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ADDENDUM

Protocol two, therapist B: male therapist, 5 years experience.

T: I can think of a few incidents. I think I generally don't just from my theoretical perspective don't use self-disclosure that much, but there have been some.. memorable one's I don't know.

Um, with children, I'll talk firstly with children, I do some work with children, I work in a children's home. One of my kids, this is just a recent one, one of my kids was a learning disabled child referred from an educational psychologist and I found it quite difficult joining with him. I'd already seen him for many sessions and I'm normally quite distant in the sense that the social workers normally hug them quite a lot and I think in the therapy it's inappropriate.

We were just looking at the difficulties that he has in differentiating between left and right and how the other kids mock him at school and that sort of thing and um I just.. in that I kind of felt for him because I think I had had similar difficulties when I was at Nursery School. I'm left-handed and I kind of remember having difficulties sometimes, perhaps a little bit slower than the other kids and I just thought, well I suppose it kind of came from him in a sense, I just thought well maybe if I was able to share that with him it would help me to bond with him a little bit more. And I've got sort of two freckles on my right hand and nothing on the left, and that I always sort of use that and that it was quite easy to see, so I told him, I told him the story that I used to have difficulty and it was quite interesting because he's quite an attention deficit disordered child so he doesn't focus and he focused quite well and I think it worked quite well in a sense in that **one**, I think he was able to understand somebody else had a similar problem somewhere and was now trying to help him and that it wasn't so bad and

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then we kind of did an exercise on what he could use, what was different from his left and right. We found a scar on his leg that he could use. But I think for... I don't know if it changed the therapy from there on but I think that kind of sharing worked quite well. It was the only one I've ever done with him, but it worked quite well in helping us to join.

R: Right.

T: Adults, I don't know how I feel about it, it's quite a difficult one I suppose to talk about. Yes, (sigh) in this hospital I work quite a lot with disabled people, people with physical disabilities, burns and that kind of thing, and I think the same kind of situation arose with one burnt patient that I have been seeing for quite a long time. She was burnt in an industrial... this is more or less an industrial hospital, burnt in an industrial accident, okay..

R: Yes..

T: chemical burns, not really on her face, but down her neck and I think it came across her breasts and stuff. And a lot of the therapy was kind of about the meaning of that in terms of her life, and her sexuality and those sort of things, and that sort of thing, and I was kind of... I was struggling in a kind of a sense to relate to that.... and I think a lot of her anger was focused at me in the sense here's someone works in an industry and who's kind of okay and she's not okay.... she's not okay, and I think also because she was female and I'm male there was a dynamic, unusual dynamic in that she felt awkward and I think she wanted a lot of affirmation from me that she was okay, and she wanted to know because I was male and which is quite difficult for me to deal with in the therapy. Um, and I was trying to look for... for... some way of kind of getting around that of being able to say that everyone is scarred in some way or another from the picture

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that I was trying to get and I was trying to think of something of myself and all that I could really think of was that when I was at school I had bad acne, and how difficult that was as an adolescent when you're trying to get girlfriends and how self-conscious I was, which was kind of some of the issues that she was talking about. So I brought up that issue and I was trying to say that we all have our own scars, sort of thing and sometimes they're bad sometimes they're not but I don't think that she responded to it that well in the sense that I felt the response that I got... interesting, not in that session but subsequently.

The therapy went reasonably well but I think what she was king of saying was: "How dare you compare adolescent acne with a severe burn on my.... on my breasts?" which I kind of understood so I thought that fell a bit flat in the sense that I was almost trivializing her injuries, um, in that sense I find it quite.. I suppose my training, my orientation has generally been an object relations one. In that sense one can work with the I and You and not just objects, but I think one has to use it **so** carefully and use a lot of care.

Some of my colleagues are very disclosing about themselves and about their relationships and I never, I never reveal anything about my sexual orientation or my relationships. Whether I'm married or not married, that kind of thing, I've always shied away from, but There have been times when I've tried to use specific incidents like that to try and help.

As an intern I remember one of my lecturers X, a kind of family therapist, um, in one of the groups. We did a group therapy and most of them were depressed. He was looking at an analogy on a scale of one to ten of how low everyone has been, and it was like a sharing thing in the group, and I was quite alarmed about.... when it kind of came to him, I thought well as a therapist he would be left out of that and he was quite willing to sort of share, and he said that he

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had been as low as a two which is pretty low on the scale, and I was kind of quite shocked. But I think it worked really well in that group setting for the people to know that the therapist isn't some kind of God up there that he doesn't have personal problems, or issues, or whatever and in that sense it can be quite valuable that even though they might be down at a two at the moment that there's someone who's helping them that's functional and all of that.

R: That's right.

T: So that' wasn't something that I did but it was an experience that I had of self-disclosure that worked. I haven't done many groups subsequent to that so I didn't have the opportunity but I think the group focus can be very powerful in that sense.

Um, for the most part I think I don't... I don't at all. The difficulties that I've had quite a.. which I think all therapists have is when people ask questions, like: "How old are you?", "Are you married?", "Do you have children?", and I think ideally I get quite uncomfortable with that in the sense that I from my theoretical perspective I think one must try and be as much of blank screen as much as one can but, um, that's not always possible and I always judge it on what I think the issue is about. Sometimes I will quite easily answer a question about my age and other times I would directly not answer it and tell them that I'm not answering it so I don't have a rule, I think it's.. as I said earlier on it's how I feel about the appropriateness of it and whether it's going to be valuable, and perhaps a part of myself that kind of feels drawn to it um, so it's not always just a kind of theoretical.. coming from a theoretical point of view. I don't think I've ever said to anyone that I'm married or not married, or I have children, but generally around issues concerning my age and that sort of thing...I would never reveal things about sexual orientation because I

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think that has far more to do with the individual's issues than the therapy itself.. so I think it can be quite destructive so I think it's kind of.. in my experience I've had both good and bad experiences of it. Similar to using a paradox in therapy, I think you've got be very skilled and be able to use it effectively and appropriately rather than to kind of spill out, and I suppose in an extreme form it can be abusive, almost a way of violating boundaries with a patient like with a sexual dynamic or something like that. You can say well it was under the guise of self-disclosure, like when a therapist has been seductive with a patient and I think that, that can be very very dangerous 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.

It's difficult for me to comment on at what point in therapy it can occur, whether it should happen kind of in the beginning trying to bond with a patient, or whether later on, and I think it's,... there's probably no rule, and I think I've probably done it more nearer the beginning parts of therapy than later on, maybe because the need seems to have been stronger if there are difficulties in bonding with a patient, but maybe that's cheating.

R: If we can get back to that incident of the woman that was burnt, it seems as if that was an attempt at "joining" right? When in the therapy was this, was it also earlier on?

T: Yes, there, the type of therapy done at the hospital is generally short-term because people are only hospitalized for, if I say short-term possibly about four months in the case of a burn victim. Sometimes there is follow-up, but sometimes they're referred out so... I stand to be corrected, but probably about the fourth or fifth session, nearer the beginning, but I only had about sixteen sessions with her

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(disturbance from outside).

R: Was this something you had pondered on, or did it occur spontaneously?

T: I hadn't thought about it before the session. It came up in the session, I can remember that quite distinctly, but it was almost out of a sense of desperation when I was kind of... I was feeling that we were missing and I felt that she was kind of.... you know, yes perhaps I kind of felt threatened in the sense that she.... I think she had a lot of anger about people that were okay and she felt that she wasn't okay and I think I kind of wanted to say well not everybody is okay all of the time and that I too at some point was scarred, so, yes it perhaps came out of that sense of feeling that I was losing her in the therapy and I was kind of becoming a "bad object", not really somebody that she felt was empathizing with her, but somebody that couldn't relate to her. It was an attempt to try to relate to her, yes spontaneous in that sense. I hadn't kind of pondered over it before the session and thought that I would try and draw an analogy and come up with this. Yes, I suppose I drew on myself in a sense that I did have to think about when I felt most vulnerable in that kind of way and that was in adolescence.

R: And what then actually finally prompted you to tell her? What in the therapy prompted you at that time? Was there a specific sort of an incident or..

T: I'll have to think... (pause).... I think, I stand to be corrected, I don't have my notes here, but I think it had something to do with her kind of constantly saying that no-one understands, I don't know what it's like, I as therapist don't know what it's like you know, what it actually means, how can I sit there and kind of try and help her and say that it's going to be okay or what ever it was that I was saying

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when I haven't had that kind of experience, and that I think that was really the prompt to kind of say: "Hold on I have had something.. similar kind of experience... perhaps it wasn't as severe..." although I didn't say that but I think that that's how she experienced it.

R: How deep was your disclosure? Did you reflect on your feelings at that time, or was it pure content?

T: No, I think it was deep, and it sounds odd, but I think.... it sounds amusing in retrospect, but at that time I think at adolescence I was very sensitive. I mean sometimes I didn't go out because of it and that kind of thing. I think it was quite a difficult thing in the sense, it wasn't just like the freckles on the hand.. there was an emotional impact. I don't think I got into the she became therapist mode, um, I kept it at a content level but I think I experienced it emotionally. I think it was quite a genuine sharing, um, in the sense that it was.. I did feel scarred at that time, I did feel that people didn't want me because of it, and I said that to her. So it was something to me, it wasn't like a, some superficial kind of incident.

R: It was a genuine recollection for you?

T: Yes, yes.

R: ..and her immediate reaction?

T: I think she was so.... she had so much anger in her. I think a lot of it.. just to put it in context. A lot of the therapy was about she felt that the industrial accident had occurred because of negligence so she was very, very angry with the company and felt that they hadn't, first of all they were negligent, and second of all, they were dismissing it and saying that she's being stupid. If you saw her and she had a polar neck on or whatever you wouldn't see any

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difference. There were issues about compensation and all sorts of things, so she had an incredible amount of anger also because she was a young.. she was married and because she was a young woman she kind of felt that her sexuality had been damaged etcetera, so there was an incredible amount of anger and I think a lot of uncertainty about males, and how her husband, for example would respond to her, with her.... her kind of damaged femininity. Um, so I think I lot of her anger was kind of being directed at me, and I don't think..... she responded I think quite quietly. She didn't say um, I don't think that there was much of a joining in terms of that. I don't think that she was immediately at that time angry. I think it made her think a little bit, but perhaps the interpretation or the disclosure came far to early in the therapy because we hadn't really joined and I think as what came out later when we had established the relationship was very much like kind of: "How dare you tell me such a trivial story when I'm so severely damaged?" So.. and I think it was far too premature.

R: So it seemed to have a long-term effect on her?

T: Yes well it came, certainly she remembered it because later I think when she, when her anger with me.. when she had kind of re-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, able to kind of say that she didn't like it when I did it, well not so much that she didn't like it but she didn't respond to it that well, so it didn't really help her at that time in fact it probably fumed her anger a bit more, whereas if it came later in the therapy when she didn't see herself as so damaged... 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 empathize with

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other people. She could kind of see that there are other people in their own way, whether it's been a physical accident or not are, have things that they hide, have skeletons in their closet, whatever... these things that they're not comfortable with and I think at time she could relate to it, and in fact we did speak about it again and then she was able to kind of see that in her therapist as well, but at the time I don't think it worked that well.

R: So it actually provided a lot for the therapeutic mill? Did she explicitly tell you "How dare you...

T: No, she didn't. She was quite quiet, I think it gave her food for thought. But like the child when I used that example earlier, he immediately paid attention, he kind of warmed to me and there was something that we had in common and there was a kind of an immediate sort of joining there and it certainly was not with her then, and I think she pondered over it, and she probably ruminated over it for quite some time and then... and then got angry. How dare you compare those types of things? Um, but she didn't .. she didn't respond in that way. She didn't say you know..

R: So how did you pick up that the anger was related to the self-disclosure?

T: Admittedly in that therapy session I didn't. I think she was just generally angry and she didn't stop being angry. It wasn't a direct anger, she wasn't sort of shouting and screaming at me but it was just this kind of underlying rage I think driven by her pain and driven by her sense of injustice and all of that, and that didn't change much and I think that's why I felt that it hadn't worked. It was only probably, I don't know five or so sessions later, that we spoke about it a bit more. She said to me I think that at that time that no matter what I had said, she would have been cross. If I.. I think that's what her words were. She said

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if I had said I had lost my leg she would have said well that's not your sexuality. Because it turned out, I think at the end of it it was her sense of being a woman that was most damaged. Initially she wasn't really able to say that. She was just saying that she had been scarred as a person, not so much as a sexual being.

R: Did she sort of bring up, or refer back to the disclosure again,..

T: Yes..

R: or was it your need to discuss it again?

T: No, in fact I had more or less forgotten about it, sort of written it off. And.... I don't know exactly in what context it came up again. But I think when she was saying, it was all about, in fact it was quite near to termination, I think about three to four sessions from termination about how she was, it was in the context of her recognising 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.

R: What was it doing to you in the therapy to really genuinely share something that had been painful to you and was sort of brushed off?

T: No, I don't think... I think if it was, this is quite an interesting question. Um, I obviously... I never saw her scars, um, you know, deliberately. I didn't visit her in the ward or whatever as I do a lot of patients, because I thought that was totally inappropriate to see her breast. I could see some of the scaring on her neck, but I think I empathized so much with her that, I did feel possibly.., I kind of felt bad, I didn't feel like I had shown some part of myself which

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she said is trivial. I think I saw it in the context of what had happened to her. 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 and I think I probably almost empathised with her anger at that. I mean how can a few pimples compare to that? So I don't think I felt that I had laid a part of myself on the table and she had stomped on it. I didn't have that sense, 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, you know, in the same way that acne goes away, it will just go away, so I think I thought about in that sense rather than like I had revealed a part of myself that she had just dismissed.

