To Disclose or not to Disclose: Is that the Question?

Therapist Self-Disclosure – Understandings, Types and Influences

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Contents

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material, which to a substantial extent, has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where acknowledgement is made in the acknowledgements.

Signed_____ Date_____

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Abstract

To disclose or not to disclose: Is that the question? This dissertation suggests that the question is in fact far more complicated, as therapist self-disclosure challenges therapists to consider what will be most beneficial in each situation.

Thus, it is the complexity of the topic of self-disclosure that is explored in this dissertation. Using a modified systematic literature review, this dissertation looks at how self-disclosure is understood in analytic literature and the different types of disclosure. Three broad categories of self-disclosures are identified and discussed: implicit disclosures, countertransference disclosures and personal disclosures.

Within each of these types, the dissertation looks at what influences a therapist's disclosure, using clinical examples to explore the literature. A range of client, therapist and relational influences are discussed and a list of these compiled. This is done to assist thinking and decision making processes around therapist self-disclosure.

Chapter One – Introduction and Methodology

Introduction

> Young and eager psycho-analysts will no doubt be tempted to bring their own individuality freely into the discussion, in order to carry the patient along with them and lift him over the barriers of his own narrow personality. It might be expected that it would be quite allowable and indeed useful, with a view to overcoming the patient's existing resistances, for the doctor to afford him a glimpse of his own mental defects and conflicts and, by giving him intimate information about his own life, enable him to put himself on an equal footing. One confidence deserves another, and anyone who demands intimacy from someone else must be prepared to give it in return.

> But in psycho-analytic relations things often happen differently from what the psychology of consciousness might lead us to expect. Experience does not speak in favour of an affective technique of this kind. Nor is it hard to see that it involves a departure from psycho-analytic principles and verges upon treatment by suggestion. It may induce the patient to bring forward sooner and with less difficulty things he already knows but would otherwise have kept back for a time through conventional resistances. But this technique achieves nothing towards the uncovering of what is unconscious to the patient. It makes him even more incapable of overcoming his deeper resistances, and in severer cases it invariably fails by encouraging the patient to be insatiable: he would like to reverse the situation, and finds the analysis of the doctor more interesting than his own. The resolution of the transference, too—one of the main tasks of the treatment—is made more difficult by an intimate attitude on the doctor's part, so that any gain there may be at the beginning is more than outweighed at the end. I have no hesitation, therefore, in condemning this kind of technique as incorrect. The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him. (Freud, 1912, p. 117-118)

The above quote forms the basis for doctrine, technique and critique in psychoanalytic consideration of the therapist's use of self-disclosure. Freud outlines the main reasons for not disclosing as it may become directive, sidestep the analysis of resistance, foreclose the development of the transference or shift the focus from patient to analyst and generally does not assist in making the unconscious conscious.

While many analysts uphold the anonymity espoused by Freud, just as many argue for its opposite and have done since the beginnings of psychoanalysis. There is much evidence that Freud himself was often far from anonymous, neutral or abstinent (Lane & Hull, 1990; Basch, 1983; Balsam, 1997; Hanly, 1998; Wolf, 1992; Cornett, 1991) Following the oft-quoted excerpt above, Freud makes the following disclaimer:

> In practice, it is true, there is nothing to be said against a psychotherapist combining a certain amount of analysis with some suggestive influence in order to achieve a perceptible result in a shorter time—as is necessary, for instance, in institutions. But one has a right to insist that he himself should be in no doubt

about what he is doing and should know that his method is not that of true psycho-analysis. (1912, p. 118)

Here, although Freud tries to distance personal interventions from true psychoanalysis, he nonetheless admits their usefulness in some situations.

While Freud strove towards scientific objectivity, his contemporary Ferenczi was researching mutual analysis, where patient and analyst alternated roles, both free associating. According to Greenberg (1995), Ferenczi believed that the anonymity suggested by Freud was a myth and a conceit on behalf of the analyst; that the client could accurately perceive the weaknesses and blind spots of the analyst. Furthermore, Ferenczi proposed that anonymity may serve as a further re-traumatisation for the patient, while sharing feelings enables the patient to participate more fully in analysis and come to know his resistances, fears and transferences more completely (cited in Blechner, 1992).

Following critique from Ferenczi (1928), Freud made the following admission:

> I considered the most important thing was to emphasise what one should not do, and to point out the temptations in directions contrary to analysis. Almost everything positive that one should do I have left to "tact," the discussion of which you are introducing. The result was that the docile analysts did not perceive the elasticity of the rules I had laid down, and submitted to them as if they were taboos. Sometime all that must be revised, without, it is true, doing away with the obligations I had mentioned. (1928, p. 332)

Freud implicitly suggests that his rules and guidelines of analysis are made to be broken in certain circumstances (Shapiro, 1984).

And while Ferenczi ended his experiments with mutual analysis, ostensibly due to confidentiality considerations, his arguments against anonymity and the classical position form the basis of many critiques from interpersonal, intersubjective and relational analysts today.

Thus, nearly 100 years on "the same arguments that Freud and Ferenczi made putatively based on the same empirical observations, are regularly repeated in contemporary discussions of the issue" (Greenberg, 1995, p. 195). Yet, the issue is neither negated nor resolved and is still clinically relevant, evidenced by ongoing debate and the large body of literature on the topic.

Perhaps, as this is an age-old topic, and at the beginning of my career I could be considered as both young and eager, it is not surprising that therapist self-disclosure interests me.

What first alerted me to this topic was my awareness that with some clients I felt a pull to self-disclose, while with others I felt equally pulled to reveal nothing. While considering what dynamics in both the client and myself led me to feel this way, my next question was whether to disclose or not to disclose.

While initially filled with lofty hopes of definitively answering whether therapists should self-disclose or not, my recognition that this question remains unanswered by experienced and respected clinicians had led me to modify my expectations. Thus, to disclose or not to disclose cannot be answered simply and the topic requires in-depth consideration. Therefore, my initial question has evolved into wanting to understand self-disclosure, clarify definitions and types of disclosure, to think about my experiences of wanting to disclose and find out what things might influence a disclosure. Following a description of the methodology this will be explored in four chapters.

Chapter Two will explore the ways self-disclosure is understood in the literature. It will briefly consider disclosure types and the place of disclosure in analytic technique. It will also consider self-disclosure with respect to modality and neutrality. This will highlight some of the difficulties in thinking about self-disclosure and will consider the ways in which the therapist's theoretical understanding of disclosure influences the decision to disclose.

The following three chapters will discuss three types of self disclosure: implicit disclosures, countertransference disclosures and personal disclosures. These distinctions are made following the identification of disclosure types from the literature and as a way to organize and make sense of the vast amount of information on the topic. However, it is also important to note that while these distinctions have heuristic value they may look different in practice (Blechner, 1992) which will be discussed further in the main body.

Chapter Three will look at implicit disclosure, exploring what constitutes an implicit disclosure, and using a clinical example, consider what influences disclosure. It will consider what would be involved in making this implicit disclosure explicit, moving it from the realm of non-verbal to verbal.

Chapter Four will look at countertransference disclosure, providing a theoretical basis from which this disclosure type can be understood and using an example to consider what factors influenced my disclosure. Following the same structure, Chapter Five will look at personal disclosures.

Finally, Chapter Six will summarise the findings of the literature review, consider the clinical implications, acknowledge the limitations of the study and identify areas for further research.

Methodology

This dissertation was conducted using a modified systematic literature review. Below, the systematic literature review will be briefly outlined and the methodology evaluated in the context of psychotherapy. It will be explained why and how the review has been modified and an outline of this particular review will be provided.

Systematic reviews are a common research method in evidence-based practice, where all available literature on a given topic is reviewed to determine best practice (Trinder, 2000). Literature is found using a set of search criteria and the search narrowed or expanded using specific inclusion and exclusion criteria. The data are then analysed and the findings summarised and critiqued in the review. From this, implications for practice and areas of further research are defined (Sackett, 2000).

Systematic reviews generally use quantitative data from experimental research as the primary evidential source, usually randomised control trials (DeAngelis, 2005). Naturally, this becomes problematic for psychotherapy which has relatively little data of this nature. "Many areas of medicine are acknowledged to lack evidence from methodologically robust studies such as randomised control trials and this extends to many aspects of psychiatry including psychotherapy" (Margison et al, 2000, p. 123).

In this way the evidence-based practice framework can be critiqued in that it is primarily geared towards the evaluation of quantitative as opposed to qualitative data. Grant and Giddings suggest that the evidence-based practice movement aligns with a "positivist approach to knowing" (2002, p. 14), contrasting with psychotherapy, which values the unknown. As Jones states: "Mental events seem to be immeasurable and probably always will be" (cited in Milton, 2002, p.161). Goodheart (2004) implies psychotherapists can and do use evidential sources, including observation, experience, patient reports, peer discussion, professional literature and countertransference.

Therefore, the methodology of this study will be modified to include qualitative studies and professional opinion as evidence. Further modification will be in the use of vignettes from my clinical practice which will serve as a lens through which to review the literature. I will discuss this further at the end of Chapter Two.

Geddes (2000) suggests "the goal of Evidence based practice is to identify the study design best suited to provide the least biased answer possible to a question" (p. 83). Thus, while requiring modification, a systematic review of relevant literature remains the best way to acquire knowledge to inform my practice. Other methodologies were considered, such as qualitative interviewing of therapists about their disclosing behaviour. However, this would not provide as much data about the topic and may be a useful method for further research.

In keeping with the systematic review process my work begins with a clinical question: In psychodynamic psychotherapy, how is self-disclosure understood; what are the types of self-disclosure and what influences a therapist's disclosure?

The review was largely undertaken at the Auckland University of Technology library, using electronic databases, books and the interloan system. Reference lists of relevant articles were searched and the library hand-searched. Further material was obtained by reviewing other articles and books by frequently cited authors.

