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An investigation of unconscious countertransference disclosure

Constance M. Pasalis

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ABSTRACT

Unconscious countertransference disclosures (UCDs) are a unique kind of self-disclosure explored peripherally in the current literature. This exploratory study placed UCDs in the context of self-disclosure and countertransference as they have evolved conceptually over time. Thirteen participants, recruited through snowball sampling, responded to the focusing question: How do clinicians make meaning of unconscious countertransference disclosure? During a one-hour face to face interview participants responded to this question from the point of view of clinician and client. Consistent with what one might expect, participants attributed clients knowing what they had not consciously been told on a spectrum from the concrete (non-verbal cues) to the more metaphysical (spiritual or unconscious communications). Though it makes sense, it was an unexpected finding to hear participants consistently describe the type of client with which they were working, specifically clients with a trauma history, as a way to explain UCDs. This study also surfaced how challenging it can be for clinicians to work with UCDs as they can be “terrifying.” Finally, research of clinical pairs (client and clinician) could further the understanding of the impact UCD’s have on the therapeutic process and therapeutic outcomes.

An Investigation of Unconscious Countertransference Disclosure

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

Dina M. Pasalis

Smith School for Social Work
Northampton, MA 01063

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CHAPTER I

Introduction

Gradually, then, I came to the conclusion that the patients have an exceedingly refined sensitivity for the wishes, tendencies, whims, sympathies and antipathies of their analyst, even if the analyst is completely unaware of this sensitivity (Ferenczi, 1955, p156).

Clients know their clinicians. As evidenced by the above quote, the depth of this knowing has been debated. Some believe the clinician controls the depth of knowing. Specifically, the clinician's willingness to disclose the information they choose, when they choose. Ferenczi offers a different perspective. He suggests that clients get to know their clinician through other means; means outside of the control of and perhaps even the awareness of the clinician. This study will explore how it is that clinicians today make sense of Ferenczi's conclusion.

Need for Study

Whether and how best to use the countertransference – "...the thoughts, feelings, fantasies and unconscious reactions a therapist has about her client..." (Berzoff, 2011, p. 225) - in the therapeutic encounter has been and continues to be debated. Myers and Hayes (2006), reference earlier research by Gelso and Hayes (1998) that documented therapists' reports of experiencing countertransference in as many as 80% of sessions. Much of this research focuses on conscious self-disclosures, i.e. information (whether banal or intimate) a clinician consciously shares about him or her self. Little research has been done to investigate how clinicians make sense of their unconscious self-disclosures. This exploratory study is an attempt to understand how clinicians make sense of unconscious countertransference disclosures.

Key Concepts

The key concepts of this thesis include transference, countertransference, intersubjectivity, disclosure, unconscious disclosure and unconscious countertransference disclosure. I will separate these concepts into three categories. Transference, countertransference and intersubjectivity will be discussed as one set of concepts, disclosure, unconscious disclosure and unconscious countertransference disclosure as another.

Berzoff (2011) defines countertransference and transference this way “Countertransference refers to the therapist’s thoughts, feelings, fantasies and unconscious reactions to a client; transference refers to the client’s thoughts, feelings, fantasies, and unconscious reactions to the therapist.” (p. 225). Countertransference and transference have thus been defined as opposite sides of the same coin - one set of experiences by the therapist, the other by the client. Intersubjectivity is in effect the interplay between these experiences. Berzoff (2011) gives credit to Ogden (1994) for coining the term “analytic third” to describe the dynamic space that is created as a result of this interaction.

In the literature, disclosure is generally defined as something a therapist (or client) shares verbally and with intention. They assume the person making the disclosure (the clinician in this case) is conscious of what they mean to say and is in fact saying what they mean. This assumption is particularly true in the research (Myers & Hayes, 2006 and Yeh & Hayes, 2011) used to study the effects of disclosure. And yet, from the time of its inception unconscious communication has been an underpinning of psychoanalysis. We must assume that as clinicians we disclose information to our clients without awareness. Like any disclosure, what we communicate unconsciously may be banal, intimate or triggering.

Communication requires both a person who wants to disclose information (feelings, thoughts, ideas) and a person who is interested in or available to know and/or receive what is being disclosed. In the space where our clients - consciously or unconsciously - receive what we unwittingly share with them an unconscious countertransference disclosure occurs. When the client makes us aware of what they have learned from us, we wonder how to make sense of it. This study will explore how clinicians currently go about making meaning of these disclosures – for themselves and for/with their clients.

Research Question

How do clinicians make meaning of unconscious countertransference disclosure? This research hypothesizes three possible responses to this question. First, clients don't know what a clinician is thinking, feeling or experiencing because they can't know unless the clinician has told them. This belief stems from the concept that clinicians control what they communicate. Countertransference, in particular, is something they may devote time and energy to understanding to prevent the possible leaking of these feelings into the therapeutic dyad.

Second, one would imagine that others believe unconscious communication is an intrinsic part of psychodynamic work. If clinicians believe their clients have an unconscious that communicates outside the bounds of the conscious mind, they may also believe this to be true for clinicians. As such, they may explain unconscious countertransference disclosures as one part of an unconscious process of communication.

Finally, some portions of clinicians may fall between these two extremes. They recognize and have had experience with the permeability between what is known and what isn't and they recognize a sense of self that is somehow separate and/or immune from this permeability.

CHAPTER II

Literature Review

The analyst's self-disclosure has been one of the most controversial and widely debated topics that have arisen in the last two decades (Atikune, 2010, p. 1).

The following literature review summarizes and critiques the results of both theoretical and empirical literature on the subject of a clinician's self-disclosure. No empirical research was found on the topic of unconscious countertransference disclosure. Few articles on unconscious disclosure (also termed "self revelations" by Levinson (1996) and "unwitting self-disclosure" by Gans (2011)) resulted from a search in PsychInfo; none were empirical studies.

A bounty of articles exists on the topic of self-disclosure – they include both the theoretical and the empirical. As a result, the Theoretical Literature section of this review will include material on conscious and unconscious self-disclosure. The Empirical Literature section of this review will be limited to research on conscious self-disclosure.

Theoretical Literature

The literature on self-disclosure attempts to answer three questions:

- What is self-disclosure?
- How does self-disclosure happen?
- How has the narrative of unconscious self - disclosure evolved over time?

Together the authors attempt to define and describe different aspects of self-disclosure. In their efforts they highlight what we have learned and what may be missing from our

understanding of self-disclosure. In these instances, the clinician communicates the self-disclosure with intention. The articles assume the clinician has control over what, when and why they are self-disclosing. With only one exception (Suchet, 2004) these articles focus on conscious self-disclosure, although a few (Brody, 2013; Gans, 2011; Jacobs, 1999; Levinson 1996) describe or make passing reference to unconscious self-disclosure.

What is self-disclosure? Hill and Knox (2002) - as cited by Ziv-Bieman (2013) – created categories of self-disclosure. They included information ranging from “biographical facts” (e.g. professional training) to “strategies” the clinician had found helpful for different life events (p. 62). In addition they included the disclosure of “feelings” (p. 62). Feelings evoked for a clinician through a past experience as well as “immediate thoughts or feelings toward the patient/therapeutic relationship and process” (p.62).

Brody (2013) highlights less commonly referred to types of self-disclosure. She introduces self-disclosures that require “vulnerability” (p. 45). Specifically, she is referring to a “...disclosure about a medical event, a fact, an intrusion of our human-ness” (p. 45). She asserts this type of disclosure “...is different” and then wonders “Or is it?” (p. 45).

How does self-disclosure happen? Jacobs (1999) outlines the way self-disclosure happens. The first occurs naturally over the course of a session with a client. As “an image, a fantasy, a memory, an affect” (p. 160) occurs to a clinician they share it. The second occurs in response to questions from clients. Largely, he describes what sound like generic inquiries – curiosity about the tastes and interests of a clinician. Jacobs also refers to a third type of disclosure; one that occurs “...outside of the analyst's awareness through slips, errors, and other, often nonverbal, means” (p. 160). For self-disclosures that result from proactive sharing or in

response to a client's question, Jacobs later describes the importance of disclosing responsibly; with intention and care so as to allow the disclosure to be of benefit, not harm.

He spends little time exploring unconscious disclosures, but acknowledges their importance in the therapeutic dyad. They are, he states, "...often neglected in discussions of self-disclosure. This omission has led in turn to the underestimation of the importance of this pathway for the transmission of countertransference and other unconscious communications on the part of the analyst" (p. 165).

Brody (2013) makes passing reference to a type of unconscious self-disclosure. She describes disclosing to her clients the need for a medical procedure that would temporarily paralyze her facial muscles and the ultimate finding of that surgery, a malignant tumor. Briefly, she writes, "Peggy's dream [about an impending tornado] prompted me to wonder if I had already communicated my condition, an unconscious communication that preceded even the pathology report" (p. 49). In this instance Brody describes curiosity about the unconscious disclosure of unconscious content.