R: It's quite interesting how it became an issue later on when you had almost forgotten about it. She was still working with these issues.

R: Yes, well I find that generally, I've got a small private practice. I do far more long-term therapy there, sort of have patients for three or four years and I find there that often, ... I'm not talking about self-disclosure necessarily, often things that we've dealt with very early on in the therapy are brought up later. Maybe it was... it's this whole thing to do with timing of interpretations or the timing of something, which the more I kind of work, the more I realize is important. Yes like with any kind of interpretation you can... like with her, if I said she was angry in the first session, she would have left, even if I was aware of her anger, um, even though you're aware of it, it's important to time it properly, it's the same thing with a paradox and even with self-disclosure, you need to see it in the context of the therapy, rather than just use it as a tool or whenever you feel the need. So often something that is mentioned, perhaps a premature interpretation, the person won't deal with it then, but hang onto it and deal with it at

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a later time in therapy. I think in this kind of case, in this setting, we miss that because we terminate before those kinds of things would come up. It's very much short-term therapy.

R: It seems that with your theoretical approach, you can't exercise it to its full extent?

T: I think in the hospital despite my object relations kind of orientation, one has to work very eclectically. I mean with the in-patients in the psychiatric ward I do a lot of cognitive-behavioural work. There's never been any self-disclosure in that sense. I think the only times I've done it is more in terms of the interpersonal kind of therapy or the dynamic context.

R: Is there anything else about self-disclosure that you're still aware of, or do you feel you've exhausted it?

T: (pause) Maybe I'm repeating myself. I think like if I was supervising training therapists, I would, I would, if I was asked my position on that I think I would say that ..I don';t know why I'm always drawing a parallel with a paradox, I think it can be a very, very effective tool. I think I've had both positive and negative experiences of it, which doesn't necessarily mean that, having negative experiences doesn't necessarily mean that it's inappropriate. I think that one just has to be very, very careful about how and when you use it and whether it's your own issue or not that's being brought into it and whether you're doing it to aid and assist the therapeutic process rather than a kind of a need that you have to be inappropriate with a patient, let's say seductive or something or simply to share a part of yourself, spilling out, that must be used very appropriately and that one needs a lot of skill and guidance in being able to do that, or a lot of experience in being able to use it appropriately but I think like paradoxic and any forms of

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interpretation it can be very, very effective in the therapy, I think I've had experience with that with children, and I think it could be very, very effective, and sorry one other thing I didn't mention. I get quite a lot of referrals from high schools in my private practice and so people, adolescents, sixteen, seventeen year olds and I think I'm getting much older now (laugh) but I think initially when I qualified, I qualified quite young but in a sense almost by definition I was young and I was able to relate in a sense to their music and their culture, the kinds of clothes they're wearing, watching the movies they like and that's almost automatically a sense of self-disclosure

R: This is to do with the linking again?

T: Yes, but I must say in that sense, I suppose it falls under self-disclosure. When they talked about R.E.M. ..I don't know what the groups are now, but five or seven years ago it was more, I was kind of able to say, you know it they ask if I know the band, I'd say yes and that kind of thing. But I would really shy away from a sense of answering questions from a patient on myself, on anything personal about myself. Even patients, if I've kind of, if I've had to postpone sessions because I've been over leave in December or something like that I'd very much shy away from questions on where I've been, who I went with. With that I'm very ...... A lot of my colleagues are quite open about that. So I think I would use it very specifically in particular situations.

R: You seem to be quite anonymous in that regard and the disclosures that you described seem to convey a common ground..

T: Yes, attempts to join.

The therapist felt at this point that he had exhausted his awareness of self-disclosure at this point.

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Meaning units, re-articulated meanings, and central themes

1. **I can think of a few incidents.**

The therapist can cognitively recall a few incidents. Self-disclosure is not an isolated phenomenon.

(P) therapist's original positioning:

immediate recollection of incidents - the therapist can recall a few incidents of self-disclosure.

2. **I think I generally don't just from my theoretical perspective don't use self-disclosure that much, but there have been some.. memorable one's I don't know.**

The therapist has a principled point of departure and framework for conducting therapy. This does not generally allow for self-disclosure. There have been disclosures but he is not sure whether they've been worth retaining.

(P) therapist's contextual positioning:

theoretical principles and restricted S-D - the therapist has a principled way of conducting therapy which does not allow for self-disclosure;

recalling insignificant instances of S-D - the therapist has implemented S-D but these instances have not been worth retaining.

"the childhood disability"

3. **Um, with children, I'll talk firstly with children, I do some work with children, I work in a children's home. One of my kids, this is just a recent one, one of my kids was a learning disabled child referred from an educational psychologist and I found it quite difficult joining with him.**

The therapist discusses children first. He does therapy with children and works in a children's home. He is immediately aware of a specific child-patient who was learning disabled. The therapist found it difficult to link with this patient.

(I) unfolding relational matrix for S-D:

difficulties in securing therapeutic bond -the therapist experiences difficulties in bonding with a learning disabled male, child patient.

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4. **I'd already seen him for many sessions and I'm normally quite distant in the sense that the social workers normally hug them quite a lot and I think in the therapy it's inappropriate.**

The therapeutic relationship was already long-standing. The therapist compares his stance towards the child with social workers who physically show affection to the children, and experiences himself as being detached. He is cognitively aware that within the therapeutic context it is inappropriate to physically join with the patient.

(I) unfolding therapeutic constellation for S-D:

extensive therapeutic contacts - the therapy had extended temporally over many sessions;

therapist's detachment within alliance - detached compared to the social workers, therapist deems it therapeutically inappropriate to physically contain the patient.

5. **We were just looking at the difficulties that he has in differentiating between left and right and how the other kids mock him at school and that sort of thing and um I just.. in that I kind of felt for him because I think I had had similar difficulties when I was at Nursery School. I'm left-handed and I kind of remember having difficulties sometimes, perhaps a little bit slower than the other kids and I just thought, well I suppose it kind of came from him in a sense, I just thought well maybe if I was able to share that with him it would help me to bond with him a little bit more.**

The therapist taps from his reflective past experience to grasp the patient's problems at school and with other children. He reflects upon his previous experience and experiences emotional confluence. He thought to enter it into the therapeutic space so as to establish a therapeutic bond. The therapist is reflectively and cognitively aware that the similarities will establish a link between himself and the patient.

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(I) emerging relational matrix for S-D:

therapist's emotional alignment with child - therapist experienced a personalized empathic responsiveness due to a shared life-context;

awareness of S-D to establish bond - the therapist thought to enter his previous experience into the therapeutic space so as to assist the bonding process.

6. **And I've got sort of two freckles on my right hand and nothing on the left, and that I always sort of use that and that it was quite easy to see, so I told him, I told him the story that I used to have difficulty**

The therapist has two freckles on his right hand and nothing on the left hand so that he could always use the freckles to distinguish left from right. The therapist told the patient that he used to have difficulty.

(I) S-D incident:

relating a story harmonizing with patient's difficulties - the S-D constituted a sharing of a physical attribute with which the therapist has previously had difficulty.

7. **and it was quite interesting because he's quite an attention deficit disordered child so he doesn't focus and he focused quite well and I think it worked quite well in a sense in that one, I think he was able to understand somebody else had a similar problem somewhere and was now trying to help him and that it wasn't so bad and then we kind of did an exercise on what he could use, what was different from his left and right. We found a scar on his leg that he could use.**

The therapist's disclosure assisted the patient to realize that somebody else had had a similar problem and was now trying to help him. The disclosure also minimized the patient's problem. The disclosure then provided therapeutic working material as therapist and patient explored the patient's body for similar attributes that could be used in the same way as the therapist had used in his past.

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(I) effect of S-D:

patient's immediate attentiveness

minimizing effect on patient - problem was minimized, and he realized that somebody else has had the same problem; patient's awareness of support - patient was able to accept support from someone who had been in a similar situation.

(I) post-incidental therapeutic situation:

joining to address patient's difficulties - S-D provided therapeutic material, therapist and patient joined to further assist the patient in coping with his difficulties.

8. **But I think for.. I don't know if it changed the therapy from there on but I think that kind of sharing worked quite well. It was the only one I've ever done with him, but it worked quite well in helping us to join.**
The disclosure did not necessarily alter the course of the ensuing therapy but it assisted the bonding process. Self-disclosure stands out as an isolated phenomenon within this psychotherapy's lived context.

(I) effect of S-D:

strengthening therapeutic bond - the S-D did not alter the course of the ensuing therapy, but it did assist the bonding process.

9. **Adults, I don't know how I feel about it, it's quite a difficult one I suppose to talk about.**
Self-disclosure with adult patients presents itself in the therapist's awareness as a perplexing phenomenon.

(P) therapist's original positioning:

therapist's perplexity at discussing S-D with adults - therapist perplexed, finds it difficult to talk about.

"wounded femininity"

10. **Yes, in this hospital I work quite a lot with disabled people, people with physical disabilities, burns and that**

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kind of thing, and I think the same kind of situation arose with one burnt patient that I have been seeing for quite a long time. She was burnt in an industrial ... this is more or less an industrial hospital, burnt in an industrial accident, okay

The therapist works in an industrial hospital mainly with physically disabled people, for example people who have sustained burn injuries. The therapist recalls a situation with a burnt patient whom he has being seeing for a long time. The patient was a female who had been burnt in an industrial accident.

(I) unfolding therapeutic constellation for S-D:

<u>female, burnt patient</u> - burnt in an industrial accident;

<u>long-standing therapeutic relationship</u>

11. **chemical burns, not really on her face, but down her neck and I think it came across her breasts and stuff. And a lot of the therapy was kind of about the meaning of that in terms of her life, and her sexuality and those sort of things, and that sort of thing,**

The patient had sustained chemical burns down her neck and across her breasts. The therapeutic data was constituted by the meaning of the injuries in terms of the patient's life and her sexuality.

(I) unfolding therapeutic constellation for S-D:

<u>visibility of patient's wounds</u> - the therapist is aware of scars on neck and breast;

<u>containing the sexual implications of injury</u>

12. **and I was kind of...... I was struggling in a kind of a sense to relate to that ...**

The therapist experienced difficulty in relating to the implications of the injury.

(I) unfolding therapeutic constellation for S-D:

<u>therapist's difficulty in joining</u> - the therapist had difficulty in relating to the patient and the implications of her injury.

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13. **..... and I think a lot of her anger was focused at me in the sense here's someone who works in an industry and who's kind of okay and she's not okay ..... she's not okay**
The therapist senses that the patient is directing her anger towards him, as his physical well-being stood out against her dis-eased physical status. The therapist senses that he is an object of her anger.
(I) unfolding relational matrix for S-D:
<u>resentment towards T's well-being</u> - anger directed towards therapist whose physical well-being contrasted strongly with her own.

14. **and I think also because she was female and I'm male there was a dynamic, unusual dynamic in that she felt awkward and I think she wanted a lot of affirmation from me that she was okay, and she wanted to know because I was male and which is quite difficult for me to deal with in the therapy.**
The gender differences between therapist and patient created a psychosexual dynamic which threatened the therapist. The therapist sensed the patient's need for reassurance from him. His masculinity became the target for the patient's needs and the therapist experienced difficulty in dealing with the implicit demands being placed on him.
(I) emerging relational matrix for S-D:
<u>interactive psychosexual dynamic</u> - unfolding of a psychosexual therapeutic dynamic where the therapist senses patient's need for reassurance from him;
<u>appeal for affirmation from therapist</u> - the therapist's masculinity was creating an inevitable and immediate involvement;
<u>therapist's discomfort at sensing appeal for affirmation</u> - the therapist was bewildered and uncertain as how to manage this appeal from the patient.

15. **Um, and I was trying to look for ... for ... some way of kind of getting around that of being able to say that everyone is scarred in some way or another from the picture**

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that I was trying to get

The therapist attempted to circumvent the therapeutic demands placed upon him by generalizing the patient's injury towards a broader perspective.

(I) emerging therapeutic constellation for S-D:

attempt to bypass impending involvement - the therapist seeks to generalize to avoid having to deal with immediate and imminent involvement.

16. **and I was trying to think of something of myself and all that I could really think of was that when I was at school I had bad acne, and how difficult that was as an adolescent when you're trying to get girlfriends and how self-conscious I was, which was kind of some of the issues that she was talking about.**

The therapist searches for something personal to share with the patient. He recalled an adolescent incident when he had acne. This was a trying time for him and he recalls being very self-conscious especially in terms of his psychosexual and interpersonal functioning. He could relate this to what the patient was dealing with.

(I) emerging therapeutic constellation for S-D:

formulating S-D from therapist's past - the therapist searched his past to find an incident which he could relate to the patient.

17. **So I brought up that issue and I was trying to say that we all have our own scars, sort of thing and sometimes they're bad sometimes they're not**

The therapist shared his adolescent past in an attempt to generalize the patient's injury.

(I) S-D incident:

generalization of scarring - the disclosure included the therapist's adolescent past with the message that everyone is scarred to a certain degree.

18. **but I don't think that she responded to it that well in**

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the sense that I felt the response that I got .... interesting, not in that session but subsequently.
The impact of the disclosure was not apparent in the moment of revelation. The therapist sensed a negative response during subsequent therapeutic contacts.