The databases used consisted of Psychoanalytic Electronic Publishing (PEP) which contains full text articles from ten psychoanalytic journals between 1920 - 2000 and PsycInfo which provides references, citations and abstracts to literature in the

behavioural sciences and mental health. Key words were used in the searching of both databases as shown in the tables below.

Table 1 PEP

Search Term	Articles
"Analyst$ self-disclosure"	14
"Analyst$ disclosure$"	15
"Therapist$ disclosure$"	6
"Analyst$ revelation$"	0
"Analyst$ neutrality$"	12
"Countertransference disclosure"	52
"Non disclosure"	26
Anonymity (in title)	2
Abstinence (in title)	20
Neutrality (in title)	35
Total	132

Table 2 PsycInfo

Search Term	Articles
Therapist self-disclosure	161
Analyst self-disclosure	10
Therapist disclos$	44
Anal$ disclos$	158
Therap$ neutral$	102
Anal$ neutral$	125
Countertransference disclos$	30
Non disclosure	80
Anal$ revelation	3
Anal$ anonym$	11
Anal$ abstin$	19
Total	743

From these searches double-ups were removed and exclusion criteria applied. This included those articles not in English and those articles which pertained to group, adolescent, child or family psychotherapy, as my focus is individual adult psychotherapy. Literature containing the search terms but not relevant to the topic was also excluded. These exclusion criteria reduced the literature to 382 references. Further criteria excluded all literature that came from other modalities, such as psychology, counselling, CBT and humanistic approaches (including Gestalt and Existential therapies), while including all literature from analytic or psychodynamic perspectives. This is because one of the fulcrums of the self-disclosure debate in psychodynamic psychotherapy is the effects of disclosure on transference and countertransference. Arguments from modalities which do not take these phenomena into account do not serve as an adequate base for comparison.

Furthermore, although searching "neutrality" systematically, this has not been used systematically in the dissertation. The intent is to provide an overview of neutrality in relationship to self-disclosure, and therefore it is not within the scope of this dissertation to systematically review and discuss neutrality.

From this a body of 122 references remained, which were read and critically evaluated in order to inform practice. A further 24 references were identified via hand searching, reference lists from the literature and recommendations from supervisors and peers.

The dissertation draws largely upon psychoanalytic literature, whereas I practice psychodynamic psychotherapy. While these are very similar disciplines and it is not within the scope of this dissertation to compare the two, Allison (1994) notes important differences.

> In most psychotherapy, interpretation and neutrality are less rigorous, and the relationship may be utilized supportively—either deliberately by specific interventions, or simply through the vis-à-vis format often used. By contrast, psychoanalysis proper does not have specific goals, is less directive, and therapist support beyond the structure of the treatment itself is usually inadvertent and more restricted. (pp. 344-45)

As Allison suggests, psychodynamic psychotherapy is inherently a more interpersonal and relational discipline. Simply by client and therapist facing each other we can assume that psychotherapy may already involve more therapist self-disclosure.

Therefore, techniques and interventions of psychotherapy may not be completely akin to those of psychoanalysis. However, because the body of literature on psychodynamic psychotherapy alone is not large enough to review the topic, analytic literature has been included. In both, transference and countertransference are central and both are derived from the work of Freud. Thus, with due consideration of the differences, the arguments from analytic literature can be analogous to psychodynamic psychotherapy. The words, 'analyst' and 'therapist' will be used interchangeably throughout the body of this work. The terms 'analysis' 'therapy' and 'psychotherapy' will also be used thus.

Chapter Two – Understanding Self-Disclosure

As already noted, literature about therapist self-disclosure is vast. Additionally there are a number of ways that self-disclosure is defined, understood and discussed. In relationship to the first part of the research question, this chapter will explore and critique the broad understandings of self-disclosure in the literature.

The term self-disclosure was first used in a therapeutic context by humanistic therapist Sydney Jourard in 1958, who referred to it as "the process of making the self known to other persons" (cited in Matthews, 1988, p. 521). Such a broad definition becomes problematic when trying to understand self-disclosure, its types and influences. It is first necessary to understand the how the self is revealed, what is revealed and how this can be understood in a therapeutic context.

In trying to elucidate this process, writers have created some distinctions between types of disclosure. The most common differentiation is made between those disclosures that are deliberate, i.e. verbal disclosures of thoughts, feelings, countertransference and biographical information and those which are inadvertent or unavoidable, i.e. style of dress, office furnishings, and facial expression (Frank, 1997; Hirsch, 2001; Jackson, 1990; Langs 1982; Psychopathology Committee of the Group for the Advancement of Psychiatry, 2001). However, these distinctions are overly general, particularly in the grouping of verbal disclosures. It is necessary to further differentiate self-disclosures.

Disclosure Types

Aron (1996) noting this point names several types of disclosures, including:

- Implicit Self-disclosure – e.g. style of dress
- What the analyst is thinking with the patient
- Immediate affective response to the patient
- Thinking and affective responses to the interactions between patient and analyst
- Explaining why analyst feels as he or she does
- Answering questions e.g. age, marital status.

Aron (1996) suggests further distinctions within each of these types of disclosure including, whether the disclosure is spontaneous or thought out, who initiates the disclosure, the content, and whether or not the disclosure opens or closes exploration. Thus, disclosures can be considered both in terms of type, e.g. implicit or countertransference, and then further understood in terms of context.

Thus, not all disclosures are equal. A disclosure of a therapist's personal history is not analogous to a disclosure of a countertransference feeling and unhelpfully grouping self-disclosures can miss the motivations, uses and effects of different types (Davis, 2002; Greenberg, 1995). In recognising these differences, a critique can be made of much of the literature, in that a) it is not always clear what is meant by self-disclosure and b) arguments for and against self-disclosure are treated as absolute, even though they may not be mutually exclusive. For example Maroda (2002) argues for disclosure to complete affective communication, which will be discussed more in Chapter Three, while Teicholz (2001) argues against disclosing to clients who cannot tolerate the different subjectivity of the therapist. In reality these are two quite distinctive things; one relates to mutual affect regulation and moderation, while the other relates to a client's inability to differentiate between me/not me. However, a homogenisation occurs, where these are all considered self-disclosures and further a polarisation occurs, where self-disclosure becomes something that is considered always appropriate (Renik, 1999) or always inappropriate (Fleischmann, cited in Brice, 2000).

Therefore, a goal of this dissertation is to more fully consider the different types of disclosure and how these differences might influence the therapist's disclosure. In considering influences and the decision to disclose, this dissertation, while acknowledging unconscious aspects of all disclosures, is primarily interested in conscious disclosures. While it is not possible to consider every variant of disclosure, based on synthesis of the reviewed literature and a need to categorise disclosures in a manageable way this dissertation groups them into three broad types.

The first category is implicit disclosures: the way the therapist presents him or herself as a person in the room, such as style of dress, tone of voice or office furnishings (Davis, 2002). The second category is countertransference disclosure: the sharing of the analyst's feelings towards the patient Ehrenberg (1992) and of thoughts and observations related to the analytic encounter (Burke 1992; Cooper, 1998a). Finally

personal disclosures: the therapist's biographical information and personal thoughts and feelings, such as martial status, holiday plans, past experience and opinion (Goldstein, 1994).

The remaining chapters will be structured around these types. However, the dissertation will first consider the general ways self-disclosure is thought about in the literature.

Technique, Occurrence or Enactment

A baseline question about self-disclosure is whether it is a technique that can be used in certain situations to further certain therapeutic aims, (Frank, 1997; Gerson, 1996a 1996b; Maroda, 2002; Renik, 1995, 1996, 1999); simply a one-off event that occurs uniquely in each dyad (Aron, 1996; Greenberg, 1995; Hanly, 1998; Jacobs, 1999; Orange & Stolorow, 1998); or at worst, an enactment (Adler & Bachant, 1996; Baker, 2000; Langs, 1982) where the therapist is drawn into playing out a role from the client's past (Gabbard, 1995), or enacts his/her own transference. A view of disclosure as enactment, event or technique has different implications for the understanding and use of self-disclosure.

Disclosure as a technique implies usefulness, purpose, credibility and a sense of standardisation. It suggests that it is possible to consider when disclosure is indicated and contraindicated, that self-disclosure can be part of the therapist's standard repertoire and may be generalised to certain situations.

Self-disclosure as a one-off event implies an ad–hoc nature, that each disclosure is so unique that it cannot be thought about in theory but only in practice (Hanly, 1998). In this view, self-disclosure may be useful but is an extra-analytic event and cannot be generalised.

Disclosure as enactment is generally seen as an error and a sign of the therapist's difficulty in managing countertransference. An enactment is considered to have taken place when the therapist responds unconsciously to the client, outside of normal behaviour and in an uncontrolled way (Maroda, 2002). Bollas (1989) is careful to define disclosure as "congruent with the character of the analyst" (p. 488) thus distancing self-disclosure as a technical intervention (congruent) from an enactment (incongruent).

However, distinguishing between technique and enactment is not as easy as Bollas implies, given the acknowledgement that the therapist cannot always be conscious of what is occurring in the relationship (Bolognini & Sechaud, 2000; Greenberg, 1995). Disclosures can be made consciously for one purpose but be unconsciously motivated by another, thus becoming "pseudo deliberate self-revelations" (Hanly, 1998, p. 552). For example, a disclosure of holiday plans may be done consciously to develop a working alliance and foster open communication, while unconsciously motivated by competitiveness. Thus, an outwardly technical intervention can become an unconscious enactment.

