

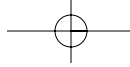
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Use of Self and the Ethical Approach to Practice with Adolescents

The astute clinician recognizes that the use of self in the clinical relationship with adolescents is very important for the success of treatment. Use of self, of course, is not just self-disclosure. It consists of a wide range of subtle, overt, conscious and unconscious responses and interactions with the adolescent client. How and what one discusses with an adolescent client is an important decision that must be handled ethically. This chapter will examine the theoretical underpinnings of the so-called use of self in clinical work as well as examine and critique the different types of issues that may necessitate self-disclosure.

HISTORY AND ORIGINS OF COUNTERTRANSFERENCE THEORY AND USE OF SELF IN ADOLESCENT PRACTICE

Many years ago in my doctoral dissertation I wanted to examine the nature of the clinical relationship. I was especially intrigued by the fact that most if not all clinicians experience a wide range of emotions with their clients, and the way in which they understand and decipher the origins and meaning of those feelings can have a profound impact on all areas of treatment, especially on the use of the therapeutic relationship. The emotional reactions of both client and therapist contribute to the success or failure of the therapeutic relationship. The careful management of that relational process is at the heart of therapeutic work (Hubble, Duncan, & Miller, 1999; McNamee & Gergen, 2002; Mitchell, 1988; Stolorow, 1992). This is what one might call the use of self in clinical work (McKenzie, 1995). In contemporary clinical nomenclature this complex concept might be referred to as the intersubjective or relational area of the clinical relationship (McNamee & Gergen, 2002; Mitchell, 1988; Stolorow, 1992). A basic review of the transference and countertransference concepts, including the notions of intersubjectivity and relational therapy, will help set the stage for the discussion of this important aspect of the clinical relationship with adolescents.



Freud discovered and developed the concept of *transference* in his work with analytic patients in the late 1800s and early 1900s. In psychoanalysis, the patient free-associates and says whatever comes to his mind. The analyst must be a blank screen, that is, not pollute or gratify the patient in any way that may interfere in his ability to free-associate. One of Freud's most famous patients, Anna O., reached a point in her analysis where she found it difficult or even refused to continue to free-associate. Freud recognized this to be a resistance to the treatment and redoubled his efforts and encouragement that she continue to free-associate. Over time Anna O. did resume the free association, but with a new twist in content and emotion. She now free-associated almost exclusively about Freud himself. Freud initially was baffled and overwhelmed by this dilemma. This was a difficult resistance indeed. He must get her to resume discussing her issues, not her relationship with or fantasies about him, he thought. Anna O., however, refused to do much else but focus on her relationship with Freud. She discussed her feelings, wishes, hopes, and dreams about him. Freud eventually began to understand that this was an important issue for her. What did it mean? Freud hypothesized that perhaps Anna O. was in fact discussing issues in her own life history—important relationships, emotions, fears, wishes—and was disguising them unconsciously as symbolic issues with her analyst. In other words, she did not really feel this way about Freud (whom she presumably did not know much about) but was actually *transferring* onto him her own life issues. As Freud was able to decipher this symbolism and interpret it to Anna O., she was able to have insight not only into her relationship with Freud but into the meanings of those same interactions in her past and present life. Anna O.'s improvement in analysis was the proof that Freud had stumbled upon a remarkable discovery not only about analysis but about human nature in general (Freud, 1938).

This rudimentary discovery has important implications for all types of clinical work as well as for understanding an equally important element of human interactions. Most of us at some point in our lives distort or misunderstand our interactions with significant others owing to our past relationships. That is human nature, Freud would say. The important thing is to be aware of that distortion so that it does not interfere with one's life. Far too often, especially in intimate relationships, problems occur through misunderstandings, distortions, and projection. That is why the therapist's and client's self-awareness are an integral element of successful therapeutic work.

Along with the concept of transference, Freud also developed the notion of *countertransference* or, simply put, the therapist's transference. It was Freud's recommendation that therapists go through their own analysis in order to become aware of their own neurotic life issues so that these would not interfere in their analytic work with patients. This approach to handling countertransference became known as the *classical position*. The

management of countertransference, however, has gone through a tremendous evolution over the past hundred years.