Suchet (2004) suggests the possibility of communication between the unconscious of the clinician and the unconscious of the client i.e. outside the control of the clinician. She describes an impasse with a client that results from "...the unconscious communication of her subjectivity to her [client]" (p. 265). In brief she describes a several month process over which her client has dreams, somatic experiences (e.g. nausea, headaches) and emotional distress that mirror her dreams, somatic experiences and emotional distress - specifically as they relate to Suchet's decision to and subsequent process of becoming pregnant. Though hers is but one case study, she suggests the many ways countertransference is experienced by a client, ways that go beyond words. This in fact is something Freud himself identified. According to Atikune (2010) "In his

technique papers, Freud (1912/1958) discussed...the idea that ‘... the UnCs. of one human being can react upon that of another, without passing through the Cs’ (Freud, 1915/1958, p. 184)” (p. 10).

How has the narrative of unconscious self-disclosure evolved over time? In each of the descriptions of self-disclosure outlined above lies countertransference, i.e. the therapist’s thoughts, feelings, fantasies and unconscious reactions to a client. Many of the articles on countertransference disclosure describe a common narrative.

Psychoanalytic theory is rooted in the belief that clients have feelings about their therapists (transference). Shedler (2006) states “Transference refers specifically to the activation of preexisting expectations, templates, scripts, fears and desires in the context of the therapeutic relationship. In psychoanalysis this transference is the heart of therapy” (p. 23). From its inception psychodynamic theory has defined and treated pathology by making use of transference.

Early on, psychoanalytic theory expected neutrality of the clinician (as cited in Ziv-Bieman, 2013, p. 8) "The physician should be impenetrable to the patient, and, like a mirror, reflect nothing but what is shown to him" (Freud, 1912/1958, p. 118). Clinicians were meant to be a tabula rasa - a blank slate - onto which a client could project their thoughts, feelings, fantasies and unconscious reactions. The clinician would maintain their inner neutrality as the client wrote, painted and drew all over them. It was expected that the clinician do nothing to impede this progression. Their job was to offer interpretations of what was happening for the client as if everything that happened in the room was detached from the clinician. Any thoughts, feelings, fantasies and unconscious reactions to a client the therapist had, were to be handled outside of the session. The clinician was expected to work through them with their analyst,

colleagues or self-discipline. Burke and Tansey (1991) summarize this concept well through the following statement “Although the analyst may privately realize that he has been emotionally stirred by his patient, he may nevertheless believe that it is in the best interest of all to maintain the image of impassivity” (p. 351).

Slowly, starting with Ferenczi, psychoanalysts began to recognize more and more the prevalence of countertransference. Because Ferenczi stepped outside of the bounds of propriety he and his theories were discredited. Jacobs (1999) states “In the minds of many traditional analysts, self-disclosure became linked with improprieties, with confessions of love and sexual passion, with acting out, and with misuse of the transference” (p. 161). After half a century of the disavowal of countertransference, clinicians began to grapple with it once again. Each new school of psychoanalytic thought (object relations, self-psychology, relational, etc) opened the door a bit further in acknowledging and figuring out how to make sense and use of countertransference. Rather than disavowing their thoughts, feelings and experiences of their clients, these schools began to explore how countertransference could be part of the treatment for psychopathology. Atikune (2010) nicely encapsulates four general orientations to self-disclosure that range from “nondisclosure” to “systematic disclosure.” Again, this range is held in a frame that assumes the clinician has control over what is disclosed.

Some authors recast this evolutionary narrative from disavowing to responsibly embracing countertransference. For example, Jacobs (1999) challenged the neutrality so interwoven with Freud. By placing Freud in context - fighting for a new field – the perception that he produced his results objectively was essential. Freud wanted his work to be consistent with medical norms of the day. He felt it essential that his work appear objective, devoid of

subjective influence, in order for it to be deemed credible. Jacobs (1999) suggests, "...things were often otherwise" (p. 162).

Empirical Literature

Most studies on self-disclosure attempted to measure the impact of disclosures on the therapeutic process, not the impact on treatment outcomes. The first study discussed in this section, by Barrett and Berman (2001) will highlight the one attempt to do just that. The remainder of the section will summarize the key findings of the studies that attempted to measure the impact of countertransference disclosure on the therapeutic process (Myers & Hayes, 2006; Yen & Hayes, 2011; Audet, 2011).

Impact of self-disclosure on treatment outcome. Barrett and Berman (2001) conducted a study in a college counseling center at the University of Memphis that attempted to measure the impact of self-disclosure on treatment outcomes. Subjects were randomly selected, though clients with severe mental health issues - like psychosis - were screened out of the study. Clinicians were all doctoral students in clinical psychology. In addition, they used observers – also students - to assess the frequency and level of disclosures in the sessions between therapist and client. With one client (over the course of four sessions) the clinician was asked to reduce their disclosures, with a second client they were asked to increase the number of disclosures. The study showed "...clients in the increased disclosure condition reported less symptom distress and indicated that they liked their therapist more" (p. 601).

Although the study suggests disclosure has an impact on treatment outcomes, it cannot be known from this study whether therapist self-disclosure has a positive effect on therapy or whether reduction in self-disclosure has a negative impact. It may have been helpful to have a control group. The control group would have consisted of a third client with whom the therapist

did not attempt to control their amount of disclosure. In addition, when therapists disclosed more, they also tended to provide more intimate information. This study did not account for this impact on the client or the observer.

Finally, the sample was relatively homogenous. The clinicians and patients were relatively close in age, gender and racial makeup. As a result, self-disclosures may have had a different impact than if there had been more difference between therapist and client. In addition, the general theoretical orientation for the clinicians was Cognitive Behavioral Therapy (CBT). CBT therapists are less likely to see therapeutic value in countertransference much less in the disclosure of that countertransference. The results may have been different with psychodynamic clinicians – particularly those aligned with Self Psychology, Relational and Intersubjective theory - who see the value of countertransference and practice making meaning of it on their own and with their clients.

Impact of countertransference disclosure on therapeutic process. Most of the studies completed to date investigated the impact of countertransference disclosures on the therapeutic process. I will discuss three such studies here. Two quantitative studies by Myers and Hayes (2006) and Yen and Hayes (2011), one qualitative study by Audet (2011). In 2006, Myers and Hayes identified four dependent variables they thought would be affected by countertransference disclosures. In a controlled, classroom setting, students were asked to view a 10 minute video clip of an interaction between actors playing the roles of a therapist and a client. They were then asked to evaluate the therapists' "expertness," "attractiveness" and "trustworthiness" as well as the "session depth and smoothness" (Myers & Hayes, 2006, p. 178). In addition, they led the observers to believe that some therapeutic relationships were positive, and some were negative. They found, according to their third party observers, that disclosures had little impact on

attractiveness and trustworthiness (Myers & Hayes, 2006). They did however discover that when the alliance was perceived to be positive, the therapist was viewed as more expert and the sessions were rated as deeper (Myers & Hayes, 2006, p. 181). Consequently, when the alliance was perceived to be negative the therapist was rated as less expert and the sessions as more shallow (Myers & Hayes, 2006, p. 181).

Myers and Hayes (2006) clearly outline the limitations of their study. The first and most obvious is that the study was completed in a laboratory (Myers & Hayes, 2006, p. 183). The clinician and client were actors playing parts, not real people with a real relationship. This researcher agrees with their assessment. As convincing as actors may be, they lack the authenticity and spontaneity of a real relationship. A relationship that has developed over time. A relationship that isn't scripted and evolves with the help of the unconscious. In addition they acknowledge that therapy is a process. A single 10-minute clip, even if it were a real interaction, does not help the observer know how it is worked with over the course of the session and in the sessions that follow (Myers & Hayes, 2006, p. 183). In addition, the observer has little insight into what led to the interaction and how it fits into the multi-layered work of the treatment.

Yeh and Hayes (2011), the authors of the second quantitative study, added two additional variables to the work of Myers and Hayes. They added "therapist provision of hope" and "perceived universality between the client and therapist" (p. 323). In addition, they focused more on the nature of the countertransference disclosure. They hypothesized that a less resolved countertransference disclosure would result in a higher universality ranking and a more resolved countertransference disclosure would result in a higher ranking for all other variables. This theory held true in part. Resolved disclosures did result in higher rankings for 3 (trustworthiness, attractiveness and provision of hope) of the 5 variables. (p.325) A clinician was not ranked

higher on expertness or the session's smoothness and depth when an unresolved disclosure was offered.

The limitations of this study are similar to the 2006 study with a few additions. The most significant limitation was the procedure by which the ratings were captured. (Yeh & Hayes, 2011 p. 326). Instead of being completed in a controlled environment the video clips were sent to students. They were able to view them anywhere and could stop in the middle if they were distracted by something else. As a result there were a high percentage of responses that seemed to miss the type of disclosure provided.

I offer three additional limitations to these quantitative studies. First, the person doing the observing is not part of the relationship. Even if they could have witnessed 10 or 12 minutes of an authentic exchange, their investment and understanding of the exchange would be limited by their distance and lack of investment in the interaction. The observer is not a client impacted by the disclosure of their therapist - to whom they would presumably have some level of attachment. Instead they are an outside observer digesting another piece of information devoid of the intersubjective or relational context of the dyad. Second, the observers were students. Given all of the adjustments of late adolescence/early adulthood it is likely that in addition to the external distractions that may have occurred, their internal world may also have distracted them from reading the clips clearly. Third, these studies assume that the benefit of the countertransference is delivered through the content. They suggest that the type of words spoken (resolved or unresolved, general or personal) holds the key to the benefit of the disclosure.