Furthermore, "your technique is my transference-countertransference enactment, and vice versa" (Burke, 1992, p. 245), highlighting a difference between classical and relational views of self-disclosure. In the former, an enactment is a failure on behalf of the therapist, even if it can be used to advantage (Adler & Bachant, 1996; Baker, 2000) while in the latter, enactment is seen as a necessary part of analytic work (Ehrenberg 1992; Newman, 1992; Renik, 1995, 1996, 1999) and furthermore must be made explicit for the client to understand how they recreate old patterns (Gill, 1984: Hirsch 1987; Wachtel, 1986). Transferences can not be fully understood until they are enacted with the therapist, and cannot be fully resolved until therapist and client together find a different way out of a familiar situation (Mitchell, 1988).

Critique can be rallied against all of these ways of thinking. A blanket view of disclosure as either always technique or enactment is simplistic, missing different intent, context and effect.   As Murphy notes, "Therapist self-disclosure can be well timed, well understood, geared to the developmental needs of the patient and helpful, or it can be random defensive, geared to the needs of the therapist and destructive to the psychotherapeutic relationship" (1996, p. 11).

Viewing disclosure as a one-off event attempts to overcome this black and white thinking, recommending consideration of the unique factors of each relationship and moment. However, emphasising uniqueness risks limiting discussion of where some disclosures could be generalised to more than one therapy (Gerson, 1996c). Thus a gap may exist between theoretical thinking about self-disclosure and the practical realities of the uniqueness of each relationship.

Blechner (1992) notes this gap:

> I acknowledge the flaw endemic to all discussions of psychoanalytic technique — in striving for descriptive precision; we may be diminishing, in our discussion, the interactional dynamism that is essential to a working, collaborative psychoanalytic relationship. I believe that describing a technique sui generis has heuristic value, nevertheless, and presumes that in actual practice, its application will always be more complex and subject to mutual interactional regulation between analyst and patient. (p. 165)

Here, Blechner advocates flexibility in technical thinking. Herein, this dissertation aims to merge theoretical thinking with practical situations, to establish ways of thinking about disclosure that can be applied to the uniqueness of each situation.

Modality and Disclosure

Definitive views of self-disclosure as technique or enactment are related to fixed theoretical understandings. suggesting that the therapist's theoretical base, or modality is a key influence in the decision to self-disclose. This is supported by both qualitative investigation (Simon, 1988) and opinion in the literature (Basson, 1997; Buechler, 1993; Busch 1998; Farber, 2005; Greenberg, 1986a; Hoffman, 1983).

Discussions about self-disclosure centre around two distinct theoretical models, namely the classical/analytic model and the relational/intersubjective model. While a comparison of the two schools would encompass a whole dissertation, the key differences and their relevance for self-disclosure shall be identified.

A summary of the different views of pathology, relationship and cure are shown in Table 3 below. It is acknowledged that this oversimplifies these modalities and risks the polarisation being critiqued in the literature. However, this will summarise and make sense of a vast amount of information. In reality, these differences lie more along a continuum.

Table 3

Classical View	Intersubjective View
Transference/past	Relationship/here and now
Fantasy	Reality

One person/analyst as observer	Two person/analyst as participant
Frustration	Gratification
Doctor/patient	Equal humans
Insight	Experience
Regressive/old object	Reparative/new object
Intrapsychic pathology /Drive Conflict Model	Interpersonal pathology
Resistance	Mutual resistance

In the classical view, the client suffers from intra-psychic conflicts related to instinctual drives. The client brings transferences, which are projected onto the neutral analyst. Frustration maintains motivation (Lane & Hull, 1990) and the therapist refrains from gratifying the client's wishes to maintain momentum and focus on the unconscious and the transference. Through abstinence and interpretation, the therapist assists the client to develop insight into his transferences. In short, "thoughts feelings impulses dreams fantasies and traumatic memories are to be revealed to an objective, understanding and empathic listener. In this way, the power for the patient's critical superego is reduced, fostering the emergence of unconscious material, With the development of healthier ego controls the patient is slowly freed from the debilitating anxiety that keeps him from living more fully" (ibid, p. 33).

Naturally, if fantasy is accorded primacy, controlled regression seen as a way for the client to re-experience the therapist as an old object and interpretation the vehicle through which the client recognises his old object representations, then there is little room for self-disclosure, or any manifestation of the therapist's personality. This could clearly impede the client's ability to distinguish between his own transference and the reality of the therapist (Davis, 2002). Similarly, if the client's conflicts are intra-psychic then the therapist's own material would simply create confusion. "It is a one neurosis, not a one person relationship" (Adler & Bachant, 1996, p. 1038).

A number of valid critiques of the classical model can be made as new understandings emerge about a) the role of countertransference as data in the analysis (Strean, 1999); b) constructivist philosophies, discarding the notion of the purely objective observer and the recognition that there is no objective truth about the client to be discovered (Kirman,

1998); c) the relational role of development, particularly the primary caregivers role in affect regulation and mentalisation (Bromberg, 2002; Fonagy, Gergeley, Jurist & Target, 2002; Maroda, 2002; Stern, 1985) resulting in reconsideration of the drive model to a more relational one, and d) an acknowledgment of the client's ability to know and think about what is occurring and subsequent diminishment of the therapist's role as arbiter of truth (Hoffman, 1983).

It is largely from these developments and critiques that the relational intersubjective model emerged. Here, there are two subjectivities in the room which interact with and influence each other (Aron, 1996; Burke, 1992; Levine & Friedman, 2000; Mitchell, 1988; Orange and Stolorow, 1998; Renik, 1995, 1996). The therapist "originates interactions by his presence and ideas" (Moraitis, 1993, p. 333). Zeddies, refers to a "relational unconscious" (2000, p. 473) where the content of the therapy is created by the client, therapist and their relationship. Therefore, transference is co-constructed and is based on the fit between the client's pathology and therapist's personality (Gabbard, 1995). Thus, the therapist not only has the possibility to be experienced as an old object but also the potential to act as a new object (Cooper & Levitt, 1998). Therapy occurs in a "two person" as opposed to a "one person" paradigm (Kirman, 1998).

Of course if the therapist's subjectivity influences the analysis, then there is greater scope for that subjectivity to be shared. However, just because an analyst works intersubjectively does not follow that he/she will use disclosure (Gill, 1983), nor do intersubjective principles justify the use of self-disclosure. "Any observation obviously reflects analytic subjectivity, but this interactional mode differs considerably from direct expression of analysts' feeling states or personal data about analysts' lives" (Hirsch, 2001, p. 121). Bernstein (1999) further suggests the therapist's personality is not the same as his subjectivity; however Peters (1991) argues that personality is inseparable from technical choices.

This again points to oversimplification and polarisation, where intersubjectivity becomes synonymous with disclosure. Arguments can easily focus on comparing modalities as opposed to considering the indications or contraindications of self-disclosure. Furthermore, when theory becomes the largest influence, the decision to disclose becomes inherently therapist centered, since modality choice is in large part due to the therapist's personality and philosophy (Aron, 1997; Hirsch 2002; Renik,

1995; Strean, 1999). Thus, theoretical, modality based discussions about self-disclosure assume not only homogeneity about disclosure types but also about clients and their needs, further evidenced by a lack of discussion or research about the effects of self-disclosure on clients (Farber, 2005; Jacobs, 1999).

Neutrality and Disclosure

Just as self-disclosure can be understood as a reflection of modality, self-disclosure is frequently discussed in relation to neutrality. Neutrality is a complex concept; however, three key points emerge about neutrality in relation to self-disclosure.

Firstly, neutrality has come to be juxtaposed with self-disclosure. Freud not only cautioned against self-disclosure but offered an alternative, the concept of the mirror which has become synonymous with neutrality, abstinence and anonymity. Added to the metaphor of the "surgeon" (Freud, 1912, p. 115) who puts aside all feeling, it is easy to see how a picture of a neutral analyst as someone who said little and showed little personality emerged.

However, it is of note that Freud did not use the term neutrality, which originated in an English translation by Strachey in 1924. Similarly, Freud discussed these concepts in a particular social context, including the positivist movement in science (Bernstein, 1999), Victorian culture (Frawley O'Dea, 1998), his largely hysterical client base (Buechler, 2002), his views on countertransference as destructive, and his position as both practitioner and pioneer of psychoanalysis, attempting to prove it as a science (Greenberg, 1986b).

Freud also made a number of tempering recommendations, including that the analyst have "sympathetic understanding" (1913, p.140) and be aware of the patient's capacity for depravation (1915), clearly suggesting his recommendations were not dogmatic but adaptable to circumstances. As Gill (1983) notes, Freud and neutrality are frequently misunderstood.

Secondly, neutrality suffers from similar disagreements about its technicality as self-disclosure. Neutrality is considered as either a stance or a technique, each of which are different. However, within these two frameworks, unlike self-disclosure which is homogenised, neutrality is almost the opposite, in that "every analyst has his own way

of defining and using his position of neutrality" (Hoffer, 1985, p. 774). Some of the understandings of neutrality are briefly outlined below.

Neutrality as a stance refers to the analyst's internal position, first described by Anna Freud (1966) as remaining equidistant from id, ego and superego, giving equal attention to conscious and unconscious aspects of the client's material. The therapist's neutral stance is also described as regulating his/her emotions despite outside influences (Cooper, 1996) and as an internal potential space (Bollas, 1983), perhaps similar to Bion's (1967) view of entering the room without memory or desire. This may be difficult to achieve, given our hopes and treatment goals for clients (Beucheler, 1999; Poland, 1984).

In more recent recognition of the personal influence of the therapist, a neutral stance has come to encompass openness, paying equal attention to observing client and therapist (Wolf, 1983; Wolf & Leider 1984) and being ready to reformulate understandings as new data emerges. Franklin refers to this openness as "essential neutrality" (1990, p. 214).

Neutrality as a technique is behavioural, closely related to abstinence and anonymity. Descriptions of technical neutrality include: avoiding all interventions other than clarification or interpretation (Langs, 1982) and having responses but choosing not to share them (Chused, 1997; Hanly, 1998). Technical neutrality is linked to the analytic frame, providing space for the patient's free associations (Adler & Bachant, 1996) and as a way to avoid enactment and maintain boundaries (Scaturo, 2005).

