of the nature of the therapeutic relationship as well as different opinions as to what constitutes the "analyzable" and "working" data within psychotherapy.

This approach is entirely different to the psychoanalytic conceptualizing of the transference relationship. Mahrer and Fairweather (1993: 12) referring to Jourard (1968, 1971) and other authors, have referred to the "encountering-meeting of one's whole self and another's whole self". This implies

that "the client and therapist are wholly open to one another, to the real self of the other, each one relating on the basis on the inner responses and feelings evoked by the other, each participant having access to the conscious, preconscious, rational, irrational, and unconscious dynamics of the other" (Mahrer and Fairweather, ibid). This has important implications for the use of self-disclosure by the therapist and will also be taken up again in the next section.

Philips (1981-82: 137) has also portrayed the shift from transference to encounter in the following way: "In contrast to the psychoanalytic search for the disguised, unconscious, infantile complex, the phenomenological approach attempts an unbiased, presuppositionless grasp of the patient's subjective, phenomenal world". This implies that the "working" data is profoundly different to that revealed within psychoanalytic psychotherapy.

According to May (1986-87) the concept of transference can undermine the whole experience and sense of reality in therapy. Shlien (1987: 15) has taken a provocative stance on the issue of transference, and has suggested that it is a defense mechanism used to deny or disguise the reality and natural consequences of the therapist's behaviour. His outspokenness in this regard has been expressed in the following way: " 'transference' is a fiction invented and maintained by therapists to protect themselves from the consequences of their behaviour".

Lietaer (1993) has pointed out that not all existential-humanistic therapists have rejected the concept so bluntly. Although several theorists influenced by humanistic-existential psychology have subordinated the transference relationship to what they deemed the essential dimensions of

therapy (Curtis, 1981), May (1986-87) feels that what has been lacking in psychoanalytic circles is a concept of encounter. It is within this encounter that transference has genuine meaning.

The suggesting of a subordination of the transference suggests that transference is not by-passed but construed differently to traditional psychoanalytic formulations. Phillips (1981-82) has captured the essence of this argument. He has noted that the existential therapist may take one of two approaches to transference phenomena.

In the first instance, the therapist can dismiss it as antithetical to the concerns of existential psychotherapy. For instance, Rogers felt that he could avoid transference phenomena by being congruent and non-authoritarian with clients (Tobin, 1991). In the second instance, the therapist could reinterpret transference from an existential point of view.

In this regard, Lietaer (1993) has emphasized the crucial and fundamental difference between transference in psychoanalytic thinking and humanistic psychology in the following way (36): "The emphasis is not on working to achieve insight, which consists of recognizing and genetically understanding how the client distorts the therapist and relates to him in a structure-bound way, but on the corrective emotional experience".

To facilitate this statement, Lietaer (1993) cites Gendlin (1968: 222):

> It isn't enough that the patient **repeats** with the therapist his maladjusted feelings and ways of setting up interpersonal

situations. After all, the patient is said to repeat these with everyone in his life, and not only with the therapist. Thus, the sheer repeating, even when it is a concrete reliving, doesn't yet resolve anything. somehow, with the therapist, the patient doesn't **only** repeat; he gets **beyond** the repeating. He doesn't only **re**live; he lives **further**, if he resolves problems experientially.

It is now clearly evident that the humanistic-existential movement focuses on the "visible" and "here-and-now" relationship between therapist and patient. There is a direct and mutual experiential contact and this is based on the immediacy of the encounter. These therapists are working with presently available material and do not need to assume a stance to facilitate regression. The shift from transference, regression, and distortion to the immediate encounter has amazing ramifications for the possibility and appropriateness of therapist self-disclosure.

3.2.2.2. Congruence.

According to Vanaershot (1990) Rogers (1957) introduced the concept of congruence as one of the necessary sufficient conditions of therapeutic personality change. Rogers designed a "face-to-face" type of therapy in which the therapist is highly involved with the client's experiential world (Lietaer, 1993: 19).

Fundamental to this stance is that the therapist adopt a natural and spontaneous **attitude** without favouring regression and transference. This implies that the "real" relationship is of prime importance and in this regard the therapist

serves as a model where his or her congruence encourages the clients to take risks to become themselves (Lietaer, ibid).

Rogers (1961: 61) has described congruence in the following way:

> By this we mean the feelings that the therapist is experiencing are available to him, available to his awareness, and he is able to live these feelings, be them, and able to communicate them if appropriate. No one fully achieves this condition, yet the more the therapist is able to listen acceptantly to what is going on within himself, and the more he is able to be the complexity of his feelings, without fear, the higher the degree of his congruence.

This description implies that the therapist be a psychologically well-developed and integrated individual and according to Lietaer (1993: 22) requires that the therapist acknowledge flaws and vulnerabilities, thereby accepting the positive and negative parts of oneself. The therapist must therefore be capable of openness without defensiveness. This implies that the therapist be able to function in personal and intimate relationships without interference from one's own personal problems.

Wexler (1974: 111) interprets this formulation of congruence to mean that the therapist is "genuine" or "whole" in his relationship with the client, there being no discrepancy between what he overtly expresses and what he internally experiences.

This concept elicits many questions about the implied use of

self-disclosure especially as it pertains to the therapist's openness and honesty during the encounter, and will be taken up again later.

3.2.2.3. Unconditional positive regard.

Lietaer (1984) has described unconditional positive regard as a multi-dimensional concept. He concludes that in empirical factor analytic research, this basic attitude seems to be composed of independent dimensions, namely positive regard, nondirectivity, and unconditionality.

Synonymous to positive regard, Lietaer (1984: 42) used the term "*nonpossessive warmth*". Bohart (1991) has spoken of *prizing* and *unconditional regard* as attitudes held towards the person. In this regard, the person is prized in his or wholeness regardless of how he or she is behaving. This furthermore implies that the therapist does not differentially approve or disapprove of any particular class of behaviours or experiences of the client. All of the behaviours are equally prized and accepted by the therapist as worthwhile.

This does not however refer to something that the therapist overtly expresses to the client. In other words the therapist does not tell the client of his unconditional positive acceptance of him. This then implies rather that there is an absence of any differential evaluation by the therapist (Rogers, 1957) cited in Wexler (1974).

This attitude is similar to Lietaer's (1984: 42) description of nondirectivity, which he also termed "client-centredness". This refers to an attitude of respect, approaching the client as a unique and independent person, with the right to his own point of view.

It is interesting to note that unconditional positive regard and congruence are described as attitudes, for example Wexler (1974) and Bohart (1991). This has important ramifications for the role and place of therapist self-disclosure and this will be discussed in a following section. It is also interesting that both Wexler (ibid) and Bohart (ibid) have subordinated congruence and unconditional positive regard to a description of empathy. Empathy however has an expressive element as well and this will be discussed now.

3.2.2.4. Empathy.

A major shift that has taken place from orthodox psychoanalysis to humanistic therapy, is the change in listening stance. There has been a shift from an archaeological listening stance to an empathic listening stance. Tobin (1991: 13) has described the major therapeutic stance to be the use of "sustained empathy". Empathy has occupied a central role in humanistic psychology for many years (Bozarth, 1984: Hart, 1970) cited in Bohart (1991) and Vanaershot (1990).

Tobin (1991) cites Rogers' (1951: 29) definition of the empathic attitude:

> It is the counselor's function to assume, in so far as he is able, the internal frame of reference of the client, to perceive the world as the client sees it, to perceive the client himself as he is seen by himself, to lay aside all perceptions from the external frame of reference while doing so, and *communicate* (italics added) something of this empathic understanding to the client.

The question of communicating this understanding to the client, raises compelling questions about therapist self-disclosure, that is, to what extent does one convey one's understanding?

Client-centered therapists are interested in the immediate encounter, the here-and-now, and the presently available experiential world of the client. Empathy is employed to track the moment-to-moment unfolding of that experience. Although the focus is on the here-and-now and presently available, the therapist does not only focus on the immediate awareness (Bohart, 1991).

Wexler (1974: 97) has spoken of empathic responding where the therapist becomes a "*surrogate information processor*". This implies that the therapist function as an alternate organizer of the meaning of the particular information in the field that the client is processing. The therapist works with the information that the client is attempting to process, but to the extent that the client's processing is less than optimal, the therapist's organizations held out to the client can function to compensate for where the client's processing is deficient (Wexler, 1974: 97). This points towards an expansive function and Miller O'Hara (1984) states that the therapist expands the patient's consciousness, particularly at the beginning of therapy.

This line of reasoning also carries with it the implication that it is the unattended to and unsymbolized aspects (but presently available) that empathic therapeutic responses often address (Gendlin, 1968) cited in Bohart (1991). There is thus a focus on the empathic apprehension of currently available experiencing, but without reference to "deeper" determinants (Bohart, 1991: 39).

In recent years, empathy has gained more importance in psychoanalytic writing, and some authors, for example Bohart (1991) and Tobin (1990, 1991) have compared empathy across humanistic and psychoanalytic frameworks. In this regard, self psychology, due to its sustained empathic stance, serves as a important mediating influence between humanistic psychology and psychoanalysis. This will become clearer in a subsequent section of this chapter.

Empathy is not a unitary construct, and Bohart (1991) cites Gladstein and associates (1987) who have identified over eighteen different kinds of empathy. Berger (1987: 40) has described empathy as a "complex dynamic process". However, this study is interested in whether the conveyance of empathy implies the use of self-disclosure and this will be discussed in the section devoted to therapist self-disclosure within the existential-humanistic therapeutic relationship.

At this stage, it is important to note that with the profound shift from an archaeological to an empathic listening stance, there is significant emphasis on the immediate, here-and-now encounter. Transference phenomena with an emphasis on past experience and patient fantasy lose significance within these approaches. This has radical ramifications pertaining to the nature of the therapeutic process and relationship.

3.2.2.5. Implications for therapist self-disclosure.

Within psychoanalytically oriented forms of psychotherapy, the therapist encourages, recognizes, and interprets the vicissitudes of transference by remaining essentially a "blank screen" to the patient (Curtis, 1981: 501). This stance renders therapist self-disclosure inappropriate.

The philosophical assumptions on which existential-humanistic

psychotherapy is based makes the use of therapist self-disclosure a less contentious issue. Nevertheless, a certain amount of confusion and inconsistency pertaining to the appropriateness of the use of therapist self-disclosure is evident. This will be discussed in terms of *congruence* and *authenticity, and empathy*. The questions that have been raised in previous sections will now be discussed and therapist self-disclosure within the existential-humanistic relationship will be appraised.

One could commence with the concept congruence to illustrate the diversity of opinion regarding an equation of this concept with therapist self-disclosure. The concepts "authenticity" and "genuineness" are integrated with this discussion. Bozarth (1990: 61) has referred to genuineness as an attitudinal quality. Comments by Bozarth (ibid make it difficult, for purposes of this discussion, to conceptually separate the two concepts, for example:

> My assessment of Rogers' comments in the literature, his demonstration films, and from previous personal communication led me to conclude that *Carl Rogers did not alter his fundamental views of client-centered therapy*. I noted that he was quite consistent in his fundamental views of the importance of the conditions of empathy, unconditional positive regard, and genuineness as attitudinal qualities that therapists needed to experience with their clients, and of his dedication to go with his clients in the direction that the client wanted to go and in the way the client wanted to do it. He became somewhat explicit about the importance of being

genuine in the relationship. The importance of genuineness as the primary condition to him was expressed in dialogue with Wood (Rogers and Wood, 1984), and in an earlier statement when he commented that genuineness

> alone may be facilitative (Rogers, 1967). He clarified this in an interview shortly before his death saying that 'if you have other feelings other than empathy, then congruence takes preference over everything else' (Hobbs, 1985).

Lietaer (1993) is outspoken in a qualified use of therapist self-disclosure as it pertains to this term. After quoting Rogers' (1962) definition of authenticity, which follows in the next paragraph, Lietaer (ibid) highlights the qualified use of self-disclosure.

> (the therapist)... openly has the feelings and attitudes that are flowing in him at the moment. This involves self-awareness; that is, the therapist's feelings are available to him - to his awareness - and he is able to live them, to experience them in the relationship, and to communicate them if they *persist* (italics added). The therapist encounters his client directly, meeting him person to person. He is *being* himself, not denying himself.

Lietaer (1993: 17):

> ... let me state that it does not mean that the therapist burdens the client with overt expressions of all his feelings. Nor does it mean that the therapist discloses his

total self to the client. It does mean, however, that the therapist denies to himself none of the feelings he is experiencing and that he is willing to experience transparently any *persistent* feelings that exist in the relationship and to let these be known to the client.