(I) effect of S-D:

<u>delayed reaction from patient</u> - no immediate effect evident, subsequently the therapist sensed a response.

19. **The therapy went reasonably well but I think what she was kind of saying was: "How dare you compare adolescent acne with a severe burn on my.. on my breasts?" which I kind of understood so I thought that fell a bit flat in the sense that I was almost trivializing her injuries, um, in the sense that I find it quite....**
The disclosure did not disrupt the therapeutic process but the therapist sensed that the patient had been outraged by his trivializing of her injury and the meaning and implications that this had in her life-world.

(I) post incidental therapeutic situation:

<u>non disruptive effect of S-D</u> - the S-D had no immediate disruptive effect.

(I) effect of S-D:

<u>patient's outrage at trivializing of her injury</u> - outrage at the therapist's trivializing of her injury. The therapist fully grasps and understands the meaning of the disclosure from the patient's point of view.

20. **I suppose my training, my orientation has generally been an object relations one. In that sense one can work with the I and You and not just objects, but I think one has to use it so carefully and use a lot of care.**
The therapist's principled approach to conducting psychotherapy creates sufficient space for human contact, but within these boundaries he approaches self-disclosure with caution.

(P) therapist's reflective positioning:

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theoretical orientation and human subjective involvement - allows for human and authentic contact.

(P) therapist's contextual positioning:
cautious and judicious approach to use of S-D

21. **Some of my colleagues are very disclosing about themselves and about their relationships and I never, I never reveal anything about my sexual orientation or my relationships. Whether I'm married or not married, that kind of thing, I've always shied away from, but there have been times when I've tried to use specific incidents like that to try and help.**

The therapist compares his participation with that of his colleagues. This helps him to affirm his own stance. He is adamant that he does not disclose intimately private information. He is particularly elusive about information pertaining to his psychosexual and interpersonal relationships. He has however attempted to use incidents that assist the therapeutic process.

(P) therapist's established position:
comparison to disclosing colleagues
abstinence from imparting intimate information - the therapist has firmly established that he never imparts information pertaining to his psychosexual orientation.

(P) therapist's reflective positioning:
avoiding imparting personal information
S-D as intervention to secure therapeutic bond - on occasion the therapist has imparted information to assist the therapeutic process.

22. **As an intern I remember one of my lecturers X, a kind of family therapist um in one of the groups. We did a group therapy and most of them were depressed. He was looking at an analogy on a scale of one to ten of how low everyone has been, and it was like a sharing thing in the group, and I was quite alarmed about ..he had, when it kind of came to him, I thought well as a therapist he would be left out of that and**

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he was quite willing to sort of share, and he said that he had been as low as a two which is pretty low on the scale, and I was kind of quite shocked.

The therapist has received a disclosure within a group psychotherapeutic context. The members of the group were mostly depressed. The members were sharing the extent of their depressions with the other members. The therapist had a preconceived idea that the therapist would not disclose information about himself. The unexpected disclosure of the therapist had a profound impact on him.

(WI) unfolding therapeutic constellation for S-D:

depressed members of group psychotherapy

(WI) emerging relational matrix for S-D:

interpersonal sharing of extent of depression - the group members were sharing the extent of their depressions.

(WI) S-D incident:

therapist's sharing of extent of depression - the therapist conveyed to the group that he had already experienced profound depression;

therapist's alarm at therapist's S-D - the therapist was surprised that the therapist took a turn to share the extent of his depression with the other group members.

23. **But I think it worked really well in that group setting for the people to know that the therapist isn't some kind of God up there that he doesn't have personal problems, or issues, or whatever and in that sense it can be quite valuable that even though they might be down at a two at the moment that there's someone who's helping them that's functional and all of that.**

The therapist senses that the members of the group had benefitted by the disclosure in the sense that pre-conceived ideas about relational inequality could be re-assessed.

(WI) effect of S-D:

therapist's reappraisal of relational inequality - upon reception of S-D, the therapist sensed that the group members could re-assess therapeutic relational

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inequality.

24. **So that wasn't something that I did but it was an experience that I had of self-disclosure that worked. I haven't done many groups subsequent to that so I didn't have the opportunity but I think the group focus can be very powerful in that sense.**
This was not something that the therapist did himself, but it was an experience of self-disclosure that had a positive result. He has not conducted many group therapies subsequent to that experience so he has not had the opportunity to implement self-disclosure within the group context, but he is aware that self-disclosure can have a powerful impact on the group focus.
(P) therapist's reflective positioning:
awareness of profundity of S-D effect within group context - awareness that S-D could have a powerful impact on the group focus.

25. **Um, For the most part I think I don't...I don't at all.**
In a general sense, self-disclosure is not an imminent possibility.
(P) therapist's contextual positioning:
limited application of S-D - generally the therapist refrains from implementing S-D.

26. **The difficulties that I've had quite a.... which I think all therapists have is when people ask questions, like: "How old are you?", "Are you married?", "Do you have children?", and I think ideally I get quite uncomfortable with that in the sense that I from my theoretical perspective I think one must try and be as much of blank screen as much as one can but, um, that's not always possible and I always judge it on what I think the issue is about.**
The therapist senses that all therapist's are perplexed by direct appeals from patients. These appeals create unease within the therapist, due to his guiding and working

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principles which prescribe a stance where one is invisible and inaccessible to one's patients. This stance is not always possible to maintain, and then the question/appeal is weighed in terms of its therapeutic meaning.

(P) therapist's contextual positioning:

attempting to remain invisible and inaccessible - the therapist's guiding working principles suggest a detached stance which the therapist finds difficult to maintain at all times.

(P) therapist's reflective positioning:

discomfort upon direct appeals to share - creates discomfort in the therapist, as to share on this level disharmonizes with his guided, theoretical working principles;

management of direct appeals by appraising their inherent meaning/intention - each appeal weighed in terms of its therapeutic meaning/significance.

27. **Sometimes I will quite easily answer a question about my age and other times I would directly not answer it and tell them that I'm not answering it so I don't have a rule, I think it's.. as I said earlier on it's how I feel about the appropriateness of it and whether it's going to be valuable, and perhaps a part of myself that kind of feels drawn to it um, so it's not always just a kind of theoretical.. coming from a theoretical point of view.**

Each appeal is weighed in terms of its therapeutic value. Each is weighed differently, there are no pre-set or pre-established rules concerning disclosure. The possibility of disclosing and its management relies not only on theoretical principles but is also intimately tied up with the therapist's person.

(P) therapist's contextual positioning:

personal attributes of therapist as partial determinants to self-disclose - relies on personal attributes of therapist as well as theoretical working principles.

(P) therapist's reflective positioning:

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lack of consistent guidelines to manage direct appeals - the therapist employs no definitive or consistent response.

28. **I don't think I've ever said to anyone that I'm married or not married, or I have children, but generally around issues concerning my age and that sort of thing... I would never reveal things about sexual orientation because I think that has far more to do with the individual's issues than the therapy itself.. so I think it can be quite destructive so I think it's kind of.. in my experience I've had both good and bad experiences of it.**

The therapist is hesitant to present in the therapeutic space information that could reveal his participation in interpersonal relationships specifically his sexual participation. This is too imposing on the therapeutic dyad and inappropriately gratifying for the patient, and refutes the pre-established working principles within the therapeutic alliance. The therapist has previous experiences of such disclosure, some with positive and others with negative consequences.

(P) therapist's reflective positioning:

recalling limited sharing on a personal level

conflicting outcomes from sharing on a personal level - the therapist has experienced positive and negative outcomes, cannot recall specific incidents where he has imparted biographical information.

(P) therapist's established position:

abstinence from imparting psychosexual orientation - the therapist consistently refrains from imparting information concerning his sexual orientation, and sees this as inappropriately gratifying for the patient.

29. **Similar to using a paradox in therapy, I think you've got be very skilled and be able to use it effectively and appropriately rather than to kind of spill out, and I suppose in an extreme form it can be abusive, almost a way of**

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violating boundaries with a patient like with a sexual dynamic or something like that. You can say well it was under the guise of self-disclosure, like when a therapist has been seductive with a patient and I think that, that can be very very dangerous.

When considering the therapeutic application of self-disclosure the therapist compares it to other therapeutic interventions and subjects it to the same rigorous conditions. Self-disclosure exists on a spectrum with the remotest possibilities corrupting the psychotherapeutic frame. In this regard sexuality presents itself in the therapist's awareness and presents itself as a potentially hazardous form of self-disclosure.

(P) therapist's contextual positioning:

conditional S-D implementation and comparison to other therapeutic interventions - when considering and appraising the use of self-disclosure, the therapist compares it to other therapeutic interventions;

judicious use of S-D - requires skill and judicious judgement from the therapist;

effect of very intrusive S-D - potentially hazardous consequences.

30. **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.**

At certain instances self-disclosure can enhance or establish the common human bond that exists between therapist and patient. In this sense the therapist's professional stance and his human engagement in the patient's unfolding life-world merge.

(P) therapist's contextual positioning:

value of S-D in enhancing common human bond - S-D potentially enhances the common human bond and establishes confluence between the co-constitutors of the therapeutic alliance.

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31. **It's difficult for me to comment on at what point in therapy it can occur, whether it should happen kind of in the beginning trying to bond with a patient, or whether later on, and I think it's,..there's probably no rule, and I think I've probably done it more nearer the beginning parts of therapy than later on, maybe because the need seems to have been stronger if there are difficulties in bonding with a patient, but maybe that's cheating.**

The therapist has no closure about when in the therapeutic process self-disclosure should be implemented, that is, whether it should be used during the beginning phases of the process to assist bonding, or at a later stage. He is not aware of any particular/specific guidelines, but upon reflection realizes that he has used it mainly in the beginning phases to assist the bonding process. He reserves the possibility that this could constitute a deceitful manoeuvre.

(P) therapist's contextual positioning:

questioning the temporal location S-D - the therapist has not attained closure about the timing of S-D;

S-D as deceitful bonding manoeuvre - the therapist realizes that it may be deceitful to implement a S-D to assist the bonding process.

(P) therapist's reflective positioning:

timing of S-D to assist bonding - upon reflection, the therapist establishes that he has implemented S-D early in therapy to assist bonding and joining.

32. (when?) **Yes, there, the type of therapy done at this hospital is generally short-term because people are only hospitalized for, if I say short-term possibly about four months in the case of a burn victim. Sometimes there is follow-up, but sometimes they're referred out so... I stand to be corrected, but probably about the fourth or fifth session, nearer the beginning, but I only had about sixteen sessions with her.**

Within the working environment of the therapist, the

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therapies are usually of short duration. With the burnt patient, the therapist's disclosure occurred nearer the beginning of therapy, that is the fourth or fifth session.

(I) S-D incident:

phasically early occurrence of S-D - *in the beginning phases, +/- 4/5 therapeutic contact.*

33. (spontaneous?) **I hadn't thought about it before the session. It came up in the session, I can remember that quite distinctly**

The therapist can clearly recall that the disclosure arose within the temporal confines of the therapeutic space. The therapist did not deliberate upon the possibility of self-disclosure prior to the session in which it occurred.

(I) emerging therapeutic constellation for S-D:

spontaneous S-D formulation within therapeutic session - *the disclosure was not meditated upon prior to the session in which it occurred, but arose within the temporal boundaries within which it occurred.*

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

clarity of recollection of spontaneity of S-D - *the therapist can accurately recall that the S-D arose within the session in which it occurred.*

34. **but it was almost out of a sense of desperation when I was kind of.... I was feeling that we were missing and I felt that she was kind of... you know, yes perhaps I kind of felt threatened in the sense that she....**

The therapist felt threatened by the alienation that was developing in the therapeutic space. The patient's experience and the therapist's experiential flow were parallel with no basis for the patient to feel understood. The therapist was fearful of the absence of a link between himself and the patient.

(I) emerging relational matrix for S-D:

therapist's threat of alienation - *the therapist was overwhelmed and threatened by the developing alienation*

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between himself and the patient.

35. **I think she had a lot of anger about people that were okay and she felt that she wasn't okay and I think I kind of wanted to say well not everybody is okay all of the time and that I too at some point was scarred, so, yes**
The therapist sensed that the patient was angered by people that were not scarred, and this stirred the need in him to relate to her that not everyone is alright all of the time and that he too was scarred at some point.
(I) emerging therapeutic constellation for S-D:
patient's anger at unscathed people - angered by people who were not scarred;
therapist's need to reassure by sharing personal scarring - needed to convey to the patient that all people are scarred at some time, and that he too had been scarred.

36. **it perhaps came out of that sense of feeling that I was losing her in the therapy and I was kind of becoming a "bad object", not really somebody that she felt was empathizing with her, but somebody that couldn't relate to her.**
The therapist was increasingly uncomfortable at being experienced negatively and at having his empathy negated. He felt at a loss and felt threatened by the increasing alienation that was occupying the therapeutic space.
(I) emerging relational matrix for S-D:
negation of therapist's empathic responsiveness - the therapist sensed that the alliance was severed by the patient's misconstruction of his empathic responsiveness.

37. **It was an attempt to try to relate to her, yes spontaneous in that sense. I hadn't kind of pondered over it before the session and thought that I would try and draw on an analogy and come up with this.**
The disclosure originated in the lived-context of psychotherapy, and represented a spontaneous gesture to reach out and relate to the patient.

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(I) S-D incident:

S-D as spontaneous gesture to reach patient - the therapist had not pondered over the disclosure or formulated it outside of the therapeutic session in which it occurred.