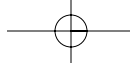
By the 1950s with the development of object relations theory, most experienced clinicians recognized that countertransference was a ubiquitous phenomenon. The countertransference of the therapist could not be eliminated through successful analysis or psychotherapy, as Freud once thought, but was ongoing. Each client brings with her her own transference issues based upon past and present circumstances, and those issues influence the therapist depending on that therapist's life history. This shift in countertransference theory and management became known as the *totalist position*. The South American analyst Heinrich Racker is probably most notable for developing a systematic way to recognize and manage countertransference issues in the treatment relationship (Racker, 1968; Tansey & Burke, 1989).

In recent years there have been even further modifications and evolution of the concept and management of countertransference. Recognizing that the development of the therapeutic relationship contains elements and contributions from both the client and the therapist, the *specialist position*, more recently referred to as the *intersubjective* or *relational position*, recommends that the clinician base his interventions upon the mutual development of an intersubjective relationship that is unique to the two parties involved and based upon each member's personal culture (Mitchell, 1988; Saari, 1986; Searles, 1979; Stolorow, 1992).

How does all of the complex theory and history presented above help us understand basic clinical work with teenagers? Recognizing that transference and countertransference can be important elements of clinical work with all populations is a useful part of any clinician's knowledge base. Knowing that the therapeutic work is relational and that there are potentially meaningful constructive and destructive elements involved helps the practitioner better serve the adolescent in practice.

Adolescents typically present and utilize transference in a much different manner than do adult clients. Many clinicians and theorists believe that it is not a good idea to encourage a traditional transference relationship with an adolescent. Adolescents are moving away from their infantile dependency, and too much exploration or revisiting of this time period can be overwhelming and even dangerous. However, it has been my experience that all adolescents present some form of transference elements in treatment and that the way in which the clinician responds out of her own countertransference can be extremely helpful and even pivotal in the successful treatment of adolescents. A review of another psychodynamic theory will shed some important light on this issue.

The theory of self psychology has been discussed in previous chapters. Kohut believed that all people have an emotional need throughout life for the three types of self-objects: mirroring, idealizing/merging, and twinship. That need is greater in infancy and childhood and becomes less as we reach



adult emotional maturity. Adolescents are still growing and maturing physically and emotionally and also have a greater need for self-objects than do most adults. As adolescents begin their second individuation process, as Blos might say, they tend to invest less of their time and energy in the family and their emotional relationships with primary caretakers. But they still need emotional connections with important others in order to help them develop an autonomous and emotionally mature sense of self. Most teens turn to their peer group or other idealized figures for this type of emotional sustenance. Sharing common values, interests, ideas, and philosophies with a group helps to give the adolescent a sense of purpose, security, and self-esteem. They are not yet capable of knowing or trusting their own sense of these things. Belonging to the group provides the emotional security necessary to help them make the ultimate transition to a more adult sense of self.

Although all three self-object needs are certainly a part of the adolescent's move toward an emotionally secure identity, I believe that *twinship* has the greatest prominence during this time period. So much of the adolescent's life and sense of purpose during this time period is wrapped up in how he is or is not like his peer group. Whether or not many adolescents accept peers into their world often is a result of how well they fit into a peer group's perspective. When an adolescent moves from one group to another, the move usually has something to do with an internal shift in her sense of self. The goals, values, and ideals of her existing peer group no longer fit her, and she may then turn to another.

For example, in my own adolescence, my alcoholic father pushed me (figuratively and literally) to play high school football. Erikson might say that my decision to join the freshman team was a move toward foreclosure of a part of my budding identity more than my own choice. Be that as it may, I joined the high school football team and along with it became a part of that social clique. Each social clique that an adolescent may join or identify with is relevant to that teenager's identity search. The jock/athlete clique may be appealing or disgusting to a particular adolescent because of how it is understood by him and the meaning it holds for him. This is true for all social groups, even in adulthood. In hindsight, my reason for joining the football team and clique associated with it probably had more to do with complying with or even pleasing my father than with wanting to be in it.