In his formulation of authenticity, Jourard (1971) has pushed this concept to its limits to actually prescribe the utilization of therapist self-disclosure. Based on humanistic concepts and dimensions, Jourard (1971: 133) describes the "disclosing therapist", and defines authenticity as:

> ... being oneself, honestly, in one's relations with his fellows. It means taking the first step at dropping pretence, defense, and duplicity. It means an end to "playing it cool", an end to using one's behaviour as a gambit designed to disarm the other fellow, to get him to reveal himself **before** you disclose yourself to him.

This implies an "equality" within the therapeutic relationship, a different stance to traditional psychotherapeutic approaches.

Mahrer and Fairweather (1993) echo these reciprocal considerations by urging therapists to expose, reveal, or disclose what is occurring inside. This enables the patient to do the same so that the back-and-forth process constitutes an encounter with reciprocal revealing and disclosing of each participant's deeper material.

Jourard (1971) further cites studies that have shown that it is not the technique or the theoretical orientation of the therapist which fosters growth but rather the manner of the therapist's **being** when in the presence of the patient. Jourard (ibid) suggests further that therapists be themselves in the presence of the patient, and let themselves be, avoiding **compulsions** to silence, to reflection, to interpretation, to impersonal technique, and kindred character disorders, but instead to strive to know their patient, involving themselves in his situation, and then responding to his utterances with their spontaneous selves. This to Jourard was what fosters growth.

Specifically concerning an equation of the concept congruence with self-disclosure, Vanaershot (1990) has confirmed that Rogers states that it is certainly not the aim for the therapist to express his own feelings. Vanaershot (ibid) cites Rogers (1957) to assert that if the therapist's feelings are standing in the way of the therapist's unconditional positive regard and empathy, it might be necessary to express them. But even this does not mean that the therapist should talk out these feelings to the client and that expressing these either to a colleague or supervisor might be just as effective.

van Balen (1990: 69) has clarified this to account for the "persistent feelings" taken from a previous quote, namely Rogers (1962) cited in Lietaer (1993). He has suggested that if after discussion with a colleague or supervisor, if, "even then these feelings remain ("persistent feelings"), and continue to prevent the desired empathic receptivity, a direct mention of them may be necessary.

Johnson (1971: 17) represents a less restrained approach and represents most probably the most radical proponent of

explicit and direct congruence. He has specifically spoken of a "congruent encounter". Citing an example he recalls having told a seductive but frigid female client: "I want to attack you sexually, I want you to explode and overflow". Johnson (1971: 19) feels that such personal involvement is the generative force in the process of psychotherapy. In his own words: "I let the other know that I am there, that I am real, and that I am deeply committed to our common bond of therapeutic encounter".

In his formulations of this involvement Johnson (1971: 19) rejects the term "disclosure" sensing that it "connotes some disclosure *about* the therapist rather than a direct experiential participation *of* the therapist in the personal encounter between himself and the client. In congruent participation then the therapist communicates something of himself to the client. It reflects a personal communication from the therapist of his own subjective feeling toward the client (Johnson, ibid).

At this stage one could refer back to the question of empathy and how the therapist's empathy is *conveyed* or *communicated* to the patient. In this regard, one can consider reflection of feeling as a response mode to convey *empathy*. Bozarth (1984), commenting specifically on Rogers, has noted that in the early 1960's there appeared to be some changes in his (Rogers) response patterns in therapy. This included a shift towards the attitudinal or experiential aspects of therapy and a departure from *reflection of feeling*. Rogers (1987: 39) bluntly rejected this phrase in the following way:

> I even wince at the phrase *reflection of feeling*. It does not describe what I am trying to do when I work with a client. My responses are attempts to check my

understanding with the client's internal world. I wish to keep an accurate, up-to-the-minute sensitivity to his or her inner searchings, and the response is an endeavour to find out if I am on course with my client. I regret that the phrase *reflection of feeling* has come to be used to describe this complex type of interaction.

Sundararajon (1995: 259) has captured Rogers' sentiments by discussing the fate of any "original word" which degenerates with popularity into a term of everyday use, and she specifically cited "reflective listening" (259) in this regard. Rogers (1987: 39) explains that "reflection of feeling" can be taught as a cognitive skill which contributes to the misrecognition of the genuine sensitive empathy and personal involvement of the therapist.

Bozarth (1984, 1990) has brought to awareness an evolution of *self-expressive interventions* as they pertain to the expression of empathy. This shift is intricately tied to the change from "non directive" to "experiential" (Lietaer, 1993: 32).

The time that has been earmarked for this change is the time between 1955 and 1962. In this regard, Wexler (1974) has described the aim of the client-centered therapist as being to help the client engage in an optimal mode of experiencing. The therapist thus becomes, on a moment-to-moment basis a facilitator in helping the client engage in a more productive mode of experiencing.

According to Gendlin (1970) cited in Lietaer (1993), this evolution has allowed the therapist to bring in something from his own frame of reference, as long as he keeps

returning to the client's experiential track.

Tobin (1991) has discussed Rogers' changing opinion on disclosing negative feelings. He cites Kahn (1985) who pointed out that Rogers' emphasis on prizing, unconditional positive regard, and empathy suggests an acceptance of the expression of positive feelings toward patients. Apparently, only later in his career did he begin to feel that feelings in general, including anger and other negative emotions should be revealed to clients if they are **persistent.**

As can be seen throughout this discussion, Lietaer (1993) has repeatedly and consistently qualified the use of therapist self-disclosure and demonstrated that the essential ingredients of existential-humanistic psychotherapy do not imply the unqualified use of therapist self-disclosure.

In an attempt to answer the crucial and fundamental questions about "what" to disclose, Lietaer (1993) employs Yalom's (1980: 414) basic criterion, namely: "does our self-revelation serve the client's growth process?" This criterion provides one with boundaries, and Lietaer (ibid) interprets this to imply that the therapist will only exceptionally mention facts from his or her personal life. This implies that self-revelation has little to do with the therapist's personal past or present life. What are then left to reveal are the therapist's feelings towards the client in the here-and-now, towards what happens in the session between client and therapist.

Yalom (1980) has been outspoken in this regard. He states clearly that it is of no service to disclose personal and past factual information about oneself. In harmony with Lietaer (1993), he suggests that therapists only express or reveal their feelings toward the client in the here-and-now,

towards what happens in the session between both of them. One is reminded here of the self-involving statements described in the previous chapter, and it seems as if there is a strong interpersonal colouring attached to these recommendations.

Lietaer (1993) is furthermore conservative in this regard to maintain that the feelings that are expressed are those that are **persistent.** Although the philosophical assumptions of existential-humanistic psychology make self-disclosure a viable therapeutic intervention, there are nevertheless boundaries. The type of self-disclosure advocated is consistent with the fundamental working principles of this psychological movement. The self-disclosures described above imply immediacy and focus mainly on the therapist's involvement in the psychotherapeutic situation. Even Johnson's (1971) radically different approach reflects the therapist's subjective involvement in the therapeutic encounter, and because it is restricted to his definition of congruence reflects a certain amount of discretion, qualification, and reserve.

3.2.3. Summary.

The humanistic tradition represents a marked departure from the orthodox "blank screen" and **archaeological mode of listening** towards an **empathic listening stance.** With such a radical shift transference is dealt with in the context of a relationship between two real people (Weiner, 1983). The transference relationship therefore becomes subordinated to the essential dimensions of therapy as set out above (Curtis, 1981; Lietaer, 1993).

It has been illustrated throughout this discussion that these dimensions represent an attitude within the therapeutic

situation. Although there is a use of self by the therapist this does not necessarily imply the **active** use of therapist self-disclosure.

Although one has become aware of minor inconsistencies regarding the appropriateness of therapist self-disclosure, the philosophical assumptions upon which existential-humanistic psychotherapy rests, makes this a viable option during psychotherapy. Therapist self-disclosure is not met with the heated debate nor the opposition as within certain psychoanalytic frames of reference. With this in mind, one could now commence with a discussion focusing on therapist self-disclosure within psychoanalytic paradigms.

3.3. A psychoanalytic view of therapist self-disclosure.

3.3.1. Introduction.

Within psychoanalytic frameworks, the definition of the psychotherapeutic relationship remains vague, confusing and controversial. There is profound confusion as regards the concepts fundamental to an understanding of psychoanalytic technique. These concepts bear directly on the nature of the relationship, specifically the nature of the therapist's participation within the relationship. This exerts an influence on the appropriateness of self-disclosure by the therapist.

In working towards the conceptualization of the nature of the therapeutic encounter the concepts neutrality, anonymity, transference, and countertransference need to be discussed. They co-exist and interact to influence the evolving nature of the therapeutic relationship. When one grapples with clarifying the nature of the therapeutic relationship, conceptualization of one theme mutually affects the other.

They are therefore in dialogue and a shift in the description of one causes systematic shift in the others and ultimately, the entire relationship functions differently.

For instance, when referring to the previous section on the existential-humanistic approach, a change in the conceptualization of the therapist's stance spontaneously called for a reappraisal of transference. Despite the inter-relatedness of these concepts, they will nevertheless be discussed separately, and then integrated in a section that pertains to the nature of the therapeutic relationship. With a comprehensive description of these concepts it is hoped that the place of therapist self-disclosure within psychoanalytic circles can be grasped and systematized.

Within the following discussion, relevant interpersonal attitudes as well as relevant concepts pertaining to self psychology and objects relations theory will be discussed. The reason for inclusion of these approaches will unfold during the discussion.

When discussing psychoanalytic theory, it is deemed necessary to implement organizing threads. For this reason various paradigms and models will be implemented to assist in systematizing the literature. These then serve as a point of departure and frame of reference for a discussion of the concepts central to psychoanalysis.

Greenberg's (1981) and Gill's (1983) paradigms, and Greenberg and Mitchell's (1983) and Mitchell's (1988) models will be integrated and reviewed. Greenberg (1981: 246) described the concept of paradigm as suggesting ... "the compatibility, although by no means the identity, of theories which are in fundamental agreement on such issues as the position of the observer in the observational field, the nature of the

subject matter (here, the nature of man), the determinants of motivation, the constituents of regulatory structure and so on".

This implies that: "Theories within a given paradigm approach the question of the therapeutic action of psychoanalysis similarly to other theories with the same paradigm, and quite differently than theories with the opposing paradigm" (Greenberg, 1981: 247).

A review of these paradigms aids in placing object relations theory and self psychology in perspective and describes their role and place within psychoanalytically orientated psychotherapy. This is deemed necessary as these approaches bear fundamentally on the analyst's stance, and the conceptualization of transference and countertransference, and hence the "action" of psychoanalysis. These innovative approaches within psychoanalytic thinking have challenged the very premises on which psychoanalysis has been established, and call for the reformulation of psychoanalytic concepts.

3.3.2. Paradigms and the therapist's participation in the therapeutic situation.

At this stage the concepts model and paradigm need to be clarified. Greenberg (1981) referred specifically to paradigm. Greenberg and Mitchell (1983: 380) based on Greenberg's (1981: 247) terminologies namely "drive/structure" and "relational/structure", refer to models, thus "drive/structure model" and "relational/structure model". Mitchell (1988) also referred to models.

Although it may appear that the researcher is using these concepts interchangeably, when reference is made to Greenberg

(1981) or Gill (1983), "paradigm" will be implemented and when reference is made to Greenberg and Mitchell (1983) and Mitchell (1988), "model" will be implemented.

Therapist participation implies the assumption of a role by the therapist within the analytic encounter. The role is circumscribed by the therapist's theoretical orientation. Allegiance to a certain paradigm defines the therapist's concept of the "working" and "analyzable" data within the analytic situation, and then his or her participation and role within the therapeutic alliance.

To understand the connection between lineage with a certain paradigm, the nature of the "working" data and the therapist's participation, the paradigms and models, as mentioned above have been integrated. Greenberg (1981) and Gill (1983) have specifically employed these paradigms to approach the question of the analyst's participation within the analytic situation.

Greenberg (1981) delineated two major competing paradigms which have dominated the history of psychoanalytic theory. The first is the "drive/structure paradigm" (Greenberg, 1981: 247) which originated in the early work of Freud, and has as foundation the biological, instinct base. Gill (1983: 201) referred to this as the "drive-discharge paradigm".

The second is the "relational/structure paradigm" (Greenberg, 1981: 247) which is a field theory, and which does not have as foundation the drive theory. Gill (1983: 201) termed this the **interpersonal** paradigm. The distinguishing feature, therefore, is that the drive paradigm understands structure as the transformation of original drive energies, while the relational paradigm sees structure as the developmental sequelae of early interpersonal exchanges. These names thus

point to the origin which theories within each paradigm postulate as accounting for the consistencies and regularities of personality which are embraced by the term "structure" (Greenberg, 1981: 247).