As clinicians we know that people can deliver content with varying degrees of affect. Too little affect and it is difficult to make contact with or feel connected to a person's plight. Too much affect and we may be flooded by the others emotion, unable to do anything but consider

how we might help them to regulate their affect. Thus, the delivery – tone of voice, facial expression, timing, etc. - of the content may influence how an observer may register the disclosure. Additionally, it ignores the concept of unconscious countertransference disclosures. The way in which the actors as people communicate with each other rather than as prescribed by their script. In short, there may be a level of communication that occurs that is not intended, not measured, but possibly observed.

Audet's (2011) qualitative study sought to better understand "client perceptions of the impact receiving therapist disclosure may have on therapeutic boundaries and the therapist's professional qualities" (p. 90). Nine minimally structured open-ended interviews were conducted. Each transcript was read several times. Excerpts on therapeutic boundaries were culled and then had their themes analyzed. These themes were clustered into overarching themes. Once the overarching themes from each transcript were identified, those themes were compared across participants.

From this analysis Audet learned clients recognize both the boundaries of therapy and the value of therapist disclosures. Specifically, disclosures seemed to reduce the power differential, without reducing perceptions of professionalism. In addition, they increased client's perception of their role as co-creator and collaborator in their own therapy. Two participants reported unsatisfying experiences with disclosure. The first resulted from too intimate a disclosure, the second from repeated storytelling. Both pulled the client away from their own therapeutic experience and left them doubting the competence of their therapist.

The sample size of this study was small. With only one person of color it was also homogenous. For these reasons the results are not generalizable to broad sections of therapeutic dyads.

Critique of the empirical literature – a review of biases and assumptions. In all of these studies the participants are largely white (90% white in the Hayes studies, no racial demographics were offered for the Barrett study, only one person of color in the qualitative study, both clinician and therapist were white in the case study). The clinicians were predominately white, exclusively so in the video clips and qualitative studies. Most of the participants were female in the quantitative studies (58% 2001, 67% 2006, 78% 2011).

In addition, the belief that the content of the words would define the benefit of countertransference (as described in the initial studies) strikes me as white male normative. It is rational. What we see on the surface is in fact what impacts the interaction. The more subtle forms of communication, the connection of this communication with the whole self – mind, body and soul – creates more opportunity for both a feminist and multi-cultural perspectives.

Bringing It All Together

Surveying these articles together highlights the synergy and the dissonance between the theoretical and empirical literature. Both sets of articles articulate a desire to better understand the use of self-disclosure as a mechanism for improving the therapeutic process and its outcomes. In general the empirical studies suggest a positive benefit from self-disclosures. By studying the frequency and delivery of the disclosure they report reduced symptomology (Barrett & Berman, 2001) and power differential (Audet, 2011). They report an increase in regard for the therapist - likability (Barrett & Berman, 2001), expertness (Myers & Hayes, 2006), trustworthy (Yeh & Hayes, 2011), attractiveness (Yeh & Hayes, 2011) and sense of co-creation (Audet, 2011). They also report an increase in session depth and smoothness (Myers & Hayes, 2006).

In general the theoretical commentary supports these results. Over time, more and more authors have espoused the benefit of a clinician's self-disclosure. In both sets of literature there is

an emphasis on making sure that a clinician discloses countertransference and information about themselves with care.

Although the theoretical literature acknowledges the existence of unconscious disclosure it rarely does so with a specific focus on countertransference. Levenson's (1996) "self revelations" and Gans (2011) "unwitting self-disclosures" are described as self-disclosures unique to the clinician. Pieces of a clinician's personality that operate independently of a client (bathroom décor, payment practices, etc). In addition these disclosures are described in a way that doesn't acknowledge the fact that a client may be conscious of these disclosures even if the clinician is not. As such they provide little insight on how a clinician makes sense of unconscious countertransference disclosures.

Study's Importance

Countertransference is and always has been an important component of psychoanalytic work. Much of the discussion about countertransference has focused on disclosure - whether, how much, how often and when a clinician should disclose countertransference to a client. A handful of authors (Brody, 2013; Gans, 2011; Jacobs, 1999; Suchet, 2004) have offered their own experiences of unconscious disclosures, some (Brody, 2013; Suchet, 2004) have even extended an invitation for us to wonder how to make sense of such occurrences. This study will attempt to explore and give voice to the ways in which clinicians make meaning of unconscious disclosures.

CHAPTER III

Methodology

Research Purpose and Design

The purpose of this study is to explore clinicians' experience of unconscious countertransference disclosure. Specifically, I am interested in how clinicians make sense of the disclosure and whether/how they make use of it as a therapeutic tool. Much of the literature on countertransference suggests that a clinician has control over what she does and does not share. This suggestion assumes that the clinician controls what a client does or does not know about her. Ferenczi (1955), Suchet (2004) and others suggest the possibility of a different kind of communication between clinician and client. To better understand this phenomenon, the focusing question of this study was "*Have you ever had the experience of your client knowing what you are thinking, feeling or experiencing without having told them?*" The limitations of this study prevented the exploration of this question with clinician and client pairs. As a result, a sub question posed to the clinician as client was included "*As a client, did you ever have that experience with your clinician?*"

As previously reviewed, little research has been done on unconscious countertransference disclosure. In the absence of other studies, the most appropriate methodology to study this question is exploratory. As a result a qualitative approach was taken to complete this research.

Snowball sampling, a nonprobability sampling method, was used to identify 13 clinicians as participants. Solicitations for participation in the study began in November of 2013, after approval by Smith's Human Subjects Review Board. Data collection began in December 2013

and continued through February of 2014. Participants were recruited through list serves and by invitation. Participants completed a short (15-30 minutes) pre-screen by telephone and a long (45-75 minutes) semi-structured interview.

Given the topic of study, only those clinicians who were able to define countertransference and acknowledge experiencing it with clients were included in the study. In general, participants reported being eclectic in their approach to work with clients. However, all of them reported using a psychodynamic frame as the theoretical foundation for their practice, even if other theoretical models informed it.

Sixty-two percent of the participants identified as white, the remainder as mixed race (23%) or clinicians of color (15%). The professional background of the participants included social workers, psychologists and a psychiatrist. Each clinician had been practicing from 11 to 47 years with a median of 30 years of practice.

Ethics and Safeguards

All of the interviews were conducted in private and in locations chosen by the participants – usually their office, but in a couple of instances their home. At the start of each interview a consent form was reviewed and signed (Appendix A). The freedom of each participant to stop the interview or decline to answer a question was emphasized during this review. In addition, the potential for discomfort resulting from the role reversal - being the interviewee instead of the therapist - was highlighted.

Once complete this researcher transcribed the interviews. The name of the participant was not on the audio recording nor did it appear anywhere in the transcript. Each interview was then password protected and shared with the participant to ensure the removal of any features that might identify their clients or themselves. As documented in the HSR application (Appendix

B) all research materials including recordings, transcriptions, analyses and consent/assent documents were stored in a secure location. According to federal regulations they will remain in storage for three years. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data has been password protected.

Data Collection

A majority of the interviews were conducted in person, however two interviews were conducted via virtual technology (SKYPE, FaceTime). These participants were either at a geographic distance not reachable by the resources available for this study or scheduling limitations prevented a face-to-face interview. The interviews were recorded via a hand held recording device then transcribed.

The core questions posed to participants during the semi-structured interview (Appendix C) fell into three categories. The first category focused on assessing whether a clinician had experienced unconscious countertransference disclosures and how frequently. The second category focused on generating the narrative experience of clinicians during unconscious countertransference disclosures, in essence, how they handled the disclosures when they occurred. The third and final category sought to better understand how clinicians made sense of them.

Data Analysis

Grounded Theory was used to analyze the results. According to Strauss and Corbin (2008) a grounded theory is one that is inductively derived from the study of the phenomena it represents (p.23). In simpler terms, the theories and concepts set forth in the discussion section of this paper are generated directly from the participants' answers. There are four general stages for

this analysis. Reading the transcript is the focus of stage one. This researcher transcribed the interviews. Thus, prior to the reading this researcher listened to the interview. During the first read this interviewer also listened to the interview a second time. At the end of this stage, notes were made to capture the essence of the interview. Copies of the transcript were also sent to participants to confirm accuracy. Stage two involved another reading. This time with an eye toward marking the text – underlining, circling, highlighting. Notes were put in the margins - identifying themes/codes. Once a set of codes was created, the transcript was re-read as part of stage three. Each passage was then assigned a code. These codes were then grouped together with the relationships between groups providing another way to generate theories and concepts. Finally, in stage four, this researcher interpreted the themes – linking them to the research question and literature.

CHAPTER IV

Results

The purpose of this study is to explore clinicians' experience of unconscious countertransference disclosure. Specifically, whether unconscious countertransference disclosure happens, how clinicians make sense of the disclosure and whether/how they make use of it as a therapeutic tool. This section will describe how – in their own words – clinicians make sense of their unconscious countertransference disclosures.

