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## Projective Identification, Self-Disclosure, and the Patient's View of the Object: The Need for Flexibility

Robert T. Waska, M.S., MFCC

Received December 2, 1998; revised February 25, 1999; accepted March 12, 1999. From the San Francisco Institute for Psychoanalytic Psychotherapy and Psychoanalysis. Address correspondence to Robert T. Waska, P.O. Box 2769, San Anselmo, CA 94979.

### Abstract

Certain patients, through projective identification and splitting mechanisms, test the boundaries of the analytic situation. These patients are usually experiencing overwhelming paranoid-schizoid anxieties and view the object as ruthless and persecutory. Using a Kleinian perspective, the author advocates greater analytic flexibility with these difficult patients who seem unable to use the standard analytic environment. The concept of self-disclosure is examined, and the author discusses certain technical situations where self-disclosure may be helpful.(The Journal of Psychotherapy Practice and Research 1999; 8:225–233)

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Jacobs[1] writes,

**Our technique calls for restraint, neutrality, abstinence. But with some patients this leads to resistance. In such instances we may need a different approach to engage these patients. Some patients need more of us. (p. 247)**

Some patients seem to need a modified method of interpretation at particular junctures in the treatment. Others demand a flexible approach throughout the analysis. These are usually patients who have acute paranoid fantasies of being attacked, rejected, and abandoned.

## PROJECTIVE IDENTIFCATION

Other Sections▼

Melanie Klein proposed the term *projective identification* in 1946.[2] She described an intrapsychic phenomenon by which certain parts of the ego were put into parts of the object, for defensive and protective reasons. Since then, Kleinians have elaborated on her concept and made it a cornerstone of Kleinian theory and technique.

Ogden[3] summarized these developments:

**Projective identification . . . is a psychological process that is simultaneously a type of defense, a mode of communication, a primitive form of object relationship, and a pathway for psychological change. As a defense, projective identification serves to create a sense of psychological distance from unwanted (often frightening) aspects of the self; as a mode of communication, projective identification is a process by which feelings congruent with one's own are induced in another person, thereby creating a sense of being understood by or of being "at one with" the other person. As a type of object relationship, projective identification constitutes a way of being with and relating to a partially separate object; and finally, as a pathway for psychological change, projective identification is a process by which feelings like those that one is struggling with, are psychologically processed by another person and made available for re-internalization in an altered form. Each of these functions of projective identification evolves in the context of the infant's early attempts to perceive, organize, and manage his internal and external experience and to communicate with his environment. (p. 362)**

Rosenfeld[4] felt projective identification was more than just defense:

**One has to realize that projective identification is not just one single process but includes many different types of projective identification. There are also processes which are similar to projective identification but not identical with it and it now seems important to differentiate and understand these processes in greater detail. In a previous paper . . . , I suggested first of all that it was important to differentiate between projective identification used for communication and projective identification used for defensive purposes such as ridding the self of unwanted parts of the self. I also described a third very important form of projective identification which is frequently observed in the transference relationship of the psychotic patient which seems to be based on a very early infantile type of object relationship. In this form of projective identification one observes that the patient believes that he has forced himself omnipotently into the analyst and this results in a fusion or confusion with the analyst and anxieties relating to the loss of his self. Here the projection of omnipotent or deluded parts of the self into the analyst often predominates. (p. 263)**

## EASING ANXIETY WHEN WORKING WITH THE TRANSFERENCE

Other Sections▼

With some patients, making direct and specific interpretations of the transference and of projective identification (PI) mechanisms is what helps ease their anxiety. This is the avenue I try first because it usually works. If the usual approach to dealing therapeutically and analytically with a patient doesn't seem to help, and I have explored the reasons why, I may try a modified contact.

Concerning the importance of working with the transference, Strachey[5] writes,

**Instead of having to deal as best we may with conflicts of the remote past, which are concerned with dead circumstances and mummified personalities, and whose outcome is already determined, we find ourselves**

**involved in an actual and immediate situation, in which we and the patient are the principal characters. (p. 133)**

Whether the analytic situation is flexible or standard, one hopes that it is an exploration of the transference/countertransference dynamics, since this is where the patient's unconscious fantasies and anxieties manifest.