An important implication for the nature of the analyst's participation is that when drive is retained at the centre of the theory, it is assumed that analytic change derives from interpretation, from some version of making the unconscious conscious, rather than from aspects of the **actual encounter** with the analyst (Greenberg, 1981).

This distinction between drive/structure and the relational/structure is not always clear cut, especially if one would like to label these paradigms as intrapersonal or interpersonal respectively. The following paragraphs demonstrate this.

According to Greenberg and Mitchell (1983), there are two men who, more than any others have dominated the field of psychoanalysis. In the first instance they describe **Freud's** creation of psychoanalysis in terms of his early decision to build his theory on a vision of man emphasising the internal workings of a psychic apparatus fuelled by the energy of instinctual drive.

Secondly, they describe the innovative significance of **Sullivan's** alternative framework of the interpersonal field and his study of the development of the self. Sullivan's radical departure from drive theory constitutes a fundamentally different approach to the problem of object relations with vastly different implications for theory construction.

Interpersonal psychoanalysis, as described by Greenberg and

Mitchell (1983) does not constitute a unified, integral theory, as does classical Freudian drive theory, but represents instead a set of different approaches to theory and clinical practice held together by shared underlying assumptions and premises, drawing in common on what has been characterized as the relational/structure model.

Greenberg and Mitchell (ibid) cite Sullivan, Fromm, Horney, and Fromm-Reichmann in this regard, and names of more recent and prominent authors, for instance, Buechler (1993, 1996), Ehrenberg (1982, 1984, 1992a, 1992b, 1995), Gill (1983), and Wachtel (1982, 1993) can be attached.

In some instances there appears to be a blending of paradigms. The **object relations** theorists exemplify this. They have in some instances remained intrapsychic even retaining some aspects of the drive model but they nevertheless place primary emphasis on the infant's early object relations. In this regard, Melanie Klein has been mentioned by Greenberg and Mitchell (1983), Grotstein (1982), Mitchell (1981, 1995), and Sutherland (1980), and presents a position midway between the drive/structure model and relational/structure assumptions and formulations. She is thus seen as a transitional figure between the drive/structure model and the relational/structure model.

Fairbairn, cited in Greenberg and Mitchell (1983), Grotstein (1982), Mitchell (1981, 1988) and Sutherland (1980), developed a theoretical perspective, which along with Sullivan's interpersonal psychiatry, provides the purest and clearest expression of the shift from the drive/structure model to the relational/structure model.

There are however marked differences between Fairbairn, an object relations theorist, and Sullivan, an interpersonal

theorist, although both are placed within the relational/structure model. These differences have been noted by Greenberg and Mitchell (1983) and pertain to the fact that Fairbairn with his emphasis on internal representations, has remained intrapsychic, whereas Sullivan's emphasis on operational concepts and the tendency of the person to avoid anxiety, remains interpersonal.

These two theorists exhibit the diversity within the relational perspective, and this bears fundamentally on the therapist's role within the psychoanalytic situation and ultimately on the nature of his or her participation.

Greenberg and Mitchell (1983) have also grouped together the **American Ego Psychologists**, such as Kernberg, Mahler, Jacobson, and Hartmann. These authors have attempted to approach object relations through the conceptual model of Freud's drive theory.

Each author therefore retains drive at the centre of the theory, but attempts to modify the theory to account for the data derived from the study of object relations. Jacobson and Mahler specifically attempted to reconcile drive theory with data generated by the study of the early relationship between mother and child. Kernberg attempted to retain his lineage with Freud by integrating the approach of Jacobson and Mahler with concepts imported from the work of Klein and Fairbairn.

It now becomes evident that the drive/structure model is consistent in terms of what constitutes the major focus of the theory and the action of psychoanalysis. Within the relational/structure model, there is profound diversity. To illustrate this diversity, particularly as it pertains to the action of psychoanalysis, Greenberg (1981) has pointed to

some of the considerations advanced by analysts of the **British School of object relations** who construe the participation differently to the **American Interpersonalists.**

Whereas the interpersonalists participate **with** the patient, the object relations theorists participate **in** the patient's illness. This mode of participation will become clear in a discussion on the countertransference. There is much conceptual confusion as regards many of the American authors and their residence in a paradigm. The confusion arises when authors such as Volkan (1993) refer to Kernberg, Mahler, and Jacobson as object relations theorists. Greenberg and Mitchell (1983) have discarded the tendency to refer to these American ego psychologists as American object relations theorists. Although the American ego psychologies are in essence object relations theories, they differ fundamentally from the British object relations theorists in that they have approached object relations through the conceptual model of drive theory. They are therefore operating out of two entirely different conceptual systems.

In addition to the drive/structure model and the relational/structure model, Greenberg and Mitchell (1983: 385) added a "mixed model", which they feel is an attempt to circumvent the choice between a drive/structure paradigm and relational/structure paradigm. This is done by juxtaposing relational theorizing alongside the classical system. According to Greenberg and Mitchell (1983) these theorists, and they cite Kohut and Sandler as belonging to this group, neither abandoned nor stretched drive model principles, but preserved them and mixed them with relational model observations and formulations.

Concerning Kohut, there is confusion as to the abandonment of the drive model. Some authors for example, Basch (1991) and

Ornstein (1991) have demonstrated that when it comes to the practice of therapy and the therapist's involvement, Kohut's listening stance of **sustained empathic enquiry** has cleansed the field from its biological infiltrations.

Gill (1983) has clearly formulated that Kohut's theory represents a significant, though not complete abandonment of the drive structure. In a later publication, Mitchell (1988) placed self psychology, which was developed by Kohut, in the relational matrix. To place this in perspective, Mitchell's (ibid) models can briefly be described.

Mitchell (1988) distinguished between the drive-conflict model, the developmental-arrest model, and the relational-conflict model. In this instance, the drive-conflict model is the same as Greenberg and Mitchell's (1983) drive/structure model, with the same bearing on the action of psychoanalysis. Within Mitchell's (ibid) models, the development-arrest model and the relational-conflict model comprise the previous "mixed" and relational/structure model.

According to Burke and Tansey (1991), Mitchell (1988) placed Winnicott and Kohut in the developmental-arrest model. "As the very title of this model suggests, psychopathology is viewed as a result of essential strivings for self-cohesion that are thwarted by significant parental figures" (Burke and Tansey, 1991: 361). As a result of failures by parental figures over time the child is left to sequester his or her longings for self-cohesion. An understanding of Kohut's conceptualizing of transference, which is explained in a following section, will facilitate an understanding of his position in the developmental-arrest model.

Within the relational-conflict model, human development is determined by the "relational matrix" (Burke and Tansey,

1991: 370) that each individual builds up and maintains over time. This relational matrix includes the intrapsychic structure acquired through interpersonal experiences which the individual continues to establish and re-establish in new environments (Burke and Tansey, 1991).

With a brief overview of these paradigms and models, their bearing on the nature of the "working" and "analyzable" data within the analytic situation can now be approached. The best way to understand the "action" of any psychoanalytic theory is by examining its central concepts, namely, neutrality, transference, and countertransference.

3.4. Psychoanalytic concepts and the therapist's participation.

3.4.1. Analytic stance.

When discussing the analyst's stance, one should commence with a reappraisal of the concept **neutrality**. This serves as an appropriate point of departure because a description of stance in contemporary schools of thought either represents a move away from, a reformulation of, or an expansion of the concept neutrality. This will now be clarified and related to the various trends within psychoanalysis.

The neutrality concept will now be discussed and various avenues of exploration will be opened. This then facilitates a discussion of the transference and countertransference. Neutrality originated in Freud's early theory and many phrases reflect his idea of this concept. He used terms such as "blank screen", "evenly hovering attention", "reflecting mirror", and "surgical detachment" (Greenberg, 1986: 90). These terms imply that the analyst should be an external, objective, and impartial observer. A descriptive

synonym within Freudian theory is the word **anonymity.**

This implies that within orthodox psychoanalysis, connotations of indifference are attached to the term neutrality. Goldstein (1994) has listed the characteristics associated with neutrality within classical, orthodox conceptions of the term. These characteristics refer to abstinence, anonymity, and fantasy in stead of reality in the analysis of the transference.

That prime importance is awarded to the analyst's anonymity and fantasy instead of reality implies that the therapist is firstly an old object, and only later a new object for the patient (Burke and Tansey, 1991). According to Greenberg (1986), this concept is not widely accepted within contemporary trends. Neutrality has been challenged and reformulated by various *interpersonal* theorists, for example Ehrenberg (1982, 1984, 1992a), Wachtel (1982) and Wachtel, Lichtenberg, and Greenberg (1986).

Wachtel et al. (1986) believe that ideas and practices associated with neutrality are deeply flawed. The stance of neutrality was defined so as to assure that the waters of transference are not muddied. Sullivan (1970) pointed out that one could never really remain out of the field. This implies that one cannot avoid influencing what one is observing. We always observe something in relation to ourselves (Wachtel et al. 1986).

This insinuates that what transpires does not only have to do with the person of the analyst. Some of what the patient experiences, he would likely experience in similar fashion whoever was sitting in the therapist's chair and any particular analyst certainly evokes different reactions in different patients.

The interpersonal impact upon the concept of transference creates a shift in the conceptualization of neutrality and ties up with Breger's (1984) definition. He describes neutrality as the therapist not playing his side of the interactive game. Instead the therapist must attempt to understand the interaction and invite the patient to step outside the immediate press of feeling and behaviour and engage in a process of mutual understanding. It is therefore only when the therapist does not assume the role that is automatically and spontaneously expected of him that such exploration is possible.

With this understanding of neutrality, one can see that, within the interpersonal orientation, there will never be any fixed rules on how to be neutral with all patients. The term has thus expanded from a unimodal, static definition to a dynamic, unique, and interactional dimension of psychotherapy. In this instance, each analytic encounter must be understood on its own terms. Being neutral could therefore imply being quiet, and it could also imply being the opposite. Given this definition of neutrality, that is not assuming the expected role, could involve the analyst in any number of activities.

Greenberg (1986) commenting along these lines and pushing this argument to its limits has even suggested that self-revelation could mean being neutral. One can thus see that the concept neutrality is retained, but that it has been modified so as to exclude the connotation of the blank screen.

Buechler (1993) has underscored three important implications of this conceptualization of the interpersonal stance as outlined above. Firstly that each situation with each patient requires us to examine what would constitute

neutrality, which suggests that the meaning of any interpersonal event is shaped by a particular interaction. Secondly, that emotional expression by the analyst may be required to maintain neutrality. Thirdly, that awareness of what the patient tends to invite the analyst to enact is vital to the analytic process. The question of how one's theory affects one's stance within the therapeutic relationship, and ultimately how one practices psychotherapy, should now have become more pronounced.

Upon revision of paradigmatic residence of these interpersonal theorists and implementing Greenberg and Mitchell's (1983) models, it is clear that they dwell within the relational/structure model. Within this relational context, an alternative definition for neutrality needs to be formulated. Greenberg (1986) has formulated this.

> Within the relational model, the therapist inevitably participates somewhere within a historical continuum of the patient's relationships with others. This implies that he "fits" somewhere into the patient's representational world, either assimilated into an old relational pattern or experienced as new, and different from what the patient has experienced before. That the therapist participates is not a matter of choice, but technique is a matter of specifying how he should participate (Greenberg, 1986: 97).

One now becomes cognizant of a delicate balance that the therapist has to strive to attain. This requires that the therapist strike a balance between being seen by the patient as an old object and as a new object. At this point one can now formulate Greenberg's (1986: 97) new definition of analytic neutrality as it pertains to the relational/structure model: "Neutrality embodies the goal of establishing an optimal tension between the patient's

tendency to see the analyst as an old object and his capacity to experience him as a new one".

Of significance are the technical implications. One has now shifted from a static definition to a definition which presupposes that the activity of the neutral analyst is always dependant upon the quality of the patient's relationships with others. Neutrality is therefore not to be measured by the analyst's behaviours at any moment, but by the particular patient's ability to become aware of and to tolerate his transference (Greenberg, 1986).

Stolorow, Brandchaft, and Atwood (1987) exemplifying the **intersubjective approach** have quite profoundly reconceptualized the analyst's stance. One is reminded that this approach is an extension of self psychology as set out by Kohut. The self psychologists have replaced rigid anonymity, strict abstinence, and experience-distant neutrality with a more human therapeutic climate and experience-near-empathy.

