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Between a Tabula Rasa and the Transparent Self: The "Therapist's Use of Self" Revisited

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> A blessing is not something that one person gives another. A blessing is a moment of meeting, a certain kind of relationship in which both people involved remember and acknowledge their true nature and worth, and strengthen what is whole in one another. By making a place for wholeness within our relationships, we offer others the opportunity to be whole without shame and become a place of refuge from everything in them and around them that is not genuine. We enable people to remember who they are.
>
> —Rachel Naomi Remen, M.D.,
> *My Grandfather's Blessings*

I have recently been quite shaken by my experiences with two patients. In both these relationships, I followed what has become standard practice for me, that is to reformulate the therapeutic structure anew with each patient, to be as responsive as possible to the unique needs of each patient. Accordingly, I varied from the traditional framework of psychotherapy in the ways in which I endeavored to make myself available to these patients, during the therapeutic hour and outside of sessions. While this seemed to be initially very helpful, at some point both of these patients appeared to have largely lost sight of the distinction between the literal and the symbolic. What they came to want from me, and even demand from me, is that I *be* the person for them that they experienced themselves as needing me to be. I have felt frightened by the intensity of their needs, inadequate to the task, and came to believe that I had betrayed them by suggesting somehow that I could provide such a thing, and then failing to do so. I worried that colleagues would be critical of me for being so neglectful as to allow things to progress to such a mutually torturous place.

This is not the first time that I have come to question the concept of the "therapist's use of self." This concept has become one of the most readily

identifiable features of an experiential approach to psychotherapy. Earl Brown provided what is perhaps the most succinct summation of experiential psychotherapy, and it places the emphasis clearly on the therapist's use of self. "What is apt to be impactful with someone, is someone else being themselves with you, which then encourages you to be yourself with them" (Brown, personal communication, 1990).

Over the years, it has seemed to me that the "use of self" has come to mean tacit permission for the therapist to say or do anything that came to mind, without a consideration of the context of the therapeutic relationship. My worst fears were realized when I attended a workshop given by Carl Whitaker, who was his usual provocative self. As I was leaving, I overheard a therapist enthusiastically proclaim, "That was incredible! I can't wait to get back to my office and try some of those lines on my patients!" The concept of the therapist's "use of self" has come to imply a veneration of the unconscious of almost religious proportions, a belief that anything that surfaces from the unconscious of the therapist is necessarily therapeutic. Almost as if one could not simultaneously be conscious and authentic.

Freud strove to replace the unconscious mind with the conscious, and saw the unconscious as the seat of pathology. It is almost as if the "use of self" had become a reaction formation to the classical position of analytic neutrality. In the former, there is a veneration of the conscious mind and exiling of the unconscious as countertransference. In the latter, there is an extolling of the unconscious and a disregard of the value of the conscious mind.

For the past 15 years I have been seeking to understand a balance between these two positions, between the tabula rasa and the transparent self. Some of the questions I continually ponder are whether authenticity is always spontaneous, or does it also include conscious choices? Does authenticity on the part of the therapist imply the absence of a therapeutic role, or can one be authentic within a role? These questions are beyond the scope of this article, and undoubtedly beyond the scope of my lifetime. What I would like to do here is to return to the starting place, to our "roots" if you will, to see how the early writings in experiential psychotherapy might inform these questions.

I was surprised when I went back to the original text in experiential psychotherapy, *The Roots of Psychotherapy*, written by Carl Whitaker and Tom Malone in 1953, and found that the phrase "therapist's use of self" was not yet used. (Although the book is co-authored by Whitaker and Malone, I think it is fair to say that it well represents the collective wisdom of the entire group of early experiential pioneers, including Dick Felder, John Warkentin, Nan Johnson, William and Ellen Kiser and Rives Chalmers.) This should not be surprising, as the phrase "experiential psychotherapy" itself is not used by the authors to describe their work until 1962 (Brown, 1982).