38. **Yes, I suppose I drew on myself in a sense that I did have to think about when I felt most vulnerable in that kind of way and that was in adolescence.**
The self-disclosure revealed an aspect of the therapist's lived-world and did not draw from his immediate experiencing. He searched his past for an incident/situation when he had felt as vulnerable as the patient.

(I) emerging therapeutic constellation for S-D:

searching past to formulate S-D- the therapist searched his past experience reflecting on when he had felt as vulnerable as the patient.

39. (prompted?) **I'll have to think... (pause) I think... I stand to be corrected, I don't have my notes here, but I think it had something to do with her kind of constantly saying that no-one understands, I don't know what it's like, I as therapist don't know what it's like you know, what it actually means, how can I sit there and kind of try and help her and say that it's going to be okay or whatever it was that I was saying when I haven't had that kind of experience, and that I think that was really the prompt to kind of say: "Hold on, I have had something.... similar kind of experience...perhaps it wasn't as severe..." although I didn't say that but I think that's how she experienced it.**
The therapist's experience of feeling shut-out and alienated as an unresponsive and unempathic participant enhanced his readiness and prompted him to reach out to the patient by disclosing a similar event from out of his lived-world.

(I) emerging relational matrix for S-D:

patient's overt negation of therapist's empathy - confronted the therapist in terms of his capacity for

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empathic responding;

<u>S-D prompt to rectify misconstruction of therapist's empathy</u> - therapist wanted to rectify patient's misconstruction of his empathy by reaching out and sharing from out of his past.

40. **No, I think it was deep, and it sounds odd, but I think....it sounds amusing in retrospect, but at that time I think at adolescence I was very sensitive. I mean sometimes I didn't go out because of it and that kind of thing. I think it was quite a difficult thing in the sense, it wasn't just like the freckles on the hand.. there was an emotional impact.** Assuming a backward glance, the therapist's adolescent past seems amusing to him. The therapist can accurately recall the emotional impact at the time and the interpersonal difficulties he had endured.

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

<u>retrospectively assessing the emotional impact</u> - within the research context the therapist is aware that assuming a backward glance the content of his disclosure might depart humorously from the seriousness of the emotional impact at the time.

(I) S-D incident:

<u>therapist's emotional encounter with his past</u> - therapist accurately recalled the emotionality of his adolescent past which made his S-D a genuine encounter with his past.

41. **I don't think I got into the she became therapist mode, um, I kept it at a content level but I think I experienced it emotionally. I think it was quite a genuine sharing um in the sense that it was..I did feel scarred at that time, I did feel that people didn't want me because of it, and I said that to her. So it was something to me, it wasn't like a, some superficial kind of incident.**

The therapist did not reverse the therapeutic roles. He verbally conveyed the disclosure on a content level, but his

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personal experience of the disclosure was on a profoundly deeper emotional level as he accurately recalled his feelings of rejection.

(I) S-D incident:

sharing on a content level - *remained on a content level, where the therapist maintained his professional stance;*

therapist's emotional encounter with his past - *an emotional recollection of his past, a genuine moment of sharing.*

42. (her immediate reaction?) **I think she was so.... she had so much anger in her. I think a lot of it.. just to put it in context. A lot of the therapy was about she felt that the industrial accident had occurred because of negligence so she was very, very angry with the company and felt that they hadn't, first of all they were negligent, and second of all, they were dismissing it and saying that she's being stupid. If you saw her and she had a polar neck on or whatever you wouldn't see any difference.**

The extent of the patient's injury was not always clearly observable, and could easily be obscured by what she was wearing. This facilitated her perception of people trivializing her experience of the injury. Prior to the disclosure the therapeutic working data consisted primarily of dealing with the patient's anger towards the company that she had been working for. The anger was stirred by the company's negligence contributing towards the accident, as well as the dismissal of the seriousness of the injury.

(I) unfolding therapeutic constellation for S-D:

invisibility of patient's wounds

patient's anger towards employer - *patient's anger two-fold, firstly towards employer for negating the seriousness of her injury and secondly the negligence which contributed towards the accident.*

(I) effect of S-D:

patient's unsubsiding anger- *any S-D effect was masked by her overwhelming and unsubsiding anger and fury.*

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43. **There were issues about compensation and all sorts of things, so she had an incredible amount of anger also because she was a young.. she was married and because she was a young woman she kind of felt that her sexuality had been damaged etcetera, so there was an incredible amount of anger and I think a lot of uncertainty about males, and how her husband, for example would respond to her, with her .... her kind of damaged femininity.**

There were matters pertaining to compensation and other matters pertaining to the accident. This stirred enormous anger which was seriously aggravated by the fact that the injury touched upon her sexual role as woman. This elicited anxiety about men and specifically how her husband would respond to her wounded sexuality and femininity.

(I) unfolding therapeutic constellation for S-D:

concern about employment compensation - *comprised therapeutic working data;*

concern about male sexual responsiveness - *the patient was concerned about the impact of the accident on her role as woman and sexual being, specifically her husband's response to her wounded femininity.*

44. **Um, so I think I lot of her anger was kind of being directed at me, and I don't think..... she responded I think quite quietly. She didn't say um, I don't think that there was much of a joining in terms of that.**

The therapist became an object of the patient's anger. The patient originally responded quietly to the disclosure with no immediate overt reaction being evident.

(I) unfolding relational matrix for S-D:

therapist as object of patient's anger

(I) effect of S-D:

dilution of effect with no joining - *no immediately evident effect, no bond established.*

45. **I don't think that she was immediately at that time**

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angry. I think it made her think a little bit, but perhaps the interpretation or the disclosure came far to early in the therapy because we hadn't really joined and I think as what came out later when we had established the relationship was very much like kind of "How dare you tell me such a trivial story when I'm so severely damaged?" so,..and I think it was far to premature.

The therapist senses that the patient was not immediately angered by his disclosure and that it had provided food for thought. Upon deliberation the therapist acknowledges that the disclosure was ill-timed. The disclosure extended beyond the immediate to exert an influence into the future therapeutic contacts. Over a period of time the patient was more able to formulate the impact of the disclosure. This had been a humiliating and minimizing experience for her.

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

appraising the ill-timing - upon reflection the therapist senses that it was ill-timed, that is, it was premature, before adequate bonding had been established.

(I) effect of S-D:

delayed anger at trivializing of injury - no immediate anger at the disclosure, during subsequent therapeutic contacts the effect became evident, which consisted of her anger at her injury being trivialized and minimized.

46. (long-term effect on her?) **Yes well it came, certainly she remembered it because later I think when she, when her anger with me.. when she had kind of re-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, able to kind of say that she didn't like it when I did it, well not so much that she didn't like it but she didn't respond to it that well, so it didn't really help her at that time in fact it probably fumed her anger a bit more, whereas if it came later in the therapy when she didn't see herself as so damaged.....**

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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 empathize with other people.

The disclosure was not immediately fruitful. Once the patient had appropriately re-directed her anger towards the employer, she could reassess the impact of the disclosure. She admitted that she did not appreciate the disclosure at the time, and that she hadn't responded well to it. The therapist is aware that the disclosure might have enhanced her anger, and that it might have had a different effect had it occurred at another time during the therapeutic process. During the more advanced stages of therapy the patient's wounds had healed significantly and she had processed and reassessed her feminine role to a point where she could begin to empathise with others.

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

<u>re-direction of patient's anger</u> - patient's anger becomes re-directed to employer.

(I) establishing the effect of S-D:

<u>belated acknowledgement of negative response to S-D</u> - patient shares with the therapist that she had not originally accepted and appreciated his S-D.

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

<u>considering S-D at an advanced phase</u> - therapist senses that during more advanced stages of therapy when the patient had reassessed her sexuality and had retrieved ability to empathise, the S-D might have had a differential effect.

47. **She could kind of see that there are other people in their own way, whether it's been a physical accident or not are, have things that they hide, have skeletons in their closet, whatever... these things that they're not comfortable with and I think at time she could relate to it, and in fact we did speak about it again and then she was able to kind of**

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see that in her therapist as well,
The patient could recognise that other people also attempt to conceal aspects about themselves. She could relate to this and upon further discussion could relate to this in her therapist as well.
(I) established effect of S-D:

patient's heightened empathy towards others - patient could eventually understand and grasp that other people, including her therapist are burdened by weaknesses.

48. **but at the time I don't think it worked that well.**
At the time of the disclosure, the therapist did not reach the intended effect.
(I) effect of S-D:

therapist's sensing of diluted effect - the therapist senses that the S-D did not have an immediately positive effect.

49. (Did she explicitly tell you "How dare you... ?) **No, she didn't. She was quite quiet, I think it gave her food for thought.**
The disclosure elicited no immediate perceptible effect. It remained implicitly in the patient's awareness as substance for rumination.
(I) effect of S-D:

P's private responding and elicitation of rumination - the patient responded privately, and the therapist senses that the disclosure elicited deliberation.

50. **But like the child when I used that example earlier, he immediately paid attention, he kind of warmed to me and there was something that we had in common and there was a kind of an immediate sort of joining there and it certainly was not with her then,**
With the child patient, there had been an immediate effect and the disclosure had the intended and desired effect as anticipated by the therapist. With this particular patient,

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the effect was totally different.

(I) effect of S-D:

<u>comparing S-D experiences</u> - with the child, bonding was established immediately after the disclosure, but with the adult patient there was no bonding effect.

51. **and I think she pondered over it, and she probably ruminated over it for quite some time and then..... and then got angry. How dare you compare those types of things? Um, but she didn't ..she didn't respond in that way. She didn't say you know..**

The disclosure became a private event for the patient. She extricated it from the temporal and physical boundaries of the therapeutic frame and meditated and pondered over what had been said. She did not directly confront the therapist with the impact that it had had on her. This was rather inferred by the therapist.

(I) establishing S-D effect within an emerging therapeutic constellation:

<u>patient's private experiencing</u> - the therapist senses that the patient pondered internally on his disclosure and then became angry.

52. (How did you pick up that the anger was related to the self-disclosure?) **Admittedly in that therapy session I didn't. I think she was just generally angry and she didn't stop being angry. It wasn't a direct anger, she wasn't sort of shouting and screaming at me but it was just this kind of underlying rage I think driven by her pain and driven by her sense of injustice and all of that, and that didn't change much and I think that's why I felt that it hadn't worked.**

Within the moment of the disclosure the therapist was oblivious to its impact. The patient did not disengage from her passionate anger. There was no observable subsiding of her pervasive anger and fury, and the therapist paralleled this with the disclosure having had no effect.

(I) establishing S-D effect within an unfolding therapeutic

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constellation:

<u>therapist's felt sense of patient's rage and pain at feelings of injustice</u> - the patient's unsubsiding pain and rage allowed the therapist to assess his disclosure as having had no positive and fruitful effect.

53. **It was only probably, I don't know five or so sessions later, that we spoke about it a bit more. She said to me I think that at that time that no matter what I had said, she would have been cross. If I..I think that's what her words were. She said if I had said I had lost my leg she would have said well that's not your sexuality. Because it turned out, I think at the end of it it was her sense of being a woman that was most damaged.**

The patient upon reflection of her emotional experiencing at the time of the disclosure reveals that she was so self-absorbed that no disclosure would have elicited any empathy from her.

(I) establishing the effect of the S-D:

<u>delayed temporal placement of acknowledgement</u>- the patient and therapist started establishing the effect of the disclosure approximately five contacts after the disclosure;

<u>patient's sharing of immediate insignificance</u>- the patient explains that no profound disclosure would have had an effect on her.

54. **Initially she wasn't really able to say that. She was just saying that she had been scarred as a person, not so much as a sexual being.**

Originally the patient was only cognitively aware of her physical scars, the sexual implications were only realized at a later stage.

(I) unfolding therapeutic constellation for S-D:

<u>patient's original, asexual experience of wounds</u> - the psychosexual implications were not immediately in the patient's awareness.

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55. (Did she sort of bring up, or refer back to the disclosure again.. ?) **Yes..**

(your need?) **No, in fact I had more or less forgotten about it, sort of written it off.**

The therapist had abandoned the disclosure as an unsuccessful intervention. He was unaware of its continuing influence within the patient's reflective awareness.

(I) post-incidental therapeutic situation:

therapist's oblivion to effect of S-D - *the therapist had abandoned his disclosure as an unsuccessful therapeutic intervention.*

56. **And .... I don't know exactly in what context it came up again. But I think when she was saying, it was all about, in fact it was quite near to termination, I think about three to four sessions from termination about how she was, it was in the context of her recognising 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.**

The disclosure continued to exert an influence in the patient's awareness until the termination phase of therapy. She then shared this impact with the therapist who had been oblivious to the patient's total experience of his disclosure. The disclosure had gradually assumed importance in the patient's experience of her injury and contributed towards its meaning in her life-world. The patient could reflect upon the meaning of the disclosure as well as her inner processing of the disclosure over time. The patient conveyed this to the therapist near termination.

(I) establishing S-D effect within an emerging therapeutic constellation:

awareness of others' burdens - *centred on awareness of "others" being burdened and having scars.*

(I) establishing the effect of S-D:

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approaching of termination

sharing the grasping of implications of S-D - shared with the therapist that she could now relate to the meaning and implications of his disclosure.