The concept neutrality has been replaced with the concept of **sustained empathic enquiry.** In intersubjective terms specifically, neutrality is replaced with the precept that the analyst's interventions should, as much as possible, be guided by an ongoing assessment of what is likely to facilitate or obstruct the evolving, illumination, and transformation of the patient's subjective world.

Kohut cited in Tobin (1990) has stressed that taking an aloof, objective stance with patients reinforces their experience of themselves as being alone, unworthy of understanding, and needing to adapt to the reality of others in order to survive. This does not imply that therapists express feelings to clients, or be inappropriately self-

revealing, indiscriminately supportive, or confrontative (Tobin, 1990).

Tobin (1990) furthered this argument by comparing it to the empathic caretaker who knows instinctively what his or her child needs for the furthering of psychological or emotional growth without infantalizing or pushing the child beyond his or her capable limits.

As with the rule of abstinence, the empathic stance decisively shapes the therapeutic dialogue, but in an entirely different direction. Mitchell (1988) has placed the intersubjective theorists in the developmental-arrest model. In contrast to the drive-model wherein the analyst is first experienced as an old object, within the developmental-arrest model, the analyst is experienced firstly as a new object, and then with minor empathic failures as an old object and then with the necessary intervention, a new object.

As will become evident in the discussion focusing on countertransference, on a continuum from strict anonymity to personal revelation, certain object relations theorists appear to be at the extreme end of the continuum that represents personal revelation. Two such authors who will frequently be referred to throughout this study are Bollas (1983) and Maroda (1991), as they advocate expression of countertransference affect.

With their directions to regress with the patient and in the case of Bollas (1983:6) to become "situationally ill", one could err in thinking that this represents a marked rejection of the blank screen concept. Upon closer examination, however, they are closer to the traditional formulations of the "blank screen" concept than their interpersonal and intersubjective counterparts.

To help understand this statement, Bollas' (1983:2) concept of "countertransference readiness" can be explained. In his own words (3):

> The psychoanalyst's establishment of mental neutrality is akin, in my view, to the creation of an internal potential space (Winnicott, 1974), that functions as a frame (Milner, 1952), inside which the patient can live an infantile life anew without the troublesome impingement of the clinician's judgements ... By establishing a countertransference readiness I am creating an internal space which allows for a more complete and articulate expression of the patient's transference speech than were I to close down this internal space and replace it with some notion of absolute mental neutrality or the idea of scientific detachment.

Bollas (1983) compares this countertransference readiness to Freud's metaphor of the mirror function, except that in this case the analyst's feelings become of paramount importance during the unfolding of the transference. Mitchell (1995: 89) has referred to the analyst as a "featureless container" in this regard where ... "The analyst's experience in question is interpreted as only the patient's projected into the analyst".

It was stated earlier that this concept as set out by Bollas (1983) resembles the blank screen approach. This is because, during mutual regression, the patient creates an environment where little or no room is left for any reality. The actual personality of the analyst is extricated, and object usage

(Mitchell, 1995; Winnicott, 1971; Winnicott, 1968 cited in Mitchell, 1993) by the patient takes place.

In contrast the interpersonal and intersubjective approaches allow for a certain amount of reality as contributed by the analyst. This will become more significant in a discussion of the transference, and again in the final integration of concepts in defining the nature of the therapeutic relationship.

It was mentioned in the previous section devoted to a discussion of analytic stance that Hoffman (1983) has authored an article on critiques of the blank screen concept. This has helped to systematize the literature pertaining to this concept. In his writing he has implicitly demonstrated the enmeshment of one's conception of transference and one's conception of neutrality. A discussion of these critiques will therefore address the mutuality of these concepts. Before this discussion can commence however, it is imperative to first review the literature pertaining to transference.

3.4.2. Transference.

What is relevant to this study is the changing nature of the conceptualization of transference, and how this bears on the reality of the relationship. This shift in conceptualization brings about an alteration in how the therapist's participation in the psychotherapeutic situation is construed.

Freud recognized and accepted that the patient's transference reactions and resistances produced the essential material for the analytic work (Greenson, 1967). The analytic situation was then arranged so as to facilitate the maximal development of transference reactions. The analyst therefore conducts

himself so that the transference in all its aspects develops in its own terms (Gitelson, 1973).

Wachtel (1982, 1993) has referred to this as the **rhetoric of emerging and unfolding**, which implies that regardless of the person of the analyst, as long as he "gets out of the way", the transference will unfold. This line of reasoning demonstrates once again the mutuality of analytic stance and transference, and it is precisely within the notion of the rhetoric of emerging and unfolding, that the blank screen approach by the analyst is conceptually justifiable. This mode of participation by the analyst is in harmony with the drive/structure model (Greenberg and Mitchell, 1983) and the drive-conflict model (Mitchell, 1988).

Transference has been radically reformulated by neo-Sullivinian, self psychology, and intersubjective approaches. Object relations theorists have shifted transference phenomena to a pre-oedipal level, and this has interesting ramifications for the conceptualizing of the countertransference, and the nature of the analyst's stance. These changing formulations need to be addressed.

Kohut (1968) and Kohut and Wolf (1978) have radically altered the transference concept. Fundamental to this transference is Kohut's selfobject concept. To facilitate understanding of this discussion on the changing conceptualizing of transference, the selfobject concept needs to be clarified.

Although Grotstein (1982) states that previous object relations theorists had already implied such a concept, it was Kohut (1968) who explicitly formulated this concept and included it in the transference concept.

According to Levine (1983), the term with which self

psychologists denote the people and things that patients use to maintain their emotional equilibrium as if they were parts of their own selves is the **selfobject.** Stated more simply, selfobjects are objects which are experienced as functional parts of the self. This represents an extension of the self concept beyond the boundaries of the subject's intrapsychic and bodily self to include ways in which objects, which, to an outside observer appear to be external to the subject's self, are related to by the subject as if they were psychically internal (Levine, 1983).

This extension of the self beyond the physical boundaries is what separates self psychology from object relations theory (Ornstein, 1991). This selfobject concept with its transferences ensures that self psychology and the intersubjective approach, which is in essence, an extension of self psychology remains intrapsychic.

A significant point to be made concerns the control that one expects to exert over selfobjects, as one exerts control over other body parts. The expected control is therefore closer to the concept of the control which a grown-up expects to have over his own body and mind than to the concept of the control which he expects to have over others (Kohut and Wolf, 1978).

What is relevant for a study of psychotherapy is that at least for some patients, the need for selfobjects and the qualities and defenses against their relatedness to selfobjects constitutes a major source of their psychopathology and a powerful determinant of the kind of relationship that they will develop in psychotherapy (Kohut and Wolf, 1978). If one recalls the models set out above, Kohut resides in Mitchell's (1988) development-arrest model. Within the analytic situation, according to Burke and Tansey

(1991: 362): "The developmental-arrest therapist views the patient as striving to establish within the safety of the therapeutic interaction the type of relationship that will allow him to unlock his developmentally frozen needs for self growth".

The selfobject concept leads to a discussion of a self psychological conceptualization of transference. These can be referred to "selfobject" or "narcissistic" transferences (Kohut and Wolf, 1987; Levine, 1983). It is the ongoing need for specific homeostasis providing interactions with the selfobjects that determines the unique quality of relatedness that develops in the important relationships in the lives of patients, as well as those which they form with their therapists (Levine, 1983).

In the light of this, three types of transference can be delineated. In the first instance, one could refer to the **idealizing transference** (Kohut and Wolf, 1978: 413) in which the therapist is related to as a source of soothing, tension regulation. This is comparable to the child's reliance upon the parent for the provision of soothing and comforting for the maintenance of its stimulus barrier.

The second transference configuration pertains to the **mirror transference** (Kohut and Wolf, 1978: 413) which refers to the therapist's participation as facilitator in the patient's deepening awareness and recognition of his self. A significant function of the therapist within this transference is to reflect the patients' perceptions of their selves so that they can receive assistance in the development of a sense of conviction that what they perceive about themselves is true (Levin, 1983).

Wolf (1988: 185) cited in Cornett (1991) describes

twinship/alterego selfobjects as sustaining "... the self by providing the experience of a perceptible presence of essential likeness of another's self". Kohut (1968) had originally integrated this into his concept of the mirroring transference and described it as a less archaic form, in which the patient assumes that the analyst is like him or that the analyst's psychological make-up is similar to his.

Cornett (1991) has cited authors such as Baker and Baker (1987) and Detrick (1985; 1986) to demonstrate how twinship/alterego selfobject needs have become separated from mirroring selfobject needs. In this instance, the **bipolar** self becomes **tripolar** with twinship/alterego selfobject development constituting the third pole (Baker and Baker, 1987) cited in Cornett (1991).

As an extension of Kohutian self psychology, the **intersubjective approach** warrants discussion. This approach has elaborated on the tri-polar transference configuration, and reformulated transference as an **organizing activity.**

According to Stolorow et al. (1987), the concept transference may be understood to refer to all the ways in which the patient's experience of the analytic relationship is shaped. They state: "Thus transference, at the most general level of abstraction, is an instance of **organizing activity** - the patient **assimilates** (Piaget, 1954) the analytic relationship into the thematic structures of his personal subjective world" (36).

From this perspective, transference is not a regression nor a displacement from the past, but reflects rather an expression of the continuing influence of organizing principles and imagery that crystallized out of the patient's early formative experiences (Stolorow et al. 1987). An

important link with interpersonal approaches such as Chrzanowski (1982) and Wachtel (1982, 1993) hinted at in an earlier paragraph, now becomes evident. Wachtel (ibid) formulated his concept of **cyclical psychodynamics** which locates the heart of the psychodynamic process, not in the patient's preserved past but in the vicious cycles which past events set in motion.

It appears that the intersubjective approach does not allow for the rhetoric of emerging and unfolding as set out by Wachtel (1982), that is, the events do not just "unfold" regardless of the analysts. The traditional formulations of transference, enhanced by an archaeological mode of listening do not allow for assimilation, whereas the interpersonal approaches and the intersubjective approach do.

Kohut's (1968) conceptualization of transference does not reject the rhetoric of emerging and unfolding. This is confirmed by Kohut (1977:215) cited in Hoffman (1983) in the following way:

> the essential transference (or the sequence of the essential transferences) is defined by pre-analytically established internal factors in the analysands personality structure, and the analyst's influence on the course of the analysis is therefore important only insofar as he through interpretations made on the basis of correct or incorrect emphatic closures- either promotes or impedes the patient's progress on his *predetermined* (italics added) path.

It is now evident that the intersubjective approach adheres to the cyclical psychodynamic viewpoint and that the Kohutian

approach adheres to the principle of emerging and unfolding. In this regard, the intersubjective approach appears to be a mediating influence between Kohutian self psychology and a fully interpersonal approach.

Loud appeals for therapist self-disclosure have come specifically from American Interpersonalists and British Object Relations theorists. These appeals are heard within a discussion of countertransference. Before this can be understood, their conception of transference must also be outlined. This conception has borne dramatically on the nature of the therapist's participation within the analytic situation.

Object relations approaches expand the concept of transference to include not only a projecting onto but a projecting **into** the analyst. Within this theorizing, transference is rooted in **primitive pre-verbal infantile**, hence **preoedipal** experience. This is consistent with the Kleinian concept of projective identification, as explained by Sutherland (1980) and Grotstein (1982).

In this instance, the patient is seen as not merely distorting the analyst, but also doing things to the analyst's mind, projecting **into** the analyst in a way that **affects** him or her.

These primitive defense mechanisms will be explained in a later section, but at this stage, it is imperative to grasp the shift that has taken place from an oedipal to a preoedipal level of functioning and the effect that these defense mechanisms have on the therapist's participation.

To aid in summarization and integration of what has been discussed with the analyst's participation being an exclusive

focus, Hoffman's (1983) paradigms can be employed. As mentioned in the previous section, a discussion of these paradigms also bridges the gap between a discussion of transference and the analyst's stance.

Hoffman (1983) has identified two types of paradigms and critiques of the blank screen concept and how this relates to the nature of the analyst's participation within the transference.

The first group of critiques pertain to the **conservative** critiques who retain the notion that a crucial aspect of the patient's experience of the therapist has little or no relation to the therapist's actual behaviour or actual attitudes. The conservative critic reserves the term transference for this aspect of the patient's experience. At the same time, however, he objects to a failure to recognize the importance of another aspect of the patient's experience which is influenced by the "real" characteristics of the therapist, whether these real characteristics promote or interfere with an ideal analytic process.

In contrast to conservative critiques, the **radical** critiques reject the dichotomy between transference as distortion and non-transference as reality based. They argue that the transference always has a significant plausible basis in the here-and-now. These critiques therefore deny that there is any aspect of the patient's experience that pertains to the therapist's inner motives that can be designated as distorting of reality.

