Nothing but the Truth: Self-Disclosure, Self-Revelation, and the Persona of the Analyst

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The question of the analyst's self-disclosure and self-revelation inhabits every moment of every psychoanalytic treatment. All self-disclosures and revelations, however, are not equivalent, and differentiating among them allows us to define a construct that can be called the analytic persona. Analysts already rely on an unarticulated concept of an analytic persona that guides them, for instance, as they decide what constitutes appropriate boundaries. Clinical examples illustrate how self-disclosures and revelations from within and without the analytic persona feel different, for both patient and analyst. The analyst plays a specific role for each patient and is both purposefully and unconsciously different in this context than in other settings. To a great degree, the self is a relational phenomenon. Our ethics call for us to tell nothing but the truth and simultaneously for us not to tell the whole truth. The unarticulated working concept of an analytic persona that many analysts have refers to the self we step out of at the close of each session and the self we step into as the patient enters the room. Attitudes toward self-disclosure and self-revelation can be considered reflections of how we conceptualize this persona.

The question of the analyst's self-disclosure and self-revelation inhabits every moment in every psychoanalytic treatment—even though we might wish to believe otherwise. Just as it is not clear exactly what we mean when we use the word *self* in our metapsychology, I suggest that the referent of “self” in “self-disclosure” is also not without

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complexities. This paper will explore the relationship between the information disclosed or revealed by the analyst about herself and the self of the analyst. I am proposing that all self-disclosures are not equivalent and that differentiating among them allows us to define a construct that I am terming the analytic persona. I believe we analysts rely on an unarticulated concept of an analytic persona that guides us, for instance, as we decide what constitutes appropriate boundaries. To what extent does disclosed information actually reveal something that represents what could be understood as the analyst's identity? What is it that is disclosed? What is the relationship between the analyst's identity as analyst and identity as a person? “Self” is often used in our field as if there were a unitary self we either reveal or not, and as if it were an all-or-nothing issue, when it is more helpful to consider the self not only as layered but also as multifaceted and shifting with each context—to consider, in other words, aspects of self. I propose that bringing the notion of persona to bear on this issue may clarify some seeming contradictions in our understanding of technical and theoretical issues.

Just as the concept of persona denotes a part of a self that represents the whole self in that moment, so too is the title of this paper complete as is, even as “nothing but the truth” brings to mind its partner phrase, “the whole truth.” Our professional ethics call for us to tell nothing but the truth and simultaneously for us not to tell the whole truth. The frame and structure of the analytic setting free us to do just that. The frequency of sessions places an optimal pressure on both analyst and patient to become emotionally intimate; the limits placed on the contact by time, technique, and ethics contribute to the development of that paradoxical “as if” mode of reality that is the hallmark of the transference neurosis. Just as we rely on our patients to be able to walk out the door and conduct their lives in a way that is detached from the regressive experience of the treatment, so too do our patients rely on us to do the mirror image of this. Many analysts already have an unarticulated working concept of an analytic persona, the self we step into as the patient enters the office and step out of at the close of each session. Our attitudes toward self-disclosure and self-revelation can usefully be considered reflections of how we conceptualize an analytic persona. Levenson (1996) succinctly clarifies the distinction between disclosure and revelation:
To reveal is to allow to be known what has heretofore been hidden (a passive act). To expose is to make public something reprehensible, a crime (we are not dealing with that), and to disclose is to act, to make known an occurrence that has been under consideration but, for valid reasons, has been kept under wraps. I would like to elaborate that distinction. Self-revelation (unveiling) would refer to those aspects of the therapist that are inadvertently or deliberately permitted to be apprehended by the patient. Self-disclosure would be whatever the therapist deliberately decides to show (or tell) the patient. [p. 238].

My views are consistent with the distinction Meissner (2002) draws between disclosures that emphasize the real relationship and those that serve to strengthen or maintain the therapeutic alliance. I do not mean to suggest that active, intentional self-disclosure ought to be a regular and common occurrence. Self-revelation, on the other hand, is an inescapable part of every moment. What I am arguing is that certain kinds of disclosures and revelations have reference to part of the analyst's self that belongs to an analytic persona.

**Persona: A Definition for Psychoanalytic Purposes**

“Persona” as it relates to the analyst's self-disclosures and self-revelations can be thought of in a somewhat pejorative sense. For instance, as Hanly (1998) comments:

> When I look back over the path that these reflections on the self-disclosure of the analyst have taken, I discern a direction toward an attitude of skeptical openness toward self-disclosure. I am not skeptical about the efficacy of timely, sound interpretations. I am skeptical about self-disclosures. They can be damaging to the analytic relationship and the analytic process. But interpreting involves a dimension of self-disclosure that we disregard at our peril and that constantly tests us. This dimension of self-disclosure, which contributes importantly to the therapeutic alliance, constitutes the opacity—the capacity for selflessness—that places the patient and his or her needs at the center of the analyst's interest and occupation. To confuse neutrality with anonymity is to deny the inevitability, as well as the psychological necessity, of being oneself as distinct from being only an artificially contrived, anonymous, professional persona [p. 564].

