DO ASK, DO TELL?
Narcissistic Need as a Determinant of Analyst Self-Disclosure

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In its infancy, and certainly up to the middle of the last century and beyond, the psychoanalytic frame hinged on the assumption of a healthy analyst treating an ill patient. Two minds were engaged, but in the consulting room only one was deemed worthy of study. Countertransference problems, it was thought, would be mostly eliminated through one’s training analysis. To the extent that some countertransference reactions remained, they were viewed as reactive to the patient’s psychology and never to be acted upon or shared. In later years, induced and other countertransference responses were seen to provide valuable diagnostic information, but it was not until the mid-1980s and the beginning of the relational turn that this field of study would expand in any significant way.

Now, over the course of the past twenty years, psychoanalysis has been evolving from a one- to two-person psychology that examines not just the mind of the patient but that of the analyst as well (Mitchell, 1993). Intersubjectivity theory (Atwood & Stolorow, 1984) and its assumption that minds are by definition engaged in a constant cross-fertilization of mutual influence has brought us to the edge of a precipice. After trying for decades to comply but suddenly faced with the knowledge that Freud’s caution to withhold any evidence of our own personalities was

Earlier versions of this paper were presented at the 18th annual interdisciplinary conference of the International Federation for Psychoanalytic Education, Toronto, Canada, October 2007, and to the New York State Society for Clinical Social Workers, Metropolitan chapter, February 2008.
not in fact possible, we have been finding ourselves in exciting but often frightening and strange new territory. Freed of the illusory restrictions and limitations of absolute, blank-screen neutrality, we now hold on to a more flexible, less fixed frame. We also now know, that even without deliberate sharing, patients often know a great deal about us. Contemporary psychoanalytic theory has taught us that in certain situations, with certain patients and at certain moments, judicious use of self-disclosure may be indicated (Greenberg, 1995). For some of us, this perspective—newly granted “permission,” if you will—merely supports what already comes naturally. Others of us enter in to the option of self-disclosure more slowly, even reluctantly perhaps. As with any clinical technique, analyst temperament, personality, and style preference can and should influence whether or not one trends toward more or less selective disclosure. With this freedom to choose comes greater opportunity for efficacy, but also uncertainty, anxiety, and greater responsibility.

With the advent of relational and intersubjectivity theory, there is a growing body of literature on the technical considerations of self-disclosure (Aron, 1996; Bromberg; 2006; Renik, 2006). Also still innovative is an expanding discussion of the analyst’s personality and how this affects the treatment (Eigen, 2004). Sometimes these threads inform each other, and we have some quite excellent, usually first-person writing on countertransference and other personality factors that affect the decision to disclose, especially around enactments. Less prevalent though is an examination of the analyst’s “normal” narcissistic needs, issues, and self-regulatory functions that can either lead to ill-advised disclosures or inhibit sharing that might be needed.

DIFFICULT TERRAIN

Though growing, I suspect that the still relative paucity of literature on this topic may in part be explained by how uncomfortable it makes us feel. Long gone are the good old days of right and wrong, black-and-white thinking about theory and technique—when you either disclosed or, more likely, you did not. Until relatively recently only Sullivan (1953), the Interpersonalists who followed (Chrzanowski, 1986; Levenson, 1992), and a few inde-
pendent thinkers and iconoclasts (Eigen, 1992; Searles, 1959) could be called on for theoretical support. But in this newer, betwixt world of more frequent and differential use of self and selective transparency, we sometimes find ourselves missing and perhaps even longing for the clearer guidelines of analytic yesteryear. Uncertainty and the realities of practice in this grayer zone—especially with regard to our desire to be seen or to hide, and other personal needs that can no longer be ignored if we are to embrace contemporary theory—may make us anxious and even frustrated or irritable. Readers of earlier versions of this paper have reported feeling stimulated but at moments uncomfortable or distracted by having to think about or be reminded of some of these ideas. Among other feelings and thoughts, I have certainly experienced my own occasional discomfort in reflecting on and addressing these issues.

