# CHAPTER FOUR: THERAPIST SELF-DISCLOSURE: A PRACTICAL PERSPECTIVE AND INTEGRATION.

## 4.1. Introduction.

Upon review of books that focus exclusively on therapist self-disclosure, such as Berg and Derlaga (1987), Chaikin and Derlaga (1974), Chelune (1979), Stricker and Fischer (1990), and Weiner (1983), certain theoretical and practical issues arise that have not been comprehensively addressed and systematized in the previous chapters. These issues will now be discussed and where appropriate become integrated with points of focus already delineated.

These as yet inadequately addressed concepts refer to the types and the indications and pitfalls of therapist self-disclosure. Curtis (1981), Goldstein (1994), Mathews (1988), Wachtel (1993), and Weiner (1983) represent authors who have attempted to systematically address the pitfalls and advantages of therapist self-disclosure. With this review the major points of focus in the previous two chapters can be integrated and systematized.

## 4.2. The types of therapist self-disclosure.

Within the confines of verbal self-disclosure by the therapist during adult individual psychotherapy as set out in chapter one, many types of self-disclosure still remain. There is a wide range of responses that the therapist potentially could make within the psychotherapeutic dialogue.

To create some kind of order yet not lose the complexity and multi-facetedness of this phenomenon, three broadly defined categories of self-disclosure can be formulated, explained, and utilized. Although a galaxy of responses exists within

each category, no significant information is lost, yet summarization and eventual integration into a system becomes possible. These categories are also conceptually manageable. They will now be named, briefly defined, and then clarified in the following section.

Firstly, there are the self-disclosures that are considered to be **antitherapeutic** or **disjunctive** (Palombo, 1987). They are normally a product of the therapist's pathology or residues of previous pathology. These responses have no origin in the therapeutic relationship and arise solely from out of the anti-therapeutic needs of the therapist. A discussion of these events is closely coupled with a discussion of the contraindications for the use of therapist self-disclosure.

Secondly, there are the disclosures that refer to some aspect in the therapist's reality **external** to the therapeutic situation. These refer to specific events in the therapist's life. Examples include marriage (Flaherty, 1979) and illness (Dewald, 1994).

Thirdly, one could refer to **internally based disclosures.** The word internal indicates that these disclosures arise from within the therapeutic encounter.

Each of these categories will now be discussed. Exclusivity is not claimed, and these categories by no means imply that all therapist responses are exhausted. This is purely an attempt to systematize the literature with the organizing principle being the bearing of these disclosures on the reality of the therapeutic relationship.

### 4.2.1. Disjunctive or anti-therapeutic self-disclosures.

These interventions have been discussed by Maroda (1991), Palombo (1987), and Weiner (1983). Many authors warn against the senseless discharge of emotion that undermines the patient and gratifies the therapist, for example Ehrenberg (1984).

Weiner (1983) states that the therapists who probably most frequently make damaging disclosures are poorly trained persons who become emotionally involved in ways they are ill equipped to deal with, and adequately trained therapists who are psychologically or interpersonally vulnerable. Weiner (ibid) also states that disclosing can help the therapist avoid dealing with aspects of the patient that provoke his own anxiety by changing the focus of the treatment from patient to therapist.

If the therapist should feel compelled to disclose there is thus the danger of an unconscious collusion to avoid talking about the patient. The therapist could also be exploiting the therapy to meet his or her own needs. Kottler (1986) cites Herron and Rouslin (1984) who mention that excessive self-disclosure may be done to relieve the therapist's own discomfort with the inherent inequality of the relationship.

When discussing antitherapeutic interventions, one is spontaneously tempted to define them as **countertransference-based** issues. This becomes problematic with greater awareness of the complexity and multi-facetedness of the concept countertransference. As seen in chapter three the concept countertransference has expanded profoundly to include the totality of the therapist's reactions to the patient during the ongoing therapeutic process.

One is also reminded of Winnicott's (1949) distinction between objective and subjective countertransference. If countertransference is to include the totality of therapist's reactions as formulated above then the role of therapist self-disclosure is conceptualized less stereotypically than in the past (Palombo, 1987).

This discussion once again bears profoundly on the controversy in psychoanalytic thought. The traditionally defined or orthodox analysts could view any form of self-disclosure as a deviation or parameter (Langs, 1976) in technique, whereas some contemporary analysts such as Maroda (1991) after clearly distinguishing between objective and subjective countertransference, would view the revelation of subjective countertransference as disjunctive and the objective countertransference, if appropriately timed, as therapeutically productive.

Although countertransference is mostly considered to be a multifarious phenomenon, the current distinction being made between an objective and subjective countertransference assists in separating the anti-therapeutic and therapeutic disclosures.

If one refers to chapter three, it is evident that the self-disclosures as advocated by Bollas (1983) and Maroda (1991) for instance, are not stemming from the therapist's own idiosyncratic, or ego-syntonic (Weiner, 1983) needs, but are grounded in the unique interaction and interplay between therapist and patient (Ehrenberg, 1992a, 1992b). These are wholly different to the self-disclosures that are made within the subjective countertransference, and which would be deemed an inappropriate intervention.

Amongst the many condemnations regarding disjunctive

responses, Palombo (1987) has noted the possible therapeutic value as well, and that is that such a response could demonstrate the therapist's humanity, fallibility, and imperfection.

### 4.2.2. Externally based self-disclosures.

The self-disclosures to be discussed in this section are entirely different in nature, arise out of circumstances in the therapist's life and are therefore referred to as **intercurrent** or **special events.** These will now be discussed and for purposes of this discussion be referred to as **externally-based** self-disclosures.

The multiple and varied issues that affect the lives of everyone also affect the life of the therapist and these can impinge upon the traditional privacy of the usual psychotherapy situation (Dewald, 1994).

These events, due to their nature and importance to the therapist lead to the inevitability of self-disclosure (Lane and Hull, 1990). An example frequently encountered in the literature is serious **illness** (Dewald, 1982, 1994; Friedman, 1991; Grunebaum, 1993) in the analyst or someone in his or her immediate family. Appointments may have to be cancelled, and this may necessitate a self-disclosure about the nature of the illness. Additional examples include pregnancy (Al-Mateen, 1991; Lax, 1969; Stockman and Green-Emrich, 1994; van Niel, 1993), marriage of the therapist (Flaherty, 1979), and the divorcing therapist (Johansen, 1993).

These events are disclosed in the real relationship between therapist and patient. The way these disclosures are managed however, depends on the patient's psychodynamic make-up, and the nature of the relationship.

### 4.2.2.1. Disclosures bearing on the real relationship.

In this instance, the disclosure has little or no bearing on the transference relationship and in this sense is insignificant to the patient's pathology or psychodynamic make-up. Weiner (1983) offers an illustrative example of a real-life event being dealt with in the real relationship between therapist and patient. It concerns a psychoanalyst revealing his wife's severe illness to his analysands, who found this to be a positive experience for them in a different way.