For the radical critique the distinguishing features of the neurotic transference have to do with the fact that the patient is selectively inattentive to certain facets of the therapists behaviour and personality, that the patient

chooses one set of interpretations and that his emotional life and adaption are unconsciously determined the particular viewpoint he has adopted.

Importantly too, he has behaved in such a way as to actually elicit overt and covert responses that are consistent with his viewpoint and expectations. The transference therefore represents a way not only of construing but also of constructing and shaping interpersonal relations in general and the relationship with the analyst as well (Hoffman, 1983).

In this regard, one is reminded of Wachtel's (1982, 1993) theory of **cyclical psychodynamics** which explicitly rejects the rhetoric of emerging and unfolding, and places emphasis on the "real" relationship between therapist and patient.

Hofmann (1983) then placed the conservative critiques and the radical critiques within paradigms, namely the **asocial** paradigm and the **social** paradigm respectively. It is interesting to note that he placed Kohut with the conservative critiques which has an asocial conception of transference. This is linked to comments made earlier about Kohut not rejecting the rhetoric of emerging and unfolding as set out by Wachtel (1982, 1993).

Kohut (1977) cited in Hofmann (1983) did nevertheless advocate less restraint and more friendly, spontaneous involvement, as regards the analyst's stance, and defined analytic neutrality as "... the responsiveness to be expected, on an average, from persons who have devoted their life to helping others with the aid of insights obtained via the empathic immersion into their inner life (252).

Amongst the radical critiques Hoffman places as examples

Ehrenberg (1982), Searles (1978-1979) and Paul Wachtel (1982) who strongly adhere to the cyclical psychodynamic point of view. There is an underlying view of reality that the radical critiques share, and this view basically pertains to the notion that reality is not a pre-established given or absolute. This means that what the patient's transference accounts for is not a distortion of reality but a selective attention to and sensitivity to certain facets of the analyst's highly ambiguous response to the patient in the analysis (Hoffman, 1983).

Although Hoffman (1983) did not mention the intersubjective approach which is an extension of Kohutian self psychology, the lineage with the social paradigm is evident. This seems plausible in the light of what was discussed earlier regarding their non-acceptance of the rhetoric of emerging and unfolding, that is their increased awareness of the real qualities of the therapist and the therapeutic interaction.

This implies that the therapeutic process focuses attention on the contributions of both patient and analyst (Stolorow et al. 1987). The intersubjective approach therefore rejects the rule of abstinence as prescribed by the blank screen approach.

With their profound modification yet resemblance of the blank screen approach, the object relations approaches adhere to the rhetoric of emerging and unfolding, with the analyst's personality being extricated for the therapeutic process (Hoffman, 1983). For this reason they are placed within the asocial paradigm.

3.4.2.1. Implications for therapist self-disclosure.

Within American interpersonal approaches and object relations

approaches, cries for therapist self-disclosure are heard within discussions of countertransference. Appeals for self-disclosure within a self psychology framework are heard from within a discussion of the transference, and specifically within the twinship or alterego transference. This normally revolves around a debate of whether empathy is conceived as curative in its own right, that is, whether it becomes a corrective emotional experience or whether interpretation remains the curative factor (Goldstein, 1994). These arguments have been subject to debate and contention by two authors namely Chernus (1991, 1992) and Cornett (1991, 1992).

Cornett (1992: 219) has referred to an "orthodoxy" in self psychology which places interpretation at the centre of psychological cure. The heated debate between the two above-mentioned authors began in 1991 when Cornett argued for self-disclosure as an empathic response to the patient's need for an alterego or twinship experience.

Adhering to this line of thought, he feels that therapist self-disclosure presents itself as a useful tool with some clients who reach impasses in treatment which are based on twinship deficits. Based on these assumptions, Cornett (ibid) explains how he admitted or confessed to a patient that he too is a homosexual.

Chernus (1992) has criticized this approach harshly stating that it has downplayed the importance of insight. She has questioned the long term effects of the experience as well as the amount of structural change taking place within the patient. According to Goldstein (1994), this issue remains unresolved in self psychology.

This conflict in the literature is possibly a reflection of the roots on which this theorizing has been built. Tobin

(1990) has discussed Kohut's fluctuation regarding the issue of interpretation versus empathy as a corrective emotional experience. Tobin (ibid) has discussed the ways in which Kohut changed ideas on this issue, at first magnifying the importance of empathy as being curative in its own right, and then being swayed by pressure from orthodox analysts to underscore the importance of interpretation once again.

Whereas the self psychological approaches have dramatically reformulated the conceptualization of transference, the object relations theorists have done so with countertransference which has radical implications for the possibility and appropriateness of therapist self-disclosure within their frame of reference. This is due to the fact that within a discussion of countertransference, the issue of the therapist's involvement explicitly comes to the fore.

3.4.3. Countertransference.

There appears to be greater controversy pertaining to countertransference than what there is to transference. There is voluminous literature on countertransference, for example, Epstein and Feiner (1979) and Alexandris and Vaslamatzis (1993), and this remains one of the central concepts within the theory of psychoanalysis.

Countertransference concerns therapist **affect**, and definitions differ vastly. This study is ultimately interested in how the therapist implements the countertransference. There are varying opinions regarding this, and fundamental to such a discussion is an understanding of the shifts that have taken place in the conceptualizing and defining of this multifarious concept. Within the psychoanalytic literature, there has been a move to a more expansive formulation as to what comprises

countertransference, as well as a move to increasingly explicit uses of countertransference affect.

One could commence this discussion with a brief revision of some earlier formulations of countertransference and proceed to more inclusive or holistic conceptualizations which have occurred within developing trends in psychoanalytic thought.

Freud (1910) cited in Boyer (1979) and Gans (1994) considered countertransference to be the obverse of transference. He described it as the repetition of the analyst's irrational, previously acquired attitudes, *now* directed toward the patient, and was assumed to be absent except in situations in which the therapist was inadequately analyzed. Freud thus deemed it necessary that the analyst eliminate such unconscious reactions as obstacles to treatment. It was considered a disturbing factor as it interfered with the emotional neutrality of the analyst, and contaminated the transferential field.

The more recent approaches to countertransference, as formulated by various object relations approaches, such as Bollas (1983), and Maroda (1991) are inclined to define countertransference as the **whole** of the analyst's attitudes and behaviour towards the patient. In the process however, they do not deny or by-pass pathology or residues of pathology in the therapist.

Maroda (1991) for instance frequently refers to the problems that can arise when the analyst is inadequately analyzed. This is however referred to as a subjective or idiosyncratic countertransference. In his seminal article "Hate in the Countertransference" Winnicott (1949: 70) distinguished between an "objective" and a "subjective" countertransference. He defines the objective

countertransference as such: "... the analyst's love and hate in reaction to the actual personality and behaviour of the patient, based on objective observation. In a similar vein, Volkan (1993: 156) has referred to this aspect of the countertransference as "common". McDougall (1993) has spoken of general countertransference reactions.

It remains evident that Freud's definition is not by-passed nor discounted. This point of view merely extends previous formulations. Segal (1993) has recapitulated the theoretical expansion that has taken place, and has commented that as analysis has developed, transference, which was at first considered a major obstacle in treatment, has come to be seen as the fulcrum on which the psychoanalytic situation rests. She feels that countertransference, first seen as a neurotic disturbance in the psychoanalyst, preventing him from getting a clear and objective view of the patient, is similarly also increasingly recognized as a most important source of information about the patient as well a major element of the interaction between patient and analyst. Gabbard (1993) and Gans (1994) have echoed this by describing countertransference as a source of valuable diagnostic and therapeutic information.

Elaborating upon Segal's (1993) comments, one could also recall the growth of the concept transference to include not only a projecting **onto** but a projecting **into** the analyst. Within this framework, Maroda (1991) has authored a book, namely: "The Power of the Countertransference: Innovations in Psychoanalytic Technique". After extensive experience with severely regressed patients, she has described many instances of being the recipient of these previously cited primitive defense mechanisms.

Being the recipient in this instance implies the rhetoric of

emerging as well as an objectivity. It implies that regardless of the personality of the analyst, he or she will become the recipient of the primitive defense mechanisms. This can be traced to Mitchell's (1995: 89) concept of a "featureless container", and linked to Winnicott's (1971: 125) concept of "object usage".

In concert with this is an awareness of another dimension of the countertransference, and this refers specifically to its effect on the technique of psychoanalysis and the degree and nature of the therapist's participation. This shift can briefly be explained in the following way.

Within the **id** or **biological model**, the analyst is expected to remain a blank screen intended to encourage regression so as not to distort the patient's transference behaviour (Fischer, 1990: 9).

Interpersonally, one could speak of **mutual participation**, which is already a major shift in terms of original, orthodox analytic stance. In this instance the therapist is expected to be a participant-observer.

The **intersubjective approach**, as discussed in the section pertaining to transference implies a **mutual regulation.** This implies that although the focus of the analysis is still the subjective intrapsychic experience of the patient, a major influence on the experience is the therapist himself. One thus needs to understand both sides of the intersubjective unit (Thomson, 1991). This implies a very intricate and intimate connection between the patient's transference, and the therapist's countertransference.

After closer review of the literature, one could almost refer to the countertransference, as the therapist's transference.

This may be said as this approach emphasizes that the countertransference is broadly conceptualized as a manifestation of the analyst's psychological structures and organizing activity (Stolorow et al. 1987). This countertransference has a decisive impact in shaping the transference and co-determines which of its specific dimensions will occupy the experiential foreground of the analysis (Stolorow et al. 1987).

The **object relations** approaches that have arisen from the treatment of severely disturbed populations, speak of **mutual regression.** The British object relations theorists specifically advocate this intentionality and mode of participation. They operate from out of the relation/structure model as set out by Greenberg and Mitchell (1983), and the relational-conflict model (Mitchell, 1988).

It has been during the treatment of more severely disturbed populations by analysts such as Blechner, M.J. (1996), Bollas (1983), Buechler (1996), Epstein (1979a, 1979b), Gabbard (1993), Giovancchini (1982), Kernberg (1970, 1974, 1993), Maroda (1991), McDougall (1993), Volkan (1993), Watson (1996), Wilkinson and Gabbard (1993), and Winnicott (1949) that the "special demands" placed on the analysts by these patients were eventually recognized and made explicit. These demands have threatened and taxed the orthodox and classical definition of the neutral analytic stance.

Many of these contemporary authors are presently addressing the impact of these demands upon the therapist. It is also becoming increasingly evident that the issue of countertransference and its implementation within the therapeutic encounter is a prominent focus in the recent literature, and this is thus currently a very controversial concern.

Up to now the changing conceptions of psychoanalytic concepts have been discussed, with the focus being on how these reformulations have borne on the nature of the therapist's participation. It has however been within an immersion into the literature on countertransference, that **specific appeals** for revelation by the analyst have become apparent.

The focus has narrowed from one of the therapist's participation to one of specific appeals for disclosure by the therapist. As mentioned earlier, these cries are heard chiefly from two sources; firstly, from the neo-Sullivinians, such as Ehrenberg (1982, 1984, 1992a, 1992b, 1995) and Feiner (1982); and secondly, from the British object relations theorists who rely on Winnicott's contributions and the Kleinian concept of projective identification (Wilkinson and Gabbard, 1993). This includes authors such as Bollas (1983) and Maroda (1991).

Although the American ego psychologists such as Kernberg (1993) for instance, describe the same impact upon the therapist as the British object relations theorists, they do not immerse themselves in the patient's pathology in quite the same way, nor do they encourage the expression of countertransference affect.

Ehrenberg's (1982, 1984, 1992a, 1992b, 1995) formulations are not coupled to any specific diagnostic category. In contrast the object relations theorists and American ego psychologists, for example Kernberg (1970) have built their theorizing about the therapeutic relationship around specific diagnostic groups. These groups pertain to the personality disorders and specifically the **borderline** and **narcissistic** disorders.

In documenting the treatment of these populations, these

analysts have revealed the preverbal, preoedipal, primitive transferences with the accompanying primitive defense mechanisms employed by these patients. It has been noted how these defenses **affect** the therapist, and how these affects can be employed in the psychotherapeutic situation.

Personality disorders have been written about in many ways, but it has specifically been the American ego psychologists, the neo-Sullivinians, and the object relations theorists who have focused on the impact on the therapist when treating these patients. As explained earlier, the American ego psychologists and the British object relations theorists are operating out of different conceptual systems. In spite of this however, both orientations base their theorising on the concept of **projective identification.** The difference between these approaches lies in the containment and management of this defense mechanism in the analytic situation.