57. (What was it doing to you in the therapy to really genuinely share something that had been painful to you and was sort of brushed off?) **No, I don't think... I think if it was, this is quite an interesting question. Um, I obviously... I never saw her scars, um, you know, deliberately. I didn't visit her in the ward or whatever as I do a lot of patients, because I thought that was totally inappropriate to see her breast. I could see some of the scaring on her neck, but I think I empathized so much with her that, I did feel possibly.., I kind of felt bad, I didn't feel like I had shown some part of myself which she said is trivial. I think I saw it in the context of what had happened to her.**

The therapist had never physically seen the full extent of the patient's scars. He deemed it therapeutically inappropriate to see her in the ward. The therapist extricated the disclosure from the immediate therapeutic context, abandoned his immediate experience and assumed the patient's frame of reference to evaluate the impact of his disclosure.

(I) unfolding therapeutic constellation for S-D:

physical detachment from patient's wounds - the therapist maintained his professional stance, the scarring across the breast remained invisible.

(I) effect of S-D:

therapist's empathic responding to impact - the therapist assumed the patient's frame of reference to understand why his disclosure did not have the intended effect.

58. **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**

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and I think I probably almost empathised with her anger at that. I mean how can a few pimples compare to that?
The therapist extricated his disclosure beyond the physical and temporal boundaries of the therapeutic frame to assess its therapeutic value. Creating sufficient distance from the immediacy of experience to reflect, the therapist experiences himself as presumptuous and finds greater affinity with the patient's pre-supposed and unvoiced anger at the minimizing disclosure.

(I) effect of S-D:

therapist's self-condemnation for inaccurate empathy - the therapist privately re-considered the disclosure, and experienced himself as having been overbearing.
assumption of patient's position to understand S-D effect - the therapist assumed the patient's vantage point to grasp her experience of the disclosure.

59. **So I don't think I felt that I had laid a part of myself on the table and she had stomped on it. I didn't have that sense, 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, you know, in the same way that acne goes away, it will just go away, so I think I thought about in that sense rather than like I had revealed a part of myself that she had just dismissed.**
The therapist did not feel that he his exposure had been abused or disrespected. He felt guilty for having minimized the patient's injury in the same way that her employer had done. He understood the impact and meaning of the disclosure from the patient's vantage point.

(I) effect of S-D:

therapist's experience of guilt for minimizing patient's injury - the therapist assumed the patient's vantage point to understand the meaning of his disclosure. This stirred guilt feelings for having minimized the implications of her injury. He did not feel that his openness had been abused.

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Protocol three, therapist C: Female therapist, 4 years experience.

T: Well, when you ask about self-disclosure it's something that I've thought about a lot because I mean, because I suppose in a way it boils down to also about what I believe therapy is, because I believe that it's a lot about a relationship with the patient, more than even techniques, tricks, gimmicks or interpretations, and sometimes the conflict is about how **real** you are, and how **honest.** When someone asks a hard question, what do you do with it? or a personal question? At what point are you being not real in deflecting the question or turning it back on them and saying: "Well what do **you** think?" or "Why is it important for you to know that about me?"- exploring their fantasy about the question. So sometimes I struggle with the genuineness.

The one time that I... and it's not even related to what I'm saying, but the example that I'm thinking of I see a young girl that I've seen for a long time. She's twenty three and she's very borderline personality... trait, I mean she's got a disorder but she's quite a miserable young woman and she's very dependant in therapy, and I see her quite often, I see her at least twice a week, and at one time I was seeing her three times a week after her discharge from the ward, so there's been quite an intensive therapeutic relationship. Although she's quite blocked in the therapy and that, it's not a very academic kind of a therapy, it's very much a relationship, about a supportive relationship. We've gone through a number of crises, and she tests the limits constantly. She wants to be friends. I mean we've managed to make that explicit her fantasy of wanting to be friends. Often I think that she pushes boundaries, and the one time about self-disclosure... I had a dream about her on the weekend. It was a very, very vivid dream and I think it was about a whole lot of things that were going on in the

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therapy, about her being quite needy and in a crisis in her life and she... it was my birthday, and she had found out because the year before when it was my birthday, she was in the ward, and all the staff were wishing me happy birthday, and I had brought a cake so she knew it was my birthday, and she'd obviously made a note and she brought me a card and a small gift for my birthday. Now because she's a T patient (the hospital) and she doesn't pay me, I accepted the gift, because, you know, I think it was her giving something. We talked about it, but I felt quite uncomfortable. It was like a boundary issue. So I dreamt about her on the weekend, and in our session after the weekend, she came and she was a bit, um, funny, and she didn't want to talk, she was uncomfortable and she said she was cross with me, and that she had dreamt about **me** on the weekend, and she'd had a dream and she described the dream, and I felt such a.. I really wanted to tell her that I had dreamt about her. I felt such a **pressure** to tell her, but I didn't because I felt like it would be too much information to give her. But it was such an enormous pressure on me, like **internally**. I really just wanted to say to her: "But you know, I also dreamt about you, it's such a co-incidence, we're clearly thinking so much about the same issues". But I didn't because I felt that it was **very** inappropriate for me to have told her but I did feel this kind of inner pressure to tell her which I think was about me trying to reassure her that she did mean something to me that the gift meant something to me, it wasn't.... I didn't just discard it, and I felt quite.... I was quite distracted when I was... when she told me about her dream, because I was thinking about my dream. The dreams were the same themes. My dream was also.... they were both about us breaking boundaries with each other. Her dream was about that I was seeing her as a private patient, and I went to her house to see her, and my dream I can't even remember what exactly it was, but it also felt like an inappropriate relationship between us, so I think that we were thinking and feeling the same things, and I could use it in the therapy, but my need

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to tell her that I had the same dream, you know, was quite **powerful.**

R: So you had an immense need to relate this to her?

T: Yes, to kind of connect it to her, but I didn't and I think I did the right thing by not telling her, um, and by kind of holding back, but I was.... I was astonished at how strong the urge was to tell her, and how much I got then in the therapy.. quite distracted internally thinking I had the same dream, and almost saying "I mustn't tell her, I must keep quiet now, **hold back! hold back!**

R: You were busy struggling with yourself, that you couldn't quite...

T: Ja, it wasn't destructive in the therapy, because I could use **her** dream and also, I think that she was struggling with the same issues about how much can she tell me. I feel like we were reflecting each other in quite an unusual way. But with her, she is the patient that... often she will ask me a lot of personal questions. In fact I saw her yesterday, and she said to me, we had been talking about going away in December, and she asked me am I going away in December and in fact what I did..... I thought I gave quite a... I said: "I haven't even thought about it!", instead of just saying to her about the fantasy of being abandoned, I just said: "Look I haven't thought about it" and she said, no, I must give her six months notice if I'm going away on a holiday. It's all about her neediness, but it was interesting because she's a patient that particularly makes.. er requests information about me all the time and the one time when I had such a need to give it to her and she hadn't even asked.

R: And what happened to you afterwards?

T: I felt quite uncomfortable. Firstly, I felt uncomfortable

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that I had the dream about her and I felt... it was.... I can't remember, it was **just so amazing**, I kept thinking it's amazing that somewhere there's such an.. almost an enmeshment between us, I mean the boundaries are good in the therapy, but I think we almost.... that somewhere.... it made me think a lot. I mean it was a very thought provoking incident. I thought a lot about how the therapy.. she's very dependant on the therapy but also that in some ways I'm also very invested in it. She's done very well, she's managed to... **I** feel in some ways I've managed to keep her out of hospital so I've invested in it, so it made me feel like... I suppose one's also in wanting to tell her about the dream maybe to acknowledge also that I'm invested in the relationship, which I wouldn't want her to really **know**, but I think that maybe that's what it was about. About how.... I suppose in terms of being a new therapist as well it's important to have patients that are doing well, getting better, and she is one that I feel is getting better. She is doing well so maybe that was it....... but I was just thinking about that now.

R: It seems as if the awareness of the disclosure has forced a lot into mind? You've sort of evaluated the relationship?

T: **Absolutely**, it was quite **powerful**. I was **uncomfortable afterwards**. After the session even, I felt like.... it was right at the end of the day. I drove home kind of feeling a little bit **unsettled**, and it did provoke a whole lot of thoughts for me and feelings, and also critical, I was thinking, I'm very inappropriate, maybe I've got to evaluate how I feel about this patient, and why she's so important. And why I dream about her is an issue in itself. You know, I do dream about patients every now and again, but I think with her because it's a very significant therapy, made me think about how important the therapy was for me in terms of my self-esteem and my... because I've struggled with her a lot, I mean she went through a time when she felt she had been betrayed by me, so she was very angry and I struggled to

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kind of.... to help her to stay in therapy and also for me not to be angry with her about her acting out. So it was a very interesting experience.

R: Did that urge arise again subsequently?

T: With her?

R: Yes.

T: No, not in the same way, because normally with her, as I say, in the therapy, I'm much more... I feel like I try to model like just being real. So, I will talk about a movie I've seen if she's talking about a movie, and says: "Have you seen the movie?" I will say: "Ja, I've seen it", and I don't feel like it's an urge to tell her, rather than me use that as a common experience to talk about what she thought of it and what I underst... so I don't think I ever felt that same urge.
But with other patients, I was thinking there was someone, I can't think of an example of something I said. I'm trying to think of a concrete example, but I know that sometimes when I've felt that I've self-disclosed inappropriately, or when I've said too much, which hasn't necessarily been very personal, but maybe I've felt: "Now why did I need to say that?" I get like.... I feel quite embarrassed, I get like a flush, I get very self-conscious, I suddenly think, what have I said, I'm trying to think of an example... and especially in the ward with my in-patients. My out-patients are much easier, my private patients because.... with the in-patients, because they're around all the time and they see the other patients, I think it might be like... I think one time was last year we had a patient that committed suicide and other patients in the ward were also my patients and I had to deal with it in the therapy, and someone asked me um, a few weeks later, something about this young woman who had killed herself. Did I know, and almost without thinking, I

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said, and I was quite honest that that had been quite a shock for me and afterwards, I thought I didn't know if it was therapeutic for the patient to hear that but it was almost as if I didn't think about it before I said it. And then I suddenly felt this flush as if I'd said too much. I'm a bit **vulnerable** now, a bit **exposed**...or...

R: Almost like sticking out like a sore thumb.

T: Yes, that's the experience I had. In retrospect thinking about it, the patient didn't even think, she was fine about it she didn't have the same knowledge about what therapy is **supposed** to be and it was much more my reality about what I had said, but that feeling of being suddenly so self-conscious about what I had said.

R: Almost as if it happened too quickly?

T: Yes, my big issue is that I'm scared I speak without thinking and it's my struggle as a therapist to keep thinking and not just.... I'm not a silent therapist. It's not in me to be that, so.. and my struggle is to moderate my need to connect ..

R: Could we perhaps just go back to that first example? While you were talking, I thought of something. That struggle that you had in the therapy, did the patient pick it up? Did she query your attentiveness?

T: No, she didn't say anything, maybe because she spends a lot of her time in therapy not looking at me. She'll kind of look down, look at her shoe laces, and play with her shoe laces, and she was talking while I was thinking and describing the dream and... and often she's quite silent, and then we're both silent, and I just wait for her sometimes, and I think that what happened, she'd spoken, I started thinking and then she was silent and I just waited for her to

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carry on speaking to me, she then did, so she didn't notice.

R: Was there a time that you thought you're going to tell her?

T: Almost, yes, there was, there was a time when I almost thought that's what you're thinking.... you must stop... I **mustn't say it**, you know, but there was **such a need**, there was a time when I felt I'm about to tell her, it's just going to come out of my mouth and I'm going to regret it, but I kind of said to myself: "I'm going to regret it if I tell her". I don't want to tell her, it's not appropriate for her to know. I don't want her have like that special..... I don't want her to feel she's special because, you know, all it would do is enhance her fantasy that that we've got a special relationship, that I'm not just her therapist, I'm her friend, that she's my most important patient, which she isn't. But she is an important... she obviously has a significance that's more than her but what the whole therapy means, so I kept saying, I knew...... I think my thought was I'll regret it if I tell her, I'll be cross with myself, I'll feel like I was unprofessional, that I was succumbing to my **own** needs and not **her** needs.

R: So the need was arising within yourself. But if seems that you weighed up the therapeutic value?

T: Ja, I was very conscious, I was very... that's why I think the distraction was weighing up the therapeutic value a bit. I thought that also because she's got such a need to be special to be a friend, she articulates it. We've explored it and I've been very firm always in saying: "I'm your therapist, I can't be more than that" She once wrote me a pleading letter about when she wants to cut herself can she phone me at any time. And I said no she couldn't that she must phone the ward or she must phone the hospital, or she must phone a friend, but I'm not there, I can't be there for

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her and it wouldn't be helpful. She was very upset with me about that. So I've always tried very hard to keep her focused that this is therapy, and not a friendship. You know, she tried to invite me to a birthday party she was having. She got a friend to phone me to invite me to a surprise birthday party for her, and I had to say no. I had to explain to her that I understood why she wanted me there although it was, it was a very special thing that she asked me from her and it meant a lot to her, that she needed to understand why I couldn't be there. So I think that was why I didn't want her to know that she was even in my dream.

R: Where was your need coming from?

T: Ooh, oh!!

R: I'm not checking you out, but what made you feel you would like to tell her this?

T: I think partly it was an excitement, partly, like a kind of "Wow! we had the same.." such a congruence... or such a co-incidence.

R: Spontaneous.

