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Sara R. Willott
Experienced and Inexperienced
Therapists: A Comparison of
Attitude toward and Use of
Countertransference Disclosure

ABSTRACT

This descriptive exploratory study examines the relationship of clinical experience and attitude toward countertransference disclosure and use of countertransference disclosure. The study surveyed therapists for answers to the following questions: Are there any differences in the attitude towards countertransference disclosure between experienced and inexperienced clinicians? Are there any differences in the use of countertransference disclosure between experienced and inexperienced clinicians? Is there an association between attitude toward and use of countertransference disclosure for the sample as a whole; and is there any variance in this association between experienced and inexperienced therapists? Three-hundred-and-thirty-seven therapists completed the survey, yielding significant results.

The major findings included the following: Experienced therapists use countertransference disclosure significantly more frequently than inexperienced therapists, and there is a more significant positive relationship between attitude toward and use of countertransference disclosure in experienced therapists. The data also showed that inexperienced therapists have a more favorable attitude towards countertransference disclosure than do experienced therapists, even though they use it

less frequently. There is a significant positive relationship between attitude toward and use of countertransference disclosure for inexperienced therapists, but it is not as strong as that for experienced therapists. Although the differences between attitude and use were significant, the measure of difference between inexperienced and experienced therapists was actually quite small.

EXPERIENCED AND INEXPERIENCED THERAPISTS:
A COMPARISON OF ATTITUDE TOWARD AND USE OF
COUNTERTRANSFERENCE DISCLOSURE

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2007

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CHAPTER I

INTRODUCTION

The purpose of this descriptive exploratory study is to explore the differences between experienced and inexperienced therapists in their attitude towards and use of countertransference disclosure. Therapist self-disclosure is embedded in a long history of debate around its use as an effective tool in psychotherapy. While research has been conducted around self-disclosure of personal history, relationships, sexual orientation, and professional background, no research has empirically investigated disclosure of countertransference among clinicians. However, countertransference disclosure is being utilized more in therapy than it has been in the past (Kahn, 1991). Psychotherapists are finding a wide array of uses for countertransference disclosure. Burke & Tansey (1991, p. 377) write:

Countertransference disclosure, which meets with a fundamental incompatibility in the drive-conflict model, and only a narrow acceptance in the developmental-arrest model, finds a welcoming theoretical home in the relational-conflict model. Relational-conflict theorists debate, not the potential of countertransference to inform a therapist about the patient and the interaction, but rather if, when, and how much of the countertransference responseiveness should be introduced into the direct interchange with the patient.

Those investigations which have presented a systemic study of clinician use of countertransference disclosure do not examine the association between attitude toward and use of countertransference disclosure. Additionally, available quantitative data describes countertransference disclosure in light of other focal points of the study,

placing limitations on the study's ability to broadly describe countertransference disclosure among clinicians (DiCello, 1996; Edwards & Murdock, 1994; Hendrick, 1988; Meyers & Hayes, 2006). Currently, there have been no systematic investigations of the relationship between level of therapist experience and self-disclosure of any form. While differing definitions of countertransference have been a source of debate among clinicians as outlined by Tansey & Burke (1989), this study defines countertransference disclosure as the deliberate verbal communication of associations, thoughts, or feelings that arise in response to the experience of the client. Within the debate, this definition has been articulated in more current schools of thought such as post-modern psychoanalysis and intersubjective theory. While countertransference disclosure has gained more acceptance over the years, the ways in which countertransference disclosure is used in order to achieve therapeutic goals requires further inquiry.

Because of limited guidelines instructing use of countertransference disclosure, countertransference disclosure's direct effect on relationship dynamics and boundaries, and the numerous factors to be taken into consideration prior to the use of countertransference disclosure, countertransference disclosure is a complex tool in therapy. As such, its complexity provides a challenging process of engagement for inexperienced clinicians. However, while history has been slow to accept any form of clinician self-disclosure as an effective tool in therapy, clinicians are beginning to use self-disclosure more readily without research to aid supervision for new clinicians who seek to use self-disclosure. This problem is even more complex when self-disclosure involves countertransference. The following literature review will first look at the evolution of psychotherapy from Freud to current post-modern intersubjective theories of

psychotherapy and how these theories have propelled the changing trends in use of self-disclosure. Clinical reasons for countertransference disclosure will be examined followed by an examination of the trends in clinician beliefs around the use of countertransference disclosure with various client populations. The literature will also seek to examine some of the many difficulties faced by new clinicians as they decide whether or not to use countertransference disclosure during psychotherapy.

CHAPTER II

LITERATURE REVIEW

This chapter will illustrate why there is ongoing debate around the usefulness of countertransference disclosure and why the attitudes toward and uses of countertransference disclosure may differ for experienced and inexperienced clinicians. First, the discussion will elaborate on the historical movement from the classical psychoanalytic view of the therapist as a neutral, non-responsive observer to the contemporary vision of the therapist as an engaged, authentic participant. This historical review will look at discoveries in quantum physics, interpersonal therapy, humanist therapy, and feminism in order to present an illustration of how intersubjective theory has emerged within the psychoanalytic field. Intersubjective theory will be explained in order to elucidate the relational perspective of two-person psychology where the relationship between client and clinician becomes an essential focus of therapy, rather than the focus remaining entirely on the client. Outlining this theoretical perspective will provide a foundation for understanding the context of this study's operational definition of countertransference disclosure. The structure of this study's focal points around therapist attitudes toward and uses of countertransference disclosure are reticulated around the main principals found within intersubjective and relational theory. Intersubjective theory has been chosen to contextualize the discussion around the current debate underlying countertransference disclosure among experienced and inexperienced

clinicians. This discussion begins with a historical account of the evolution in thinking around self-disclosure. Because countertransference disclosure is a fairly new term in psychotherapy, there is a scarcity in literature on this type of disclosure. In providing a historical account and overview current beliefs around countertransference disclosure, this review of literature often discusses general self-disclosure when it relates to countertransference disclosure.

A History of Self-Disclosure

Intersubjective theory in clinical psychoanalysis has had an impact on the art of practice and psychodynamic philosophy for the past twenty-five years. Intersubjective theory has evolved out of the paradigm shift from one-person psychology to two-person psychology (Berzoff & Mattei, 1999; Safran & Muran, 2000; Stern, 2004;). Historically, classical, psychodynamic drive theory has situated the therapist in an objective role as a “blank screen,” so that the inner-world of the client is not disturbed (Bowles, 1999). Under Freud’s original methodology, the clinician was expected to control all conscious countertransference in order to refrain from influencing and/or disrupting the client’s transference relationship (Gerson, 2004). The minimization of countertransference aided the clinician in maintaining the un-reactive, objective perspective (Bowles, 1999). This objective stance was used so that the clinician could utilize their authoritative knowledge in order to cure the patient. (Kahn, 1991). The very notion of authoritative knowledge has been re-conceptualized in the shift from one-person to two-person psychology and will be revisited in a discussion on the reconsidered importance of the therapist’s subjective knowledge. Prior to the shift in thinking around subjective

knowledge, countertransference was not considered useful under any circumstances due to the sole reliance on objectivity.

Shifting Among Different Schools of Therapy

The historical underpinnings of the paradigm shift from relying on objectivity to an inclusion of subjectivity and the move from one-person to two-person psychology reach back to the 1920's when quantum physics was just underway. In the 1920's and 1930's, discoveries in quantum physics such as Heisenberg's Principal of Uncertainty rocked the modern face of science by illustrating how the very act of observation changes reality. This monumental discovery renounced the plausibility of the completely objective, distanced observer (Curtis & Hirsch, 2003). This pivotal evolution in science unabashedly found its way into psychodynamic theory. As Curtis and Hirsch (2003) state, "If the observer were also a participant in the world of particle physics, then the analyst was certainly a participant in interactions with the patient," (p.69). In classical drive theory, self-disclosure is considered a clinical impropriety. However, as science began to redefine the limits of objectivity in particle physics, psychotherapists began to integrate these scientific discoveries into psychodynamic theory. As a result, the guidelines within classical psychodynamic theory which imposed regulations around concepts such as objective observation and therapist self-disclosure began to splinter under the acknowledgment of the inevitable subjective engagement of the therapist. The change has fostered therapists who are more tolerant of self-disclosure. Objective observation has given way to considerations around the usefulness of countertransference as the therapist's subjectivity has become conceptualized as a possible therapeutic tool.

From the 1920's to the 1940's, Harry Stack Sullivan acted as a precursor to intersubjective principals by proposing that therapists act not as blank screens, but as people capable of enacting transmutative interpersonal interactions by relating to clients as subjective individuals. In his own clinical work, Sullivan cultivated change within the client through the interpersonal exchange between clinician and client. Sullivan's interpersonal theory of interaction proved useful in working with clients who could not develop a transference onto a "blank screen" therapist. While Sullivan began to acknowledge the importance of the relationship as a mode of healing rather than objective, authoritative knowledge, it appears he held a more Freudian notion of countertransference. Additionally, Sullivan is not known to have condoned clinician self-disclosure (Curtis & Hirsch, 2003). Sullivan's evolution from a drive-theory perspective of psychoanalysis to a more interpersonal theory of psychoanalysis was later folded into object relations, self-psychology, and intersubjectivity (Bowles, 1999). Sullivan's principals began to build the bridge between one-person and two-person psychologies, thrusting psychotherapy towards an understanding of the dyad as a culmination of two subjective experiences.

In the 1950's and 1960's, Carl Rogers expanded Sullivan's interpersonal principals of therapy to include the therapist as one who should show unconditional, positive regard for the client. This school of therapy no longer maintained a belief in the need for the therapist to remain objective in order support the transferential relationship to the clinician. The philosophy of unconditional regard encouraged clinicians to rely less upon objectivity while pushing for the therapeutic use empathy and love. In this sense, therapists were directed to utilize their emotions as therapeutic tools in the

relationship. Despite these changes, Rogers did not publicly condone the disclosure of emotions to clients (Kahn, 1991). The revolutionary era of the 1960's ushered in a new awareness of the power relationships between client and clinician as cross-cultural work and the feminist movement challenged old ideas within the system. While classical psychoanalysis has commonly viewed the therapist as an authority in understanding the individual's life through an objective, scientific lens, postmodern psychodynamic theory, feminist theory, and intersubjectivity have sought to question the usefulness of the therapist's authoritative stance (Berzoff & Mattei, 1999).

In classical psychotherapy, the therapist was believed to hold knowledge which granted authority over the client while dethroning the client of any authority. The politics of the 1960's promulgated a need for a more egalitarian relationship between the client and clinician as, "the undemocratic psychoanalytic relationship was anathema, relying as it did on a severe power imbalance between therapist and client," (Kahn, 1991, p.11). In post-modern psychotherapy and intersubjective theory, the process of constructed reality and the supposition of mutual influence has dismantled the formal hierarchical structure by crediting the clinician as one who has knowledge with the client rather than knowledge over the client. Postmodernism has deconstructed the therapist's position of authority by focusing on the therapeutic importance of relationship between client and clinician, rather than utilizing knowledge of the clinician without attention to the relational experience (Darwin, 1999).

From Objectivity to Intersubjectivity

The shifts that have occurred from Freud to Sullivan to Rogers have altered the way that many therapists value and utilize authority, objectivity, subjectivity, and

countertransference disclosure. Intersubjective theory has arisen out of the philosophical shift from the requisite objective, neutral involvement of the therapist to a belief in the inability to remain entirely neutral, influencing therapists to acknowledge their subjective involvement within the therapeutic frame. Intersubjectivity rests on the acknowledgement of the inevitable meeting of subjectivities within the psychological field (Darwin, 1999). While first conceptualized as a way to describe relational dynamics by Atwood and Stolorow (1984), this manner of thinking and focus developed into an intersubjective systems theory by the early nineties (Stolorow, Atwood, & Orange, 2002).

Intersubjective theory does not primarily focus on drives and defenses, but emphasizes the present relationship between client and clinician. Acknowledging the inevitable subjectivity of the clinician, intersubjective theory incorporates the clinician's subjective influence into a greater understanding of the client. "Intersubjectivity is not simply another school of psychoanalysis but a *clinical sensibility* that brings to the foreground the interplay of the two subjectivities," (Berzoff & Mattei, 1999, p. 256). This clinical sensibility and its conceptualization of countertransference and disclosure can be found in the interpersonal theoretical orientations to varying degrees. In acknowledging the centrality of the two subjective individuals within the therapeutic dyad, one way to utilize and explore this central focus on relationship is through attention to the clinician's countertransference and disclosure of countertransference. Within the therapeutic frame, self-disclosure is a method of acknowledging what the clinician holds, acknowledging what is part of the dyad and utilizing this knowledge for therapeutic means (Davis, 2002). In its broadest sense, intersubjectivity is described as a theory that:

Focuses on the interaction between the therapist's subjective experience and the

client's subjective experience, emphasizing their reciprocal, mutual influences on the clinical relationship and treatment process. The therapist and client co-construct a shared reality in which each participates (Bowles, 1999, p. 365).

This shift from a one-person psychology to a two-person psychology has dissolved the once assumed clear line of separation between observer and observed or subject and object, thus expanding the central focus of therapy to often include the relationship rather than simply the client (Berzoff & Mattei, 1999; Safran & Muran, 2000).

Definitions of Countertransference

Fueled by the postmodern principal of social construction based on the dissolution of the neutral, objective observer, clinicians of two-person psychology do not attempt to remain impartial to the field of inquiry or client because it is believed impossible to remain entirely impartial (Berzoff & Matei, 1999; Curtis & Hirsch, 2003; Neimeyer & Bridges, 2003; Safran & Muran, 2000). Countertransference to get operationally defined as any specific emotion within the therapist which arises in reaction to the client. Within this understanding, countertransference or the feelings that arise in response to the client and relationship are normalized and considered a ubiquitous component of therapy.

Historically, countertransference has been defined as those reactions within the therapist which arise out of unresolved conflict. This conceptualization of countertransference as transpiring from the clinician's own neurosis is considered to be the "classicist" view, whereas definitions of countertransference which broadly encompass the therapist's overall response to the client are considered to be a more "totalist" definition of countertransference (Burke & Tansey, 1991).

Over the last six decades, the conceptual debate around countertransference as a response to unresolved conflict versus countertransference as a natural and healthy

process in psychotherapy has coincided with other less mainstream constructions of countertransference. In Dicello (1996), the definition of countertransference reviewed includes: unresolved conflicts, transference of the therapist, therapist characteristics, any unconscious thoughts and feelings towards the client, and the therapist's healthy response to the client (Sandler, Dare, Holder, & Dreher, 1992). Over time, while Freud's followers agreed that countertransference should be excluded from any therapeutic dialogue, it was noticed that countertransference could be used to inform the therapist on aspects of the client's process (Kahn, 1991).

Discussion of countertransference is certainly not a new phenomenon. As early as 1951, it was espoused that countertransference should always be disclosed if the therapist displayed any signs of such countertransference to the client (Little, 1951). The intersubjective view of reality as a co-constructed mutual influence of two subjective individuals supposes that countertransference is inevitable, naturally occurring, and continuous, (Curtis & Hirsch, 2003; Natterson & Friedman, 1995; Safron & Muran, 2000). With the aforementioned shifts in psychotherapy, the majority of clinicians have come to view countertransference as those reactions which naturally occur when in the presence of another person (Burke & Tansey, 1991; Streaun, 1999). The current trend in thinking around countertransference complements relational theories of interaction, which view countertransference as ubiquitous in any therapeutic relationship. Some veins of relational theory believe that the therapist and client share similar levels of emotional reaction to the relationship, although the emotional reactions can be different. (Kahn (1991) describes the pervasive nature of countertransference:

Gradually therapists came to recognize that no matter how much personal therapy they had had, no matter how “well analyzed” they might be, two complex dramas were inevitably played out in every consulting room, and one of them was going on in the unconscious of the therapist. (p.128)

An intersubjective definition of countertransference encapsulates the mutuality of reactions in the room by including, “The ways the analyst’s organizing themes contribute to the codetermination of the transference,” (Sorter,1999, p. 248). Countertransference does not arise under a certain given pretext or combination of variables; countertransference is the ongoing subjective response to the client and to the relationship that takes place in the here and now. Stolorow, Brandchaft, and Atwood (1987) consider countertransference to be a primary component in the intersubjective matrix. As countertransference has undergone a transformation in definition and cause, so too have beliefs around general clinician self-disclosure.