However, “persona” can also be used in a nonpejorative manner that can clarify our thinking about self-disclosure in the analytic setting. I will use the term to delineate the analyst's available and presented self in a given moment or setting. The *New Oxford Dictionary of English*
defines persona as “the aspect of someone's character that is presented to or perceived by others: her public persona.” The analytic persona is the self as perceived, or available to be perceived, by the patient. Frank (1997) outlines a prescription for an analytic/therapeutic persona:

Analytic authenticity demands a willingness to reveal one's personal involvement—not just as an anonymous or understanding persona—but as one who is engaged in, while examining, the fullness of the possibilities that might develop within and between the participants during the analytic interaction. It must be understood, however, that it is never advisable for the analyst to rush eagerly or compulsively to reveal his or her experience to the patient—each impulse, fantasy, accomplishment, or quirk, for example—in order to respond authentically [p. 309].

Let me offer two brief clinical examples that demonstrate the ways in which analysts already use the principles of an analytic persona and “nothing but the truth.” Judith Chused (2001) gave a presentation in which she described lovely work with a latency-aged child. The young patient was unable to express certain thoughts and feelings, and Chused articulated them for her as a self-disclosure as if she, the analyst, had been experiencing them herself. During the discussion period, Chused was asked about the extent to which she felt able to use this technique with patients. Her reply was that she could not lie to patients and that she could take on, assume, and articulate only feelings with which she herself could identify. In other words, if the patient were experiencing something that Chused felt was alien to her, she could empathize with the patient but could not assume the affect state, as she had with this patient. If an analyst is able to conceptualize, form associations to, create metaphors for, or fantasize about something, then this, by definition, represents an aspect of self. In terms of Meissner’s distinction between the real relationship and the therapeutic alliance, Chused has presented a particular version of the self-as-object that will enhance the therapeutic alliance. Empathizing clearly must involve identification: I understand Chused’s distinction as referring to the strength or depth of her identification.

What I want to stress in this example is that Chused speaks of taking on a role, of playing a part, for the benefit of her patient. She describes a limit to the extent she can do this, and this limit involves what she feels potentially to be true of herself. This is precisely what I mean by the persona of the analyst, that it is a part or potential part of
the analyst that is disclosed or revealed to the patient; it does not have to represent the entire truth of the analyst's being, though it must represent something that the analyst is able to assume, if only in fantasy, as part of her self. It is nothing but the truth but not the whole truth. Metapsychologically, we could conceptualize an analytic persona as representing a benign split in the psyche, often a consciously chosen one. Naturally, a persona may be adopted for defensive purposes as well and may reflect an enactment of countertransference (in the narrow sense of an unconscious, and possibly countertherapeutic, response to the patient).

My second example of the use of an analytic persona is provided by Diane Martinez (Brice 2000, p. 553), who reported on a case in which she had made spontaneous interpretations to a patient. One was that the patient yearned for compliments, but that “the positive effect is gone in thirty minutes—like that old saying about Chinese food.” The second concerned the patient's tendency to engage in multiple anonymous sexual encounters while really wanting a more serious relationship. Martinez commented, “Looking for a life partner in the park is like shopping at K-mart for an Armani suit!” She felt that what she had said had been “foreign” to her, as she in fact thinks differently about Chinese food and knows that one can find designer clothes in unlikely places. Because Martinez herself brings up the question of having stated as true something she was not certain she believed, we need not question whether this ought to be considered a metaphor; if she had considered her statement to be only metaphoric, she would not have been troubled by the way she had presented these interventions.

Martinez is described as uttering both of these statements spontaneously and in a way that was emotionally genuine and meaningladen to both her and the patient. We could call this acting, perhaps, or we could say that it represents an analyst using parts of the self that are only in part reflective of what she would profess to believe and that have a semblance of truth only in that moment. I would suggest that this acted, created self-presentation is an example of the appropriate use of an analytic/therapeutic persona. Perhaps the aspect of self that is being disclosed here is the analyst's wish to be of help to the patient and her willingness to feel or believe things she ordinarily does not for the sake of that potentially therapeutic moment. So it is as if what is being revealed is something like this: “I say these plausible things that I may believe only in this moment, and they represent what I feel in a consistent
way, which is that I want to help you.” The choice to make these statements, to include them in the analyst's persona, comes from the analyst's work ego. And to return to Chused's point, there are limits to what she can represent herself as feeling or being.

To look at the issue from another perspective, let us consider the analyst's silences. A patient notices on my car's side window a small Amherst College decal. She talks in session about what it means to her that I had attended such a fine school and chose to spend my time seeing her for a somewhat reduced fee. I do not comment on her factual assumption. Such events are the bread and butter of analysis, grist for the mill in the work of exploring the transference. My silence, I think, is similar to Martinez's remarks about Chinese food and designer clothing. Silence here is an action taken for therapeutic reasons, an action that allows the patient to assume something about the analyst that may or may not be true. Unquestionably, an act of omission (not confirming or correcting a patient's assumption) is not identical with making a statement to a patient that does not reflect one's usual or consistent beliefs. But the two types of intervention involve the building of an analytic persona. What is truthful in my permitting the patient to believe what may be an untruth is my wish to allow the transference to deepen so that the patient and I may learn more about her mind. This may be akin to the social phenomenon of the “white lie.” A white lie may facilitate a social encounter, and allowing a patient to believe what may be untrue about the analyst may facilitate the analysis. “Lying,” both socially and analytically, however, may express not only altruism but also cowardice, hostility, or masochism.¹

There are many situations that highlight the extent to which our usual assessment of what is truthful is flexible and situation-dependent. Consider the use of the case illustrations in papers such as this in our literature. Do you assume that I have just told you the truth in the vignette of the patient and the decal? You probably understand that I

