CHAPTER SEVEN: PRESENTATION OF RESULTS.

7.1. Protocol one.

Therapist A: Female psychotherapist, 13 years experience.

T: I'm very acutely aware of the fact that I'm very strict about self-disclosure, okay. I think as a young inexperienced therapist, there were times when I was tempted and did do some self-disclosure, but I've learnt over the years to trust in the wisdom of the old therapists who said: "Don't do that" I've found that inevitably that it creates a burden for the patient which you then have to work through with them. You know, you can't burden them with your stuff, no matter how well-meaning you are.. because I've found that inevitably if I'm tempted to disclose something about myself, it's countertransference, it relates to me and my stuff and I think that **mostly**, I think there are occasions when you can identify, let me think, I try and be fairly strict about the projective identification type of situation where you are aware of a reaction in you, and you have to sort out what that reaction is? Is it a projective identification of some kind, or is it countertransference, or what? I'm quite aware of that, and when I'm in doubt I generally don't. But I think that to adopt a hard and fast rule where you say you **never** self-disclose, I think that it's probably counter-therapeutic, there are times when it **can** be therapeutic.

Um, I remember once, okay once long ago, I had a young girl in therapy who gave me a life history very similar to my own, okay, and I think that's always a danger sign, because you sit there and you think, "that's me!", and I look around and that's exactly where I was X number of years ago, and I think that at that point there is a pressure on me to say "Look, I understand, I've been there too", and to say something along

the lines, "You can get through it, it's okay". In other words to provide her with some comfort. The pressure on me was very great to do that and that was in terms of my feeling a real **tug** inside, um, of empathy for where she was at, to the point of where I was feeling myself react. I was actually seeing myself in the patient and I think then the pressure on me to say something like: "Look, don't worry I've been there, you will get through it, and you will be okay". I think the danger then is then to say: "Look all you have to do is A,B,C," and then you start breaking down all the basics of therapy, when you do that, um, and ja, you have to recognize that when you have that feeling, when you've had that urge to do that, you are probably running a severe risk of exposing your own truth to another person.

R: So you were aware of an immense pull?

T: A tremendous pull, yes

R: How long did you sit with that? Was it over a long time, or was it an isolated moment in the therapy?

T: It was over several therapy sessions where I began to think, that's remarkable, I've had a similar experience, and it built up for a very long time, when I was actually sitting there thinking, I'm stunned, this is my very own life story being repeated to me..

R: Strikingly similar..

T: .. and then it was a particularly emotional session where she broke down and cried and she had reached a kind of crisis point, a turning point which I recognized, there was a very deep recognition in me of what she was going through, and I think what I read into that was her need, and I fell into the

trap, I did eventually say... You know I thought about it a lot afterwards, and um, the temptation then is to say: "Look I've been there, I really do understand", because over and over, you find, I find people in therapy to say something like: "You couldn't possibly understand, you probably don't have a care in the world", and they can't imagine that because you're sitting in the therapist's chair that you could possibly understand where they have been.

R: Was this happening to this person as well?

T: I think it was, I was aware of how much I had achieved since I was in the position she was in. I was aware and **possibly** the countertransference there was of me wanting some recognition from her of what I had achieved. So, it was ultimately a selfish act I think.

Now, I remember at the time, I obviously didn't break down and sob and tell her my whole story, I must have said something like "I **really** do understand, I **really, really do understand**". And with non-verbals were kind of giving the message that I do understand more than I'm letting myself say. But I kind of left it at that point.

R: Right..

T: I'm just trying to think if I did or if I'm not covering up for myself. But you know there is a recognition, I remember I still have regular supervision about my work, and I remember during supervision telling my supervisor something about my own experience, and she...she looked me straight in the eyes and said "Don't we all?" and somewhere there was this "Oh, her too!". She'd also been there. It was something related to **being** a therapist, the experience of **being** a therapist. I think her message to me was, um, don't

worry you're just feeling the way a therapist normally feels, but it constituted a reassurance. But there was that moment of recognition which is very subtle where it **is** a self-disclosure.

R: So your self-disclosure to that specific patient was not necessarily profound in terms of content or depth. It sounds more like a hint at your empathy coming from the fact that you had been there?

T: Yes

R: And the effect of the disclosure, on yourself, the patient, the relationship?

T: Um..(pause) I didn't experience a noticeable change. I mean she didn't end therapy, go running, and I think that I didn't experience anything destructive as having happened. I think that what happened was for a while the focus was on me, rather than on her, and um, I've been doing some reading about this kind of stuff. I don't know if you know the article by Searles, "The Patient is Therapist to the..

R: Yes.

T: ...and I think then what you have is you digress and you have the patient trying to fix you for a while to make sure that you're okay and as I recall one or two incidents of the patient saying something to me like: "Now did you also experience this?" and then there was a pressure on me to disclose more, which for a while distracts you from therapy in that you've got to patch up that hole, you know, you've got to keep saying things like: "Well, what I experienced is not important".

R: So, there weren't subsequent disclosures.

T: No, not with that person. I was very aware of the breach after that and I thought about it a lot because for me, I don't know, it's a bit of an issue this whole story of how human you are in therapy, and how distant and sort of blank you must me, and I think that there's a big problem in my thinking.

R: About the blankness?

T: Yes, and I query whether you in fact don't self-disclose to some small extent anyway in **every therapy**, okay because you're constantly..... I work face to face, and I find it impossible not to react to what people are saying and in formulating some form of empathic reaction. You inevitably through your choice of words, the way you turn your head, there are all kinds of subtle ways in which you are betraying I think, how you are responding. You know I think you can't not self-disclose to some extent, or else you really start becoming too remote, too detached.

R: And you did in fact mention earlier, when discussing that patient, that your body language may have conveyed more empathy than what normally would have been the case.

T: Yes, yes, yes.

R: And you definitely noticed a shift in focus onto yourself?

T: Yes, there was a shift in focus on to myself. I was aware of stepping out of the therapist's role in a strange kind of way, um, I believe that you have to have a modicum of realness in your dealing with people. There's a limit beyond which you cannot go, you know, and not be yourself. You are

in the therapy and as such you **are involved.** I think you have to be if you're going to do any kind of meaningful work.

For years I didn't work this way. My style was very much more distant and formal. I used to love to lapse into teaching, and then you realize that that's a defence on your own part too. You can't avoid engaging and being real. I think you've got to constantly tread this line of not overstepping the limits, and really getting to communicating something about your own needs.

R: So in your growth as a therapist, you maybe have become more spontaneous in terms of sharing?

T: Ja, it's a strange paradox, okay. I've become more spontaneous in sharing of myself and yet less open to disclosing content about myself, okay.

R: Yes.

T: It's been a very strange process, and with that has come an awareness and a need to not step into other roles like a teaching role, um, something like that, and because of my basic training the temptation to do that was very strong, and it took me a long time of trying to figure out what was really going on, and further studies to sort that one out, and I think there's a way of doing it without doing it that you discover after you've worked with people. I suppose in a way, there is no way ultimately that you cannot not be involved, and you are after all shaping what's happening, you are!

R: Right.

T: I've just thought of something else..

R: Yes

T: ....there was one therapy where I, um, it was a man this time, told me something **really devastating** about him. At this stage I struggle to .. oh yes, okay, I remember what it was.... he had been through a very bad experience and he started getting very intensely enmeshed in his feelings related to that incident and I teared up, um, and we kind of dealt with that one, because I believe that he's got to deal with that. You can't tear up, the patient sees you, you have to deal with that, okay.

R: Right

T: So I remember dealing with that, um, in some sort of standard way, like saying, "You must of noticed me reacting, how did that affect you?" and working through that. He told me **months later** that for him that was one of the most significant moments in the therapy, um, that stood out for him as a beacon.

R: Were you not aware of the impact at the time?

T: No, no, no

R: The tears forced you to disclose your feeling?

T: Yes, yes

R: Had this been building up, or was it a critical incident that just happened?

T: Um, this particular patient had had a very, very long,

long series of sessions in which he couldn't show feelings, and when he finally did, it was to some sort of break through, and I was aware of saying "Oh, thank God, at last we've touched it!" There was that level of thinking, thank God we've touched something here. At the same time I was quite taken aback by the depth of the pain that he was feeling and to watch what he'd actually.. to watch that....that pain.... I think that's what made me react and I had an intense, **intense** desire to comfort him then, and I think that was... you know you often get the type of patient that tries to get sympathy out of you, but I think when people really come out with some sort of horror story, and you can actually sense what it must have been....

R: So it wasn't something that you'd been through yourself like the previous case we discussed?

T: It was something similar. It was similar in the sense that it involved a death, and having experienced death myself, I could relate to it, okay, it was that broad, but the details of it were not the same. It was his father dying in his arms, now my father didn't die in my arms..

R: Sure, okay,..

T: ..but I lost my father and um, I think that it was the helplessness, and the burden that had been placed on him. He was only a child, so I think to some extent it possibly echoed within me, because I've lost somebody, and because I have a child, and I wouldn't want my child to go through that.

R: So there appear to be plenty of associations?

T: There are associations that relate to me.

R: Tell me how you wanted to comfort him? Was it verbal, sort of pacifying?

T: I had a very strong desire to comfort him physically, I wanted to put my arms around him and stroke his head. And it's just a sense of you get to a certain level of pain in human experience, and it goes beyond words in a way, and I think that brings us into a whole other thorny issue.

R: That's right..

T: And I think in many respects we walk a tight rope.

R: What happened then?