Technical neutrality also bears specific relation to transference. Loewald suggests that the neutral analyst "must be objective and neutral enough to reflect back to the patient what roles the latter has assigned to the analyst and to himself in the transference situation" (1960, p.16).

However, just as disclosures can have unconscious motivations, so too can neutrality, by avoiding affective engagement (Maroda, 2002), sadistically withholding (Ehrenberg, 1995) or defensively avoiding the therapist's own feelings (Rosenblum, 1998) thus becoming "false neutrality" (Poland, 1984, p.293). Furthermore, behavioural neutrality may be experienced by the client as safe and calming or dangerous and provocative, therefore not actually being neutral (Basescu, 1990).

Variations in definition give rise to a key issue, where disclosure and neutrality are frequently compared without identifying which type of disclosure is being compared with which type of neutrality. Technical neutrality is easily seen as opposed to self-disclosure, while neutrality as an internal stance can mean that neutrality and self-disclosure are not mutually exclusive (Burke & Tansey, 1991; Greenberg, 1986a; Simon, 1988; Stricker, 1990).

Baker (2000), Shill (2004) and Hirsh (2001) outline a further critique, noting the way in which the difficulty in defining and achieving neutrality is often used as an argument to dispose of it and instead employ self-disclosure. This relies more on disproving neutrality rather than demonstrating the effectiveness of disclosure, again foreclosing discussion about which stance or behaviour is most therapeutic in a given situation.

Here, neutrality and self-disclosure are polarised (Levy and Inderbitzen 1992; Davis 2002) This is evident in the reviewed literature where the neutral analyst is described as a "nonperson" (Menaker, 1990, p. 103) who is "uninvolved" (Frank, 1997 p. 282), while disclosure is authentic and genuine (Maroda, 2002; Renik, 1999). As Crastnopol (1997) points out, disclosure is not necessarily more authentic than being concealed. For example, saying "I'm glad you came today" following absence may be used defensively, disclosing one affect to conceal another (Josephs, 1995), namely the therapist's irritation that the client missed the previous session. In this way, as Aron (1996) notes, disclosures both conceal and reveal and thus cannot be always considered as offering "the gift of intimacy" (Fisher, 1990, p. 12).

Aware of tendencies to oversimplify and polarise, Burke (1992) and Aron (1996) suggest that disclosure should be thought about in terms of asymmetry and mutuality, where mutuality is the extent to which both parties influence the relationship, while asymmetry is the extent to which only one party is the focus of the relationship. In this way the relationship can be mutual, acknowledging the inevitable influence of the analyst and asymmetrical, focusing on the thoughts and feelings of the client. Considering how these two facets of the relationship interact at any particular time allows for the uniqueness of each relationship, making self-disclosure open for use from either a classical or intersubjective position.

Similarly, Bacal and Herzog (2003) advocate use of "specificity theory" where the therapist tailors the treatment process to the needs of each client by assessing optimal responsiveness. However, there is little to guide the therapist in assessing what will be optimal in any given situation. It is this area that will be addressed in the later parts of this dissertation, identifying whether there are common considerations or influences which may help guide the therapist's disclosure in each unique situation.

Conclusion

This chapter has discussed how self-disclosure is understood in the literature, in terms of type, place in technique, relationship to modality and relationship to neutrality. Several key critiques emerge from this. Firstly, lack of differentiation between disclosure types misses the different ways disclosure can be used. Secondly, polarised views of self-disclosure, evidenced in discussions about technique and modality, are largely theoretical and minimise the reality of each unique therapy. Thirdly, the juxtaposition of disclosure and neutrality can be questioned given the numerous ways both of these terms can be understood.

It can further be concluded that these understandings will also influence the therapist's decision to disclose. The therapist's definition of self-disclosure, view of self-disclosure in relationship to modality and understanding of neutrality all play a part in whether or not the therapist discloses, what is disclosed and how. However, purely theoretical understandings can miss the client and may not give a full picture of what influences disclosure. Thus, this dissertation aims to identify further influences in the following chapters and to bridge theoretical thinking with clinical practice.

Importantly, the literature does not explicitly talk about what influences a disclosure, instead raising certain themes or issues as a way to advocate for or against self-disclosure. As noted in the introduction, this is not the purpose of this dissertation, but rather to more fully explore what would influence a decision to disclose. These themes will be reviewed and critiqued, with a focus on how they manifest in clinical situations through the use of illustrations as a framework to organise and review the literature.

The following chapters will review different types of disclosure and the influences of disclosure, beginning with implicit disclosure in Chapter Three, countertransference disclosure in Chapter Four and personal disclosure in Chapter Five.

Chapter 3 – Implicit Disclosure

This chapter will look at ways in which therapists disclose implicitly and the influences in this type of disclosure. These influences will be viewed through the lens of a clinical illustration and will further look at what might influence a decision to make an implicit disclosure explicit.

Understanding Implicit Disclosure

The literature suggests three main types of implicit disclosure. The first includes physically observable things about the therapist, such as dress and furnishings. "Analysts show themselves all the time in their dress, in their office surroundings, in their manner of speaking, in the way they establish time and money ground rules and in the myriad ways of being that are publicly observable" (Basesceu, 1990, p.51).

Secondly, implicit disclosure includes the therapist's style: the questions asked, what is focussed upon, facial expression, what is remembered and interpreted or what is forgotten (Aron, 1996). Renik (1995) notes that even silence communicates, displaying the therapist's response to the client's material. Greenson (cited in Orange & Stolorow, 1998) gives an excellent example, citing a client who was able to ascertain his therapist's political affiliations based on his questioning of some political topics and not others.

Thirdly, interpretation is an implicit disclosure, where a correct interpretation reveals the therapist's own feelings and experiences (Aron, 1992). "It takes one to know one, and in his correct interpretation the therapist reveals that he is one" (Singer, 1968, p. 369). For example, an interpretation of a client's attempt to elicit anger could implicitly disclose that the therapist had felt angry. Equally, an incorrect interpretation discloses, perhaps more so, since the therapist may be responding more to something about himself than the client. Cooper (1998a, 1998b, 1998c) refers to these alluded disclosures as "virtual disclosure".

Implicit disclosures are usually viewed as unavoidable, non-verbal, inadvertent and unconscious (Frank, 1997), concerning what is shown to the client rather than what is told. However, not all verbal disclosures are deliberate and conscious, nor all non-verbal disclosures are inadvertent and unconscious. Addressing this issue, Levenson

distinguishes between self-revelations and self-disclosures. "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" (1996, p. 238).

Accepting the inevitability of implicit disclosure creates an assumption that there is little therapist control or decision-making in these disclosures. However, the therapist's clothing, office decoration, what the therapist responds to, what is interpreted, facial expression and tone are all a product of decisions, although perhaps made unconsciously. Thus, while acknowledging unconscious aspects to all disclosures, this dissertation is primarily interested in conscious disclosures.

While not distinguishing between revelation and disclosure, this dissertation uses Aron's (1996) term "implicit" suggesting the covert nature of these disclosures rather than distinguishing whether they are verbal or non- verbal or whether therapist or client are aware of them. Furthermore, both personal information and countertransference feelings can be disclosed implicitly, thus implicit disclosure is not a discrete category and overlaps with other types. The implications of this overlap will be discussed in Chapter Six.

The following paragraphs will consider implicit disclosures more fully, through the lens of a clinical example, considering conscious and unconscious influences. The chapter will also consider what would influence making the implicit disclosure explicit, as is recommended by a number of authors.

Carrie – An Example of Implicit Disclosure
Carrie spent most sessions telling anecdotes about her young daughter. She had difficulty talking about herself and could acknowledge this difficulty but was largely dismissive of invitations to talk about it. Attempting to get Carrie to talk more about herself I began to respond less to her material about her daughter, i.e. keeping my face expressionless and not using minimal encouragers. Alternately, I attempted to use her observations about her daughter to shift the focus back to her. Implicitly, I was saying "I'm not so interested in that, but I am interested in this".

Consciously I attempted to foster Carrie's psychological mindedness. However unconsciously I may have been motivated by my own frustration and in showing interest in some topics over others I could easily have been training her to be a 'good client'. Perhaps a further implicit disclosure was made, namely "I am frustrated with what you are talking about." This frustration may have been countertransferential but also influenced, as Frank (1997) suggests, by my own personality and meta-theories, where personal responsibility is a core value.

Thus, my implicit disclosure likely contained both technical and enacted elements, conscious and unconscious influences. Goodman (1995), acknowledging the unconscious aspects of implicit disclosures suggests that they are more likely to represent an enactment. He identifies the tension between containing and responding. As a container, the therapist reflects upon affective responses to a client and develops awareness of the client's projective identifications. In responding the therapist can consciously verbally reflect what has been contained, or reflect it unconsciously through implicit communication, which is where Goodman sees enactment occurring. Therefore, responding can be a function of containing, i.e. completing the cycle of affective communication, or a sign of inadequate containing, particularly if done unconsciously.

Disclosure resulting from an inability to contain is often linked to the young and eager therapist. Davis (2002) suggests that new therapists have less experience with transference and countertransference, find it difficult to contain the projections of their clients and place less trust in their ability. In this example perhaps an inability to contain frustration was being enacted. However, it cannot be assumed that these difficulties only belong to inexperienced therapists. Simon's (1988) qualitative study concludes that experienced therapist's are more likely to disclose than new therapists because they feel more relaxed. However, it is unclear whether being relaxed facilitates helpful or unhelpful disclosures.

Furthermore, the extent to which my feelings of frustration were disclosed, e.g. through tone of voice or facial expression, or apprehended by Carrie is unknown. Josephs (1990) proposes that client's consciously or unconsciously compare their felt experience of the therapist with what is said, ascertaining the unsaid. Hoffman (1983) similarly suggests that the client is the interpreter of the analyst's experience and is aware of what is being communicated through implicit disclosure. A question arises regarding the extent to

which these disclosures affect the client and the relationship; however, no research exists on this issue.