The Debate around Therapist Self-Disclosure

With the deepened emphasis on the co-construction of the therapeutic relationship through increased clinician participation in post-modern psychotherapy, psychotherapists have begun to question the use, effectiveness, and purpose of clinician self-disclosure. In one survey of client experiences, out of nine different therapist responses, clients ranked self-disclosure as most helpful (Hill, Helms, Tichenor, Spiegel, O’Grady, & Perry, 1988). Therapist self-disclosure of general to more specific topics is a concept in psychotherapy which has clearly evolved out of the movement from Freudian psychoanalysis into interpersonal and post-modern modalities of therapy. In order to maintain neutrality and encourage transference, Freud directed clinicians not to use any form of self-disclosure.

However, in his own experimentation and practice as a therapist, Freud did occasionally use self-disclosure, disclosing his own dreams and stories of childhood (Gabbard & Lester, 1995; Goldstein, 1994). Until more recently, discussion of clinician self-disclosure has been limited (Maroda, 1999). On the more conservative end of the spectrum, clinicians argue that self-disclosure can invoke forms of seduction and punishment. Contrasting this conservative position, encounter therapists of the 1960s and 1970s modeled authenticity for the client by revealing all countertransference (Kahn, 1991). Therapists in interpersonal and humanist schools along with those influenced by feminist theory, self-psychology, and object relations often believe that positive achievements can arise out of therapist self-disclosure (Margulies, 2001). For example, most psychotherapists who practice from a central grounding in feminist therapy believe that self-disclosure can be used in order to achieve feminist values such as egalitarian relations and a sense of personal connection between client and therapist. Although once considered a clinical *faux pas*, clinician self-disclosure has become more accepted as a tool in therapy by many clinicians.

In intersubjectively focused clinical sessions, the therapist focuses not solely on the client, but on how the therapist's own psyche or subjectivity is shaping decisions and affecting the client's subjectivity or experience of self and other (Bowles, 1999). The "intersubjective field" composed of the client's subjectivity and the clinician's subjectivity, is the main construct within which therapeutic engagement occurs (Stolorow & Atwood, 1992). Safran and Muran (2000) state:

Two minds create intersubjectivity. But equally, intersubjectivity shapes the two minds...intersubjectivity in the clinical situation can no longer be considered only as a useful tool or one of many ways of being with another that comes and goes as

needed. Rather, the therapeutic process will be viewed as occurring in an ongoing intersubjective matrix (p. 78).

Because intersubjectivity is the process of mutual regulation and recognition between both individuals in the dyad, self-disclosure can be a validation of the natural process of subjective experience and co-creation which occurs in therapy. Maroda, (1999) writes that self-disclosure is “very compatible, if not *most* compatible with intersubjective theory,” (p. 487). Burke and Tansey (1991) write about the use of countertransference disclosure in order to increase the intersubjective discourse which, “Allows for an eventual discovery of disavowed aspects of the patient with which the therapist has identified. In such instances, explicit disclosure helps to illuminate what has occurred,” (p. 377).

Disclosure may be useful in order to help clients learn more about their own transference and their own experience of self. However, one critique is that self-disclosure arises out of a reaction to countertransference (Goldstein, 1994; Lane & Hull, 1990). Davis (2002) suggests that while therapists may be aware of countertransference while disclosing feelings, therapists may not be fully aware of how the countertransference is affecting the intention and drive to disclose. By allowing their emotions to lead their self-disclosure, therapists may create an unintentional experience that causes the relationship to regress. Interestingly, DiCello (1996) reports on one of the arguments against countertransference disclosure among more classicist views of countertransference disclosure, “Communications of the countertransference result in the analyst simply discharging his/her own unresolved transference into the therapeutic interaction and shifting focus of the therapeutic work away from the patient’s

experience,” (p.27). Other therapists who support self-disclosure believe that some disturbances which arise from self-disclosure can be useful in working through transference distortions (Mathews, 1988). When considering the potential for countertransference disclosure to result in harmful outcomes, the importance of therapists’ personal awareness becomes a central concern. This concern, among others, is revisited in the evaluation of the challenges inherent in countertransference disclosure.

Intersubjective theorists do not suggest that therapists freely self-disclose without critical analysis and reasoning behind each self-disclosure. Natterson & Friedman (1995) write that under no circumstances does intersubjectivity suggest that a therapist should disclose any and all affect during treatment. Self-disclosure of affect should only be used to enhance the client’s experience of self in relation to other, affect management, and emotional attunement in a manner that can be an opportunity for learning and growth (Maroda, 1999).

While intersubjective theory’s questioning of authority within the therapeutic dyad certainly has provided support for countertransference disclosure, the re-conceptualization of hierarchy and authority within the 60s and 70s era of civil rights and feminism proved to be a powerful influence on perceptions around countertransference disclosure. It is extremely important to note that even with this repositioning of authority, the relationship has never been considered symmetrical in nature. According to Natterson & Friedman (1995):

Considerable asymmetry exists in a state of co-equality and mutuality. At the core, therapist and client put forth equal emotional involvement and the returns it generates (in the form of nurturance, development, integration, and understanding) differ between the two participants (p.34).

While disclosure of countertransference destabilizes the traditional hierarchical structure, it does not produce a perfect symmetry of power. The process of the client/therapist relationship, as one that is co-created through the sharing of two subjective worlds, can manifest itself without one subject utilizing powerful measures of authority (Schamess, 1999a). However, in being entrusted with the client's personal experience and expectation for safety and respect, the therapist inherently maintains a position of power. This asymmetry within the relationship is at the heart of arguments against countertransference disclosure. It is because of this power imbalance that countertransference disclosure could be so harmful and why disclosure must be so carefully considered (Goldstein, 1994). Countertransference disclosure has the potential to adjust boundaries, safety, and holding of the client *because* of the therapist's power.

Interestingly, therapy models which have de-emphasized the importance of therapist's authority over the client, placing greater emphasis on the life of the relationship, are often less skeptical of countertransference disclosure. As stated above, feminist therapists take a less divisive stance on therapist disclosure, adhering to a more supportive stance on disclosure compared to other therapeutic models. Margulies (2001) writes that humanist theorists, including feminist therapists, show the greatest support for self-disclosure. In object relations, Winnicott (1949) acknowledged the therapeutic use of disclosing some feelings to clients. Self-psychology which focuses on the development of self in relation to others also includes theorists who accept the therapeutic use of self-disclosure. While the therapeutic use of self-disclosure has been considered by many therapists who utilize object relations and self-psychology, it is noted that these orientations do not necessarily follow a relational or intersubjective

interpretation of treatment. Ornstein and Ganzer (1997) note that therapists operating under these theoretical models do not emphasize therapist participation or therapist subjectivity. However, Goldstein (1994) believes that self-disclosure can encourage and support self-object transferences. Barrett & Berman (2001) studied client perception after therapists made disclosures which included personal facts or feelings and reactions to the client. Clients reported lower levels of symptom distress and greater attraction to therapists. Those self-object transferences may result in alleviation of symptoms.

Goldstein (1994) writes:

Refraining from self-disclosing may also be risky. It may expose the patient to trauma and make the patient inaccessible even when the therapist attempts empathically to relate to why the patient feels he or she needs the therapist to actually respond and with it means to the patient to be frustrated (p. 424).

What Research says about Countertransference Disclosure

Although countertransference disclosure has gained more ground in therapeutic practice, little research has been conducted on the practice of countertransference disclosure (Simon 1988; Stream 1999). It is believed that due to the earlier beliefs around countertransference as seated in unresolved conflict, up until most recently, writing on countertransference in psychoanalytic technique has failed to address disclosure (Burke & Tansey, 1991). In many studies, the specific type of therapist disclosure is never defined, leaving an unclear picture of what is being explored. Upon initial investigations of self-disclosure over the years, such disclosure was not differentiated into specific types nor was it clearly defined. McCarthy & Betz (1978) report that the wide variance in definitions of self-disclosure may be cause for some incongruency in research findings on disclosure. Reynolds & Fischer (1983) stated that at

the time of their research, the study of specific types of disclosure was on the rise. Twenty years after researchers have begun to differentiate between different disclosures, countertransference disclosure is still absent from any considerable amount of investigation.

Another challenge involved in the exploration of countertransference disclosure is the attempt to encompass countertransference disclosure as it is experienced from different vantage points depending on the theoretical orientation of the therapist. Because each theoretical orientation has different therapeutic goals, what may be considered a benefit from one perspective may be considered damaging to the therapeutic process from another perspective.

Therapists who work from a more drive-conflict model of development such as Freudian psychoanalytic theory may view countertransference as arising from conflict and, thus, disruptive to the process of the client's transference neurosis (Burke & Tansey, 1991). Therapeutic focus as a core of the therapeutic frame can differ according to theoretical orientation. Mathews' (1988) study stated that the most common reason therapists gave for refraining from general self-disclosure was because disclosure takes the focus off of the client, but Mathews did not detail the specific types of disclosure being considered in his study. Reynolds and Fischer (1983) and McCarthy and Betz (1978) also report that therapists who disclose experiences or feelings which arise outside of therapy take the focus off of the client. However, those therapists who utilize countertransference disclosure by discussing feelings which arise within the session maintain the focus on the client. It is important to consider that while one of the main arguments against the use of therapist self-disclosure deals with maintaining the focus on

the client, some theorists believe that countertransference disclosure enhances the focus on the client.

In the following discussion on countertransference disclosure, it is important to remain cognizant of the power of definition and how countertransference is defined. In some of the studies which have highlighted countertransference disclosure, the definition of countertransference being used is not clearly stated. The debate around countertransference disclosure is often less a matter of whether or not disclosure is ethical, but how countertransference is defined. From the studies on general self-disclosure, the evidence around disclosure will be used to elucidate the arguments around, uses of, and attitudes towards countertransference disclosure as it has been defined in this study.

Why Therapists Disclose Countertransference: Goals and Outcomes

The theoretical shifts in psychotherapy which have brought countertransference and therapist self-disclosure into a more acceptable light provide a foundation from which the motivation to use countertransference disclosure can be explored. While countertransference disclosure has been overshadowed by studies on general disclosure, some reasons why therapists use countertransference disclosure have been outlined by practitioners and researchers. Simon's (1988) study on general self-disclosure reports that some therapists self-disclose based on a theoretically informed decision, while other therapists make general disclosures without considering the theoretical implications. In most circumstances, therapists choose to self-disclose based on the following factors: therapeutic goals, characteristics of the therapist-client relationship, client characteristics, and theoretical orientation (Meyers & Hayes, 2006, Simon, 1988). Gorkin (1987) reports

that some of the therapeutic goals which provide the motivating force behind countertransference disclosure include the following: clarification of reality for the client, communication of the client's impact on the therapist, and adjustment during impasse (as cited in Maroda, 1999). The following section will look at general self-disclosure as it is used to model for the client, build therapeutic alliance, clarify reality for the client and therapist, and increase the sense of equality between therapist and client. The discussion around general self-disclosure will be related as closely as possible to countertransference. After these therapeutic goals are presented, disclosure of positive feelings, negative feelings, and erotic feelings will be looked at more closely.

Modeling

Modeling communication and management of feelings is often cited as a reason for general self-disclosure (Doster & Nesbitt, 1979; Simon, 1988). In Simon's (1988) study, modeling was the most cited reason for disclosure. Before taking a more in depth look at Simon's study it should be noted that Simon defined self-disclosure as, "verbal behavior through which therapists consciously and purposefully communicate private information about themselves to their patients," (p.405). Despite the inexplicit definition of self-disclosure, Simon's study introduces plausible reasons for countertransference disclosure. In Simon's (1988) study, clinicians disclosed to model problem-solving skills, self-acceptance, assertiveness and healthy relationships. Countertransference disclosure provides an opportunity for the therapist to model discussion around emotion and to encourage a wider range of expressed emotion from the client (Strean, 1999).

Countertransference disclosure also allows the therapist to model comfortable discussion around difficult feelings such as aggression (Maroda, 1999). By disclosing

such feelings, the therapist encourages the client to disclose. Research shows that therapist self-disclosure increases client self-disclosure by modeling such disclosure (Meyers & Hayes, 2006). Maroda (1999) states that modeling through disclosure may be helpful for those who can benefit from experiencing another person's subjective experience.

Therapeutic Alliance

Another highly cited reason for using self-disclosure in Simon's (1988) study was to construct and maintain a good therapeutic alliance. Theorists have spoken on the utility of self-disclosure as a way to improve therapeutic alliance (Safran & Muran, 1996). While research points to disclosure as a way to enhance or repair alliance, using countertransference disclosure while the quality of working alliance is low can damage the alliance. Under such circumstances, therapists may be viewed as less expert and shallower than those who refrain from disclosure. However, when the working alliance is good, countertransference disclosure is viewed as useful in therapy (Meyers & Hayes, 2006).

Nilsson, Strassberg, & Bannon (1979) report that those therapists who disclose their reactions to the client were seen as warmer and more attractive than the non-disclosure therapists. McCarthy & Betz (1978) found that therapists who primarily disclose countertransference (defined as self-involving statements at the time of publication) may have greater alliance with clients. Meanwhile, those therapists who disclose information such as personal details unrelated to the process are seen as less expert and less trustworthy. Reynolds & Fischer (1983) completed a study which again confirmed that therapists who use countertransference disclosure are seen as more

trustworthy and expert than those who use general self-disclosure. Merluzzi, Banikiotes, & Missbach (1978) also report a positive relationship between therapist disclosure and attractiveness.

Gorkin, (1987) writes that self-disclosure can be used to establish humanity, honesty, and authenticity, (as cited in Maroda, 1999). Therapists who work to establish these qualities may be experienced as more attractive and trustworthy. Dowd & Boroto (1982) report that therapists who used self-disclosure of a current situation similar to client, past self-disclosure of a situation, or countertransference disclosure were not viewed differently by clients. However, all three types of disclosure made the therapists significantly more attractive than those therapists who just summarized the points at the end of the session or those who ended with dynamic interpretation. Thus, while Dowd & Boroto (1982) support the use of disclosure rather than summary, the study found no difference between the effects of general disclosure versus countertransference disclosure.

Interpretation of Reality for the Client

Therapists also disclose in order to validate or clarify the client's interpretation of reality. Countertransference disclosure can provide an opportunity for growth in the client's insight into reality (Gorkin, 1987). For example, some clinicians use countertransference disclosure to communicate an emotional reaction to the present therapeutic experience which differs from the client's emotional experience (Cooper, 1998a ; Streaan, 1999).

Empowerment of the Client

In addition to providing a reality-check for the client, therapists have used countertransference disclosure to empower the client. This section will consider the drive towards greater equality between client and therapist as the triggering force behind empowerment. Next, empowerment used as a method of increasing the client's sense of agency will be reviewed. Finally, the use of countertransference disclosure in order to shift the imbalance in power created by a client's race and/or culture will be explored.

Within relational therapy, the intersubjective composition of the dyad has caused theorists and practitioners to question the legitimacy of the therapist's once assumed authority over the client. Operating under this belief, feminists, intersubjectivists, and other therapists who believe in promoting a greater sense of shared equality and power between therapist and client may use countertransference disclosure as a way to increase parity within the dyad. Simon (1988) reports that some therapists disclose for the purpose of enhancing the client's autonomous sense of self and equality within the relationship. Peterson (2002) states that because of the feminist emphasis on client autonomy, some feminist therapists might consider a restriction against all forms of self-disclosure to be an ethical wrongdoing. While Levenson (1996) reports that self-disclosure can reinforce the clinician's authority in the mind of the client, other theorists suggest that within certain contexts, self-disclosure can empower the client. For example, Maroda (1999) has stated that disclosure of countertransference which may not parallel the client's feelings can be empowering when the therapist acknowledges that the client's experience is no less correct than the therapist's experience. In considering the factors involved in therapist self-disclosure, Simon (1988) writes:

Is the therapist suggesting his or her own superiority by being neutral? The high disclosers see their use of self-disclosure as an important way to communicate their care, respect, and parity with their patients. According to their thinking, therapists who do not share themselves are withholding respect and care and are elevating their own status. In answer to the above question, the low disclosers are not attempting to establish superiority and regarded equality as a non-issue. As human beings they are equal to their patient; as professionals they contribute their expertise. (p. 411)

Another frequently stated reason for self-disclosure in Mathews, (1988) was, “To promote feelings of universality” (p. 530). Although Mathew does not clearly define universality, universality suggests a shared experience, power, or sense of equality. Although perceptions of power and authority lie at the heart of intersubjective theory and countertransference disclosure, the literature has not looked at how clinician countertransference disclosure affects the power dynamic within the asymmetrical therapeutic relationship. It is possible that the therapist’s use of countertransference disclosure in order to model disclosure is effective because it empowers the client. Given the aforementioned research which shows that clinician countertransference disclosure increases client self-disclosure, modeling may work by *empowering* the client to self-disclose.