The concept of the therapist participating as a person in the therapeutic relationship has currently penetrated even some of the most conservative theoretical

bastions of our field, including psychoanalytic and behavioral approaches. However, in the early 1950s, when *The Roots of Psychotherapy* was published, classical Freudian analysis was by far the predominant approach. The value of analytic objectivity and neutrality was taken for granted. Whitaker and Malone (1953/1981) suggested that this dogmatic adherence to objectivity was the result of the extent to which the early analysts became personally involved with their analysands. "Certainly, a schizophrenic withdrawal is the most universal mechanism for adapting oneself to the anxieties elicited when one is precipitated into deeply symbolic human relationships" (p. 170).

In this climate, to suggest that the therapist must be involved as a whole person in the relationship, with not just analytic cognition but with a full range of affect, was ground-breaking and courageous. Whitaker and Malone (1953/1981) suggest a relationship with the patient that is neither objective nor impersonal. "Beyond his professional involvement, the therapist also participates personally in this relationship with all the affect and personal feeling that he would ordinarily have in a comparable interpersonal relationship of a nonprofessional character" (p. 119).

Analytic theorists are particularly cautious about the inclusion of the analyst's affective or unconscious experience, seeing those as countertransference and impediments to the treatment. The originators of an experiential approach to psychotherapy were very clear that they were advocating the involvement of the therapist at every level, from the cognitive to the affective, the conscious to the unconscious, the rational to the nonrational. The inclusion of the unconscious dynamics of the therapist is particularly valued, to the extent that they are understood as an essential element of any effective psychotherapy. "The relationship of the unconscious of the therapist to the unconscious of the patient underlies any therapy" (Whitaker & Malone, 1953/1981, p. 65).

Whitaker and Malone (1953/1981) were equally outspoken concerning the emotional involvement of the therapist with the patient.

> The very process of therapy has its foundations in the duality of the affective participation of both individuals. Without the affective participation of the therapist, therapy is not possible. This participation goes beyond simple empathy with the patient's feelings, goes beyond a vicarious experience of feeling in response to the patient's feelings and, when analyzed, appears as a rapid alternation in feeling in both participants, each responding to the other with different feelings, the totality of which moves the process of therapy along toward its conclusion. (p. 120)

In contrast to the belief in classical analytic psychotherapy that the therapist is responsible for withholding unanalyzed countertransference experience from the patient, Whitaker and Malone (1953/1981) differentiate between substantial countertransference experience which the therapist has not resolved that would be detrimental to the therapy, and what they call "slivers," or "areas of minor transference difficulties that are not worked through" (p. 151). They refer to the "patient-vectors" and the "therapist-vectors" that are always present in both patient and therapist. In any effective psychotherapy, the therapist is primarily

in her therapist-vector, and the patient is mostly able to make available his patient-vector to the relationship. As in more traditional approaches to psychotherapy, the authors understand the patient-vectors of the therapist as potential impediments to the therapeutic work. However, the authors make a radical departure in their belief that the therapist's capacity to also bring her patient-vectors to the relationship is a critical and necessary ingredient for successful psychotherapy. "Were the therapist free of all patient-vectors, he would be no therapist at all" (p. 165). The therapist-vectors of the patient assist the therapist in working through these issues. "The most obvious person who can be involved, and can help the therapist to break up the patient-vectors in himself, is the patient" (p. 178).

Whitaker and Malone (1953/1981) believe that this process is helpful to the patient "probably because the relationship is thereby bilateral" (p. 165). I understand this in the same way that parenting a child can help to resolve unfinished issues from one's own family of origin. Whitaker and Malone (1953/1981) believe that getting the patient's help in working through these "slivers" is primarily helpful to the therapist and provides the primary motivation for being a psychotherapist. Thus, the genesis of Whitaker's statement to a patient, "I'm here for me. If you can get anything out of it, so much the better" (personal communication). They speculate that the decreasing interest in their work that some senior therapists experience toward the end of their careers is the result of having resolved the majority of these "slivers" and having less interest in what new patients might have to offer.