It is also unknown how accurately clients interpret implicit disclosures. As Kirman notes, everything that the analyst presents to the client is available equally for his transference use. "To assume that truths about the analyst are continually revealed to the patient is to deny the patient's subjectivity" (1998, p 12). Carrie might have been aware of my frustration, however she may have interpreted its origin as quite different to my understanding. I suspect she assumed my frustration was because I was tired of hearing about her, rather than because I wanted to hear more.

Making the Implicit Explicit

Acknowledging the scope for misinterpretation of implicit messages, it is easy to see why some authors advocate naming the elephant in the room, suggesting that since the analyst's constant implicit revelations influence the relationship in both observable and unobservable ways, that they should be made explicit and verbally disclosed (Chused, 1997; Ehrenberg, 1995; Fisher 1990: Frank, 1997; Maroda, 1997, 2002; Renik, 1995, 1996). Maroda suggests that when the therapist's responses are pushed away and hidden they are more likely to result in unhelpful outbursts. She asks: "Wouldn't it be better to reveal this material as a matter of course rather than waiting for it to build beyond the analyst's tolerance and burst forth like some alien within?" (2002, p. 84).

My experience with Carrie may have presented an opportunity to let her know how I experienced her discussions of her daughter and explain why I was not responding to this material. However, a decision to do this would be based on a number of assumptions.

Firstly, that the therapist's feelings accurately represent something about the client. However, if we assume that clients communicate projectively, then therapists can do likewise. As noted above, my frustration could equally have been my own transference, something central to my experience but irrelevant to Carrie's. Thus, my own dynamics may influence the disclosure more than the needs of the client. Racker (1968) noting the complexity of the interplay between the unconscious of therapist and client, uses this very point to argue against self-disclosure. In a more vehement critique, Eagle (2000) and Bernstein (1999) suggest that in attempting to create a more mutual and

symmetrical engagement, such disclosure ironically creates a new one-person psychology, where the therapist becomes the focus.

In this way, Eagle and Bernstein raise questions of initiation of disclosure and frequency. It is one thing to discuss the therapist's impact if it is bought up by the client and another for the therapist to introduce this for discussion. This risks the narcissistic use of the client by the therapist, discussed more fully in Chapter Four. This risk is perhaps greater the more frequently the therapist initiates disclosure. A further risk of frequent disclosure is that therapists may feel expected to disclose. When this occurs, Wilner (1998) suggests therapists may unconsciously withhold experiences to avoid disclosure. "One may be experientially closed and self-disclosing at the same time, as more and more may be disclosed about less and less" (ibid, p.430). This suggests a reduction in the potency of disclosure.

Many authors suggest disclosure should be used 'judiciously' (Aron, 1996; Cooper, 1998a, 1998b; Rachman, 1998), with the implication that judicious is infrequent. However, this may be a difficult thing to judge, since what is judicious or frequent may be a personal and arbitrary decision and be different for different clients. In evidence of this arbitrariness Callan (2005) recommends one disclosure per client per year!

Maroda (2002) recommends disclosing in response to a question only after exploring the question and in consultation with the client, suggesting that the client's initiation is an important influence in disclosure. However, not all decisions about self-disclosure can be handed to the client, particularly low functioning clients, who may not have the ego strength to judge what they need. Furthermore, this recommendation contradicts Maroda's earlier statement about disclosing as a matter of course to avoid the "alien within" (p. 84), again demonstrating the impossibility of creating fixed guidelines about disclosure.

Conversely, Renik (1999) proposes that explication of the implicit should occur all the time, suggesting that clients are often unfairly expected to try and guess what is on the therapist's mind. "Case specific factors and judgements relevant to a particular clinical moment never militate against self-disclosure; they determine the form of the analyst's self-disclosure" (ibid, p. 533). He assumes that the therapist is a large and looming figure for the client and that the client is interested in what is occurring within the

therapist. Furthermore, he assumes that the client has enough observing ego to discuss these dynamics usefully. In the example above, Carrie is frequently dismissive of my interventions and would likely be disinterested in a disclosure. Further, this may represent a damaging countertransference enactment, where I become more interested in myself than her, as was Carrie's mother.

Josephs (1990) notes that in many cases, clients choose not to apprehend implicitly disclosed information. For example, Carrie knows my office is not my own, and despite this, recently exclaimed "I just bought some cushions like yours." Her transference wish for twinship overrode her knowledge that the office furnishings were not statements of my personal taste. Jackson (1990) advocates non-disclosure out of respect for clients' needs to discover things about the therapist in their own time. As Kirman (1998) proposes, the therapist's constant implicit revelations could suggest need for more caution, as opposed to more disclosure.

Conclusion

Implicit disclosures can be complex and while often inevitable, this does not mean that they cannot be thought about or their impact and influences analysed.

My implicit disclosure to Carrie involved both conscious and unconscious influences. It was also influenced by my personality and my own transferences. In recognising this implicit disclosure, I was faced with the decision of whether or not to make the implicit explicit. I chose not to do this, influenced by my assessment of Carrie as a client who largely experienced twinship and mirroring needs.

While this chapter discussed one example, it can easily be imagined that other implicit disclosures may involve similar choices influenced by conscious and unconscious elements in both client and therapist. In the following chapter, I will look at understanding countertransference disclosure and further influences in therapist disclosure.

Chapter 4 – Countertransference Disclosure

Countertransference disclosure is most frequently referred to in the literature and involves verbalising the therapist's countertransference feelings and experiences. However, this becomes more complex when considering differing definitions of countertransference. This chapter will look at ways of understanding countertransference disclosure. It will draw from the reviewed literature what influences a countertransference disclosure using a clinical illustration.

Understanding Countertransference Disclosure

Viewed in Freudian terms, countertransference is the analyst's responses to the client's unconscious communication which must be overcome (Freud, 1910). Disclosure of this countertransference can be seen as burdening the client and evidence of the therapist's inability to contain his/her own transference (Tansey & Burke, 1989). From this perspective, countertransference disclosures represent a negative enactment on the part of the therapist.

Contemporary views of countertransference see the analyst's thoughts and feelings as a source of analytic data; however, there are a number of ways this data can be understood. One view sees countertransference in projective terms, as communication from the client elicited in the therapist (Kirman, 1998).

In this view, disclosure becomes an interpretive act (Aron, 1996), with the specific intent to name a projected feeling, as opposed to sharing something of the therapist's self. Furthermore, it is suggested that self-disclosure is a required technique in the interpretation of projective identification (Cooper 1998a; Cornett 1991; Warburton, 2004) since the therapist must find a way to communicate to the client that their projective messages have been received, understood and processed.

Cooper (1998b) argues that there is little self in this disclosure and refers to "analyst disclosure" signifying use of the analyst's professional self as opposed to sharing something personal. Meissner agrees, suggesting that affective responses, such as noticing a client's or her own sadness in a session are "ordinary analytic intercommunication between analyst and analysand," (2002, p. 836), not self-disclosures.

However, it cannot always be assumed that countertransference feelings come from the client, or that the therapist is accurately attuned to the client's affective communication. Although intersubjective, this view seems to ignore the therapist's subjective interpretation and suggests a clear distinction between the therapist's personal response and projective identification; that the therapist is so well analysed as to be able to tell the difference. However, as Greenberg writes "I am not necessarily in a privileged position to know, much less to reveal, everything that I think or feel" (1995, p. 197).

Aron (1991) suggests the term countertransference is misleading, as it implies a reactive response and "minimizes the impact of the analyst's behavior on the transference" (p. 33). Eagle (2000) proposes that the Freudian view of countertransference should not be wholly discarded, since the role of the therapist's own transference, pathology and capacity to enter enactment must be taken into account.

Another view sees countertransference as the totality of the therapist's responses, including those which originate in the therapist and the client (Rosenberg, 2006). This increases what may be shared in a countertransference disclosure, including a) feelings in response to the client (Bollas, 2001), b) other feelings and thoughts that emerge in the session (Ehrenberg, 1995), c) feelings and thoughts about the client that emerge outside of the session (Aron, 1996), d) the analyst's free associations to the client's dreams or material (Bollas, 1983, 1989) and e) associations that are absent from and related to the client's associations (Aron, 1992).

This view supports a mutual and more symmetrical view of analysis, where the unconscious material of both participants is meaningful to the analysis. Here, countertransference disclosure can also be motivated by other intents, to introduce the different subjectivity of the therapist (Cooper, 1998a), or to let clients know how they affect the therapist (Ehrenberg, 1996; Jacobs, 1999), developing insight into their ways of relating. Little (1951) suggests that both objective and subjective feelings should be shared, to avoid enactment.

> Analysts often behave unconsciously exactly like the parents who put up a smoke-screen, and tantalize their children, tempting them to see the very things they forbid their seeing; and not to refer to counter-transference is tantamount to denying its existence, or forbidding the patient to know or speak about it. (p. 38)

Little further advocates for admitting mistakes, including an explanation of what in the therapist's personality or countertransference response led to the mistake, supported by Bollas (2001) and Renik (1999).

Here, countertransference disclosure is a process comment where the analyst lends "participatory powers to an experiential and reciprocal process" (Ginot, 1997, p. 366) to explicate the understanding of the relationship. Orange and Stolorow (1998) question the very notion of selfhood as an isolated mind, suggesting that the self is a relational construct and that what is disclosed by the therapist is a creation of, and therefore relevant to, both parties.