As the therapist is freer to show his or her affects, vulnerabilities, and anxieties, particularly as they are felt countertransferentially, patients have become freer to express a wider range of emotion in the therapy, particularly as they experience their affects in the transference (Strean, 1999, p. 127, citing Strean 1993).

If clients feel free to disclose affect and experience, that freedom to communicate with honesty can provide an empowering experience for the client.


As a tool for changing the power-differential, countertransference disclosure may be extremely useful in dyads where race, ethnicity, and other aspects of the client’s identity place the client in a minority power status position in relation to the therapist.

While theorists propose self-disclosure as an effective tool in such situations, the literature questions the effectiveness of countertransference disclosure in balancing the power differential among therapist and client. Meyers & Hayes (2006) have stated the need for more research around the consideration of cultural context in the use of disclosure, and how disclosure can be used when there is a cultural or racial power differential between client and clinician. Kim, Hill, Gelso, Goates, Asay, & Harbin (2003) found that with Euro-American therapists, East Asian American clients found “disclosures of strategies” more helpful than “disclosures of therapist approval” or therapist feelings.

In a survey of African American clients, while these clients preferred disclosure of interpersonal relationship with parents and experiences of success and failure from white clinicians, they did not prefer disclosure of feelings or attitudes. These same clients had a stronger preference for disclosure of feelings when asked to visualize an African American clinician (Cashwell, Shcherbakova, & Cashwell, 2003). In another study, the reciprocity effect or increased disclosure due to therapist disclosure was found when black therapists disclosed to black clients. However, when white therapists increased disclosure to black clients, those clients decreased their disclosure, and in fact, disclosed more to the non-disclosing white therapist (Wetzel & Wright-Buckley, 1988). Based upon the research presented, contrary evidence points to the complexity of issues of race and power in relation to countertransference disclosure. In Berg & Wright-Buckley’s (1988) study, findings concluded that white peer counselor self-disclosure of family history and personality increases disclosure for both white and black clients. Less client disclosure has been indicated as one of the most concerning issues in mixed-race

dyads (Ridley, 1984). Thus, disclosure practices which may increase client disclosure within mixed-race dyads is valuable to the overall treatment. .

Movement Through Impasse

Self-disclosure can be a tool for moving through impasse (Cornett  1991; Darwin, 1999). Burke & Tansey (1991) write about the usefulness of countertransference in informing the clinician on the failure to be empathic when such failure may be supporting the impasse. Aaron (2006) writes about the use of self-disclosure during impasse, stating that a third space can be created through clinician self-disclosure. Maroda (1999) has noted that countertransference disclosure may sometimes be the only way to move through an impasse. When the clinician communicates some conflict in thinking or a double-mindedness about an issue to the client, a third space for a joint reflexivity is opened up. This third space can serve to shift the seesaw action of therapist/client communication. From a self-psychological perspective, impasse is less about client resistance and more about the therapist's empathic failure and inability to fulfill self-object needs. Sometimes self-disclosure can re-establish an empathic connection (Goldstein, 1994). While both Gorkin (1987) and Ehrenberg (1995) state that countertransference disclosure can be used to disrupt an impasse, research has not described how often and with what types of impasse countertransference disclosure can be effectively used.

Disclosure of the Positive, Negative, and Erotic

In addition to looking at therapist uses of countertransference disclosure within the literature, research in the early 1980's looked at countertransference disclosure by differentiating between positive disclosure and negative disclosure. During this period, a

group of researchers studied countertransference disclosure, but referred to this type of disclosure as a self-involving statement. In Remer, Roffey, & Buckholtz's (1983) study, a positive self-involving statement was defined as, "direct, present expression of the counselor's positive feelings about or positive reactions to the statement or behavior of a client," (p. 121). This same study defined negative self-involving statements as, "direct, present expression of the counselor's negative feelings about...the statement or behavior of the client," (p.121). Remer et al. (1983) measured undergraduate student responses to positive and negative self-involving statements which were read off of a script. For these students who were asked to place themselves in the perspective of the client, therapists who used positive self-involving statements were rated as more attractive. Results also indicated that positive statements may encourage clients to share their feelings. For negative self-involving statements, students responded with comments that were based in the past rather than the "here and now." Clinicians wishing to base therapy more in the present may perceive negative self-involving statements to be counter-therapeutic. This study's results have been challenged by Reynolds & Fischer (1983) in which no difference among responses to positive or negative statements was detected. However, Andersen and Anderson (1985) conducted a study in which therapists using positive self-involving statements were rated as more expert, trustworthy, appropriate, and attractive than those using negative statements. In addition, Andersen and Anderson (1985) found that subjects tested as more willing to continue to meet with those therapists who disclosed positive countertransference.

While countertransference of positive feelings may increase therapists' attractiveness in the eyes of the client, it also appears that such disclosure may be easier

for therapists than disclosure of negative feelings. Pope and Tabachnick (1993) report that therapists can find it extremely difficult to admit feelings of anger or hatred towards clients. Despite discomfort, Searles (1975) writes that sharing scornful feelings with clients can improve relatedness under some specific circumstances (as cited in Burke and Tansey, 1991). Pope and Tabachnick (1993) report that therapists' fears of being assaulted by clients was not a serious problem until the late 1960's. In a survey of therapists conducted by Pope and Tabachnick (1993), 97.2% of therapists reported feeling fear around clients committing suicide with 90.9% of therapists feeling fearful that clients would get worse. Fifty-three percent of the participants in the survey reported feeling so fearful about clients that eating, sleeping, and concentration was affected. Because it is reportedly harder for therapists to admit feelings of anger and hatred, the use of negative countertransference disclosure is certainly an important issue for consideration in further research. With so many therapists reporting feelings of fear and even debilitating fear, it is important to consider how such emotion is handled. Research on countertransference disclosure was done in the 1980's, but such disclosure was defined as self-involving statements. While most of the research done in the 1980's on positive versus negative self-involving statements appears inconclusive, some theories on positive and negative disclosure have been expounded upon by other theorists. Kahn (1991) describes how Carl Rogers believed that it was imperative to communicate positive regard to the client. Kahn (1991) writes that communication of positive regard can be done either explicitly or implicitly and that choices must be made according to what will be most helpful. It is important to communicate positive regard to support self-esteem and therapeutic alliance. Kahn (1991) discusses the importance of how communication takes place, suggesting that

in most cases, actions and presentation speaks much louder than words. Kahn (1991)

writes:

It is a safe bet when clients ask, directly or indirectly, if their therapists like them, they are doing a good deal more than asking that question. They are telling their therapists something important about a lack of secure self-esteem. The requested reassurance may provide temporary relief, but it does not address the underlying issue, (p.152).

Kahn (1991) also infers that the issue of countertransference disclosure of negative feelings by drawing upon humanist theory. Kahn writes, “Consider sharing a negative feeling only if it is striking or persistent or is interfering with your capacity to be fully present with the client,” (Kahn,1991, p. 156). Kahn advises therapists to consider the motivation for such a disclosure. If the motivation is to move therapy along and benefits the client, such disclosures should be communicated so there is the least risk of such disclosure sounding like a criticism. Pulling from the writings of Carl Rogers and Merton Gill, both forerunners to intersubjective theory, Kahn suggests that disclosure of negative emotions must be made if it is clear that the client is aware of such emotion. In instances where clinicians realize they have engaged in a failure of empathy and the client is clearly affected by this failure, disclosure of such failure must be made. While disclosure of negative feelings is understandably a complicated issue, disclosure of erotic feelings is both understudied and extremely controversial (Goodyear & Shumate, 1996).

It wasn't until 1986 that therapists' erotic countertransference was even discussed in the literature (Pope & Tabachnik, 1993). The literature has been remiss in exploring the use and purpose of therapist's nurturing, protective, sexual, and tender feelings (Schamess, 1999b). Pope, Spiegel, and Tabachnik (1986) have found that sexual attraction to clients is common for both male and female therapists with 87% of therapists

surveyed reporting feelings of sexual attraction to clients. Another survey found that 57.9% of participants reported sexual arousal with a client in the room, while 87% of therapists reported at least some sexual attraction to clients (Pope & Tabachnik, 1993). In the same survey, over 50% of therapists reported a wide experience of client hugs, flirting and statements of sexual attraction. Pope, Tabachnik, & Spiegel (1987) found that the majority of psychologists found it unethical to disclose feelings of attraction to a client, and that 78.5% of respondents had not conducted some form of disclosure of erotic feelings (as cited in Goodyear & Shumate, 1996). Part of the controversy around erotic countertransference disclosure may be that erotic feelings for clients are often disavowed by therapists. Not only is there a dearth in literature, there are also few courses in graduate school which provide training around erotic emotions (Elise, 1991). In research by Silvia (2003), the following dialogue took place between Silvia and the study participant:

Student: That's why you have to go to supervision and therapy. Because your supervisor will pick up on things that you're disavowing. My supervisor does that.

Silvia: Can you give me an example of how she does that?

Student: It's mostly around erotic countertransference. She says all the time, 'Well, it's normal for people to have feelings in their bodies.' And I'm like, 'No, no, I'm not attracted. It's not coming up.' [whispered] No sexual feelings, (p. 52-53).

Goodyear and Shumate (1996) conducted a study in which 120 licensed mental health professionals rated therapists when these therapists disclosed erotic feelings while also communicating a clear prohibition of any sexual activity with the client. Participants rated these therapists as less therapeutic and less expert, but these same therapists were not seen as less trustworthy or attractive. In this study "Perhaps respondents perceived

erotic disclosure as a matter of skill (i.e., expertness) rather than as violating explicit or implicit client–therapist covenants,” (Goodyear & Shumate, 1996, p. 615). The implications of this study were not fully supportive of the use of erotic countertransference disclosure, but the study did not entirely prohibit the use of such disclosure either. Unfortunately, a taboo against sexual feelings towards clients continues to exist, encouraging therapists to remain unaware of such feelings or to ignore erotic emotions (Elise, 1991). Interestingly, while the use of erotic countertransference disclosure is widely debated, Pope & Tabachnik (1993) reported that one in ten therapists reported flirting with clients. However, little is known about the effective use of erotic countertransference or about the frequency of such use in current psychotherapeutic practice.

Countertransference Disclosure and the Beginning Clinician

While little has been written on the topic of erotic countertransference disclosure, there is no literature on how experience affects the use and attitude towards countertransference disclosure among experienced and inexperienced clinicians. To date, no empirical studies have investigated issues concerning the inexperienced therapist and countertransference disclosure. While some literature has addressed inexperienced therapists and general self-disclosure from a theoretical perspective, no literature has looked at countertransference disclosure in light of beginning therapists. The following discussion will look at how the delicate and complex issues around countertransference disclosure appear when transposed onto the practice of the inexperienced clinician. Although many theorists are willing to discuss the benefits of self-disclosure, most theorists express caution and concern around inexperienced therapists disclosing

information to clients. While Berzoff and Mattei (1999) acknowledge that self-disclosure has a place in intersubjective practice, they also discuss the danger in self-disclosing when beginning clinicians do not have experience setting boundaries, managing countertransference and transference, and negotiating enactments. Berzoff and Mattei (1999) write:

Should beginning therapists be taught to self-disclose and if so, how should they learn to make selective self-disclosures based upon the client's needs and not their own? Can or should we encourage students to break out of an analytic frame before they have developed the discipline to remain within one? How does one teach postmodern stance which questions the therapist's knowledge and authority when beginning students are struggling mightily to manage their own doubts about their therapeutic legitimacy? (p.380)

Other clinicians state that beginning clinicians should not use self-disclosure (Cooper, 1998a). "Because clients are more apt to be harmed by indiscreet or inappropriate self-disclosure than by withholding personal information, commission may be a greater danger here than omission" (Mathews, 1998, p. 525). The following section will look at what skills are needed in order to consider and use countertransference disclosure. Highlighting these skills in the context of the burgeoning therapist will illustrate the issues and debates around the inexperienced therapist's use of countertransference disclosure.

Self-Awareness: Understanding the Emotions so that the Emotions are most Useful

Countertransference is ever-present, always affecting the therapeutic relationship (Strean, 1999). Little (1951) writes about the issue of feeling overwhelmed by countertransference and the challenge that is presented in trying to decide whether or not to self-disclose. While feeling overwhelmed by countertransference is one challenge, the

cultivation of self-awareness in session is required for the effective critical analysis of countertransference disclosure as a possible option in therapy.

Because it is possible to act out countertransference through countertransference disclosure, inexperienced clinicians must use awareness, intention, and control in order to avoid an error which can have serious ramifications under the asymmetrical nature of the relationship (Kahn, 1991). According to intersubjective theorists, this self-awareness can be imperative to the relationship, because countertransference reactions may be unconsciously assessed by the client (Hoffman, 1983).

Not only must beginning therapists examine how their subjective or countertransference position may be affecting the client, they must use self-awareness in order to conceptualize how their countertransference may be *unconsciously* heard by the client regardless of conscious disclosure. Countertransference disclosure requires the need for self-awareness, assessment of intersubjective relations, assessment of biosychosocial details of the client, and the ability to withstand countertransference pressure. It is important for therapists to consider that their personal needs not be the dominating factor behind self-disclosure (Mahalik, Van Ormer & Simi, 2000). Countertransference disclosure can be used to fuel a deeper investigation of countertransference and transference between client and therapist. Here, countertransference disclosure serves as a tool to understand the meaning of countertransference.

While this method allows for the understanding of countertransference to arise through disclosure, the therapist must still use attentiveness and a theoretical framework to elicit a greater sense of clarity around the countertransference. Burke and Tansey

(1991) report that one of the most important tasks for the therapist wishing to use countertransference disclosure is to understand the degree to which the countertransference is being directly influenced by the client. This task requires an in-depth knowledge of the self in order for the therapist to readily differentiate between feelings which may be arising from the therapist's own relational history and organizing principles versus feelings which are being directly influenced by the client. For example, the therapists' attentiveness to self can prevent her from making poor choices when deciding to whether or not to self-disclose. While therapists must struggle with the seemingly illimitable factors to be considered when disclosing countertransference, Davis (2002) discusses some of the harmful reasons why some therapists choose to disclose. Davis writes that beginning therapists can be compelled to disclose to clients when the client's transference causes the inexperienced therapist to feel uncomfortable. In addition, new clinicians may problematically choose *not* to disclose in order to maintain anonymity which temporarily defends against vulnerability, intensity, and inadequacy. *Judging the Source of Countertransference, Being Attuned, and Measuring the Working Alliance*

Another challenge which can arise when deciding whether or not to disclose comes when the therapist must distinguish between countertransference and projective identification. Maroda (1999) defines projective identification as referring, "Only to those times when intense, unexplained, and ego-dystonic affect is stimulated, usually repeatedly, in the therapist or analyst," (p.233). Again, for the inexperienced therapist who is still discovering the shades of countertransference, the line between countertransference and projective identification is often extremely ambiguous and

difficult to assess. In the case of projective identification when the client projects feelings onto the therapist which are then experienced as the therapist's own felt emotions, many theorists have reported how disclosure of affect can provide a safe method for mirroring the client's emotions, communicating the client's power to affect another, and for the safe holding of those emotions which can only be distantly felt (Maroda, 1999; Searles, 1975; Winnicott; 1949). The uses for disclosure of feelings originating from projective identification can be very similar to those therapeutic achievements arising from countertransference disclosure, thus requiring the therapist to carefully assess motivations behind countertransference disclosure. Being able to consider the subtle differences between countertransference and projective identification allows the therapist to more deeply understand when to disclose and why to disclose. Again, for the inexperienced therapist, drawing a distinction between different origins of affect can be an extremely challenging task.

Therapists must also remain correctly attuned during an impasse in order to successfully use countertransference disclosure. Correct attunement allows the therapist to assess what unmet needs are present within the intersubjective client-therapist dyad. This attunement can prevent unintended consequences. If needs are not properly assessed prior to self-disclosure, the client can actually be encouraged to avoid certain feelings and memories. In addition, the following reverberations from disclosure can affect the dyad: the positive patterns which are working within the relationship can undergo an unintended disruption, the client may temporarily lose the ability to work with the experience of being separate from the therapist, and reenactment of pathological interaction may take place (Goldstein, 1994).

While the ability to stay attuned to the client can be extremely beneficial in addition to the capacity to distinguish between projective identification and other countertransference, the ability to judge the state of the working alliance may also be a valuable tool when deciding whether or not to disclose. The state of the working alliance may play a part in whether or not countertransference disclosure is experienced as useful. Meyers and Hayes (2006) found that only when the working alliance was good was countertransference disclosure viewed as an effective tool. The therapist's ability to assess the working alliance can also be an extremely essential skill.