With more territorial individuals who see the world as divided into puppets and string pullers, a more cautious stance can prove helpful. First, I make comments about the PI mechanisms they use with external objects in day-to-day life. Next, I interpret the interpersonal context of PI, between patient and therapist. I may stay at this level for a long time. In fact, it may be as far as some patients can go. Making genetic PI interpretations also seems helpful if this type of patient becomes anxious. It certainly is a retreat from the transference and an avoidance of the here-and-now relationship, but usually these are cases where nothing else works. Finally, after laying groundwork with interpretations of their PI efforts with external objects and of the interpersonal context of the transference, I proceed to more standard interpretations of the intrapsychic nature of PI within the here-and-now transference. This flexible approach is a way of warming up to the mutative moment in which the interpretation directly refers to the object of the patient's fantasy, the therapist.

Again, I only mention this warming-up approach to working with PI as a method I have had to use as a deviation from or modification to more usual interpretive techniques. A few very difficult patients have benefited from it. I would stress the need for the therapist's careful examination of the countertransference, to avoid using this modified approach to act out the patient's PI fantasies.

Both patient and therapist need to free-associate during the session. The patient is encouraged to speak his mind in totality. Then, the therapist must quietly examine the contents of her own mind for information that applies to the situation and judge what would be useful in verbal intervention. I often find my emotional response to a patient takes the form of a conscious mental picture or story concerning some type of one- or two-person conflict. I then find a way to put that countertransference image into words, if the analytic moment seems right. My interpretation is formulated on the current relational and internal interplay between therapist and patient.

Strachey[5] has summed up the vital points in making interpretations. He writes,

**A mutative interpretation can only be applied to an id impulse which is actually in a state of cathexis . . . interpretations must always be directed to the "point of urgency." At any given moment some particular id impulse will be in activity; this is the impulse that is susceptible of mutative interpretation at that time, and no other one . . . but as Melanie Klein has pointed out, it is a most precious quality in an analyst to be able at any moment to pick out the point of urgency . . . a mutative interpretation must be specific: that is to say, detailed and concrete. (p. 149)**

Some patients are so gripped by paranoid fantasies that they hear almost any interpretation as an attack, even when it is detailed and concrete. Some have such sadistic superegos that they take any interpretation as a cruel judgment. These patients are difficult to maintain in treatment because interpretations that normally soothe actually make things worse. The therapist is caught, with the patient, in a vicious cycle. What works best with some of these cases is to interpret that cycle.

However, interpreting the source and intent of the projection can push patients into being more defensive and regressed. Making an interpretation about *other* aspects of their PI fantasies can allow them to explore their thoughts and emotions without feeling as pressured to re-own their unwanted affects and thoughts. Knowing enough about the patient's fantasies and anxieties to position the interpretation where the patient will best receive it is important. Malcolm[6] has done interesting work in this area. Some patients can take in the information if I say, "I am really stuck right now. I feel I can't say much without making it worse." This would be the use of self-disclosure in the service of the patient's ego. Essentially, I would be disclosing my feelings as the stuck and cornered aspect of their ego, which has become lodged within my psyche through PI.

## THE ISSUE OF SELF-DISCLOSURE

Other Sections▼

Self-disclosure has many proponents and many detractors. Recent discussions have been numerous.[7–14] *Psychoanalytic Inquiry*[15] devoted an entire number of the journal to this issue, and an article in *Contemporary Psychoanalysis* brought together several

discussants.[16] Many other papers, panels, and workshops have occurred in the last few years.

However, the issues are far from being resolved. Most of the literature available tends to be from analysts within the intersubjective, interpersonal, or self psychology schools. There is a marked absence of material from the Kleinian school on disclosure. I hope to fill some part of this void with a few thoughts on the use or misuse of disclosure.