First, it is important to articulate how clinicians become aware of their unconscious disclosures. As one participant noted – “if it’s unconscious, how can we talk about it?” Almost exclusively clinicians reported becoming aware of their disclosure from a client’s reaction. Participants generally reported both explicit (client asking a clinician outright about their observation) and implicit (through behavior or patterns of interaction) communication by their clients that helped them become aware of the client’s knowing. In one instance a clinician reported how the act of writing – over the course of a year – helped them become aware of an unconscious disclosure that had contributed to a multi-year impasse.

Second, it is important to provide examples of the kinds of disclosures reported. Examples ranged from how a clinician was feeling in the moment (annoyed, frustrated, pleased and affectionate) to details about a clinician’s personal history (separation from a partner, family illness and personal illness/medical complication). Some examples included knowledge or information that was not obviously germane to the therapeutic dyad (pregnancy of a colleague, location of clinician’s vacation and complications that occurred with other clients.)

Third, all, but one, of the participants had been in therapy and/or analysis. As a result, most of them described this phenomenon from the point of view of client and clinician. In general, clinicians described their own experience in similar terms as their clients.

Demographics

A total of 13 participants answered all of the demographic questions during the pre-screen interview. All participants have been practicing as clinicians for over a decade with the range being from 11-47 years (this includes time in training) and a median of 30 years. Most of the participants reside in the Northeastern United States, but not all.

The respondents identified their sex as 77% female and 23% male. The respondents identified their gender as 69% feminine, 23% masculine and 8% both.

Participants ranged in age from 36 – 72 years old. The median was 56 years of age. Eight (62%) participants identified their race as white. Of those, 3 added Jewish as an “other” descriptor. One (8%) participant identified their race as African America. One (8%) participant identified their race as Asian/Pacific Islander. One (8%) participant identified their race as mixed Hispanic/Latina (o) and white. Two (15%) participants identified their race as mixed Native American/American Indian and white.

Most of the participants had either a PhD in clinical psychology (31%) or a LICSW (31%). One participant had a PhD in education, another an MD and the third a Licentiate in clinical psychology. Regardless of the training for licensure nearly all participants (12) reported additional psychoanalytic training. All participants (13) reported that psychoanalytic theory deeply informed their practice and was in fact the primary theoretical orientation with which they identified. Other modalities also informed participant’s work with clients but none were consistent across the population.

Most of the participants (11) worked predominately with adults 18-20 and over. One participant worked predominately with young adults 18-25. One participant worked with a mix of kids (11-13) and adults (30-70).

Frequency of Unconscious Countertransference Disclosure

All participants in this study acknowledged the existence of unconscious countertransference disclosures (UCD) except one. A majority of them reported feeling that these disclosures happened all the time. So frequently in fact that it might be difficult to know the frequency as they suspected their clients didn't always bring the disclosure into the clinician's consciousness. As one participant said, "It probably happens often without it ever being recognized because often I think patients are afraid to say anything." The others felt that they occurred often, but less frequently. One participant reported never having the experience of unconsciously disclosing their countertransference.

Clinician Explanations for Clients Knowing, Without Having Been Told, What a Clinician Is Thinking, Feeling or Experiencing

In general, participants attributed three things to the phenomena of UCD. First, participants reported clients with a trauma history or those who had been in treatment with the clinician for some time were more able to pick up a clinician's countertransference. Second, participants offered non-verbal and autonomic cues as an explanation for UCD. Third, participants reported spiritual ("meditation," "energy," "the universe"), unconscious communications and "not knowing" as an additional explanation for UCD.

Type of client. Nearly all the clinicians attributed a client's ability to pick up their unconscious countertransference disclosures to a client's history or diagnosis. Participants described how trauma, and the hyper-vigilance that is often associated with it, enables some

clients to be better attuned to their clinicians. Clients with borderline features, Dissociative Identity Disorder and psychosis were most frequently mentioned. In addition, they frequently attributed the length of a treatment to a client's ability to pick up their unconscious countertransference disclosures. Participants reported that clients who knew a clinician longer would know them better and thus could better read them.

Example A.

When I have had DID patients it's been like bizarre attunements...I used to have a lot more sort of borderline dissociated patients. I think this stuff comes out a lot more there...they tend to be people who are traumatized and so they have learned to be very attuned to people around them. To the coming of possible trauma, to possible threats. So, they're always vigilant in the world and always aware of the tiniest nuance of change of emotion of the people around them because they might get hurt. People with worlds not so threatening, don't have to be so attentive.

Example B.

The one that just came into my head. I have a client who is very surprisingly tuned in, in an almost psychotic way...that kind of thing happens a lot, that people are very tuned in. I think depending on who they are my experience is that the more unstructured people are internally, the more they know. I think we all have that capacity, but... That's my theory.

Example C.

I have a client right now that I've seen for almost 5 years. So, there's that component of how we've known each other for a long time.

Autonomic and non-verbal cues. Many participants described the unconscious non-verbal cues they may have given to clients – particularly to those who spent a lifetime reading such clues. At times the clinician could identify the cue because the client named it. At other times the clinician assumed they must have done something – they couldn't say specifically what, but something - that clued the client in. A few clinicians attributed the knowing to autonomic responses (e.g. flushed cheeks, trembling). They referenced the work of neuroscientists who have demonstrated how much we learn, pick up and know about each other through these nearly imperceptible changes.

Example A.

Well, a clinician can always have control over what they verbally disclose. They might be able to exert control over what they behaviorally disclose but they cannot control what they autonomically disclose. So, the flush in your cheeks, rapid eye blinking, sometimes trembling, certain facial expressions. So we are constantly revealing ourselves.

Example B.

I think she noticed an expression, which I usually didn't have at least when she was in the room. And asked whether I was feeling sad or something was going on that I looked differently.

Example C.

I have one client that very recently told me that he thought that I was very annoyed with him. I was flabbergasted because, a minute prior I had clearly thought "Oh my God. This

guy is so annoying sometimes.” And when he brought it up... It felt like he had read my mind, my feeling, my... I thought I was probably making a face or I don’t know maybe I looked away, maybe I disconnected and he felt it.

Example D.

I’ll observe myself, “What am I doing? Am I playing with my fingers? Am I...what are my legs doing?” And some patients will say, “You look more restless. You are moving a lot more today.” And I’ll go like “Oh, wow!” Something’s going on...you know? Laughter. So sometimes they give you a little help along the way.

Example E.

I had a patient ask me if I was frustrated with them. The reality was that I was frustrated with them. I had not said that I was frustrated with them, but the patient picked it up. Based, both on my body language because my arms were crossed and that my tone was a little shorter.

Example F: Clinician as client.

So, I went to see her and I tried to - I mean, it was not easy for me to do that—because I really wanted her to know something that I hadn’t been happy about. And, I remember—she would sometimes sit like this— but I remember that she made that gesture as I was speaking and I realized she wasn’t going to be listening. And that was not a very happy moment and all she could do was say something like, “Well I’m sorry that....” In a way that clearly conveyed that she was not that sorry. Or she didn’t understand it. Or she just couldn’t take it in.

Spiritual, unconscious communications and not knowing. Participants who attributed autonomic or other non-verbal communications as the most rational reason for their client’s

ability to know their clinician's thoughts, feelings or experiences without having been told often also commented about some other process at work. For some, this process was explicitly spiritual, for others it was referred to as "unconscious communications" and for others there was bewilderment – a sense of not knowing and wonder. The following section highlights these different attributions.

Spirituality. Several clinicians described intentionally creating a mindful environment. This mindfulness served to cultivate a more permeable form of communication – both conscious and unconscious. Meditation, sage, astrology and even a medium informed this work.

Example A.

It just felt like it was through the universe in so many ways. It didn't feel like it came from me.

Example B.

It's a kind of meditation where you take in someone else's anger or whatever they're giving you - and you just breathe it in—and you breathe out and you just kind of wish them peace or joy or some more positive emotion you get back to them... So, I was just doing this, not saying very much in the room now and then saying a little something. The whole session he was still in the same [agitated and combative] frame of mind. As he was ending the session he said to me "You know, sometimes this just feels like a very sacred space."

Example C.

She openly sensed that something was going on in here....She could tell right away bad stuff had been going on. And she could feel it. We talked about it. She practices that stuff [Wicca]. She had an absolute clear sense that something was wrong in here...Sounds

crazy I know. Right? We're in a whole other realm of spirituality there's no doubt about it.

Example D.

...there is a throb in the universe that we all can hook into. I think life is about that.

Sorting out what your particular permutation is of that. So, I think of it as being open to anything. When I work I really try to be open to whatever comes in and work with whatever comes in.

Unconscious communications. Nearly a quarter of participants spoke about unconscious communications as a way to explain the surprise and awe they experienced from UCDs.

Example A.

It's as the client speaks and you're at the point of connectedness what's said by the client is often my thoughts. And what I say will hopefully often be the client's thoughts...So, they're sort of weird specific moments of "How did you know that? That I was thinking that?"

Example B.

Yeah. That was like one of the most bizarre unconscious communications. She said like "Either the two of you are married or having an affair." Holy shit, I've never met him [a person the participant knew of through a mutual friend], but we are.

Example C.

Because I think if one, as a therapist if you're using an empathic stance to feel and think your way into the patient's world one of the results of that is the patient begins to feel and think her or his way into your world so that it becomes much more bidirectional. And, I suppose some people would say there is then unconscious communication.