Just as considering countertransference as purely projective misses the role of the therapist's own dynamics, considering countertransference as the totality of responses can be equally problematic. Here, almost any response that the therapist has can be considered countertransference and potentially be disclosed. This creates greater potential for the misuse of self-disclosure, namely that under the guise of countertransference and collaboration, the focus of the therapy could shift to the therapist (Gill, 1983). Alternatively, the therapist could more freely project and attribute his own pathology to the client. Furthermore, similar assumptions are made as described in Chapter Three, namely that the therapist is always aware of his countertransference responses, that these are of interest to the client, that the client has capacity to tolerate either the different subjectivity of the therapist or the intimacy of disclosure, and that the client has enough observing ego to discuss the dynamics occurring.

Both projective and totalistic views of countertransference invite questions about Racker's (cited in Feinsilver, 1999) distinctions between countertransference that is concordant, an experience of the client's self representations, or complementary, an experience of the client's object representations. Projective countertransfernece can perhaps be understood as concordant, since it represents a disowned aspect of the client. However, there is little mention of complementary countertransference in the literature, raising the question, as Cooper (1998a) does, whether complementary countertransference is seen as less appropriate. Perhaps naming feelings, similar to others in the client's life, may be seen more as an enactment. This is something which could be considered further. Certainly, in the example below, the less palatable feelings of frustration and contempt (likely complementary) were not disclosed.

These considerations invite questions about content. Buechler (1993) suggests that each therapist will have largely unformulated ideas about what contents are appropriate. However, a clear line has been drawn against disclosure of erotic countertransference (Davis, 2000; Ehrenberg, 1992; Gabbard, 1996, 1998; Barnett, 1998) which is considered as a boundary violation, with the exception of Davies (1998) and Frawley O'Dea (1998) who argue that erotic feelings can be disclosed on a symbolic level. Breger (1984) suggests that negative feelings should never be disclosed as they are always perceived as attacking and therefore likely to censor the client's free association. However, this again assumes homogeneity about clients and their responses.

Most examples in the literature refer to disclosing the different subjectivity of the therapist, although this may be concordant. There is very little written about disclosure of similar subjective experiences. Thus, the literature largely misses the potential use of disclosure to join or to "foster the client's connection to the human condition" (Cornett, 1991, p. 56).

In these ways the understandings of countertransference will influence not only the decision to disclose but what will be disclosed, why, when and how. The following paragraphs will explore further influences structured around a clinical example.

Sylvia – The Decision to Disclose
This illustration will consider a countertransference disclosure and discuss the issues and influences involved.

Sylvia presented as though her life was perfect, marred only by the bulimia which bought her to therapy. However, Sylvia had survived a brutally abusive father and an un-protective mother. In response Sylvia had created a perfect fantasy world where both she and her mother were perfect.

This fantasy manifested in the way she spoke incessantly and happily, even about terrible things, seeming not to need anything. Conversely, I often felt overwhelming affect, largely anger and sadness. Sylvia seemed to idealise me while simultaneously rendering me impotent, not allowing me space to speak.

In the weeks leading to my disclosure I had been feeling angry at Sylvia's denial and frustrated at feeling nonexistent. During a powerful supervision session, I became deeply connected with the grief I was feeling about her abuse and recognised just how

vulnerable and upset I felt. It seemed that she had projected her vulnerability and fear into me. Through my own tendencies to avoid vulnerable feelings I had covered the vulnerability with anger. In this way the projective identification was a "mutual event" which also found some hook within me (Maroda, 2002, p. 111).

Following this supervision and based on the influences I will discuss below, I decided to use a countertransference disclosure to let Sylvia know that her projective messages had been received and that I could experience and survive her intolerable and terrifying feelings.

The session began as usual where Sylvia talked at me for several minutes about her week and how great things were.

> *Sylvia: …so on the positive note I have been reading lots of books, yeah so that's all good.*
>
> *Jayne: You know, I have been thinking about you over the week [Oh thank you] and I have had a lot of feelings [Yeah]. I notice I have been very connected with your vulnerability.*
>
> *Sylvia: Yeah, I guess I have been feeling quite vulnerable. It's just that I don't want to go back there. It's like when is all this shit going to end? I just want to be happy.*
>
> *Jayne: You don't really want to feel the feelings underneath.*
>
> *Sylvia: I know sometimes I do just push them away. I don't know what would happen if I let them all come (pause).*

My ability to recognise and process the projected feelings and to show Sylvia that I could survive them allowed her to begin to reintegrate her disowned feelings. In the following weeks, we experienced a deepening of the working alliance and Sylvia began to talk more about her past and recognise her denial and unreality.

Influences

A number of themes in the literature about disclosure relate to this example. The following paragraphs will consider how these themes influence the decision to disclose.

Geller (2003) suggests that the decision to disclose is largely related to treatment goals. The pursuit of a goal is also linked with the therapist's understanding of the client's

needs and difficulties. In this case, understanding Sylvia's difficulties with affect regulation and the goal of developing containment of feelings and mentalisation influenced my disclosure. Furthermore, Tantillo (2004) suggests that self-disclosure is particularly effective with eating disordered clients because of the cognitive distortions associated with starvation, the lack of mutuality in early relationships and their reliance on projective defenses.

Maroda (2002) notes that with clients who struggle to regulate affect, the therapist must model how to feel by expressing feelings. Like early caregivers, the therapist can reflect feelings without the overwhelming emotional intensity to which the client feels them, thus facilitating affect regulation. This type of countertransference disclosure can create a new object experience, which may assist exploration and questioning of old object experiences (Burke, 1992; Ehrenberg, 1995).

Busch (1998) further suggests a relationship between the client's level of insight and the therapist's disclosure. In measuring the working alliance through the client's use of the analytic space, he suggests that the therapist's perception of the alliance is a key influence in disclosure. The lower the client's capacity for self-exploration (weak alliance) the more the therapist relies on his own feelings to understand the client and discloses them in the interpretive process. I had to experience and speak about the feelings which Sylvia could not bear on her own, for her to develop insight about her disowned feelings and begin to talk about them.

My disclosure was also influenced by my theoretical understanding. I defined my disclosure as one of countertransference, largely an interpretation of projected feelings, letting Sylvia know that I could both contain and respond to them (Goodman, 1995). The disclosure served a technical function, putting Sylvia in touch with disowned parts (Jacobs, 1999). This disclosure did not share my different subjectivity but rather acknowledged of the joining of our subjectivities, that we could both feel vulnerable.

However, the factors influencing a disclosure are not only conscious or only within the therapist. Aron (1996) suggests that client and therapist both desire to be seen and known. Although largely interpretive, my disclosure was also influenced by an unconscious desire to be seen by Sylvia as a separate person with feelings and responses, after months of feeling non-existent and invisible.

Barnett (1998), Peterson (2002) and Rachman (1998) state that it is unethical to disclose to meet the therapist's needs which risks using clients narcissistically. Flournoy (1971) notes that analysis is frustrating for the analyst's narcissism, in that he is frequently unseen and ignored, while Crastnopol (1997) suggests that the desire for recognition unconsciously motivates many self-disclosures. Busch (1998) suggests the risk is higher for clients who were used narcissistically by caregivers, while Epstein (1995) argues that disclosure can result in an alliance with the client's false self, which is used to adapting to the needs of others.

However, considering the role of unconscious communication, the needs of the client and therapist may not be so easy to differentiate. My need to be seen may also have been a further projective identification of Sylvia's childhood feelings of invisibility.

Consideration of narcissistic use of clients also relates to power. Advocates of disclosure suggest it brings the therapist onto a human level with the client and removes the therapist as the one who knows, allowing for a more collaborative relationship (Ehrenberg, 1995). However, equally, due to its infrequency and level of intimacy, the client can pay specific attention and importance to disclosures, making the therapist seem more powerful (Crastnopol, 1997).

The key difficulty in both of these arguments is the assumption that the therapist's power is negative and the difference between having authority and being authoritative is collapsed (Greenberg, 1999). Ironically, disclosure is often advocated to emphasise the real relationship and the therapist as a real person, while attempting to deny the reality of the therapist's power and influence as a professional. Furthermore, a denial of the therapist's power can also circumvent the analysis of some transference, since the therapist has both real power and power assigned transferrentially (Levy & Inderbitzin, 1997). Bernstein (1999b) notes that maintenance of authority can assist the therapist to symbolise and think about what is occurring in the relationship, rather than simply participating.

I would argue that my disclosure to Sylvia was powerful and was evidence of my power as a therapist to create a shift in the relationship, unlike her mother who I suspect could not protect her. My disclosure was geared to provide a new object experience, of a responsive and attuned other, as opposed to fostering regression (Wasserman, 1999), particularly important for clients with trauma history (Silk, 2005).

The use of power further relates to the tension between participating and observing. As a participant, the therapist on equal footing with the client, wittingly and unwittingly engages in enacting the client's object representations as a way to understand what is occurring.   As an observer, the therapist is mindful of the interactions occurring and of the conscious and unconscious of both self and client (Hirsch, 1987). Here, the therapist is seen more as the expert who can observe and comment, and while informed by countertransference, will use it as a way to formulate interpretations.

However, the lines between observation and participation are not so clear. With Sylvia, if I intervened too often with interpretations I became the abusive father, where she would appear terrified and try to please me. However, if I simply observed I became an unwitting participant, enacting what I imagine was her mother's inability to intervene and protect.

Aron (2006) suggests in this type of situation an impasse is created and recommends disclosure to negotiate this, a recommendation supported by other authors (Breger, 1984; Ehrenberg, 1995; Hanly, 1998; Militec, 1998; Strean, 1999). By verbalising the therapist's inner process or conflict, a third position can be created, moving outside of complementary transference/countertransference positions (Aron, 2006). By mentalising in Sylvia's presence about my responses to her I became an "observing-participant" (Fromm, cited in Hirsch, 1987, p. 208) where participation was required to maintain the ability to observe.

In this instance, all of these considerations combined towards making a decision to disclose. However, this is not to say that this was the only appropriate intervention. Furthermore, while some influences suggested self-disclosure was appropriate, such as Sylvia's need for affect regulation, equally my own unconscious need could suggest that the disclosure was inappropriate.