¹ On another occasion, a patient looked my name up at Amazon and “discovered” that I had written many books. As it turns out, there is another Susan S. Levine who has written on sex therapy; I have written one book on psychoanalytic theory. I did clarify this to the patient, who had wondered whether I had in fact written all of those books. If the patient had not inquired directly and if this issue had emerged well into treatment, I would probably not have provided the information. In this situation, at the beginning of treatment, it felt as though providing this information to the patient fell within any patient's appropriate need to know the credentials of a potential therapist. However, my needs were also involved—I felt uncomfortable with allowing this patient to make an incorrect assumption about my area of expertise.
may have changed particular facts in order to protect the patient's identity (see, on this point, Ogden 2005). So do I lie when I tell you about this “patient,” or do you assume that I tell you nothing but the truth—or a “truth equivalent”—even though not the whole truth? This is analogous, I think, to the notion of saying to a patient something that is momentarily or potentially true in a given clinical moment and context. What does it mean to you that I have not let you know what the truth of the matter is?

I am not suggesting that intentional lying in the sense of saying something to a patient that we know, or believe at that moment, to be untrue is a good thing. What I am arguing is that both in analysis and in everyday life, our feeling of telling the truth is context-dependent and only partially reliable. It is better to accept that what we utter may be only a partial truth even as we believe it to be nothing but the truth or even a whole and permanent truth; the truth of an utterance may reside in the spirit rather than in the letter of our utterance. As Mitchell Wilson put it to me in a personal communication, “Because the analyst has an unconscious just like the patient, it's entirely possible we don't know why we said or did a certain thing. In that sense, we are unreliable in our self-reporting and this possibility must or ‘should’ be a part of our working attitude. We are always lying ‘a little,’ it seems to me, even if we mean to speak the entire truth.”

Painting our Own Portraits and the Evoked Persona

Inasmuch as I have proposed elsewhere (Levine 2003) that an analysis can be conceived of as a creative object, perhaps an apt analogy to my concept of persona can be found in literary theory. What I have in mind here is the way in which, although we know that the author is the creator of the speaker (or narrator) in a work of literature, there is not an identity between the two. In other words, we are not justified in assuming that we may learn more about the speaker than exists within the data of the work itself by studying the life of the author (Beardsley 1958, pp. 238-239). Now obviously this applies to an aesthetic or critical study of the work, as opposed to a psychoanalytic or biographical examination of the author. But it is an important distinction. I am proposing that the persona of the analyst represents a carefully or not-so-carefully studied selection of the self of the analyst, but that what is presented
and perceived does not accurately represent the self of the analyst with permanent or global validity. And just as the creator of a work of art does not possess the authority to determine the meaning of the work, what “is” in it, so too must the analyst share that authority with the patient.

Psychoanalysts have long known that patients perceive us in a manner determined by their own character and neuroses. What has been focused on much less is the way in which the analyst, according to his or her own character and neuroses, appropriately structures and manipulates the data about him or herself to which the patient has access. Even an analyst who tells no specific personal fact (putting aside the fact of the disclosures we make through our office decorations, cancellation policies, etc.) reveals a great deal through the empathy embedded in each and every intervention. The very facts of what we choose to say and not to say and of what we select in the patient's material are of the greatest significance.

*Persona*, as I am using the term, refers to the sum of all the presentations of self by the analyst that are available to the patient—this includes disclosures and revelations that are intended or unintended, conscious or unconscious, tacit or explicit, and episodic or continuous acts and utterances. Ideally, these presentations will manifest the benevolent manipulation that is part of the new developmental experience we hope to provide (*Loewald 1960*). Our ethics require that this be done with the best interests of the patient in mind. We can also understand this as similar to the ways in which parents ordinarily speak to their children, giving them information that is age-appropriate, and protecting them from what might be overwhelming—but, ideally, never lying to or misleading them.

*Persona*, self-disclosure, and self-revelation are characterized by dimensions of deliberateness, temporality, activity, prominence (background vs. foreground), and purpose (anticipated therapeutic effect). My office decorations, for instance, constitute an old revelation; if I were to answer a patient's question about whether I have seen a particular movie, that would be a new disclosure. The first is nonverbal, the second would be verbal. The decorations are more or less constant and, while once an active choice on my part, now feel to me to be a more passive and implicit rather than chosen or intentional disclosure. The revelations implicit in my office decor are usually in the background rather than the foreground. And when is a disclosure considered to have taken place? When we “make” it or when the patient perceives
it? Of course, as a patient changes she may be able to perceive data to which she had previously been oblivious. And how do we understand “disclosures” within the transference—information we give that had particular meaning to a particular patient, data that are understood within the idiomatic frame of reference of the individual? We may need to respond as if the patient's perceptions were indeed actual disclosures—this is what it means to allow oneself to be used in the transference. The patient's perception of the analyst's intention is significant too. In other words, does the patient believe that he or she receives “knowledge” of any particular piece of information with or without the analyst's wish that it be known or the analyst's knowledge that it is has been “discovered”?

I believe that even when we think we know who we are in a given moment, or that we can predict our own responses in some future moment, we are likely to be at least partly mistaken. While I do not wish to throw the issue of character entirely out the window, it would nonetheless be problematic to consider the self a knowable, enduring, and stable entity. Simply using the term self so freely does not mean we ought to fall into the trap of believing that we truly understand what such a thing as a self is and whether it exists as anything more than a convenient or necessary narrative construct that saves us from experiencing life as unending chaos. Thus, in what I am saying there is no implication that the persona of the analyst is a pathological construction. It is a reflection of how we all function all the time. As Frank (1997) notes, “Clearly, it is simplistic to think of analytic authenticity merely as revealing one's true reactions to the patient” (p. 307). To a very great extent we always are who we are in relation to the environment in which we find ourselves.