Weigert[17] writes,

**The unconscious of the analyst is a receiving organ. His countertransference, lifted into consciousness, becomes an important source of information in the analytic process. Any rigidity, any automatization of attitude or procedure can become a defense against intuitive insight and block the passage from the unconscious to the conscious processes of the analyst. It is therefore important that the spontaneity of the psychoanalyst not be muffled by the rigidity of his technique. (p. 703)**

This captures the essence of being flexible and receptive to patients and whatever they bring to the analytic relationship. Countertransference is often the best tool to detect PI within the transference. It is also the vehicle through which self-disclosure usually emerges. However, there is no particular reason to share one's own thoughts and feelings about matters outside of the immediate clinical situation.

I feel self-disclosure is rarely necessary, but when it is, it is for very specific technical reasons. Rather than as a supportive gesture based on ideas of relational connection or intersubjective interaction, self-disclosure is best used as a clinical tool of interpretation that specifically targets patients' fantasies about their objects. The actual disclosure is a revealing of particular countertransference thoughts and affects that have been generated by the patient's PI mechanisms. So self-disclosure and analytic flexibility, as I am defining them, are not shifts away from analytic treatment to supportive therapy. They are more a therapeutic stretching of certain analytic postures to accommodate moments of extreme difficulty in the patient-therapist dyad. Therefore, this approach differs from Pine's ideas[18] on using supportive techniques to supplement the standard interpretive approach.

In other words, clinical judgment may deem that the best interpretation to be made in the moment is a description of how the patient's projections affect the patient's object. This is also an exploration of the intricacies of patients' defensive relationships to their objects rather than a direct interpretation of the leading anxiety that pushes them to engage in their defensive maneuvers.

Clinical judgment helps the analyst match and balance interpretations to the patient's level of psychic urgency at any given moment. These interpretative decisions are made by evaluating the affect, physical gestures and sensations, and associations in both analyst and patient. Neutrality and abstinence are necessary and helpful procedures, yet there are times when they can be loosened. For example, some patients with paranoid character structure will debate over why coming in once a week isn't just as good as coming in twice a week. Similarly, they might argue that they can achieve the same degree of health from coming in three times a week as from four times a week. With some of these patients, trying to explain the rationale behind our clinical recommendation would be an acting out by the therapist of “I will prove to you why you must be here” as well as an avoidance of the transference. This is usually in tune with these patients' tug-of-war PI fantasy.

With other patients, giving them “the facts” can be helpful in paving the road to future interpretations. It can temporarily help them to trust the relationship enough to stay rather than flee. It also helps them feel that they have some power or say in a relationship that may seem dangerous or confrontational. Providing a matter-of-fact response can help them proceed with their material. At the same time, offering our clinical rationale when asked can be used for the wrong reason: as a coercive weapon to circumvent resistance. Therefore, clinical judgment is crucial.

Again, flexible approaches are helpful only for select cases. Using a flexible approach, including self-disclosure, should be a carefully thought-out detour from standard technique that is used for specialized reasons.

### *Clinical Material*

One patient, Frances, was mired in obsessive fantasies about power, control, and justice. She used manic defenses to be always correct and better than her analyst. Any interpretations I made, she had already thought of. This was to prevent the breakdown of her omnipotence and to avoid the loss of her fragile, idealized object. We could have no differences. Part of her anxiety was about my keeping secrets. Frances felt I might have knowledge about her or her problems that I didn't share. This was unacceptable because it showed we were separate and different. It also made her feel inferior and humiliated.

During one period of her analysis, Frances became convinced that I had an opinion about her condition that I wasn't sharing. She demanded to know. Her insistence to have what she "had a right to know" escalated over several hours. It began to take on an obsessional and paranoid quality. She would not rest until I handed over the secret. Frances felt that I had a piece of her, and she was ready to fight for it to prevent a collapse of her integrity and feeling of power. After one rather grueling hour, with her becoming highly agitated and demanding, I felt cornered, controlled, and on the verge of being rejected. In other words, I was sure she was about to quit her treatment unless I gave in and "surrendered the goods."

Between these sessions, I found myself thinking and worrying about our relationship. It occurred to me that I was feeling as she often had growing up. She had felt bullied and controlled by an alcoholic father and a manipulative mother. Frances had wanted to obsessively confess all her shortcomings to her mother, since any aggressive or sexual feeling made her dangerous and sinful. By confessing to her mother, she regained her feeling of being better than her family. Omnipotence or loss were her choices. Using my countertransference and my knowledge of her background steadied me.