Self-disclosure involves a departure from the relative anonymity most psychoanalysts used to rely on. Lew Aron (1996) makes the point that people who are drawn to becoming psychoanalysts will by definition have conflicts around intimacy and the desire to be known by another. Aron posits that narcissistic conflicts around voyeurism and exhibitionism are the rule rather than the exception in our profession. Why else, he asks, would we choose a profession where we listen so intently to others while sitting silently and hidden? The fact that analysts are never really invisible—even if they try (Frank, 1997)—and that patients often want desperately to know us—raises tremendous anxiety for those of us struggling with our own longings to be known and defensive temptation to hide. It is my contention that it is often these (usually) dissociated, frequently shame-laden narcissistic issues—as much as and in some cases more than the stated technical considerations—that inform an analyst’s decision to disclose or decline to. Though we begin with a brief overview of some historical and more recent thinking about self-disclosure that will be more or less familiar depending on the reader’s exposure to relational theory, I leave a fuller discussion of the better known aspects of the analyst’s self-revelations to others (Aron, 1996; Bromberg, 2006; Farber, 2006; Wachtel, 2008; among many others). Following the overview, beginning in the section I call The Analyst’s Needs and for the remainder of the paper, I ex-
plore this less charted territory of the analyst’s mind: the narcissistic needs that affect self-disclosure. The theoretical portion of the paper incorporates some brief clinical vignettes and is followed by three case examples to illustrate these concepts.

LOOKING BACK, MOVING FORWARD

As early as 1912, Freud cautioned the analyst to beware of the intuitive wisdom that might suggest telling patients about ourselves as a way of forging a closer bond and model for their own disclosures. Such revelations, he cautioned, would only serve to inhibit the patient’s. Other than Ferenczi (1949), who many see as the forefather of relational theory, and, later on, Searles (1959), this remained the conventional, mostly unchallenged wisdom until the arrival of the Interpersonal school (Sullivan, 1953), the Intersubjectivists (Atwood & Stolorow, 1984) and the Relationalists (Mitchell, 1988; Mitchell & Aron, 1999). More recent writers from these schools (Aron, 2006; Maroda, 2005), while in many cases still adhering to Freud’s initial warning, also believe that judicious disclosure can and should be used as an option to resolve therapeutic impasses and reinforce the mutual if not symmetrical nature of the relationship as part of a more authentic, less hierarchical treatment. While some analysts still stick to the letter of Freudian law, others, like the formally quite classical Owen Renik (1999), believe that the analyst must always “play one’s cards face up in analysis” (p. 522). Stereotyped assumptions of relational theory aside, most Relationalists are of the more moderate opinion that it is an option that should be used only selectively (Aron, 2006; Bromberg, 2006; Maroda, 2005). This is the ethos that informs the following pages.

DO ASK, DO TELL?

I think for many of us, the first association to the term self-disclosure is whether or not to answer our patients’ questions about being married or having children. Of course religion and ethnic background (How many times I’ve heard on the way out the door, usually following an early session, “Kuchuck,” that’s an interesting name . . .) and where we live or went to school come
up a lot too, but biographical disclosure is just one area to consider. In the course of daily practice, we are faced with whether or not to share what we are thinking in sessions—in that way even an interpretation or observation is a form of disclosure as we reveal some aspect of ourselves based on what we choose to say or withhold. Not too long ago, in a group where patients were talking about how difficult their relationships were, I said something in response along the lines of “relationships are often hard work but one hopes that the good more often than not outweighs the bad—I understand it may not always go or feel that way.” Several members laughingly—and of course correctly—said they felt they had just learned something about my relationship—including the fact that I was in one. Whether or not to disclose affective responses, thoughts, or feelings about interactions in the room, whether or not you thought about a patient outside of a session—I read a book or saw a play you might be interested in—are all on the table and subject to the same theoretical deliberations. This paper focuses on these deliberate disclosures rather than the inadvertent ones like dress, office décor, running in to a patient on the street, and so on, and additional forms of revelation that may be beyond our conscious control.