T: Yes! Like: "Can you believe it? I also dreamt about you!" But I think that the other need was to reassure her that she was important because I think that was her need, because she was saying: "You are in my dreams..." She was saying to me: "I was irritated, you're in my dreams, you're coming into my dreams unbidden.." But I think that what she was really saying is that: "You're so important to me, you mean a lot to me and I want you to be my friend", and I think her need was for me to say: "Yes, you are special, I even dream about you". So I think that was **her** pressure. I **don't** work, like in psychodynamic terms... where there.... there was a kind of a pressure, almost an identification as well, like I also

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dream about you, we're together, we're the same, I'm not your therapist and you are not my patient, we're actually people who dream about each other. So it was her need, I think, to hear in some way that she's special to me or different or that I take her out of the therapy, that I think about her between..... Every now and again she'll say to me at the end of the session: "You've got so many patients, you never think about me or I know...". I know she was cross with me once, she often gets cross with me. She said she was thinking of not coming, it was about the same time as the dream. She was thinking about not coming to the therapy. She was irritated with me, but she came because she knew she would be spiting herself, because I could give away her slot, I could just fill it, I'm busy, and I could just fill her slot with anyone and maybe I was responding to that in her, to say: "No, you are important, I think about you between sessions", or... does it make sense?

R: You're very aware of your, well as you called it, your enmeshment with her in the relationship?

T: Yes, I am...... it's unusual for me... she's the patient I've struggled with the most to keep separate from me because she's very needy, and very dependant. She's the kind that when I suggested..... I was seeing her three times a week and I suggested we take it to two times a week, because she was coping and doing better, she resisted and she was upset with me and felt that she couldn't cope and I felt scared to tell her, I was reluctant to say to her: "Look really you can cope. I can't be here for you, I'm not your mother". I mean I didn't say it to her in those words..... Other people are much better, you know I can say: "You're doing really well and maybe we have to think about terminating". But with her I struggle because she's been very suicidal at times, and she's very serious in her acting out and she's not unlikeable, she's not a nasty girl, so she's..... so there's something that makes me very defensive about her. So it is

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an unusual.. it's probably the most problematic therapy in terms of the countertransference.... There are times she has made me angry....

R: Have you ever told her that?

T: Yes, once, I told her that I thought that she was sabotaging the therapy, and that she needed to spoil things. But I didn't say that I was angry about it, I didn't tell her that I had been angry with her. But there was an incident when I told her that she was sabotaging the therapy, and that she was needing to make me bad. I said that I was refusing to be that and that it was her choice what she wanted to do. She was threatening to terminate, she took an overdose even, and she was never going to come back and see me and I had betrayed her trust forever and ever and basically what I said is: "Your time is here and I'll be waiting for you. If you come, you come, if you don't you phone and tell me you can't come, and then we'll think about terminating". Of course, she came, eventually, about a weeks.. or two weeks worth of trauma...,

R: In instances like this, do you tell about the impact on you, or do you sort of define your role?

T: Well, I've told her if she's made me feel protective of her. I once said that she was making me feel quite protective of her and I wondered what that was about and I think that was because she was telling me a story of where she was a victim, and I said I wondered if she needed people to feel sorry for her.... protective.... because I had felt quite protective when she was telling the story, and once she said to me I looked sleepy. I can't remember what it was. There had been a long, long silence in the therapy. It was late, it was one of these evening sessions. I was so cold, I think I yawned or I moved, and she said: "You're bored!", and I said: "No, I think I'm falling asleep" You know, I

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didn't really lie, I just said I was scared I was going to fall asleep or something, and I think she knew because it was late and she'd been quite for about an hour (laugh) about forty minutes of the session.... she like muttered and she like didn't haven't much to say, it was hard to talk, and she was bored. I have sometimes said what she's done to me, not always interpreted it, just said it..... or just left it there for her to take up, but also to be real but..... because I could have said to her: "No, I'm not bored, why does she think I'm bored?" **But I was**, I was like restless, I was feeling tired, it was late, it was the end of the week. And I thought, look if I lied to her, pretend to her...... That's one of the issues, like sometimes when a patient asks: "Are you cross with me?" and you are cross with them. Sometimes it's not useful to say to them: "Well why do you think that?" and make them doubt their reality, 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?

R: Confirm it for them

T: Ja, just to sometimes be real because with borderline patients particularly, their sense of reality is not always good and they judge reality in such idiosyncratic or egocentric ways so they think you're angry when you aren't, but if they say "Are you irritated with me?" and you are irritated with them and that reflects it accurately, maybe it's not always useful to make them doubt themselves, make them own it all when it is actually also your feeling sometimes as well.

R: So with this person, I almost get the feeling that you're very honest.

T: Well, I try to be. But it's hard sometimes, because she does ask me a lot of inappropriate questions sometimes. She

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asked me the other day: "Do you have a sister?", and I just left it and she carried on about her sister. I mean, ja, she often asks, and I just leave her and she'll often ask again, but those kinds of things like trying to get into my family, I don't think..... asking if I've got a sister suddenly is also like asking if I'm going away in December, but about the sister also... like I don't want to bring my family, my life into this room, it's not for that, it doesn't affect her if I have a sister or not. She's not affected by... you know.... but it's an interesting.... ja... (silence)

R: It's interesting that with a regressed patient one would confirm their perceptions which could then consist of a self-disclosure.

T: Yes, or disconfirm them if they're wrong. Like sometimes she'll ask: "Am I boring you?" and she isn't, then why did she think that? Then I'll explore the fantasy. She didn't ask if she was boring me, she asked if I was tired.... (pause)

R: Is there anything else about self-disclosure, or do you feel you've exhausted it at this stage?

T: I was thinking of another example. It was quite a hard one for me to deal with. It was a private patient who came to see me for the first session. He had been referred to me and he's a gay guy. I knew he was gay, and he hadn't been in therapy. A lot of issues and he said to me: "I want to know what your attitude is...." In the session, we were contracting, we were talking about what was going to be happening, and I asked him if there was anything he needed to ask that I hadn't covered, and he said he'd like to know my real attitude towards homosexuality, not just my professional attitude, not just like to say the right thing. And I was quite astounded
because I'm the kind of person.... I believe I'm very okay

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about homosexuality, um, my boyfriend's brother's gay, and I'm very close friends with a lot of gay people, and it's something I feel I've resolved a long time ago, my issues with it, so I was quite astounded to be questioned like that you know, (laugh) by a patient in such a direct way, such a challenging way... your **real** attitude, not your professional attitude, like I accept anything..... or that I say: "Well, actually I'm a Kleinian therapist and I think it's an element of narcissism", or whatever, and I was so taken aback and I didn't know how to answer him. I was lost for words and I think he saw that, that I was quite.... and in the end I said to him: "Well. I can't ..." Obviously I said to him, something like, um... he obviously thinks my professional attitude is that I accept it but that he doubts that I'm genuine but I can't prove to him that I'm genuine and that he has to give me the chance, or not, as the case may be because I don't think that there's anything I can do that will convince him and that he must just judge me by how I relate... and he took that and he was fine with that but it took me a long time to think what to say to him. Because I wanted to say to him: "I'm fine about gay people. One of my best friends...." It sounds like tripe, so phoney. I thought why do I need to convince him it's okay, it's his issue. And then I could look at it, well it's his issue and why is he so uncomfortable? But also the reality is that there probably are people who are very uncomfortable. There are a lot of psychologists who are uncomfortable, or who don't feel okay about homosexuality, so he has a right to assume that maybe I think that it's a perversion, or immaturity, or a problem. So I had to think... and also because it was the first session and he hadn't decided.... he hadn't had time to think about did he want to come back and see me. I needed to respect his right to know genuinely but I didn't know how to convince him. I didn't know how to say: "No I'm fine, it's really just your issue", because it was his issue not mine. That was a hard one, when you're asked quite a hard question and you feel like there's no answer you

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can give that will satisfy the patient, but that you also feel that you owe him some kind of response, without just avoiding the issue which is a real issue, I think, as well as the patient's issue. I think a patient has a right in some ways to say: "What kind of therapy do you do?" You know, I would feel uncomfortable if I went to someone who was a very religious counselor, and suddenly I realized, like halfway through, that what he believed was that I was living in sin. Often patients have the need to know some basic things about the kind of way you work, but also it's hard to tell.... You can't always describe to someone how you work, because the experience of therapy is in the process of it not in like a three word.. "Well....". And if I knew, like if I could say: "I'm a Jungian analyst" (laugh), you know, but I'm not, you know. I'm still very young and inexperienced and I'm feeling my way. That's quite hard when patients want to know. That was... it hasn't really happened in another way but that particular question did get me now.

R: I suppose it being the first session makes it difficult to handle in the normal therapeutic way.

T: Yes there's no basis for knowing each other.

R: That's right.

T: I did feel that he had a right to know. Because I would be upset if I were to see a therapist and I was a gay and I found out that the therapist thought that it was a problem that I was gay. That wasn't the reason that he was coming to therapy, because he wasn't coming because he was gay. He was coming because of other reasons. He was very clear about why he had come, um, his relationship that had broken up and a lot of direction. It wasn't about now at the age of forty five wanting to be made ungay. If someone comes to me and says "I'm gay and I'm happy about it", it's different. So he came to me and said: "Look this is who I am, is that okay

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with you?" He was saying to me: "I don't want you to change that, don't waste your time trying to resolve my homosexuality!", and the therapy was a very successful one, partly .. I think the tone I set by saying that he must judge me, that it's up to him to choose, I'm not going to give assurances. It was helpful for him, and it was actually a very successful short-term therapy.

T: Is that enough?

R: Yes, thank you.

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

1. **Well, when you ask about self-disclosure it's something that I've thought about a lot because I mean, because I suppose in a way it boils down to also about what I believe therapy is, because I believe that it's a lot about a relationship with the patient, more than even techniques, tricks, gimmicks or interpretations, and sometimes the conflict is about how real you are, and how honest.**

The therapist has frequently expended thought on self-disclosure. Her beliefs about self-disclosure are intimately tied to her approach and conceptualizing of the therapeutic relationship. Ultimately psychotherapy is constituted by a relationship co-constituted by the therapist and patient. The therapist is perplexed and in conflict about how honest and genuine one is within the therapeutic encounter.

(P) therapist's original positioning:

existing deliberations on S-D - prior to the research interview, the researcher had already ruminated over S-D.

(P) therapist's established position:

S-D beliefs tied to conceptualizing of psychotherapy.

psychotherapy as relationship - psychotherapy consists primarily of a relationship co-constituted by therapist and patient.

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(P) therapist's contextual positioning:
<u>confusion as to authenticity of therapeutic presence</u> - therapist perplexed as to the extent to which one should be honest and authentic within the encounter.

2. When someone asks a hard question, what do you do with it?... or a personal question? At what point are you being not real in deflecting the question or turning it back on them and saying: "Well what do you think" or "Why is it important for you to know that about me?"- exploring their fantasy about the question. So sometimes I struggle with the genuineness.

The therapist has no closure on self-disclosures that pertain to inflexible questions posed by patients. The therapist is uncertain as how to respond to these appeals and the question of authentic participation is unresolved for this therapist. To remain anonymous by diverting the question to the patient to focus on his/her speculations and reasons for the question diverts from the natural, spontaneous and actually existing therapeutic relationship. The conflict between being natural and diverting to speculations is mediated by the therapist's need to be authentic.

(P) therapist's contextual positioning:
<u>perplexing enquiry into management of appeals for disclosure</u> - the therapist is perplexed as to how to deal with direct questions from patients. She vacillates between anonymity and authentic participation and responsiveness.

(P) therapist's reflective positioning:
<u>bewilderment regarding authenticity of therapeutic presence</u> - the therapist has been perplexed as to how authentic her participation within the encounter should be.

"The co-incidental dream"

3. The one time that I... and it's not even related to what I'm saying, but the example that I'm thinking of I see a

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young girl that I've seen for a long time. She's twenty three and she's very borderline personality... trait, I mean she's got a disorder but she's quite a miserable young woman and she's very dependant in therapy.

The therapist recalls a young female patient who has been in therapy with her for a long time. She is twenty three years old with disordered personality traits. The therapist experiences her as being miserable and dependant in the therapy.

(I) unfolding therapeutic constellation for S-D:

difficult to contain female patient - a twenty three year old female.

well-established therapeutic alliance - well established, long term;

therapist's experience of dependant and contemptible patient - experiences patient as miserable and senses dependency.

4. **and I see her quite often, I see her at least twice a week, and at one time I was seeing her three times a week after her discharge from the ward, so there's been quite an intensive therapeutic relationship.**

The therapist and patient have an intense relationship in terms of the frequency of their contacts.

(I) unfolding therapeutic constellation for S-D:

well-established alliance with frequent contacts - the therapist sees the patient often which has facilitated the development of an intense therapeutic relationship.

5. **although she's quite blocked in the therapy and that, it's not a very academic kind of a therapy, it's very much a relationship, about a supportive relationship.**

The therapy deviates from principle and theory and the relational and interactional dimensions are fundamental. This relational field represents a "holding" and "containing" environment.

(I) unfolding therapeutic constellation for S-D:

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supportive containment of patient - primary focus is relationship characterized by a holding and containing environment.

6. **We've gone through a number of crises, and she tests the limits constantly. She wants to be friends. I mean we've managed to make that explicit her fantasy of wanting to be friends. Often I think that she pushes boundaries.**
The relationship has been strengthened by the management of moments of impending danger. The patient constantly attempts to transgress the therapeutic boundaries, by seeking more personal involvement from the therapist. These needs have been explicated within the therapeutic frame, and are known to both participants within the field.
(I) unfolding relational matrix for S-D:
explication of patient's needs for intimate involvement - the need for friendship has been explicated and is known by both participants;
patient's attempts to violate therapeutic boundaries - repeatedly attempts to transgress the pre-established therapeutic boundaries.