This had a less profound effect on the transference relationship, and within the reality of the psychotherapeutic interaction, these patients responded with sympathy, eagerness to be helpful, and efforts to be supportive and comforting. In this process they discovered more about their ability to be helpful to others. This demonstrates a real-life event that was dealt with in the real relationship between therapist and patient.

### 4.2.2.2. Disclosures bearing on the transference relationship.

There are intercurrent events that have strong potential transferential components. Although they are events that originate in "reality" and are disclosed to the mature adult observing ego of the patient, they could enhance or accelerate the transference. One such an event is the therapist's pregnancy. This is an event which is a highly visible and personal characteristic (Stockman and Green-Emrich, 1994) and that inevitably and unavoidably breaks the anonymity of the therapist (Flaherty, 1979).

Lax (1969: 363) has described her pregnancies as "a personal

event in the life of the analyst that cannot be hidden from the patient and intrudes into the analytic situation. The so-called anonymity and neutrality of the analyst is interfered with". As van Niel (1993: 125) has succinctly stated: " A therapist's pregnancy affords one of the most influential of all "real" events in the therapeutic relationship. Because the pregnancy is obvious and its meaning evocative, a reaction to the situation is unavoidable"

Lax (1969: 363) has captured the significance of pregnancy to the transference relationship in the following way:

> It is consistent therefore with analytic theory to expect that, for the patient, the analyst's pregnancy has a special significance of a highly-charged stimulus and evokes deep-seated childhood conflicts, fantasies, and wishes. The patient whose analyst becomes pregnant while he is embroiled in the transference neurosis has a singular opportunity to re-experience many of his pregenital and oedipal struggles ... since there are variations in transference reactions which depend on differences in the aetiology of the particular neurosis, it is to be expected that there will also be differences in the patient's reactions to the analyst's pregnancy. It is likely that specific historic events in the life of the patient and differences in character constellation also evoke individual transference variations.

Along the same lines Weiss (1975) and Fenster et al. (1986) cited in Jackson (1990) have reported that patients are often

stimulated to produce previously unavailable material from their past and are able to then create new solutions to their conflicts during their therapists' pregnancies.

Al-Mateen (1991) has commented on how patient's own childhood conflicts surrounding the birth of siblings and loss of mother's love are brought into the therapy and are intensified. She has described pregnancy in the therapist as a template for dependency, abandonment, and sexuality issues.

Weiner suggests that a therapist's self-disclosure could reawaken previous trauma and serve as a corrective emotional experience in the transference relationship. He cites an example of where a **death** in the life of the therapist may result in a therapist-patient interaction that repeats an earlier trauma for the patient, with the therapist unwittingly reenacting a pathogenic parental response.

Weiner (1983) illustrated this with a vignette where the therapist's disclosure of a death that impinged on the therapeutic relationship helped correct the effects of parental secrecy and denial. In this instance, the therapist's disclosure repeated and corrected the patient's traumatic childhood experience, enabling the patient to see the therapist less as a withholding mother and to discuss her sexual difficulties more openly.

These statements and descriptions serve as examples and illustrations of where a disclosure in "reality" enhances the transference relationship. The disclosure, which arises from out of the therapist's life upon disclosure then becomes grist for the therapeutic mill, and leads to widening circles of therapeutic enquiry.

### 4.2.2.3. Disclosures bearing on the countertransference.

The disclosure of certain intercurrent events may bear profoundly on the countertransference. To illustrate this, the therapist's illness can be considered, as this event is currently under the spotlight in the literature.

Gurtman (1990) writing about his personal experience in this regard has stated that it has the most dramatic effect on the treatment process. This is absorbing seen in the light that this topic has been relatively uninvestigated until very recently (Counselman and Alonso, 1993; Dewald, 1994).

Gurtman (1990), referring to the previous neglect, attributes it to the conflict and anxiety that serious illness elicits in the analyst which could result in avoidance and denial. One wonders if the recent illumination of these countertransference issues and the confrontation of the issues of what information to provide patients with is running parallel to trend in psychoanalytic thinking to share countertransference affect with patients. Is this ferment serving to eventually compromise the therapist's anonymity in all respects?

These countertransferential issues pertain mainly to the therapist's denial of his or her illness, denial of mortality, discomfort about personal exposure, or the need by the therapist to feel appreciated for having been ill, with the need to experience sympathy or other gratification from the attention of the patient.

The denial of the illness and mortality sets the stage for an unconscious collusion in the transference and countertransference collusion. The therapist is tempted to agree with the patient's flattering view of him or her as

invincible. In the process the therapist denies his own vulnerability to illness, aging, and inevitable death (Counselman and Alonso, 1993).

Alternatively, the denial could prevent the therapist from disclosing his or her illness to the patient. This runs the risk of undermining the real relationship between therapist and patient, and damaging the integrity of the patient. When a psychotherapist denies such significant episodes in his or her life, the patient avoids them also, and the psychotherapeutic situation becomes burdened by the lack of the patient's information about the charged emotional attitudes of the therapist (Kaplan, 1993).

At this stage one could now discuss the responses that comment on the interpersonal and interactive dimension of the encounter between therapist and patient.

### 4.2.3. Internally-based self-disclosures.

If one considers the range of responses that have their origin in the therapeutic situation, there are basically two types. There are the complementary responses (Palombo, 1987) and the self-involving statements (Andersen and Anderson, 1989; McCarthy and Betz, 1978; McCarthy, 1979; Reynolds and Fischer, 1983), and these will be discussed.

Palombo (1987: 111) has coined the term **complementary responses.** In this instance, the therapist reveals some aspect of himself, his or her circumstances (present or previous) that resemble the patient's. At first, one may be tempted to define these responses as externally based. They may refer to something external in the therapist's life, yet it is the therapeutic situation that elicits this response, and for this discussion these disclosures are therefore

referred to as internally based.

The **self-involving** statements arise from out of the **interaction** between therapist and patient, of which the content reveals a commentary about the interactive field. These refer to the self-involving disclosures already touched upon in chapter two. These disclosures have no bearing on any external events, and are a unique product of the interaction and interpersonal involvement between the co-participants of the therapeutic encounter. Of fundamental importance is how these self-involving disclosures underscore the importance of the real relationship between therapist and patient.

To illustrate a complementary position, the vignette as explicated by Palombo (1987: 112) can be cited:

> While treating a young woman who was the victim of incest a woman therapist found herself reliving intensely an episode of sexual abuse by a babysitter in her own childhood. As the therapist struggled with her feelings she found herself distancing from the patient and unable to respond. Suddenly she found herself sharing the episode with the patient and began to weep quietly. The patient, who during her childhood had felt isolated because she could not turn to her depressed mother for support, found herself once more burdened and needing to help the person from whom she expected to receive help and protection. This repetition within the transference/countertransference was not experienced as traumatic, however; rather, it brought home to the patient the extent of

her childhood deprivation and the disavowal of the intense feelings she experienced then.

This vignette helps illustrate how an event related in "reality" engages the transference and becomes a corrective emotional experience.

