Self-disclosure And Analytic Space—some Issues Raised By Jay Greenberg's Paper On Self-disclosure

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DR. GREENBERG CITES Freud's objections to the analyst making direct self-disclosures to his patients, and these arguments concerning the possible ways in which direct self-disclosure might disadvantage the patient are indeed plausible. But Freud led the way for other analysts to continue for too many years to be either, at best, uninterested in, or, at worst, oblivious to the actual impact that they might be having on their patients. As Ferenczi (1933) pointed out, in ignoring or otherwise invalidating his patient's experience of the analyst's negative impact, the analyst may be likely to inflict on his patient an unwitting traumatic repetition of the kind of mystification that the patient grew up with in his family of origin.

Freud was more interested in forcibly overcoming his patient's resistances to accepting his idea of the truth than in any possible negative impact that his interpretative activity might have been having on them. Freud's need to be right eclipsed any awareness of the ways in which his conduct of the analytic interaction might disempower his patients to the point of keeping them stuck in their neurosis.

This was evident in Freud's treatment of Dora. He had little appreciation for the possible destructive impact of his own countertransference on Dora, blaming her willfulness for the failure of the treatment, and never understanding any of the unwitting ways in which he was repeating with her the abusive, exploitative acts of the other adults in her life.

Notwithstanding the fact that his essay "Analysis Terminable and Interminable" ranks among his major contributions, it is worth noting that the impetus for writing it rose from his need to justify himself vis-à-vis Ferenczi's complaints and grievances about the shortcomings of his analysis with Freud.

Perhaps beginning with Ferenczi, analysts of the interpersonal school increasingly have come to understand the analytic interaction to be one

of mutual influence and to understand that one of the main tasks of the analyst is to internally process the feelings induced by the patient so as to minimize their potential negative consequences for the treatment and enable the patient to process the unwitting impact that both the analyst and his method might be having on him.

It has been noted by Edgar Levenson that for analysts of the interpersonal school the demystification of experience has taken precedence over the detoxification of fantasy (Levenson, 1982, p. 365).

The question is, what in any given analytic interaction might be the impact of the analyst's direct self-disclosure on processes of mystification and demystification?

Regarding the issue of direct self-disclosure, I agree with Dr. Greenberg that it is not particularly useful to attempt to come up with any sweeping statements and that our task requires us to come to grips with an endless flow of decisions each in the context of a particular moment of a given patient—therapist relationship. We can only evaluate the negative or positive impact of a given instance of self-disclosure by closely tracking its consequences for the treatment.

For reasons that I hope to make clear as I develop this discussion, I tend to be cautious about making direct self-disclosures to my patients.

In the case of Mr. C., Dr. Greenberg illuminates how much therapeutic leverage was gained when he heeded his misgivings about directly answering Mr. C.'s question about whether Dr. Greenberg had received his message about the absent check. Dr. Greenberg, by his silence, refused Mr. C.'s invitation to enter into a collusion to continue to deprive the analytic interaction of its emotional authenticity. His silence made it possible for Mr. C.'s aggression to make a more direct
entry into the analysis and made it possible, as well, to resolve Mr. C.'s resistances to the transference, bringing his conflicts vis-à-vis his analysis and his analyst into the open.

In regard to Dr. Greenberg's example of the analyst who thinks that she should, in the interest of the analysis, authenticate the patient's speculation that she was both excited and anxious about her recent publication, Dr. Greenberg raises the question, what might such an admission conceal? He then goes on to discuss a number of possibilities.

By being given this information the patient is actually being deprived of the opportunity to expose what the analyst might be concealing. It would have been in no way inauthentic for the analyst to say in response to the patient's question, "Is it true?"—"What comes to mind if it is true?"—thereby inviting the patient to contact the widest range of possible thoughts and feelings that she might have about her analyst's subjectivity. A direct answer aborts this process.

I would like to build on Dr. Greenberg's discussion of the complexities of the issue of the analyst's self-disclosure by relating some of my own experiences, both as an analyst and as a patient.

One of the most interesting and engaging patients I have worked with made the issue of my admitting or not admitting my true feelings for her a central feature of the analysis for several years. She correctly assessed my feelings for her to be positive and was very insistent that I admit the truth about this. She presented emotionally convincing arguments that a neutral stance, however analytically correct I might think it to be, was therapeutically wrong for her.

I felt pressured by what my patient was convinced was an authentic therapeutic need. However, I did not feel manipulated, as I have felt in response to other patients who have made similar demands, and while I was mindful of Balint's caution about inducing a malignant regression by being too gratifying to a patient (Balint, 1968) it did not feel right to me to "stonewall" her.