Example D.

I think that we are always disclosing continually...largely outside of your control. So, you can say this or not say that but your patients may have all kinds of ideas about you anyway. And, so you might as well assume that when you are vulnerable, they know it. And, just make sure that you are prepared for their knowledge.

Not knowing. At some point during an interview there would often be a point at which the participant would report not knowing how to explain UCD. This was often expressed with a sense of humility and/or awe at what is not known about the communication between a client and their clinician.

Example A.

I'm not sure you can. I think sometimes it's not so logical...But, unconscious connections, that's like saying why do people fall in love. You can't. You can say, she's beautiful or he's really handsome and has a great sense of humor and they're really smart and really interesting, But none of that... So are 20 other people. So, I don't think you can adequately put words to an unconscious connection.

Example B.

I can't necessarily make sense of it. I think you can be open to it. I think it's about being open. The more open you are in developing your intuition and your senses, the more you notice. The more you absorb. I think you have to be careful with it.

Example C.

I don't know how one knows... You know I mean how does intuition work? How does that sort of intuitive knowing work?

Example D: Clinician as client.

I cannot explain how in the world I knew this.

What Clinician's Do When Their Clients Make Them Aware That They Have Unconsciously Disclosed Their Countertransference

Participants described a wide range of responses – from denial to being curious with their client - when faced with their unintended disclosure.

Validate the experience. Most frequently they described disclosing to the client that they did in fact feel the way the client imagined they did. In short letting the client know they read the clinician accurately, even if this was less than favorable for either the client or the clinician.

Example A.

I was kind of finding myself being annoyed with her. And she said, “Well, I’m worried that you’re annoyed with me.” And I said, “I am.”

Example B.

We were talking and she said, “I’ve been feeling lately that I am your favorite patient. Is that true?” Laughter...I said, “Absolutely! That was true.” She obviously picked up something in me that conveyed that.

Example C.

“So, are you angry at me? Are you one of those people who are angry at me?” And I say “Well, you know what actually now, I am angry at you.”

Example D.

He said “You just look tired or something.” And so I said, “Well, lately, I have been.”

Example E.

She could tell that I was affected by a loss. And she said, “I have the sense that your father has died and this is why you have been rescheduling.” So I asked her if she wanted to know why I had rescheduled. And she said “Yeah.” And I said, “Well, you’re right actually my father died.”

Example F: Clinician as client.

She thought it was really important that I understand that it wasn’t all in my mind. That there was actually something really strong in her that she was bringing in and that she actually felt really bad about having brought that in because it wasn’t just about our process. That it was something that she was actually starting to feel, that she had felt a certain kind of... She had had a reaction to that that she had thought about how hard it had been for her. So, my trust in her just went [gesture of her thumb up and are moving towards the ceiling]...

Being curious together. Participants also reported that they stepped into a shared state of curiosity about what might be happening. Often, when in this situation, the clinician was not only unconscious of the disclosure but unconscious of the countertransference as well.

Example A.

I’ll question myself with her. I’ll say, “Yeah, I think you’re right and I have to think about why I was doing that.” And then I’ll let her postulate too and I’ll be like “Maybe that, but I think it could have been blah blah blah...”

Example B.

... A patient told me that he thought I was feeling...that I was different today than I had been - the patient had been in therapy about a year—that I was acting differently or

looking differently, feeling differently and I could not figure out for the life of me how I was feeling differently than usual. It was the last patient of the day, and a couple of hours after he left that evening I began to feel sick and I had a 102 fever and.... Clearly he had picked something that was happening and I had no conscious knowledge of at all...and when he came in the next day I told him “Remember how you thought I was feeling differently, well I came down with a fever last night, so you must have been pretty attuned to my physical state.” And his response was “Thanks for telling me. I always think I am mistaken when I make those kinds of judgments.”

Example C.

But I was surprised. I was surprised that all of this had happened in her. All of this anger at me for being this brutal dismitter of her. I thought she didn't know that part of me. Laughter. I am out of touch with that part of me. But, it is probably around.

Example D.

I'm thinking of a client who kind of read my mind or could see what I felt even before I could realize it in the moment. And then when she brought it up to me I thought “Wow, that really does resonate with me in some way.”

Deflection and reframing. In addition to the affirming responses outlined above, participants also reported responding with deflection or a re-framing response to clients knowing what they were thinking, feeling or experiencing without having been told.

Example A.

Gee she'd be very wounded. I mean, she doesn't have the ego strength, especially with me, for me to say something like that to her.

Example B.

My response was that. That it was interesting that it was now that he's wondering or that he's thinking about what I might be thinking. And, of course I didn't tell him that I was actually thinking that. I don't... Laughter... I don't... You know if I thought it would help him I might do it, but I typically don't – don't tend to self-disclose...I think he would've been horrified...Right now there is so much shame for him that if he knew that I in fact had the thought that he is annoying it would still be, I think right now he would experience it as this just this terrible breach. You know, how one person that he... that he trusts I mean we're at that place where he trusts me enough where he can say something like that. I don't think we're at the place yet where he could tolerate the notion that his mind can do something to my mind.

Example C.

I just asked her what that meant to her and what that would mean and what she was concerned about. She went right into her own stuff about it. She didn't want to know or need to know or even ask. We didn't have to go there. I probably would have answered if she had asked. But, she never did.

Example D.

I think she could see that I actually was kind of happy about something that she said. It evoked a positive feeling and a positive memory for me. And, she could kind of see me probably beam up a little bit and it's interesting cause I was trying actually to contain it.

Example E.

Maybe, I'm just hiding. Being comfortable a little more. Ok, I'm just going to stay in this sweet spot for now.

Example F: Clinician as client.

And then, I began to have doubts. When I came back the next day, I was feeling anxious about telling her what I [knew] because I felt like she wasn't going to react well at all.

And so I told her. Her reaction was [defensive] And I said – I was pissed off and I let her know...

Feeling Evoked in Clinician by Unconscious Countertransference Disclosures

Though feelings are imbedded in the examples above, there is one feeling that repeated itself frequently that seemed important to identify on its own – vulnerability. The vulnerability stems from being unexpectedly seen. In a client's seeing the clinician there is a lack of privacy a lack of separateness, an exposure. Participants often referenced surprise and an element of fear when clients made them aware of their unconscious disclosures. This was particularly true when they weren't conscious of the countertransference.

Example A.

You suddenly realize that– we think our emotions or our thoughts are really private even if you are a relational person. Even if you believe in how this all gets communicated and it's co-created you still somehow think that what is inside your mind or body is yours.

You know?

Example B.

... In terms of this there was part of me that was glad that she was so far off on my vacation because I didn't feel like she was inside me all the time. In a way that I don't always know. So, I think that the underbelly maybe is that it's a bit terrifying and unnerving.

Example C.

... I think what happened with that was I felt - I'm very careful not to reveal things - I'm fine about most things, but with this I felt like um - that's not how I advertise myself. That's not a way that I would like to be known, as a front-runner thing. So I felt uncomfortably known. Seen. Known... That felt a little more intrusive and personal.

Example D.

But there are some things that clinicians seem to feel that their patients shouldn't know or some things that they don't want them to know. You know? If a therapist is feeling unusually vulnerable. He or she may not want the patient to know that... There is a self-protectiveness that comes into play...

Example E.

My colleagues would not like it. I think people whose sense of self is a little more fragile have a lot more difficulty with this fluidity stuff. Cause, if you don't have a strong sense of self it's very hard to let yourself be known because you are always afraid patients are going to discover your vulnerabilities.

CHAPTER V

Discussion & Conclusions

Summary of Findings

In general the findings of this study are consistent with what one would expect given the theoretical and empirical literature. All participants reported experiencing countertransference with clients as expected given the study by Gelso and Hayes (1998). Nearly all of the participants experienced unconscious self-disclosures as suggested by several authors (Gans, 2001; Jacobs, 1999; Levenson, 1996). Some were unwitting self-revelations, but many also described unconscious disclosures that were more similar to the types of disclosures described by Brody (2013) and Suchet (2004). These disclosures included the participants' affective state as it related to the client (anger, affection, frustration) as well as affective states unrelated to the client (fatigue, grief, waning health) but that may have indirectly impacted the dyad. The disclosures also included information about the clinician (a recent break up, the death of a parent, trauma experienced by other clients in the participants' practice).

In addition, all participants described the benefit that may arise from self-disclosure (increased trust and therapeutic alliance). Many also commented on the potential hazards of self-disclosure to clients (therapeutic rupture). All but one participant reported experiences of unconsciously disclosing their countertransference to clients. It may be that the one participant who did not report experiencing the phenomenon was influenced by their training, which was more classical and therefore more focused on minimizing the leakage of countertransference into a session. It may also be that the participant was unaware of unconscious countertransference

disclosures as a few weeks after our interview the participant reported experiencing an UCD for the first time. It is interesting to note that this participant seemed to think about her practice differently following the interview, suggesting that perhaps more discussion of such disclosures in schooling or workshops might better prepare clinicians to recognize and make use of UCDs.