T: What happened was we obviously stayed a while with his feelings, crying and all this sort of thing, and, um, after a while, he pulled out of it, you know: "Oh well, that's life". He backed out of it and I said something like: "Well, that was a pretty tough experience" and I first left it. I try to avoid things like that happening at the end of therapy, you've got to have time. We did have time at that particular time, and at the end he said something like: "Oh that's life, I suppose one can't dwell on that sort of a thing, it happens". And you can read into that some sort of a message to comfort you: "I don't want to upset you as well", and later I said something along the lines of: "You noticed me during that time reacting, how did you feel about that?", and, um, his reaction was something like: "Oh well, I didn't mean to upset you" So there was actually no acknowledgement then ..

R: Yes

T: I remember that what we dealt with was his need to not

upset me, so we kind of went through it on that level. But as I say it was literally months and months later, and the interesting thing was then it was an occasion when he felt particularly close to me, and he wanted,... his impulse at that stage was to overstep the limits from his side. It was very strange thing. He actually was feeling extremely happy and he was feeling so joyful and so wonderful that what he wanted to do was **grab** me and dance around the room with me, okay.

R: Yes

T: And maybe on that level, there had been some sort of subtle unconscious unvoiced willingness for physical contact, maybe that made it easier for him to come out with it in another way, and I then said: "You really want to share this with me". Once again we didn't, and he then went on to say: "Yes, I really feel close to you now. I feel as close to you now as I felt when we had that session once". He said to me: "You know I must tell you, you know that for me was so meaningful, that meant so much to me, and I often think of my therapy and I think of that one session..." and he said that that was a very special moment. So we went through that again. To him it was so special because to him it was a signal that in spite of all the sessions that we have been through where I am so professional and I may smile nicely, and I may be communicating certain things about myself, but I'm actually very professional and in that sense he wonders, and he did wonder whether I really cared about him. And for him that was a signal that I really cared. He couldn't quite believe it, as I was a therapist and I was sitting listening because he was paying me to do so.

R: So it definitely had quite a profound effect on him over the long term, and you weren't actually aware of the impact

that it had had?

T: Not at the time, no, not at the time.

R: What about when he told you about the impact, did it change things?

T: Oh my goodness, yes it did change things. What happened then was a **whole series** of sessions around this issue of why could he not give me a kiss on the cheek if he felt this was necessary, and this was part of a normal relationship. Wait, okay, that makes it sound a little stranger than it was. It was more related to what is closeness and caring and what are the limits of closeness and caring in the different situations, and how one expresses closeness in the different situations, appropriately or inappropriately, with different people, and how if I had been a male therapist, he wouldn't have the impulse to dance me around the room, so it lead onto a lot of work in terms of what his needs were as he defined being close to somebody.

R: It became a relationship issue?

T: It was a complete, a whole relationship issue. And then some confrontation from him to me in terms of if I really cared, why do I not show it then, why do I make it difficult for him, and strange enough a lot of anger in terms of the limits that were there, you know dealing with how difficult it is to acknowledge that there are limits.

R: So it seems to have spread, not only from within your relationship. It seemed to touch on other relationship issues as well. So the whole thing became therapeutic data..

T: It was very enriching for the therapy, **extremely** so, and what that says to me is that if something like that happens, if you end up reacting like that, I actually learnt how to handle that from watching another therapist, otherwise I don't know if I would have been able to do it that way, and when I watched that other therapist do that, the particular demonstration also showed me how it enriched that relationship, and how one then can walk that fine line between being human yet not burdening the patient with your own stuff, um, and I felt particularly good, and I still feel good that it's led to so much richness and deepening of the therapy, and it really was a good thing in the end.

So from this point of view..... and this is something that I'm grappling with at the moment. Um, I'm writing a thesis myself, and for me this is the issue that....if you cannot avoid communicating, okay, where do you draw the line, okay? I think that you inevitably disclose things about yourself, inevitably. You then have to try and remain human and engaged with that patient. You have to then, if you find yourself reacting like tearing up when a patient describes something painful.. I think as long as you're honest and you go away afterwards, and you try and work with the extent to which that stuff was really yours and really his and appropriate or inappropriate, or what the meaning of it is, it happens spontaneously.

I have another patient who regularly, I get angry at the stuff she tells me...I find myself getting **extremely angry** and this relates to the way she is treated by a member of her family, and to me that is clearly countertransference issues, okay. Now apart from the fact that maybe my eyes dilate, or I blush, I don't communicate that.

R: You haven't told her how angry you are?

T: No, because I think, you know, I have a sense that she must pick something up. She must pick up something, she can't ....
(therapist appears tearful)

R: You're very uncomfortable with this feeling.

T: Um, I'm uncomfortable to the extent that I don't want to burden her with my stuff, alright,um and I think that to me that I've moved in my own growth to the opposite pole from where I used to be, where I used to say: "Tell this person to get off your back!", teaching, assertiveness.

R: Okay

T: And, um, and my sense of **outrage** and **fury** that this person could have treated my patient in this particular way. I have to recognize that were I really to give voice to that I would be overstepping the limit.

R: I've misunderstood you, I thought you were angry with the patient.

T: No, no, no, no. No it's a case of the patient telling me about being abused by someone else, verbally and whatever..

R: So you must be powerless?

(silence for a long time, the therapist appears to be distracted and emotional by the nature of the discussion. The researcher decides not to probe unless the patient spontaneously offers more information. The researcher took this decision as the therapist had already offered a dearth of phenomenologically useful data, and had been bold and candid in her responses. To intrude upon an emotionally

intense memory seemed inappropriate at this stage)

T: This is a very difficult topic that you've chosen to write about.

R: Yes.

(a short and general discussion ensues. The therapist and researcher exchange a few ideas about their post-graduate studies and then terminate the discussion)

7.2. Meaning units, re-articulated meaning units, and central themes.

1. I'm acutely aware of the fact that I'm very strict about self-disclosure, okay,

The therapist is immediately aware that she has a principled, and disciplined approach to therapist self-disclosure.

(P) therapist's original positioning:

<u>discipline regarding S-D</u> - when S-D presents itself in the therapist's awareness, she immediately positions herself in terms of her discipline regarding S-D.

2. I think as a young inexperienced therapist, there were times when I was tempted and did do some self-disclosure, but I've learnt over the years to trust in the wisdom of the old therapists who said: "Don't do that".

There has been a shift in the therapist's positioning in terms of using self-disclosure. When she was younger and had not possessed accumulated practical knowledge, self-disclosure would present itself as an enticement to which she would at times succumb. With accumulating experience over time the therapist is prone to relying more on the knowledge of experienced therapists who advocate that one not self-disclose.

(P) therapist's reflective positioning:

<u>shift towards restrictive use of S-D</u> - there has been shift in the therapist's positioning in terms of the use of self-disclosure. She leans more heavily on the advice of experienced therapists to refrain from disclosing.

3. I've found inevitably that it creates a burden for the patient which you then have to work through with them. You know, you can't burden them with your stuff, no matter how well-meaning you are.

The therapist has discovered that self-disclosure unavoidably places undue concern on a patient, which must be processed therapeutically. The therapist believes that one cannot weigh down a patient with one's personal material even though the disclosure might have had another, well-intended meaning.

(P) therapist's reflective positioning:

<u>burdening effect on patient</u>

<u>assimilating and integrating the S-D</u> - S-D ultimately constitutes primary working data.

(P) therapist's established position:

<u>prescription not to burden patients</u> - the therapist believes that one cannot weigh down a patient with one's personal material.

4. ..because I've found that inevitably if I'm tempted to disclose something about myself, it's countertransference, it relates to me and my stuff and I think that mostly, I think there are occasions when you can identify, let me think, I try and be fairly strict about the projective identification type of situation where you are aware of a reaction in you, and you have to sort out that reaction. Is it a projective identification, or is it countertransference, or what. I'm quite aware of that and when I'm in doubt I generally don't.

The possibility to disclose is experienced by the therapist as an enticement. Upon recognition of the emotional impact,

she extricates herself and intellectually interrogates this awareness. This intellectual analysis vacillates between the awareness of a reciprocal responsiveness within the encounter and the possibility of an awakening of personal inner experiences not related to the encounter. The therapist is disciplined in her locating of this response, and within the region of "not knowing" the imminent disclosure is held in abeyance.

(P) therapist's reflective positioning:

enticement to reveal personal material - the need is experienced as a temptation and is related to the therapist's private and personal material;

containing- and intellectually interrogating the felt sense to share - from an unfolding awareness wherein S-D is experienced as a temptation, follows a private inner dialogue where the therapist extricates herself for intellectual interrogation to attempt to establish ownership of feeling and content. If the therapist remains uncertain of the ownership, the S-D is suspended.

5. But I think that you adopt a hard and fast rule where you say that you *never* self-disclose, I think that it's probably counter-therapeutic, but there are times when it can be therapeutic.

Although the therapist's over-riding concern is that self-disclosure could impede the therapeutic process, she reserves the possibility that it could somehow assist the therapeutic process. To uncompromisingly dismiss the possibility of self-disclosure negates the moments when it could be helpful.

(P) therapist's contextual positioning:

perplexing questions about the therapeutic value of S-D - therapist perplexed as to the therapeutic value of S-D, need to protect the therapeutic alliance.

"A childhood memory"

6. Um, I remember once, okay, once long ago, I had a young girl in therapy who gave me a life history very similar to my own, okay, and I think that's always a danger sign, because you sit there and you think, "that's me!", and I look around and that's exactly where I was X number of years ago, and I think that at that point there is a pressure on me to say "Look, I understand, I've been there too", and to say something along the lines, "You can get through it, it's okay". In other words to provide her with some comfort.

The therapist has previously been in a situation where a young female patient narrated a course of life events that were profoundly similar to her own. Upon awareness of such similarity, the therapist always exercises caution. This mediates the close alignment and the internal pressure to provide comfort and encouragement through revelation of the similarity.