Over time I found myself feeling alienated as I tried to join in the social activities associated with the jock clique. It felt unnatural to me, and I did not feel comfortable or even feel like myself when I was around many of the members of that peer group. To me they felt phony. As a result, over time I left that group and moved to one that I perceived as the antithesis of it . . . the greasers or what might be called gang bangers today. This group appealed to me on a conscious level because they were all disgusted with jocks and saw them as the enemy. This was just perfect for me. I could now find purpose in being opposed to another group's ideology. Of course I now

recognize that this move was also a move against my father and in many ways represented the symbolic expression of my anger toward him. Did I have any awareness of these possible explanations at the time? No. However, I do believe that many teenagers are drawn to certain peer groups and interests for similar reasons.

Twinship with others during adolescence enables the teenager to develop confidence and self-esteem. Adolescents are continually searching to know how they are similar to or different from others in their world. When an adolescent enters into therapy, even if it is forced upon her, those twinship needs often come into play in the form of requests for self-disclosure from the therapist. When adolescents demand self-disclosure from their therapists, usually they are demonstrating their crucial need for twinship. This does not mean that the clinician must disclose every single detail of his life to the adolescent client. The practitioner should be sensitive to the reasons for those requests and bear in mind how a careful use of self-disclosure may help to solidify the therapy relationship.

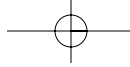
If an adolescent is able to recognize that her therapist shares some of her own interests, ideas, values, and ideology, it helps to foster a much more secure therapeutic bond. It also serves the greater purpose of creating a context in which the dyad can now begin to discuss and explore many areas of the teenager's life. It is not necessary that the clinician share everything about himself or answer all questions that the adolescent asks about him. What is important is that the practitioner recognize the reason for this request and the possible benefits developmentally in responding carefully to them.

Mark A. Hubble, Barry L. Duncan, and Scott D. Miller's book *The Heart and Soul of Change: What Works in Psychotherapy* (1999) emphasizes the fact that there are a variety of different interventions and approaches that work in treatment. Key to success is the clinician's careful use of self, because of the adolescent's need for twinship in the identity formation process.

Another important reason to tend to the adolescent's need for twinship through the appropriate use of self is that it helps to solidify trust in the therapeutic relationship. From a self psychology standpoint, it helps to ensure the development of mirroring and idealizing/merging self-objects. Even if the practitioner is using a purely CBT approach with a teenager, the use of self and twinship needs can increase the likelihood of developing greater trust in an intervention plan. The relationship with an adolescent client is the crucial element in any successful treatment effort.

THE CLINICAL VALIDATION METHOD AND USE OF SELF WITH ADOLESCENTS

Most if not all clinicians experience extreme emotions or discomfort in their clinical work with clients from time to time. The intensity of these experiences can interfere with or derail the clinical work. Usually they take the



form of uncomfortable or even overwhelming thoughts and emotions that may interfere with the clinician's objectivity, empathy, or even his ability to formulate and carry through on interventions. In the most traditional sense this can be understood as countertransference. However, countertransference as discussed above is essentially an intersubjective and relational process. That means that the feelings and emotions of the clinician derive from the therapeutic relationship as well as from the practitioner's own life. When a therapist working with an adolescent experiences overwhelming thoughts and emotions that interfere in the process, how does he understand and work through them?

The *clinical validation method* addresses the phenomenon discussed above. It is a simple process in many ways, with profound implications for clinical work. It goes something like this: Let's say a clinician working with an adolescent experiences extreme emotional anxiety in the session. Let's also say that this emotional anxiety is so overwhelming that the clinician has difficulty listening to the client. What can she do in the session to help her understand this process and get back on track?

The clinical validation method suggests that the practitioner explore her working models of self and other. A *working model* is the mental and emotional construct that any clinician has developed in her own mind about herself and her client. The method would suggest that the clinician first explore her own working model of self as it relates to the extreme emotions experienced in the session. This means allowing herself to become introspective and explore the ways in which these thoughts and/or emotions may be part of her own life experiences. Using the example mentioned above, a clinician might wonder, "Why am I feeling this intense emotion right now? Is there something the adolescent is discussing that in some way relates to my own life or my own emotional issues or vulnerability? Is there something about me that is being triggered by what is happening between us right now?" These and many other avenues of exploration are very helpful in trying to pinpoint whether or not the difficulty in therapy is tied to the clinician's experience, her working model of self. If upon some fairly comprehensive scrutiny, the clinician is not able to identify any issues associated with her own working model of self, she can then begin to explore her working model of the client.