Considering the Client

Not only do inexperienced therapists have a range of factors to consider before understanding why they may or may not want to disclose countertransference, inexperienced therapists must also consider the needs of the client. The following discussion presents selected descriptions of different ways the client's characteristics affect the therapist's decision to disclose. It is important to consider the challenge of assessing a client's character and background when thinking about the possible uses of countertransference disclosure. For example, the client's reality-testing, characterological issues, boundaries, race and ethnicity can affect how a client reacts to therapist disclosure. For Simon (1988) the consideration of client characteristics readily came before the decision to disclose for many therapists. Those therapists motivated to empower the client and improve the sense of equality within the relationship were most likely to disclose to clients who were labeled as "low functioning," "borderline," or to those clients who had trouble seeing the therapist as a whole person. With character disordered clients, disclosure can be used to negotiate idealization and client self-

defamation (Mathews, 1988). Dalenberg (2000) writes that it can be very valuable to use countertransference disclosure with clients who have a traumatic history.

Professional Self: The Process of Development

Therapists must learn to use self-awareness and self-reflexivity within their practice in order to fully acknowledge their subjective position and how that position affects the other (Chenot, 1998; Safran & Muran, 2000; Stolorow & Atwood, 1992). The cultivation of the ability to assess one's subjectivity in the context of another so that the therapist's subjective self is most useful slowly evolves with experience. While this awareness is being cultivated, beginning therapists may feel more overwhelmed than seasoned clinicians in learning how to acknowledge and work through countertransference due to all of the new information and experiences that are constantly being re-visited. Silvia's (2003) study looked at the use-of-self in 2nd-year MSW students by conducting qualitative interviews. Out of those interviews, two of the five most discussed dimensions of use-of-self were use of self-disclosure and use of countertransference. The development of the therapist's professional sense of self and ability to conceptually utilize theoretical constructs in an active manner can take several years for the therapist to achieve (Saari, 1989). Silvia (2003) notes that the integration of personal and theoretical values within the burgeoning therapist's professional use-of-self takes experience and time. The consideration of attitude toward and use of countertransference disclosure among inexperienced therapists is rooted in the therapist's "Oscillation of attention between the self and various theoretical concepts" (Silvia, 2003, p. 81). This oscillation between self and theory is complicated by the uncertainty and error inherent in self-disclosure as referred to by Goldstein (1994). For the inexperienced therapist, the

learning process is a composition of attention to the self's values and organizing principals, internalization of theoretical knowledge, and differentiation between professional self and professional others such as supervisors and professors.

Implementing personal values such as feminist ideals is not fluidly woven into the inexperienced therapist's practice but may be integrated in evolutionary jumps. Thus, those inexperienced therapists who value ideals such as authenticity, egalitarian interaction, and clear boundaries learn over time how these values can be best utilized and upheld within the dyad and how the use-of-self shifts depending on each unique dyad.

It is during this learning process, when the professional sense of self has not yet been melded with the ability to analyze and thoughtfully use theoretical guidelines and constructs, that practices which actively affect boundaries, therapeutic focus, and power may be looked upon with reticence, if not, trepidation. Countertransference disclosure asks the therapist to use awareness of emotional reaction as it relates to the professional self versus the personal self and history, but it also beckons the therapist to consider theoretical orientation and professional consideration of boundaries. For this reason, many inexperienced therapists are warned against the use of self-disclosure. However, inexperienced therapists who come from a theoretical orientation which departs from the classic psychoanalytic ideal of the "blank screen," are learning to "be real," and "genuine," which means acknowledging countertransference and utilizing countertransference within the relationship (Silvia, 2003). Upon being asked what it means to be real, one student acknowledged the importance of countertransference disclosure, "You know, I've felt moved by clients before and have felt tears come to my

eyes...even just saying, 'I feel emotional about that. Maybe you noticed that I have tears in my eyes. It's because I'm really hearing what you're saying' ...that's being real," (p.43).

Because of what is required from the therapist in deciding to use countertransference disclosure, the reluctance around disclosure among trainers and inexperienced therapists is understandable, but countertransference disclosure is utilized now more than it has been in the past (Kahn, 1991). Referring to use-of-self which has been defined as use of authenticity, disclosure, and countertransference, one MSW student states in Silvia (2003) study

It's more of using who you are...I think it's a really difficult—in a way—concept. Only because...I think it's only going to continue to develop for me. I think I'm just beginning to be able to embrace that concept. Um, and actually be effective in actually using myself. I think in the beginning, especially at [my school], you get so scared off about self-disclosure and all these types of things (p. 49).

Burke & Tansey (1991) write about the "persistence of the blank screen ideal," but for many new therapists, the blank screen is a thing of the past (p.352). With the blank screen no longer seemingly so persistent, it is important to consider why training around self-disclosure is still embedded in such fear.

The conservative view on countertransference disclosure uses prohibition as a guideline which protects the therapist from having to question whether or not disclosure may be helpful. Silvia (2003) reports "You never have to wonder: Should I answer that question? Should I share this feeling? The answer is comfortably and forever no," (p. 147). Inexperienced clinicians who operate under less conservative strictures are not shielded from the place of ambivalence and contemplation which can inhabit the debate around proper use of countertransference disclosure. Perhaps experience does not

necessarily remove all ambivalence around disclosure; rather, experience may allow the therapist to accept ambivalence and proceed with caution.

Berg-Cross (1984) studied clinician disclosure among 64 male therapists and found a relationship between type of disclosure and years of clinical experience. Disclosures of a variety of affect were reported. However, disclosure of negative affect, such as feeling criticized, were met with feelings of discomfort among the more seasoned clinicians of more than seven years experience. Therapists questioned the legitimacy of sharing negative affect with clients, but such affect was shared more as therapists became older. Seasoned clinicians may experience discomfort and vulnerability around disclosing negative affect but experience allows the therapist to balance discomfort with the rational needs of the therapeutic dyad.

In light of the slow development of professional use-of-self in practice and the sense of danger and ambivalence felt by inexperienced clinicians, it is perhaps not surprising that there is a paucity of literature on training around countertransference disclosure. Silvia (2003) writes:

Participants in this study discussed the significance of learning what not to bring into the room with the client and frequently discussed the sense of danger their training programs imparted about professional boundaries and self-disclosure in the first year of training. With experience, participants began to discern the boundaries between appropriate and inappropriate content to bring into the clinical encounter (p. 79).

Silvia also reports that when asked about training around the use-of-self such as use of countertransference and self-disclosure, students believed that there was a need for more explicit instruction on the matter. In an interview, Silvia (2003) asks a student about the training around self-disclosure in school:

Silvia: Meaning, at the beginning of the training program, they scare you away from self-disclosure?

Student: Basically. I feel like very much so....So when you're new at it, it's very difficult to see the difference between self-disclosure and use-of-self. So it's kind of like there, together, and you're thinking, 'I'm not going to tell anyone anything about me.' The poor person asks you a question and you're there sweating it out (p. 49-50).

It appears that there is extreme caution around self-disclosure in some graduate trainings, which may be paralleled by limited training around the management of emotions which are more controversial such as hatred and erotic feelings. Pope & Tabachnik (1993) surveyed respondents who rated the graduate training around dealing with feelings of anger, fear, and sexual arousal as inadequate. "To the extent that such discomfort may lead to neglect of these issues in training programs, therapists-in-training may lack the support to develop the knowledge, resources, confidence, and skills to acknowledge, accept, and understand such feelings when they occur in the therapist's work (Pope & Tabachnik, 1993, p. 151).

As of 1986, most graduate training students in clinical psychology had not dealt with the issue of feelings of attraction towards the client. In a survey of over 500 psychologists, over 50% had received no training on the matter (Pope, Spiegel, & Tabachnik, 1986). Unfortunately, there is no literature to date which presents a more current picture of the education around erotic countertransference. Given the variable skills required for the optimal use and consideration of countertransference disclosure, the wariness of inexperienced therapists in using countertransference disclosure becomes clearer. Nevertheless, while inexperienced therapists may be warned against the use of disclosure, this only emphasizes the need for training and education around the use of

self-disclosure and countertransference. Given the weaknesses in psychology training as suggested in the literature above and the apparent lack of literature on current training programs in social work, a deeper understanding of how students are trained around the uses of and attitudes towards countertransference disclosure appears necessary.

Summary

Countertransference disclosure has become more recognized as a viable tool in therapeutic practice among a wide range of psychotherapists. Although research has presented a variable list of uses for countertransference disclosure, countertransference disclosure has emerged out of a history of heightened skepticism around the cause of countertransference and the supposed damaging nature of self-disclosure.

Countertransference disclosure's variable array of uses is illustrated in the review of literature on theoretical writing and studies providing both qualitative and quantitative data. Theoretical discussions around countertransference disclosure propose reasons why countertransference disclosure can be effective at achieving certain therapeutic needs. For example, in considering the asymmetrical structure of the therapeutic dyad, the epistemology of therapeutic knowledge within the intersubjective frame, and the contemporary non-authoritarian stance of the therapist, theorists support the use of countertransference disclosure as a way to effect a more egalitarian relationship. In this case, the increased sense of mutuality cultivated by such disclosure may increase the client's sense of agency. Theory and research to date suggest that therapists use countertransference disclosure to model communication, improve the therapeutic alliance, encourage countertransference disclosure, address issues of impasse, and clarify points of reality for the client.

Because psychotherapy has slowly shifted from an emphasis on the dangers of self-disclosure to a more relational, intersubjective understanding of the therapeutic dyad, countertransference has become an inevitable and important informing and constructing force within the therapeutic dyad for many psychotherapists. As the conceptualization of countertransference in practice has been impacted by interpersonal psychology, humanist therapy, particle physics, feminism, and intersubjective theory, among other evolutions in thinking, this movement is accompanied by a critical look at boundaries, power, the construction of knowledge, the nature of objectivity, and an emphasis on the relationship in therapy. These concepts have produced a discourse around therapeutic practice which has begun to alter the once prohibitive attitudes around self-disclosure, and more specifically, countertransference disclosure.

Although attitudes around countertransference disclosure have been shifting over the last fifty years, the negative effects of countertransference disclosure are still vitally present as cautionary factors against the decision to disclose. Therapists must be careful not to blur boundaries, react in defense to the client, act out personal histories, or be motivated by personal needs. Avoiding these detrimental effects of countertransference disclosure often takes a deep level of personal awareness and a solid understanding of the intersubjective nature of the work. As such, inexperienced therapists can potentially face a monumental challenge in deciding whether or not to use countertransference disclosure. In addition to such challenges, the literature suggests that the graduate training around practices of disclosure may be deficient or extremely prohibitive around the use of countertransference disclosure. This study will attempt to answer questions around the practices and beliefs of experienced and inexperienced therapists in relation to

countertransference disclosure. Understanding the attitudes toward and uses of countertransference disclosure will hopefully deepen the way in which the current trends in psychotherapeutic practice are conceptualized, while needs for training around such issues are further explored.

CHAPTER III

METHODOLOGY

The purpose of this study is to examine the differences between experienced and inexperienced therapists in their attitude toward and use of countertransference disclosure. For the purpose of this study, countertransference disclosure is defined as the following: when the therapist consciously chooses to verbally communicate with the client any specific emotions that arise in reaction to the client.

The study will also examine the significance of association between attitude toward and use of countertransference disclosure for the sample as a whole as well as for the two sub-samples. There is an expectation that the data for experienced therapists will show a more favorable attitude toward and more use of countertransference disclosure as well as a more significant association between attitude and use.

Because of the very limited knowledge around countertransference disclosure among experienced and inexperienced therapists, the design of this study is both exploratory and descriptive in nature. The study will employ quantitative methods so that the variables can be measured more precisely and the results generalized to the larger population. In addition to quantitative data, the survey will gather qualitative data using two open-ended questions which will be used to provide greater depth of information. The study will use a survey to describe demographic characteristics of the sample and to measure attitudes toward and uses of countertransference disclosure.

Sample

The sample was composed of experienced therapists, defined as having seven or more years of practice experience, and inexperienced therapists, defined as having less than seven years of practice experience. For inclusion in this study, participants needed to be a candidate for the following degrees: MSW, Ph.D, Psy.D, or the participants needed to hold one of these three degrees. Participants who did not state their candidacy or degree status were excluded from the study. Other degrees in the mental health profession were not included in the study due to differences in training and field work during degree candidacy.

Once the study was approved by the Human Subjects Review Committee (Appendix A) sample recruitment was done online by emailing possible respondents from randomly selected schools, newsgroups, and websites. Some randomization was implemented for sample recruitment. Randomization was achieved from list serves which had psychology and/or social work school listings. Schools were given a number and that number was randomly chosen. If the schools listed did not have an email list of students and/or professors on the web site then another school was chosen. All respondents were contacted with an email (Appendix B) introducing the nature of the study, the risks of the study, and an online link which took participants directly to the survey. Sample recruitment of experienced and inexperienced therapists took place using over 70 individuals listed in the directories for Wyoming and Virginia on findatherapist.com. Wyoming and Virginia were the two states which were randomly chosen by drawing a number with each state being awarded a number. Possible respondents were contacted at the following schools: University of California at

Bakersfield, University of Delaware, University of Pennsylvania, University of Oregon, University of Michigan, University of North Texas, and Boston University using student and/or faculty directories. Recruitment emails were sent to over 200 Ph.D candidates at Adelphi University and over 150 MSW candidates and/professors at Tulane University. A directory of social workers and psychologists on clinicalsocialwork.com was emailed for potential participation in the study as well as 15 therapists listed on <http://st.therapeuticdirectory.com/> in the following zip code areas: 02125, 77345, 04011, 97220, and 90003. A recruitment email was also sent out to Smith College Alumni as well as to current Smith students. Smith students were not randomly selected. The Smith College Alumni were selected by randomly drawing a class years and emailing those selected classes of alumni. Although all of these approaches to random sampling were conducted, the majority of the study sample had affiliations with Smith College School for Social Work.

Ethics and Safeguards

One of the study's risks may have been around participants' emotional reactions to the questions. If any participants considered countertransference disclosure morally unacceptable, unprofessional, or a harmful aspect of practice in therapy, the survey may have evoked negative memories or emotions. Participants may have felt shame, discouragement, or other negative emotions when asked about possible uses of and attitudes around countertransference disclosure. Another potential risk is that memories of countertransference disclosure that may not have benefited the client may have evoked negative images and feelings as well.

In addition, it is possible that participants may have felt there was a bias in the questionnaire that affected the way they thought about psychotherapeutic practice or a bias which may have offended participants. Participants may have also wanted to change the way they think about countertransference disclosure or may have come away with questions about countertransference disclosure. If such participants did not have any peers or professionals to discuss such changes in attitude or belief, this situation could present feelings of frustration, isolation, and confusion. In order to support participants who may have suffered any harmful effects, the following website link of referrals was included in the recruitment email:

<http://www.helpstartshere.org/common/Search/Default.asp>. This website directs individuals to the national registry of social workers where they can search for a worker by state, specialization, age focus, and insurance. All participants were kept anonymous and all information held in confidence. The anonymity of the survey and sample of participants who are not from a vulnerable population considerably minimized the risk to participants.

Benefits to participants may have included the following effects after participating in the study: 1) Increased awareness around countertransference disclosure which may increase the ability of the therapist and/or bring curiosity and excitement to the therapist, 2) Opportunity for therapist growth and/or improvement in using countertransference disclosure, 3) Opportunity for therapist to gain an awareness which reduces any past feelings of shame, frustration, or confusion around countertransference disclosure, 4) Positive feelings which result from completion of the survey if the therapist feels they have helped an individual, and 5) Participants may learn about thesis surveys, helping

them to understand more about the thesis process which could be beneficial for students who may complete a future thesis.

Because this study was conducted online, a waiver of signed informed consent was obtained from HSR committee. There was communication to the participant that informed them about the nature of the survey, possible risks and benefits, length of time, information stating that consent was through submission of the survey, and a the link to the referral sources. Participants were informed that submission of their survey was their consent (Appendix B).

The data from the completed survey was kept in a database on a computer with a password lock that was accessible only to the investigator and the statistical analyst. The email lists were kept separate from the database in another password-locked database. After the study was completed and my thesis had been approved, dissemination of the findings would be in aggregate form. Thus, no identifying information was presented within the thesis or during dissemination. The data from the survey in the password-locked database will be kept for three years under federal guidelines.