(I) unfolding therapeutic constellation for S-D:
shared life contexts - young female who presented a life-context resembling the therapist's.

(I) emerging therapeutic constellation for S-D:
therapist's cautionary interlude to striking similarity - therapist stirred by striking similarity of shared life contexts, cautionary interlude.
therapist's inner pull to respond with comfort and encouragement.

7. the pressure on me was very great to do that and that was in terms of my feeling of a real tug inside, um, of empathy for where she was at, to the point of where I was feeling myself react. I was actually seeing myself in the patient and I think then the pressure on me to say something like: "Look, don't worry I've been there, you will get through it, and you will be okay"

The therapist experiences a personalized empathic reaction

during which she becomes a full participant in the patient's unfolding narration. Within the immediacy of the experience of actually sensing the patient's reality, and being able to identify fully with it, the therapist felt an enormous inner pull to acknowledge the similarity of her own previous experience. This acknowledgement would consist of a disclosure which would convey encouragement and reassurance to the patient.

(I) emerging therapeutic constellation for S-D:

therapist's alignment and pressure to reassure and encourage - close alignment with patient, actually sensing the patient's life-world, inner pressure to share with patient.

8. I think the danger then is then to say: "Look all you have to do is A,B,C," and then you start breaking down all the basics of therapy, when you do that, um, and ja, you have to recognize that when you have that feeling, when you've had that urge to do that, you are probably running a severe risk of exposing your own truth to that person.

There is an inherent risk that the therapist could explicitly guide and instruct her patient. This would over-simplify the patient's experience and short-circuit the pre-established working principles on which psychotherapy is based. This intercepts the unfolding of the therapeutic process. When the internal pressure wells up within the therapist she is also immediately aware of the impending possibility of providing the patient with her personified experience which might have potentially negative consequences.

(I) therapist's contextual reflection on S-D:

cautionary interlude upon awareness of similarity - *upon the felt sense to instruct and guide her patient, the therapist is cautioned against intercepting the pre-established working principles and imposing personified*

experience upon the patient.

9. It was over several therapy sessions where I began to think, that's remarkable, I've had a similar experience, and it built up for a very long time, when I was actually sitting there thinking, I'm stunned, this is my very own life story being repeated to me..

Over several therapy contacts the therapist became increasingly observant of the similarity of experiences. Over an extensive period of time, the therapist's experience of this similarity progressed and amplified to a point where she felt overwhelmed and closed-in by the re-counting and reliving of her previous experience in the immediate therapeutic encounter.

(I) unfolding therapeutic constellation for S-D:

increasing profundity of shared life-contexts - similarity of life contexts became apparent over several therapeutic contacts.

(I) emerging therapeutic constellation for S-D:

therapist's bewilderment at similarities - the therapist reached a point of becoming perturbed by the similarity of life events.

10. ..and then it was a particularly emotional session where she broke down and cried and she had reached a kind of crisis point, a turning point which I recognized, there was a very deep recognition in me of what she was going through, and I think what I read into that was her need, and I fell into the trap, I did eventually say..

The highly charged emotional nature of the therapy session distinguished it from others where the patient reached a crucial moment which the therapist could sense and own. The therapist could identify with, validate and accurately acknowledge the patient's experience. The possibility of saying something had been present for a long time and this

awareness presented itself with possible pitfalls. The ultimate result was that the therapist's felt sense of the patient's need prompted her to succumb and she eventually said something.

(I) emerging therapeutic constellation for S-D:
emotionally highly charged therapeutic alliance.

(I) emerging relational matrix for S-D:
sensing the patient's need for S-D

(I) S-D incident:
implicit awareness of pitfalls upon disclosure - the therapist had been implicitly aware of the pitfalls of disclosing to the patient.

11. You know, I thought about it a lot afterwards, and, um,
The self-disclosure exceeded the temporal and physical boundaries of the therapeutic space and continued to exert its presence in the therapist's mind. She evaluated and deliberated on her self-disclosure.

(I) *effect of S-D:*
pervasiveness of therapist deliberations - S-D elicited extensive deliberations beyond the immediate therapeutic frame.

12. the temptation then is to say "Look, I've been there, I really do understand", because over and over I find people in therapy to say something like: "You couldn't possibly understand, you probably don't have a care in the world", and they can't imagine that because you're sitting in the therapist's chair that you could possibly understand where they have been.
The need to convey understanding arises from the therapist's previous experiences where she sensed the patient's misconstruction of the alliance in terms of inequality pertaining to emotional status.

(I) therapist's contextual reflection on S-D:

<u>therapist's enticement to convey understanding</u> - within the emerging relational matrix, the therapist experiences an enticement to explicitly convey understanding;

<u>therapist's previous experience of patients' misconstructions of her empathic capacity</u> - the therapist has previously encountered patients who experience relational inequality in terms of emotional status and then misconstrue the therapist's ability to be empathic.

13. I was aware of how much I had achieved since I was in the position that she was in. I was aware and possibly the countertransference there was of me wanting some recognition from her of what I had achieved. So it was ultimately a selfish act I think.

The therapist could disentangle herself from the immediate encounter to acknowledge her personal mastery over the situation the patient was in. The therapist upon reflection senses that at the time she may have had a need to receive acknowledgement and appreciation from the patient for her mastery. The therapist accepts the possibility that fundamentally the self-disclosure was activated and potentiated by self-interest.

(I) S-D incident:

<u>therapist's implicit demand for recognition</u> - S-D potentiated by self-interest where the therapist needed to convey mastery to receive recognition from the patient.

14. Now, I remember at the time, I obviously didn't break down and sob and tell her my whole life story. I must have said something like: "I *really* do understand, I *really, really do understand*. And the non-verbals were kind of giving the message that I do understand more than I'm letting myself say. But I kind of left it at that point.

The therapist recalls that at time of disclosure it was

clearly perceptible that she was reserved and that she did not directly and explicitly reveal her entire situation. Her disclosure was also not verbally emotionally loaded, and conveyed clear and concise understanding of the patient's experience. The therapist's non-verbal involvement enhanced the verbal disclosure. The therapist did not dwell on her disclosure at the time and extricated herself.

(I) S-D incident:

concise conveyance of understanding - conveys understanding concisely, not emotionally loaded, non-verbal responsiveness enhances verbal counterpart of disclosure.

15. I'm just trying to think if I did or if I'm not covering up for myself.

Upon reflection, the therapist reserves the possibility that self-disclosure presents itself as a threat and that she might be defending herself by being deceiving about the extent of her involvement at the time of the disclosure

(I) therapist's contextual reflection on S-D:

reflection on accuracy of content - upon reflection the therapist pauses to consider that she may be deceiving about the actual content to what was disclosed.

16. But you know there is a recognition, I remember, I still have regular supervision about my work, and I remember in supervision telling my supervisor something about my own experience, and she looked me straight in the eyes and said: "Don't we all?", and somewhere there was this "Oh, her too!". she'd also been there. It was something related to *being* a therapist, the experience of *being* a therapist. I think her message to me was, um, don't worry you're just feeling the way a therapist normally feels, but it constituted a reassurance. But there was that moment of recognition which is very subtle where it *is* a self-disclosure.

The therapist recalls a specific incident where she received a self-disclosure from her supervisor. The supervisor connected with the therapist by making eye-contact and conveying commonality concerning the experience of being a psychotherapist. This constituted for the therapist a reassurance of commonality which intersected her feelings of exclusion. This acknowledgement validated the therapist's experience and conveyed understanding and acceptance of her experience of being a therapist.

(WI) emerging therapeutic constellation for S-D:

relating experience of being a therapist during supervision - the therapist relates to her supervisor her experience of being a psychotherapist.

(WI) S-D incident:

supervisor's conveyance of similarity - the supervisor implied that all therapists share this experience.

(WI) effect of S-D:

validating the experience of being a therapist - the therapist felt understood and reassured.

17. I didn't experience a noticeable change. I mean she didn't end therapy, go running, and I think that I didn't experience anything destructive as having happened.

Following the disclosure there was no immediate perceptible change in the relationship. Disastrous consequences that might have ensued constitute implicit existential possibilities for the therapist.

(I) effect of S-D-

implicit awareness of destructive consequences of S-D - the therapist had been implicitly aware of disastrous consequences for the patient which would threaten the therapeutic alliance.

therapist's experience of no perceptible effect- the therapist was not aware of any perceptible changes within the therapeutic alliance.

18. I think that what happened was that for a while the focus was on me, rather than on her,

The focus shifted temporarily onto the therapist.

(I) effect of S-D:

shift in focus onto therapist - therapist became the primary concern.

19. and, um, I've been doing some reading about this kind of stuff. I don't know if you know the article by Searles, "The Patient is Therapist to the...", and I think then what you have is you digress and you have the patient trying to fix you to make sure that you're okay,

The therapist engages literature pertaining to the therapeutic relationship to assist in formulating her position with regard to therapist participation. The therapist is cognitively aware that after disclosure there is a diversion from pre-established therapeutic roles where the patient becomes concerned about the therapist's well-being.

(P) therapist's reflective positioning:

engaging literature to understand role reversal

- the therapist has relied on literature to assist her in understanding the role reversal and diversion from pre-established working roles upon S-D.

(P) therapist's contextual positioning:

therapeutic role reversal subsequent to S-D - the therapist digresses and the patient assumes the role of helper.

20. and as I recall one or two incidents of the patient saying something to me like: "Now did you also experience this?", and then there was a pressure on me to disclose more, which for a while distracts you from therapy because you've got to patch up that hole, you know, you've got to keep saying things like: "Well, what I experienced is not important".