As formulated in chapter two, McCarthy and Betz (1978), McCarthy (1979), Dowd and Boroto (1982), and Reynolds and Fischer (1983) have distinguished between **self-disclosing** and **self-involving statements**. To reiterate, self-disclosing responses are basically statements referring to the past history or personal experiences of the therapist, whereas self-involving statements are direct present expressions of the therapist's feelings about or reactions to the statements and, or behaviours of the patient (Danish, D'Augelli, and Brock, 1976) cited in McCarthy (1979).

When applying this to the nature of the therapeutic relationship, it becomes apparent that self-involving statements pertain to the real relationship, imply immediacy, and focus on the **encounter** and **interaction** in the therapeutic field. Intercurrent events as well as the complementary responses described earlier would probably constitute self-disclosing statements that, although reality-based, in both origin and disclosure, could ultimately bear on the transference relationship between therapist and patient. The sharing of countertransference affect on the other hand and as discussed elaborately in the previous chapter reflect the therapist's involvement within the analytic situation, as well as his or her **experience** of that involvement (Bollas, 1983) in some instances, and could appropriately be referred to as self-involving statements.

It has already been seen that self-involving statements have not necessarily been considered to have a deleterious effect on the therapeutic relationship. One could thus be swayed to believe that these disclosures pertaining to the countertransference affect as discussed by Ehrenberg (1982, 1984, 1992a, 1992b), Bollas (1983), and Maroda (1991) will probably not damage or compromise the professionalism or integrity of the therapist. At this point one could now turn to a controversial point in the literature and this pertains to the **appropriateness** of therapist self-disclosure.

### 4.3. Indications and contraindications for the use of self-disclosure by the therapist.

This section addresses the therapeutic and practical implications of therapist self-disclosure and attempts to answer fundamental questions regarding the usefulness, appropriateness, and advisability of therapist self-disclosure. This is probably the fundamental, crucial, and core issue that most psychotherapists ponder some time during their careers. Authors such as Buechler (1993) have asked compelling questions about the **appropriateness**, **time**, and **place** of self-disclosure by the therapist. Wachtel (1993: 207) has mentioned that:

> In my teaching and supervision of therapists in training, I have found the question of how much to reveal of oneself in the course of the therapy to be one of the most puzzling and difficult questions these therapists face, and it is often not an easy one for experienced therapists as well.

Essentially, this discussion will integrate and summarise what has been written and discussed up to now. All of the

major and critical points of interest merge and co-exist to facilitate a formulation of the indications and contraindications of therapist self-disclosure.

### 4.3.1. Indications.

Flaherty (1979) has suggested that psychotherapists should consider three sets of factors when deciding about the appropriateness of self-disclosure. These include therapist related factors, patient related variables, and the specific relationship/transference at the time of desired disclosure. When reviewing various authors' opinions concerning the indications for the use of therapist self-disclosure, for example Curtis (1981), Glazer (1981), Weiner (1983), and Goldstein (1994), one finds that these recommendations spontaneously, although not explicitly stated, fall into these categories.

Another set of factors should be considered, and these refer to the type of self-disclosure. The above set of categories as set out by Flaherty (ibid) as well as the type or content of self-disclosure will be employed to systematize and integrate the literature pertaining to the indications for therapist self-disclosure.

#### 4.3.1.1. Therapist-related factors.

As regards therapist-related factors, Flaherty (1979) included the following: personality style, dynamics, background and training, and the degree of comfort with self-disclosure. These factors are intricately related, co-exist, and partially determine and influence each other. Simon (1990a) has explored criteria for intentional verbal self-disclosure by experienced therapists. Three themes emerged from interviews that she had conducted, and these were:

theoretical orientation, the psychotherapy relationship, and therapist self-awareness. Of these three, Simon (ibid) deduced that therapist's **theoretical orientation** was the major determinant of therapist self-disclosure.

Simon (1990a) found that **high disclosers** labelled their orientations as eclectic, humanistic, existential, and "here and now"'. Their mentors were Arthur Ellis, Carl Rogers, Fritz Perls, and Werner Erhard. The **low disclosers** considered use of transference as the integral aspect of their work and were generally opposed to therapist self-disclosure. Their mentors were Freud, Karen Horney, Frieda Fromm-Reichmann, and Ralph Greenson.

This once again demonstrates the polarization in the literature where humanistic psychology is often associated with self-disclosure and psychoanalytic psychology with non self-disclosure. This argument has failed to take into account the recent ferment within psychoanalysis as regards the usefulness of therapist self-disclosure.

Another therapist related factor discussed by Rosie (1980) and Simon (1990a) pertains to the therapist's **experience.** Rosie (ibid) has stated that experienced psychotherapists self-disclose more than inexperienced psychotherapists. As already set out in a previous chapter, Simon (ibid) has hypothesized that less experienced therapists may not have clearly conceptualized their theoretical orientations and their frequency of disclosing may reflect their personal styles or anxieties, whereas therapists who are moderately experienced are probably as a group the least disclosing. Her reasons are that they may be trying the hardest to adhere to classical teachings and maintain a professional stance. The highly experienced therapists as suggested by Simon's (ibid) study, make determinations regarding self-disclosures

in a manner consistent with their professional conceptualizations which have evolved from years of study, personal growth, and clinical practice.

Mathews (1988) after conducting a survey with therapists has noted that even practitioners who are trained in the "blank screen" posture stated that it was only through **experience** and trial and error that they came to appreciate the complexity and power of their self-disclosures.

As regards **therapist self-awareness**, Simon (1990a) has found that high disclosers regard the psychotherapy relationship as mutually satisfying for therapist and patient, and that they feel it is less significant whose material is being discussed than that the patient and therapist are interacting in a deep and meaningful way.

In contrast to this are the therapists who utilize transference as the primary material, who believe that they have to be maximally self-aware to minimize distortions. These therapists are inclined to question themselves and scrutinize their needs to reveal any information before doing so.

It is evident that this facet of therapist self-awareness is intricately intertwined with theoretical orientation, and will be linked again when the nature of the relationship is discussed. It will once again become evident how the therapist's theoretical orientation and how he or she defines the nature of the therapeutic relationship has a profound effect on the implementation of therapist self-disclosure.

**4.3.1.2. Patient-related variables.**

As regards patient-related variables the following could be considered: the patient's psychic structure, ego-strength, and diagnosis. Mathews (1988) surveyed psychotherapists and found patient **diagnosis** to be an important contextual variable. Respondents to her survey seemed equally aware of the ways in which the client's diagnosis influences decisions about whether to self-disclose or not.

Therapists participating in the survey did not always agree as to which patients benefitted from which postures toward therapeutic transparency. They were however in fundamental agreement that with narcissistic patients, therapist self-disclosure, if not destructive was not of interest to them.

There has been controversy concerning therapist self-disclosure with severely regressed patients. Blanck and Blanck (1979) cited in Glazer (1981) address themselves to the issue when they recommend that there is a greater need for the therapist as a real object with patients who have subphase inadequacies. In this regard they refer specifically to patients with conflicts in the separation-individuation phase of development.