As some disturbing studies have demonstrated (e.g., Milgram 1974; Haley, Banks, and Zimbardo 1973), personality and behavior are to a surprising degree evoked by social expectations. The psychoanalytic setting is not immune to this effect, which can be benign as well as malignant. Let us take, for instance, the use of humor. While it would certainly be best left to others to characterize my sense of humor, it is probably fair to say that I have a tendency to be playful. With some patients I allow this tendency to come through, refraining only from jokes or humor that would be seductive, in bad taste, unprofessional, or otherwise inappropriate. With other patients I would rarely feel tempted to remark on the ironic or humorous side of something—and
with some patients such observations would never even occur to me. To use humor is, without doubt, a form of self-revelation, as well as potentially a disclosure, interpretation, enactment, actualization, confrontation, or any combination thereof. Whether I am playful or not in any absolute sense, there is no question that I am “being myself” and revealing myself to each of my patients. But the self I disclose is not a constant, an unvarying monolith. Inevitably, I—and all clinicians—display different selves, aspects of self, or slices of self to each patient and in all of our relationships.

We know that analysts limit the data to which patients have access, and this limiting is taught as the ideal position of the classical analyst. As Freud (1912) put it, “The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him” (p. 118). We think much less about the way the analyst actively molds the image he or she presents to the patient. As Greenberg (1995) has put it, “Consider the standard injunction, ‘Don't just do something, sit there!’ That is often good advice, but the implication is that it is possible to do nothing, which seems unlikely to me…. The decision, then, is not whether to reveal something or not; rather it is whether I choose to reveal something deliberately” (p. 201).

To take another example, in everyday life I probably act with a normal amount of patience. I am short-tempered or irritable at times with my family, less so with my friends, and very rarely so with colleagues, students, or patients. Some of this comes from the fact that it is easier to suppress, sublimate, or analyze and utilize one's irritation for the benefit of the other person for a forty-five minute session than it is when one lives with someone. But much of it comes from how I see my role with these different groups—what I want to get from the encounters and what I want to give. I define the encounters differently, I expect different things from them, and thus my threshold for irritation is different. Therefore I am less prone to experience irritation with friends, students, or patients. This means that both the self I experience and the persona I present in different settings are rather different. As Schafer (1983) notes,

In our best work as analysts, we are not quite the same as we are in our ordinary social lives or personal relations. In fact we are often much better people in our work in the sense that we show a greater range of empathizing in an accepting, affirmative, and goal-directed fashion. This observation suggests that there is a kind of second self which we develop, something
comparable to the narrative author. Robert Fliess (1942) has called this second self or at least certain aspects of it the analyst's work ego. This second self is not and cannot be discontinuous with one's ordinary personality; yet, it is a special form of it, a form that integrates one's own personality into the constraints required to develop an analytic situation [p. 291].

Levy (2005) has addressed the question of naturalness in the analyst, pointing out the inherent unnaturalness of the analytic attitude. He suggests that the increasing comfort that analysts say comes with experience may reflect not so much a natural ability as a greater technical expertise. I would suggest that the analyst's adjustment to the analytic stance reflects the development of an adaptive analytic persona that includes an acceptance of the technical demands of our craft. Because so many of our technical and strategic decisions occur unconsciously or preconsciously, they may feel to us as though they are natural; and they also appear to have qualities of artistic judgment (Levine 2003). This does not mean, however, that these components of an analytic persona do not in fact result from practice and experimentation with tactics and techniques, as well as with certain inherent elements of the analyst's character. As Glick (2003) puts it, “we both discover and create in ourselves a natural psychoanalytic style” (p. 379; emphasis added).

Levy and Inderbitzen (1992) state that “both abstinence and anonymity are relative, there being inevitable gratifications and revelations about the analyst that are part of the intimate, long-term relationship between analyst and patient” (p. 992). Renik (1995), too, emphasizes that disclosures on the part of the analyst are inevitable and that what matters is “how to manage the unavoidable condition of constant disclosure” (p. 468). And as Aron (1992) puts it, “Anonymity is never an option for an analyst. You can sit, but never hide, behind the couch!…What is critical is not whether the analyst chooses to reveal something at a particular moment to a patient, but, rather, the analyst's skill at utilizing this in the service of the analytic process. Is the analyst or, more accurately put, is the particular analyst-patient dyad able to make use of the analyst's self-revelation in the service of clarifying and explicating the nature of their interaction?” (pp. 480, 483).

However we designate it, as persona or as a second self, the analyst presents some version or mix of self-qualities to patients, and it is important for patients to have a sense of having and being permitted
access to the analyst. We give of ourselves in each interpretation, and we give the patient something to grab onto. If patients did not feel us to be present in an active way, most of them would leave treatment.

**Clinical Illustration: A Range of Disclosures of Areas of Self and Shifts in the Analytic Persona**

The following vignettes describe a range of disclosures and shifts in the analytic persona. I would like to emphasize that I do not assume that the patient perceived my interventions and disclosures exactly as I intended them to be perceived. No interaction within an analysis can be entirely “real” and free of multiply determined meanings for both patient and analyst (see Boesky 1990).