Ogden (1993) helps clarify this by stating that although projective identification provides a context for understanding clinical phenomena, it does not necessarily dictate a specific technique with which the therapist communicates or implements this understanding.

To grasp the growth and broadening conceptualizing of countertransference, these character disorders can be discussed in terms of their pathogenesis. This serves as point of departure for a detailed and comprehensive study of the impact on the therapeutic encounter. Many theorists, for example, Kernberg (1970, 1974), Kohut and Wolf (1978) and Rinsley (1989) have elucidated the pathogenesis of personality disorders. This literature is very detailed and complex and extends beyond the scope of this study. For this reason only the approaches that facilitate an understanding of the nature of these patients' therapeutic involvement will

be outlined.

3.4.3.1. The character disorders: neutrality, transference, and countertransference reappraised.

Levine (1983: 153) has described the period 1950 -1970 as the **"era of the borderline personality organization"** and the time from 1970 onwards as the **"era of the narcissistic personality disorders"**. Object relations concepts are finding increasing application in the psychoanalytic and dynamic psychotherapeutic practice in the wake of increased numbers of pre-oedipally fixated, self-disordered patients who find their way into the consulting room (Giovancchini, 1982).

In extending and deepening classical psychoanalytic metapsychology, object relations theory widens the range of clinical therapeutic technique while remaining solidly within the framework of psychoanalysis (Giovancchini, 1982). In essence then this theory remains intrapsychic. The population of borderline and other primitively fixated patients has received increasing attention. Recently the treatment of such patients has moved from an exclusive focus on psychopathology to one that includes the therapeutic interaction within a psychoanalytic frame of reference (Giovancchini, ibid).

The therapeutic process has therefore gained more recognition, and certain relational aspects are really being cast under the spotlight. This can be understood in terms of the philosophical assumptions on which this theory rests. As can be recalled from the paradigms in a previous section, these theorists have stressed the importance of the relationship between the human being and his or her caretaker in the form of psychic structures from the beginning of life, rather than the Freudian emphasis on drives and unfolding

biology (Tobin, 1990).

The expanding literature concerning personality disorders reveals that object relations approaches are gaining increasing recognition. With the treatment of narcissistic patients (Kohut and Wolf, 1978) and more specifically the borderline patients (Kernberg, 1970, 1974, 1988, 1993; Gabbard, 1993; Rinsley, 1989; and Wilkinson and Gabbard, 1993), the therapeutic process has broadened from treating only those who could from a stable transference neurosis to those manifesting more chaotic transference phenomena. These are based less on displacement, and more on projection and projective identification.

Greenson (1967) has succinctly clarified this distinction. He clearly differentiates between transference displacements and transference projections. In the first instance, the essential mechanism in the neurotic transference is the displacement onto the analyst of reactions to **whole** significant persons or **whole** object representations from the patient's past. There is then a close correspondence between the memory of such whole significant persons and such whole object representations.

In the second instance, as regards transference projection the patient is "ejecting something from within his **self-representation** onto or into another person" (Greenson, 1967:165). Such transference projections are characteristic of the severely regressed patients and have been described by many, for example Bollas (1983), Epstein (1979a, 1979b), Kernberg (1970, 1974, 1993), Maroda (1991), Rinsley (1989), and Volkan (1993).

In the analysis of transference displacements the patient's recall of the past helps him to differentiate internal from

external reality. His memories of experiences with earlier significant figures serves to reduce the correspondence between internal images and the real person of the analyst. The patient then becomes aware that he is reenacting an unresolved emotional situation from his past, and in this way the transference displacements are dissolved.

The function of the transference projection is, however, entirely different and more urgent. Its function is to preserve a weak ego against the disorganizing effects of highly charged primitive internal conflicts. By ejecting one of the conflicting elements, together with its affects and impulses, and depositing it in the other person, the ego externalizes the conflict, thereby creating an adversary situation (Epstein, 1979a).

This projection is not influenced by memory or other rational processes of the ego. The analyst may not therefore by stepping out of the adversary position reduce the patient's need to have him there. The point being made is that the differences in the nature of the transference have different effects on the therapist and call for different reactions. Before these effects are discussed, one could briefly elaborate on the nature of these defense mechanisms that elicit the effects on the therapist.

Kernberg (1970) has elaborated on the defense mechanisms of the narcissistic character disorders and they are also present in other forms of character pathology. All character defenses have among other functions a narcissistic one; they protect self-esteem. The defensive organization of the narcissistic personalities is similar to that of the borderline personality organization in general. They present a predominance of primitive defense mechanisms such as splitting, denial, projective identification, omnipotence,

and primitive idealization (Kernberg, 1970).

Kernberg (1967) cited in Adler (1982) has described the problem of splitting in the borderline. In Kleinian terms, people who use splitting as a major defense have not achieved the capacity to tolerate loving and hating toward the same person at the same time. In splitting, the loving and hating may alternate over time, that is, the patient may love the same person one minute and immediately thereafter relate to that person with hatred as if the loving relationship never existed. As part of splitting, patients sometimes can be aware of emptiness, helplessness, hopelessness and despair.

Adler (1982) describes their feelings of helplessness in the face of the storm of good and bad around and within them, but with goodness not permanently inside. If they act at a moment when they are in touch with good, loving interactions with earlier people in their life, they cannot count on their permanence. In a period of lack of gratification which may follow their positive action, and which arouses their fury, all the good can be lost. Hopelessness, depression can occur with the feeling that they are in the midst of an insoluble dilemma that permits them no consistent core experience of self-esteem and of the constancy of good internal objects. They can also not count on current people in their life because they have projected their destructive and aggressive feelings onto them or provoked them to treat them so as to justify their distrust of them. They will therefore destroy, devalue, or reject anything that others attempt to offer them.

What is crucial to this study is how these defenses manifest during the process of therapy and what effect this has on the therapist, as this above-described situation often becomes the situation between the therapist and patient in the heat

of involvement (Adler, 1982).

One now enters a discussion of the "common" (Volkan, 1993: 156), "objective" (Winnicott, 1949, 70), and general (McDougall, 1993) countertransference reactions. Maroda (1991) has referred to these as the **major affective countertransference reactions**, and the works of various authors will now be integrated to briefly explain these.

Kernberg (1970: 71), has noted that in the past some clinicians had felt that severely regressed patients did not develop a transference, and that they always kept a "narcissistic noninvolvement" toward the analyst. He then remarked that these patients in fact develop a very intensive transference. What appears as distance and uninvolvement on the surface is underneath an active process of devaluation, depreciation, and spoiling. The undoing of this transference resistance typically brings about intense paranoid developments, suspiciousness, hatred, and envy.

The greatest fear of narcissistic patients, as set out by Kernberg (1970) is to dependent on anybody else, because to depend means to hate, envy, and expose themselves to the danger of being exploited, mistreated, and frustrated. In the course of treatment, their main defenses are erected against the possibility of depending on the analyst, and the development of a situation in which they do feel dependent immediately brings back the basic threatening situation of early childhood. This person's incapacity to depend on another person is a very crucial characteristic (Kernberg, 1970).

The severity of the transference resistances of narcissistic patients burdens the analyst. Kernberg (1970) cites Jones (1913), Abraham (1919), Rosenfeld (1964), and Kohut (1966),

who describe a severely negative therapeutic reaction in which the patients constantly have to defeat the psychoanalytic process. Kohut (1966) cited in Kernberg (1970) has illustrated how a patient with this personality structure could not tolerate the analyst's being a different, independent person.

Adler (1982) and Maroda (1991) have described the **helplessness and hopelessness** that borderline-and other severe character disorders induce in their therapists. He states that on the deepest level, these patients have a firm conviction that they will ultimately find themselves alone and empty, having been abandoned and disappointed by the person they depended on, or having been destroyed or driven away by that person. The experience is akin to that of annihilation and nothingness (Little 1960, 1966) cited in Adler (1982). This conviction is also based on the state of their internal objects: these persons cannot maintain an internal image of a basically helpful person without it being overwhelmed or lost because of negative introjects or feelings.

In the transference then, these patients re-experience a situation of early, overwhelming abandonment, loss and fury, with a repetition of very early helplessness and hopelessness which was felt or perceived in an early important figure. Ultimately these feelings of helplessness and hopelessness have to become part of the psychotherapy as similar feelings are experienced with the therapist as object.

Adler (1982) and McDougall (1993) have discussed the therapist's helplessness and hopelessness in seeing, in the patient, a persistence of anger and devaluation with little evidence that there is any internalization of anything good from therapy. This mirrors the patient's own similar but

usually more intense experience. In turn the therapist's helplessness is compounded by the patient's need to reject or destroy anything the therapist tries to offer during much of this time.

McDougall (1993: 105) describes feeling "about as useful as a cloth monkey for all the good that the patient was able to get out of their analytic work together". Inevitably, the therapist's rage is aroused (Adler, 1982). It can be seen that the transference-countertransference situations that develop in the treatment of severely narcissistic patients have to be addressed and approached differently.

All the patients' efforts seem to go into defeating the analyst, into making analysis a meaningless game, into systematically destroying whatever they experience as good and valuable in the analyst. One can well imagine that in time, the analyst may begin to feel "worthless" in his or her work with such a case. Following an unsuccessful, long treatment, a defensive devaluation of the patient on the analyst's part may occur. This in turn reinforces the patient's feeling that his analyst is becoming one of those dangerous objects from whom he had attempted to escape.

Volkan (1993:156) has described the "common" countertransference reactions when treating narcissistic patients, in the following way:

> Many analysts share a kind of drowsiness that can be considered "common". For example, Kohut (1971), Modell (1976) and Kernberg (1975), and I have independently and consistently reported feeling drowsy at times during the analysis of patients with full-blown narcissistic personality

organizations, in response to their narcissistic transference. While undergoing treatment, the narcissistic patient who activates his fantasy of being self-sufficient and grandiosely above needing anyone else, and who treats his analyst as non-existent or worthless, is likely to evoke such a feeling of drowsiness.

Along similar lines, Maroda (1991) has discussed the fears of abandonment, rejection, or engulfment in the symbiotic phase of treatment with borderline patients. She states that the symbiotic phase of treatment leaves both patient and therapist vulnerable to threats of emotional or physical abandonment. Patients who are very intrusive and demanding will ultimately trigger feelings of violation and fears of engulfment in their therapists.

Maroda (1991) and Wilkinson and Gabbard (1993) have specifically discussed the fear and anxiety that are elicited in therapists. Maroda (ibid) speaks of these feelings occurring in the treatment of antisocial personality disorder, paranoid schizophrenia and borderline personality disorder. She cites a vignette in which Kernberg in the light of mounting anxiety confesses this to a patient. Wilkinson and Gabbard (1993) with a very complete and comprehensive vignette demonstrate the mounting feelings of fear, anxiety, impotence, anger and frustration during an encounter with a borderline patient.

Maroda (1991: 3) has described years of feeling demeaned, frustrated, and unsatisfied with borderline patients in the following way.

> ... even when I had lost the new therapist's

self-consciousness and awkward-ness, I still felt there was either something I had not yet mastered or something missing in the way I was practising, because at the most crucial and deeply emotional moments in treatment, everything I did seemed inadequate. Somehow, even if partially effective, my interventions seemed to fall short of the mark, to not do justice to the awesome task of responding to the patient's most heartfelt expressions. Worse still, patients I worked with over several years began to confirm my fears by telling me how unsatisfying, or demeaning, or frustrating or lonely it was for them to receive such a minimal response from me.

What happened over time, however, was that certain patients pushed me beyond my ability to contain myself. These were the most emotionally tense and demanding patients, usually those with the diagnosis of borderline personality disorder. I discovered, during the occasional episodes when I expressed my anger or frustration at these patients, that rather than being disastrous such shows of emotion were indeed quite therapeutic. In fact, they led to dramatic breakthroughs.

These transference-countertransference situations have important technical implications. One can sense the immense "pull" on the analyst to "engage" in this therapy process. An immediacy is implied, which requires of the therapist an urgent and intense involvement.

Having discussed the impact of primitively regressed patients on the therapeutic encounter, one could now consider how this is dealt with by the therapist.

3.4.3.2. Clinical uses of the countertransference: Implications for therapist self-disclosure.

In the light of what has been discussed, certain authors can be called upon to demonstrate how the **use** of countertransference has developed and evolved. As seen in an earlier section, countertransference was originally conceptualized as residues of pathology in the analyst due to incomplete personal analysis. It was considered a private event, and at all times considered deleterious to the treatment process, and therefore never utilized in the analytic encounter.

With the introduction and awareness of the special needs of primitively regressed patients, and the accompanying objective countertransference, ideas about its uses have grown. From only a private use which brings the therapist to greater awareness of the analytic encounter, for example Kernberg (1970) and Adler (1982), there are some theorists who describe a process commencing with a private use to eventual revelation of the countertransference, and then analysis of this revelation, for example, Bollas (1983).