7. **and the one time about self-disclosure.... I had a dream about her on the weekend. It was a very, very vivid dream and I think it was about a whole lot of things that were going on in the therapy, about her being quite needy and in a crisis in her life and she.....**
The therapist dreamt about the patient. The dream conveyed the pre-reflective, unacknowledged, and implicit dimensions of the therapeutic encounter.
(I) emerging therapeutic constellation for S-D:
therapist's dream reflecting therapeutic constellation - a vivid dream assisted the therapist to confront the as yet unexplicated nature of the therapeutic encounter.

8. **it was my birthday, and she had found out because the year before when it was my birthday, she was in the ward, and**

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all the staff were wishing me happy birthday, and I had brought a cake so she knew it was my birthday, and she'd obviously made a note and she brought me a card and a small gift for my birthday.

The patient had noted the therapist's birthday a year before so that when it occurred again, she presented her with a gift.

(I) unfolding relational matrix for S-D:

<u>incident of extra-therapeutic contact</u> - the patient presented the therapist with a gift for her birthday.

9. **Now because she's a T patient (the hospital) and she doesn't pay me, I accepted the gift, because, you know, I think it was her giving something. We talked about it, but I felt quite uncomfortable. It was like a boundary issue.**

The therapist construed the gift as compensation for the patient not paying for the therapy. This was discussed within the therapeutic context, but the therapist nevertheless felt ill-at-ease about accepting the gift as this represented a transgression of pre-established therapeutic boundaries.

(I) unfolding relational matrix for S-D:

<u>therapist's dis-ease at extra-therapeutic involvement</u> - the therapist accepted the gift but felt that this was a transgression of boundaries;

<u>therapeutic enquiry into extra-therapeutic contact</u> - the therapist's acceptance of the gift was dealt with within the therapeutic context.

10. **So I dreamt about her on the weekend, and in our session after the weekend, she came and she was a bit, um, funny, and she didn't want to talk, she was uncomfortable and she said that she was cross with me, and that she had dreamt about *me* on the weekend, and she'd had a dream and she described the dream.**

The therapist dreamt about the patient and during the following therapeutic contact the patient presented as

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resentful and aloof. She revealed to the therapist that she had dreamt about her and described the dream.

(I) emerging therapeutic constellation:
therapist's dream about patient

(I) emerging relational matrix for S-D
patient's anger at dreaming about therapist - patient angered by the fact that she had dreamt about the therapist.

11. **and I felt such a... I really wanted to tell her that I had dreamt about her. I felt such a *pressure* to tell her but I didn't because I felt like it would be too much information to give her. But it was such an enormous pressure on me, like *internally*. I really just wanted to say to her: "But you know, I also dreamt about you, it's such a co-incidence, we're clearly thinking so much about the same issues!"**

The therapist felt an inner force to link her dream with the patient's. The therapist's pre-reflective need was to spontaneously express the existing similarity. This was sanctioned by the therapist's reflective awareness of not wanting to furnish the patient with more information about herself and her involvement.

(I) emerging relational matrix for S-D:
therapist's inner urge to disclose dream - the therapist experienced an urgent pre-reflective need to reveal her dream to the patient.

(I) non-S-D incident:
restraining need not to furnish patient with personal information

12. **But I didn't because I felt that it was very inappropriate for me to have told her but I did feel this kind of inner pressure to tell her**

The therapist deemed it therapeutically inappropriate to share her dream and refrained. At the same time she experienced an intense and urgent pre-reflective pull to disclose.

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(I) non S-D incident:

<u>therapist's ambivalence about revealing dream</u> - the therapist was trapped between an inner pull to convey dream and a mediated need not to be therapeutically inappropriate.

13. **which I think was about me trying to reassure her that she did mean something to me that the gift meant something to me, it wasn't.... I didn't just discard it** The therapist's need to self-disclose about the dream arose out of her need to reassure her patient that she was significant and that the gift had had personal significance, and that it had not merely been discarded.

(I) emerging relational matrix:

<u>therapist's need to reaffirm patient's significance</u> - the need to relate the dream could have arisen from the therapist's need to reassure the patient that she is significant.

14. **and I felt quite... I was quite distracted when I was.. when she told me about her dream, because I was thinking about my dream**

The therapist was divided during the therapeutic encounter. She was listening to the patient's dream but at the same time focusing on her own dream. This created a diversion of thought for the therapist.

(I) emerging relational matrix for S-D:

<u>therapist's divided attention within therapeutic encounter</u> - the therapist was divided and distracted, difficulty in maintaining focus on patient's dream as she was considering her own dream.

15. **The dreams were the same themes. My dream was also... they were both about us breaking boundaries with each other. Her dream was about that I was seeing her as a private patient, and I went to her house to see her, and my dream I can't even remember what exactly it was, but it also felt**

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like an inappropriate relationship between us, so I think that we were thinking and feeling the same things, and I could use it in the therapy, but my need to tell her that I had the same dream, you know, was quite *powerful*.

The dream content was similar and both dreams symbolized the transgression of the pre-established therapeutic boundaries. The therapist used only the patient's dream as interactional data. The experience of her dream remained for private analysis of the therapeutic interaction. Even though the therapist could utilize the patient's dream as primary therapeutic data, the urge to relate her dream continued to exert great impact in her awareness.

(I) emerging therapeutic constellation:

similarity of dreams - *thematically similar, transgression of therapeutic boundaries;*

therapist's imminent and forceful need to disclose implicating dream.

16. (immense need to relate this to her?) **Yes, to kind of connect it to her, but I didn't and I think I did the right thing by not telling her, um, and by kind of holding back, but I was..... I was astonished at how strong the urge was to tell her, and how much I got then in the therapy..... quite distracted internally thinking I had the same dream, and almost saying: "I mustn't tell her, I must keep quiet now, *hold back! hold back!*"**

The therapist believes that she was therapeutically correct to deliberately refrain from exposing her dream. At the time she was astounded and taken aback by the strength and urgency of her need to tell the patient that she had dreamt about her. Internally she had to instruct herself to forcibly withhold her disclosure.

(I) non S-D incident:

therapist's need to connect dreams

therapist's disarray upon awareness to self-disclose - *the therapist was divided between a strong need to reveal her dream, but at the same time being forcibly withheld.*

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(I) therapist's contextual reflection on S-D:
<u>positive appraisal of withholding dream</u> - therapist believes that she responded therapeutically appropriately.

17. **Ja, it wasn't destructive in the therapy, because I could use *her* dream and also, I think that she was struggling with the same issues about how much can she tell me. I feel like we were reflecting each other in quite an unusual way.**
The therapist's awareness of her own dream exerted no negative effect on the encounter. The therapist believes that she and the patient were both grappling with how much they could disclose to each other and that in this sense they were mirroring one another.
(I) emerging relational matrix for S-D:
<u>shared anxiety about revealing dream content</u> - patient and therapist similar anxieties about revelation.
(I) post-therapeutic situation:
<u>unveiling and investigating the patient's dream</u> - although the therapist did not reveal her dream, she could employ the patient's dream as therapeutic working data.

18. **But with her, she is the patient that.... often she will ask me a lot of personal questions.**
The patient frequently appeals for more intimate knowledge about the therapist.
(I) unfolding relational matrix:
<u>patient's appeals for personal information</u> - the patient's appeals for private and intimate information about the therapist pervade the therapeutic situation.

19. **In fact I saw her yesterday, and she said to me, we had been talking about going away in December, and she asked me am I going away in December and in fact what I did.... I though I gave quite a... I said: " I haven't even thought about it!" instead of just saying to her about the fantasy**

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of being abandoned, I just said: "Look I haven't even thought about it" and she said, no, I must give her six months notice if I'm going away on a holiday.

The patient recently appealed to the therapist to divulge information about her plans for the December vacation. The therapist did not implement this request as therapeutic working data where the patient's fears and fantasies of separation could be addressed. The therapist replied to this request by succinctly stating that she has not yet given the vacation much thought. The patient requested that the therapist give her adequate notice before embarking on a vacation.

(EI-R) S-D incident:

appeal from patient for private information - the patient requests information pertaining to the December vacation.

therapist's neutral response to patient's appeal - does not gratify the patient with information and provides a non-committal answer.

(EI-R) S-D effect:

patient's anxiety about therapist separation - therapist's neutral response stirs separation anxiety in the patient and demands sufficient notice should the therapist take a vacation.

20. **It's all about her neediness, but it was interesting because she's a patient that particularly makes... er requests information about me all the time and the one time when I had such a need to give it to her and she hadn't even asked.**

The patient's appeals and requests for private information about the therapist are pervasive and indwelling within the therapeutic alliance. The therapist is intrigued by the fact that the one particular occasion when she had felt the need to share with the patient, there had been no specific request or appeal.

(I) unfolding relational matrix for S-D:

patient's pervasive appeals for intimate information

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(I) emerging relational matrix for S-D:

therapist's unbidden need to share - *the therapist's need to reveal her dream was not elicited from patient.*

21. (..what happened to you afterwards?) **I felt quite uncomfortable. Firstly, I felt uncomfortable that I had the dream about her and I felt... it was... I can't remember, it was *just so amazing*, I kept thinking it's amazing that somewhere there's such an... almost an enmeshment between us, I mean the boundaries are good in the therapy, but I think we almost.... that somewhere.... it made me think a lot. I mean it was a very thought provoking incident.**

After the incident, the therapist felt uncomfortable. In the first instance, she felt uncomfortable that she had dreamt about the patient. The incident elicited extensive thought and deliberation pertaining especially to the emotional confluence and nature of therapeutic boundaries.

(I) effect of non S-D incident:

therapist's discomfort - *felt uncomfortable that she had dreamt about the patient. The specific incident made her feel ill-at-ease;*

therapist's ruminations about relational entanglement - *incident elicited thought pertaining to entanglement between therapist and patient, and the nature of therapeutic boundaries.*

22. **I thought a lot about how the therapy... she's very dependant on the therapy but also that in some ways I'm also very invested in it. She's done very well, she's managed to... I feel in some ways I've managed to keep her out of hospital so I've invested in it, so it made me feel like....**

The incident summoned the therapist to evaluate the personal significance of the therapeutic encounter. The patient's progress facilitates the therapist's assessment of her professional and therapeutic integrity, and assists her in acknowledging her personal investment in the therapeutic process.

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(I) effect of non S-D incident:

<u>therapist's appraisal of personal investment</u> - evaluated her personal involvement and private gain in terms of her professional integrity. Patient's progress yields a positive assessment.

23. **I suppose one's also in wanting to tell her about the dream maybe to acknowledge also that I'm invested in the relationship, which I wouldn't want her to really *know* but I think that maybe that's what it was about. About how.... I suppose in terms of being a new therapist as well it's important to have patients that are doing well, getting better, and she is one that I feel is getting better. She is doing well so maybe that was it... but I was just thinking about that now.**

Within the interview situation the therapist realizes that revelation of the dream would arise from the need to explicate her personal involvement within the encounter. The therapist is aware that being a new and inexperienced therapist, she needs confirmation of her capacity and that a patient who is progressing well could supply this confirmation.

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

<u>ambivalence about revealing investment</u> - the dream would indirectly reveal and convey the therapist's personal involvement and meaning of the involvement, the therapist wouldn't directly acknowledge this to the patient;

<u>therapist's need for affirmation</u> - patient's progress affirms inexperienced therapist's professional capacity.

24. (evaluated the relationship?) ***Absolutely,* it was quite *powerful*. I was *uncomfortable afterwards*. After the session even, I felt like... it was right at the end of the day. I drove home kind of feeling a little bit unsettled, and it did provoke a whole lot of thoughts for me and feelings, and also critical, I was thinking, I'm very inappropriate, maybe I've got to evaluate how I feel about the patient, and why she's**

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so important.

The S-D compelled the therapist to evaluate the therapeutic relationship. She took the disclosure beyond the temporal and physical boundaries of the therapeutic situation to reappraise her involvement with the patient. She assumed a critical stance and deemed her responsiveness therapeutically inappropriate.

(I) effect of non S-D incident:

therapist's discomfort - *realized the implicit involvement, and reappraised her personal involvement and entanglement;*

therapist's re-appraisal of personal involvement - *condemned herself for inappropriate therapeutic involvement and realized the need to assess patient's significance.*

25. **And why I dream about her is an issue in itself. You know I do dream about patients every now and again, but I think with her because it's a very significant therapy, made me think about how important the therapy was for me in terms of my self-esteem and my... because I've struggled with her a lot, I mean she went through a time when she felt she had been betrayed by me, so she was very angry and I struggled to kind of.. to help her to stay in therapy and also for me not to be angry with her about her acting out. So it was a very interesting experience.**

The dream in itself is a cause of concern for the therapist. It is not unusual or atypical for the therapist to dream about patients. This particular therapy stands out for the therapist because of the enhancing effects on her self-esteem. The therapist has experienced very trying times with this particular patient. She has had difficulty in ensuring that the patient did not sabotage or compromise the relationship and has had to successfully contain and manage her own anger when the patient has explicitly expressed her inner emotion, conflict, and turmoil. These factors comprise a difficult therapeutic process, and its successful

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management has enhanced the therapist's self-esteem and worth thereby giving the therapy its personal significance in the therapist's therapeutic life-world.

(I) unfolding relational matrix for S-D:

patient's expressed anger at feeling betrayed - therapist's containing of personal emotion upon patient's expressed emotional turmoil - therapist contained her own anger and did not make it public within therapeutic encounter.