In contrast to this, Glazer (1981) cites Boyer and Giovacchini (1967) who contend that the traditional analytic posture is especially warranted for the more disturbed patients. This is due to these patients' confusion in self-object representations. Glazer (ibid) has attempted to answer for these theoretical inconsistencies and attributes them to the fact that these authors have relied upon gross diagnostic categories and continuums of mental health-mental illness that would demand more or less therapist self-disclosure.

Weiner (1983: 102) has focused specifically on ego-strength

in the following way (102):

> The less a patient's ego strength, the more likely he will be harmed by a therapist's self-disclosure. This danger must be weighed against the fact that poorly integrated patients have little tolerance for uncertainty and ambiguity and therefore have greater need to know where they stand and what they can expect from their therapists. These patients basically need to know that the therapist is dependable, trustworthy, and personally involved in the treatment process ... Being real to the patient with little ego strength reduces fantasy and encourages the patient to face the real world.

Inevitably one enters a discussion of the borderline personality disorder once again. Weiner (1983) has expressed ambivalence about self-disclosing with these patients, but the growing trend in the psychoanalytic literature to share the objective countertransference affect cannot be by-passed when talking about primitively regressed patients.

A historical trend towards increasing self-disclosure of the therapist is intimately tied up with the movement of psychoanalytic theory into object relations theory (Rosie, 1980). This is linked to the analytic understanding of patients previously deemed to be unanalyzable (Ehrenberg, 1992a), and with the accompanying elucidation of personality disorders.

At this stage, a few responses from Mathews' (1988: 528) survey will be quoted. Hopefully this will demonstrate the

complexity of the therapeutic relationship as well as the complexities involved in formulating a diagnosis. This will help to highlight the co-existence of many variables. This also implies that one cannot extricate diagnosis as a crucial contextual variable when formulating indications for therapist self-disclosure.

A 35-year old female psychiatrist gave the following response (528):

> With psychotics, I give more specific information, I am more of a real person. They are already out of contact with reality. I don't want a major transference with them, since they don't distinguish between reality and fantasy anyway. With more normal patients, such issues such as guilt, conflict, etc., are best resolved though the transference.

A 35-39 year old psychologist responded as such (528): "the request for personal information indicates that the client is becoming healthier and is beginning to model after me....."

Another male psychologist stated (528):

> Severely disturbed clients do not have a clear sense of others existing as separate individuals so when they do begin to inquire, I assume they are developing a stronger sense of reality. The key is to modify my technique for different ego strengths of my patients.

One can thus see that the criteria for disclosure with more

pathological populations is less clear and very complex, and Mathews (1988) concludes that the general approach with these populations is filled with caution.

Without reference to specific diagnostic formulations, Goldstein (1994) writing from out of a self psychology perspective has indicated self-disclosure to patients who have had repeated reality-based experiences of neglect, physical and sexual abuse, and who feel different, stigmatized, and victimized. In this instance it is felt that these patients lack a sense of entitlement to basic human needs.

Goldstein (1994) further motivates by stating that empathic exploration of their experiences and feelings can provoke deeper feelings of humiliation and difference. In this instance self-disclosure can be useful in helping patients feel less abandoned with their painful experiences. It is further felt that many patients may suffer less if the therapist tries to bridge the actual differences that exist in order to help them to bear their feelings.

Goldstein (1994) also recommends that self-disclosure be employed with patients of certain sociocultural backgrounds and alternative life styles. She states that the therapist's failure to be more real may be experienced as too different, non-affirming, or even insulting (428). It is also recommended that self-disclosure be employed with patients who share professional interests, pursuits, and affiliations with the therapist. Failure to self-disclose may be experienced as too unnatural or rejecting.

An issue or variable not yet addressed and which pertains to the therapist's and the patient's psychodynamics and alternative lifestyles is to be found in the gay literature

(Kooden, 1991, 1994; Perlman, 1991; Schwartz, 1989). As with most questions appertaining to the advisability of therapist self-disclosure, there are also disharmonious and conflicting guidelines for gay therapists. Schwartz (1989) has for instance explored the possibilities of revealing one's sexual orientation to one's patients.

His experience reveals that for many of his patients, knowledge of his sexual orientation has been a helpful ingredient to begin the "work" of psychotherapy. At the same time he warns against the possibility of a power struggle and contertransference issues when the therapist volunteers information about his or her sexual orientation.

Having considered various patient-related variables when formulating the indications to self-disclose, one can now turn to the importance of the nature of the relationship when considering indications. This discussion is closely linked to the previous chapter.

**4.3.1.3. The nature of the therapeutic relationship.**

A discussion of the nature of the therapeutic relationship is unavoidably dovetailed with a discussion of therapist-related factors. Ultimately it is the therapist, who according to theoretical orientation and training, selects a course of action, and who defines and conceptualizes the therapeutic relationship.

It is also within this perspective that the therapist formulates his or her **working assumptions**. Within this discussion the opinions of various authors, for example, Goldstein (1994), Mathews (1988), Simon (1990a), and Weiner (1983) will be integrated. A certain amount of repetition may occur as critical points of focus from previous chapters are

integrated into this deliberation.

When entering a discussion of the **nature** of the therapeutic encounter, many authors distinguish between a "real" and a "transference" relationship. A gross distinction is made when one discounts the one in favour of the other. As seen in chapter three, certain existential-humanistic theorists are inclined to do so. According to Tobin (1991) Rogers believed that he could avoid transference phenomena simply by being congruent and non-authoritarian with clients. For example Rogers (Meador and Rogers, 1979) cited in Tobin (ibid) endorses the idea that transference is caused by a therapist taking an evaluative stance with a client. On the other hand, psychoanalytically orientated therapists could undermine the real relationship and attribute all aspects of the relationship to transference phenomena.

However, such clear cut distinctions are not always made, and particularly within psychoanalytic thought, the split between real and transference is complicated by the possibility of the co-existence of both within one relationship. Simon (1990b) and Maroda (1991) have addressed the impossibility of making a distinction between the real relationship and the transference relationship. Simon (ibid), for instance, cites Kaplan and Rothman (1986) who state that all object relationships are comprised of different admixtures of blendings of real and transference components. In her own words, Simon (1990b: 595) states: "..to pretend that a therapist's reality that surfaces during psychotherapy is automatically a transferential component does a disservice to the patient".

The difficulty in distinguishing between the real and transferential aspects of a relationship points to a certain fluidity of concepts, and this is almost analogous to an

approach as delineated by Wachtel (1982). Although his formulations rest heavily on previous work, the terminology **cyclical psychodynamics** appears to be his own. This concept was discussed in chapter three but will briefly be explained to place this discussion in perspective.

It will begin to appear that when speaking in psychoanalytic terms one is not defining the nature of the relationship, but the nature of one facet of the relationship. The broader concept is thus narrowed down, so that one is rather speaking of defining the nature of the transference.