To systematize the literature in terms of the use of countertransference, Burke and Tansey (1991) implemented Mitchell's (1988) models. In their own words (352): "the issue of countertransference disclosure is a prime example of technique that can only be usefully discussed in the context of a particular model of development and therapeutic action".

It has already been explained how the drive-conflict model

(Mitchell, 1988) employs the blank screen concept and how countertransference has been viewed as a hindrance. During a discussion of neutrality, it was demonstrated how within this model, the analyst is instructed to remain unobtrusive and to "stay out of the way" so that the patient's intrapsychic conflicts can come forth in the form of the transference neurosis (Burke and Tansey, 1991).

It has also been confirmed that Kernberg and the American ego psychologists reside within this drive-conflict model. However, Kernberg (1965) cited in Burke and Tansey (1991) has changed the concept of countertransference to include a totalistic perspective. Even within the drive-conflict model then the countertransference concept has expanded. The ensuing paragraph will reveal however, that they do not advocate expression of this countertransference.

Kernberg (1970) commenting specifically on analysis with narcissistic patients, recommends that the analyst continuously focus on the particular quality of the transference and consistently counteract the patient's efforts toward omnipotent control and devaluation. He further advises that the analyst watch carefully for his long-term countertransference developments. As mentioned in a previous paragraph, Kernberg (ibid) does not advocate revealing to the patient what the analyst's reaction is.

In the above-mentioned vignette as cited by Maroda (1991) in which Kernberg's increasing anxiety forced upon him an unrehearsed revelation, Kernberg expressed shame and discontent at his revelation. He rather advises that the analyst bring the countertransference into the analytic process by constantly recognizing in the countertransference the hidden intention of the patient's behaviour. This implies that the therapist **privately** implements the

countertransference to understand what is happening in the therapeutic process. This understanding is not voiced and does not comprise "analyzable" data.

The countertransference responses are thus employed diagnostically and empathically. With the help of Grinberg (1993) the process can be described in the following way. The analysts introjects, actively and selectively the different aspects of the verbalized and non-verbalized material which is presented by the patient. The therapist then **metabolizes** the identification, and (re)projects them by means of interpretations. Metabolization implies a private sorting and processing of the analytic material. What is given back is processed and the intervention consists of an interpretation, perfectly in harmony with the philosophical assumptions of classical drive theory. This will be contrasted with an approach that appeals for mutual regression and eventual expression of the countertransference at a later stage.

When embarking on a discussion of the transference, one could not by-pass the self psychology approaches. Of particular importance, was the way in which Kohut (1968) radically altered the conceptualizing of transference within his conceptual framework. It has been demonstrated that this has had radical implications for the employment of therapist self-disclosure. Within these approaches then the issue of self-disclosure arises from the transference and not the countertransference.

Mitchell (1988) placed Kohut in the developmental-arrest model along with the intersubjective approaches. According to Burke and Tansey (1991) and Mitchell (1993) countertransference is also viewed as a hindrance in that it is an intrusion into the therapist's empathic understanding of the patient. Burke and Tansey (1991) refer to this as an

impediment to the therapist's empathic attunement to the subjective experience of the patient.

What confuses one is that Winnicott is placed in the developmental-arrest model while many authors, for example Ehrenberg (1984) and Bollas (1983), who reside in the relational-conflict model, draw heavily from his seminal article "Hate in the Countertransference" when they advocate countertransference expression. Burke and Tansey (1991) have clarified this in the following way.

To understand this argument, the vignette from Winnicott's article (1949: 200) and as cited by Burke and Tansey (1991) can be presented:

> Did I hit him? The answer is no, I never hit. But I should have had to have done so if I had not known all about my hate and if I had not let him know about it too. At crises I would take him by bodily strength, without anger or blame, and put him outside by the front door, whatever the weather or the time of day or night. There was a special bell he could ring, and knew that if he rang if he would be readmitted and *no word said about the past* (italics added). He used this bell as soon as he recovered from his maniacal attack.
>
> The important thing is that each time, just as I put him outside the door, I told him something; I said that what had happened had made me hate him. This was easy because it was so true.

> I think these words were important from the point of view of his progress, but they were mainly important in enabling me to tolerate the situation without letting out, without losing my temper and without every now and again murdering him.

Burke and Tansey (1991) confirm that Winnicott's disclosures, *after* defining them as "objective" occur under only two conditions. Firstly, as in the vignette, he advised disclosure only when the therapist can take the strain no longer. As Winnicott makes it explicit in the vignette, the possible meanings of the patient needing to engender hatred in Winnicott were not to be explored. These hate engendering episodes were therefore not viewed as an opportunity to explore the underlying meanings of what had expired.

Secondly, according to Burke and Tansey (1991), Winnicott did believe that an analyst must try to disclose to a patient the strain he has been through on the patient's behalf. They cite the following quote (Winnicott, 1949: 202) to illustrate this:

> ... there remains for discussion the question of the interpretation of the analyst's hate to the patient. This is obviously a matter fraught with danger, and it needs the most careful timing. But I believe an analysis is incomplete if even toward the end it has not been possible for the analyst to tell the patient what he, the analyst, did unbeknown for the patient whilst he was ill, in the early states. Until this interpretation is made the patient is kept to some extent in the

position of the infant one who cannot understand what he owes to his mother.

One can thus see that what is important to consider are the criteria for self-revelation. Considering the vignettes mentioned above, " ... for Winnicott, what was most helpful was not insight but new experience designed to compensate for developmental deficits experienced at the hands of unempathic parents" (Burke and Tansey, 1991).

Being aware of many disagreements between the drive-conflict model and the developmental-arrest model, Burke and Tansey (1991) nevertheless advocate that they converge in their view of countertransference as a hindrance. However, while within the drive-conflict model countertransference disclosure is met with a fundamental incompatibility, in the developmental-arrest model there is a narrow acceptance (Burke and Tansey, ibid).

In contrast to the drive-conflict and the developmental-arrest model, within the relational-conflict model, countertransference disclosure "... finds a welcoming theoretical home" (Burke and Tansey, 1991: 376). When discussing the actual expression of countertransference, one should mention Ehrenberg (1982, 1984, 1992b), a neo-Sullivinian. With many clinical vignettes she has demonstrated how a revelation of therapist emotion can overcome a therapeutic impasse. Being a neo-Sullivinian, Ehrenberg (ibid) recognizes that the analytic relationship constitutes an **interpersonal field**, and she concentrates on two aspects of the analyst's affective participation.

The first involves the use of countertransference affects to clarify the transferential issues, and the second has to do

with the analyst's affective commitment to establish and maintain a viable and consistent analytic process. In this instance, Ehrenberg (ibid) draws the same distinction as Greenson (1967: 46) between the "therapeutic" alliance, and the "working" alliance.

Without referring to any diagnostic categories as the object relations theorists for instance refer to the borderline- and narcissistic personality disorders, and without reconstructing the patient's history of repressed memories (Breger, 1984), Ehrenberg (1982: 1984) conveys her reasons for advocating the use of countertransference affect. One of these is the importance for the patient to feel that he or she has had **impact.**

Winnicott (1947, 1969) cited in Ehrenberg (1984) has commented that discovering that one has an impact, and what this impact is, helps the patient to discover the limits of his assumed helplessness, and that he has assumed omnipotence in relation to the analyst.

Another reason advocated by Ehrenberg (1984, 1992b, 1995) is that by explicitly conveying his or her reactions, the analyst could be adding a new dimension to the analytic interaction. Presenting one's reaction to the patient could stimulate an associational process which is illuminating, and could create the possibility of the patient providing a relevant interpretation of his or her own. Such a **collaborative engagement** provides an opportunity for the patient to experience and assume responsibility for his own participation (Ehrenberg, 1984).

Upon closer examination of Ehrenberg's writing it becomes clear that she does not advocate the senseless discharge of emotions by the analyst. What is conveyed is related to

countertransference affect and pertains only to the analytic situation. Ehrenberg (1984) therefore calls for a delicate judicious balance as regards the analyst's affective participation. In her own words (564):

> ... the analyst has to scrutinize constantly the clinical interaction so as to know when to react, what to address, when and how much to share of his or her reactions either immediately or after the fact, and when it would be inappropriate and burdensome to the patient to do so. This discriminating process is probably the most difficult and the most critical aspect of the work.

Spotnitz (1976) cited in Epstein (1979b), and Winnicott (1949) have discussed the patient's therapeutic need for the analyst's hateful feelings when appropriate. Epstein (ibid) has explored the vicissitudes of those transactions involving the induction of hate and anger in the analyst by those patients who are diagnosed as borderline character disorders. He has specifically addressed the issues of the damaging effects that may result from meeting the patient's hate with benign understanding and forbearance, and the maturational gains that may result should the patient receive from the analyst communications of neutralized, objective hate.

Winnicott (1949: 70) addressed this issue as it pertains specifically to hate-inducing patients. He stressed the following (1949: 70):

> I suggest that if an analyst is to analyze psychotics or antisocials he must be able to be so thoroughly aware of the countertransference that he can sort out and

> study his objective reactions to the patient. These will include hate. If the analyst is going to have crude feelings imputed to him he is best forewarned and so forearmed, for he must tolerate being placed in that position. Above all he must not deny hate that really exists in himself. Hate that is justified in the present setting has to be sorted out and kept in storage and available for eventual interpretation.

Within the same article, Winnicott (1949: 72) adds: "If the patient seeks objective or justified hate he must be able to reach it, else he cannot feel he can reach objective love".

A review of the literature pertaining to the expression of these negative feelings brings one back to a point explored by Spotnitz (1979), and that is the analytic error of the therapist behaving as if he were all good even in the face of the patient's efforts to attack and blacken him. Epstein (1979b) describes the damaging effects that may result from meeting the patient's hate with benign understanding or forbearance.

Persistent efforts of the therapist to return love and understanding for the patient's hate sets up the following vicious cycle: the patient is destructive; the therapist is forbearing; the patient is in danger of recognizing the therapist as good and himself or herself as bad; fearing devastation by guilt and self-hatred, he hates the therapist all the more for provoking this dangerous situation. The effect of this on the borderline patient then is to stress and weaken the patient's ego; feelings of badness and guilt intensify with each succeeding desperate effort to get rid of them by depositing them in the other person.

In a discussion pertaining to the procedure for the communication of countertransference feelings, Epstein (1979a) warns that **all** of the analyst's affective reactions to his patient should be internally treated and neutralized so that they are fully under control of his ego before any intervention is made. He recommends that feelings of hate be communicated after they have been reduced to feelings of irritation or frustration.

The final shift that warrants further consideration is the move from a private sorting out of emotions to an eventual expression of "common" (Volkan, 1993: 156), "objective" (Winnicott, 1949: 70) feelings. In some instances, a mutual regression is advocated.

Maroda (1991) has defined the therapeutic relationship as mutual and reciprocal, and this includes an analysis of the countertransference disclosure, where the corresponding components of the transference become the "analyzable" and "primary data" of the psychotherapy.

Bollas (1983) has written about **expressive uses** of the countertransference. He also advocates mutual regression, and to grasp this one must understand that he is operating from an object relations perspective with the following rationale (1):

> Like many clinicians these days I entertain the possibility that for differing reasons and in varied ways analysands recreate their infantile life in the transference in such a determined and unconsciously accomplished way that the analyst is compelled to relive elements of this infantile history through his countertransference. Patients may enact

> fragments of a parent inviting us unconsciously to learn through experience how it felt to be the child of such a parent, and ironically, they may almost violently hyperbolize that child they were in the transference, tentatively looking to see if we become the mad parent.

Bollas (1983) furthers this argument by stating that amidst countertransference **experiencing** the analyst may for a long time exist in an unknowable region. With this in mind Bollas (ibid) expresses the view that the analyst must find some appropriate means to selectively express some of his subjective states of mind, even when he does not know what it means.

He suggests that the analyst establish within himself a **countertransference readiness**, in which a kind of mental neutrality is cultivated, that is, a freely roused emotional sensibility in which the analyst receives news from within himself, that is reported through his own hunches, feeling states, passing images and imagined interpretive interventions. This basically implies that the analyst must find the patient within himself.

Maroda (1991) has commented on the difficult challenge this poses for the analyst to be able to temporarily lose themselves in the pathology of the patient and abstain from an identity that is inimical to him or to her. Along the same lines, Bollas (1983: 4) has commented:

> For a very long period of time, and perhaps it never ends, we are being taken in to the patient's environmental idiom and for considerable stretches of time, we do not

know who we are, what function we are meant to fulfil, or where we are going. This implies that the countertransference state is not a knowing but an experiencing one.

