CHAPTER SEVEN

Talking about oneself

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With our help, the analysand is able to face, to bear, even to react to situations which formerly were too much for him in his state of isolation and helplessness to which he had had to surrender unconditionally, even surrender with pleasure.

—Sandor Ferenczi (1930a, p. 226)

As early as 1915, Freud observed that young and eager psychoanalysts would be tempted to reveal their own thoughts and feelings to their patients in order to help the patient divulge more about themselves. Freud damns this technique by saying that it achieves nothing towards uncovering what is unconscious in the patient. He recommends that the analyst show nothing to the patient except what is shown to him (Freud, 1915a). The analyst’s abstinence and anonymity motivates the development of the transference and leads the patient to do analytic work (Freud, 1915b). Exploring the development of Freud’s thinking, Schachter (1994) reports that Freud advanced his position on abstinence and anonymity in order to inhibit erotic longings for certain female patients—the patient’s charms posed a danger for the analyst who might, under the sway of passion, abandon technique and
Progress in categorizing types of self-disclosure

The dialogue on self-disclosure avidly continues since Freud’s early writings. Some classicists such as Shill (2004) promote Freud’s position as the golden rule and as an ideal way to establish an atmosphere of emotional safety for the patient. At the same time there have been major advances in fine tuning categories of self-disclosure, thus making discussions more focused and productive. Self-disclosure can be described as occurring in a variety of circumstances. Akhtar (1995a, 1995b) notes three forms:

- **Integral**: Inevitable self-disclosure occurs all the time within the psychoanalytic situation and includes race, skin colour, age, appearance, natural quality of the voice, office décor and the style of engagement, i.e., the subjects that the analyst chooses to talk about or avoid. Some authors refer to this as self-revelation. All of us know there is little we can do about this kind of disclosure—it is part of every human interaction.

- **Situational**: There is considerable agreement about situations where one is obliged to reveal some facts to protect the analytic process. For example, most agree the analyst should reveal if illness is the reason for having to suddenly cancel a series of sessions. Also in this category is severe strain in the analyst caused by mourning a death in the family, or change in life circumstances that affect their capacity to be fully engaged in the psychoanalytic situation. The decision of how much to disclose might differ with each patient depending on their life situation or ego capacities. However, analysts diverge on the amount of information they disclose. For example, a cancellation of 2–3 sessions because of illness in an ongoing analysis would find some analysts not giving the reason for the interruption because it might preempt the patient’s fantasies. Others, however, might feel that not disclosing the reason for the interruption would provoke the patient’s mistrust.

- **Technical**: This form concerns a deliberate decision to disclose in order to positively influence the patient’s treatment. There are differences about how often and in what circumstances deliberate disclosures should be made. The analyst can do less to control integral and situational disclosures but deliberate self-disclosure emphasizes conscious choice.
Rachman (1998) furthers our thinking by offering guidelines for the use of self-disclosure by distinguishing between judicious and conspicuous self-disclosure. Most of us would agree that conspicuous self-disclosures which are impulsive and gratuitous are to be avoided. In judicious self-disclosure the therapist corrects the traumatic past and the failed experience of seeking relationships by empathizing with the patient. With his words, the therapist attempts to declare his emotions to satisfy the patient’s intense yearning for a sincere experience. Rachman’s “judicious” and Akhtar’s “technical” self-disclosures have much in common by placing therapeutic gain as the objective of the disclosure. There are many elements that determine the use of judicious self-disclosure and Rachman notes the following guidelines:

- Its use should aid the therapeutic process;
- It should be guided by empathy and not acting out;
- It should come from a conflict-free area of the analyst’s personality or one where he is aware of his conflicts;
- The content of the disclosure should meet the needs of the patient and not further the needs of the analyst;
- The disclosure should be given with care for wording and intensity during a period of a positive relationship or transference; and
- The impact of the disclosure should be analyzed with the patient; the analyst should be comfortable with what is disclosed and not convey to the patient a sense of rejection or annoyance.

By contrast, self-disclosure should be avoided when the following features are in evidence:

- It meets the needs of the analyst rather than the patient;
- Countertransference dominates; analyst and analysand are not in emotional contact;
- Unresolved needs in the analyst may contribute to a malignant regression in the patient; and
- There are elements of manipulation, control, and intrusiveness in it.

Three theoretical models

Ego psychologists

Different theoretical orientations take distinct points of view about self-disclosure. Ego psychologists whose clinical framework focuses on a one-person psychology (emphasis on the patient's psychology with the analyst in an anonymous, neutral role) feel most comfortable with relatively silent listening and undivided attention to the dynamics of the patient as they unfold. The analyst's attention is focused on resistances to free association and interpretation. This stance makes the need for self-disclosure minimal. For example, if the patient questions how the analyst arrives at a particular intervention, the response of the analyst would be to reflect the question, reasoning that the patient will be able to associate to the underlying fantasies which produce the question. The presumption is that the analysable patient has the capacity to tolerate the analyst's silence and free associate because they can imagine his thinking and feeling without the need for feedback. In this conceptualization, the analyst runs the risk of shifting the focus away from the patient's conflicts to the real interaction by making a self-disclosure (for example, answering a question). Within this theory, this disclosure might lead to a transference resistance.