When the therapist is unable to bring these patient-vectors to the relationship, the result is a therapeutic impasse. The authors suggest that "impasses in therapy may be resolved by bringing to the patient our feeling of responsibility for the current failure of the therapeutic process and our acceptance of the fact that the therapist has patient-vectors" (Whitaker & Malone, 1953/1981, p. 164). They go further to suggest that resistance in the patient is "derived from his recognition of the therapist's inadequacies" (p. 7) and that the resistance can be resolved by the "more or less complete personal involvement of the therapist and from his readiness to give to the patient that which is more than implicit in his professional role. We would even suggest that the ideal therapist would encounter no resistance whatsoever" (p. 76).

The authors' bold conclusion is that "the pathology of the therapeutic process is determined primarily by the pathology of the intra-psychic functioning of the therapist, i.e., the 'person' of the therapist" (Whitaker & Malone, 1953/1981, p. 162). They believe that it is the therapist, not the patient, that sets the limits on the depths of the psychological work that will take place in the therapy. They believe that statements such as "the patient just wasn't ready" or "the patient was too resistant" are misdirected. "Theoretically then, any patient who has a therapist adequate to his needs will get well by virtue of the intra-psychic dynamics of the patient himself" (p. 162).

All of this seems like quite a daunting task for the therapist. Any signs of resistance in the patient or any area in which the patient is not progressing are

both taken as indications of the therapist's inadequacies. It might seem that the early experiential therapists were demanding a perfection from therapists that none could achieve. However, what they are suggesting is more akin to Winnicott's concept of "good enough mothering." "The patient demands the total participation of the therapist, including even the latter's immaturities" (Whitaker & Malone, 1953/1981, p. 164). My understanding of this is that what the patient requires is not a fully actualized therapist, but a therapist who will model the process of actualizing, the process rather than the product. What is iatrogenic is when the patient becomes aware, consciously or unconsciously, that he does not have full access to all of the therapist's current capacities. Patients in psychotherapy, like children, can tolerate their experience of waiting for their therapist to grow up, but are more likely to feel wounded if the therapist withholds what the patient knows to be available.

While expounding powerfully on the theoretical value of the therapist's full participation in the therapeutic relationship, Whitaker and Malone (1953/1981) offer very little to the therapist in the way of guidelines for practice. It is not clear whether they fail to do so because the work of the early experiential group had not progressed to this level of specificity at the time of the publication of their first text, or whether it was a part of a larger reluctance to have their work codified in any way that would detract from its essence, which they believed to be essentially ineffable. Whitaker and Malone (1953/1981) do acknowledge that there are times when the therapist's unresolved issues are powerful enough to be countertransference rather than "slivers." They also make a helpful distinction between the therapist bringing in material from her life outside the therapeutic hour and the disclosure of experience generated in the here-and-now of the session. They suggest that therapist self-disclosure of real-life experience, outside therapeutic relationship, is always problematic.

> Frequently, a disturbance in the therapist's real-life situation is projected onto the therapeutic relationship and to the detriment of the patient. The therapist is essentially a participant in an isolated fantasy experience, and by making himself real to the patient, he impairs the possibility of greater depth in the fantastic relationship. (p. 169)

In an article published eight years later, in 1961, I find the first reference to conscious choice in the use of the self by the therapist. Four of the originators of experiential psychotherapy, Tom Malone, Carl Whitaker, John Warkentin and Dick Felder, in defining the therapist's role in the therapeutic relationship, state that "The therapist accepts his own dominant role and his medical responsibility, which means that he will set aside his personal anxieties and share only those related to the patient and the interview" (Malone et al., 1961, p. 214). Then, in 1967, Richard Felder published "The Use of the Self in Psychotherapy." In addition to using the phrase "use of the self" for the first time, Felder also provides more specific guidelines for the practicing therapist. He defines use of the self in psychotherapy as "to make available to the process any of the self

. . . available first to yourself and then, if you choose, to the patient." (Felder, p. 101). He also speaks to the issue of timing in the use of self.