Because it has not been studied much, the literature does not speak to how clinicians make sense of UCDs. Participants explained UCD in a way that was consistent with what one might imagine. First, it is not surprising that participants attributed client's knowing what they had not consciously been told to non-verbal and autonomic responses. In part because we acknowledge and recognize non-verbal forms of communication as common and essential to communication even outside of the therapeutic dyad. Mehrabian (1971) popularized the concept that most communication is non-verbal. According to his book, *Silent Messages*, only seven percent of what is communicated to another is through words. The way the words are communicated (tone, gestures, etc) make up the remaining ninety three percent of the communication. A quick web search brought up countless numbers of images and articles representing and citing his work.

Participants also acknowledged that control of one's words is easier than control of non-verbal responses. Control here seems to exist on a continuum with verbal communication on one end, spiritual/energetic communication on the other, and non-verbal/autonomic communication somewhere in the middle. When clinicians were asked how a client knew about their countertransference, they would often say "It must have been" or "Probably" was non-verbal, even when the participant had asked the client and the client denied such a cue. In short, they assumed they must have done something – broken eye contact, raised an eye brow, altered their tone of voice - to help their client know what they were thinking, feeling or experiencing. Even if

they were unaware of what they had done, it seemed there was greater comfort in believing they must have done something that was within their control. Control of the spiritual/energetic realm and of unconscious communications is much more elusive.

When non-verbal communication seemed an improbable source for what a client knew (relationship with another, status of another client), participants turned to less concrete explanations to make sense of the UCD. In these instances they cited unconscious or spiritual pathways as the primary source of the knowing. Psychodynamic theory, regardless of the school – Classical, Ego, Self, Intersubjective, etc – is rooted in the concept of the unconscious. The more recently formed schools acknowledge a bi-directional nature of unconscious communication through concepts like enactments. It is thus not surprising that a group of clinicians who espouse psychodynamic theory, i.e. the participants in this study, attribute the unconscious to UCD.

It may be more surprising that some attribute UCD to something more spiritual or metaphysical. Yet, we are in a time when Eastern religion and its concepts of oneness and non-duality pervade western culture in the form of yoga, meditation and mindfulness. What's more, authors like Elizabeth Mayer, “an internationally known psychoanalyst, researcher and clinician” (Mayer, 2007, Loc 5063 of Kindle Edition) have helped to make us aware of what she refers to as extraordinary knowing and the costs to disavowing this knowing.

There were three results from this study that one would not have expected from the literature. The first, participants consistently attributed the existence of unconscious countertransference disclosures to the type of client with which they were working, specifically clients with a trauma history – often diagnosed with borderline features or psychosis. The second, participants admitted to feeling vulnerable at being witnessed or seen by their clients in

ways they had not intended. The third, participant responses varied when speaking from different points of view – clinician vs. client.

The empirical literature on disclosure aims its lens of observation at the clinician. In essence they ask, how does the behavior of the clinician (the frequency or timing of self-disclosure) impact the therapeutic process (Myers & Hayes, 2006; Yen & Hayes, 2011; Audet, 2011) or outcomes (Barrett & Berman, 2001). When considering the impact of the disclosure, past research did not consider the trauma history of the client/observer, as so frequently noted by the participants of this study. They - participants of this study - highlight how critical the receiver (client) of the disclosure is.

The literature on borderline personality disorder is rife with the challenges clinicians face in dealing with countertransference (Kernberg, 1985; McWilliams, 1994; Winnicott, 1975). What is less commonly discussed is the heightened ability of these clients to pick up the countertransference and accurately report it back to the clinician. Participants in this study cited not only clients with borderline features, but also those with psychosis. A history of trauma served as the common thread amongst these types of clients. One participant described them as “bizarrely attuned.” This makes sense. Clients with a history of trauma have developed skills that allow them to pay attention to their environment. They stayed safe by reading cues others, less fearful, could ignore. Often this is labeled as hypervigilance, a symptom of a disorder. What I heard from participants was that this skill could be a strength rather than a symptom. This strength could be threatening, or might obscure a clients own issues or experience, but was a strength nonetheless.

Given the “bizarre attunement” of certain clients, it may not be surprising that participants acknowledged there were times when they wanted to hide. Their desire to hide was

not limited to interactions with trauma survivors. In some instances, the impulse arose from other vulnerabilities - fatigue, working through grief and/or health issues. In other instances, the impulse arose from the experience of being seen as a whole person, not just an object of transference. Though infrequent, participants described how fear and vulnerability arose when they were seen in a way they hadn't intended or imagined. In these moments being seen by their client was more than they could hold. They used deflection and/or disavowal to defend against what one participant described as "intrusive" observations by clients.

This seems to highlight a paradox of the work of a clinician, a professional. We are trained and schooled to facilitate the healing of others. Our healing takes place elsewhere – outside of our work as professional. And yet, when our clients witness our wounds or see us more fully they offer a kind of healing. And so, we must find a way to be vulnerable professionals. Focused on the care of our client and open to how our being witnessed and vulnerable may be an essential component toward that end.

Finally, participants were asked to answer questions from two points of view – clinician and client. In general they described similar experiences, however there were some differences. First, a quarter of the 12 participants who had been in therapy denied having had the experience of an unconscious countertransference disclosure. This is interesting, given that all participants, but one, experienced UCDs as a clinician. There are several possible explanations for this difference. Participants may have struggled to retrieve such a memory given the time that had elapsed between the experience and our interview. Sharing this information with a stranger may have required a level of exposure a participant was not willing to undertake. It is also possible, that given the association clinicians have between borderline/psychotic clients and UCDs it would have been uncomfortable to admit to an UCD of their own.

For those clients who reported experiencing an UCD as a client, they often reported that their therapist deflected/reframed their observation. The prevalence of reported deflection and disavowal may have several causes. First, it may be easier to see the limits in another (their therapist) than in themselves. Second, it may be that the therapy described by the participants may have been with therapists less inclined to self-disclosure. They often described their therapists as “classical.” Third, it may be that what we remember from a treatment is what we have yet to work through. Finally, it is also possible that their experience in therapy is in fact quite different from the way they practice.

In each of these instances the participants described the courage they needed to declare the UCD to their therapist. And, once they made the declaration, how difficult it was to persist in the face of their therapist’s disavowal. The most frequent response of participants was to “give up.” They decided they would get something else out of the work with their therapist. Some participants left treatment feeling the difference was irreconcilable. And, some stood strong and “got up on their high horse” to make sure the truth in what they were seeing got heard. All of this suggests that unconscious countertransference disclosures happen more frequently than we know, as even for clinicians trained and committed to this work it is difficult to name what we see when our therapist doesn’t see it.

Implications for Social Work Practice and Policy

This study suggests that some clients are better at picking up UCD than others. This may have practice implications. For example, one participant reported, “I knew right from the beginning that the only way this treatment would work was if I was really very open and not even attempting to hide.” This highlights how essential disclosing countertransference may be for some clients. Not once a rapport has been established, but as a necessary ingredient in forging

a strong therapeutic alliance from the start. It also suggests that countertransference disclosures may in fact be a good thing. This was echoed by participants who commented frequently on the way dealing with an UCD enabled movement through an impasse, an increase in trust and a deepening of the work. Though much of the training suggests we should only disclose such information with intention, maybe our unconscious knows better. Leaking pieces of our private selves in the exact moments when our work with a client requires it.

Perhaps the most significant implication of this study for social work practice is recognizing how our own fear of being known may impede our treatment. Fear that stems from our clients bearing witness to our vulnerabilities – our grief, our anger, our illness – even as we deny or are unconscious of the existence of these vulnerabilities. This study suggests the importance of facing this fear so as to create an environment for our clients that affirms what they see in us. This means we also have to tolerate being known deeply in some ways and not at all in others. One participant described how her client could identify her affective state “I felt like I had a psychic stalker,” but who didn’t see her as the musician she was - even as she passed her client on the street with a guitar case. In addition, the study suggests we may need to re-frame our orientation to working with clients. Rather than being surprised by what they know we should be prepared for it. As such perhaps we should be trained to prepare for and learn how to work with our unconscious countertransference disclosures.

We communicate with our body. We know this. We believe it. Yet, we receive little training on how to use our non-verbal communications with intention. If we believe, as participants suggest, that we use our bodies to communicate unconsciously it might be helpful to be more aware of how, what and when we communicate. Not to eradicate UCDs, but to be more prepared for what a client might learn about us so we can use an UCD productively. Privacy laws

and perhaps practical limitations have reduced the use of two-way mirrors and videotaping in social work training. This study suggests it might be helpful to return to these methods to help us receive feedback from others as we use our bodies with clients. At a minimum it could be helpful to receive feedback on our non-verbals during role-plays and to be encouraged to report physical gestures and movements as part of process recordings.

Although the sample size is too small to generalize, it is important to note that the participants of color reported the way in which they were either trained to deflect race – specifically the nature of their racial identity - or were negatively impacted by the way in which their therapist unconsciously disclosed their discomfort with the topic. Suggesting that perhaps there are particular topics – race and perhaps other components of social identity - that are more susceptible to UCD. This study suggests they may also be more harmful to clients as race may be particularly difficult for clients to raise and particularly difficult for clinicians to not hide from.