Busch (1998), within an ego-psychoanalytical framework, describes what kind of patient stimulates the analyst to self-disclose. The less a patient is able to use free association to self-explore, the more the analyst has to use their feeling state in responding to the patient, disclosing their feelings as part of the interpretive process. If this is necessary, it should be done in as objective manner as possible. The disclosure should lead the patient to be able explore his own ego's functioning.

Meissner (2002) believes that even if enactments (defined as an unconscious action that the patient and analyst engage in that is related to both of their conflicts) are inevitable, the analyst should try to preserve neutrality as much as possible. The therapeutic alliance (the relationship that furthers the patient's and analyst's work together) is contrasted with the real relationship (the analyst-patient relationship apart from the treatment). Self-disclosure should be used to aid the therapeutic alliance rather than the real relationship. The analyst should only answer the patient's questions if the answers might strengthen the therapeutic alliance. Analysts should self-disclose when they feel that they have committed obvious errors, but not reveal so much that the patient is burdened by their personal concerns. Blanket recommendations of unrestrained or rigid nondisclosure or the insistence on total anonymity are imposing arbitrary rules that don't help the analytic process.

There are some ego-psychologists who advocate a more deliberate form of self-disclosure that recognizes the ubiquity and importance
of enactments (Chused, 1991b; Jacobs, 1999; McLaughlin, 1991). They discuss these behaviours with their patients as a joint contribution of patient and analyst. This is a clear departure from the analyst as “blank screen” Jacobs (1999) describes under what conditions he would self-disclose. To clarify limits, he first describes the boundaries that should be observed. Analysts shouldn’t self-disclose to relieve their own tension. They must be aware how their disclosure might be heard by a regressed patient. Jacobs decides to answer patients’ questions when not answering might be hurtful. Self-analysis is useful in understanding why one answers certain questions and not others. The analyst should reflect on how the patient reacts to their questions being answered or not. These reflections form the basis of judging whether to make subsequent disclosures. It is an individual matter about when and how to self-disclose or whether we engage in banter or more formal modes of speech.

Jacobs offers examples to show the complex nature of thinking about self-disclosing and monitoring its effects.

- **Example 1**: A woman patient with considerable subtle aggression repeatedly attacked Jacobs without being aware of it. Over time he noticed how inhibiting her attacks were on him as well as how hurt he felt by them. At one point when he was particularly affected, he spontaneously disclosed the effect her words had on him. She said she was surprised but agreed that it must be true that she was so aggressive. They continued working with both feeling that Jacobs’s disclosure furthered the analytic work. He felt that this disclosure had been useful in furthering the treatment until years later when she revealed that at that time, his disclosure left her shocked. She became frightened of her own power to threaten him which led her to become more inhibited and not examine her behaviour towards him. Jacobs wondered if his intervention was worth the price.

- **Example 2**: Jacobs tried to interpret the nature of a young man’s emotional and silent withdrawal around slight hurts. Historically, the patient had a father that frequently withdrew and remained silent for little apparent reason. A variety of interpretations that focused on the patient’s experience with the father in the past and present failed to help the patient experience any relief. In one session, Jacobs was overwhelmed by how strong his own feelings of abandonment were when the patient withdrew and spontaneously disclosed to him how deeply he was affected. The patient responded, “Now you understand how I feel. All the previous times you were discussing my situation, I didn’t think you got it” (p. 176). This led to dramatic progress in the analysis with lessening of the patient’s withdrawal around minor hurts and being able to verbalize rather than enact them.

Although Jacobs doesn’t advocate self-disclosure, he vividly describes emotional situations or enactments with his patients that are clarified with self-disclosure. He differs with relational psychoanalysts who actually subscribe to self-disclosure as an important part of their technique.

**Relational psychoanalysts**

The ego-psychologists, including those who acknowledge enactments, try to limit their deliberate self-disclosures unless the patient has limited capacity to fantasize or are unable to accept the interpretations of their conflicts. They attempt to disclose as little as possible to avoid shifting the treatment away from the patient’s problem. In contrast, the clinical theory that extensively utilizes self-disclosure is the intersubjective theory of the relational psychoanalysts (Ehrenberg, 1995; Orange & Stolorow, 1998). These analysts see themselves as operating within a two-person psychology in which both the patient’s and the analyst’s feelings and behaviour are observed as part of the psychoanalytic process. They feel their position is more complex than the ego-psychologists whose theory is governed by a one-person psychology, with a more exclusive focus on the patient’s productions and emphasis on the analyst’s relative anonymity and neutrality.