> I find that today I am less likely to present my initial response(s) immediately at the start of the interview. . . . The advantage to me, the therapist, of this objectivity is the satisfaction of doing a better job and of enjoying my self-discipline. The advantage to the patient is that he finds support and confirmation rather than loss of his initiative. (p. 106)

In a later article this theme of conscious choice by the therapist seems even more developed.

> Self and other must interpenetrate for therapy to proceed, but they must remain distinct as two sources of energy and affect. In attending to the client in this way, the therapist immediately mediates his responses so as not to overload or seriously threaten the client. (Malone et al., 1982, p. 59)

From this review of the experiential literature it seems clear that there has been a significant shift in our understanding of the concept of the therapist's use of self.

> A frequent and dangerous misconception is that the way to be an experiential therapist is to operate entirely out of one's unconscious and simply report that experience, uncensored, to the patient. Nothing could be further from the truth. Whether the therapist reports her experience or not must be determined by her sense of the therapeutic relationship as it exists at any particular time. (Felder & Weiss, 1991, p. 32)

The originators of experiential psychotherapy did courageous, ground-breaking work 50 years ago, work for which they are too infrequently referenced and insufficiently credited. Their theoretical writings remained largely on the level of approach, and did not offer much to the practicing psychotherapist in the way of applied guidelines. This is likely attributable in part to the general reluctance of the group to be codified or considered a school of psychotherapy, and their general eschewing of technique or method in psychotherapy. It may also be that this is the aspect of experiential work that the originators did not have a chance to develop as fully. Regardless of their intent, the absence of clearly articulated guidelines has created a vacuum which has all too often been filled with therapists leading with their egos and own unmet needs, responding to the provocative statements of the experiential pioneers without an adequate grounding in the underlying philosophy and approach. Great harm is often done by those who imitate form without an understanding of substance.

I believe the need for such guidelines is more pressing than it has ever been. The inclusion of the person of the therapist is becoming more widespread across a wide range of theoretical approaches to psychotherapy, including behavioral, cognitive and feminist approaches. In addition, one of our rationales for neglecting

such theoretical work has been the unexamined belief that it is safer for the therapist to adopt a neutral or objective stance in the relationship, and more dangerous to include the person of the therapist. An important book by Dalenberg provides strong evidence that this is not the case (Dalenberg, 2000). For example, our clinical theories are built on the unexamined assumption that errors of intrusion by the therapist (offering advice, physical contact without full processing) are more harmful in psychotherapy than errors of distancing (refusing all self-disclosure). As a result, our clinical training programs and codes of ethics are all based on minimizing errors of intrusion, and largely neglect the issue of errors of distancing by the therapist. However, Dalenberg's research suggests that errors of distancing by the therapist are responsible for the majority of therapeutic failures, and that errors of intrusion are more easily tolerated by the patient and processed within the ongoing patient-therapist relationship. Of the patients who reported a satisfactory experience in their psychotherapy, 90% said that their therapists were more likely to make an intrusive error than an error of distancing. This research replicates consistent findings that the primary predictor of negative outcomes in psychotherapy is the patient experiencing the therapist as cold, bored or failing to understand.

It has been said that if you approach a Rabbi with an important question you will receive not an answer, but several questions and a reading list in return. I am not in a place in my career or life where I am prepared to offer answers, but I can propose some questions and guidelines for further inquiry that may be helpful.

Research on the therapist's participation in the therapeutic relationship has all too often been reduced to a study of the observable therapist behavior of self-disclosure. It is important to recognize that the therapist's experience is often communicated to the patient in many other ways that are lost if we limit our inquiry to verbal self-disclosure. These may be more difficult to study, but we have every reason to believe that they are at least as important. What is the impact on the therapeutic relationship when the therapist indwells her own experience without verbally disclosing it, and how does that compare to the impact of the therapist making her experience overtly known?

It is also important to distinguish between therapists making historical disclosure (I am in recovery) and the therapist sharing her experience in the moment (I am feeling uncomfortable). Is the disclosure of in-the-moment experience more helpful than historical disclosure? Is historical disclosure potentially more problematic? Are there times when historical disclosure is helpful, and if so, under what circumstances?