The cyclical point of view rejects the alternative point of view, namely, the rhetoric of emerging and unfolding (Wachtel, 1982, 1993). The latter mentioned defines transference in its strictest, narrowest, and most conservative sense. Accompanied by this definition is the analyst's stance, which is neutral. The analyst is required to be a blank screen as to enable the neurosis to unfold. Self-disclosure is therefore strictly abandoned. As recalled from chapter three, this approach implies that the patient brings into the psychotherapeutic situation his unique intrapsychic constellation which will unfold regardless of the person of the analyst as long as he "gets out of the way", and lets it happen. There is thus no place for therapist self-disclosure.

The cyclical psychodynamic point of view extends the conceptualization of transference to attribute more reality to the relationship. As Wachtel (1982: 259) states, this approach: "... locates the heart of the psychodynamic process not in the patient's preserved past but in the vicious circles which past events set in motion". Implementing Piagetian terms this approach allows for accommodation as well as assimilation, whereas the previous approach allows

only for assimilation.

One can now raise the question of how this bears on the issue of therapist self-disclosure. The cyclical point of view commands a different stance for the therapist, where interpersonal feedback becomes an integral part of the therapeutic situation. Chrzanowski (1982: 278)) has stated that transference becomes a "transactional manifestation", a "collaborative inquiry", and "relational participation". In his own words (278): "... my emphasis is on the collaborative effort in the exploration of the relational or transactional aspects of the therapeutic situation".

If one refers back to the section focusing on the types of therapist self-disclosure this interpersonal approach as delineated by Wachtel (1982, 1993) and Chrzanowski (1982) implies the use of self-involving therapist responses. As one spontaneously enters a discussion of types of self-disclosure, these types can be integrated into a discussion of the indications for therapist self-disclosure.

**4.3.1.4. Types of self-disclosure.**

Referring once again to the salient distinction between self-disclosing and self-involving statements, Wachtel (1993: 211) has distinguished between "disclosures of within-session reactions" and "disclosures about other characteristics of the therapist". Wachtel (ibid) asserts that this distinction, at least for some therapists, defines the boundary between disclosures that are acceptable and those that are not. It is his impression that therapists are more comfortable with the former than the latter. To fuel this argument, he cites Basecu (1990: 55):

> what the analyst says about his or her

> reactions to what transpires in the relationship between two people ... is the predominant arena of analysts' self-disclosure (and notes that it is predominant ) ... in importance, in relevance to the therapeutic work, and in frequency of occurrence. It is also probably the least controversial area of analysts' self-disclosure.

There appears to be unanimous agreement on the inherent value of self-involving statements. They are less contentious and their effect more benign than with self-disclosing statements.

Concerning self-disclosing statements, or "disclosures about other characteristics of the therapist" (Wachtel, 1993: 211) one must consider the actual **nature of material** being discussed. Glazer (1981) included this in his discussion of criteria. The variety of responses that could potentially be included in the category "outside experiences" (Glazer, ibid) mentioned above, is far too broad for gross generalization about their usefulness. These outside experiences could for instance refer to intercurrent events discussed in a previous section for which their appears to unanimous agreement that these are potentially damaging when **not** revealed.

There appears to be consonant agreement that such disclosures are necessary for the patient's emotional health. It is generally felt that not revealing information gives the patient's fantasies free rein. This then allows for no opportunity to deal with distortions, and the failure to reveal information, especially when it can provide relief, runs the risk of introducing real issues of exclusion, abandonment, and rejection (Lane and Hull, 1990).

Fromm-Reichmann (1960, 212) cited in Flaherty (1979) and Guy (1987) have commented along similar lines in the following way:

> It is, of course, possible for a significant occurrence, such as a death, marriage, childbirth, or divorce, to take place in the life of a psychiatrist while a patient is under treatment. He may unassumingly comment on his reason for the interruption and add that he is now ready for work. He should bear in mind the patient may wish to express condolences, congratulation, or merely make a comment and so he should not fail to give him an opening to do so ... the frank admission that the therapist is human and not infallible shows more respect and consideration for the patient than evasion would. It may also contribute to the process of maturing, which is part of the goal of the psychotherapeutic process.

Bellack (1981, 227-228) cited in Guy (1987) has echoed Fromm-Reichmann's call for a sensible, reasonable approach to the issue of therapist self-disclosure, in the following words:

> In all intercurrent conditions of the therapist, one main rule must be observed, namely that one should maintain as much therapeutic neutrality as possible without, however, creating artificial situations or deceptions or failing to respond and interact with the patient in a reasonable and human way where it is indicated.

He further points out that to do otherwise is to risk confusing the patient's reality testing and wounding his or her dignity. Rather than attempting to be a stone mask, Bellak (ibid) encourages the therapists to self-disclose about life-events when it seems reasonable and helpful to do so.

To further this discussion, Simon (1990b) and Counselman and Alonso (1993) are called upon as they have specifically addressed the question of how much factual information should be imparted to patients. This is after a review of the literature on therapist illness that raised many questions about what therapists who are ill should tell their patients.

They mention a lack of clear guidelines about the theoretical implications which leaves the therapist ill prepared to plan carefully or move confidently when decisions must be made. Counselman and Alonso (1993) specifically raise questions concerning planned interruptions, for example elective surgery. They ask when one should tell one's patients, and whether a therapist should tell patients anything about the nature of his or her illness, and if so, when?

Simon (1990b) after noting her personal reactions to her own therapist's heart attack accompanied by cancelled sessions, has formulated explicit recommendations. She feels that in addition to informing patients about the logistics regarding cancelled appointments, further information is needed during a lengthy absence.

She specifically recommends that patients be told who they can call for further information and for assistance, if warranted. To keep the psychotherapy process and relationship alive, she additionally recommends that patients be contacted

at intervals during the break to inform of the therapist's progress and to confirm date of continuation of therapy. Simon (ibid) ultimately recommends that therapists handle crises in a manner consistent with their theoretical orientations and with respect for their real relationships with their patients.

It is advised that psychodynamic psychotherapists disclose little information beyond what is logistically necessary, thereby impinging minimally on the transference relationship. Therapists who are labelled as existential will probably freely share details of their situations.

Simon (1990b) aware of the still existing grey area realizes that to be theoretically consistent, professionally responsible, attentive to one's own needs, and cognizant of the real relationship between oneself and one's patients requires a delicate balance that one can strive for.

Simon (1990b) also mentions the importance of the patient's diagnosis. For example it is felt that a lower functioning patient requires ongoing professional contacts with an alternate therapist. Most borderline patients need regular information for a consistent source with whom they could initiate contact as the need is felt.

This reflects a flexibility tuned to the nature of the therapeutic relationship, as well as patient's needs. Simon (1990b) finally recommends that once sessions are resumed, information regarding the status of the therapist's health, including reassurance about prognosis, is recommended.

Mention of Maroda (1991) at this stage can further accentuate the importance of the type of material being disclosed. She strongly advocates the expression of countertransference

affect, but strongly discounts the sharing of any other personal information.