The therapist specifically recalls a couple of incidents where the patient appealed for confirmation of similarity and validation concerning her experience. A precedent had been set for further disclosure by the therapist. This caused the therapist to feel divided and perplexed during the therapeutic encounter as she had to continually negate and minimize the importance of her own experience and return the patient to the felt sense of her own experience.

(I) post-incidental therapeutic situation:

<u>precedent for S-D</u> - appeal from the patient to share more on a personal level;
<u>therapist's distraction to secure therapeutic role</u> - pressure to maintain therapeutic focus on patient which diverted the therapist's attention.

21. I was very aware of the breach after that and I thought about it a lot

The therapist was conscious of feeling that she had abandoned her pre-established working role. The awareness was indwelling causing the therapist to frequently muse over her disclosure.

(I) effect of S-D:

<u>therapist's ruminations about abandonment of therapeutic role</u> - experienced having abandoned her pre-defined working role, this elicited rumination about her disclosure.

22. because for me, I don't know, it's a bit of an issue this whole story about how human you are in therapy, and how distant and sort of blank you must be, and I think there's a big problem in my thinking.

The therapist is perplexed as how to be present to her patient. This perplexity oscillates between exhibiting the qualities of being mutually human and being aloof and

inaccessible. The therapist is confused as to her cognitive formulation of how she must present herself to her patients.

(P) therapist's contextual positioning:

<u>oscillation between a human and a detached therapeutic stance</u> - therapist is uncertain of how to be present to her patients. She is divided between two poles - authentic actual existence or inaccessible (genuine experiencing obscured).

23. Yes, and I query whether you in fact don't self-disclose to some small extent anyway in *every therapy*, okay, because you're constantly..... I work face-to-face, and I find it impossible not to react to what people are saying and in formulating some form of empathic reaction. You inevitably, through your choice of words, the way you turn your head, there are all kinds of subtle ways in which you are betraying I think, how you are responding. You know, I think you can't not self-disclose to some extent, or else you really start becoming too remote, too detached.

The therapist questions whether self-disclosure does not permeate all therapeutic contacts. The therapist faces her patients and they are both visible to one another. She finds it unavoidable that many cues (verbal and non-verbal), involuntarily reveal her reacting and responding during the therapeutic encounter. The therapist believes that one cannot avoid minimal self-disclosures and that if one could forcibly do so, one would become alienated.

(P) therapist's contextual positioning:

<u>questioning the pervasiveness of S-D</u> - S-D is an indwelling facet of all therapeutic contacts;

<u>threat of alienation</u>

(P) therapist's reflective positioning:

<u>inevitability of therapist responsiveness</u> - physically present to patient, possibility of empathic responding being immediately transparent.

(P) therapist's established position:

<u>face-to-face therapeutic stance</u> - works face to face and is fully visible to patients.

24. Yes, there was a shift in focus onto myself. I was aware of stepping out of the therapist's role in a strange kind of way,

Subsequent to the disclosure, the therapist became the primary point of concern. The therapist was conscious of abandoning her therapeutic role in an unaccustomed way.

(I) effect of S-D:

<u>awareness of abandoning therapist's role</u> - the therapist's experience becomes primary focus and in this sense the therapist is aware of having abandoned her therapeutic role.

25. um, I believe that you have to have a modicum of realness in your dealing with people. There's a limit beyond which you cannot go, you know, and not be yourself. You are in the therapy and as such you *are involved*. I think you have to be if you're going to do any kind of meaningful work.

The therapist believes that there must be a small quantity of genuineness when relating to people. Being a co-constitutor of the therapeutic relationship, the therapist is included, and this inclusion is necessary to engage a meaningful therapeutic process.

(P) therapist's contextual positioning:

<u>co-constitution of therapeutic field</u> - therapist included in the relationship, genuine responding necessary to co-constitute a meaningful therapeutic process, awareness of boundaries.

26. For years I didn't work this way. My style was very much more distant and formal. I used to love to lapse into teaching, and then you realize that that's a defense on your

own part too. You can't avoid engaging and being real. The therapist used to be didactic and was not always experientially involved within the therapeutic relationship. She was more detached from the patient's experience and employed a rigid therapeutic style. The therapist has realized that to be didactic represents a defensive manoeuvre and that one cannot avoid being included in the therapeutic encounter and being genuine.

(P) therapist's reflective positioning:

shift towards inclusion in therapeutic field - shift from didactic stance to authentic encounter and inclusion in unfolding of relationship.

27. I think you've got to constantly tread this line of not overstepping the limits, and really getting to communicating something about your own needs. The therapist experiences a delicate balance and a disciplined approach towards expressing her own needs. There is a crucial point were one would be transgressing pre-established therapeutic boundaries by revealing one's personal needs.

(P) therapist's contextual positioning:

therapist's awareness of boundaries and communication of own needs - cautionary interlude, seeking judicious balance between participating yet not expressing own needs.

28. It's a strange paradox, okay, I've become more spontaneous in sharing of myself and yet less open to disclosing content about myself, okay. It's been a very strange process, and with that has come an awareness and a need to not step into other roles like a teaching role, um, something like that, and because of my basic training the temptation to do that was very strong, and it took me a long time of trying to figure out what was really going on, and

further studies to sort that one out, and I think there's a way of doing it without doing it that you discover after you've worked with people. I suppose in a way, there is no way ultimately that you cannot not be involved, and you are after all shaping what's happening, you are!

The therapist's shift in terms of her participation within the therapeutic encounter has been conflicting, and she experiences this as an unaccustomed shift. The therapist has allowed herself greater freedom to share the therapeutic encounter but this has not been paralleled by the sharing of personal material. This shift has been bewildering to the therapist and she has relied on literature to assist her in this transition. There is less of a need to digress to previous didactic stances which arose from her fundamental training. She is increasingly aware that she is a co-constitutor of the therapeutic field and her awareness of the inter-subjectivity allows her to realize her capacity to mould what transpires and evolves within the therapeutic field.

(P) therapist's reflective positioning:

<u>paradoxical shift, inclusion and less disclosure</u> - shift from a didactic stance to an inclusion in therapeutic field, more intensive participation and less personal disclosure;

<u>reliance on literature in assisting the shift towards inclusion</u> - therapist has engaged in further study to assist in formulating the nature of her participation;

<u>therapist's bewildering experience of shift towards inclusion</u>

"An emotional encounter"

29. I've just thought of something else..... there was one therapy where I, um, it was a man this time told me something *really devastating* about him.

The therapist spontaneously recalls a specific male patient

who revealed to her something profoundly disturbing.

(I) unfolding therapeutic constellation for S-D:
patient's disturbing narration - male patient related a story which the therapist found disturbing.

30. At this stage I struggle to.. oh yes, okay, I remember what it was... he had been through a very bad experience and he started getting very intensely enmeshed in his feelings related to that incident

At first the therapist struggles to recall, and then spontaneously remembers that the patient had been through a very bad experience. He turned inward and became increasingly entangled in his own painful emotions pertaining to the bad experience.

(I) unfolding therapeutic constellation for S-D:
patient's intense experiencing - intense immediate experiencing related to a previous bad experience, turned inward and became increasingly entangled with his painful experiencing.

31. and I teared up, um, and we kind of dealt with that one, because I do believe that he's got to deal with that. You can't tear-up, the patient sees you, you have to deal with that, okay.

The therapist was saddened and wounded by the patient's story which was pre-reflectively expressed through her tearfulness. The therapist upon reflection and having extricated herself from her intense "in-tuned-ness" felt compelled to explicate her responding.

(I) implicit S-D incident:
therapist's tearful response - pre-reflectively expressed inner responding through tearfulness;
therapeutic exploration of implicit S-D - therapist attempted to explore with the patient her expressed emotionality.

32. So I remember dealing with that, um, in some sort of standard way, like saying: "You must have noticed me reacting, how did that affect you?" and working through that. The therapist recalls managing her emotional reaction in a normal therapeutic way. She acknowledged her reaction and questioned the impact that it had had on the patient. This was then processed.

(I) S-D incident:

<u>questioning the impact of implicit S-D</u> - therapist acknowledged her emotional responsiveness. This constituted a S-D which was followed by therapeutic inquiry regarding the impact of the implicit S-D on the patient.

33. He told me *months later* that for him that was one of the most significant moments in the therapy, um, that stood out for him as a beacon.

At a much later stage, the patient revealed to the therapist that that incident had stood out as a meaningful moment. It was an isolated moment within the therapeutic process.

(I) effect of S-D:

<u>patient's belated acknowledgement of significance</u> - retained meaningfulness of disclosure over extended period of time before acknowledging it to therapist.

34. This particular patient had a very, very long, long, series of session in which he could not show feelings,

The relationship had been long-standing and established during which the patient did not express emotion.

(I) unfolding therapeutic constellation for S-D:

<u>patient's emotionally blunted functioning within alliance</u>

- over a long series of sessions the patient had not expressed emotion.

35. and when he finally did, it was to me some sort of break

through, and I was aware of saying: "Oh thank God, at last we've touched it!" There was that level of thinking, thank God we've touched something here.

The therapist is excited and relieved at the patient reaching previously unattained levels of experiencing within the therapeutic situation. Within the patient's experiential flow, the therapist is an observer and her experience of the patient's intense experiential flow is private and unvoiced, that is, expressed inwardly.

(I) emerging therapeutic constellation for S-D:

patient's heightened emotional experiencing - reaches intense levels of experiencing which were previously not evident;

therapist's inner relief at patient's emotionality - privately relieved by patient's capacity to express inner emotion.

36. At the same time I was quite taken aback by the depth of the pain that he was feeling and to watch what he'd actually... to watch that pain...

At the same time, the therapist was overwhelmed by the intensity of the patient's emotional pain of which she was becoming a participant observer.