Freud’s prohibition against disclosing bears repeating. Protecting a patient’s right not to know something about us—even if they ask, preserving the asymmetrical nature of a treatment where the focus remains on the patient’s psyche even though we may also be silently examining our own, providing enough psychic space for our clients to project and for the transference to expand unencumbered are all worthy goals. More current thinking also has its place. Of utmost importance, but without being burdened by it as they so often were in childhood, patients need evidence of our humanity; to see that in our own way we also struggle with imperfection and vulnerability, and sharing may be one way of conveying that. Introducing our own subjectivity to help patients become curious about themselves and in the interest of separation-individuation or, when timed properly, as a challenge to narcissistic defenses; providing insight into our thought process in ways patients might not have had the advantage of accessing with parents; disclosing as a way of reinforcing the mu-
tuality inherent in any good relationship and as a model for the patient to reflect, feel, and share; making space—where appropriate—for ourselves to feel more engaged and connected, can all—as per patient and moment in treatment, of course—be of great value.

There are additional, more recently highlighted imperatives to disclose supported by current research (Wallin, 2007). Our earliest and often most formative experiences occur before we have language. Findings from attachment theory, neuroscience, and infant studies support the fact that along with traumatic experiences of misattunement and other parental limitations or violations, these early, preverbal experiences are stored not as memories that can be retrieved through words but rather as unprocessed, unintegrated affects and bodily sensations. Much of the value of analysis then is not just in the verbal work but rather in the nonverbal experiences of therapy that occur via the analyst's physical and affective countertransference responses and in the enactments that patients and therapists unwittingly co-create. “That which we cannot verbalize, we tend to enact with others, to evoke in others, and/or to embody” (Wallin, 2007, p. 121). These enactments are often the analyst's only chance of accessing early and/or traumatic material crucial to understanding and helping our patients work through their preverbal or traumatic experiences. Not only are we missing vital information if enactments are not recognized and processed, but impasses and destructive repetitions are the rule rather than the exception in the case of unresolved enactments. Enactments can only be understood and worked through in dialogue with the patient. Often, we must lead the way by disclosing something of our experiences.

While many examples of this kind of disclosure come to mind, here I am thinking in particular of a patient with whom I felt ignored, shut out, and deadened. As a result, I found myself disengaged and at times resentful. Eventually suspecting that we were probably in the midst of an enactment and that I might be feeling something of her nonverbal experience, I decided to try to push through some of my feelings of guilt and slight embarrassment and share part of my experience with her. Though not previously expressed by her in words, this opened up an oppor-
tunity for my patient to identify these very same feeling states within herself, and to reflect on the fact that she felt frightened by the closeness of our contact and shut down and distanced from and resentful of me in ways she must have felt with her too-close, frightening mother. Hers was an early attachment experience coded before the acquisition of language. As a result of the enactment and disclosure, she came to recognize this way of being as a template for our and most of her relationships. This was an understanding that we might not have had the opportunity to come to had I not disclosed what I felt. In light of this newest research then, it is my contention that it becomes even more important to attempt to work through our resistances to and difficulties with selective, clinically indicated disclosures.

CONTEMPORARY PERSPECTIVES

Any disclosure involves some expression of conflict or feeling (Cooper, 1998). We might then assume that disclosures will often lead to, be prompted by, or be inhibited by feelings of vulnerability or other strong emotions. Different analysts will find the process more or less affectively charged, and some disclosures will be less likely to be as predicated on subjective fluctuations as others. However, as I will discuss later, it is not always possible to know the extent to which subjectivity plays a role in leading to or inhibiting a self-disclosure. Knight (2007) believes that in order to be available to our patients we must be able to selectively share feelings with them and even let them know at times that they have had an impact on us. She acknowledges that this can be quite frightening because being known can mean showing what had previously been hidden from patients and possibly oneself. She and others make the point that most patients want to know, impact, and transform the analyst as much as they hope to be similarly affected by the treatment (Maroda, 1999). Not just the patient but also the analyst fears surrendering to this process; surrender gets too easily confused with masochistic submission and loss of power (Ghent, 1990).