At this stage, it is interesting to become aware of how certain theoretical orientations advocate different types of self-disclosure. Various object relations theorists have advocated the expression of self-involving statements with particular emphasis on affect. This implies a very profound self-disclosure, yet Maroda (1991) in spite of these profound disclosures, strongly disavows the sharing of **any** other personal or private information. Some self psychologists such as Cornett (1991) advocate the expression of complementary responses to facilitate a self object transference.

In summary, this discussion once again underscores the importance and powerful impact of the therapist's theoretical orientation. Of fundamental importance is how the therapist defines the therapeutic alliance, and how he conceptualizes his working assumptions.

If one adheres to the gross categorization of humanistic, real, and self-disclosure on the one hand, and psychoanalytic, transferential, and anonymity on the other hand, then one should formulate indications in concert with a humanistic approach, and contraindications in concert with a psychoanalytic approach. This would resemble Curtis' (1981) distinction. However, the introduction of object relations theory with its expanding conceptualization of countertransference, and the interpersonal or neo-Sullivinian movement with their expanding concept of transference has profound implications for a simplistic definition of the nature of the therapeutic relationship. This has radical implications for therapist's stance, and ultimately for the employment of therapist self-disclosure.

## 4.3.2. Pitfalls and contraindications for the use of therapist self-disclosure.

When engaging a discussion of contraindications for the use of self-disclosure by the therapist, one spontaneously enters a discussion of the misuses of this intervention, and ultimately many ethical issues are addressed. Few authors have explicitly formulated contraindications, and only a few can be cited, namely Curtis (1981), Weiner (1983), and Goldstein (1994).

Weiner (1983) has addresses the issue of expressing **empathy** and feels that it must be limited. Expression of empathy may lead to a symbiotic transference reaction, a rearousal of feelings and experiences from that period of infancy when differentiation from one's mother was incomplete (Silverman, 1972) cited in Weiner (1983).

In addition to this an empathic response can obstruct therapy by reducing anxiety. Without anxiety there is little motivation for change and less possibility for the patient to have a full experiential understanding of his psychopathology (Weiner, 1983).

Weiner (1983) also discussed the **repetition of a trauma.** Just as a disclosure to a patient can set the stage for the patient's further appreciation of his or her assets and can be helpful in working through the ill effects of exclusion and abandonment, so too can the patient be traumatized by the therapist's disclosure. The therapist can overburden a severely taxed ego or repeat an earlier trauma.

Goldstein (1994) has also cautioned against **burdening a patient.** In a similar vein, Maroda (1991) has discussed the danger of letting a patient feel **engulfed** by the therapist.

Weiner (ibid) cites Givelber and Simon (1981) who reported a case in which the therapist's disclosure of a personal loss significantly derailed the therapy of a psychotic person. In this case the patient experienced the therapist's revelation as an overwhelming demand that she care for him. This experience evoked traumatic aspects of her childhood, and the therapist later acknowledged that he told her about his loss because of his own need to be cared for and to deflect her rage at his emotional vulnerability, and not because she needed real information about him to establish or reinforce her fragile reality testing.

Doster and Brooks (1974) have referred to positive self-disclosures, where a therapist reveals his or her **mastery** over a situation that the patient is struggling with. These disclosures have an inherent risk, and that is the patient could, in the light of such a disclosure, feel ill-equipped and inferior.

Curtis (1981) has warned against the danger of **setting a precedent** for future behaviour. It is felt that if the therapist discloses in one situation he might unknowingly be setting a precedent by which the patient may request, or demand, additional information in a less appropriate context. This could establish an inconsistency in the patient's eyes which could eventually attenuate the therapeutic alliance.

As seen in a previous section, self-involving statements keep the focus on the client. Self-disclosing statements run the risk of shifting the focus onto the therapist. This runs the previously mentioned and additional risks of gratifying the therapist, or burdening the patient.

Goldstein (1994) from out of a self psychology framework can be called upon to further the discussion of

contraindications. She cautions therapists not to self-disclose when idealising needs are primary. Learning distressing facts about the therapist could cause premature de-idealization.

In a similar vein, self-disclosure is not recommended when needs for mirroring are primary and the patient is very self-absorbed to the extent that the therapist does not exist as a real or separate person. In this instance, self-disclosure could be experienced as an unwanted intrusion.

Goldstein (1994) further feels that requests for personal information may reflect resistance to the self-object transference. Once again the importance of the type of self-disclosure comes to the fore. Whereas complementary type responses could facilitate the self-object transference, sharing of external information could disrupt it.

**4.4. Summary.**

To aid in summarization and systematization, and integration, various categories of therapists as employed by Palombo (1987), can be utilized. Although it was not Palombo's (ibid) intention, this nevertheless represents an attempt at integrating indications with types of self-disclosure.

In the first category are the therapists and authors who consider self-disclosure acceptable. In this regard, Weiner (1983) has referred to the **type of therapy**. This category includes the therapists who work with groups of substance abusers, or severe delinquents and who feel that the mutual sharing of past experiences is necessary to achieve the therapeutic goal (Palombo, 1987).

In the second category are the therapists or authors who

consider self-disclosure, at times, necessary though mostly undesirable. Within this category, Palombo (ibid) discusses the general consensus on the sharing of special events in the therapist's life. He recommends that these parameters (Langs, 1976) must eventually be discussed and their meaning worked through. This working through process will be discussed at a later stage.

Within this category, Palombo (1987) also places the therapists who work with severely regressed patients. The general feeling, as seen in chapter three, is that the direct expression of these self-involving statements is beneficial to therapist and patient, and furthers the treatment.

In the third category are the authors who consider self-disclosure to be untherapeutic. These therapists and authors feel that therapists should not share countertransference feelings, nor any personal information under any circumstances. These are the traditional orthodox psychoanalytic therapists and Palombo (ibid) cites Langs (1973) as an example.

When discussing the indications and contraindications of therapist self-disclosure, one can see that there will probably never be any clear-cut guidelines pertaining to this issue. Both Weiner (1983) and Cornett (1991) have termed it a risky intervention.

It is now apparent that each therapeutic encounter is unique, and that there are a number of variables co-existing to determine its original character and composition. These variables have, amongst others, to do with the fact that there are two personalities present within the lived-reality of psychotherapy.

The patient as well as the therapist bring into the therapeutic situation a way of relating and interacting that is unique. The therapist has a formal training, a theoretical orientation that he adheres to and feels comfortable with, and how he has integrated all of this into his or her **parent theory of human beings** (Mahrer, 1983) is also akin to his way of conducting therapy. This uniqueness ensures that closure on this topic cannot be attained.

The uniqueness of encounter and self-disclosure ensure that the formulation of indications and contraindications is complicated by the qualifications that one has to keep making. These qualifications refer to all of the mediating variables as outlined above. These pertain to **therapist variables**, partially discussed in the previous paragraph, **patient variables**, and **relationship variables.** These all culminate in the moment of the disclosure, and demonstrate the embeddedness of this concept. To complicate this, the embeddedness is not only contextual in nature but processional as well.