In one session, a graduate student who had come to analysis because of a writing block described a chapter of his dissertation that he was working on. He spoke with great detail and clear inspiration, and at the end of the session I commented on what appeared obvious to both of us, that the patient had essentially composed the chapter in the session. The following week, under pressure to complete the chapter, he demanded to have my notes from the session, reasoning correctly that I take practically verbatim notes. He said that he felt they belonged to him. This felt entirely different from a patient requesting to see the clinical record—to which the patient does have legal rights, whether or not it would be beneficial for him or her to exercise them. I encouraged the patient to explore his feelings, and I wondered aloud what might be getting in the way of his recalling what he had said. This did not lead to a diminishing of the intensity of his request or to an increase in his curiosity about why he would make such a demand. This was most unusual for this patient, who was generally eager to explore the workings of his mind. After a couple of sessions, the patient chose to sit up rather than lie down, saying that this issue did not feel to him as though it was something to be analyzed. I identified with the patient in his frustration, having had my own share of difficulty with writing; and yet I also felt a mounting sense that to comply with his request would damage our relationship and put me in the position essentially of

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2 My paper “To Have and to Hold: On the Experience of Having an Other” (2004) considers the importance of the patient's feeling a sense of ownership of the analyst and feeling, in a corresponding way, that the analyst holds the patient in mind.
a stenographer. It felt to me like an impasse—and a test having to do with my conviction in the therapeutic process. My clarifications and interpretations were not helpful, and the patient became more and more focused on the imagined solution that my notes would provide.

It was unusual, to say the least, for this patient to seem so inaccessible, and I was uncertain how best to proceed. I decided that as I did not know what was really going on (this occurred about a year into treatment), the only thing I could do was to regard my reactions as vital data that were emerging from the interaction between us. Other clinicians may well have reacted quite differently, both in how they might have experienced such a request from a patient and in how they decided to respond to it. I decided to speak to this patient about my own very complicated reactions. I confirmed that, as he had thought, I did take down much of what he had said (as opposed to writing a commentary) and that I would sometimes also jot down my own associations or reactions. I also said that my writing was a routine part of my way of working with a patient who was on the couch. As such, it felt as though he was asking me to share something private, as though someone had demanded of him that he hand in his research notes in lieu of his fully articulated and written thoughts. In other words, he was asking for access to my private process rather than to my end product. He considered all this carefully and, much calmer, said that he liked the way I worked and did not want to do anything that would make me have to change it. He added that he would not want me to feel constrained about what I wrote because of the chance that he would later ask to see it; he quickly recognized that this was not to his advantage. It seemed to me as though the patient had retreated from what had felt like an attack on my analytic persona—an attack fueled by his own needs, anxiety, and disappointment (not to mention his wish to take my writing for his own). The patient returned to the couch, and we were gradually able to focus on what was happening in his mind to obstruct access to his previous creative mental state, as well as on what confronting me in such a way might have meant.

The point of this vignette

3 Rachel Kabasakalian-McKay has noted (personal communication) that this vignette describes a negotiation between analyst and patient. The patient had been considering the “chapter” as solely his creation and reducing me to the role of stenographer. I was attempting to hold to the ways in which the content of that hour was also a co-creation. The notes had come to symbolize this co-creation. “For the analyst to disclose as she did the investment of her self in the process of that hour (‘holding out’ against being reduced to the role of a stenographer)—and in the relationship

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is that I spoke with candor about my method of working and my feelings. The disclosure felt to me to be deep, intimate, and yet somehow not of a personal nature.

My purpose in taking this action was to restore three things: first, the conditions under which I could best help this patient; second, a threatened therapeutic alliance; and, third, the patient's belief that my refusal to accede to his demand was in his interest. Perhaps the major rationale for disclosing in this very deep way was to explain to the patient a stance I had taken that I had no other way of explaining and that he had the right to understand. The circumstances required me to deepen the way in which I made myself available to this patient, although I did not feel that the disclosures involved material that was fundamentally outside the analytic endeavor. Let me contrast that with a different type of disclosure, one that involved my personal life outside the analysis, also with this patient.

On one occasion this patient remained in town over a long weekend in order not to miss a session. He had been undecided about his plans for a long time and we had spent many sessions exploring what this signified; a central issue involved his fear of intimacy and his willingness to make a deeper commitment to the analysis. After all this, I ended up needing to cancel this session due to an ill child. I knew I would not be able to reach the patient in person at that particular time, so I left him a voice-mail message to the effect that a pressing family situation had come up unexpectedly, that I would have to cancel, and that I was sorry to have to do this at the last minute. It is extremely rare for me to cancel appointments, I struggled about doing so in this situation, and I felt terrible about it. Before the next session, I reflected on how best to handle the situation in the upcoming hour. This was different from in the impasse about the notes: here I felt that I had initiated an action that could reasonably be experienced by the patient as hostile, in that I had violated the safety and reliability of the therapeutic frame. When we next met, I waited to see how the patient would respond. As I had expected, he spoke of his rather strong responses to this event—

4 The vignettes in this paper are skewed insofar as they present unusual events in my clinical work, events that pushed me to respond in ways that were also unusual. with the patient—seemed to facilitate the patient's recognition of her, specifically of her own subjectivity in relationship to him. This seemed to shift him away from viewing her in the instrumental way that he had for the previous several sessions.” I would add that the patient may have identified with my defense of my own work process.
I had not told him in my message the specific reason for cancellation beyond what I described above. This patient had taken an important step in deciding to attend a session, and I then acted in a way that said, in essence, that the session was less important to me than it was to him. In the session, I felt that it would be appropriate for me to explain a bit beyond this and said to the patient that I would be willing to do so. After he indicated that he had also felt this way, I offered him the choice of whether he would like me to do so first or to talk about his feelings and fantasies first. (My rationale for giving the patient this option, I think, had to do with returning to him the measure of control of the time that my cancellation had violated.) He chose the latter option and guessed that it probably was a child's illness. After he had reached what seemed like the end of his associations to this, I confirmed that his conjecture had been correct.