I became comfortable in dealing with the pressure of her demands when I decided that I did not have to tell her as much as she wanted to know, but only as much as would leave me feeling intact as her analyst. What I gave was not enough for my patient, leaving her feeling frustrated and angry at my refusal, as she understood it, to give up my position of male dominance in favor of a more equal relationship.

In retrospect I think we both profited from our engagement in this difficult interaction: myself, in that I discovered that I could comfortably maintain my boundaries and my analytic stance without having to take rigid positions; and my patient, because she actually became increasingly empowered vis-à-vis the persecutory and oppressive objects in both her internal and external object worlds.

Our struggle ended to make way for the next phase of the transference, in which I lost my luster as the object of need and desire and served instead as the object who fails and disappoints.

Dr. Greenberg points out that "even in moments when we are telling our patients about ourselves we are, consciously or unconsciously, deciding what not to say." We may be unwittingly engaged, in other words, in a subtle process of mystifying the patient. By telling him even what he wants to know about us, we may be limiting his possibilities for imagining or even perceiving what he may not want to know about us, and thereby limiting his possibilities for thinking and imagining or actually recognizing the worst about us, and this may suit us better than we might like to believe.

I might have unwittingly inflicted something like this on a patient in the vignette I am about to relate, were it not for her sensitivity to my therapeutic errors and were it not for her determination to preserve the integrity of her analysis.

From time to time this patient would spontaneously put a direct question to me. Typically I would respond by asking, "What makes you ask?" Occasionally I would lapse and answer her question directly. In the aftermath of a session in which I did this she would suffer somatic symptoms usually accompanied by a depressive mood swing.

The actual question and answer might seem to be inconsequential, even innocuous. It was the lapse that mattered. I remember one session in which she stopped talking about what she had been discussing and asked, "Don't you find what I have been talking about to be dreadfully boring?" I remember being somewhat taken by surprise. I had been listening to what she was saying with considerable interest, and I answered, "Not that I know of."

My patient's symptomatic and depressive reactions would typically clear up when she connected them to the realization that she experienced my answering her directly as hurtful. She assimilated such responses into the core of her self as an uncaring, even abusive act, signifying, in her own words, "an abandonment of the analysis," and the possibility, as well, that I could not be depended on to keep appropriate boundaries. The prospect of this was terrifying for her, given how damaging her parents' failures were in this regard. Such lapses might also raise the frightening thought that I might be
planning my retirement. She thought the likely immediate precipitating cause of such a lapse was some intense anger that I
did not know I felt toward her.

While I experienced my patient's negative attributions to me as both emotionally disagreeable and upsetting, because I
subscribe fully to the understanding—as put by Dr. Greenberg—that I am not privileged to know everything I think and
feel, I was not inclined to argue, even internally, with my patient's view of things. I might have only taken silent issue with
her idea that I might be planning my retirement.

That my giving her a direct answer was a breach of the treatment frame

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that I had established with her was unarguable, and both her assimilation of this lapse as an abandonment of the analysis
and its traumatic impact on her made sense to me—apart from whatever I understood my conscious intentions toward her
to have been.

Regarding the anger she imputed to me, I was usually unable to contact it, but when I asked for her ideas about why I
might be angry with her she usually came up with very plausible possibilities, such as that I might have reached, without
having realized it, the limits of my tolerance for being faulted by her.

Eventually when she would spontaneously ask me a direct question, she learned to protect herself from the danger that
I might give her a direct answer by immediately admonishing me, "Don't answer that!" And eventually she cured me of
such lapses to the point that she could depend on my remembering to control my impulse to answer her directly and to ask
instead, "Should I answer you?"

I want to discuss now a problem that can arise when the analyst makes self-disclosures to the patient with the idea that
it is important to inform him of his interpersonal impact. The problem here is in the possibility of engaging the patient's
cooperation on a false-self basis. In this regard, I hope I will be appropriately self-disclosing in relating an experience that I
had in analysis prior to my becoming a candidate at the White Institute.

I had been in this analysis for about three years, and I was applying for admission to the White Institute for
psychoanalytic training. My analyst was a training analyst at another institute to which it did not make sense for me to
apply because its time requirements were practically impossible for me to meet. The White Institute, in any case, was the
institute of my choice. During one session, I was discussing some of my concerns about my upcoming admission
interviews, oblivious of any impact that I might be having on my analyst and oblivious of the implications for my current
analysis should I be accepted for training at the White Institute.