(I) emerging therapeutic constellation for S-D:

therapist's startling reaction to patient's painful experiencing - the therapist felt overwhelmed by depth of patient's pain and level of experiencing.

37. I think that's what made me react and I had an intense, *intense* desire to comfort him then,

The therapist responded to the patient's experiencing and she experienced an urgent need to console him.

(I) implicit S-D incident:

therapist's longing to console patient - the therapist experienced a powerful and urgent need to console

patient.

38. and I think that was... you know you often get the type of patient that tries to get sympathy out of you, but I think when people really come out with some sort of horror story, and you can actually sense what it must have been

The therapist is familiar with patients that are sympathy-seeking where she manages to maintain a detached stance, but at the same time she is aware of people that present with devastating experiences that one can accurately sense and feel.

(I) therapist's contextual reflection on S-D:

<u>reference and comparison to other patients</u> - reflectively assessing the needs of other patient's places the therapist's responsiveness in perspective.

39. It was something similar. It was similar in the sense that it involved a death, and having experienced death myself, I could relate to it, okay, it was that broad, but the details of it were not the same. It was his father dying in his arms, now my father didn't die in my arms... but I lost my father and I think that it was the helplessness, the burden that had been placed on him. He was only a child, so I think to some extent it possibly echoed within me, because I've lost somebody, and because I have a child, and I wouldn't want my child to go through that.

The therapist could relate facets of her previous experience to the patient's. She has also lost a father and senses helplessness in the patient. The patient's childhood experience and trauma resounds in the therapist as she has a child herself and this enhances her responding.

(I) unfolding therapeutic constellation for S-D:

<u>tracing of therapist's empathic responding to her past</u> - therapist senses patient's emotionality through associations and similarities from her own experience.

40. I had a very strong desire to comfort him physically, I wanted to put my arms around him and stroke his head.
The therapist felt an urgent need to physically contain and mollify her patient.
(I) implicit S-D incident:
<u>therapist's compelling desire to console patient</u>- urgent pre-reflective need to console patient.

41. And it's just a sense of you get to a certain level of pain in human experience, and it goes beyond words in a way, and I think that brings us into a whole other thorny issue.
The therapist senses that beyond a certain point of painful human emotion words are inadequate and that one enters a terrain that must be approached with caution.
(P) therapist's contextual reflection on S-D:
<u>therapist's awareness of elusive boundaries</u> - cautionary interlude and awareness of fragility of boundaries.

42. And I think in many respects we walk a tight rope.
To exist in a region with potential hazardous consequences is common to all therapists.
(P) therapist's contextual positioning:
<u>awareness of potentially hazardous therapeutic space</u> - all therapist's enter a region with potentially hazardous consequences.

43. What happened was we obviously stayed a while with his feelings, crying and all this sort of thing
The therapist and patient remained engaged in the immediate while the patient cried.
(I) transitional therapeutic situation:
<u>containing patient's tearfulness</u> - therapist and patient engaged in the patient's immediate experiencing, namely his expressed emotionality, therapeutic focus on the patient.

44. and, um, after a while he pulled out of it, you know: "Oh well, that's life".

The patient abruptly withdrew from the intensity of the moment and trivialized his emotional pain and intensity.

(I) transitional therapeutic situation:

patient's disengagement from intense experiencing - the patient withdrew from the intensity of the moment to minimize his felt pain.

45. He backed out of it and I said something like: "Well, that was a pretty tough experience" and I first left it.

Once the patient extricated himself from the immediacy of his experience, the therapist assumed a reflective stance to comment on his experience. The therapist left it at that and did not pursue further meaning.

(I) transitional therapeutic situation:

therapist reflection on patient's experience - therapist withdraws from immediate encounter and reflects on significance of patient's previous experience.

46. I try to avoid things like that happening at the end of therapy, you've got to have time. We did have time at that particular time, and at the end he said something like: "Oh that's life, one can't dwell on that sort of a thing, it happens".

The therapist is very aware of the temporal boundaries within the therapeutic situation, and is hesitant to allow an emotional climate to develop towards the end of a therapeutic contact. The patient disentangled himself from the immediate intensity of his experiencing by resigning himself to the inevitability of certain life events.

(P) therapist's established position:

awareness of temporal confines of encounter - avoids intense emotional experiencing towards the end of a therapeutic session.

(I) transitional therapeutic situation:
patient's resignation to inevitability of life events

47. And you can read into that some sort of a message to comfort you: "I don't want to upset you as well"
The therapist sensed that the patient did not want to disturb her.
(I) transitional therapeutic situation:
therapist's felt sense of patient's need not to perturb her - therapist senses that the patient's comments are a gesture to comfort her.

48. and later I said something along the lines of: "You noticed me during that time reacting, how did you feel about that?"
The therapist extricates herself. The intensity of the situation placed into the past and reflected upon.
(I) S-D incident:
verbal confirmation of affect - therapist acknowledges and explicates responsiveness, queries impact upon patient.

49. and, um, his reaction was something like: "Oh well, I didn't mean to upset you".
The patient conveys to the therapist that he did not intend to perturb her.
(I) effect of S-D:
patient's denial of intention to perturb therapist - denies having wanted to perturb therapist.

50. So there was actually no acknowledgement then. I remember that what we dealt with was his need not to upset me, so we kind of went through it on that level.
The therapist's disclosure was dealt with indirectly more in terms of the patient's response to her involvement. The

therapist's involvement is not addressed, and the primary working data is constituted by the patient's need not to upset the therapist.

(I) post-incidental therapeutic situation:

<u>therapeutic management of patient's wish not to perturb therapist</u> - constituted not primarily by disclosure but by patient's anticipated effect on therapist. The patient's need not to upset therapist constituted primary working data immediately after the verbal S-D.

51. But as I say it was literally months and months later, and the interesting thing was that it was on an occasion when he felt particularly close to me, and he wanted... his impulse at that stage was to overstep the limits from his side. It was a very strange thing. He actually was feeling extremely happy and he was feeling so joyful and so wonderful that what he wanted to do was *grab* me and dance around the room with me, okay.

Several months later the patient encountered a moment during which he felt particularly close to the therapist. He experienced an impulsive need to transgress the pre-established therapeutic boundaries. This is an unfamiliar occurrence to the therapist. The patient was so elated that he wanted to grab the therapist and dance around the room with her.

(I) establishing S-D effect within an emerging relational matrix:

<u>patient's elation and impulse to join physically</u> - the patient experienced a warm disposition towards therapist and wished to share this on a physical level.

52. And maybe on that level, there had been some sort of subtle unconscious unvoiced willingness for physical contact, maybe that made it easier for him to come out with it in another way, and then I said: "You really want to share this

with me".

The therapist attempts to elicit from the patient his need for closeness. She is intimately aware of the physical pull that exists within the therapeutic space.

(I) establishing S-D effect within emerging relational matrix:

patient's implicit pre-existing wish for physical contact - the therapist senses that the patient has an unacknowledged need for physical contact;

therapist's reflection on patient's wish to share elation - the therapist reflects the patient's need to share with her.

53. Once again we didn't, and he then went on to say: "Yes, I really feel close to you now. I feel as close to you now as I felt when we had that session once". He said to me: "You know I must tell you, you know that for me was so meaningful, that meant so much to me, and I often think of my therapy and I think of that one session..." and he said that that was a very special moment. So we went through that again.

The implicit awareness of the need for physical contact remains unvoiced and is not recognized within the explicit immediate encounter. The patient links his present experience of the immediate relationship to a previous encounter when the therapist had been tearful. This encounter stands out in the patient's awareness as a particularly and memorable moment. The patient and therapist process this awareness therapeutically.

(I) establishing the effect of S-D:

patient's acknowledgement of significance of implicit S-D - explicitly acknowledges the personal meaning of the therapist's responsiveness in a previous session.

54. To him it was so special because to him it was a signal

that in spite of all the sessions that we have been through where I am so professional and I may smile nicely, and I may be communicating certain things about myself, but I'm actually very professional and in that sense he wonders, and he did wonder whether I really cared about him. And for him that was a signal that I really cared, I think he couldn't quite believe it, as I was a therapist and I was sitting listening because he was paying me to do so.

The therapist's self-disclosure mediated her professional aloofness and her human capacity for caring. For the patient it symbolized her humanity which was obscured by her professional stance. The professional nature of the therapeutic contact clouded and confused the patient about the therapist's human capacity for sharing.

(I) established effect of S-D:

<u>patient's perception of therapist humanity</u> - could sense the therapist's humanity and capacity for caring, S-D mediated the therapist's professional stance and her humanity.

55. Oh my goodness! Yes it did change things. What happened then was a *whole series* around this issue of why could he not give me a kiss on the cheek if he felt this was necessary, and this was part of a normal relationship. Wait, okay, that makes it sound a little stranger than it was.

The self-disclosure constituted a therapeutic process which elicited further therapeutic enquiry about the definitive nature of a therapeutic relationship and a normal relationship. The patient was confused as to why his spontaneous gestures were not appropriate within the therapeutic relationship.

(I) post-incidental therapeutic situation:

<u>widening therapeutic enquiry into dimensions of relational contact</u> - the effect of the disclosure widened to address the nature of the therapeutic relationship in

comparison to extra-therapeutic relationships.

56. It was more related to what is closeness and caring and what are the limits of closeness and caring in the different situations, and how one expresses closeness in the different situations, appropriately or inappropriately, with different people, and how if I had been a male therapist, he wouldn't have the impulse to dance me around the room, so it lead onto a lot of work in terms of what his needs were as he defined being close to somebody.