Participants endorsed disavowal and deflection as legitimate responses to UCD. When describing their experience as clients they expressed anger, frustration and annoyance when their therapist responded in this way. As such, it might be important to pay closer attention to choosing this course of action and the impact on treatment.

Supervision is essential. Nearly every clinician described the invaluable role supervision played in the sorting out and making sense of unconscious countertransference disclosures. Many of the most senior clinicians described current and past experiences of supervision that enabled them to hold and reframe UCD.

Limitations and Strengths of Study

Limitations. All of the participants in this study identified psychodynamic/psychoanalytic theory as the one with which they most identified. If UCD is as pervasive a phenomenon as many of these participants describe it is likely that clinicians in other modalities experience it as well. The explanation offered by non-psychodynamic clinician's might be quite different than participants of this study who may predisposed to the idea of a more permeable membrane between the consciousness of a client and a clinician.

The median length of time participants had been working with clients is 30 years. This makes the group august. A less experienced group of clinicians might provide a different set of answers to these questions. This may be particularly true when describing their experience in therapy. Less experienced clinicians may have worked with therapists who are more intersubjective and relational when practicing psychodynamic psychotherapy.

I completed the study via snowball sampling. As such all of the participants were connected to a professional network. This may have contributed to the high proportion of participants who trained and/or lived in the Northeastern United States. Participants in a different region of the country may have responded differently. In addition, because they were all part of a similar network, participants from a different network may have had different orientations and biases to the concepts.

Participants reported perceptions of what they do which may get blended with what they think they should do. Thus, their self reporting – as indicated by their less favorable reporting of their own clinicians may have made it difficult for them to identify the frequency with which they disavow what a client believes they know.

This study may have fallen into a similar trap as the empirical literature reviewed herein. In an attempt to study a discrete phenomenon I have taken unconscious countertransference disclosures out of its theoretical context. Were a specific theoretical lens – or several – to be applied to the responses offered by clinicians a different set of results or interpretations might arise. Some might argue that UCD is nothing more than part of an enactment. One could contend that it is impossible to isolate one side (the clinician's) of an unconscious process. This may be true and yet it seems important – for the furthered understanding of vulnerable professionals – to try.

Strengths. The racial diversity of this study helped provide a more rich set of responses. Specifically – clinicians of color were more likely to reference the complicating factor of race in UCD. The way in which they were guided by their supervisors to defend/re-frame questions about their race and the way in which race was left out of their treatment. "...Sometimes I think how was I conceptualized developmentally without really talking about those other things [race]."

Participants were open and transparent in response to this researcher's questions. In generally, they were actively engaged and leaned into what they generally described as a vulnerable topic. Without their willingness and courage the findings may have been less robust.

Areas for Further Study

It might be helpful to study the prevalence and impact of UCD with different client populations. For example, it might be interesting to return to the population of the Yeh and Hayes (2011) study and see if the respondents had a history of trauma. If so, how did their history correlate to their perception of the events in the dyad? This study suggests that those respondents with a history of trauma may yield a different set of perceptions than those without.

In general, clients make clinicians aware of UCD. As such, it would further the understanding of UCD to explore the experience of clients. It might be particularly fruitful to explore the same UCD with a clinical pair. This would allow a better understanding of how a similar event was experienced by the different members of the therapeutic dyad. It might be particularly interesting to explore two kinds of pairs. One, a clinician and a non-clinician, the other two clinicians with one in the role of client. In fact at the end of one interview, after having described an UCD raised with their therapist, a participant said, “You should talk to my therapist now.”

As stated in the critique clinicians believe the length of time in treatment impacts UCD. Future areas of study might include looking at the frequency and impact of UCD in early-, mid- and late- phase treatment.

Conclusion

In conclusion, consistent with what one might expect, participants attributed client’s knowing what they had not consciously been told on a spectrum from the concrete (non-verbal cues) to the more metaphysical (spiritual or unconscious communications). Though it makes sense, it was an unexpected finding to hear participants consistently describe the type of client with which they were working, specifically clients with a trauma history, as the explanation for UCDs. This study also surfaced how challenging it can be for clinicians to work with UCDs as they can be “terrifying.” Research of clinical pairs (client and clinician) could further the understanding of how clinicians can best use UCDs in the therapeutic process.

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APPENDICES



APPENDIX A

Consent Form

SCHOOL FOR SOCIAL WORK

**Consent to Participate in a Research Study
Smith College SSW • Northampton, MA**

.....
Title of Study: An Investigation of Unconscious Countertransference Disclosure

Investigator(s): Dina M. Pasalis, School for Social Work Candidate 2014 XXX-XXX-XXXX

Introduction

You are being asked to be in a research study of unconscious countertransference disclosure. You were selected as a possible participant because you are a licensed clinician and expressed an awareness of countertransference. Please read this form and ask questions, if you have any, before agreeing to be in the study.

Purpose of Study

The purpose of the study is to better understand the prevalence of clinician's unconscious countertransference disclosures, how clinician's makes sense of and perhaps even use those disclosures.

This study is being conducted as a thesis requirement for my master's in social work degree. Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

If you agree to be in this study, you will be asked to:

- Complete one 15-30 minute pre-screen phone interview.
- Complete one 60-minute face-to-face interview.

Risks/Discomforts of Being in this Study

Clinicians report experiencing countertransference in up to 80% of their sessions (Gelso and Hayes, 1998). Discussing the details of that countertransference with a stranger – not a

supervisor, therapist or trusted colleague – may be distressing. This study will attempt to explore the unintentional disclosure of this sensitive information. This may further exacerbate this distress. As a result, confidentiality will be paramount. If at any point during the interview you feel the need to pause or stop the interview entirely, this request will be granted.

Benefits of Being in the Study

The benefits of participation may include the opportunity to better understand unconscious countertransference and the therapeutic process. It may offer time for reflection on a topic often disavowed or left un-examined. It may also create greater insight into your experience of being with your clients

Confidentiality

The records of this study will be kept strictly confidential. Research records will be kept in a locked file, and all electronic information will be coded and secured using a password protected file. The audio recording of this interview will be limited in access to this researcher and a hired professional transcriber. The recording will be kept for one year, the expected duration of this project.

We will not include any information in any report we may publish that would make it possible to identify you. The data will be kept for at least three years according to Federal regulations. They may be kept longer if still needed for research. After the three years, or whenever the data are no longer being used, all data will be destroyed.

Payments

You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely at any point during the study. If you choose to withdraw, the researcher will not use any of your information collected for this study. You must notify the researcher of your decision to withdraw by email or phone by December 15, 2013. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Dina Pasalis at dpasalis@smith.edu or by telephone at phone number. If you like, a summary of the results of the study will be sent to you. If you have any

other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study researcher.

.....

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

.....

[if using audio or video recording, use next section for signatures:]

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

APPENDIX B

HSR Application

Smith College School for Social Work
Human Subjects Review Application

Project title: An Investigation of Unconscious Countertransference Disclosure

Name of researcher: Dina M. Pasalis

Check one: MSW PhD

Home phone: XXX-XXX-XXXX Email: dpasalis@smith.edu

Research advisor: Hannah Karpman

As the signature below testifies that I, as the researcher, pledge to conform to the following: As one engaged in research utilizing human subjects, I acknowledge the rights and welfare of the participants involved. I acknowledge my responsibility as a researcher to secure the informed consent of the participants by explaining the procedures and by describing the risks and benefits of the study. I assure the Committee that all procedures performed under the study will be conducted in accordance with those federal regulations and Smith School for Social Work policies that govern research involving human subjects.

Any deviation from the study (e.g. change in researcher, research methodology, participant recruitment procedures, data collection procedures, etc.) will be submitted to the Committee in the form of a change of the study protocol for its approval *prior* to implementation. I agree to report all deviations to the study protocol or adverse events IMMEDIATELY to the Committee.

Researcher: Dina M. Pasalis

11/11/13_

(Typed name)

(Signature)

(Date)

Research Advisor/Committee Chair: Hannah Karpman

(Typed name)

(Signature)

11/11/13

(Date)

(For Committee Use)

REVIEW STATUS: Exempt Expedited Full Not Approved

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Board (HSRB).

Chair, Smith College SSW HSRB

Date

DESCRIPTION OF RESEARCH PROJECT INVOLVING HUMAN PARTICIPANTS

Clinician's report experiencing countertransference, i.e. thoughts, feelings, fantasies and unconscious reactions to a client, in nearly 80% of their sessions. There are differences in how clinicians perceive the value of this information and how or whether or not to disclose countertransference. Much of the literature assumes that clinicians have control over what they do and do not disclose. This study will explore clinician's experience of unconscious countertransference disclosure – whether it happens, how they make sense of the disclosure and what they do with it.

PARTICIPANTS: if you are only observing public behavior, skip to question d in this section.

a). How many participants will be involved in the study?

12-15 ___ N=50 ___ +50 ___ Other (how many do you anticipate) ___

b). List specific eligibility requirements for participants (or describe screening procedures), including exclusionary and inclusionary criteria. For example, if including only male participants, explain why. If using data from a secondary de-identified source, skip to question e in this section.