As Weiner (1983) has stated, therapeutic interventions of any kind are rarely followed by an immediate, dramatic reaction. They are usually locked in a chain of therapeutic events that result in emotional growth, therapeutic stalemate, or worsening of the patient's condition. Glazer (1981) has succinctly stated that self-disclosures persist beyond the moment for which they were intended. This unfortunately further invalidates generalization of the research material discussed in chapter two. This is due to the methodological failure to account for the lived psychotherapeutic process.

Hill (1992) has criticized researchers for their focus on client behaviour that occurs immediately after the therapist intervention. One is also reminded of a statement by Stricker

(1990) proposing that self-disclosures are not inherently good or bad. There are too many constraining and qualifying variables. A self-disclosure that is well-timed, well understood, and geared to the needs of the patient can be highly constructive (Stricker, ibid). Within another context, or a different phase of the process the same disclosure could be deleterious to the course of the treatment.

Stricker's (1990) comments about the disclosure being **understood** demonstrates the importance of what is actually **done** with the disclosure. This implies that the disclosure does not act by itself (Weiner, 1983). This insinuates that some aspect of the relationship has changed.

Additionally, previous discussion of the effect of disclosures on the reality or transference of the relationship has laid the foundation for a formulation of the importance of how the disclosure is managed. Any self-disclosure becomes workable therapeutic material, and most are probably resolved within the therapeutic encounter. This ties up with Palombo's (1987) comments earlier. An additional ramification of what is being said is that the actual effect of the disclosure may not be immediately observable.

At this stage the problem formulation can be restated.

## 4.5. The problem formulation reappraised.

Chapters two, three, and four demonstrate that self-disclosure has been written about and studied in various ways. The **Journal of Counseling Psychology**, as one example in chapter two provides many examples of quantitative, empirical research conducted within analogue or artificial counseling contexts. The methodological flaws pertaining to these studies reveal an unintentional by-passing of the

processional and contextual embeddedness of self-disclosure. There is also an unerring focus on the patient. The experience of self-disclosure for the therapist and how he or she deliberates on this issue, what mediates the disclosure, and the eventual effect on the therapist as co-constitutor of the relationship has been by-passed and neglected.

The journal **Contemporary Psychoanalysis**, as one example from chapter three, utilizing entirely different terminologies, and pertaining specifically to psychotherapeutic paradigms, provides other insights. The latter articles are qualitative in nature and provide data from vignettes, anecdotal material, and expansive clinical experience. Although the vignettes and other illustrative material reveal something of the therapist's experience, this has not been systematized in any way. The overriding focus on countertransference disclosure has also marginalized the concept of therapist self-disclosure.

These two bodies of knowledge, namely the information obtained from chapters two and three are not in harmony, rarely complement each other, and it is difficult to place them in dialogue. A strained link has however emerged, and this is the increasing awareness of **self-involving statements** as set out in chapter two. The self-involving disclosures brought to awareness the relational embeddedness of self-disclosure. Primacy of these disclosures could comprise a promising start to tracing the contextual and processional variables pertaining to self-disclosure which have otherwise been by-passed within the quantitative research literature.

These vastly different and contrasting bodies of knowledge contribute to the lack of agreement regarding recommendations to disclose or not, and also complicate the formulating of a research design. Chapter four, which has attempted to

systematically account for the types of self-disclosure, and the recommendations and contra-indications for self-disclosure, has underscored the difficulty in isolating and encapsulating self-disclosure from its therapeutic context.

At this stage an alternative research approach is called for. An approach is required that can explicate the experience and meaning of the disclosure for the therapist. To answer to this need a phenomenological research approach has been selected. Phenomenology which concerns itself with human subjective experience, is considered appropriate in the light of the progressive "humanizing" of the therapeutic relationship as illuminated in chapter three. In this chapter, certain psychoanalytic approaches, such as self psychology were thought to bridge the gap between psychoanalysis and phenomenology (Tobin, 1990). It was also these approaches that called for radical re-formulation of the psychotherapeutic relationship, and ultimately self-disclosure. With shifts towards a greater appreciation of human subjective experience, it is deemed appropriate to implement a method of conducting research that respects and accounts for this subjective experience.

**4.6. Bibliography.**

Al-Mateen, C.S. (1991). Simultaneous pregnancy in the therapist and the patient. *American Journal of Psychotherapy, XLV*(3), 432-444.

Andersen, B. and Anderson, W. (1989). Counselor's reports of their use of self-disclosure with clients. *Journal of Clinical Psychology, 45*(2), 302-308.

Berg, J.H. and Derlaga, V.J. (1987). *Self-disclosure: Theory, research, and therapy.* New York: Plenum Press.

Bollas, C. (1983). Expressive uses of the countertransference. *Contemporary Psychoanalysis, 19*(1), 1-34.

Buechler, S. (1993). Clinical applications of an interpersonal view of the emotions. *Contemporary Psychoanalysis, 29*(2), 219-235.

Chaikin, A.L. and Derlaga, V.J. (1974). *Self-disclosure.* Morristown, New Jersey: General Learning Press Psychology Series.

Chelune, G.J. (1979). *Self-Disclosure: origins, patterns, and implications of openness in interpersonal Relationships.* San Francisco, California: Jossey-Bass Publishers.

Chrzanowski, G. (1982). Discussion, Vicious circles, by P. Wachtel . *Contemporary Psychoanalysis, 18*(2), 259-283.

Cornett, C. (1991). The "risky" intervention: Twinship selfobject impasses and therapist self-disclosure in psychodynamic psychotherapy. *Clinical Social Work Journal, 19*, 49-61.

Counselman, E.F. and Alonso, A. (1993). The ill therapist: Therapists' reactions to personal illness and its impact on psychotherapy. *American Journal of Psychotherapy, 47*(4), 591-602.

Curtis, J.M. (1981). Indications and contraindications in the use of therapist's self-disclosure. *Psychological Reports, 49*, 499-507.

Dewald, P.A. (1982). Serious illness in the analyst: transference, countertransference, and reality responses.

*Journal of the American Psychoanalytic Association, 30*, 347-363.

Dewald, P.A. (1994). Countertransference issues when the therapist is ill or disabled. *American Journal of Psychotherapy, 48*(2), 221-230.

Doster, J.A. and Brooks, S.J. (1974). Interviewer disclosure, modeling, information revealed, and interviewee verbal behavior. *Journal of Counseling and Clinical Psychology, 42*(3), 420-426.

Dowd, E.T. and Boroto, D.R. (1982). Differential effects of counselor self-disclosure, self-involving statements, and interpretation. *Journal of Counseling Psychology, 29*(1), 8-13.

Ehrenberg, D.B. (1982). Psychoanalytic engagement. *Contemporary Psychoanalysis, 18*(4), 535-555.

Ehrenberg, D.B. (1984). Psychoanalytic engagement II: Affective considerations. *Contemporary Psychoanalysis, 20*(4), 560-599.

Ehrenberg, D.B. (1992a). On the question of analyzability. *Contemporary Psychoanalysis, 28*(1), 16-31.