The relational analysts argue that in practice the patient’s productions and behaviour are much influenced by the analyst’s actual behaviours. If analysts are empathically involved with their patients, they find it impossible to portray themselves as an anonymous blank screen. They believe if they remain abstinent and neutral, the patient experiences them as only intellectually involved and too detached to be able to offer enough emotional help to resolve their conflicts.

How does this point of view apply to self-disclosure? Orange and Stolorow argue that working within the intersubjective framework, the analyst always has to consider how he and the patient
Goldberg (1987) discussed the place of apology in psychoanalysis and psychotherapy. He describes the complex interaction of the analyst’s theory and the patient’s capacity to tolerate frustration leading to the analyst’s decision whether to apologize (similar to a self-disclosure) for a mistake. Will the patient have the capacity to analyse the interaction with the analyst if the analyst doesn’t apologize? If not, an apology might further the therapeutic alliance. When the analyst has to decide whether to apologize or not, they often have to wait to see if their decision was correct.

Rachman (1998) has a number of suggestions about the timing and appropriateness of self-disclosures. If the analysand observes a previously unspoken and unacknowledged attitude in the analyst, the analyst should reflect whether he has contributed to the patient’s feeling. The analyst should be able to accept the subjective experience of the analysand. Instead of the classical position of analysing resistance, the analyst and patient together should search for subjective meaning. It is important to accept the truth of the analysand’s observations rather than interpret or question them. Examples: “You are right, I’m angry.” “I wasn’t aware of it, but you’re right. I have been tired during this session”. It is always important for the analyst to differentiate personal issues from those of the patient so as not to blame the patient for the analyst’s feelings.

**Neo-Kleinians**

Another theory governing self-disclosure comes from a neo-Kleinian perspective. This involves the analyst reporting to the patient an emotion he feels as a result of the patient’s projection (projective identification). Marcus (1998) gives a clinical example: One day during a session with a male patient he felt intensely sad. The patient wasn’t reporting any sadness and the analyst was unaware of sadness that was coming from his thoughts. Marcus assumed that the patient was projecting the feeling into him. The analyst told the patient of his sadness and said that although it might be his own feeling, he thought the sadness was coming not from the patient’s words but from his tone. The patient replied that he was not sure whose sadness it was but that he was glad the analyst was feeling it and not him.

In the following sessions, however, the patient shifted to a sad topic. He described an early deficient relationship with his mother without affect. He had been told that when he was one year old, his mother

... the benefit of an analyst’s willingness to self disclose is that it establishes the analyst’s fallible view of his own participation .... something that analyst and patient can talk explicitly about together (p. 529).

Within a classical analytic perspective, the focus would be on analysing the meaning of the patient’s criticism of the analyst’s intervention. Although this strategy might be meaningful in understanding an aspect of the patient’s mental functioning, it steers clear of the possibility that the criticism was justified. Even though Renik posits that judicious self-disclosure is valuable and should be done more often, he believes that certain feelings should be withheld. He gives the example of a female patient wearing a sexy dress on a summer day who asked him how she looked. He told her that she looked “terrific” but didn’t mention that he also was excited by her because she would interpret this disclosure as seductive.
had to have a bilateral mastectomy, following which she withdrew her affection from him. As he described this history with his mother, the analyst again felt intensely sad while the patient continued to feel removed from his emotions. The patient had been told of this history of his mother’s illness and didn’t remember the events or the feelings connected to them. The analyst continued to feel sad and kept telling the patient about it. After several sessions the patient “took back” part of the sadness. With this new sad feeling, he could reconstruct his emptiness and sadness in response to this early deficient relationship. Then, for the first time, he was able to discuss with his mother this period in their lives. Now, they were both able to experience the deep sadness of those lost years.

With extensive experience disclosing his feelings to his patients, Marcus became increasingly convinced how helpful this had been for his patients. He came to feel that he didn’t have to be too concerned about what he revealed either unconsciously or deliberately. Most often, the disclosure was helpful to the analysis and if it were a mistake it could be analysed as any other error. At first, he agreed with the majority of analysts (Renik, 1995; Gabbard, 1996) that freedom to self-disclose did not include sexual feelings, but then had some clinical experiences that made him change his mind with specific patients. On certain occasions, he found revealing sexual feelings to be helpful to the patient and their progress in treatment.