When Frances arrived for the next hour, she refused to use the couch and demanded that I tell her what I thought of her. She was anxious and agitated. She said she was on the verge of quitting. Frances was an obsessive neurotic, mostly organizing her mental life within the depressive position.[19,20] However, she easily regressed into paranoid-schizoid[2] persecutory fantasies. Therefore, I felt it important to be very sure of what unconscious state she was in that day before making my interpretation. If she were mostly managing her inner world from the paranoid-schizoid perspective, I felt it would be unwise to make a transference interpretation about her thoughts and feelings toward me. This usually makes such a patient increasingly defensive and prone to a paranoid flight. In such a situation, I find it more clinically helpful to interpret the ego's vision of the object. This might include some self-disclosure. Therefore, I was ready to tell Frances that I was feeling confused and cornered, as if things would go sour if I did not "come up with the goods." I was ready to share my thoughts with her about how she was doing. Nevertheless, I felt nervous about what she needed and how everything suddenly seemed to have so much weight, as if everything could rise or fall based on what I said.

When I began to tell Frances that I was willing to talk with her about her worries and to try and help her out with what she needed, she calmed down. She visibly regrouped and began to relate to me from much more of a depressive stance. I was less of a dominating dictator in her eyes. When I acquiesced somewhat to her fantasy about our tug-of-war, she felt less gripped by severe anxieties. When I saw that she had reintegrated somewhat, I decided to make a more standard PI interpretation concerning the transference.

I said, "You want me to tell you what I think of you. You grew up with a father whom you wanted to be close to and to get inside and understand. You wanted to look up to him and be close to him. You craved to know how he felt about you. Instead, you had a father who was angry and drunk most of the time. You felt blocked from knowing him and from knowing if he cared about you. Then he killed himself and you felt you would never be able to get inside him and know. Now, you are letting yourself be more vulnerable with me and are starting to want to know about me. You want to know how I feel about you, but you are worried I am blocking you as well. This makes you furious and sad and you want to try and push your way in. That conflict of wanting to be inside of me and feeling shut out is happening more and more lately. You are hoping I will see that and help you out."

This was a more oedipal-based interpretation that directly addressed her urges and fears. She listened intently and immediately seemed to relax. After a long silence, she began associating to memories of her childhood and her desires to be close to her father. Frances also told me she wanted to find out more about me but felt unsure if I would be nice or if I would be mean and withhold things. Based on my assessment of her intrapsychic structure, her unconscious fantasies and anxieties, and my own countertransferences, I was able to make sense out of her PI mechanisms and offer an appropriate interpretation.

These deviations from regular technique only apply to some patients who are very defensive and paranoid. These are the patients

who are unusually rigid, controlling, and scared of others.

One paranoid, psychotic patient was so anxious about not getting a handshake from me at the end of each hour that she alternated between shouting at me for being a cold, mean bastard and begging me for some sign of compassion and love. She was so locked into her fantasy of me as a teasing, distant father whom she needed desperately and immediately that asking her to discuss it was like pouring gasoline on a fire. We were at a stalemate. I shook her hand at the end of the hour. Not surprisingly, she complained that it was a miserable, cold gesture and she wanted a "real handshake." Overall, what did happen was that we became less stuck.

Gratification is nevertheless a tricky matter. Some patients will become insatiable and others will pose the question, "If you fed me that time, why not all the other times?" I think it is inaccurate to automatically assume a person with ego defects needs gratifying support. This woman could not and would not continue unless I gave in to her demand and her need. Some patients do indeed create an ego emptiness from excessive PI. It is an emptying of the self into the object. Also, through excessive and destructive PI and splitting, the ego can become fragmented and disintegrated. As with all patients, deficits, conflicts, demands, and needs are always found together, never apart. A patient can demand immediate satisfaction, pushing and manipulating the therapist into various levels of acting out. This is always a danger and must be noticed, explored, and analyzed. However, it is a situation that can't always be avoided.