The therapist's disclosure provided therapeutic data in terms of intimacy in extra-therapeutic relationships. This spread from deliberation about the therapeutic relationship to other relationships. A widening circle of therapeutic enquiry ensued as to the appropriateness of sharing in various relationship and specifically the expression of emotion within various relationships. The enquiry then became more centred again with the patient questioning the nature of his impulse and therapist sexuality.

(I) post-incidental therapeutic situation:

<u>widening enquiry into relational boundaries, sharing and closeness</u> - S-D provided increasing levels of therapeutic enquiry into sharing in interpersonal relationships;

<u>therapist sexuality and physical sharing</u> - the therapist's sexuality was appraised in terms of intimate sharing, relationship between therapist and patient constituted primary working data.

57. It was a complete, a whole relationship issue. And then some confrontation from him to me in terms of if I really cared, why do I not show it then, why do I make it difficult for him, and strange enough a lot of anger in terms of the limits that were there, you know dealing with how difficult it is to acknowledge that there are limits.

The self-disclosure which originated in the therapeutic

relationship extended to having far-reaching therapeutic implications, and the therapeutic relationship became the primary working data. This included the patient's desire to experience the therapist on more intimate terms and to experience her humanness. The self-disclosure had set a precedent for further "human" involvement from the therapist. When dealt with in a therapeutic way, the patient was angered by the boundaries which prohibited physical contact with the therapist.

(I) post-incidental therapeutic situation:

patient's confrontational anger at confirmed boundaries - *patient angered by pre-established therapeutic boundaries prohibiting more intimate contact with therapist, patient confrontational towards therapist about therapeutic boundaries.*

58. It was very enriching for the therapy, *extremely* so, and what that says to me is that if something like that happens, if you end up reacting like that,

The self-disclosure with its ensuing therapeutic enquiry enhanced the therapeutic process adding depth and this has conveyed something to the therapist about her reacting.

(I) effect of S-D:

enriching effect on therapeutic process

59. I actually learnt how to handle that from watching another therapist, otherwise I don't know if I would have been able to do it that way, and when I watched the other therapist do that, the particular demonstration also showed me how it enriched that relationship, and how one can walk that fine line between being human yet not burdening the patient with your own stuff, um, and

The therapist recalls having being an external observer of therapist involvement, reactivity, and disclosure. She observed how that particular event deepened the therapeutic

relationship and convinced her that it is possible to attain the delicate balance between being authentic without becoming over-involved to the extent of burdening the patient with one's personal material.

(WI) S-D incident:

<u>therapist as observer of S-D</u> - the therapist witnessed another therapist disclosing to a patient.

(WI) effect of S-D:

<u>enhancing effect on therapist positioning</u> - assisted her with positioning herself in terms of her involvement and participation.

60. I felt particularly good, and I still feel good that it's lead to so much richness and deepening of the therapy, and it really was a good thing in the end.

The therapist has a positive recollection of the enhancing impact that her self-disclosure had on the therapeutic relationship- and process. She considers it to have ultimately been positive.

(I) therapist's contextual reflection on S-D:

<u>appraising positive impact on therapeutic process</u> - therapist feels positive about the disclosure and its impact on the therapeutic process.

7.3. Narrative tableau.

This tableau includes the following:

1. positional terms and informative phrases.
2. situational terms and relational phrases.
3. situational terms and informative or relational phrases

for witnessing incidents.

1. Positional terms and informative phrases:

therapist's original positioning:

discipline regarding S-D, 1

7.4. The experience of therapist self-disclosure: A binding text.

Preamble:
Therapist self-disclosure is a complex interpersonal event. Each disclosure occurs in a **unique therapeutic relationship**, and in a **unique therapeutic context.** During its unfolding, there are various **critical moments** and **inter-related incidents** that comprise the experience.

Due to the **nascent and unfolding process character**, the binding text will be presented in the following way: "Before self-disclosure"; "The unfolding and emerging of self-disclosure"; "The moment of self-disclosure"; and the "The post-disclosing therapeutic situation". These will be referred to as "processional themes".

To account for the variegated and unique contextual nature of each description, the unfolding and emerging, the actual moment of disclosure, and the post-disclosing situation, each will be introduced with an intersubjective structural description. A detailed and illustrative description of the

disclosing experience will then follow. Where appropriate, first person (original) phrases or descriptions will be implemented, which will accentuate and account for the individual varieties.

Before self-disclosure:

Before self-disclosing, a therapist is engaged in therapeutic dialogue with a patient. Fundamental to this dialogue is the therapist's "modus operandi". He or she has a way of conducting therapy and a way of being present, or a way of being available to patients. Some therapists are more assured than others about their therapeutic presence, others are still struggling with different approaches and ideas. They waver between the ideas of being inaccessible and detached, and being authentically involved.

Therapists change in their way of conducting therapy. They could, for instance, shift from a didactic- to a more detached stance, or from a distanced and authoritative therapeutic position to greater and more intensive involvement. This shift is assisted by accumulating experience, where the therapist can learn that being didactic is not helpful to patients.

For some therapists a shift in his or her therapeutic stance can be a perplexing journey. A therapist might, for instance, start awakening to her capacity to shape the therapeutic process. This elicits a compelling inner debate about the fragility of therapeutic boundaries, and the extent to which one can be involved in a therapeutic relationship, without imposing one's own truth upon the patient.

Prior to a specific self-disclosing incident, all therapists have experienced discomfort when patients have asked them **direct, personal, and private questions.** This is perplexing

to them and they have ruminated over the management of these questions. Some therapists are puzzled as to how they should respond to these questions. Other therapists have, through experience, formulated specific ideas as to the management of patient's requests, or the management of unexpected crises that could cause the therapist to be absent from therapy. They are then able to anticipate how to deal with these unrehearsed situations. Other therapists are less certain about how to cope with these requests, and debate the question of how honest one should be with one's patients.

Therapists hold certain beliefs about self-disclosure, for example, that it is not helpful to a patient, or that it burdens a patient, or that it is a selfish act by the therapist to bring himself or herself into the therapeutic picture.

A therapist can, through very specific experiences or incidents, cherish definite beliefs about using self-disclosure. This can include recommendations with specific groups of patients, for example, a therapist through working with borderline patients can become cognizant of the fact that such patients benefit from honest and forthright feedback. This can include a disclosure about one's encounter experience (for example, "especially borderlines, if they've reflected reality correctly for once, maybe it's useful to confirm their reality rather than to say: 'Well that's your fantasy that I'm bored', you know").

Although therapists reserve the possibility that self-disclosure can have therapeutic benefits, they are generally conservative about using it and espouse a limited and cautious approach. Some therapists have formulated a disciplined and restricted approach to the containment and management of the felt sense to share on a personal level.

They urge that, should they feel tempted to share with a patient, they first exercise caution so as to examine and gain clarity on this need. They hold an inner dialogue to ensure that they do not allow personal material that is unrelated to the actual therapeutic encounter to impinge on the therapeutic process.

The unfolding and emerging of self-disclosure:

Despite these held and sometimes changing values and beliefs, certain **critical and unrehearsed events or situations** intrude upon and disrupt the therapeutic process. These events are unfamiliar to the therapist and he or she may not be accustomed to managing such events or situations. This comprises a bewildering and distracting experience for the therapist. Self-disclosure springs from such an **unacquainted and unaccustomed encounter experience**, and the therapist is then **jolted** out of his or her accustomed way of relating to the patient, and **senses impending loss.** This loss can refer to the fear of physically or emotionally losing a patient, the awareness of losing one's pre-established role as therapist, or the threat of waning therapeutic boundaries where one forfeits one's therapeutic integrity. A therapist can be threatened by increasing detachment, to the point of feeling severely alienated. With the awareness of impending loss, the therapist can attempt, in various ways, to restore the therapeutic alliance or his or her therapeutic role.

Prior to the self-disclosure, there is a **specific initiating or prompting experience**, which either ushers in or restrains the disclosure.

Self-disclosure can be a critical component of this perplexing encounter experience, for example, if a therapist should spontaneously and without prior mediation, respond to a patient by being tearful. For another therapist, self-

disclosure can arise spontaneously and simultaneously to the unaccustomed encounter experience. For example, if a therapist is astounded by a compelling similarity, the awareness to convey this similarity emerges intuitively. In another context, self-disclosure can emerge as a possibility to restore the severing of a strained therapeutic alliance. It serves as a deliberate and planned strategy by the therapist.

Detailed and illustrative description of the unfolding and emerging:

Self-disclosure can unfold in a situation in which the therapist feels closed-in, trapped, and overwhelmed by the astounding awareness of **compelling similarities** between herself and her patient. This happens when the patient narrates something that resounds powerfully with the therapist's past. The therapist can reach a stage of sensing a loss of agency (for example, *"..I was actually sitting there thinking, I'm stunned, this is my very own life story being repeated to me.."*). The therapist then becomes personally involved in the patient's narration and this arouses different emotions.

An older therapist may have experienced such encounters in previous therapeutic encounters. She will then be better prepared for such situations. She will know how to identify, encapsulate, and manage the disposition that she feels towards certain patients (for example, *".... there are obviously ways in which one uses one's experience, you know, in a, you know, in a way that enables you to deeply understand something that someone is saying without having to bring yourself into the picture that you can, you know, use in that way"*). This prevents the disruption of the therapist's focus during the therapeutic dialogue.

However, for a less experienced therapist, this compelling similarity can arouse an **unaccustomed inner responsiveness**, and the dramatic awareness of the similarity and her involvement creates a possibility for the therapist to deviate from pre-established ideas and beliefs pertaining to her therapeutic participation and self-disclosure. A sense of losing her pre-established therapeutic role and established boundaries, alerts her to exercise caution.