Data Collection

Data collection took place using a survey which consisted of a demographics section and two sections on attitude toward and use of countertransference disclosure. Respondents were asked to complete an online self-administered questionnaire that was developed for this research project. This method of administering the survey was chosen for its cost-effectiveness and speed. Rubin and Babbie (2007) remark that a major disadvantage to online surveying is that the respondents will tend to be in higher economic brackets and more educated than the larger population who may not fill out

online surveys. Because the study was focusing on those individuals working towards advanced degrees or already having earned an advanced degree, this population trend was not considered to be a serious disadvantage in the study.

The anonymous, self-administered questionnaire is thought to be a good instrument for this study rather than qualitative interviewing or survey interviewing, because of the controversy surrounding countertransference disclosure. Respondents may have been more willing to anonymously report controversial attitudes and practices (Rubin & Babbie, 2007). Dicello (1996) conducted a previous survey on aspects of countertransference disclosure. Ten questions from her survey were used in the survey created for this study. This study's survey titled, "Countertransference Disclosure: Attitudes and Uses," was composed of 38 questions on attitude toward and use of countertransference disclosure and ten demographic questions. The survey also consisted of two open-ended questions which provided another source of data for analysis (Appendix C and Appendix D).

One of the weaknesses of this study, was attempting to define countertransference disclosure in a way that would be clearly understood by respondents as they completed the survey. Because definitions of countertransference disclosure have considerable variation, the respondents may have been asked to change their understanding of countertransference disclosure in order to answer the survey. Thus, the act of studying countertransference disclosure through the survey may have affected the respondents' attitudes towards countertransference disclosure. "The act of studying that topic—an attitude, for instance—may affect it," (Rubin & Babbie, 2007, p. 143). In addition, while the survey attempted to measure the action of disclosing countertransference, surveys are

only able to measure self-reports of actions rather than the action itself. However, Rubin and Babbie (2007) also state that the standardized nature of surveys promotes a strong reliability within the study which is more difficult to obtain through observation.

Data Analysis

Descriptive and inferential statistics were used to look at and analyze the sample data. Descriptive statistics provided frequency distributions on various individual questions on attitude toward and use of countertransference disclosure so that data between experienced and inexperienced therapists could be compared. Variance and mean were examined to describe the participants' responses on various questions. Particular attention was given to describing the variance between participants' attitude toward disclosing positive emotions and attitude toward disclosing negative emotions. The variance in use of disclosing positive versus negative emotions among both sub-groups was also taken into consideration. Descriptive statistics were used to examine the data gathered from demographic questions. A content analysis was used to analyze the data from the open-ended question.

In order to measure attitude toward and use of countertransference disclosure, four scales were created; there were two scales of attitude toward countertransference disclosure and two scales of use of countertransference disclosure. Reliability analysis on the scales was run to assess the internal reliability of the scales. Several of the hypotheses tested were measured using inferential statistics. In order to adequately assess the probability that the relationships and differences found between independent and dependent variables did not result from chance, inferential statistical tests were performed. The first hypothesis of association measured the relationship between attitude

toward and use of countertransference disclosure in the entire sample. A Pearson Correlation was run to test this hypothesis. A Pearson Correlation was also run to look at this association within both sub-samples, i.e., experienced and inexperienced therapists. T- tests were run to assess if there was a statistically significant difference between the experienced and inexperienced therapists in their attitudes toward and use of countertransference disclosure (Appendix F, Table 6). One of the open-ended questions was coded and analyzed for content (Appendix I, Table 8). The data were also examined for emergent themes related to: 1) the ways in which client-therapist power dynamics might be affected by countertransference disclosure, 2) the content of disclosure, and 3) recollections of training related to self/countertransference disclosure.

The study explored the attitude toward countertransference disclosure and use of countertransference disclosure among experienced and inexperienced therapists by surveying the sample of respondents. The data was used to describe the differences between the two sub-samples on attitude toward countertransference disclosure and use of countertransference disclosure. In addition, the relationship between attitude and use among both sub-samples was described.

CHAPTER IV

FINDINGS

The data from this study show that there is a significant difference between experienced and inexperienced therapists in their attitude toward and use of countertransference disclosure. Experienced therapists use countertransference disclosure significantly more than inexperienced therapists, and there is a more significant positive relationship between attitude toward and use of countertransference disclosure in experienced therapists. The data also showed that inexperienced therapists have a more favorable attitude towards countertransference disclosure than do experienced therapists, even though they use it less frequently. There is a significant positive relationship between attitude toward and use of countertransference disclosure for inexperienced therapists, but it is not as strong as that for experienced therapists.

The sample of respondents was initially composed of 395 participants (N=395). Those respondents who did not indicate their years of practice or type of counseling degree were eliminated from the pool of respondents. At the end of collection and elimination, the sub-sample of experienced therapists was 148 and the sub-sample of inexperienced therapists was 189.

Demographic Data Survey

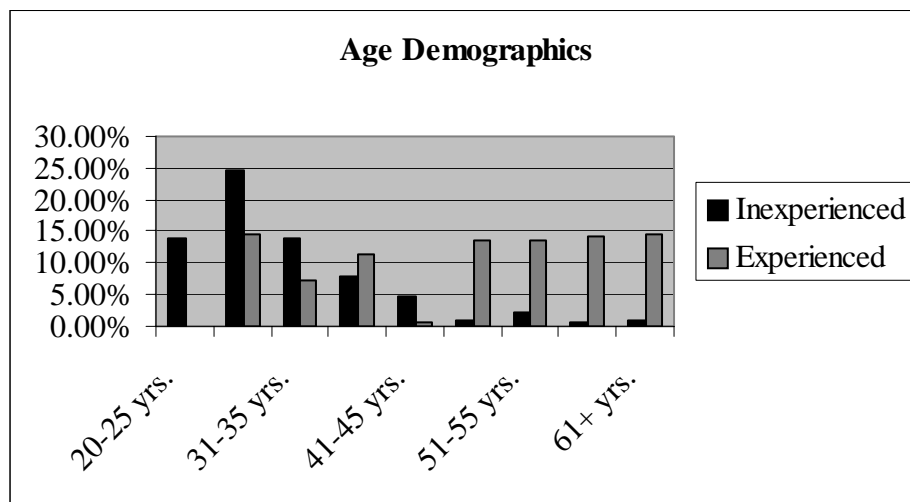
The sample of participants was divided into two groups based on the independent variable of years of clinical practice experience. The group of experienced therapists

represented 43.9% of the sample while the inexperienced therapists represented 56.1% of the sample.

Age

It is noteworthy and not surprising that the experienced therapists as a group were older (See Figure 1).

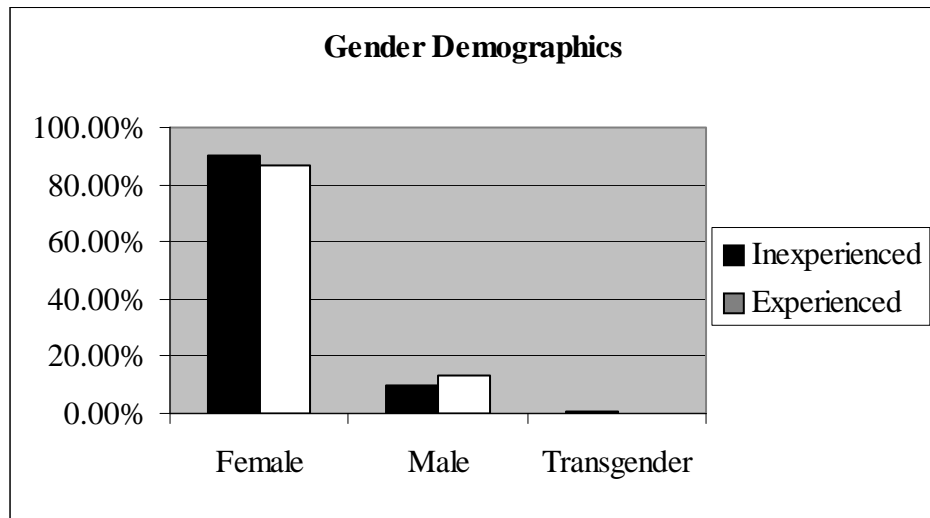
Figure 1: Age Demographics



Gender

It is noteworthy that both sub-samples were predominantly female (>85%) (see Figure 2)

Figure 2: Gender Demographics



Race and Ethnicity

Participants were asked to indicate their race and/or ethnicity. Both sub-populations were predominantly Caucasian (See Table 3 and Table 4).

Table 3: Race/Ethnicity of Inexperienced Participants

<u>Racial/Ethnic Identity</u>	<u>Frequency</u>	<u>Valid Percent</u>
African American	8	4.2
Hispanic	6	3.2
Latino	2	1.1
Asian	4	2.1
Multiracial	6	3.2
Caucasian	155	82.0
Afro-Caribbean	1	.5
Black	1	1.1
Caucasian and Jewish	2	1
Jewish	1	.5
White/Latina/Jewish-Sephardic/Ukrainian	1	.5
Askenazi		

Table 4: Race/Ethnicity of Experienced Participants

Racial/Ethnic Identity	Frequency	Valid Percent
African American	6	4.1
Hispanic	1	.7
Latino	2	1.4
Asian	1	.7
Multiracial	2	1.4
Caucasian	130	87.8
Arab-American/Irish-German American	1	.7
Irish American	1	.7
Latino/Caucasian	1	.7
Lebanese	1	.7
Radical Rejector of the Concept	1	.7
I dislike Categorizing	1	.7

Years Practicing Therapy

It is noteworthy that roughly 50% of experienced therapists have more than twice as much experience than the most experienced inexperienced therapist; this may not be surprising given that the two sub-samples were selected based on below or above seven years of experience (See Figure 3 and Figure 4).

Figure 3: Inexperienced Therapists' Years Experience.

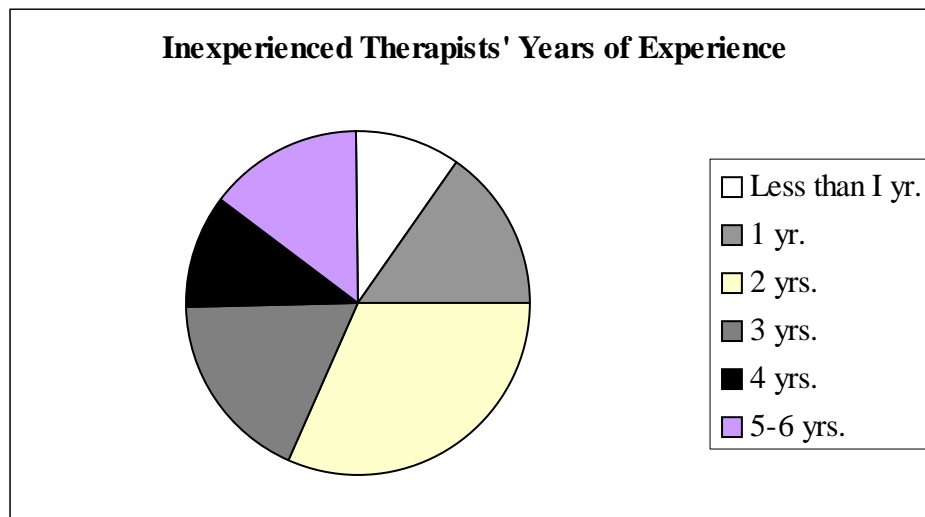
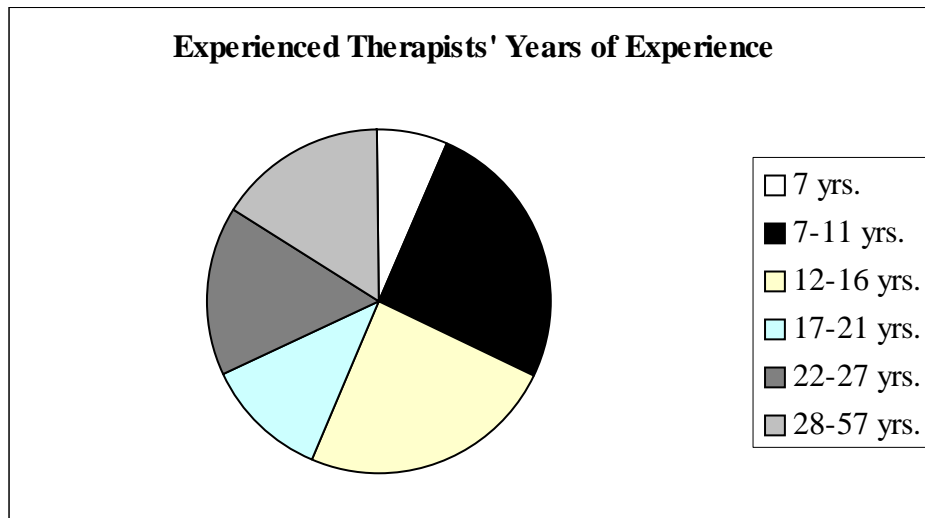


Figure 4: Experienced Therapists' Years Experience



Education and Licensure

While less than half of the inexperienced therapists were social workers; almost all of the experienced therapists were social workers. This may have been an artifact of sampling (see Figure 5 and Figure 6).

Figure 5: Inexperienced Therapists' Education and Licensure

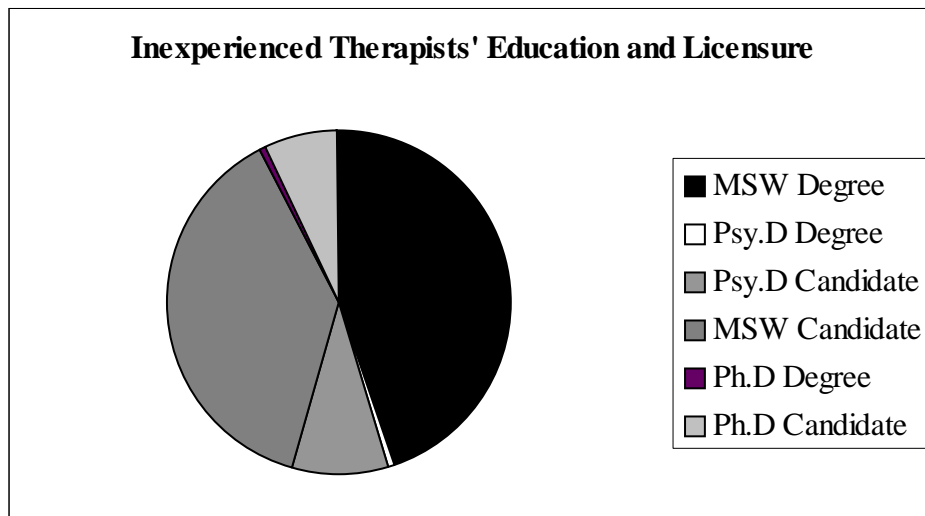
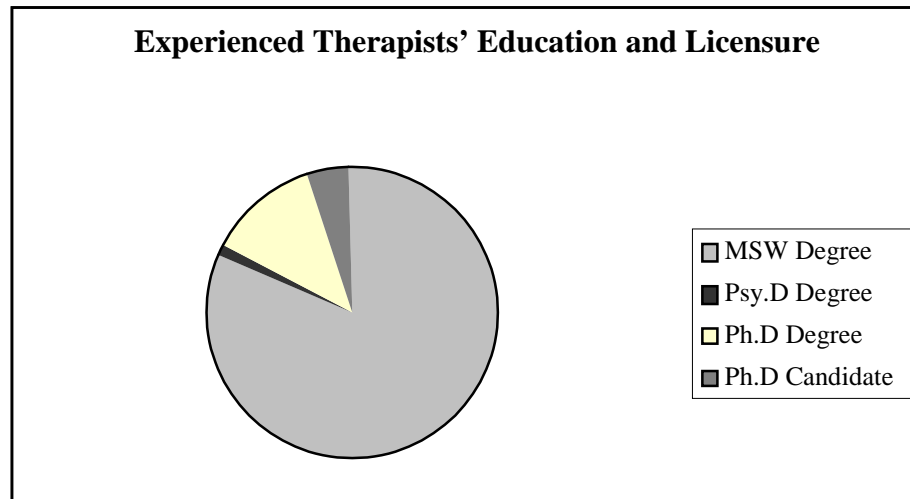


Figure 6: Experienced Therapists' Education and Licensure



Theoretical Orientation

Participants were asked to rate the influence of ten different theoretical orientations on their therapy practice. The majority of therapists in both groups appeared to operate under an eclectic mix of orientations, reporting that multiple orientations were influential or highly influential (See Table 5).