The point I wish to make is that this disclosure—necessary and appropriate, I think—felt entirely different from the disclosure described earlier about the way I work and my need for privacy. This second was a disclosure of an element of my personal existence rather than of my existence with this patient. But both of these disclosures felt extremely intimate. The purpose of this second disclosure was to prevent a malignant and actual power imbalance from developing that would impede the understanding of how these issues had already been alive for the patient. It felt as though it would be disrespectful of me not to confirm his conjecture. Here, as in the first illustration, the effectiveness of the disclosure had to do with the restoration of the therapeutic alliance, which cannot exist if the patient feels that he has been treated without common human decency; my real-relationship disruption of the work required real-relationship decency in response. My disclosure had given the patient access to information I would not normally have allowed to enter my analytic persona; however, my cancellation had already amounted to a disclosure-equivalent, and one that had had a destructive effect. I had introduced a turbulent element and it was incumbent on me to return the analysis to its previous state in which the patient was the primary source of turbulence.

5 Almond (1995) has an interesting take on the effect of the analyst's forthrightness. “Forthrightness, another means of emphasis, might seem in conflict with selflessness and anonymity. It is not. The difference is between ‘I noticed that you seem cheerful today’ and ‘I noticed that you seem cheerful today.’ That is, the focus remains on the patient. Forthrightness counters learned inhibitions on directness in social situations. A major function of socialization is to train us not to make direct,
Another type of disclosure seemed to be from an intermediate area. At the beginning of my work with this patient, he had not asked me much at all about my credentials. This became an issue later on, as we came, over many months, to understand how powerless he felt in knowing almost nothing about me and what it would mean to him to have some information. He said he needed to know about my academic and professional training, as well as some other things, such as whether I was married or single. In some ways I felt as though it made no difference at all whether he had this information or not, as I knew we would explore the meaning for him of whatever I said or did not say. But what would have mattered a great deal was the sense of coercion I felt, and the way in which revealing this information would have constituted a submission to a demand. I did not give him any information about my family, but did tell him about my educational background and professional training. And I found myself including my undergraduate school and major. It was clear to me as soon as I spoke that this information belonged to an area outside my analytic persona. That I included this is most curious. I understand it as an expression of my wish to be transparent and known—and also perhaps as representing an unconscious submission. What I did not yet know was whether my choice here also represented my side of an ultimately productive and beneficial enactment. In other words, was it for the patient's benefit? While I would not consider this to be a boundary violation, it did feel like a boundary crossing. But, at that point in the treatment, perhaps the patient needed to know that I was doing something out of the ordinary. Indeed, he did immediately speak about this information as being extremely revealing and in a different category.6

A disclosure of the first kind—active, conscious, and intentional in real time, and disclosed for the benefit of the patient—about my note-taking

6 The first and third vignettes may make it seem as if the patient's curiosity and my disclosures occurred in quick succession. This was not the case. We continued to explore analytically the significance of the first event for years. The matter of my training had come up numerous times before my disclosure and we continued to work on it long after.

Confrontational statements to people about their impulses, or how they defend themselves characteristically. ‘You are acting aloof and distant to protect yourself from feeling sad’ is not a comment that would be welcome at a cocktail party, or on a bus. But in analysis we want directness—the analyst’s forthrightness models for the patient, encouraging directness about affects, fantasies, and thoughts about the self and the other” (p. 479).
and need for privacy, is a disclosure of aspects of myself that in some sense already belong to the patient. It is a revelation to the patient of something that in fact is already in the room with him, whether he knows it or not and whether I have articulated it or not. I would say that this is a disclosure of the persona of the analyst. The persona is the area of the analyst that he or she is potentially willing to let the patient have, and this willingness to be had is for the benefit of the patient, for predominantly altruistic reasons. I want to distinguish this from the notion of self-disclosing a reaction that one believes is the result of a projective identification. In this situation, the analyst is revealing something that is thought to have originated from the patient. There is, of course, no definitive way to tell the difference (although there may be a sense of foreignness to some projective identifications). In fact, the projective process can only work by what the patient stimulates in the analyst that is already there to be acted upon. It is the fact of the analyst's willingness to be acted upon that I wish to emphasize.

The second and third vignettes describe disclosures of material not normally in the therapeutic arena, information that neither I nor the patient would normally introduce in this fashion. Both disclosures emanated from outside what Hoffman (1994) has referred to as the “relatively protected position” of the analyst that is “likely to promote the most tolerant, understanding, and generous aspects of his or her personality” (p. 199). When I intentionally move beyond this more customary position, I have the sense of needing to act with special caution, of being on alert, of being in new territory. It is this feeling that alerts me that I have moved outside my analytic persona.