Ehrenberg, D.B. (1992b). *The intimate edge: Extending the reach of psychoanalytic interaction*. New York: W.W. Norton and Company.

Flaherty, J.A. (1979). Self-disclosure in therapy: Marriage of the therapist. *American Journal of Psychotherapy, 38*, 442-452.

Friedman, G. (1991). Impact of a therapist's life threatening illness on the therapeutic situation. *Contemporary Psychoanalysis, 27*(3), 405-421.

Glazer, M. (1981). Anonymity reconsidered. *Journal of Contemporary Psychotherapy, 12*(2), 146-153.

Goldstein, E.G. (1994). Self-disclosure in treatment: What therapists do and don't talk about. *Clinical Social Work Journal, 22*(4), 417-433.

Greenson, R. (1967). *The technique and practice of psychoanalysis* (vol. 1). London: The Hogarth Press.

Grunebaum, H. (1993). The vulnerable therapist: On being ill or injured. In J.H. Gold and J.C. Nemiah (Eds.), *Beyond transference: When the therapist's real life intrudes* (pp. 21-50). Washington, DC: American Psychiatric Press, Inc.

Gurtman, J.H. (1990). The impact of the psychoanalyst's serious illness of psychoanalytic work. *Journal of the American Academy of Psychoanalysis, 18*(4), 613-625.

Guy, J.D. (1987). *The personal life of the psychotherapist.* New York: John Wiley and Sons.

Hill, C.E. (1992). Research on therapist techniques in brief individual therapy: Implications for practitioners. *The Counseling Psychologist, 20*(4), 689-711.

Jackson, J.M. (1990). The role of implicit communication in therapist self-disclosure. In G. Stricker and M. Fischer (Eds.), *Self-disclosure in the therapeutic relationship* (pp. 93-101). New York: Plenum Press.

Johansen, K.H. (1993). Countertransference and divorce of the therapist. In J.H. Gold and J.C. Nemiah (Eds.), *Beyond transference: When the therapist's real life intrudes* (pp. 87-108). Washington, DC: American Psychiatric Press, Inc.

Kaplan, A.H. (1993). The aging and dying psychotherapist: Death and illness in the life of the aging psychotherapist. In J.H. Gold and J.C. Nemiah (Eds.), *Beyond transference: When the therapist's real life intrudes* (pp. 51-70). Washington, DC: American Psychiatric Press.

Kooden, H. (1991). Self-disclosure: The gay male therapist as an agent of social change. In C.Silverstein (Ed.), *Gays, lesbians, and their therapists: Studies in psychotherapy* (pp. 143-154). New York: W.W. Norton and Company, Inc.

Kooden, H. (1994). The gay male therapist as an agent of socialization. *Journal of Gay and Lesbian Psychotherapy, 2*(2), 39-64.

Kottler, J.A. (1986). *On being a therapist*. London: Jossey Bass Publishers.

Lane, R.C. and Hull, J.W. (1990). Self-disclosure and classical psychoanalysis. In G. Stricker and M. Fischer (Eds.), *Self-disclosure in the therapeutic relationship* (pp. 31-46). New York: Plenum Press.

Langs, R.J. (1976). The therapeutic relationship and deviations in technique. *International Journal of Psychoanalytic Psychotherapy, 4,* 106-141.

Lax, R.F. (1969). Some considerations about transference and countertransference manifestations evoked by the analyst's pregnancy. *International Journal of Psycho-Analysis, 50,*

363-372.

Mahrer, A.R. (1983). *Experiential psychotherapy: Basic practices*. New York: Brunner/Mazel Publishers.

Maroda, K.J. (1991). *The power of countertransference: innovations in analytic technique*. West Sussex: John Wiley and Sons.

Mathews, B. (1988). The role of therapist self-disclosure in psychotherapy: A survey of therapists. *American Journal of Psychotherapy, XLII*(4), 521-531.

McCarthy, P.R. (1979). Differential effects of self-disclosing versus self-involving counselor statements across counselor-client gender pairings. *Journal of Counseling Psychology, 26*(6), 538-541.

McCarthy, P.R. and Betz, N.E. (1978). Differential effects of self-disclosing vs self-involving counselor statements. *Journal of Counseling Psychology, 25*, 251-256.

Palombo, J. (1987). Spontaneous self-disclosures in psychotherapy. *Clinical Social Work Journal, 15*(2), 107-120.

Perlman, G. (1991). The question of therapist self-disclosure in the treatment of a married gay man. In C. Silverstein (Ed.), *Gays, lesbians, and their therapists: Studies in psychotherapy* (pp. 201-209). New York: W.W. Norton and Company Inc.

Reynolds, C.L. and Fischer, C.H. (1983). Personal versus professional evaluations of self-disclosing and self-involving counselors. *Journal of Counseling Psychology, 30*(3), 451-454.

Rosie, J.S. (1980). The therapist's self-disclosure in individual psychotherapy: Research and psychoanalytic theory. *Canadian Journal of Psychiatry, 25*, 469-472.

Schwartz, R.D. (1989). When the therapist is gay: Personal and clinical reflections. *Journal of Gay and Lesbian Psychotherapy, 1*(1), 41-52.

Simon, J.C. (1990a). Criteria for therapist self-disclosure. In G. Stricker and M. Fischer (eds.), *Self-disclosure in the therapeutic relationship* (pp. 207-225). New York: Plenum Press.

Simon, J.C. (1990b). A patient-therapist's reaction to her therapist's serious illness. *American Journal of Psychotherapy, XLIV*(4), 590-597.

Stricker, G. (1990). Self-disclosure and psychotherapy. In G.Stricker and M. Fischer (Eds.), *Self-disclosure in the therapeutic relationship* (pp. 277-289). New York: Plenum Press.

Stricker, G and Fischer, M. (1990). *Self-disclosure in the therapeutic relationship.* New York: Plenum Press.

Stockman, A.F. and Green-Emrich, A. (1994). Impact of therapist pregnancy of the process of counseling and psychotherapy. *Psychotherapy, 31*(3), 456-462.

Tobin, S.A. (1991). A comparison of psychoanalytic self psychology and Carl Rogers's person-centred therapy. *Journal of Humanistic Psychology, 31*(1), 9-33.

Van Niel, S.M. (1993). Pregnancy: The obvious and evocative real event in a therapist's life. In J.H. Gold and J.C. Nemiah (Eds.), *Beyond transference: When the therapist's*

*real life intrudes* (pp. 125-140). Washington, DC: American Psychiatric Press, Inc.

Wachtel, P.L. (1982). Vicious circles. *Contemporary Psychoanalysis, 18*(2), 259-283.

Wachtel, P.L. (1993). *Therapeutic communication: Principles and effective practice*. New York: Guilford Press.

Weiner, M.F. (1983). *Therapist disclosure: The use of self in psychotherapy*, Second Edition. Baltimore: University Park Press.

Winnicott, D.W. (1949). Hate in the counter-transference. *The International Journal of Psycho-Analysis, XXX*(2), 69-74.