Table 5: Theoretical Orientation Demographics

Theoretical Orientation	Highly Influential	Influential	Little Influence
Cognitive-Behavior	I 22.8%	I 44.4%	I 29.1%
	E 17.8%	E 45.9%	E 34.9%
Relational Therapy	I 22.8%	I 46.6%	I 16.9%
	E 29.7%	E 47.3%	E 14.2%
Ego Psychology	I 16.4%	I 45%	I 20.6%
	E 21.5%	E 52.8%	E 19.4%
Self-Psychology	I 27.5%	I 39.7%	I 21.2%
	E 22.5%	E 48.6%	E 20.4%
Behavioral Therapy	I 11.7%	I 34.6%	I 46.4%
	E 5.1%	E 32.4%	E 47.8%
Feminist Therapy	I 10.1%	I 29.1%	I 31.2%
	E 15.3%	E 41.7%	E 29.7%
Freudian Psychology	I 9.5%	I 36.5%	I 36%
	E 15.3%	E 34.7%	E 39.6%
Narrative Therapy	I 14.3%	I 36%	I 27%
	E 9.3%	E 35.7%	E 32.9%
Solutions-Focused	I 15.3%	I 36.5%	I 31.7%
	E 14.2%	E 34.8%	E 37.6%
Humanist Therapy	I 11.1%	I 22.2%	I 34.9%
	E 11.6%	E 38.8%	E 31%

Caseload

Respondents were asked to report on the majority of their caseload. If two or more populations composed the majority of their caseload, respondents were able to identify the multiple dimensions of their majority caseload. By far, the majority of respondents' caseload was composed of adults with adolescents composing the next largest group of clients (See Figure 7).

Figure 7: Client Caseload

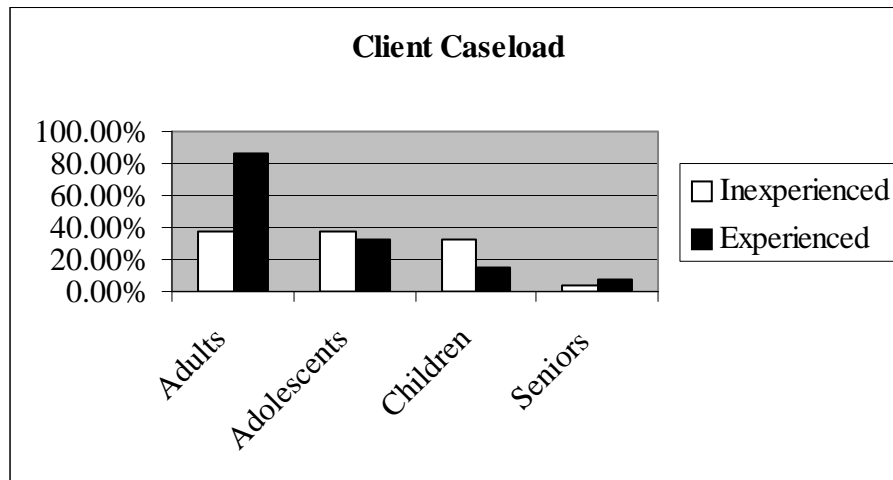


Figure 7: The following percentages represent client population which composes all or a majority of the therapists' caseload.

Countertransference Disclosure: Attitudes and Uses Scales

In order to measure attitude toward countertransference disclosure, two sets of scales were created. Attitude 1 scale was created by clustering the first four attitude questions (See Instrument, Appendix D) together. These questions were taken from the Attitudes-towards-Countertransference Disclosure Questionnaire previously published in a dissertation on countertransference, intimacy, and gender (DiCello, 1996). Attitude 1 Scale demonstrated high internal reliability ($\alpha = .86$, $N = 340$, number of items = 4). Attitude 2 Scale included questions from Attitude 1 Scale so that Attitude 2 scale could include a wide array of aspects of attitude. Attitude 2 scale was composed of questions 1-4 and 11-22 with question 14 reversed (See Instrument, Appendix D) and also demonstrated high internal reliability ($\alpha = .85$, $N = 325$, number of items = 15)

Two scales measured variations of use of countertransference disclosure. Use 1 was also composed of questions from DiCello (1996) Attitudes-towards-

Countertransference-Disclosure Questionnaire, consisting of questions 5,6,7,8,9, and 10. It demonstrated high reliability ($\alpha = .75$, $N = 344$, number of items = 6). Use 2 Scale was composed of questions 5,6,7,10 and 23-35, and it had a higher reliability rating ($\alpha = .85$, $N = 331$, number of items = 17) (Appendix E, Table 5).

In order to test the hypothesis that a positive relationship exists between attitude and use among the entire sample, a Pearson r correlational analysis was run between the attitude and use scales. There were significant, positive relationships between the attitude and use scales for the sample as a whole. There were positive correlations between Attitude 1 Scale and Use 1 Scale ($r = .452$, $p = .00$, two-tailed), Attitude 1 Scale and Use 2 Scale ($r = .528$, $p = .00$, two-tailed), Attitude 2 Scale and Use 1 Scale ($r = .457$, $p = .00$, two-tailed), Attitude 2 Scale and Use 2 Scale ($r = .579$, $p = .00$, two-tailed). While there were significant correlations between all scales, the correlations were in the weak to moderate range.

In the inexperienced sub-sample, Attitude 1 Scale and Use 1 Scale were significantly correlated ($r = .495$, $p = .00$, two-tailed), Attitude 1 Scale and Use 2 Scale were significantly correlated ($r = .481$, $p = .00$, two-tailed), Attitude 2 Scale and Use 1 Scale were significantly correlated ($r = .567$, $p = .00$, two-tailed), Attitude 2 Scale and Use 2 Scale were significantly correlated ($r = .564$, $p = .00$, two-tailed).

In the experienced sub-sample, significant positive correlations existed between all scales. Attitude 1 Scale and Use 1 Scale were significantly correlated, with slightly lower strength than inexperienced sub-sample ($r = .472$, $p = .00$, two-tailed). Attitude 1 Scale and Use 2 Scale were significantly correlated, with much higher strength than inexperienced therapists ($r = .635$, $p = .00$, two-tailed). Attitude 2 Scale and Use 1 Scale

were significantly correlated, with less strength than inexperienced therapists ($r = .493$, $p = .00$, two-tailed). Attitude 2 Scale and Use 2 Scale significantly correlated with considerably more strength than inexperienced therapists ($r = .685$, $p = .00$, two-tailed).

Using two attitude scales (Attitude 1 Scale and Attitude 2 Scale) and using two Use Scales (Use 1 Scale and Use 2 Scale), it was possible to examine the data for differences between experienced and inexperienced therapists in their attitude toward and use of countertransference disclosure (Appendix F, Table 6). Attitude 1 Scale showed significant differences in attitude toward countertransference disclosure between the experienced and inexperienced sub-samples ($t(269.08) = 1.994$, $p = .047$, two-tailed); the experienced sub-sample had a mean of 3.37 while the inexperienced sub-sample had a mean of 3.55. This small difference in means suggests a very small difference in attitude based on Attitude 1 Scale. There was a significant difference shown in the Attitude 2 Sub-Scale ($t(257.15) = 2.674$, $p = .008$, 2-tailed). The experienced sub-sample had a mean of 3.34, while the inexperienced sample had a mean of 3.50. The inexperienced therapists had a slightly more agreeable attitude towards countertransference disclosure than the experienced therapists.

Use 1 Scale also showed a significant difference ($t(335) = 2.862$, $p = .004$, 2-tailed). Unlike the attitude scales, experienced therapists had a higher mean (2.46) than the inexperienced therapists, who had a mean of 2.27 on reported use of countertransference disclosure. Use 2 Scale also showed a significant difference ($t(335) = 2.862$, $p = .004$, 2-tailed). The experienced sample again had a higher mean of 2.35 with the inexperienced sample measuring at 2.22. While the use is significantly higher among experienced therapists, the range in amount of use is quite similar among both sample groups.

Specific Emotions and Specific Uses of Countertransference Disclosure

Both experienced and inexperienced therapists reported more disclosure of emotions around process, emotions of worry, happiness, frustration and excitement than emotions of, boredom, fear, closeness, and erotic feelings. Overall, disclosure of positive feelings was used more than disclosure of negative feelings. However, negative feelings were generally disclosed more than erotic feelings and feelings of closeness, while frustration was disclosed more than positive feelings (Appendix G, Table 7).

In this study, therapists were asked a number of questions around the issue of power and how power is affected by countertransference disclosure. Around 60% of both groups of therapists generally agreed that countertransference disclosure could be used to model for the client and to provide an experience of the “here and now,” but only 37% of experienced therapists believed that countertransference disclosure promoted a greater feeling of equality between therapist and client. Meanwhile, 45% of inexperienced therapists believed that countertransference disclosure could be used to promote equality. While 43.4% of experienced therapists believed that countertransference disclosure could change the power differential, 50% of inexperienced therapists believed that countertransference disclosure could change the power differential. A similar percentage of therapists showed general agreement towards countertransference disclosure being a source of empowerment to clients with 49.7% of experienced therapists and 58.5% of inexperienced therapists generally agreeing on the use of disclosure to empower clients and generally agreeing on the use of countertransference disclosure in order to empower clients. However, 24.7% of experienced therapists and 22.6% of inexperienced therapists and have occasionally used countertransference disclosure to change the power

differential, and therapists from both groups reported greater use of disclosure for other therapeutic goals such as modeling emotions.

Fifty-three point one percent of experienced therapists and 47.6% of inexperienced therapists report occasionally using countertransference disclosure to model how feelings are communicated. Similarly, 47.3% of experienced therapists and 48.4% of inexperienced and occasionally use countertransference disclosure to provide a better understanding of reality for clients (Appendix H, Figure 8 and Figure 9).

Content Analysis on Open-Ended Portion of Survey

A content analysis was performed on the following question: “Did any of your graduate classes discuss clinician self-disclosure? If so, what kind of self-disclosure (i.e. countertransference disclosure, disclosure of professional details, disclosure of religion)? Please describe the conversation around self-disclosure.” From this question, participants commented on the type of training around general self-disclosure, while often commenting on the pedagogy or absence of training on countertransference disclosure. Of the 337 participants who were included in this study, 109 experienced therapists (N=109) and 145 inexperienced therapists (N=145) answered the question. The question was thematically coded and quantified to measure the following themes: discouragement of self-disclosure, training on countertransference disclosure, level of discouragement in the classroom and encouragement and caution (Appendix I, Table 8)

Discouragement of Self-Disclosure

Both experienced (N =39/26 %) and inexperienced (N=85/59%) therapists stated that self-disclosure was discussed in the classroom, and did not indicate that self-

disclosure was discouraged (Appendix J, Figure 10). For example, one inexperienced therapist writes:

Self-disclosure was covered in my practice class as well as Psychodynamic Theory class. The direction was ambiguous, as it should be, allowing for individual assessment and personal style. My practice instructor was tactful in addressing that not all therapists have great boundaries (what brought us to this place?), and that less is more when using self-disclosure

The data examined whether therapists who had been in graduate school longer ago reported discussion which was not discouraging against the use of self-disclosure differently than those therapists who have more recently attended graduate school. Those therapists with more years of experience attended graduate school longer ago than therapists with fewer years of experience. Unlike the inexperienced sub-sample, the experienced sub-sample had a very wide range in years of experience, with participants attending graduate school anywhere from 10 to 60 years ago. The data was analyzed to see if those experienced participants, who had been in graduate school more recently, reported their experience of graduate school differently than those participants having attended school in prior decades. In this study, years of experience did not have an impact on the level and type of discussion around self-disclosure in school for experienced therapists (Appendix J, Figure 11).

Training on Countertransference Disclosure

While some participants only referred to general self-disclosure, some participants reported discussion around countertransference disclosure in the classroom. While only 6.42% of the experienced sub-sample reported classroom discussion of countertransference disclosure, 21.38% of the inexperienced sub-sample reported some or a great deal of discussion on the use of countertransference disclosure in the

classroom. Although, very few experienced therapists received any training around countertransference disclosure, some participants recalled explicit instruction around the matter. One experienced therapist writes:

Frequent discussion of self-disclosure, especially around personal family dynamics and countertransference. Generally, it was discussed about how to ensure that the disclosure was conscious in intent, and was not for self-gratification.

Level of Discouragement in the Classroom

The level of reported discouragement around self-disclosure differed between experienced and inexperienced therapists. While 41.28% (N=45) of the experienced sub-sample reported discouragement of the use of self-disclosure, 24.83% (N=36) of the inexperienced sub-sample reported discouragement. Of the 41.28% of experienced therapists who were discouraged against the use of disclosure, 17.43% mentioned being strictly prohibited against the use of self-disclosure with no mention of self-disclosure's therapeutic uses. One experienced therapist writes, "Self disclosure was pretty much verboten in my graduate and post-graduate training." However, only 5.52% of the inexperienced sub-sample mentioned being strictly prohibited against the use of self-disclosure. Most inexperienced therapists explained that the classroom discussion involved an air of caution but included training on the benefits of disclosure. One inexperienced therapist writes, "Usually the conversation would be centered around the benefits and risks of self-disclosure and impressed upon me the need to thoughtfully think through the consequences of self-disclosure and to be sure that it is used for the benefit of the client." Given the change in overall perceptions on the use of self-

disclosure over the years, the differences in types of discouragement between both experienced and inexperienced groups is not surprising.

Encouragement and Caution

In the sample of respondents, 26.61% (N=29) of experienced sub-sample reported classroom conversation which presented a cautionary tone around clinician self-disclosure, whereas 34.48% (N=50) of the inexperienced sub-sample reported a cautionary tone. While 13.76% (N=15) of the experienced sub-sample reported classroom discussion which emphasized the therapeutic benefits of self-disclosure, 22.76% (N=33) of the inexperienced sub-sample gave the same report.

CHAPTER V

DISCUSSION

This chapter presents a discussion of the findings in this study. This section also draws upon theoretical literature to broaden and contextualize the discussion, while utilizing data found in the qualitative portion of this study to bring depth to the quantitative exploration of countertransference disclosure. This exploration will address the small difference between experienced and inexperienced therapists, while also focusing on the meaning of these differences. Further, the strengths and limitations of this study, implications for therapeutic practice and training and future research are expounded upon in this chapter.

Current Findings and Previous Literature

Prior to this study, no empirical studies have been conducted on the difference between experienced and inexperienced therapists in their patterned use and thinking around general self-disclosure or countertransference disclosure. The scarcity of current research presents a challenge to using pre-existing data in order to discuss the findings of this study. While empirical research has looked at the trends around general self-disclosure, it has not elucidated the significant differences found between experienced and inexperienced therapists in their attitude toward and use of countertransference disclosure. This study first looked to see whether there was a significant association

between the attitudes of therapists and the use of countertransference disclosure therapists.

Therapists' Overall Attitude Toward and Use of Countertransference Disclosure

There was a statistically significant positive association between attitude and use which suggests that what therapists believe about countertransference disclosure relates to how they use countertransference disclosure in practice. These results suggest that the therapists' attitude, whether positive or negative, is linked to their use of countertransference disclosure, suggesting that countertransference disclosure may not be arbitrarily used by either group of therapists. In this case, these results suggest that even for inexperienced therapists who are still codifying their theoretical framework and understanding, their attitude is more related to their use of countertransference disclosure just as attitude is related to use of countertransference disclosure for experienced therapists. While this study cannot describe the causal relationship between attitude and use, this research does present a link between attitude and use, with a stronger relationship existing between these variables for experienced therapists than for inexperienced therapists.

The statistically significant difference was small between the attitude toward and use of countertransference disclosure between experienced and inexperienced therapists. Therapists with seven years experience answered questions very similarly to therapists with less than seven experience. Unfortunately, the absence of current literature on the attitudes toward and uses of countertransference disclosure among therapists makes it difficult to elaborate on these findings. However, it has been found that the ability to use theoretical constructs takes several years for therapists to achieve (Saari, 1990). This

study found that while inexperienced therapists believed in the efficacy of countertransference disclosure, these beliefs were not readily exercised in therapy through use. The lower rate of use among inexperienced therapists may relate to the developing ability to integrate theory into practice.