He reports the following clinical example: A thirty-nine-year-old woman, seen for nine years in analysis, was as usual complaining about him. She was always angry, feeling that all he wanted to do was to take her money and make her dependent on him. As she seemed to continue to complain in one session, he noted that he didn’t feel attacked. He was also aware that she seemed softer and more attractive and he had sexual feelings for her. This led him to ask if she was aware of other feelings besides her anger. She was embarrassed and wondered what he meant. He responded wondering if she was having sexual feelings. She said it was true and it made her very embarrassed to admit it. She wondered what prompted him to ask. He replied that he was having a sexual response to her even though she was expressing anger. He added that he believed that his sexual feelings were his way of detecting her sexual feelings. This led the patient to say she was angry with him for not having sex with her and wondered if they both wanted it, why weren’t they having sex? He replied that while sex might be momentarily satisfying, it might damage her growing trust and prevent her from exploring her deepest feelings. She asked if it didn’t make him angry to want sex but not to be able to have it. He responded that even if frustrating, it could lead to growth for both of them.

Marcus felt that this exchange led to considerable progress. The patient was able to feel powerful instead of a helpless victim of paternal neglect. She could now better tolerate the analyst as a frustrating parental figure in the transference. Marcus concludes that as long as he was not seductive and certain that he would not act on his sexual feelings, he could risk disclosing them. Earlier in his career, he recalled a stalemate with a female patient. In following the prohibition against disclosing sexual feelings, he didn’t tell her of his loving and sexual feelings towards her when she had asked him directly how he felt. She had told him that she imagined him being attracted to her. At the time he remained silent. Retrospectively, he realized how withholding he had been in not validating her perceptions of him.

How can one reconcile Marcus’ position about disclosing sexual feelings to certain female patients with the general admonition not to disclose those feelings? This takes us back to Freud’s initial warning: if the analyst responds to the seduction of his female patients, he is in danger of being seduced away from the analysis and will succumb sexually. Marcus defends his disclosure by being clear in his own mind and with his patient that despite his sexual feelings, he would not have sex with her. From his description of his interaction with this patient, it appeared that her capacity to postpone gratification was limited. I believe that by disclosing his sexual responsiveness and at the same time frustrating gratification, he gave her a “corrective emotional experience”. Instead of the frustrating father in the transference which she couldn’t tolerate, he became the more complex loving but frustrating analyst who supported her learning to tolerate disappointment. Some would argue this is not analysis because the transference is not analysed. Or, this patient can’t be analysed because she doesn’t have enough capacity to tolerate frustration. Moreover, many analysts might not be able to deal with the disclosure of sexual feelings without the fear that they would act on them. Marcus’ clinical description is not meant to suggest a blanket recommendation to disclose sexual feelings in response to patient’s demands. It seems likely that his patient didn’t have the capacity to fantasize about sex without undue frustration about not being able to act. What appeared to be most embarrassing about revealing her sexual
feelings was the expression of her neediness. It seems convincing that Marcus’ disclosure helped his patient.

An attempt at synthesis

Can we resolve some of the different points of view on self-disclosure offered by the above clinical perspectives? In a review of self-disclosure, Billow (2000) takes the focus away from theories that strongly recommend it as well as those that caution against it. Whether spontaneous or deliberate, self-disclosure should be studied for what it reveals and what it hides. He expands thinking about self-disclosure by applying it to all of the analyst’s deliberate or spontaneous words and what emotional attitudes they reveal or hide. He wonders how the patient reacts to disclosures at the moment they are spoken and over time. To reveal the complexity of assessing the analyst’s behaviour, he describes a fantasy to illustrate the dimensions of this assessment. Here is the fantasy: a candidate analyst seeks supervision to determine the right response to a patient’s request at the end of a session “Is it all right to take some out-of-date magazines from the waiting room to use for my work”? The analyst responded in a classical mode, “You know your request ... may seem casual, but everything that takes place here has some meaning that sometime emerges as we leave time for reflection. Let’s take some time and come back to your question in another session ...” (p. 88) The candidate then sees a few supervisors of different clinical persuasions, who tell the candidate that what he is doing is either right or wrong or what they would have done instead. He feels alternately comforted or anxious by their suggestions, all of which are convincing. He then goes to yet another supervisor who focuses on his supervisory experience. Is he learning something new? Is he developing any convictions about what he is doing or should be doing? Are he and the patient doing the right thing? Does this supervisor know what he is doing? The young analyst supervisee wonders. He thought his latest supervisor was a relationalist but he wasn’t sure. What did he want him to do? Maybe the answer is for him to act according to what he thinks is right at the moment and then learn from his subsequent interaction with the patient whether he was right or not. He both likes and doesn’t like the freedom and ambiguity associated with this approach.

The conclusion from this fantasy is that much of what the analyst says or does is ambiguous and often doesn’t follow a particular theory.

All disclosures, whether they are spontaneous or deliberate or the products of a recognized enactment, are to be studied in the context in which they are occurring as well as retrospectively as they potentially acquire new meaning. Even a detailed clinical description that stays close to the data of a self-disclosure can be understood as a partial description of the analyst’s intellectual and emotional experience at that moment. It is not the actual or whole experience itself. How can we integrate what appears to be disparate theories? The ego-psychologists with their focus on one-person psychology and their preference for anonymity and neutrality appear to have a much different approach than the relationalists’ emphasis on interaction in the intersubjective field with a two-person psychology. The theoretical approaches that dictate whether or not to self-disclose appear to be irreconcilable, but if we observe what is actually done in clinical practice the differences are less.