The openness of self that I feel within my analytic persona is a part of my regular stance with patients. It stands in stark contrast with the feeling that I ought not reveal something that comes from outside the analytic arena. It feels different to speak openly with patients about my responses in session than it is to reveal even a seemingly trivial piece of personal information. I believe that the question is not how deep a particular disclosure is but rather whether it comes in a segment of self that I had planned to include in the therapeutic encounter. We have drawn a line; we have selected what will go into the persona we present to patients. When we cross that line, we (and our patients) feel and know it.
We withhold information for the patient's immediate benefit and in order to maintain for ourselves the conditions under which we feel we can be most helpful. When we do not respect these requirements, this results in boundary crossings and potential boundary violations. While some disclosures would clearly constitute boundary violations and others would be minimally personal, there is a wide middle ground in which analysts determine their own lines. For instance, if a patient begins to talk about a movie he has just seen and asks me if I have seen it, I may well choose to answer—it will depend on what I think the patient needs of me and what I judge will contribute most to (or might impede) the flow of material at that moment. However, if a patient considering an abortion were to ask about my personal experiences or opinion, I would not consider answering. In the first instance, I have revealed what I have done on a recent evening and perhaps my taste in film. In the second, I would be revealing a fact that might imply to the patient that I did or did not approve of her morality, what I have or have not done in my private life, and so forth. These issues certainly have relevance to who I am but in their specifics are not properly a part of a conversation with a patient. They represent private and intimate facts, information I exclude from what I am willing to share. Jacobs (1999) distinguishes disclosures about his whereabouts on vacation, or the books he reads, from his disclosures of fantasies he has during a session that seem related to the patient's material. I believe that the distinction he draws is virtually identical to mine between what falls outside and inside the analytic/therapeutic persona.

We make determinations all the time about which parts of ourselves we make available to the patient and which we withhold. What about a therapist who tells his patient that he is about to be married, that he has been divorced twice, that he has twins (whose pictures are in his office), and that he is about to put central air conditioning in his vacation home? In a sense this information is less intimate than my telling a patient about my feelings within a session—that is to say, less close to sharing one's self. Yet I would consider the other therapist's disclosures

7 An enactment, for instance, may well involve a crossing (as in my revelation of my undergraduate training). This may be an important and productive part of the process. However, if it is not recognized as such by the analyst, it has the potential to be damaging to the patient.
to be violations of professional boundaries and his definition of therapeutic persona to be highly problematic. For another example, a colleague of a relative sought treatment with me. I had to consider whether I would be willing to work with someone who had met members of my family and knew already so much of the actual circumstances of my life. I felt something akin to nakedness as I contemplated this possible treatment, and this reveals the degree to which I feel I need a certain privacy in order to be dressed and professional with a patient. I chose not to enter a situation in which I would not have the power to withhold information that I felt it would not be to the patient's benefit to know and that would undermine my ability to work. It would have left me inadequate room both for the patient's fantasies and for me to create an optimal analytic persona.

**Persona Disclosed, Self Anonymous: The Emotional Availability of the Analyst**

The relationship of the analytic persona to the self may be akin in certain respects to that between narrative and historical truths. One need not be certain of the relationship between persona and self and narration and history for psychoanalysis to be helpful. In the final analysis, what matters is that emotionally effective interactions have taken place between analyst and patient. The effectiveness of those interactions rests on there being an emotional genuineness rather than a truthfulness that would be identical to or as broad as what would exist in any other relationship the analyst might have. The analyst's emotional authenticity counterbalances offering few factual disclosures. And emotional authenticity requires us to tell nothing but the truth but certainly not the whole truth, even if we were able to know it ourselves.

Let me try to articulate this paradox by looking to my experience of my training analysis. Of course no training analyst can ever be completely anonymous to a candidate analysand, because both share membership in the same institute. This said, though, my analyst was quite classical in technique most of the time, elegantly reserved and unrevealing of personal information. I knew some facts about him before treatment began but learned very little during the analysis itself. Yet, despite this, I came to feel a sense of security that I knew him very profoundly, that I could predict his reactions, and that I knew everything about him that truly mattered. After a time, I was rarely surprised.
by anything he said or did within the analysis, that is to say, anything that emanated from his analytic persona. My patients say similar things to me, how strange it is that they feel they know me well even without knowing the sort of things they are accustomed to knowing about other people with whom they are close. Patients come to know such things as kindness, empathy, humor, curiosity, demandingness, wit, relentlessness, the tendency to show off, self-awareness. And in the light of familiarity with these qualities, knowledge of specific facts, revelations, or reactions in specific sessions may contribute rather little. I felt that I knew my analyst well despite the fact that he remained largely anonymous to me. Perhaps it is accurate to say that I knew him only profoundly—or that I knew only his analytic persona.

A clinically effective analytic persona may include much self-disclosure or very little and vastly different mixes of self-disclosure and self-revelation. Let us consider a proponent of self-disclosure such as Owen Renik (1993). Renik at times includes in the cards he plays face up (Renik 1999) his opinions about the patient's issues or actions:

All in all, I find that self-disclosure for purposes of self-explanation facilitates the analysis of transference by establishing an atmosphere of authentic candor. When my patients experience me as saying what I really think—about them, myself, us—they respond in kind. All too often, it seems to me, clinical analysis deteriorates into a game in which the patient feels free to bring up all sorts of ideas, without taking any of them quite seriously. When the analyst does not disclose what he or she is really thinking, and disclose it as completely, as straightforwardly as possible, the patient is not encouraged to do so either. Disavowal gets built into the analytic discourse from both sides, and the patient's exploration of his or her experience is vitiated by a speculative, hypothetical, “as-if” quality. My experience is that the hardest thing for a patient to do is to discuss with his or her analyst profound convictions about the analyst's real character, to tell the analyst the sort of things that the patient suspects the analyst probably hears from friends and family members [Renik 1995, p. 493].