Another psychotic patient came to me to stop smoking. His symptom, inability to stop smoking, was a fragile oral compromise that helped him keep from becoming floridly psychotic. When in the first meeting he asked me if I had ever smoked, I said yes and that I had quit. This type of clinical decision, to make a shift in my standard clinical technique, was based on an on-the-spot assessment of the patient's ability to maintain connection to a fantasy of a good object. This patient appeared on the verge of plummeting into severe paranoid-schizoid fears and delusions. Sometimes an interpretation will do; other times, a combination of self-disclosure and interpretation is needed.

Unfortunately, some patients are so inundated with persecutory fantasies about the torturous character of their world and their objects that this type of technical deviation only postpones the inevitable flight out of treatment. However, gratification via the therapist's self-disclosure can foster further analytic exploration and interpretive work. Disclosure can serve as a momentary buffer to the patient's annihilation anxiety, making it possible for some patients to proceed to the more analytic work.

This approach would be applicable only with select patients who are overwhelmed by internal destructive forces and who take interpretations as attacks. These patients are not amenable to analysis at that clinical moment, thereby requiring a temporary parameter. In this sense, the parameter is not "nonanalytic." It is simply a necessary precursor to, or place-holder for, analytic work. It "prepares the soil" for some patients to enter a more traditional analytic treatment.

With one borderline patient, I chose to make a comment that was at once gratifying, self-disclosing, and interpretive. She asked me why I hadn't called her when her father was dying. If I had simply been quiet, she would have reacted violently because her anxiety about being dependent on me was very high. Therefore, I chose to say, "I thought of calling you, but felt it would be too intrusive or confusing. However, your wanting me to call you sounds like you would have liked me to. I think you want me to call you so I can take care of you and be like a loving father. At the same time, I think you wanted me to call because for *you* to call *me* feels like your being dependent, weak, and vulnerable, and that scares you." My self-disclosure was in the form of an interpretation.

I consider all of these technical shifts away from standard or ideal analytic procedure still to be true to the basic analytic approach. The goal remains the same: the analysis of the transference, of unconscious fantasies, and of principal conflicts regarding destructive and loving forces.

The flexible approach can be a partial collaboration with the resistant side of the patient. This tradeoff is helpful, but only in cases where it is absolutely necessary. For example, one patient would always become concrete, paranoid, and withdrawn when I would make here-and-now interpretations. I found over time and with experimentation that it was better to make more reconstructive comments than here-and-now transference comments. These genetic reconstructions were helpful and often led to her making associations to more current anxieties, but I was also collaborating with her avoidance of the transference. My approach with her was a technical judgment based on her being very defensive, paranoid, and lacking in certain symbolic functions. If I tried to explore her anxieties, she typically regressed quickly into a fight-or-flight reaction. When she told me that her male friend from college had visited and they ended up "sharing the same bed," I asked how that was. I thought it was clear that I was asking her how

she felt about being in a sexual situation with a man she had only been friends with up to now. She replied, "Well, my ability to stretch out and use the whole area of the bed was compromised."

If I dug deeper, she rapidly decompensated into a markedly paranoid stance. Therefore, I felt unable to say or do much of anything. In this way, she controlled me as she felt controlled by her objects. She projected the controlled and helpless little girl part of her ego into me and dominated me with the cold, crazy, and cruel mother aspect of her ego. Although she related to me this way many times over the years, I was still amazed at how cold and distant she could be. She was still apt to react with fear and retreat when I made transference comments or when she thought I was doing something unfair and controlling.

The analytic standards of neutrality and abstinence are helpful therapeutic tools. However, the degree to which these tools are helpful in a treatment depends on the details of the patient's current fantasies and anxieties. In some portions of a treatment, the ratio of analytic standards to nonanalytic interactions can vary widely. At certain times in an analysis, the treatment might be filled with extratransference material, extratransference interpretations, mutual acting out, and various interpersonal interactions. The analyst has to be aware of this shifting ratio and mindful of why it is occurring and when to intervene to change the balance. However, the clinical atmosphere of day-to-day analytic therapy is always in flux.