Here are some examples where clinicians of different theoretical orientations might agree about self-disclosure. Both ego psychologists and relationalists might agree that those patients who have the capacity to fantasize about the analyst’s thoughts and actions without extensive feedback from the analyst, are probably less likely to need the analyst to self-disclose and might even be distracted by gratuitous self-disclosures of their analyst. They might also agree that those patients who don’t have sufficient ego-capacity to fantasize about the relationship with the analyst and not able to easily free associate to periodically analyse themselves are more in need of self-disclosures from the analyst regarding the analyst’s thinking, emotions and experiences. Another area of agreement concerns those patients who are prone to provoke enactments even in analysts who carefully maintain neutrality and anonymity. Further, patients who have trauma as a prominent feature of their backgrounds usually require self-disclosure from the analyst to resolve their conflicts. For all events that require a decision about self-disclosure, it is important for the analyst over time to observe the patient’s reaction. This empirical approach will further our understanding of the use of self-disclosure.

Self-disclosure and illness

Here, I will focus on a specific type of self-disclosure, e.g., illness in the analyst. I will give examples of how three analysts managed their own serious illnesses within their practices. It is rare in the psychoanalytic
literature to find research on the impact of the analyst's illness on the patient. We are fortunate that Galatzar-Levy (2004) has done such research and the results of that work will be reported here. I will also report on myself as well and examine how I coped with illness and report two cases where I used different rationales of disclosure.

Akhtar's distinction between situational and deliberate self-disclosure is relevant to this discussion. In most cases, if not all, the analyst suffering from a serious illness is forced to depart from the usual anonymity of the analytic situation because of the exigencies of treatment. Is there a litmus test for what should be revealed to the patient? Keep that question in mind as you read the cases. In respect to deliberate and judicious self-disclosure, how do you determine "What is in the best interests of the patient’s treatment?" Can the analyst be objective in answering that question?

There are three categories of illness that can pose different responses from the analyst. The first category is the situation of a short acute illness that can't be anticipated but involves the analyst cancelling sessions or choosing to work when ill. Under these circumstances, self-disclosures might be either spontaneous or deliberate. Many analysts elect not to disclose the reason for the cancellation or their transient impaired function. If the patient brings up either questions or observations concerning this illness, the analyst may reflect them back to the patients. Other analysts might simply disclose their short illness to the patient, feeling that it serves the alliance to disclose the reality of the analyst's functioning. The second category is the emergence of an illness which doesn't appear life-threatening but involves considerable changes in scheduling or cancelling of sessions. Here again, some analysts will avoid self-disclosure unless the patient confronts them with accurate observations and/or questions about their health. Finally, the third category would be where the analyst has a chronic illness that is life-threatening. An analyst who works with their patients under those circumstances often has a heavy burden in maintaining their analytic focus.

Schwartz (1987) had an acute illness that fell into the second category. He suddenly had to be absent from his practice for four to six weeks but anticipated correctly that he would have a complete recovery. He called his patients to tell them that he would have to be absent because of illness and told them that he would return in six weeks and then would reschedule appointments. He returned after four weeks recovered from his illness. He decided not to self-disclose further information about his illness with his patients but rather focus on their fantasies about it. This was effective in deepening the exploration of their transferences. What is clear from his descriptions is that his illness didn’t interfere with his analytic capacities.

Pizer (1997) made a courageous attempt to conserve the analytic frame with her patients during the course of prolonged treatment for breast cancer including chemotherapy. Her illness puts her in the third category: a chronic illness that was life-threatening. She disclosed to all of her patients that she had breast cancer, experiencing it as an inescapable self-disclosure. At the same time she monitored the effect of her disclosure on her patients. She gave her patients every opportunity to plan ahead and express whatever feelings they had about her being ill. She was surprised at how strong and capable she felt considering her illness.

One patient responded to her disclosure as follows: "I feel really bad about feeling helpless and I don’t want you to make anything out of it.” Pizer answered: "What to make of it? Here I am telling you my condition and at the same time rejecting your repeated offers of help". Later the patient complained, “Yes, I’m aware of the transference implications, but I’m so angry!” Pizer’s clarification: “Look, if five years ago when you came here, I gave you the choice of seeing an analyst that would get cancer and one that wouldn’t, which one would you choose? I know who I would choose” (p. 457). She explained that if she were not ill, the patients’ statements of helplessness and anger would have led to inquiry rather than disclosure. I’m impressed with how resourceful Pizer was in responding to her patients’ strong reactions to her illness.