Should the patient be struggling with a situation that the therapist has already endured, he or she can experience sympathy towards the patient (for example, *"sometimes one feels very warmly towards the patient"*). For some therapists this experience is an **intense reminiscence**, such as with "the childhood memory". There is an ardent and personalized identification with the patient's situation. The therapist can become so **intimately aligned** to a point of sensing a need from the patient for reassurance. The therapist is then prompted by an **enticement** to **ally with**, to **assist** and to **embolden** the patient to be able to cope with the arduous or demanding situation (for example, ".. *and I think then the pressure on me to say something like: "Look, don't worry I've been there, you will get through it, and you will be okay"*). This prompting is heightened or intensified by the therapist's awareness of patient's misconstruing her empathy due to a perception of relational inequality (for example, "..because over and over I find people in therapy to say something like: 'You couldn't possibly understand, you probably don't have a care in the world', and they can't imagine that because you're sitting in the therapist's chair that you could possibly understand where they have been").

Should the therapist recall a situation in which she herself was a recipient of a reassuring disclosure, she can then grasp the positive and growth enhancing effect of such a

disclosure from the patient's point of view, and this assists her to implement her experience to sustain the patient in a similar way. This is what happened with therapist A when her supervisor validated her experience of being a therapist.

A therapist can also be unfamiliar and unprepared for an **unusually disturbing narration.** The therapist, unprepared for the intensity of emotion that she experiences, can for instance, be overcome by tearfulness. This is especially profound if the patient had already been in therapy for a long time during which he was emotionally blunted. This facilitates the therapist's surprise and alarm at the emotional climate that the patient stirs (for example, *"This particular patient had a very, very long, long, series of sessions in which he could not show feelings, and when he finally did, it was to me some sort of break through, and I was aware of saying: 'Oh thank God, at last we've touched it!' There was that level of thinking, thank God we've touched something here"*). The therapist can merge with a patient's intense painful experiencing, and with this passionate emotional alignment perceive the inadequacy of words. This can elicit a strong need to physically contain, hold, soothe, comfort, and rescue the patient. The therapist is then cautioned by a sensing of her entering a terrain that should be approached with caution. This is understood to be a territory with potentially hazardous consequences, and there is a sense of losing one's therapeutic integrity and space. The therapist can, upon reacting tearfully, realize that it would be therapeutically appropriate to assimilate this with the patient. This then serves as a **prompt** to verbally acknowledge the fact that one has responded, and to restore the alliance and her role as therapist.

A therapist can be unprepared for a **specific shared and implicating event**, as for instance, when a patient reveals a

dream that is strikingly similar to a dream that the therapist has had. The dream can arouse within the therapist an awareness of the nature of the therapeutic relationship. The unfolding context prior to the shared dream is significant in that the therapist can, for instance, recall previous instances of the patient's forceful intrusion. This can heighten her (the therapist's) wariness to reveal her dream to the patient. The therapist is cautioned against forfeiting the therapeutic boundaries that had been an arduous task to establish, given the intrusiveness of the patient.

Within this context, an intense inner struggle can ensue where the therapist is trapped between an urge to reveal the dream and a need to defend against the fusing of therapeutic boundaries. This is a distraction for the therapist, who is divided about revealing her dream. At the same time that she is attentive to the patient's dream content, she is fighting the compelling and urgent desire to unveil her dream. The tug-of-war that ensues compels the therapist to analyze the relationship and her personal investment and needs within the encounter.

This can be a condemning experience for the therapist who admits to herself that her self-esteem as beginner therapist hinges strongly on the patient's progress. The therapist who has, within the relationship established a tradition of warding off the patient's intrusiveness and attempted violations of boundaries, is astounded by the realization of her personal investment in the relationship. This deliberation is perplexing for the therapist who realizes the fragility of boundaries and fears loss of her therapeutic integrity. She wavers between reassuring the patient of her significance, and her commitment to strengthening the therapeutic boundaries. The therapist can be prompted to

deliberately withhold her implicating dream by the anticipation of being regretful. This anticipation is stirred by previous encounters in which the therapist might have spontaneously been revealing and then very regretful of her unmediated disclosure.

Some self-disclosures arise as a **planned therapeutic strategy** to restore the therapeutic alliance. A therapist can, for instance, feel de-railed by an impending collusion. There could, for instance, be a lively relational interplay with an interpersonal sexual dynamic. The therapist's sexuality can make him an inevitable candidate to gratify a patient's needs for sexual affirmation. Upon appeals by the patient for such affirmation, the therapist can feel targeted and ill-equipped to deal with these demands in a therapeutically appropriate manner. He can become increasingly uncomfortable with the narrowing affiliation and he can sense a loss of his personal distance as well as a loss of his therapeutic integrity. Self-disclosure can emerge as a planned intervention to awaken the patient to a common human bond that includes people other than the therapist. Should the therapist's inability to gratify the patient lead to a devaluation by the patient of the therapist's empathy the therapist can then sense an impending loss of an esteemed role as empathic therapist. He can then be prompted to rescue the alliance by disclosing that he has been in a similar situation, and that "all" people have scars of some nature.

Even a therapist who appears prepared and equipped to deal with any therapeutic situation, can be de-railed by an unusual and perplexing encounter experience. The therapist can experience an **overwhelming encounter experience**, an experience that is perplexing due to its pervasiveness, its arduous and atypical nature, and due to its foreignness to the therapist. For example the therapist might feel

extremely weary during each encounter with the same patient. She is then confused and perplexed as to the meaning and origin of her experience.

Upon the realization that she is increasingly detached and distanced in the therapeutic sessions, she can deliberate on the nature, origin, and meaning of her experience. Within this meditation, she can become aware that she has unwittingly been assuming a role responsiveness. This then represents a symbolic alignment where the therapeutic constellation mirrors the patient's extra-therapeutic relational matrix. The therapist's cognizance of her symbolic role assumption serves as the prompt to formulate an intervention where her encounter experience is unmasked and disavowed. The purpose is then to awaken and foster interpersonal insight within the patient.

The moment of self-disclosure:

Every act of self-disclosure is **unique in content and conveyance**, and **links various experiences.** Some self-disclosures link a specific past experience of the therapist to the patient's predicament. These disclosures vary in terms of the extent of factual information provided to the patient, and in terms of the therapist's emotional alignment. This alignment depends on the therapist's intentionality.

Other disclosures specifically link the therapist's immediate encounter experience. This could be either a spontaneous reaction to the patient's encounter experience or a structured and interpretative disclosure.

The linking process can be a once-off linkage, or it can extend into future therapeutic sessions, where the original self-disclosure serves as a point of departure to sustain further insight-enhancing links.

The linking process can extend into the post-disclosing situation, where the self-disclosure ultimately provides therapeutic working data.

Detailed and illustrative description of the moment of disclosure:

Self-disclosures that link the therapist's past experience to the patient's situation can be **meagre in verbal content** (for example, *"I **really** understand, I **really, really do** understand"*). This disclosure demonstrates the therapist's first-hand experience and understanding of the patient's predicament. There can be a non-verbal counterpart to the verbal utterances. The tone of voice or the non-verbal participation can enhance the power of what is being revealed (for example, *"And the non-verbals were kind of giving the message that I do understand more than I'm letting myself say"*). The therapist is linked to her past **and** to the patient's painful situation, and an intense therapeutic alignment is authenticated.

A disclosure that links a therapist's past experience can, in another context, be factually more expansive. For example, the therapist who was reminded of his own childhood disability when struggling to bond with a learning disabled child. He provided a **concrete** example of a similar difficulty to link with the child-patient. Although the childhood memory arose spontaneously, it was employed deliberately to form an empathic link with the patient.

Linkage of a therapist's past experience does not always reveal a passionate alignment with the patient. The therapist can align emotionally with his past without creating or experiencing an emotional affiliation with the patient. A therapist can deliberately search his past for an event to relate to the patient. The purpose of this

disclosure can be to defuse an impending relational collusion. The therapist's intention is then to establish extra-therapeutic links, and his disclosure is not a spontaneous, but a forced link with his past. Even though the disclosure might be elaborate in content, there may be no fervent alignment with the patient.

Disclosures that link the therapist's immediate encounter experience can be **highly implicit.** For example, when a therapist becomes tearful at the witnessing of a patient's painful experiencing during the narration of a profoundly disturbing experience (for example, "... *he had been through a very bad experience and he started getting very intensely enmeshed in his feelings related to that incident and I teared up,...*"). Without words the patient can become aware of the therapist's felt empathic responsiveness, and the therapist's felt alignment with the patient is visible. An intense empathic link between therapist and patient is established.

In another context, yet also linking a therapist's encounter experience, a disclosure can take the form of an **interpretation**, where the therapist's experience is not conveyed or expressed directly, but can be inferred by the patient. In this context the therapist's encounter experience is linked to the patient's extra-therapeutic relationships. The therapeutic relational matrix is juxtaposed with the patient's extra-therapeutic relational constellations. If the patients grasps the meaning of the interpretation, he or she will be able to assume the therapist's encounter experience (for example, "... *I mean she could obviously interpret from that that I feel distanced from her..*"). A structured and interpretative disclosure, such as this, extends into future therapeutic contacts. For instance, once the therapist had interpreted the meaning of

her encounter experience, namely her sleepiness, she could continue to link certain events throughout subsequent therapeutic sessions (for example, "*... well I didn't say this all at once, but I could link it afterwards*"). The original disclosure serves as a point of departure to link subsequent events or experiences.

When a disclosure becomes therapeutic working data, such as when the disclosure is discussed by patient and therapist, it can elicit widening circles of therapeutic enquiry, and link more experiences. This occurs in the post-disclosing situation.

The post-disclosing therapeutic situation:
Within the post-disclosing situation, there can be an **immediately perceptible effect**, which is construed by the therapist to be either positive or negative. A disclosure that is positively evaluated will not elicit extensive deliberation, but can be retained for further evaluation and comparison with other self-disclosing incidents.