The client's working model is based upon the clinician's ongoing development of a sense of the client's history, emotions, development, relationships, and so on. The clinician may ask herself: "Is there something about what the adolescent is discussing that may be filled with anxiety? Am I feeling something that the client is unaware of or working through in his life? Am I responding to some nonverbal cues from the client that could generate extreme anxiety in me?" These questions and many more will help the clinician explore her working model of the adolescent in order to identify the source of the difficulty.



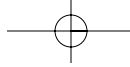
One might ask, “Am I supposed to be doing all this while I’m actually sitting with the adolescent?” The answer is yes. We all listen on many different levels simultaneously in every clinical session. We have many different ears working all the time in session. We listen to the manifest content—the exact words the client is saying and the issues and events that are being discussed. We listen to the diagnostic part of the session, the clinical meaning of the material. We also listen to our own feelings about all of the things the client is discussing. We can’t help but experience how this material makes us feel. We may also (dare I say it) be thinking about our own lives and when the session will be over and what other things we want to do that day. We listen on many different levels *simultaneously*. This is part of the professional role of the practitioner. It is part of the development of our professional self. It takes years to develop confidence in this ability, and it is also an ongoing process that is deeply layered. But we all listen on many levels all the time.

The clinical validation method would suggest that if the clinician is able to identify the source of the intense distraction, she is able to experience a sense of relief, and with that relief gain the ability to reengage with the client. The insight into the source of emotional distraction allows the clinician to be less troubled by it. She can now come back to the session and the client with a greater degree of understanding about self and other. She can attend more directly to the client and the client’s issues.

This may sound like a rather linear progression: explore your own issues, explore the client’s issues, find the source. Ah ha, insight! Everything is now okay. The problem is that most of the explanation for these types of difficulties lies in an intersubjective/relational realm of experience in which both the client and the clinician participate. It is probably never just the client’s issues or the therapist’s issues that are the source of the clinician’s anxiety; it is more likely to be the result of an interactive process that combines elements from both worlds. However, that does not mean that the process of clinical validation is useless. The sense of relief and ability to reengage in the therapeutic process demonstrate the validation of the search. The following example may help to demonstrate this technique.

CASE EXAMPLE

When Judy came to see me for therapy she was a junior in high school. Her parents brought her in for treatment because they were concerned about her physical and emotional withdrawal from the family. They came in without Judy for the first session and expressed many of these concerns in person. In addition, Judy’s father gave me a novel that Judy was apparently reading that gave him and his wife concern. The novel was very dark, depressing, and sexual in content. Judy’s parents were worried that their daughter was withdrawing into herself and becoming obsessed with evil and the pessimistic parts of life. They told me that when they spoke with Judy about coming to therapy she was very open to the idea. I worked with Judy on an almost exclu-



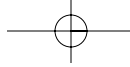
sively individual basis, with occasional family meetings to review how therapy was going. Judy's parents understood that my work with their daughter was confidential, but they also were informed that if I felt that Judy was in danger of hurting herself, I would certainly inform and involve them immediately.

I wasn't quite sure what to expect when Judy came in alone for the first session. She appeared somewhat odd in both her physical appearance and her approach to conversation and interaction. One might characterize Judy as being goth in her appearance. She initially dressed primarily all in black, with heavy black eye makeup, lipstick, and fingernail polish. Sometimes her hair would be jet black, sometimes black and pink, sometimes all blue, and so on. She seemed not only shy in her demeanor but also a bit disorganized in her ability to communicate her thoughts and feelings. Her ideas were not delusional or odd in any way, but her ability to accurately *express* those ideas seemed compromised. It was as if Judy were thinking and feeling a great deal about herself and life but unable to verbally express her thoughts and feelings as clearly as she wanted. This was how I first encountered her.