In the disclaimer about the patient preferring an analyst without cancer, it is impossible to know to what extent her patients felt obliged to stay with her out of a sense of guilt. This sense of obligation would probably have an impact on the course of the analysis with patients, inhibiting their anger or frustration.

Morrison (1997), having had recurrent breast cancer, has written about her struggle to determine how, when, and what to disclose to her patients. This illness puts her in the third category: a chronic illness that she knew would end her life. Her article was published posthumously three years after her death. She saw patients for the most part in once a week psychoanalytic therapy. During her final reoccurrence, although
she thought she had disclosed to most, she had only told four of her eight patients that she was terminally ill. One patient she finally told was typical. A female patient who had a long history of sexual abuse didn’t recognize her therapist’s absences, signs of fatigue, and occasionally falling asleep as signalling any illness. Morrison had to tell her. The awareness that her therapist’s illness was traumatic permitted her to get more emotional in describing the history and current effects of her sexual abuse. As we might imagine, many tribulations were embedded in the therapist’s work. She had to help each of her patients deal with information about her illness and their potential loss. She wondered: Would she accept new patients? Did her self-disclosure permit patients to decide to continue or end treatment? The therapist had respect for the concept of timelessness in treatment. By discussing her ideas about how long she was going to live, would she take away the open-endedness of therapy? She found herself not wanting to impose additional loss by stopping the treatment of two patients who had suffered severe losses themselves. If a patient was going to terminate, should she tell them the extent of her illness? She didn’t tell a new patient of her illness until the fourth session. She gave the patient the choice of therapy with her or being referred to someone else. The patient decided to work with her despite her serious illness. Morrison answered the question of her capacity for neutrality by stating that her ability to observe her own mind remained intact.

We can raise a number of questions and concerns about therapists such as Morrison who elect to work even though they are aware of their dwindling physical strength and occasional inattentiveness. It is difficult to imagine Morrison being able to consciously and deliberately control her disclosures throughout her illness. Nevertheless, she reports that despite her illness, she was able to conduct herself well. Reservations arise concerning her personal motives not to disclose the extent of her illness. Why did she disclose her illness to only four of her eighteen patients, although she thought she told almost all of them? It is not unlikely that she sought to maintain her practice as long as possible despite the possibility she might be ineffective. She might have countered this accusation by saying: she felt an obligation to her patients not to abandon them; she enjoyed her work which was emotionally life sustaining; and she needed the income from her practice. Despite her courage, one must ask if it was always in her patients’ best interest that she continued their treatment. It is difficult to judge who could answer this question since we have no reports from her affected patients.

Reviewing patients’ reactions, Galatzer-Levy (2004) gathered empirical data that revealed how ten patients were affected by their analysts’ terminal illnesses. After acknowledging the heroic analysts who have described their work in the face of life-threatening illness, he sagely noted that the patients’ perspective has been given short shrift. He then reviewed the clinical experience of ten patients who sought more analytic treatment following the death of their analysts. Several reported that their dying analysts had an “understandable” denial of the severity of their illness. The patients’ collusion in this denial often affected them adversely. Difficulties arose during the illness and after the analyst’s death involving significant boundary violations. These boundary violations concerned the analyst engaging in role reversals with the patients feeling they had to protect their analysts.

Galatzer-Levy (2004) gives specific examples of what patients recalled concerning situations around their analyst’s illness and death and their reactions to it. The patients observed signs or things about their analyst that led to rational concern about their capacity. They tried to make a direct reference to these observations but also tried to limit how much they told their analyst. No patient got a clear description from the analyst about their illness. Evidence such as marked weight loss, impaired mental function or incontinence were met with denial, rationalization, or an interpretation of the patient’s motive for trying to perceive the analyst as ill. Although reassurance was not used as part of an analyst’s technique, the analysts nevertheless reassured their patients that they were not observing signs of a life-threatening illness. The ill analysts made grandiose statements tinged with humour such as “I will live forever”. The patients were fairly convinced that their analyst was more ill than the analyst let on and sometimes protected the analyst by not confronting them with questions about their health. Many patients were involved in an analytic community where they were tempted to ask other analysts questions about the health of their analyst. They felt humiliated thinking that friends and colleagues knew more about their analyst’s health than they did. They wanted to find out more about their analyst’s status but were conflicted about asking others since this would compromise their analyst’s privacy. When they found out about the illness from another source and reported this to their analyst, in every instance the analyst expressed anger at the
source which the patient experienced as disguised anger at themselves for having inquired.

The ten patients described by Galatzer-Levy represent a select sample and one could view these patients as those whose analysis failed for unknown reasons. Many questions are raised by this research: were the analysts not able to maintain adequate analytic treatment because of their illness? Was the patient unable to deal with the trauma of the impending and final loss of the analyst because of their underlying pathology? Among those patients who didn’t seek further treatment, were there some who were successful in working through the trauma of their analyst’s terminal illness? How can the patient and the analytic community learn more about the limitations of the seriously ill analyst’s competence? These questions are not answered but direct our attention to the general problem of how patients and the analytic community can evaluate the functioning of individual analysts.