Vulnerability, anxiety, and ambivalence around the intimacy that can come of mutual sharing are frequent themes in the literature, and more than one author shares his or her reluctance
to give up the position of adored, idealized other as a result of disclosing affect or other material that reveals one’s humanity and imperfection (Davies, 2003; Gody, 1996; Silverman, 2006). As one of my long-time patients said with a mix of disappointment and relief in response to my disclosing something that made me seem more human and less idealizable, “Real people can’t protect and nourish you the way Superman can.” While recognizing the developmental importance of his observation, we both felt a sense of loss and sadness about having to relinquish the cape.

There are a number of quite moving accounts of analyst illness, absence, and other trauma. A central challenge in all of these situations is deciding how much or little to disclose and to whom, while still honestly and authentically maintaining the integrity of the patient’s psychic space and the clinician’s need for privacy (Gerson, 1996; Morrison, 1997; Pizer, 1997). One clinician eloquently describes the loneliness that set in during the time between realizing that she would have to close her practice of eighteen years and when she began to tell her patients (Sherby, 2005). Holding on to what feels to be a secret, even if clinically indicated at the time, took a toll on her and, in some cases, those she worked with. This experience became the basis for a larger exploration of the subjective aspects of self-disclosure that I think makes a rare and important contribution to this discussion.

If there is a consistent theme in the literature—and this is certainly borne out in my own observations and experience—it is that to a greater or lesser extent, some combination of narcissistic need, desire, disequilibrium, and vulnerability are almost always at play when we make or inhibit an otherwise clinically indicated self-disclosure. Because these quite normative narcissistic features can be uncomfortable or disconcerting—not to mention ego-dystonic and often unconscious, they are not always as readily understood or openly acknowledged and written about except in occasional, often brave, first-person accounts (Davies, 1994; Eigen, 2006; Searles, 1959). I believe that identifying and recognizing these narcissistic, self-regulatory needs is at least as central—and in some cases more so—to achieving a thorough understanding of the indications for and against judicious self-
disclosure than are the more commonly studied theoretical reasons for and against disclosing.

THE ANALYST’S NEEDS

As I hope is clear by now, when I mention the analyst’s narcissistic needs, I am referring to the everyday, inevitable “normal” experiences of need for connection, appreciation, respect from self and others, self-esteem, emotional balance, safety, and so on that all human beings—each in our way—strive for in work and other relationships. I am most definitely not referencing severe narcissistic pathology, which can lead to under- or overdisclosure, among a host of other problems (Finell, 1985). As has been pointed out, however, it is healthy and reasonable to expect that analysts will desire particular experiences with particular patients. Controversial as some still seem to find this, we can derive what many believe to be legitimate gratification of needs through providing psychoanalytic treatment (Maroda, 2005; Wilson, 2003).

We often love and are loved by our patients. I rarely see a clear distinction between transference love and so-called regular love and I have to wonder—how can love not affect narcissistic supplies and stir our narcissistic needs? Also of note in this discussion is the fact that the nature of the transference–countertransference continuum and the highs and lows of the work can wreak havoc upon even the most stable psyche. Who among us hasn’t felt himself or herself to be quite competent, insightful—perhaps even talented—in one moment or phase of a treatment or with a particular patient, only to find oneself feeling stuck, possibly impotent, and lost soon after or later that day with a different patient? Many of us have experienced some version of these feelings within the same session. Suffice it to say, if we are practicing psychoanalytically, we are engaged in some form of intimate relating and narcissistic needs are mutually stirred and present. Against the backdrop of our own and our patients’ personal histories, this is the fertile climate of affect and need in which disclosing, concealing, or some combination of the two takes shape.
NARCISSISTIC NEED AS A DETERMINANT OF DISCLOSURE