Despite the awkward nature of our initial interactions, it certainly appeared that Judy wanted to be there. She seemed pleasant and interested in discussing whatever was on her mind at the time. The problem for me was that there seemed to be a terrible disconnect between what Judy openly expressed in session and my ability to respond to it with words that fit for Judy. I wondered as I saw her initially if she was suffering from the beginnings of some sort of psychotic disorder. I had seen many teenagers and young adults who were in the early period of developing schizophrenia, but Judy was different. She seemed to be highly intelligent, sensitive, and introspective. Her trouble appeared to have more to do with a sense of isolation, a sense that no one was able to understand her unique inner world or validate it for her.

I genuinely liked Judy. As I got to know her, I realized that her initial goth appearance was but one of many that Judy possessed. Judy, as I soon found out, was an artist. She expressed this artistic ability in virtually every area of her life. Some weeks Judy came in with her hair up, skin-tight jeans, a rock group T-shirt, and sandals. The next session she might have her hair straightened and wear a severe minishirt with fishnet stockings and high heels. The next week, she might be dressed as a spinster librarian in a frumpy floor-length skirt, an antique blouse, and more traditional hairstyle. Although her physical look changed with the wind, her personal style of interaction was always consistent and reliable.

Judy was also into a variety of artistic endeavors in her life. She painted in a wide range of mediums—oils, pastels, watercolors, and so on. She also sculpted and did a great deal of work with photography. Judy enjoyed taking pictures of animals, landscapes, human interactions. She also wrote very symbolic and intensely emotional poetry about human relationships. I came to know this awkward Judy as someone who possessed great depth and yet felt misunderstood and isolated in life.

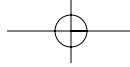


The awkwardness that I continued to experience with Judy was extremely troubling. I truly cared about Judy, enjoyed seeing her, and wanted desperately to help her feel better about her life. While I saw her I continually searched my own working model of self in order to ascertain how my own issues were contributing and/or interfering with Judy's therapy. I recognized almost immediately that the emotional identity struggle that she was obviously going through was in some ways similar to my own. Many sensitive adolescents (myself included) feel a sense of isolation and loneliness in their search for self. I too had very deep thoughts about people, relationships, life, sex, spirituality, and so on. The difference was in my ability to stay a bit more connected to people through mainstream activities and conversation. I did not suffer from the same type of emotional and verbal awkwardness as Judy did. Judy seemed so obviously handcuffed by her verbal ability. And yet it wasn't that she did not have a very wide vocabulary or social sense. Judy's difficulty seemed to lie in her inability to put her complete complex emotional ideas into the correct words for her. It was almost as if language as she knew it was not sufficient to capture the full meaning of her experience. I realized that my task was to help her find a way to do just that.

There were many different ways in which I tried (and eventually succeeded) in helping Judy feel better about herself. One of the ways was to share some of my own experiences with emotional confusion in response to the confusion that Judy seemed to be expressing in her conversations in session. When Judy seemed to stumble in her ability to express a complete sense of her experience about something in her life, I would help her piece it together. I might share how that particular incident seemed reminiscent of something I had gone through in high school with friends, parents, or teachers. I would attempt to convey the complexities of emotion that I had experienced back then and how troublesome they had been for me. I would also share how isolated and alone that type of thinking could make one feel. I was attempting to form a *twinsip* experience with Judy. I wanted her to realize that although she might not feel able to communicate her exact emotions regarding a particular experience, I could relate to it. I perhaps had had a similar experience.

CASE DISCUSSION

This use of self eventually helped Judy not only to feel a greater sense of connectedness with another (me) but also to develop the ability to communicate it to others. One might say that it was a form of attunement or, from a neuroscience standpoint, that Judy was developing new neural networks that enabled her to transmit her thoughts and feelings in clearer language. Language, after all, comes from successful completion of early attachment with primary caretakers. Even though our conversations were always focused on day-to-day events, relationships, artistic endeavors, and so on, we were building a new relationship in which Judy could better define herself and feel



more competent in life. The intensely relational and intersubjective nature of our therapeutic relationship is what was so helpful to Judy in the end.