The similar theoretical orientations between the sub-samples in this study may explain the similar percentages of experienced and inexperienced therapists who held a positive attitude towards countertransference disclosure and reported similar uses of countertransference disclosure. The theoretical orientations reported in the demographic section are similar for both groups of therapists. Current literature has looked at how therapists who are guided by interpersonal and humanist schools, along with those influenced by feminist theory, self-psychology, and object relations, often believe that therapeutic benefit can come from therapist self-disclosure (Margulies, 2001). Relational theory is also more supportive of countertransference disclosure. Almost all of the therapists in both groups considered one or more of these theoretical orientations to be highly influential in their practice

Disclosure of Positive and Negative Emotions

Both experienced and inexperienced therapists reported more disclosure of emotions around process, emotions of worry, happiness, frustration and excitement than emotions of boredom, fear, closeness, and eroticism. Aside from feelings of worry and frustration, disclosure of positive feelings was used more than disclosure of negative feelings with disclosure of negative feelings. When asked about the use of disclosing feelings of anger to clients, 22.3% of experienced therapists reported disclosure of anger occasionally to frequently where as only 13.7% of inexperienced therapists reported

disclosure of anger occasionally to frequently. This finding is consistent with a previous study in which therapists of over seven years experience were more likely to express disclosure of negative affect than inexperienced therapists (Berg-Cross, 1984). Berg-Cross (1984) studied clinician disclosure among 64 male therapists and found a relationship between type of disclosure and years of clinical experience. Disclosures of a variety of affect were reported. Therapists of over seven years experience expressed discomfort around disclosing negative affect, such as feeling criticized. Therapists questioned the legitimacy of sharing negative affect with clients, and such affect was shared more as therapists became older.

It may be appropriate that countertransference disclosure focusing on negative affect, eroticism, and closeness which could be more hurtful to the client or more repetitive of earlier relationship failures, are viewed with even more caution than countertransference disclosure that conveys a more positive affect. The literature has done little to investigate therapists' experience of loving, nurturing, sexual, or tender feelings (Schamess, 1999b). As reported, therapists who disclose positive feelings are seen as more expert, trustworthy, appropriate, and attractive by clients than those who disclose negative feelings (Andersen & Anderson, 1985). It is possible that, just as Pope and Tabachnick (1993) report, that therapists can find it extremely difficult to admit feelings of anger or hatred towards clients, therapists may also find it more difficult to admit any negative feelings towards their clients.

As reported in the findings, both sub-samples in this study were more willing to disclose feelings around process, worry, happiness, frustration and excitement than feelings of closeness. It is important to consider why therapists were less disclosing of

feelings of closeness. Goldstein (1994) states that within the therapeutic dyad, the asymmetry within the relationship gives countertransference disclosure the power to harm clients and repeat past injuries, reinforcing the need for consideration of boundaries. Perhaps disclosure of feelings of closeness is more threatening to the relationship than disclosure of other feelings because closeness. Additionally, both groups reported extremely low levels of erotic countertransference. In the study, only .7% of experienced therapists occasionally disclosed erotic feelings, only .5% of inexperienced therapists occasionally disclosed erotic feelings. This rate of disclosure reflects the literature which states that feelings of nurturance, boredom, anger, and hate are easier to acknowledge than sexual emotions towards a client (Elise, 1991). A previous survey found that 57.9% of participants (therapists) reported sexual arousal with a client in the room and 87% of therapists reported at least some sexual attraction to clients (Pope & Tabachnik, 1993). Although research illustrates the presence of countertransference disclosure, the reports of disclosure around erotic feelings were extremely limited in this study. Because of the social taboos which place heavy constraints around when it is appropriate to express sexual feelings in society as a whole, it is understandable that such constraints are played out in the therapeutic relationship. It is also important to consider that the degree of harm imposed on the client may be higher and more long-lasting with disclosure of sexual feeling, due to the experiences of self connected to expression of eroticism such as gender, body, and power.

Therapists' Reports on Their Graduate Training

By looking at the participants' data on the pedagogy of self-disclosure gathered in the open-ended question, it is possible to understand the attitudes toward and uses of experienced

and inexperienced therapists. Almost twice as many inexperienced therapists went through training without being overly discouraged against the use of self-disclosure. This research complements the slightly more positive attitude towards countertransference disclosure among inexperienced therapists. While inexperienced therapists reported a higher level of cautionary tone around self-disclosure in graduate training than those reported by experienced therapists, inexperienced therapists also reported that their training emphasized the therapeutic uses of therapist self-disclosure at a higher rate than their experienced counterparts. This finding may explain the more positive attitude among inexperienced therapists accompanied by lower levels of use. As therapists are being trained to embrace certain aspects of self-disclosure, they are also being directed to exercise caution.

While 41.28% of experienced therapists reported discouragement around the use of self-disclosure, 24.83% of the inexperienced therapists reported that their training included some discouragement of self-disclosure. Experienced therapists were also more likely to have instruction which prohibited the use of self-disclosure than inexperienced therapists. Newer constructs in psychotherapy such as countertransference disclosure are often treated with extreme caution and/or prohibition in training. As therapists have more time to think about and experiment with countertransference disclosure, it is likely that just as the level of discouragement and prohibition in training has decreased over the years for general self-disclosure, the level of discouragement around countertransference disclosure in training may also decrease.

A possible contributing factor to similar attitudes between both sub-populations was that experienced therapists had undergone more change in thinking around self-disclosure. It can be inferred that if change in thought has taken place around self-

disclosure in general, change may also have occurred around countertransference disclosure. Of the 31.28% of experienced therapists who were discouraged against the use of self-disclosure, 12.84% mentioned a change in attitude over the years, which has evolved into a more accepting attitude towards self-disclosure. No reports indicated change which was more prohibitive of self-disclosure. Unlike experienced therapists, only 2.07% of inexperienced therapists discussed having a change in thinking around self-disclosure. The research from the open-ended question shows that some experienced therapists who may have trained under a more classical background have shifted to a more accepting attitude towards countertransference disclosure. Experienced therapists have had more time and experience to develop their own belief systems around self-disclosure. Although some experienced therapists may have been educated during a period marked with more conservative attitudes towards countertransference disclosure, as the philosophy around psychotherapy has changed, experienced therapists have had the opportunity to change their thinking from that which was cultivated in graduate school. One therapist of over seven years wrote:

I was taught that countertransference issues should not be relayed to the clients. Also taught that self-disclosure was not helpful. I have now decided both of these depend on the client and sometimes are needed to continue a successful treatment.

While experienced therapists have been able to adapt their practice to the shifts in thinking around countertransference disclosure, inexperienced therapists have undergone training which has been more encouraging towards the therapeutic use of countertransference disclosure. Despite these differences, inexperienced therapists' training and experienced therapists' ability to shift their own practices may be cause for


the similar attitudes towards and uses of countertransference disclosure between both groups of therapists.

Strengths and Limitations of the Study

This study may have had some methodological biases and personal biases inherent in the research. It is hoped that the biases in this study did not affect the accurate portrayal of the population's attitude and use around countertransference disclosure. However, the survey did state that the definition of countertransference disclosure was pulled from a relational understanding of the term. Therapists who are familiar with relational therapy's more accepting view of countertransference disclosure may have picked up on a bias towards the survey's topic of study. One methodological bias is that the survey may have encouraged respondents to participate in a social desirability bias if they believed that the researcher held a more positive view of countertransference disclosure. The questions on the survey were written to try to minimize the visibility of the researcher's subjective opinion of countertransference disclosure, but it is possible that this personal bias affected some of the wording of the questions.

It is important to consider that therapists who are drawn more towards contemporary theory and practice may have taken this survey, as the letter requesting participation stated that the research of the study was informed by relational theory. It seems likely that most of the therapists who completed the survey held some interest around the topic of countertransference disclosure. A sample which may be more curious about contemporary psychodynamic practice and/or particularly interested in countertransference disclosure may be more in tune with contemporary practices which

are more accepting of countertransference disclosure. It is possible that the sample of therapists in this study hold a more positive attitude towards countertransference disclosure compared to the general population therapists.

Over half of the sample in this study consisted of social workers  who are influenced by relational therapy. The preferred theoretical orientations among this study's sample may have greatly contributed to the positive attitude toward countertransference disclosure. The use of countertransference disclosure and the positive attitude toward countertransference disclosure may be lower among a different sample of therapists who are less influenced by relational therapy.

One of the strengths of the study was that, while the population surveyed may have not been a true representation of the general population, the large number of respondents and randomization in sampling made the findings generalizable. The survey was composed of a section with questions around attitude and use and a section with demographic questions. The demographic survey allowed a comparison of the subsamples and a look at possible variables other than attitude which may have influenced the use of countertransference disclosure. A strength in this study was that the survey allowed participants to answer questions which may have been potentially threatening or difficult to honestly answer. With the survey, participants could honestly answer questions about practices that may have been forbidden or discouraged in the classroom and/or in the field.

Another strength in this study was the use of the open-ended question. This question provided an extremely rich source of data around participants' previous training

which provided much needed depth to the numerical data which was gathered in the rest of the survey.

Implication for Practice and Training

The implications for psychotherapy practice and training illustrate a need for the inclusion of more training around countertransference disclosure and related issues. Additionally, an exploration of the purpose and fluidity of boundaries which complements the progression of intersubjectively informed theory and practice is suggested. It is concerning that while so many inexperienced therapists have a similar attitude if not more positive attitude towards countertransference disclosure compared to experienced therapists, the participants' reports of discussion around countertransference disclosure were extremely low. With only 21.38% of inexperienced students reporting discussion around the disclosure of countertransference in training, this indicates that therapists may be cultivating their beliefs around countertransference disclosure through experiences in supervision, discussions with peers, and patterns in their own practice. The majority of training around countertransference disclosure seems to take place out in the field when the issues which complicate countertransference disclosure such as power dynamics, boundaries, and use of self are so complicated. Despite this gap in training, experienced and inexperienced therapists are not isolated from the continuing progression in intersubjective thinking around the client-therapist dyad. Inexperienced therapists are being educated around theoretical orientations which depart from the classic psychoanalytic ideal of the 'blank screen' are learning to 'be real' and 'genuine,' which is aided by the acknowledgement of countertransference within the relationship (Silvia, 2003). Similarly, experienced therapists who were trained in a more traditional

psychodynamic manner but practice more contemporary methods of therapy have had to learn to 'be real' and 'genuine.' With the growing number of therapists who may self-disclose, it is important to discuss issues such as boundaries and power dynamics in training so that therapists can apply what they learn to the specific therapeutic tools. The theoretical frameworks that foster countertransference disclosure are often taught in clinical social work schools (along with a variety of more traditional frameworks), but graduate level training is moving cautiously in its embrace of intersubjectivity and in discussion around countertransference disclosure.

Both students and practitioners are cautioned to be careful in adopting a full acceptance of self-disclosure, even more so, countertransference disclosure. It is in the disclosure of countertransference that the most damage can be done by the therapist: 1) not monitoring her own narcissism, 2) not keeping the treatment goals and needs of the client foremost, 3) not disclosing at an opportune time and 4) having a lack of clarity on about the emotional aspects of the countertransference both internally and in the interaction of the disclosure. The data from this study suggest that a similar percentage of both experienced and inexperienced therapists have a positive attitude toward countertransference disclosure. The transitions which have occurred in postmodernism and intersubjectivity have resulted in a more positive attitude toward the use of countertransference disclosure, but even those therapists with a positive attitude are cautious about using countertransference disclosure. This caution (as indicated by small levels of use) is higher in newer therapists who have a positive attitude toward countertransference disclosure. This higher level of caution among inexperienced therapists may not be entirely due to cautionary pedagogy, but to a lack of experience.

Goldstein (1994) writes that this lack of experience among therapists can only produce greater uncertainty and error.

Graduate training which focuses on power dynamics and boundaries will assist with this uncertainty and error. Training may also serve upcoming practitioners by including more discussion around the disclosure of negative feelings and other emotions which may be extremely harmful to the therapeutic relationship. Pope & Tabachnik (1993) reported that graduate students rated the graduate training around dealing with feelings of anger as inadequate. While Pope and Tabachnick (1993) report that therapists have a difficult time admitting feelings of anger, it may be that experience over the years with such feelings makes it easier to deal with anger. This study found that experienced therapists disclosed negative feelings such as anger at moderately higher rates than inexperienced therapists. This finding suggests that inexperienced therapists are more reticent around the disclosure of feelings which are potentially destructive to the therapeutic alliance. However, it is possible that practice has made experienced therapists more comfortable disclosing such feelings. It may also be that experience offers more opportunity for use of disclosure. Perhaps it is not that experienced therapists are more comfortable disclosing anger, but that they have had more experiences disclosing all emotions due to their longer time in the field.

Future Studies

Because the data suggests that there has been an increase in positive discussion around self-disclosure with less discouragement around the practice, further studies on the specific classroom pedagogy around self-disclosure and countertransference

disclosure may discover areas of concern where issues around boundaries may not be adequately addressed.

Another under-researched area of concern is that of erotic countertransference. While the use of erotic countertransference disclosure is widely debated and there are high numbers of reported flirtation and attraction on behalf of therapists, further research on the classroom discussion around countertransference disclosure of erotic feelings may be necessary to help provide training around boundaries and power.

In addition to future studies on disclosure of erotic countertransference, studies on disclosure of positive and negative feelings are also needed. Taboos against therapist anger and hate need further exploration. Research on the reasoning behind what is disclosed and what is not among inexperienced and experienced therapists will assist the field in its continual process of creativity, growth, and change around the conceptualization of the therapeutic relationship. Practitioners will benefit from research which looks at how boundary maintenance relates to disclosure of feelings. With changing conceptions around client empowerment and authority, increased self-disclosure, and greater focus on the relationship, further research on how therapists who use countertransference disclosure are maintaining boundaries in psychotherapy will be of use to practitioners.

Finally, further research is needed on the relationship of countertransference disclosure and length of treatment. Given the complex nature of navigating the client-therapist dyad while using countertransference disclosure, it seems likely that countertransference disclosure may serve different purposes and achieve varied outcomes depending on the length of treatment. While characteristics of the client, therapeutic

alliance, and self awareness of the therapist have a deep impact on how and when countertransference disclosure may or may not be useful, length of treatment may also prove to be a very important factor when looking at countertransference disclosure in the context of the relationship.

Conclusion

The attitudes held towards countertransference disclosure among therapists relate to how therapists use countertransference disclosure in their practice. As experienced therapists are influenced by current trends in psychotherapy and inexperienced therapists are educated within the parameters of these current trends, the therapeutic relationship, understanding of boundaries, and ways in which countertransference disclosure is used will continue to evolve. This study is meant to encourage therapists and educators to further consider the uses and effects of countertransference disclosure within the practice of psychotherapy. Experienced and inexperienced therapists are proving to hold similar attitudes toward and uses of countertransference disclosure during a postmodern time which has resulted in changes in theory and practice around traditional conceptualizations of authority, therapist use-of-self, and boundaries. The current exploration of attitude toward and use of countertransference disclosure within psychotherapy will continue to evolve, but this evolution must be influenced by therapists who are driven by a desire to discover therapeutic practices which meet the changing needs of the client within the therapeutic dyad.

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Appendix A
Human Subjects Review Committee Approval Letter

December 29, 2006

Sara Willott
135 Sydney Street, #3
Dorchester, MA 02125

Dear Sara,

The Human Subjects Review Committee has reviewed your submissions. You did an excellent job in putting together the materials. We are able now to approve your project. However, we do need a note from the South Shore Community Mental Health Clinic saying that you have permission to recruit there. Also, in your email to the potential participants, add that you may also use the material for presentations.

Please send the amended e-mail and the copy of a permission letter to Laurie Wyman. You may start to do your email recruitment before you have the letter from South Shore, but wait until you have sent that letter to us before you start there.

Please note the following requirements;

Consent Forms: All subject should be given a copy of the consent form.

Maintaining Data: You must retain signed documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your very interesting project. I'll bet the experienced folks are a lot more willing to share their personal reactions than are the beginning workers. I notice that the

longer I practiced the more transparent I became and I was happy when Michael White said it was OK, in fact, necessary!

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Bruce Thompson, Research Advisor

Appendix B
Recruitment Letter

Dear Potential Study Participant,

My name is Sara Willott and I am in my last year at Smith College School for Social Work. I am working to earn an MSW with a focus in clinical social work. I am conducting a quantitative research study and would greatly appreciate your participation.

My research is around the attitudes toward and uses of countertransference disclosure among more experienced and less experienced therapists. In this study, countertransference disclosure has been conceptualized using a relational therapy perspective with a specific focus on emotional countertransference. In the survey, countertransference disclosure is when the therapist consciously chooses to verbally communicate with the client any specific emotions that arise in reaction to the client. I will use the data from this research project to complete my MSW thesis, give presentations, and submit articles for publication.

If you choose to participate, you will be asked to complete an anonymous online survey concerning demographic questions and questions regarding your attitudes about and uses of countertransference disclosure. The survey should take between 10 to 20 minutes to complete. The survey can be found at surveymonkey.com which uses firewalls and data encryption to protect your identity. You will be included in the research if you currently have or are working towards an MSW, DSW, Psy.D, or Ph.D. You will be excluded if you do not meet the above criteria.