A disclosure that is **negatively perceived** by the therapist usually elicits rumination. This is either about the effect of the disclosure, or the fact that the therapist had felt the need to share with a patient on a personal level. This in itself can comprise a disturbing experience for the therapist.

In some instances a therapist can be **oblivious** of the effect on the patient, and an event or situation within a subsequent therapeutic encounter, can lead to a **belated or delayed acknowledgement** of the effect or impact. The self-disclosure then elicits therapeutic working data. When a disclosure is assimilated in this way, the therapist can begin to **resolve** some issues that have perplexed him or her about self-

disclosure and about his or her therapeutic participation. Other therapists, however, in spite of a successful resolution of the disclosure, remain **perplexed** as to its value and use.

Detailed and illustrative description of the post-disclosing therapeutic situation:

Self-disclosures that have been **positively assessed** by the therapist can have different effects depending on the therapist's intentionality, and the context in which it occurred. If, for instance, a therapist is struggling to bond with a child and he implements a disclosure about a similar past experience to draw the patient more intimately into the therapeutic situation, he can find that the patient responds positively. The therapist can sense that the patient experiences support and this can align them more closely. The therapist and patient both feel empowered to address the patient's difficulties.

Such a positive experience can prompt the therapist to depart from previously cherished beliefs about the restricted use of self-disclosure. He can accept that self-disclosure might be implemented in instances where the bonding process requires a sustaining intervention (for example, *"..but I think there probably are moments where it can facilitate the process, the sense of personhood that exists between a therapist and a patient and a move toward wholeness in therapy and for joining"*).

Without warranting undue concern from the therapist, a disclosure can reach its intended goal. This occurred with the intervention that was formulated to disown the therapist's sleepy encounter experience and thereby awaken the patient's interpersonal insight. In this instance, the therapist became perceptive of positive growth within the

patient. The patient ceased her excessive verbalization that had been exhausting and distancing for the therapist. The patient's awakening interpersonal insight led the therapist to a positive appraisal of her disclosing intervention.

Whether a therapist disclosed or not, the fact that he or she **felt the need to disclose** can be a perplexing experience in and of itself, and can merit extensive reflection. If a therapist is pondering on **why** she felt the urge to disclose, and **why** she almost did, she can become very self critical (for example, "*.. it did provoke a whole lot of thoughts for me and feelings, and also critical, I was thinking, I'm very inappropriate..*").

The fact that the therapist feels the need to share can be an uncomfortable and unsettling experience and can, after the incident, coerce the therapist to evaluate the nature of the therapeutic relationship and to reappraise the therapeutic appropriateness of her involvement with the patient (for example, "*... made me think about how important the therapy was for me in terms of my self-esteem and my....*"). The therapist can muse over the relational entanglement, and can ultimately positively appraise the fact that she refrained from disclosing. The withholding is the beginning of the restoration of the therapeutic alliance.

Should a therapist become uncomfortably aware of a *role-reversal* subsequent to disclosing, she can weigh it **negatively**. For instance, during "the childhood memory", the therapist became uncomfortably aware that the patient was demanding more disclosure and personal involvement from her. To a therapist who has prized a belief that self-disclosure is not beneficial to patients, and that it ultimately burdens a patient, this can be an astounding experience.

This can be exacerbated by the therapist's prior implicit awareness of destructive consequences and pitfalls associated with disclosing, and her awareness of her need to gratify her own needs for mastery. The therapist can depreciate herself, and can feel as though she has abandoned her role as therapist. This intrudes as an intense distraction, as she deliberately attempts to restore her therapeutic integrity, and to revitalize and secure the therapeutic alliance to a previous mode of functioning.

This can elicit extensive deliberation after the self-disclosing incident, where the therapist ponders the feeling that she has abandoned her therapeutic role (for example, *"I was very aware of the breach after that and I thought about it a lot"*). This can impel the therapist to consult esteemed authors in regard to ardent therapeutic situations, such as when the patient assumes a therapeutic or helper role during the psychotherapeutic relationship.

This deliberation can elicit widening consideration about the inevitability of therapist responsiveness, the pervasiveness of subtle self-disclosure, the inevitability of therapist involvement, and the awareness of elusive and fragile therapeutic boundaries.

If a therapist self-discloses with a specific intention, and he feels that his disclosure was a conveyance of inaccurate and inadequate empathy, such as with "wounded femininity", and that it did not have the anticipated and desired effect, he can criticise and condemn himself (for example, *"When I thought about it afterwards... after the session I thought quite a lot about it, and thought well, it was hell of an arrogant of me to try and make that kind of comparison.... I think I felt bad or kind of guilty that I'd.. I'd.. yes, like her company trivialized it by saying it's not so bad,*

....."). This can be a persecutory experience for the therapist and can extend to a point where, upon reflection of successful disclosures where the bonding was enhanced, he denigrates himself (for example, "... *but maybe that's cheating*"), by perceiving himself to be deceitful.

After a negative appraisal by the therapist of his disclosure, time can elapse during which time he expends no further rumination (for example, "... *in fact, I had more or less forgotten about it, sort of written it off*"). He can be unobservant of the patient's retention of the disclosure, and the patient's changing perception, experience, and growing appreciation of the therapist's sharing.

During a subsequent therapeutic contact, the specific working context can elicit from the patient, a recollection of the disclosure, and she can impart the changing effects of the disclosure on her. For instance, if a therapist implements a disclosure to awaken the patient's empathic awareness of other peoples' burdens, he can realize afterwards that he has trivialized the patient's situation. When this occurred with therapist B, he could empathically grasp the impact of his disclosure from the patient's vantage point.

With increased therapeutic progress and the assimilation of painful issues, the patient can begin to appreciate a deeper meaning of the disclosure, and the comfort which the disclosure eventually instilled is then revealed to the therapist (for example, "... *when she had kind of directed her anger quite appropriately at the company, we dealt with a lot of issues and I think she felt that I wasn't judging her, I didn't see her as someone who was damaged, she was kind of then with the dubious wisdom of hindsight, ... well firstly the wounds had healed quite a lot... but secondly she had kind of worked through a lot of the issues*

and she didn't feel that she had lost her sexuality or her femininity that she could empathise with other people..... in fact it was quite near to termination.... it was in the context of her recognizing that everybody is damaged in some way. In fact she felt quite a lot of comfort in that and the, I think she said: 'For example, when you told me....' She can relate to it now but she definitely couldn't relate to it then"). This **belated acknowledgement** of the effect of the disclosure elicited further discussion about the disclosure, and an awakening awareness of the patient's empathic capacity.

A patient can retain the self-disclosure until a specific situation resounds with the situation in which the disclosure occurred. This occurred with the male patient who felt the need to dance around the room with the female therapist (for example, "*... it was literally months and months later, and the interesting thing was that it was on an occasion when he felt particularly close to me, and he wanted... his impulse at that stage was to overstep the limits from his side..... He actually was feeling extremely happy and he was feeling so joyful and so wonderful that what he wanted to do was grab me and dance around the room with me, okay*"). This happened against the background of the therapist having previously responded to the patient in an emotional way. Within this context, a patient can then reveal his feeling and link it to how he felt when the therapist responded to him (for example, "*... and then he went on to say: 'yes I really feel close to you now. I feel as close to you now as when we had that session once'. He said to me: 'You know I must tell you, you know that for me was so meaningful.....'*").

With such a delayed acknowledgement of the impact of therapist self-disclosure, therapeutic enquiry about the

definitive nature of a therapeutic relationship and a normal relationship can ensue. This can raise questions, to be therapeutically addressed, about intimacy in relationships, closeness, and boundaries. The therapeutic relationship can serve as a point of departure to understand other interpersonal relationships, and in this sense become a vital and crucial link in enhancing extra-therapeutic interpersonal insight. This occurred during "an emotional encounter" (for example, *"Oh my goodness! Yes it did change things. What happened then was a whole series around this issue..... It was more related to what is closeness and caring in the different situations, and how one expresses closeness in the different situations, appropriately or inappropriately with different people,..... so it lead onto a lot of work in terms of what his needs were as he defined being close to somebody"*).

However, after a successful restoration of the therapeutic alliance due to a belated acknowledgement and assimilation of the disclosure, a therapist can **remain perplexed** about the therapeutic value and appropriateness of therapist self-disclosure. A therapist can for instance, continue to *compare* positive and negative outcomes of self-disclosure, and can ponder issues such as timing. This, for instance, occurred with therapist B. Reflection on previous disclosing incidents with conflicting outcomes can further baffle a therapist's formulation of beliefs about self-disclosure. For instance, therapist B whose self-disclosure was successful in enhancing the therapeutic bond with a child, may find it is less successful in another context, such as the patient with wounded femininity. To resolve this perplexing stance, and attempting to re-affirm his stance and beliefs about self-disclosure a therapist can compare himself with disclosing colleagues, or can compare self-disclosure with other therapeutic interventions such as paradoxes. A

therapist can ponder and become cognizant of extreme, abusive, and very intrusive self-disclosures. This can then assist him in re-affirming himself as a non-disclosing therapist, advocating that self-disclosure be implemented with extreme skill and caution.

In another context, after a successful restoration of the alliance due to the therapeutic assimilation of the therapist's self-disclosure the therapist can then attain closure. Without further personal interrogation or criticism the therapist can dismiss the disclosing incident as a fruitful and also a personally enhancing experience. As an example, this is what occurred with the tearful therapist during the emotional encounter. For a therapist who is perplexed as to the extent of her participation and involvement with patients, this positive incident serves as a point of departure to begin positioning herself more affirmatively in terms of the use of oneself during psychotherapy.