Strachey[5] felt that extratransference interpretations are helpful in bringing the focus back to the transference, that they are important as a vessel for the vital contents inside: the mutative transference interpretation. He writes,

**The fact that the mutative interpretation is the ultimate operative factor in the therapeutic action of psychoanalysis does not imply the exclusion of many other procedures (such as suggestion, reassurance, abreaction, etc.) as elements in the treatment of a particular patient. (p. 159)**

I would add that the flexible approach to analytic treatment with certain patients is another factor to be found alongside the important mutative transference interpretation. In fact, for some patients it is the flexible approach that makes the use and success of the mutative interpretation possible.

Many patients relate to the analyst by PI and splitting. Klein[2] writes,

**I have repeatedly found that advances in synthesis are brought about by interpretations of the specific causes for splitting. Such interpretations must deal in detail with the transference situation at that moment, including of course the connection with the past, and must contain a reference to the details of the anxiety situations which drive the ego to regress to schizoid mechanisms. (p. 21)**

Certain patients are so internally disrupted by the excessive use of splitting and PI that a flexible approach to interpretation is useful.

### *Case Material*

Franz had seen me for 7 years in psychoanalytic psychotherapy. He frequently pulled me into a sadomasochistic relationship where he first felt attacked by my interpretations and then would pull back and become oppositional. During these times, Franz would feel I was picking on him and being cruel.

The time in his treatment I wish to focus on involved his upcoming graduation from college. He was about to receive his degree in psychology and was very nervous about starting his career. His fantasies about not being liked in job interviews, not being able to compete with other new grads, and general worries about venturing out of the protection of college brought on intense anxiety. He felt trapped and began to see me as part of the group of people and places he was annoyed by. His fear turned to anger and contempt as he shifted to a manic defense. He split his objects into those that were accepting and wonderful and those that were rejecting and nasty. Franz projected his bad objects into me and his local job search. Within a few months, he was convinced that it was stupid to remain in the area when such fantastic career opportunities awaited him elsewhere. He imagined wonderful opportunities and friendship in distant locations. He devalued his therapy and any potential job offers he had in his hometown. It came to a point where he was literally thinking of moving to a far-off city he had never been to solely on the grounds that they might have entry-level psychology jobs. Franz seemed oblivious that he was about to sever his long-term relationships with his therapist, friends, girlfriend, and family.

I found myself echoing with the feelings of a bad object that had been discarded, deemed as unnecessary and worthless. These countertransference feelings were the result of Franz's PI process. These were fantasies of being unwanted and unaccepted in his new post-college life. At first, I acted out these feelings by giving him parental-like advice on the advantages and disadvantages of moving so abruptly. This made us seem to be a rebellious teenager–concerned parent pair. I was aware of this but also quite caught up in it. At one point in our stalemate, Franz pointed this dynamic out to me. I agreed with his observation and said, “I guess I am a bit thrown off course, confused. After our working together for seven years with lots of ups and downs, you told me a few weeks ago that you will probably be gone in two months. I guess I really don't know how to proceed. What should we talk about? It feels so abrupt. It's unclear what to do. I am not sure what you want.” This was a deliberate self-disclosure of the effects he was having on his object and a statement of what I felt he was probably unable to deal with directly, without projection. He had projected these unbearable feelings into me and I was now struggling with them.

Franz paused and thought about what I said. He replied, “I think I know what you mean. I've been feeling so overwhelmed by the idea of starting a career that I have not wanted to deal with anything. I am trying my best to ignore all my relationships and just think about escaping somewhere. When I start to think about going to interviews and having people not like me and reject me, I can't bear it.” I said, “I think you have been so overwhelmed with that anxiety that you have wanted me to hold onto it for you. So then I look like I'm a lecturing parent. You're hoping I can cope a little better and help you out.” In saying this, I was interpreting his projection of his own judgmental superego and his demanding oral urges that usually left him feeling either unsatisfied and angry or persecuted by the needs of others. The result of our work in this hour was a decrease in his reliance on the manic defense and more insight into his anxiety. My self-disclosure was the use of PI-induced countertransference to make an interpretation.

Through the process of splitting and PI, I had acted out portions of this patient's fantasies. I had begun to pick on Franz. I was an external vessel for his overwhelming self-doubts and fears of rejection. When I revealed my confusion to him, I was showing my own struggle with doubt, loss, and rejection. This helped him to have hope in his own ability to struggle with these troubles. On another level, I had interpreted the character of his object's struggle, an unbearable aspect of himself he had felt pressured to expel into me.