Bollas (1983) and Maroda (1991) have both answered the question as to how a patient at a primitive level uses the analyst. This is through the analyst's **affects.** The infant element in the adult patient speaks to the analyst through the sort of object usage that is 'seen' through the analyst's countertransference. The infant within the adult person cannot find a voice, unless the analyst allows the patient to **affect** him. Bollas (ibid) further feels that if the analyst possesses confidence in his own ego functioning and object relatedness then he should have the necessary capacity for generative countertransference regression within the session.

At this stage, the full articulation of preverbal transference evolves in the analyst's countertransference, and Bollas (ibid) and Searles (1986) therefore advocate that the analyst must function as a transformational object where he identifies his affects, tries to recognize them and gives them verbal representation to make interpretive use of his countertransference. Instead of using this information privately as seen with Kernberg (1970), for example, Bollas (ibid) advocates expression, also selectively of these subjective states, which enables the transference-countertransference discourse to be analyzed as it develops.

To aid in clarifying this, Ogden (1993) can be called upon. In this instance, the concept of projective identification is defined as a clinical-level conceptualization, all of which lie within the realm of observable psychological and interpersonal experience. In the first instance, are the projector's unconscious fantasies which are observable

through their derivatives, such as dreams and associations. In the second instance, are the forms of interpersonal pressure, and in the third instance are the countertransference experiences, which are real. The difference now between Kernberg's handling of the projective identification which involves a metabolization and interpretation and the British approach which involves a mutual regression and experience which comprises the analyzable data now becomes evident.

One can thus see how the concept of countertransference and the uses thereof have expanded dramatically. Viewed originally as a hindrance to the therapeutic process, countertransference has expanded to include mutual regression and a necessary counterpart of the patient's transference. It has also come to be viewed as the therapist's most valuable guide to insight into the patient's pathology. The use of countertransference has grown from a private use to aid in the making of interpretations in the transference, to a disclosure and analyzable part of the "working" data.

3.4.3.3. Summary.

Although the concepts neutrality, transference and countertransference are so uniquely intertwined, and although they co-exist to determine the analyst's participation within the analytic hour, a discussion of countertransference bears directly on the issue of self-disclosure, and expression of affect by the analyst.

The section pertaining to countertransference necessitated a discussion of character disorders and object relations theory, as it was these very therapists who noted the changing nature of the transference and the corresponding countertransference affect elicited in the therapist.

Combining neutrality, transference and countertransference, one can see how the nature of the analyst's participation develops and changes from one of abstinence in orthodox terms, to one of mutual participation in interpersonal terms, to one of mutual regulation in intersubjective terms, and to one of mutual regression in British object relations theory.

3.5. Describing the nature of the therapeutic relationship: Summary and integration.

With changes and controversies regarding the concepts and themes, **neutrality**, **transference**, and **countertransference**, which compromise the therapeutic relationship, the nature of the total relationship between therapist and patient now merits discussion.

The difficulty in extricating one concept and discussing it in isolation has already been discussed, and it is the purpose of this discussion to re-integrate these concepts and view them in combination as they co-exist to determine the nature of the therapeutic relationship.

The relationship is central clinically because technical interventions - what the analyst does or thinks he does - depends on how he construes it (Greenberg, 1986, 76-77). Freud (1905: 112-122) cited in Greenson (1967) recognized that the patient's transference reactions and resistances produced the essential material for the analytic work. The analytic situation was then so arranged that it would facilitate the maximal development of the patient's transference reactions.

Analogous to this conceptualization is the classical conceptualization of the transference. This is seen as the experiencing of feelings, drives, attitudes, fantasies, and

defenses toward a person in the present which are not appropriate to that person. There are inappropriate in that they represent a repetition and displacement of reactions originating in regard to significant persons of early childhood.

As seen in a previous section, there are critiques to this approach ranging from conservative to radical. Parallel to this distinction is the definition of the relationship which then ranges from a fully transferential relationship to a "real" relationship. The more "real" the relationship becomes, the more focus is placed on the here-and-now. This in turn determines the nature of the "primary data" and "action" of psychotherapy.

It has been demonstrated throughout this chapter that the less the rhetoric of emerging and unfolding is adhered to, and the more the cyclical psychodynamic point of view is accepted, the more reality is attributed to the relationship.

Although the discrimination between transference and reality is useful to aid in describing the nature of the "action" of psychotherapy, Maroda (1991) argues that distinctions between what is "real" and what is "transference" and "countertransference" are held to be impossible to make. She states that insistence on doing so is considered unproductive and detracting from the analytic process.

Another point needs to be conveyed and that is that no matter what your theoretical notions are, and no matter what kind of therapy you profess to conduct, fundamental to this therapy is a **relationship.** Regardless of the nature of this relationship, there is an underlying fundamental, possibly invisible relationship that exists in any therapy between patient and therapist.

Greenson (1967: 191) has referred to this part of the relationship as the **"working alliance"**, and describes it as such:

> In order for a patient to enter into and work effectively in the analytic situation, it is imperative that he establish and maintain another kind of relationship to the psychoanalyst, besides his transference reactions. This "working alliance" deserves to be considered a full and equal partner to the transference neurosis in the patient-therapist relationship.

Gitelson (1962) cited in Greenson (1967) speaks of the **rapport** on which we depend in the beginning of analysis and which eventuates in transference. He stresses the necessity for the analyst to present himself as a good object and an auxiliary ego.

It is now apparent that the total therapeutic relationship can be conceived as two-fold. In the first instance, there is the fundamental and pervasive "working alliance". The crucial factor is the therapist's empathy toward his patient and the **rapport** and trust that develops between the therapist and patient. In the second instance, is the "therapeutic alliance", and this is the part that has been relevant for this study, and which has been addressed up to now. This two fold idea emerged after ideas had been borrowed from the following authors.

After a brief survey, Greenson (1967), concludes and reveals that many analysts, including Freud, recognized that in psychoanalytic treatment another kind of relationship to the analyst was necessary besides the more regressive

transference reactions.

It seems then that in describing the working alliance, another aspect of the therapist is touched upon, and that is his or her humanness. This is found in the therapist's compassion, his or her concern and therapeutic intent towards the patient.

Langs (1982) has spoken of a "core", "background" or "holding" relationship, consisting of the following attributes: The establishment of a growth-promoting or healthy symbiosis; a sense of safety and trust, in which the therapist's honesty, integrity, and trustworthiness are a constant issue; the therapist's capacity to hold and contain the patient; and, the nonreinforcement of the patient's disturbance or neurosis.

The first four factors comprise the establishment of a set of boundaries for a potentially curative therapeutic relationship. These boundaries hold the patient in a secure fashion. They permit the patient to undergo the therapeutic regression necessary for the specific expression of the manifestations and underlying basis of the emotional disturbance. These boundaries enable the patient to communicate the derivatives of the unconscious perceptions, present and past, that have caused and perpetuated the emotional illness. These are then also termed the holding or framework-management functions of the therapist.

Schafer (1983) cited in Wachtel et al. (1986), describes an "atmosphere of safety" in which the analysand feels if it is safe to reveal any aspect of himself. He further documents that there is always room in analytic work for courtesy, and sincere empathic participation and other such personal, though not socially intimate, modes of relationship. He

refers to a "respectful affirmative attitude" and an attitude of "appreciation".

Altshuler (1989) confirms that fundamental to any therapy is the therapeutic relationship, and that there are several theoretical notions on which all therapies agree. The following factors, as set out by Frank (1974, 1982), Garfield (1983), Luborski (1985) and Strupp (1977) (all cited in Altshuler, 1989), illustrate this:

1. A healer-patient relationship, in which there is a clearly defined balance and separation of powers. One party has expertise, the other pain and need.
2. Acceptance and support of the patient. There is an implicit assumption that the patient is a good and worthwhile human being, despite motives, symptoms, and behaviour which may not be desirable. This support heightens the bond with the healer.
3. The opportunity to express emotions. Expression in an accepting atmosphere supports the idea that good people can have bad impulses and still be okay. This opportunity also allows for ventilation and abreaction and for the relaxed sense of cleansing and peace that comes with such powerful emotional activities.
4. Rituals to be observed. These are the technicalities, such as the time and duration of each session which provides a structure, and a focus, that is, something to do together. This diminishes the feeling of alienation for patients and maintains interest on both sides.
5. Systems of explanation. All therapies provide explanation. These insights recast the patient's experience.

Taken together these elements convey human interest and support and what is important is that many therapies reduce themselves to activities which draw their force from these

shared elements. Once the working alliance is operating, the nature of the therapeutic alliance comes to the fore and it is within this alliance that questions are raised as to what constitutes the "working" and "analyzable" data of therapy. Questions also arise pertaining to the therapist's involvement and the nature of and degree of his or her participation.

This study has focused specifically on the nature of the therapeutic alliance. What has become evident is how the concepts **cyclical psychodynamics** and **emerging and unfolding**, which define the nature of, that is, the reality attributed to the therapeutic relationship, bear fundamentally on the analytic stance.

In interpersonal terms the concept neutrality has been modified to include a variety of behaviours or responses from the analyst. In some instances this could even mean that self-revelation by the analyst represents a neutral attitude (Greenberg, 1986). As frequently referred to throughout the chapter and as mentioned in an earlier paragraph, the more the cyclical psychodynamic point of view is accepted, the more reality is attributed to the alliance, and the greater the move away from traditional formulations of neutrality. The intersubjective approaches and the self psychology approaches employ an empathic listening stance which rejects the neutrality concept.

These approaches, namely intersubjective and self psychology, nevertheless still assume a conservative and modest approach to the use of self-disclosure by the therapist. There are only isolated appeals for self-disclosure, for instance Palombo (1987) and Cornett (1991, 1992). The isolated appeals are complementary responses that are in harmony with the concept of the alterego/twinship transference, wherein

the analysand's twinship needs are fulfilled.

The appeals for self-disclosure by various object relations approaches are entirely different. These spring from the countertransference and are more geared to the **needs** of the therapist than the complementary responses as outlined earlier and that pertain to the self psychological point of view. The following chapter will clarify that these self-disclosures are referred to as self-involving. This means that the focus is on the interaction and the therapist's involvement in the analytic situation. At first glance, this may superficially represent the most marked departure from the blank screen concept. This misconception has already been clarified and rectified by employing the notion of **countertransference readiness** as set out by Bollas (1983).

It is interesting to note that the concept mutual regression implies an emerging and unfolding and it is precisely within this process that the personality of the therapist is extricated, which means that the blank screen approach although modified to include the countertransference readiness, is more preserved than with the interpersonal, self psychology and intersubjective approaches.

Comparable to this remark are comments made by Maroda (1991) who strongly disavows the expression of personal information not related to countertransference affect. The other approaches discussed above that reside within the relational-conflict model (Mitchell, 1988) may have a less strenuous set of rules regarding these disclosures.

Although there is much conceptual confusion as regards the paradigms and models set out above, there is no doubt that the relational/structure (Greenberg and Mitchell, 1983) and the relational-conflict model (Mitchell, 1988) allow for the

conceptual justification and validation of therapist self-disclosure.

The general notion however remains that this issue is approached with caution. Most of the therapists and authors mentioned throughout this chapter request a judicious use of self-disclosure. Cornett (1991: 49) has referred to self-disclosure as a "risky" intervention.

The implementation of therapist self-disclosure within the psychodynamic framework takes place within strictly defined boundaries and in most instances includes only the objective, metabolized, and internally treated countertransference reactions. This represents a very marginalized concept of self-disclosure.

3.6. An overview.

This chapter has focused on the nature of the existential-humanistic and the psychoanalytic therapeutic relationships. This discussion highlighted how the existential-humanistic tradition departed from the original and orthodox conceptualization of transference which prescribed an anonymous and detached stance for the therapist. The "humanized" nature of the existential-humanistic therapeutic relationship was then clarified in terms of concepts fundamental to an understanding of the humanistic tradition. Therapist self-disclosure was appraised in terms of each of these concepts.

A review of the psychoanalytic literature demonstrates that within certain analytic traditions, a progressive "humanizing" of the therapeutic relationship has taken place. This discussion implemented paradigms and models to provide organizing principles. The nature of the therapeutic

relationship could then be considered in terms of neutrality, transference, and countertransference. For the concepts transference and countertransference the implications for self-disclosure were considered.

Ultimately this discussion de-polarizes, to a certain extent, the existential-humanistic and psychoanalytic traditions in terms of the nature of the relationship, the therapist's involvement and participation, and the therapist's use of self-disclosure.

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