Inclusion:

- Graduate degree in Social Work, Psychology, Psychiatry
- Believe in the existence and value of unconscious countertransference, i.e. first choice subjects will have psychoanalytic/psychodynamic orientation

Exclusion:

- Non-graduate degree clinicians
- Clinicians who do not acknowledge the existence of countertransference and or who do not deem it a valuable component of their therapeutic work.

c). Describe how participants will be recruited? (Attach all flyers, letters, announcement, email messages etc. that will be used to recruit).

The snowball method will be used to identify participants. Two psychodynamically trained clinicians in two major metropolitan areas have been secured. Full time and adjunct staff at a local psychodynamically oriented teaching hospital will be pursued for participation. See attachment C for email communications. Though I have drafted these communications for strangers, I have become aware that I may meet possible participants through the course of my field placement/network. Should this be the case I plan to adjust the emails accordingly.

d). Is there any formal relationship between researcher and participant (e.g. teacher/student, superintendent/principal/teacher; supervisor/clinician; clinician/client, etc.) that might lead to the appearance of coercion? If so, what steps will the researcher take to avoid this situation. For example: "The researcher will not interview individuals who have been direct clients."

No formal relationships exist.

e). Does the study include accessing participants who are from "vulnerable populations"? If so, please check the appropriate: NA

- minors (under 18 years of age)
- prisoners
- pregnant women
- persons with physical disabilities

- persons with mental disabilities
 economically disadvantaged
 educationally disadvantaged
 other, please specify
-

If any of the above are anticipated participants in this study, state the necessity for doing so. Please indicate the approximate age range of minors to be involved. Participants under age 18 require participant assent AND written consent from the parent/legal guardian. Please use related forms.

RESEARCH METHODS:

(Check which applies)

- Interview, focus group, non-anonymous questionnaire
 Anonymous questionnaire/survey
 Observation of public behavior
 Analysis of de-identified data collected elsewhere
 Where did these data come from originally?
-
-

- Did this original research get IRB approval? Yes No
 (Skip to BENEFITS section)
 Other (describe)
-

a). Please describe the procedure/plan to be followed in your research (e.g. what participants will do).

A semi-structured qualitative interview will be used to collect data from my sample. In addition, basic demographic information will be collected. The responses will be recorded via a hand held recording device. There will not be a control group so all participants will receive the same treatment.

b). How many times will you meet/interact with participants? (*If you are only observing public behavior, SKIP to question d in this section.*) I anticipate meeting/interacting with each participant four times:

1. Make initial contact and schedule a time for an initial telephone conversation.
2. Screen potential participation to ensure they meet the study criteria. Confirm participation or exclusion. Schedule interview.
3. Complete one-hour interview.
4. Send "Thank You" to participants.

c). How much total time will be required of each participant?

One hour and fifteen minutes - for the interview and screen.

d). Where will the data collection occur?

Wherever is convenient for the participant, i.e. their office, a neutral space. It will be based on mutual agreement. I will make myself available to travel to the participant.

e). If you are conducting surveys, attach a copy of the survey instrument to this application. If you are conducting individual interviews or focus groups, including ethnographies or oral histories, attach a list of the interview questions as an “Attachment”. Label attachments alphabetically, with descriptive titles (e.g.: *Attachment A: Interview Questions*).

SEE ATTACHED FILES “*Attachment A: Pre Screen Questionnaire*”, “*Attachment B: Interview Questions*”

INFORMED CONSENT: (*If you are only observing public behavior, SKIP to next section*)

a). What categories of consent documentation will you be obtaining from your participants?

(Check all that apply)

- written participant consent
 written parent/guardian consent
 Child assent 14-17
 Child assent, assent 6-13

b). Attach original consent documents. *note: be advised that, once the study begins, ALL consents/assents will require [wet] signatures – no faxed or email/electronically signed copies.

See *Attachment D: Consent Form*

COLLECTION /RETENTION OF INFORMATION:

a). Describe the method(s) of recording participant responses (e.g., audiotape, videotape, written notes, surveys, etc.)

The responses will be recorded via a hand held recording device.

b). Include the following statement to describe where and for how long will these materials will be stored and the precautions being taken to ensure the security and safety of the materials.

All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

c). Will the recordings of participant responses be coded for subsequent analysis? *If you are only observing public behavior, SKIP to next section.*

Yes

No

CONFIDENTIALITY:

a). What assurances about maintaining privacy will be given to participants about the information collected?

1. Anonymity is assured (data cannot be linked to participant identities)

2. Confidentiality is assured (names and identifying information are protected, i.e., stored separately from data).

3. Neither anonymity nor confidentiality is assured

b). If you checked (2) above, describe methods to protect confidentiality.

A pseudonym will be selected for each participant. All material will be tagged and catalogued with this fictitious name rather than the participant’s actual name.

c). If you checked (3) above, explain why confidentiality is not assured.

d). If you checked (3) above, describe measures you will take to assure participants understand how their information will be used. Describe and attach any permissions/releases that will be requested from participants.

RISKS:

a). Could participation in this study cause participants to feel uncomfortable or distressed?

Yes

No

If yes, describe what steps you will take to protect them.

Though clinicians report experiencing countertransference in up to 80% of their sessions (Gelso and Hayes, 1998), discussing the details of that countertransference with a stranger – not a supervisor, therapist or trusted colleague – may be distressing. This study will attempt to explore the unintentional disclosure of this sensitive information. This may further exacerbate this distress. As a result, confidentiality will be paramount. Additionally, it will be important to “check in” with participants during the interview to ensure they are comfortable with their level of disclosure. Should they choose to stop the interview at any point, this request will of course be granted.

b). Are there any other risks associated with participation (e.g. financial, social, legal, etc.)?

Yes

No

If yes, describe measures you will take to mitigate these additional risks.

Though no additional risks are anticipated, it may be helpful to note that participants will be advised not to disclose anything that could identify their clients or put themselves into jeopardy (e.g., illegal issues, therapist-patient sex, etc.).

COMPENSATION: (If you are only observing public behavior, SKIP to the next section)

Describe any cash or in-kind payments that participants will receive for participating in this research (see guidance about payments/in-kind compensation in the Smith School for Social Work Human Subjects Review Guideline, at the HSR site in the SSW website).

A Thank You note will be the only “payment” received by each participant.

BENEFITS:

a). Describe the potential benefits for the researcher (you).

As a clinician in training, this study will help inform my own professional style and approach. I also imagine that I will be moved on a personal level by the stories I hear from experienced clinicians about their work with countertransference. As a user of psychotherapeutic services this may also help me make sense of the unconscious countertransference information I receive.

b). Describe the potential or guaranteed benefits for participants, EXCLUDING in-kind compensations.

Many clinicians report the experience of countertransference. Researchers often assume the clinician has control over their disclosure of the countertransference. Throughout the history of countertransference narratives have suggested that there may be less control over this disclosure than is assumed. This study may create an opportunity for clinicians to talk openly about the prevalence of this experience. It may help them rethink how countertransference influences their work with clients.

c). What are the potential benefits to social work/society from this research?

Given the pervasiveness of countertransference, understanding how to leverage its unintentional disclosure would be of value to all practicing clinicians and their clients/patients. The hope is that this study will begin to help understand the prevalence of unconscious countertransference disclosure and how to make sense and use of it.

d). Uses of the data:

The data collected from this study will be used to complete my Master's in Social Work (MSW) Thesis. The results of the study may also be used in publications and presentations.

Co-RESEARCHERS, COOPERATING DEPARTMENTS, COOPERATING INSTITUTIONS:

If you are working with/conducting your research at another institution or organization, include a letter of approval from that institution's IRB or agency administrator. If there are multiple researchers, indicate only one person on the Documentation of Review and Approval as the researcher; others should be designated as "Co-Researcher(s)" here.

TRAINING: Include the following statement to describe training:

"I have completed the CITI on line training course prior to HSR approval. The certificate of completion is on file at the SSW.

RESEARCHER: Dina M. Pasalis _____ DATE:

11/11/13 _____

Erk:7/22/13

APPENDIX C

60 Minute Semi-Structured Interview

Unconscious Countertransference Disclosure (several questions coming at the same topic in different ways):

- Have you ever had the experience of a client knowing what you are thinking, feeling or experiencing without having told them?
- Have you ever unconsciously disclosed your countertransference to a client?
- Have you had experiences where you realize you have communicated your countertransference without intention?

Narrative of experience:

- Please think of a time when that happened and describe the experience?
- How did you become aware of the disclosure?
- Have you had experiences when clients took note of unspoken countertransference?
- How did you respond to the disclosure?

Sense Making:

- Is there anything you would have done differently?
- How do you make sense of the disclosure? Do you make sense of it any differently now?
- As an analysand/client, did you ever have that experience with your analyst/clinician, i.e. where you knew what they were thinking, feeling, experiencing without them having told you?
- How do you make sense of this kind of knowing?
- Have you ever had the experience of knowing what your client is thinking, feeling or experiencing without them having told you?

APPENDIX D

HSR Approval



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

October 27, 2013

Dina Pasalis

Dear Dina,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

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

Maintaining Data: You must retain all data and other 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.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Hannah Karpman, Research Advisor

APPENDIX E

HSR Ammended Approval



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

November 12, 2013

Constance Pasalis
5 Stables Way
Belmont, MA 02478

Dear Dina,

I have reviewed your amendment and it looks fine. This amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Hannah Karpman, Research Advisor