Lists can by definition be limited and limiting and tend to obscure the dialectical approach that contemporary psychoanalysis has offered us in lieu of having to choose between objectivism or, in a postclassical world, relativism. Still, I hope you find the following to be a useful way to begin to organize some thoughts about the relationship between what I am calling the analyst’s narcissistic, self-regulatory needs and the tendency to disclose or refrain from disclosing. As mentioned, it is some combination of these factors that I believe more often than not enters into the analyst’s internal struggle around whether or not to disclose. Theory and technique take on a more or less dominant position in relation to these needs depending on personal and professional factors, patient and dyadic characteristics, moment in treatment, and so on. Readers might identify different or additional factors; such is the varied and complex nature of subjectivity that this cannot be an exhaustive list. Also, you may notice that in many cases these items are actually reversible. It is often, though not always, the same intrapsychic and/or interpersonal dynamics that lead to disclosures and withholdings. A further cautionary note: Ultimately, we cannot always know when our disclosures or decisions not to disclose—or any of our interventions, for that matter—are motivated by theoretical considerations, narcissistic needs and dynamics, or some combination of these and other factors. As Frank (2005), states, the personal and the technical are inseparable. I therefore offer the following list and, in a larger sense, the paper’s overall thesis as descriptive rather than prescriptive or proscriptive, and I assume that we often do our clearest thinking about self-disclosure and other interventions from that third space that arises as a result of the dialectic between theoretical and affective.

Narcissistic Self-Regulatory Reasons Analysts Do Disclose

1. Wish or need\(^1\) to brag or show off
2. Wish or need to talk about ourselves rather than more passive listening
3. Loneliness, isolation, or fatigue
4. Need for mirroring, approval, and/or love
5. Parentified wish to please and gratify patients’ stated wish to know about us
6. Discomfort with transference distortions (idealizing or devaluing) and/or a general wish to control how we are perceived
7. Maintenance of false-self presentation

Narcissistic Self-Regulatory Reasons Analysts Do Not Disclose

1. Maintenance of false-self presentation
2. Wish or need to be seen in a specific manner—usually involves the need to be idealized
3. Wish or need to avoid feeling vulnerable
4. Guilt due to feeling like one is breaking taboos by separating from mother/father, Freud, early analysts, supervisors, teachers, mentors
5. Maintenance of ego-ideal of the neutral nondisclosing analyst
6. Shame of exposure (Freud said we use the couch so as not to be stared at—perhaps also to hide and not be seen)
7. Power

CASE EXAMPLES

I turn now to some clinical examples that illustrate how closely entwined with and determining of self-disclosure or restraint these subjective experiences can be.

Sam

Some authors have written about shifting life cycle positions affecting their decisions to disclose (Leibowitz, 1996). Sam does not want kids. He and his wife are starting to feel like “freaks”—all their friends are having them and urging them to do the same. He wants to know if I have children, but wants me to tell him only if I do not. He wants to be my only child, and I understand this. I often feel like his father, and he is certainly a favorite child I have been raising these past twelve years. This dynamic has been recently highlighted during a phase of group where he feels resentful of the attention other members are get-
ting from me. He may then in fact be my only group child to know my parenting status if I tell him. What feels interesting to me and a bit unusual here is that this is an example of a potential self-disclosure about a sensitive topic for me where my “choice” will be celebrated by the patient but not by me. There is often reluctance about disclosing material that we fear might diminish us in our patient’s eyes, but this is a different situation. Unlike Sam, at the time this occurs I am sad and ambivalent about not having children and still working to come to terms with the fact that, for a number of reasons, I probably will not have them. So far, I have not told him because I am not convinced yet that it is best for him to know. The adage of when in doubt do not disclose is helpful here, and I think there might be some additional mileage we can still get out of not gratifying this request. But here we have a situation where I really do not know if my deciding not to tell him—or not knowing what would be most indicated—has more to do with theoretical and clinical considerations or, to the extent that they can be separated out, the more subjective, narcissistic needs I have been discussing in this paper. This all just makes me feel too vulnerable. If he ultimately decides to have children and I still do not, will I then feel inferior, especially as he potentially adopts the satisfied superior position in this equation? Part of me wants to tell him, yes, we are alike, and you can feel good about this similarity—the father and son who have no children or fathers. I wonder—though really just for a moment—about the potential value of letting him know I have wanted kids as a way of helping him to become more in touch with split-off parts of him that do want to be a parent. I am also aware of wanting this man who does not want to be a parent to parent me as I share my sadness about all of this. And finally, part of me wants to join him and his wife as they commiserate about feeling and possibly being treated differently for being childless.