You may leave the survey at any time and may leave questions blank. Participation of this study is anonymous. I will have no record of who has participated and who has not. The survey can be found at surveymonkey.com which uses firewalls and data encryption to protect your identity. Only I, my thesis advisor and a statistical analyst will have access to the data. The data from this study will be kept locked for a period of three years as required by Federal guidelines and destroyed if not needed for further use. Please be aware that once you have submitted the survey your information cannot be withdrawn from the study.

BY ANSWERING THE SURVEY, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY

Please click the following link to be taken directly to the survey.

Surveymonkey.com link here

Your participation will aid in furthering the knowledge around countertransference disclosure. Unfortunately, I cannot provide any financial and/or other compensation for your participation. Although the questions are generally not invasive in nature, the survey may bring up emotions such as shame, confusion, or anger. If you feel like you need to speak with someone professionally after answering any of the questions, please connect to <http://www.helpstartshere.org/common/Search/Default.asp> to find a social worker near you.

Please do not hesitate to contact me if you have any questions, comments, or concerns. If you would like to see the results of my research, please send me your email address and I will send you an executive summary of my study.

Thank you so much,

Sara Willott
swillott@smith.edu

Appendix C
Demographic Questions

Gender: Female
Male
Transgender
Other

Please type your age: ____

Degree: MSW Candidate for Degree of: MSW
DSW DSW

PSY.D PSY.D
Ph.D Ph.D

Sexual Orientation: Asexual
Gay
Lesbian
Queer
Bisexual
Heterosexual
Other

Racial Identity: African-American
Black
Hispanic
Latino
Pacific Islander
Other
Asian
Biracial
Multiracial
White

Please type years of practice doing individual or family therapy: ____

Please rank each theoretical orientation's influence on your practice by marking no influence, some influence, influential, highly influential
Cognitive-Behavioral therapy

Behavioral therapy
Relational therapy
Feminist therapy

Narrative therapy
Ego Psychology
Freudian Psychology
Narrative therapy
Solutions-Focused therapy
Humanist Therapy

If there is a theoretical orientation that is highly influential in your practice and was not listed above, please list that theoretical orientation now. _____

Please rank client description with 1 being the majority of your caseload, leave blank any population you do not serve:

Adolescents 13-18 ____
Adults 18-65 ____
Children 0-17 ____
Seniors 65 + ____

Please click the top for issues that you treat if they are represented here. If not, please leave this portion blank.

Personality disorder
Substance abuse disorder
Anxiety disorder
Mood disorder
Behavioral Issues
Developmental Disability
Trauma
Psychotic Disorder
Autism/PDD
Dissociative Disorder
Eating Disorder
Dual Diagnosis
Major Mental Illness

If none of the categories capture your caseload, briefly describe your caseload.

Appendix D

Countertransference Disclosure: Attitudes and Uses

Please complete the following questions to the best of your ability by clicking next to the appropriate answer.

This survey addresses questions around therapist disclosure of countertransference. The study focuses on use of countertransference disclosure and attitudes around countertransference disclosure. The first section of this survey is composed of demographic questions. The 2nd and 3rd section are composed of attitude and use questions around countertransference disclosure. You may skip any question at any time. If you complete the survey and press send, you have consented to participate in this research and your survey cannot be withdrawn from the study. Thank you for your participation!

2nd Section: Countertransference Disclosure: Attitudes and Uses

The definition and understanding of countertransference has undergone many changes over the years and varies among different schools of therapy. For the purposes of this study, we are looking at countertransference from the contemporary relational perspective and have chosen to focus specifically on emotion. From this perspective, countertransference is defined as *any specific emotion within the therapist which arises in reaction to the client*. In this study, please use the following definition of countertransference disclosure when answering the questions: *Countertransference disclosure is when the therapist consciously chooses to verbally communicate with the client any specific emotions that arise in reaction to the client*.

For the following questions, please mark the statements according to how much you agree or disagree: strongly disagree, generally disagree, no opinion, undecided, generally agree, strongly agree

1. ___ Countertransference disclosure does not divert from the central focus of treatment (i.e. the client), but rather contributes information from one part of the center itself (client-therapist dyad)
2. ___ Countertransference disclosure allows the patient to understand what it is like for someone to be in relationship with him/her.
3. ___ Countertransference disclosure can result in a sense of greater mutuality and intimacy in the therapeutic relationship.
4. ___ Countertransference disclosure can result in a greater sense of agency on the part of the client.

For the following questions, please mark how often you find/found yourself in the kind of situation described.

Never, very rarely, occasionally, frequently, very frequently

5. ___ I have disclosed my feelings which have arisen in reaction to a client
6. ___ I have disclosed feelings of boredom during a session with my client.
7. ___ I have disclosed feelings of anger during a session with my client.
8. ___ I have disclosed my feelings about a client's process during a session with my client.
9. ___ I have disclosed a client's emotional impact on me during a session with my client
10. ___ I have disclosed feelings of worry towards my client during a session.
11. ___ I have disclosed feelings of closeness towards my client during a session.

Attitude and Uses Continued
Section 2

Just a reminder: Countertransference disclosure is when the therapist consciously chooses to verbally communicate with the client any specific emotions that arise in reaction to the client.

For the following questions, please mark the statements according to how much you agree or disagree: strongly disagree, generally disagree, no opinion, undecided, generally agree, strongly agree

12. ___ Countertransference disclosure can allow the client and therapist to explore how each individual mutually influences one another.
13. ___ The less personal information that is shared with a client, the greater the chances of helping a client. (reverse score)
14. ___ Countertransference disclosure can establish a greater feeling of equality between therapist and client.
15. ___ Countertransference disclosure can be to the detriment of the client because it is important to remain neutral.
16. ___ Countertransference disclosure can be helpful because the client and therapist are able to acknowledge the “here and now” of the session.
17. ___ Countertransference disclosure can be more harmful to the client than self-disclosure of facts about the therapist.
19. ___ Countertransference disclosure can provide the therapist with a way to model for the client.
20. ___ Countertransference disclosure can change the power-differential between the therapist and the client.
21. ___ Countertransference disclosure can provide a better understanding of reality for the client.
22. ___ Countertransference disclosure can be a means of empowering the client.
23. ___ Countertransference disclosure can help build a better therapeutic alliance.
24. ___ Countertransference disclosure can be a tool used during therapeutic impasse.

For the following questions, please mark how often you find/found yourself in the kind of situation described.

Never, very rarely, occasionally, frequently, very frequently

25. ___ I have disclosed feelings of happiness during a session with my client.
26. ___ I have disclosed feelings of anger during a session with my client.
27. ___ I have disclosed feelings of frustration during a session with my client.
28. ___ I have disclosed feelings of excitement during a session with my client.

29. ___ I have disclosed erotic feelings during a session with my client.
30. ___ I have disclosed facts about my family to my client.
31. ___ I have disclosed facts about my personal life to my client.
32. ___ I have disclosed countertransference to model communication around feelings for my client.
33. ___ I have disclosed countertransference to change the power-differential between myself and my client.
34. ___ I have disclosed countertransference to provide a better understanding of reality for my Client.
35. ___ I have disclosed countertransference to help build the therapeutic alliance.
36. ___ I am more likely to disclose facts about my life than feelings I am having about the client.
37. ___ I have used countertransference disclosure to work through a therapeutic impasse.
38. ___ I have disclosed feelings of fear to a client

Mark the answer that best describes how often you use countertransference disclosure.

I have used countertransference disclosure with the following clients: Never, very rarely, occasionally, frequently, very frequently

adolescents
adults
elderly
children
clients with good boundaries
clients with poor judgment
clients with poor boundaries
clients with good insight into self
clients with suicidal intent
clients with poor insight into others
clients with poor insight into self
clients with below average intelligence
clients with normal intelligence
clients with a developmental disability
clients with good insight into others
short-term clients
long-term clients
clients who are a race other than my own
clients who are an ethnicity other than my own
clients who are the same race as me
clients who are the same ethnicity as me
clients with a different sexual orientation than my own
clients with the same sexual orientation as my own

Please respond to the following questions by writing as much or as little as you would like:

1. Can describe the most recent time you have used countertransference disclosure? Feel free to talk about the effect, intended effect, type of countertransference disclosure, client.
2. Did any of your graduate classes discuss therapist self-disclosure? If so, what kind of self-disclosure (i.e. countertransference disclosure, disclosure of professional details, disclosure of religion)? Please describe the conversation around self-disclosure.

Appendix E

Table 5

Alpha Coefficients

<u>Table</u>	<u>Alpha</u>
Attitude 1	.86
Attitude 2	.85
Use 1	.75
Use 2	.85

Appendix F

Table 6

T-test Results

	Experience	N	Mean	Std. Deviation	Std. Error Mean
Attitude 1	Inexperienced	189	3.55	.708	.051
	Experienced	147	3.37	.911	.075
Attitude2	Inexperienced	189	3.50	.445	.032
	Experienced	147	3.34	.619	.051
Use 1	Inexperienced	189	2.27	.465	.034
	Experienced	147	2.46	.549	.045
Use 2	Inexperienced	189	2.22	.425	.031
	Experienced	147	2.35	.460	.038

Appendix G

Table 7

Disclosure of Positive and Negative Emotions

Disclosure of Type Particular emotion	% Exp. Who answered never	% Inexp. who Answered Never	% Exp. Who Answered occasionally	% Inexp. Who Answered Occasionally
Feelings around process	4.1	8.5	45.9	51.9
Anger	28.4	50.8	20.3	13.2
boredom	64.2	82	8.1	3.2
Worry	12.2	4.2	60.1	50.3
closeness	29.3	26.5	24.5	22.8
happiness	3.4	3.2	59.5	48.7
frustration	6.1	14.9	51.0	36.7
excitement	10.8	9.0	47.3	48.1
Erotic feelings	90.5	97.4	.7	.5
Fear	33.1	45.0	20.6	23.6

Appendix H

Figure 8 Attitude toward Countertransference Disclosure for Therapeutic Use

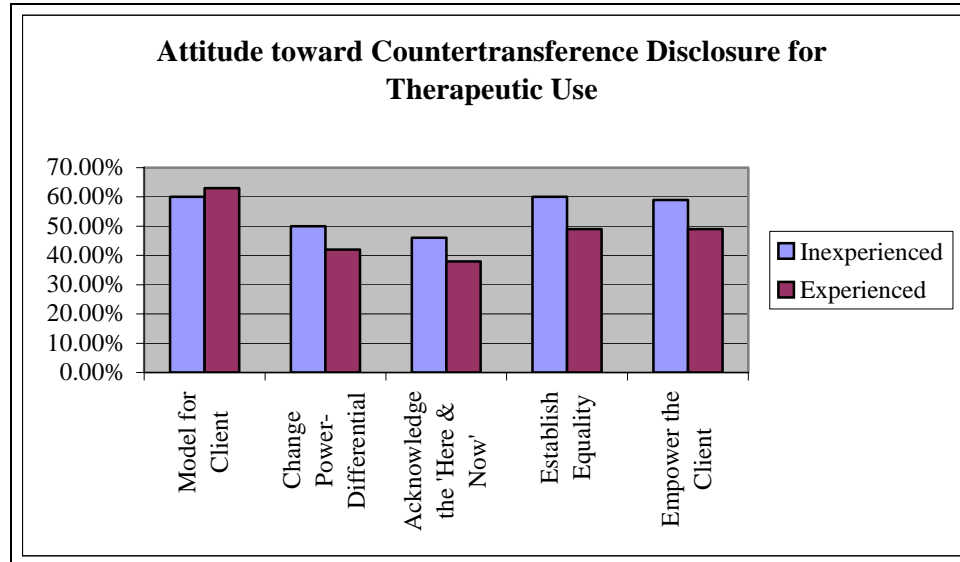


Figure 8: The percentages indicate the number of therapists who answered “generally agree” when asked about countertransference disclosure’s ability to achieve the therapeutic goals listed above

Figure 9: Use of Countertransference Disclosure

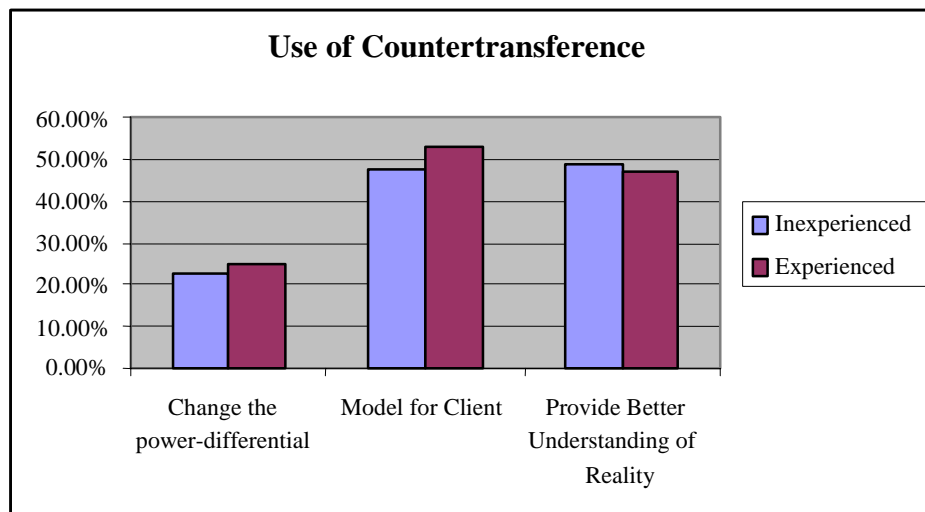


Figure 9: The percentages indicate the number of therapists who answered “Occasionally Used” when asked how often they use countertransference disclosure for the purposes listed above

Appendix I

Table 8

Open-Ended Responses

Answer Type	Experience	N	Percentage
Presence of Discussion of SD in Class	I	103	71.03
	E	37	33.945
Discussion without Discouragement	I	85	58.62
	E	39	26.35
Discussion Occurred Often	I	24	16.55
	E	10	9.17
No Discussion	I	10	6.90
	E	10	9.17
Countertransference Disclosure Discussed	I	31	21.38
	E	7	6.42
Countertransference Disclosure Not Discussed	I	12	8.28
	E	1	.92
SD often Discussed and Countertransference Often Discussed	I	25	17.24
	E	2	1.83
Disclosure Discouraged	I	36	41.28
	E	45	24.83
Disclosure Discouraged but Told to Use Caution	I	15	10.34
	E	9	8.26
Participant Changed Thinking After Graduate School	I	3	2.07
	E	14	12.84
Use Caution	I	50	34.48
	E	29	26.61
SD Can be Helpful	I	33	22.76
	E	15	13.76
Caution Around SD and Maintaining Focus on Client	I	22	15.17
	E	6	5.50
SD Strongly Discouraged	I	8	5.52
	E	19	17.43

Appendix J

Figure 10: Pedagogy without Discouragement

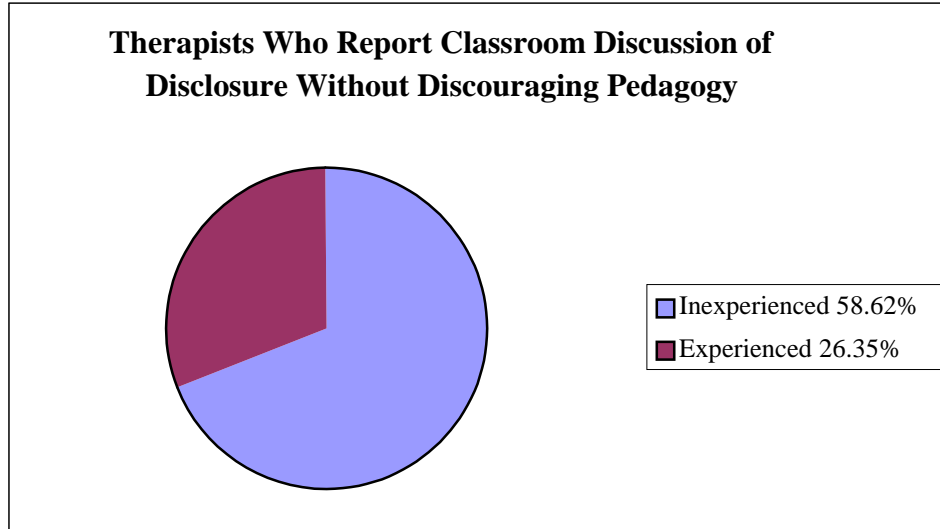


Figure 11: Years of Experience and Therapists' Report of No Discouraging Pedagogy