My analyst elected to tell me that I made her feel disregarded and perhaps even held in contempt. The impact on me
was powerful. I was stunned. I liked my analyst and I felt that she liked me and truly cared about me. I immediately
understood that she was confronting me with my insensitivity to my interpersonal impact. My self-centeredness in this
regard was not news to me. I remember thinking appreciative thoughts something like, "this was a good intervention for
me." On another level, I felt very bad about myself and very guilty toward my analyst for having

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slighted her in the way that I did. However, I only expressed my positive understanding of what she intended, I did not tell
her of my bad feelings. I think I understood that I deserved these bad feelings as a just punishment for having been so
insensitive. I dealt with my guilt by managing to delay the date of my leaving her to begin working with my White Institute
training analyst.

The impact of my analyst's self-disclosure was to engage me in making false-self adaptations to her need to have her
feelings taken account of by me. I do not doubt that the contempt I made my analyst feel was truly mine, but it was
dissociated and remained so for years to come. This intervention did nothing to facilitate its entry into the analytic
relationship. I do not mean to make the argument here that the intervention, in and of itself, was necessarily wrong. The
negative impact that this instance of self-disclosure had on me could have been turned to good therapeutic effect had my
analyst been interested in enabling me to put into words all my thoughts and feelings in response to her intervention and
had she been interested in discovering its possible destructive consequences.

My contempt did not show up in my analysis until I worked with an analyst who was much less inclined to making
direct self-disclosures and much more inclined to investigating my thoughts, feelings, and theories about him.

In one session I got up the courage to tell him about some negative thoughts and feelings that had lately been making a
rather unwelcome intrusion into my awareness. I said something like the following: "This is difficult for me to say to you,
but lately I have been having some rather uncomplimentary thoughts and feelings about you." He asked, "What
uncomplimentary thoughts and feelings are you referring to?" I said, "More often than not, I have been finding many of the
things that you have been saying to be banal and predictable, and I have been feeling somewhat contemptuous. I really hate
having to tell you this." He responded as follows, "What is your objection to telling an inferior guy what you really think of
him?" With this matter-of-fact reception, my contemptuous side was given free entry into my analysis.
In conclusion I want to comment on Ferenczi's recommendation of the analyst's full self-disclosure as necessary to safeguard the patient from becoming subjected to a traumatic repetition of being enjoined from seeing and speaking of the analyst's failings as he was enjoined from seeing and speaking of the failings of his parents. This is probably what Ferenczi thought he needed from Freud: for Freud to acknowledge and even to take the initiative in admitting his treatment errors.

I think Ferenczi was wrong in this regard. Ferenczi needed what all patients who have developed what Feiner has termed an "anti-self-system" (Feiner, 1993, pp. 462–465) prove to need in analysis. The anti-self-system is a response to their early caregivers' repeated failures to accept and tolerate the bad feelings that necessarily issue from being in any way faulted as parents.

The anti-self-system is a deeply entrenched structure that will give way in analysis only to the extent that we enable a given patient to revivify, vis-à-vis our treatment errors and failures of attunement, such feelings of hurt, disappointment, and anger as have been dissociated, dealt with by selective inattention, or turned against the self. In the process of allowing and enabling these patients to contact this sector or painful experience and put it into words, we shall be required to do what no previous caregiver has ever had the knowledge, the will, or the capability to do: We will be required to bear our own painful feelings in response to being demystified and de-idealized and in response to having our good intentions trashed. If we have succeeded in making our patient feel safe enough to be ruthlessly confrontative, should we challenge the accuracy of his perceptions and attributions or suggest that they might be based on transference, we are likely to be faulted further—for being more interested in defending ourselves and in making ourselves right than in respecting his reality.

Regarding direct self-disclosure, there is a problem in too early and too freely admitting our treatment errors rather than enabling our patients to discover them. In being too generously self-disclosing we might interfere with a given patient's transference need to place us in a position of what Winnicott termed "the object not protected" (Winnicott, 1969, p. 714) to the extent of demonizing us if necessary. Whatever there is in the way of distortion will usually fall of its own weight if investigated and left uninterpreted.

I do not believe that it serves the patient well in terms of facilitating the entry of his aggression into the analysis if we take too much initiative in demystifying ourselves in favor of establishing the optimal conditions for the patient to demystify us. If, as Dr. Greenberg has observed, the calmer atmosphere that follows a direct self-disclosure can itself be stifling, this is because one of the main risks of the analyst's self-disclosure is that it may close off rather than open up analytic space.

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