From personal experience

In an extended analytic community, we often disclose information to friends and colleagues about our personal life, political persuasions and affiliations. There is the fear that some of that information will inadvertently be revealed to our patients thus interfering with our desired anonymity. Even our social life is somewhat constrained by the wish not to be seen by our patients outside our offices. The wish not to be exposed is often most acute around our becoming ill and not wanting our patients to know about it unless we tell them. In the examples that follow, I was concerned about how to hide or reveal my illness to my patients. I will give two clinical vignettes, one where I made a decision not to disclose and a second, a decision to deliberately self-disclose. In both cases, although I thought carefully about the reasons for my actions, I was unable to predict the immediate or long-term impact of these disclosures on the treatment. First let’s consider the decision not to disclose:

Clinical Vignette: 1

One night before a full day of patients, I became ill with acute gastroenteritis. I had both vomiting and diarrhea for a couple of hours. By morning, one hour before my first patient, my symptoms abated but I felt weak. I decided to call all my patients and cancel appointments for that day. I told them that I was ill but would be able to return to work the next day. I couldn’t reach my 10:00 am patient, but felt that I would be well enough to conduct the analytic hour with her. We had been meeting for two years and though she consciously desired to get deeply emotionally involved in the analysis, conflicts around autonomy made this difficult. She never missed a session and always came to her appointments on time.

I thought over whether I should cancel the session when she came in or disclose to her at the beginning of the hour that I was somewhat ill. I felt I wasn’t seriously ill and was confident I could get through the hour. Because my patient had never cancelled, I believed I should do the same. I was proud that I almost never cancelled for any reason, let alone illness. The hour was uneventful. The patient discussed conflicts with a colleague and I felt able to listen and make some appropriate interventions. In the next hour, she was very critical of herself. Because she was part of the extended analytic community, she knew some of my other patients. At lunch one of them told her that I had cancelled his session because of illness. What disturbed my patient was her inability to detect that I was ill. She prided herself on picking up subtle cues of illness in others. She associated to her mother who always tried to hide illness or sadness from her. Then she began to question why she missed these cues with me–was she avoiding carefully observing me? Did she just assume, unlike her mother, I was always healthy? This association led to a deeper exploration of her fear of dependence on me if she became more involved in her analysis. I was pleased that I hadn’t disclosed my illness to her. If she hadn’t heard from another patient of mine that I was ill, there wouldn’t have been this opportunity to explore her fear of dependence. No doubt there would have been other instances in future sessions where this issue would take center stage but my illness provided a good occasion to jump start the inquiry.

Let’s now examine the decision to disclose:

Clinical Vignette: 2

I had seen a young professional woman in a seven-year analysis several years before. Intense maternal and paternal transferences were analysed leading to a resolution of many of her conflicts.
She was able to marry, have a child and be successful in her professional life, all of which seemed problematic at the outset of our work. Because of the nature of her occupation, she was acutely aware of others’ general physical presentation. During the course of the analysis, she began to carefully observing my movements and behavior at the beginning and end of each hour. She accurately observed as I walked to my chair behind the couch, idiosyncrasies in my gait, posture, and body posture. She also carefully listened to the quality of my voice to determine my mood, state of alertness, or health. Her observations were accurate.

After acknowledging (self-disclosure) the accuracy of her perceptions, we were able to gradually understand that the acuity of her observations helped with her need to anticipate the behavior of her mother and father. Specifically, she could always anticipate her mother’s distracted emotional withdrawal. Her father worked as a physical laborer and was often in pain after work. She observed the changes in his posture which was the result of joint or muscle pain. She learned to anticipate his angry verbal and sometimes physical outbursts. After we fully understood these connections, she no longer was as acutely aware of my physical states. However, when she became anxious around interruptions of our sessions, she returned to being intensely aware of my movements.

Fifteen years after a successful termination, she returned to treatment. Anxieties about her work, and a troubled relationship with her daughter dominated our sessions. She was only able to commit to twice-a-week psychotherapy. The process shifted away from a focus on transference possibly because of the diminished frequency and meeting face to face.

In the months prior to our resuming treatment, I had been seriously ill and required chemotherapy treatments. Fortunately, I was able to reschedule my patients, not miss any sessions and wasn’t aware of being compromised by the illness or treatment. I felt fully able to engage in my work and judged that disclosing to my patients that I had been ill would shift the focus away from their problems.