This raises a further question about how therapists might truly know when a disclosure is useful and appropriate even when all influences are acknowledged and considered. As Ginot notes, "Events assessments and clinical perspectives may continually shift, leaving decisions about self-disclosure subject to the ever changing sometimes confusing forces existing within the analyst and in the interactional field" (1997, p. 376). Furthermore, self-disclosure, like any intervention, cannot be fully evaluated until after the fact, namely by its facilitation of the client's free association (Greenberg, 1995;

Davis 2002; Hoffer, 1985). Aron (1996) suggests that a disclosure can also be measured by the deepening of the working alliance. In this case, it seemed that my disclosure helped deepen Sylvia's self exploration and enhanced the therapeutic relationship.

Conclusion

This chapter has shown the complexity and breadth of countertransference disclosures. It has also identified areas where countertransference can be used for specific therapeutic purposes: to interpret projective identification, to assist affect regulation, to introduce a different subjectivity or to let clients know their effect on the therapist.

A number of influences in disclosure were also considered. The disclosure made to Sylvia was influenced by a) my understanding of her needs and difficulties; b) treatment goals; c) the working alliance; d) my theoretical understanding of the disclosure; e) my own unconscious needs; f) my view of power; g) impasse in the therapy based on the clients transferences and h) the tension between the roles of participant and observer.

The following chapter will consider understandings and influences in personal disclosure.

Chapter Five - Personal Disclosure

This chapter will look at personal disclosure. It will draw on an illustration to identify further influences in therapist disclosure, in this instance, a choice not to disclose.

Understanding Personal Disclosure

Personal disclosure involves the therapist's sharing of information, such as whether married or unmarried, number of children, holiday plans, interests, opinions and past or current life experiences (Goldstein, 1994; Pizer, 1997). This has been separated from countertransference disclosure because it something specifically about the therapist rather than an emotional response to the client or a comment on the process of the therapy. However, as noted in the previous chapter this is not always an easy distinction.

Interestingly, in Freud's quote used to open this dissertation, he seems to specifically caution against instances of personal disclosure.

> It might be expected that it would be quite allowable and indeed useful, with a view to overcoming the patient's existing resistances, for the doctor to afford him a glimpse of his own mental defects and conflicts and, by giving him intimate information about his own life, enable him to put himself on an equal footing…. Experience does not speak in favour of an affective technique of this kind. (1912, p. 117)

Although there is much critique of Freud's non-disclosing stance, perhaps his directive about personal disclosures is still adhered to, since the body of analytic literature on personal self-disclosure is small. The literature that does exist largely refers to instances of illness (Morrison, 1997) or pregnancy (Chused, 1997), things which may eventually be implicitly disclosed anyway and will affect the therapy, for example, through absence. Pizer refers to these disclosures as "inescapable" (1997, p. 453) due to extenuating circumstances, while Peterson (2002) notes that these things must be disclosed under ethical grounds if they affect the therapy. These disclosures are not the focus of this exploration, which is more concerned with what influences disclosures made by choice rather than necessity.

Frank (1997) suggests personal disclosures are least discussed since they appear to be less about the client and may more easily be seen as enactment. Other authors concur, including Jacobs (1995), and Bollas who states; "I do not discuss my own life, or my

own issues, with the patient or with my readers…I do not discuss these matters with patients because I believe doing so destroys the analysand's freedom to use the analytical object" (2001, p. 102-103).

However, Bollas (2001) also advocates for providing his own associations to the client's material as data for analysis. Thus, he makes clear distinction between what he believes is countertransferential and what is personal. Yet it is not always possible to separate process from content (Pizer, 1997), since countertransference disclosures may be very personal, while personal disclosures might be motivated by countertransference. Thus, distinctions between disclosures can be arbitrary but help to organize the vast amount of information and literature on the topic.

Returning to Frank's (1997) observation, perhaps personal disclosures are more likely to be seen as enactment since they have a less easily identifiable intent. In the literature, only four authors were found to recommend personal disclosure. Lane and Hull suggest that in instances of crisis, disclosure of a similar past experience "may convey an element of relatedness, empathy and hope to the patient" (1990, p. 43), while Goldstein (1994) suggests that in some instances personal self-disclosure may help to form a bond between client and therapist. Connors (1997) recommends both personal and countertransference disclosure as a way to assist the client to share his own vulnerability.

This lack of discussion about personal disclosure is interesting considering developmental needs for twinship.

> In twinship, the individual recognizes herself as a human being among other human beings or as potentially similar to others in feelings, interests, and activities. But it is not enough for the individual, on her own, to perceive similarities between herself and significant others: she must feel reciprocally recognized and even welcomed in these perceptions. (Teichholz, 1997, p. 36)

It may be of use to consider how self-disclosure, particularly personal disclosures might demonstrate reciprocal recognition. Rosenbloom (2001) gives an example of a personal disclosure which allowed the client to validate his own perceptions. However, use of this disclosure would depend on the client's need. As Mitchell writes, there is a difference "between an utter helplessness due to massive depravation and a dramatic helplessness learned as a gambit to elicit a certain kind of rescue operation" (1993, p. 180). The therapist would need to decide whether gratifying twinship needs would assist

in creating a new object experience for deprived clients, or circumvent the analysis of the need, as in the example below.

Carrie – Choosing Not to Disclose

This illustration will consider a personal disclosure, discussing the issues and influences involved.

Carrie expressed an anxiety that her daughter, due to lacking input from her father, might end up alone and unable to form relationships with men. My immediate response to this was an intense wish to disclose to her that I had grown up in similar circumstances and that it had not left me alone and unable to form relationships.

I chose not to do this, instead using simple mirroring statements about Carrie's anxiety, which I believe, later in the session helped to begin to acknowledge her own loneliness which she had projected into her daughter.

Influences

The pull I felt to disclose had both conscious and unconscious elements. Consciously I wished to provide a level of reality. As someone with little outside support, I also wished to let Carrie know that she was not alone.

Unconsciously, there was an invitation to enter an enactment. Carrie frequently struggles to tolerate her feelings and is often comforted by her daughter when she is upset. There was a transferential pull to "be a good girl and help mummy" by rescuing Carrie from her difficult feelings of guilt, responsibility and anxiety. Equally, the wish to rescue from my own history influenced the pull to disclose.

The client's needs and difficulties also influenced the decision not to disclose. In relation to Carrie, Ginot (1997) recommends that disclosure is not useful for clients struggling to form a connection to their own inner life, while Goldstein (1997) suggests that disclosure will likely be experienced as intrusive when mirroring needs are primary.

Both authors also suggest that feeling pressure to disclose contraindicates its use, since a pressured disclosure may not be fully considered. Palombo (1987) further proposes that spontaneous disclosure more likely represents the therapist's attempt at self-healing, likely in this case, given my own transferential pull to soothe. Similarly, Barnett (1998) notes that therapists experiencing emotional distress are more likely to

engage in boundary violations. In this way, these authors suggest taking a "strike while the iron is cold" approach (Geller, 2003, p. 549).

Conversely, Levenson (1996) suggests that when not motivated by internal pressure disclosures are more likely to be manipulative and implicitly try to force the client to change. Menaker (1990) suggests that spontaneous disclosures are more human and real while Ehrenberg (1996) argues that spontaneity is what allows genuine engagement between client and therapist.

However, it seems false to assume that spontaneity or lack of will generate any of these things. On one side, this assumes that therapists cannot make good decisions quickly and under pressure. The other argument assumes that a spontaneous response will be more genuine and that spontaneity is needed by the client. As Josephs (1990) notes, given that therapist disclosures do not undergo the same level of scrutiny as client disclosures, there is no guarantee of genuineness.

Perhaps the issue is not so much the influence of spontaneity and timing but the level to which the therapist is aware of what is occurring. A number of authors recommend that appropriate disclosures are those which the therapist understands and processes (Burke, 1992; Gill, 1983; Hanly, 1998; Marcus, 1998; Maroda, 2002) As Cooper notes, "Instances where the analyst's self is used without selectivity and reflection are more likely to constitute a misuse of disclosure" (1998b, pp. 385-386). With Carrie I did not understand my wish to soothe, thus a disclosure would not have had a clear intent linked to treatment goals or client needs. Furthermore, had I disclosed, it would have been focussed on me rather than Carrie and would not foster a sense of inquiry (Maroda, 2002).

The therapist's understanding of the process is also related to intent and the therapist's predictions about the outcome of the disclosure. Pizer (1997) suggests therapists remain responsible for their revelations and must consider the ramifications in every subsequent interaction in the treatment, particularly since disclosures cannot be rescinded. Similarly, Jacobs (1999) suggests that while often useful, self-disclosures always have a price that may not surface for some time or be worth the benefits. Therapists must also consider the price of disclosure for themselves, since clients are not bound by the same confidentiality as therapists (Sweezey, 2005).

In this example, the early stage of therapy influenced the decision not to disclose. I was unsure how disclosure might be received and used. Aron (1996) suggests that in early stages the client requires space to experiment with their perceptions, while Gabbard (1996) notes that personal disclosures can move the client's knowledge of the therapist from the symbolic to the concrete, collapsing the area of play space. Thus, there is a difference between being known and being known about (Jackson, 1990). In being known the therapist can be symbolised and fantasised, while in being known about the scope for fantasy is reduced.

The price of disclosure may bear direct relationship to the transference. Adler and Bachant (1996) suggest that while disclosure may not always foreclose the development of transference, it will influence which aspects are developed, ones that may not be the most pressing for the client. Furthermore, it may be difficult for the client to recognize transference as opposed to a response to the reality of the therapist (Davis, 2002). Additionally, clients' limited knowledge of the therapist affords them a safety to say what is on their minds. Quoting Greenberg's client, "If I didn't know this was all projection I couldn't say a word of it" (1991, p. 52).