Janet

Clinical considerations aside, how and why do we choose the particular content we disclose? Janet, sober for two years and now able to refrain from the dangerous sexual activity that used
to accompany her binges, asked me how I felt hearing that in the midst of a lonely and anxious weekend, she decided to drink. She had recently been sharing fantasies about wanting to try to reintroduce alcohol, and though it was harder for me to imagine how this could work, we were both trying to stay open to the possibility that she might some day be able to do this. Janet was afraid I would be angry, disappointed, maybe even disgusted by her, and feel guilty that both her boyfriend and I were away at a difficult time.

Technical advantages of allowing her to stay with these feelings notwithstanding, part of me did not want to tell her that she was at least partly right because I felt that I should be above these petty, overinvested feelings or at least that she should think I am. Further complicating things was the fact that in the split seconds we sometimes have to assess these situations, I was not able to discern who, if anyone, would judge me as petty and overinvested—my patient, me, or both of us. For my own subjective, need-based reasons, then, I considered not answering. Davies (2003) and others write about the reluctance to disclose and risk giving up our status as the idealized and adored one. My wiser, or at least less narcissistically vulnerable self-state dominated, and for various clinical reasons I decided to tell her that yes, it was true that I felt some of those things, though maybe not the guilt as much as feeling sorry I was not here when she needed me to be. Knowing her propensity for either-or thinking, I also added that the positive feelings—including respect—that I feel for her are still there, and that I can have all of these feelings—positive and negative, survive, and go on feeling good about her and our relationship. She felt tremendous relief that I could admit these critical feelings since she sensed I did have them, and the disclosure validated an evolving sense that she can rely on her instincts. While I do not want to diminish the fact that for this and other reasons I think it was a clinically wise choice to disclose, I believe the choice was probably also motivated by narcissistic factors such as showing off that I can acknowledge difficult feelings and still move on, indicating how in touch I am, and revealing while safely knowing she will think well of me if I confirm what she probably already knows. I think it is important to note that this analysis is not just an exercise in
deconstruction. When possible—and dissociation and other forms of unconsciousness are such that it won’t always be possible—we need to be aware of all aspects of our choices and dynamics. This becomes important not only as a tool to utilize in deciding whether or not to disclose, but also in order to be alert to patients’ direct or indirect references to these more narcissistic motivations so we can help them process the effects of our interventions, even if it seems on the surface that the disclosure—or lack of—was useful.