Should the therapist's use of self always be conscious, or is it sometimes helpful for the therapist to bring aspects of herself to the relationship without a conscious awareness of what the impact on the patient might be? Is the use of self necessarily spontaneous, arising in the moment, or can it be done with intention? If the therapist is to bring aspects of her unconscious to the relationship, what safeguards are there that this will not be a narcissistic indulgence on the

part of the therapist or even harmful to the patient? Would the most narcissistic therapists be those least likely to ask these kinds of questions? Does asking these questions provide any kind of safeguard for our patients?

Are all aspects of the therapist's experience equally therapeutic? Is anger as helpful as pride or joy? Are there some aspects of the therapist's experience that are potentially more problematic, such as anger or sexual feelings? Does the therapist have a responsibility to be more cautious in these areas, particularly given the power dynamics of the relationship?

Is the use of self appropriate for all patients at all times, for all patients at some times, or for some patients at some times? Are the criteria for these decisions based primarily on the experience of the patient, the experience of the therapist, or some combinations of the two?

How are we to evaluate the effectiveness of instances of the therapist's use of self? The most obvious answer is to ask the patient, but the patient may not be able to describe or even fully know his answer, given the often powerful transferential response to such interactions.

Whitaker and Malone initially suggest that the therapist-vectors of the patient must be able to heal the patient-vectors of the therapist. In other writings the group articulates what seems to be a different position, suggesting that the therapist is responsible for her own issues. It seems clear that it is impossible for any therapist to keep all of her patient-vectors out of the relationship. The question then becomes how they should they be handled? Should the therapist process these patient-vectors with the patient, or is she responsible for processing them outside of the therapeutic relationship? If they are first processed outside of the therapeutic relationship is it then helpful to bring them to that relationship? Does the patient share responsibility for resolving these patient-vectors of the therapist, or does the responsibility lie with the therapist alone?

I would like to close with an important point about language. I have suggested that our colloquial usage of the phrase "therapist's use of self" has become quite different from the meaning intended by the originators of experiential psychotherapy. I would like to further suggest that the phrase itself is misleading, which may be why it is not the phrase that was originally used by the group. The phrase "use of self" implies a unilateral concept, with an acontextual focus on the dynamics of the therapist. Given the tenor of the times, a strong emphasis on objectivity and denigration of the subjective, it was a bold and courageous step to emphasize the inclusion of the person of the therapist. In today's climate, with a greater acceptance of the value of the person of the therapist, the phrase "use of self" has become limiting, even misleading.

A group of feminist developmental theorists at the Stone Center have been using the term "mutuality" to describe the nature of relatedness that experiential therapists first described 50 years ago (Jordan et al., 1991). They defined mutuality as "an openness to change and growth in both people, mutual trust and respect, an openness to being touched/moved by the experience with another." They describe mutuality as the capacity to attend to one's own experience as well as

the experience of the other, the capacity to join and separate, to be objective and subjective. In mutuality there are moments when the distinction between self and other diminishes or even disappears, and moments when it is more pronounced. A relationship of mutuality requires the capacity for boundaries that are neither too rigid, which would prevent an understanding of the other, nor too loose, which would lead to a sense of merger and experiencing the other as a narcissistic extension of yourself (Jordan et al., 1991).

I believe that this concept of mutuality captures well what the originators of experiential psychotherapy meant in discussing the therapist's participation in the therapeutic relationship. The term ''mutuality'' has the advantage of being free from misconceptions that have become attached to the phrase ''the use of self.'' Mutuality is a term that clearly communicates the relational nature of the therapeutic relationship that was intended by the originators of experiential psychotherapy. As we approach 50 years after the publication of *The Roots of Psychotherapy*, I believe that using ''mutuality'' rather than ''the therapist's use of self'' will bring us back closer to the original intent, and help us deepen our understanding of the complex nature of the therapist's participation in the therapeutic relationship.

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