There were many more elements and aspects to this interesting and multifaceted case. I saw Judy for several years. She graduated from high school and went on to major in photography at a nearby liberal arts university. She has become much more confident in herself and knows that her perceptions of the world and others are a true strength in life. She has also been able to find happiness in a series of romantic relationships at college. I still see Judy from time to time. Our sessions focus on some of the same issues that she brought the first time we met. The difference is that Judy now has found those elements to be a welcome part of her identity. Our work together enabled her to recognize that unique strength.

BASIS OF PRACTICE

The use of self that stems from transference/countertransference theory incorporates elements from all four of the areas of research knowledge discussed in this text; intuitive knowledge, practice wisdom, theoretical knowledge, and validated knowledge. All clinicians should now know through the advances in attachment research and neuroscience that intuitive notions about the importance of the therapeutic relationship are valid (Cozolino, 2002; *PDM*, 2006). The specific elements of the transference/countertransference process within the therapeutic relationship have been studied for decades (Luborsky et al., 1988). The use of self has also been one of my primary interests throughout my professional career, including my own dissertation work (McKenzie, 1995, 1999). However, the concepts remain elusive owing to the difficulty of operationalizing them for valid and accurate measurement. For example, most of the clinician's countertransference is by definition unconscious, which means she cannot validate it until at least sometime after the process has occurred. This makes the validation process complex. The clinical validation method discussed above comes very close to remedying that difficulty, however, because it incorporates all four elements of research knowledge in a very practical manner in the here and now.

SUMMARY

This case although complex and certainly not typical demonstrates the ways in which the clinician can use himself in not only understanding but intervening with teenagers. The therapy relationship is truly intersubjective. In order to help many adolescents search for their identity, the skilled clinician must draw upon his own inner experiences and empathically identify with them. This technique will be different with each client that one sees in practice. Some work will be much more concrete and goal directed. Other work will be much more emotional and inner directed, like the work with Judy mentioned above. What is important to remember is that adolescents are

searching for their own sense of self and identity. That process is different for each teenager. The astute clinician's ability to allow himself to vicariously identify with the adolescent's inner and outer experiences is the key to the development of a successful therapeutic relationship. In addition, the carefully timed and selected use of self can be of tremendous help in forming a twinship relationship that fosters the healthy development of identity (Racker, 1968; Tansey & Burke, 1989).

RECOMMENDED RESOURCES

Readings

- Mark A. Hubble, Barry L. Duncan, & Scott D. Miller, *The Heart and Soul of Change: What Works in Psychotherapy* (Washington, DC: American Psychological Association, 1999). This book does an excellent job of comprehensively examining the literature related to the success of the therapeutic relationship.
- Fred R. McKenzie, "The Clinical Validation Method: Use of Self in the Therapeutic Relationship," paper and conference publication presented at the International Conference for the Advancement of Private Practice of Clinical Social Work, Charleston, SC, June 1999. This paper, published in the proceedings, examines the history of the countertransference literature, as well as highlights Heinrich Racker's technique in light of contemporary practice.
- Sheila McNamee & Kenneth Gergen, eds., *Therapy as Social Construction* (Newbury Park, CA: Sage, 2002). This book examines the therapeutic relationship from a postmodern perspective.
- Carl R. Rogers, *On Becoming a Person* (Boston: Houghton Mifflin, 1961). This classic work examines the therapeutic relationship and the importance of empathy as part of the curative process.
- Harold F. Searles, *Countertransference* (New York: International Universities Press, 1979). This is a collection of works by Searles, who is known for his clinical and developmental insight as well as the candid and powerful ways in which he is able to share this knowledge with the reader.
- R. D. Stolorow, "Subjectivity and Self Psychology: A Personal Odyssey," in A. Goldberg, ed., *New Therapeutic Visions: Progress in Self Psychology*, vol. 8, pp. 241–250 (Hillsdale, NJ: Analytic Press, 1992). This is an important article on the subjective aspects of self psychology in clinical practice.
- Michael J. Tansey & Walter F. Burke, *Understanding Countertransference: From Projective Identification to Empathy* (Hillsdale, NJ: Analytic Press, 1989). This is a comprehensive text on the countertransference phenomenon.

Film/Television/Media

- Good Will Hunting* (1997). A wonderful depiction of the complexity and mutual contribution to the therapeutic relationship.