Michael

Vulnerability and fear of being seen as flawed can prevent an otherwise useful disclosure. Shame, Michael tells me, is incapacitating, and explains why he feels unable to show himself enough to date, apply to graduate school, and be more in the world. Even discussing shame feels embarrassing, humiliating, and almost more than he can bear. Do I understand—but how could I? As we end, I decide to tell him I know something about shame and understand how unbearable it can be. I think about the fact that, as analysts, our own histories of trauma and loss get stirred in sessions and can be quite shameful. Our fears of being seen as damaged or imperfect lead to hiding and make us less useful to our patients (Silverman, 2006). Though only a mention, this is still a very hard disclosure for me because, like for my patient, even referencing shame can feel embarrassing. Theoretical clarity seemingly intact, my thoughts then take me to these places—is this disclosure for him or for me because I love him and know he fights taking me in—maybe this recognition of similarity will allow him to let us connect more. Is this merely my need to be more openly loved by someone I love? Maybe this was just a confessional—one embarrassed man to another; see me for who I am and I will be able to help you see yourself for who you are—I too have been unable to talk about this very much. I know; I understand. So I come back to where I started from—is this disclosure for him? Just me? For both of us? Might I have helped more if my own subjectivity had led me to withhold the disclosure, allowing him to more readily stay in a place of feeling different from me in this respect? Conversely, could I have been of more help if I was able to further overcome
my feelings of vulnerability and disclose even more? Will even this minor disclosure scare him? After all, if he devalues himself for shame and insecurity, what will he do with me? I am left, like my patient, feeling shaky.

DISCUSSION

These are but three of countless cases and moments in treatment that challenge us to look beyond our classical roots and even to go beyond current contemporary guidelines for self-disclosure. Sullivan’s (1953) contention that “we are all more simply human than otherwise” (p. 32) comes to mind here, for it is with these and indeed all of our patients that we must ask ourselves not if but rather which of our specific needs are being stirred, frustrated, or gratified in the course of a session and over the lifetime of an analysis. On a moment-by-moment, case-by-case basis, even assuming dissociation and greater clarity only in the postmortem, we need eventually to be able to risk recognizing and feeling whatever discomfort and fear might arise as we become more curious about and in touch with these needs and how they impact—even determine—our decisions to share or withhold. With Sam, I was keenly aware of the role my own unresolved issues around becoming a parent played in my decision not to answer his question. Likewise with Janet, I had to struggle with my wish to be seen as the kind and healthy analyst who does not get angry or too invested in his patients’ progress before I could let myself admit to the accuracy of her perceptions and, though not spoken aloud, later needed to recognize my need to show off as a possible component of the disclosure. Finally, with Michael, shame and vulnerability took center stage, as they so often do (Eigen, 2004). Though we seem to have an easier time acknowledging guilt, I believe that shame is as central or more so to understanding the human condition and frequently motivates or, more likely, inhibits self-disclosures (Morrison, 2008).

FINAL THOUGHTS

In conclusion, I want to mention that like others who write about mutuality and the analyst’s subjectivity, I believe that with the obvious exception of pathology, exploitation, or other malig-
nant exchanges, what is good for the analyst is usually good for the patient, and growth and evolution in one often parallels the same in the other (Maroda, 2002). While discretion is always indicated, unexamined hiding is not, and it is unhealthy for us and our patients (Kuchuck, 2008). As we emerge from hiding and therapeutically reveal more of our true, sometimes less than idealizable selves, we learn—as patients do—that imperfection and mistakes are part of our humanity and in many cases even enhance the work, or at least can be tolerated and survived. Learning through experience that we do not have to live up to theoretically antiquated and stifling ego-ideals, that we can have a bias, judgment, unresolved issues, and imperfections—some of which might need to be or invariably get communicated through self-disclosure—and still be good-enough, even excellent, analysts, can be relieving and healing for all parties. Tracking the narcissistic fluctuations that lead to, accompany, or prohibit these self-disclosures allows patients and analysts to grow within a freer, safer, and more mutual therapeutic space.

NOTE
1. For a discussion of differentiating between wishes and needs, see Mitchell (1993, chapter 7).

ACKNOWLEDGMENTS
Great appreciation is due to Galit Atlas-Koch, Hillary Grill, Linda Bradley, Heather Golden, Betsy Levin, Pam Raab, and David Flohr for their support and invaluable contributions to this paper.

REFERENCES