However, I made an exception by deciding to disclose my illness to this patient. I had two reasons. Because of her acute awareness of others’ physical states, I feared that she would observe subtle cues that might reveal that I had been ill. Also, we had acquaintances in common. One of them might tell her of my illness. I worried she might find out about my illness before I told her. She might feel betrayed impairing our treatment alliance. I further imagined this could feel like her childhood situation where her mother and father wouldn’t tell her enough about their feelings. Thus I told her that I had been ill, had chemotherapy but had recovered and felt able to continue my work as before.

To my surprise, she was shocked. She hadn’t observed any changes. To her I seemed the same as I had always been. At this point, there was a shift in the treatment. She became solicitous about my health hoping that I would stay well. She reviewed her fears of abandonment that she had from early childhood and talked about earlier anxieties during the analysis fearing she would lose my support for a variety of reasons. She began to make rapid progress with the problems she presented at the beginning of this treatment resolving anxieties at work and repairing a guilt-prone relationship with her daughter. Although she had been fearful of terminating the analysis or even contemplating ending her current therapy she now seemed confident about ending. I wondered with her if my disclosure caused the shift. If I became ill, she would be on her own and have to muddle through alone. She saw it somewhat differently. My telling her of my illness, made her feel that she could manage on her own. After all, I seemed fine despite my illness. She didn’t feel obliged to stay with me. She was reminded of the pleasure she had leaving home when she was 18. She would miss her parents but she had the freedom of living her own life. A follow-up five years later, showed that she maintained her gains.

In this example, the disclosure of my illness did not have the effect that I imagined. I thought my patient would be more upset about the possible loss of my help. Instead, it became a signal to consider coping without me. Assuming that her deciding to terminate was not to avoid fears of my vulnerability, my disclosure led her to greater autonomy.

**Conclusion**

Deliberate self-disclosure, how it is used or not used, is a central issue raised in discussions among adherents of different clinical theories. Freud’s original intent was to try to avoid disclosure as a method of
warding off the dangers of sexual boundary violations. As one reviews recent literature, we begin to put away absolute provisos about self-disclosure. We can put deliberate self-disclosure or nondisclosure in the psychoanalytic context of all interactions between patient and analyst (Billow, 2000). As the psychoanalytic dialogue develops and deepens, we must recognize the greater involvement patient and analyst have with one another. In this context, questions raised by patients who are able tolerate the analyst's silence and use their fantasies to imagine answers, sometimes ask questions motivated solely by their wish to better understand the analyst's hidden feelings and thoughts. For example, "You always respond to me when I ask about A, but never about B". What is the correct response for the analyst? It depends on the analyst; his clinical theory; his customary style; the history of the analytic process and how the patient and analyst understand each other in the real relationship and the therapeutic alliance at the moment of the question. Ideally, a spontaneous or deliberate disclosure should be given with the analyst having the conviction that the patient's reaction can ultimately be understood by both of them and most importantly that the disclosure aids and abets the patient's understanding.

As one expands the definition of self-disclosure to include all interactions in an analysis, further questions emerge that transcend how clinical theory influences self-disclosure. How is the climate established in each treatment for the patient and the analyst to work together? Apart from the verbal exchanges, how can one look more closely and describe the non-verbal behavior and other contextual features that contribute to interactions? How does the analyst explain what they expect from the patient and what the patient can expect from them? How is the asymmetry of the analytic relationship understood by both? Asymmetry concerns analysts control of schedules, fees and their relative activity or inactivity. How much do analysts teach their patients about concepts such as transference, resistance, enactment and projective identification and how much do the patients experience these reactions without any explanation from the analyst? These questions may clarify the setting for single events such as self-disclosure during the course of an analysis.

A difficult topic discussed concerns when to self-disclose the analyst's illness particularly when the illness becomes chronic or life-threatening. Both from the perspective of the analyst and the patient, the problem of the analyst's possible denial of illness with the collusion of the patient is difficult to monitor or avoid. Material from Galatzer-Levy's work with the affected patients suggests the need for the analytic community to heighten awareness of this problem.

In reviewing my two cases, one a non-disclosure, the other a disclosure about illnesses, I couldn't predict what effect my action might cause. My decision had to do with thinking that my intervention would protect both me and my patients in our therapeutic alliance. I was convinced then and now that I made the correct decision, but there are other possible explanations. With my patient that I couldn't cancel, perhaps I indulged my grandiosity when imagining my illness couldn't affect my clinical performance. Maybe my patient was more upset by my hiding behind analytic anonymity. When I told my other patient about my serious illness, we could also imagine that I wanted to avoid her perceptiveness that would lead her to discover signs of my illness. Perhaps I wanted to tell her about my illness before she told me—"beat her to the punch" to relieve my discomfort.

Further clarification of whether self-disclosure is hurtful or beneficial might be achieved by more clinical investigation into the patients' reactions to their analysts' self-disclosures. The clinical study of self-disclosure with clinical vignettes invariably leads us more deeply into questions about the underlying analytic process.