If patients' fantasies are primarily about their *objects* (as in the object being caring, persecutory, or even harmed), selective self-disclosure can be helpful. If patients are mostly focused on a fantasy about themselves, it is less helpful.

Self-disclosure is not a “reality check” for the patient, nor is it a supportive measure. It is an intervention that is not often necessary, but it can occasionally prove useful with some patients in some circumstances. In these moments, it serves as a way to investigate the composition of transference fantasies and to see if the therapist's experience is the same as the patient's. It is more a clarification of the patient's fantasy.

## CAUTIONARY NOTES

Other Sections▼

Disclosures made *outside* the arena of interpretations are often countertransference acting out. But making a self-disclosure in the service of an interpretation can easily be acting out as well—disguised under the rationale that it was technically necessary. Therefore, one needs to carefully assess who will truly benefit from such a disclosure.

Self-disclosure should not be a license for "anything goes." Some therapists have taken to self-disclosing a wide variety of personal thoughts and feelings without too much scientific reasoning behind that choice. Tauber[21] writes about trying to undo the stigma of the countertransference. He comments,

> **This taboo has the harmful effect of inhibiting the analyst from recognizing the creative spontaneous insights that may occur to him in a dream, or in making use of a marginal thought or a slip of the tongue . . . With this as a hypothesis, I have discussed openly with several patients for mutual clarification, dream material of mine that involved them. (p. 331)**

I would consider this a wild use of countertransference and a way of avoiding the digestion of a patient's PI processes, which easily do evoke feelings, thoughts, and dreams.

Another form of self-disclosure that I feel is counterproductive is the expression of affect as a way of "showing" patients what impact they have on others or how affect "should" be expressed. This seems at best some type of educative, supportive counseling rather than analytic technique, and at worst it is manipulation and suggestion. Maroda[22] writes,

> **My own clinical experience has convinced me that actually expressing the affect experienced in response to the patient is often the most therapeutic intervention possible . . . the challenge for the therapist is to show and express feelings without losing control, something the patient is convinced is impossible. This truly provides a model for identification purposes that the patient can use in life. For a patient to observe his therapist experiencing and constructively expressing his or her affect means that someday the patient may be able to do the same. (p. 237)**

I believe it is dangerous to think that we can provide the mold for what is right and how to be. This is more of an attempt at re-parenting and making the patient into our image than an analytic exploration. Therapists who practice this way seem to be working mostly within the context of "reality" and interpersonal interactions. They appear to have lost sight of the huge impact of fantasy on a person's life and how that influence quickly dissolves any simplistic one-to-one answers in a complex therapy situation. Although some patients with gross cognitive impairments may need this type of direction, most patients do not. Unless the treatment is already limited by managed care, acute psychosis, or addiction, such directive and suggestive methods seem counterproductive.

## SUMMARY

Other Sections▼

Persecutory anxieties and a lack of symbolic ego function so grip some patients in the paranoid-schizoid position that they equate the therapist with the bad object, without any as-if quality. These paranoid individuals rely on destructive splitting and excessive projective identification mechanisms to cope with their frightening internal experiences. Unfortunately, these mechanisms generate a vicious cycle in which good objects are unavailable or destroyed and countless bad objects invade the ego.

These patients test the ordinary limits of analytic treatment. Using a Kleinian perspective with a certain analytic flexibility may help keep these patients in treatment long enough to begin addressing their fragile psychic states. Flexibility may include the selective use of self-disclosure. This would be limited to information directly related to the transference and to projective identification dynamics operating in the moment. The hope is that this flexibility will be a containing experience that will gradually allow the treatment to move toward a standard analytic situation. Therapists should proceed cautiously when applying this flexible approach or when using self-disclosure, because countertransference acting out or collusion with the patient's projective identification mechanisms is a real threat. Self-disclosure, even when helpful, need not be a reason to stray from the time-tested emphasis on the analysis of transference, resistance, and intrapsychic fantasy.

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Other Sections▼

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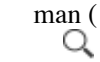
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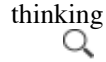
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