However, the “Renik” who is disclosed to the patient is not identical to Renik; the persona Renik that is available to the patient bears the same relation to Renik, the person, as the narrator of a novel bears to the author. What Renik “really” thinks is determined by the

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8 I was quite surprised to discover the type of car he drove, which seemed not to fit what I knew to be his style; then, after the analysis, I was also surprised by certain administrative actions he took within our institute.
situation and his role—in other words, it reflects his analytic/therapeutic persona. And, in focusing so intently on how much Renik may disclose, we may forget how much he does not disclose or reveal.

If we then turn to a very different analyst, Axel Hoffer (1985), we see a different mix. Hoffer believes that the analyst's role should be limited to conflict elucidation, leaving the patient the freedom to decide how to resolve problems. He believes that the analyst should exclude his opinions entirely, although he does not see absolute anonymity as necessary to this kind of neutrality. I must include here a personal view of Hoffer, because I believe it is essential to understanding his ideas. I believe that Hoffer's manner (and thus his analytic persona) conveys a thoughtfulness and respectfulness that would color even his "neutral" interventions. So although Hoffer may disclose few opinions and little information, this may be much less frustrating to patients than his colleagues would guess. The composition of one variety of analytic persona may provide an empathic availability that may in certain respects be equivalent to that of a very different sort of persona. As Frank (1997) notes, "the useful limits of the analyst's authenticity are strongly influenced by the analyst's personal comfort level, and some analysts can uncover far more about themselves than others in a productive fashion" (p. 310).

The patient's perception of the analyst's emotional availability and benevolent intentions toward him or her plays a crucial role and can affect the degree of comfort the patient has with the analytic persona as defined and limited by the analyst. The patient I have described in the series of vignettes above believed, for various reasons, that I was intentionally and cruelly withholding myself from him. He felt that there was a master/slave dynamic in our relationship, that this was reality as opposed to his interpretation of the situation, and, most important, that I had structured things in this way and desired them to be so. In a sense he was correct insofar as he wanted me to make available factual information that I deemed had little to do with my emotional availability.9

It is the affective feel of a disclosure that lets me know whether it comes from within my analytic persona. When a patient asks me a question that involves access to my private person, I feel a bit jolted,

9 I wonder if this bears on the pressing need at times to make disclosures of various facts to borderline patients (the patient in this vignette was not borderline). The more primitive the emotional and cognitive functioning, the less able the patient will be to accept symbolic rather than concrete availability or “giving.”

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taken aback, surprised. For example, a patient asked me as he was leaving a session if I was Jewish; another patient asked me if I was a skier. No doubt part of the jolt comes from the need to think quickly, to understand the significance of the question, and to weigh the meaning for this specific patient at this moment of answering or not answering. But I believe that part of my sense of surprise comes from something else, and that relates to this question of how open I keep myself to my patients and the extent to which I feel that my thoughts—my self—belong to the patient when I am with him. It also has to do with how open I am at any given moment to aspects of myself that I had not thought to be immediately relevant to the situation. To confront a personal question that demands information from my existence away from the patient requires that I shift from one dimension of self to another. And it is this mental demand, I think, that results in the sense of being taken aback that I experience. It requires me to shift from a dimension where I am allowing my thoughts to run unimpeded, in which I am totally open to the patient (whether or not I choose to share all my thoughts), to a dimension of self that is not currently active in my mind. It is as though the patient has called on me to open another file on the computer, one I was not working in. And so I then face the question of whether to expand the persona that I offer the patient and of how to explore the persona that the patient may have in fantasy. Whether I decide to make a disclosure depends on my best judgment of what will promote the therapeutic process and what is needed to maintain, protect, or build the therapeutic alliance. It has to do with what constitutes neutrality, a boundary crossing, or an empathic rupture for this particular patient at that specific moment. As Frank (1997) writes, “In a strict two-person sense, it is not analytic anonymity that makes possible a new relational experience, but the analyst's authenticity tempered by the asymmetry of the analytic relationship. Authenticity here refers to the analyst's genuineness, to the truthfulness with which one responds or represents oneself. It also addresses the question, Is one being true to oneself?” (p. 285).

**Persona Grata**

We shape and rely on an analytic persona in order to function for our patients. We also use and accept as a certain kind of reality the transference persona that the patient assigns us; and we allow ourselves to be used in this way. No matter how much we reveal or disclose about
ourselves, we also retain aspects of the classical neutral-anonymous position; our actual status as experts and the unobjectionable positive transference toward a healer or shaman is a necessary component of therapeutic effectiveness. Our persona comprises material, both conscious and unconscious, intended and unintended, transference-based and real. We sometimes reveal our persona and sometimes ourselves, the latter at times when we are forced by events or patients to expand our analytic persona.

How we delineate the self we present to patients and the self that we may potentially disclose is a personal as well as a theoretical matter. What defines this as a professional decision is the orienting criterion of respect for the patient's needs. But within the analytic persona—and within the bounds of the techniques, goals, discipline, and art of psychoanalysis—we have the potential to be creative and to use ourselves fully and with great freedom. And we may accept, even welcome, the concept of the persona—a construct many analysts may already use and one that helps us give credence to the ways in which we tell nothing but the truth.

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