With Carrie, a disclosure may have created joining and furthered twinship transference. However, "an assumption of mutuality may foreclose the unfolding of more regressive transference states in which the patient's core issues can come alive" (Kirman, 1998, p. 19). Carrie finds it difficult to express negative feelings and thus it seems important for her to be able to generate fantasies of difference and develop negative transference. Some of her more regressive fears emerged later in the session and perhaps would not have done had she not explored her fears for her daughter. In this way, a disclosure may have created a cure based on interpersonal suggestion as opposed to structural change (Aron, 1996).

However, these arguments come from a more singular concept of mind and self, that the client's transferences are intra-psychic and not a construction of both parties as in an intersubjective view. From this perspective, I had already coloured Carrie's transferences, likely through my implicit disclosures.

Ethical considerations also influenced the decision not to disclose. Friedman (1997) suggests that personal disclosures promise more intimacy than can be delivered. A

disclosure may have invited Carrie to consider me more friend than therapist, a boundary issue we already faced when Carrie had difficulty ending sessions. Mitchell (1998) notes the difficulty in deciding appropriate levels of intimacy in personal disclosures. Just as it may be difficult for clients to tolerate the different subjectivity of the therapist, too much intimacy may also be threatening (Auvil & Silver 1984; Rachman, 1998). Similarly, Gabbard (1994) suggests personal disclosures can lead down a "slippery slope" (p. 208), where one boundary violation easily leads into another, with sexual acting out at the end of the path.

In this instance, all of these things combined towards making a decision not to disclose, although a different decision could be made in other situations. I was not consciously aware of all of the influences at the time, yet, I still made a decision not to disclose, one that proved to be useful, given that Carrie did begin to discuss her own anxiety.

It could be argued that these decisions are made intuitively. In a qualitative study of six psychodynamic therapists, all named intuition as the key influence in deciding to disclose (Shawver, 2001). However, intuition is a rather nebulous concept. Any person can be intuitive but not everyone can be a therapist.

A number of authors suggest that, instead, empathy and attunement are the key influences in deciding to disclose (Teicholz, 2001; Rachman, 1998 Goldstein, Basch, 1998). Perhaps I was equally attuned to Carrie's anxiety, which influenced the pull to disclose, and her needs to explore her anxiety, which influenced the decision not to disclose. However, if empathy is the key influence, there is an assumption that the therapist's attunement is accurate. Furthermore there is a fine line between empathy and identification. I could have easily identified more with Carrie's anxiety, linked to my own transferences, than with her needs to explore her anxiety.

In acknowledging the limitations of empathy alone, Teicholz (2001) talks about gearing empathy towards the developmental needs of the client. She suggests that disclosures are influenced by empathy, tempered by knowledge and clinical experience.

In this instance my empathy allowed me to feel Carrie's anxiety, while knowledge of her needs and transferences allowed me to tolerate this anxiety and not act upon it. Thus, although seemingly spontaneous my decision involved a high level of largely

unconscious processing. It is perhaps the combination of empathy, knowledge and experience that constitute the therapist's unique skill.

Conclusion

Overall, as with other disclosures, consideration of the influences in personal disclosure show that there is no definitive conclusion; for every argument there is an equally plausible counter argument and further proof that each situation is different and must be considered on its merits. However, this chapter also identified a number of influences that can be thought about to assist making decisions about disclosure.

In this example my decision not to disclose was influenced by an understanding of my own transferences; b) a lack of understanding about the pressure to disclose; c) my assessment of Carrie's needs and difficulties; d) the stage of therapy; e) Carrie's transference and f) empathy and knowledge.

As the broad understandings of disclosure, implicit disclosures, countertransference disclosures and personal disclosures have been discussed, the following chapter will summarise the findings of this dissertation and discuss the clinical relevance. It will identify the limitations of the study and areas for further research.

Chapter Six – Summary, Clinical Relevance, Limitations and Further Research

Summary and Clinical Relevance

I began this dissertation with ideas of trying to prove one way or another that therapist's should or should not disclose and was easily drawn into polarisations between classical and relational, neutral and disclosing, always and never.

As I read further, I became aware of the complexity of the topic, recognising links between self-disclosure, modality, understandings of countertransference, treatment goals, client diagnosis, transference and the personality of the therapist. Self-disclosure touches almost every aspect of therapy. This recognition alerted me to the clinical relevance of understanding self-disclosure and that perhaps the process of polarisation is an attempt to simplify and make sense of the vast amount of information. Thus, the question "to disclose or not to disclose?" was modified to explore:

a) how is self-disclosure understood

b) what are the types of disclosure

c) what influences a decision to disclose.

Initially, it seemed self-disclosure was understood in so many different ways that it almost became difficult to understand. I refer to the level of contradiction and polarisation in the literature discussed in Chapter Two. I attempted to synthesise this myriad of understandings into something that could help to clarify my thinking around the topic and assist other therapists in this process. What also emerged was the extent to which the therapist's theoretical base influences the decision to disclose, pointing to further clinical relevance in understanding disclosure to guide practice.

It became apparent that self-disclosure encompassed a whole range of behaviours and was necessary to clarify exactly what self-disclosure involved. Definitions ranged from the broad, to the very specific. From the literature, three different disclosure types were identified and explored in chapters Three to Five.

However, while some clear distinctions could be made, there is huge overlap amongst implicit, countertransference and personal disclosures. In this way, types become one of a number of ways to think about self-disclosure. Another way to distinguish between

disclosures may be through intent. Chapters Four and Five briefly noted different intents, including disclosure for affect regulation, disclosure to demonstrate different subjectivity, disclosure to generate insight about the client's effect on others and the infrequently discussed disclosure for the purposes of joining. I suspect that this may be a more relevant way to consider self-disclosure in the future, since intent seems to provide clearer distinction than type.

Another observation was that in purely theoretical discussion the client is not always considered. This led to the final part of my question regarding what influences a decision to disclose, aiming to consider the interplay between theory and practice.

In answering this final part clinical examples were used as a lens through which to review arguments and recommendations in the literature and identify influences. The most relevant influences in each instance were discussed. From the four chapters and examples, the following list can be constructed of influences in disclosure:

- The type of disclosure; for example countertransference disclosure is used more frequently than personal disclosure
- The therapist's theoretical view of disclosure
- The therapist's modality
- The therapist's personality and personal style
- The therapist's experience
- The therapist's need
- The therapist's unconscious processes
- Power
- The client's need
- The client's diagnosis
- Disclosure Intent
- Ethical considerations
- Content of the disclosure
- Disclosure timing/spontaneity
- Stage of therapy
- Transference/Countertransference including the therapist's transference
- The goals of the therapy
- The working alliance

- Who initiates the disclosure
- The extent to which the therapist has processed the feeling
- Empathy.

Not all were relevant in each example and only the key influences were discussed. Similarly, the way each influence shaped the decision was of course unique, based on both the client and me. Thus, the person of the client and the therapist are perhaps the two major influences.

While framed through unique instances, the process of identifying and discussing influences is clinically relevant. Consideration of the list above can be applied to any situation. The identification of these influences allows me to be more conscious of what is at play in my own decision-making process. Furthermore, I hope my synthesis of self-disclosure and identification of influences will assist other therapists in understanding their own wishes to disclose or not disclose and their decisions about disclosure.

Limitations

In analysing systematic reviews the limitations must be taken into account (Seers, 2005). Therefore, it is appropriate to note the limitations of this study.

Most importantly, although the review is systematic, there is a level of subjectivity inherent in the choice of inclusion/exclusion criteria and the selection of quotes to illustrate points. This may be influenced by my own experiences as both a client and a therapist and my personal views about the topic. Furthermore, in making distinctions between disclosure types, some aspects naturally take precedence while others fall to the background. I have endeavoured to reduce this bias through regular feedback from my supervisors and colleagues.

A further limitation exists in exclusion of literature from other modalities, due to their lack of focus on transference and countertransference. However, in doing so a number of empirical studies were excluded, which could provide further insight into the practical uses and pitfalls of self-disclosure.

In this way, the study is limited in its use of expert opinion and case studies as the key source of data. In using empirical data there are clear guidelines as to what makes

something statistically valid. There are no such guidelines regarding expert opinions and a question remains as to how many opinions are needed to validate an assertion.

There are also limitations in the structure of this dissertation. Given the word limit and an attempt to reduce the data to a manageable level for both myself and the reader, there are a number of areas which have been missed in the discussion, including feminist perspectives on disclosure, disclosure of sexuality, disclosure in relation to gender and culture and disclosure with regards to specific client diagnoses.

Further Research

This dissertation has primarily looked at things which influence a decision to disclose. However, Chapter Five noted the way in which these factors are often understood and processed unconsciously by the therapist, sometimes in a short space of time. This raises some interesting questions and possibilities for further research about how therapists think and make decisions. Therapists' thinking could be considered more broadly, since self-disclosure is not the only area in which therapists make decisions.

This dissertation also noted the importance of the client in influencing disclosures and the way in which the client can be missed in the literature. Further research could involve looking more closely at the client and disclosure, such as the relationship between diagnosis and disclosure.

In addition, self-disclosure vignettes only provide one side of the story, namely the therapist's evaluation of the situation, as did mine, pointing to a need to research clients' perceptions and experiences of therapists' disclosures.

A key argument against the use of disclosure relates to its possible distortion of the transference. The development of transference when self-disclosure is present is a further avenue for investigation.

Conclusion

Therapist self-disclosure is multifaceted and can be thought about in a variety of ways. To disclose or not to disclose is not the question. The question is far more complex and challenges therapists to consider what will be most beneficial in each situation, given that there can be no right answers. However, the identification and awareness of

influences in disclosure and how they manifest in each unique situation can help guide thinking and decision making about disclosure.

15 043 words

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