(I) effect of non S-D incident:

appraising the personally enhancing dimensions of the therapeutic encounter - therapist assessed the personal significance of the encounter specifically in terms of her self worth and esteem as beginning therapist.

26. (urge arise again?) **No, not in the same way, because normally with her, as I say, in the therapy, I'm much more... I feel like I try to model like just being real, So, I will talk about a movie I've seen if she's talking about a movie, and says: "Have you seen the movie?" I will say: "Ja, I've seen it" and I don't feel like it's an urge to tell her, rather than me use that as a common experience to talk about what she thought of it and what I underst... so I don't think I ever felt that same urge.**

The therapist is typically real within the therapeutic encounter. If the patient asks a question about something that is being discussed, such as if the therapist saw a particular feature, she will respond to the question. This response does not represent a need from the therapist's side but rather an opportunity to express commonality. The therapist does not recall having felt the same urge to self-disclose again.

(I) post incidental therapeutic situation:

modelling authenticity

authentically sharing common experiences - if the question is related to the therapist's knowledge about what is being discussed, the therapist answers concisely.

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27. **But with other patients, I was thinking there was someone, I can't think of an example of something I said. I'm trying to think of a concrete example, but I know that sometimes when I've felt that I've self-disclosed inappropriately, or when I've said too much, which hasn't necessarily been very personal, but maybe I've felt: "Now why did I need to say that?" I get like.... I feel quite embarrassed, I get like a flush, I get very self-conscious, I suddenly think, what have I said, I'm trying to think of an example...**
The therapist attempts to recall a specific incident, and recalls the felt sense of having disclosed inappropriately. Upon such disclosure, she immediately questions her need, feels embarrassed, and feels very aware of herself within the encounter.

(P) therapist's contextual positioning:
<u>therapist's vulnerability upon spontaneous S-D</u> - becomes very aware of herself, feels at odds, and critically questions her need to disclose.

28. **and especially in the ward with my in-patients. My out-patients are much easier, my private patients because.... with the in-patients, because they're around all the time and they see the other patients, I think it might be like...**
The in-patients threaten the therapist's privacy as they remain within the immediate physical surroundings after each therapeutic contact.

(P) therapist's contextual positioning:
<u>inevitable extra-therapeutic institutional involvement</u> - the in-patients are physically present between therapeutic contacts which threatens the therapist's privacy.

29. **I think one time was last year we had a patient that committed suicide and other patients in the ward were also my patients and I had to deal with it in the therapy,**
The therapist recalls that last year a patient had committed

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suicide. The fellow patient in the same ward were also the therapist's patients and this had to be dealt with within the therapeutic frame.

(EI-P) unfolding therapeutic constellation for S-D:

intruding extra-therapeutic institutional event - *mutual contact committed suicide, therapist had to manage this therapeutically with each patient.*

30. **and someone asked me um, a few weeks later, something about this young woman who had killed herself. Did I know, and almost without thinking, I said, and I was quite honest that that had been quite a shock for me and afterwards, I thought I didn't know if it was therapeutic for the patient to hear that but it was almost as if I didn't think about it before I said it. And then I suddenly felt this flush as if I'd said too much. I'm a bit vulnerable now, a bit exposed...or...**

A patient directly asked the therapist whether she knew about the suicide of a fellow patient. Without reflection the therapist responded and admitted that it had been a shock to her. The therapist considered her remark afterwards and questioned the therapeutic value of her spontaneity. The therapist did not mediate her response, and she immediately felt conspicuous and exposed.

(EI-P) S-D incident:

patient's question pertaining to institutional incident - *directly asked the therapist if she knew of the suicide;*

therapist's affirming response to patient's question - *spontaneous revelation of affect.*

(EI-P) effect of S-D:

therapist's discomfort at feeling exposed - *felt conspicuous and exposed, questioned the therapeutic value for the patient.*

31. **Yes, that's the experience I had. In retrospect thinking about it, the patient didn't even think, she was**

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fine about it she didn't have the same knowledge about what therapy is supposed to be and it was much more my reality about what I had said, but that feeling of being suddenly so self-conscious about what I had said.

Assuming a backward glance, the therapist is able to acknowledge that the patient was not aware of the pre-established notions about the therapeutic process and the therapist's participation within this frame. The therapist perceived that the self-disclosure had no noticeable impact on the patient.

(EI-P) effect of S-D:

> *patient's oblivion to effect on therapist - the therapist could not sense that her reaction had any effect on the patient as she had no established knowledge about average therapeutic discourse.*

32. **Yes, my big issue is that I'm scared I speak without thinking and it's my struggle as a therapist to keep thinking and not just.... I'm not a silent therapist. It's not in me to be that, so..and my struggle is to moderate my need to connect ..**

The therapist is anxious and wary of responding spontaneously without first mediating her response. The therapist's way of being does not harmonize with being taciturn.

(P) therapist's contextual positioning:

> *anxiety about spontaneous participation - the therapist is wary of not mediating her need to spontaneously link with a patient.*

(P) therapist's established position:

> *active, verbal participation during encounter - abstinence from verbal participation is not in concert with therapist's way of being.*

33. (did the patient query attentiveness?) **No, she didn't say anything, maybe because she spends a lot of her time in therapy not looking at me. She'll kind of look down, look at her shoe laces, and play with her shoe laces, and she was**

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talking while I was thinking and describing the dream and... and often she's quite silent, and then we're both silent, and I just wait for her sometimes, and I think that what happened, she'd spoken, I started thinking and then she was silent and I just waited for her to carry on speaking to me, she then did, so she didn't notice.

The patient was oblivious to the therapist's division of attention as she typically remains detached during the therapeutic encounter.

(I) emerging therapeutic constellation for S-D:

<u>patient's oblivion to therapist's inner turmoil</u> - detached, unaware of therapist's internal turmoil about revealing her dream.

34. (.... a time you thought you're going to tell her?) **Almost, yes, there was, there was a time when I almost thought that's what you're thinking... you must stop... I *mustn't say it*, you know, but there was *such a need*, there was a time when I felt I'm about to tell her, it's just going to come out of my mouth and I'm going to regret it, but I kind of said to myself: "I'm going to regret it, if I tell her" I don't want to tell her, it's not appropriate for her to know. I don't want her to have like that special... I don't want her to feel she's special because, you know, all it would do is enhance her fantasy that that we've got a special relationship, that I'm not her therapist, I'm her friend, that she's my most important patient, which she isn't.**

The therapist was mediating her pre-reflective and urgent need to disclose her dream to the patient and her reflective awareness of what it would ultimately mean. The therapist was trapped between this sense of urgency and the fact that it would reveal to the patient her significance to the therapist. This would enhance her already existing assumptions that the relationship was more intimate.

(I) emerging therapeutic constellation for S-D:

<u>therapist's inner turmoil about revealing implicating</u>

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<u>dream</u> - trapped between an urgent pre-reflective need to reveal dream to patient, and the effect this would have on the patient's existing assumptions.

35. **But she is an important... she obviously has a significance that's more than her but what the whole therapy means, so I kept saying, I knew... I think my thought was I'll regret it if I tell her, I'll be cross with myself, I'll feel like I was unprofessional, that I was succumbing to my own needs and not her needs.**
The patient is significant to the therapist but more in terms of the fact that she represents part of a therapeutic process that is gratifying to the therapist. The therapist could anticipate her distress should she disclose to the patient, and that it would mean that she had transgressed her pre-established and principled therapeutic boundaries to gratify her own needs.
(I) emerging therapeutic constellation for S-D:
<u>therapist's anticipation of regret at being disclosing</u> - realized that she would be disappoint herself for gratifying her own needs.

36. (weighed up the therapeutic value?) **Ja, I was very conscious, I was very... that's why I think the distraction was weighing up the therapeutic value a bit. I thought that also because she's got such a need to be special, to be a friend, she articulates it. We've explored it and I've been very firm always in saying: "I'm your therapist, I can't be more than that".**
The therapist was divided and distracted as she had to monitor the therapeutic value of being disclosing about her dream. The patient's need for more intimate contact with the therapist has been managed therapeutically, and the therapist has always been consistent in confirming the boundaries and sanctioning her role as therapist.
(I) emerging therapeutic constellation for S-D:
<u>therapist's division of thought</u> - attempting to monitor

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the therapeutic value of being disclosing while remaining focused on the patient.

(I) unfolding relational matrix for S-D:
patient's needs for intimate contact - explicated and managed therapeutically.

37. **She once wrote me a pleading letter about when she wants to cut herself can she phone me at any time. And I said no she couldn't that she must phone the ward or she must phone the hospital, or she must phone a friend, but I'm not there, I can't be there for her, and it wouldn't be helpful. She was very upset with me about that.**
The therapist recalls a specific incident where the patient desperately appealed to her to be available beyond the immediate encounter should she need to injure herself. The therapist refused this request and suggested that she contact either the hospital or a friend. The patient was disturbed by the therapist's inaccessibility.

(I) unfolding relational matrix for S-D:
patient's appeals for permanent therapist support - requested that the therapist be permanently available; therapist's management of appeal for permanent containment - referred her to other possible sources of assistance, explicated, sanctioned, and confirmed the extent of her therapeutic involvement and availability.

38. **So I've always tried very hard to keep her focused that this is therapy, and not a friendship. You know, she tried to invite me to a birthday party she was having. She got a friend to phone me to invite me to a surprise birthday party for her, and I had to say no. I had to explain to her that I understood why she wanted me there although it was, it was a very special thing that she asked me from her and it meant a lot to her, that she needed to understand why I couldn't be there. So I think that was why I didn't want her to know that she was even in my dream.**
The therapist has persistently made the patient aware of the

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therapeutic nature of their relationship. The therapist recalls an incident where the patient arranged with a friend to invite her to a birthday party. The therapist managed this request by explicating the boundaries and this served as another reason why she wished for the patient not to know that she had dreamt of her.

(I) unfolding relational matrix for S-D:

<u>defining/clarifying the therapeutic relationship</u>
<u>patient's disguised appeals for extra-therapeutic contact</u> *- the patient attempted to transgress therapeutic boundaries by involving the therapist extra-therapeutically;*
<u>securing therapeutic boundaries upon appeal for extra-therapeutic involvement</u> - therapist confirmed the therapeutic boundaries.

39. (your need?) **I think partly it was an excitement, partly, like a kind of "Wow! we had the same..." such a congruence... or such a co-incidence. Yes, like: "Can you believe it? I also dreamt about you!"**
Spontaneously and pre-reflectively the therapist was strongly aroused by the co-incidence of the same dreams. There was a spontaneous need to link with the patient.

(I) emerging therapeutic constellation for S-D:

<u>therapist's need to convey similarity</u> - aroused by the striking similarity, spontaneous need to link with the patient.

40. **But I think that the other need was to reassure her that she was important because I think that was her need.**
The other need was to reassure the patient that she was significant. The therapist sensed this need from the patient.

(I) emerging relational matrix for S-D:

<u>therapist's felt sense of patient's need for significance</u> - sensed the patient's need for reassurance of her significance.

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41. **She said: "You are in my dreams..." She was saying to me: "I was irritated, you're in my dreams, you're coming into my dreams unbidden..."**
The patient was angered and resentful of the therapist's pervasive and indwelling presence.
(I) emerging relational matrix for S-D:
patient's agitation at therapist's indwelling presence - resentful of the therapist's unbidden and indwelling presence.

42. **But I think that what she was really saying is that: "You're so important to me, you mean a lot to me and I want you to be my friend" and I think her need for me to say: "Yes, you are special, I even dream about you". So I think that was *her* pressure.**
The therapist senses that the patient was actually trying to convey the therapist's significance to her, and that she needed affirmation from the therapist that she too was significant to her.
(I) therapist's contextual reflection on S-D:
therapist's sensing of patient's need for intimate involvement - sensed that the patient needed affirmation of her significance to the therapist. The therapist also sensed an appeal from the patient for more intimate contact.

43. **I don't work, like in psychodynamic terms... where... there was a kind of a pressure, almost an identification as well, like I also dream about you, we're together, I'm not your therapist and you're not my patient, we're actually people who dream about each other.**
The therapist does not conduct psychotherapy psychodynamically. There was a sense of mirroring and similarity where the therapeutic roles were abandoned for a relational entanglement and confluence.
(P) therapist's established position:
refuting a psychodynamic working context - the therapist

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does not create a psychodynamic working context and environment.

(I) emerging therapeutic constellation for S-D:
<u>therapist's sense of mirroring</u> - the therapist sensed an existing confluence and mirroring of her and the patient's needs.

44. **So it was her need, I think, to hear in some way that she's special to me or different or that I take her out of the therapy, that I think about her between...**
The therapist believes that the patient had a need to hear that she was special and important to the therapist and that she merited thought beyond the therapeutic frame.

(I) emerging relational matrix for S-D:
<u>therapist's felt sense of patient's need for extra-therapeutic thought and consideration</u> - believes that the patient needed to hear from the therapist that she was special and that the therapist considered her beyond the immediate therapeutic encounter.

45. **Every now and again she'll say to me at the end of the session: "You've got so many patients, you never think about me or I know... " I know she was cross with me once, she often gets cross with me. She said she was thinking of not coming, it was about the same time as the dream. She was thinking about not coming to the therapy. She was irritated with me, but she came because she knew she would be spiting herself, because I could give away her slot, I could just fill it, I'm busy, and I could must fill her slot with anyone and maybe I was responding to that in her, to say: "No, you are important, I think about you between sessions".... or does it make sense?**
The patient is resentful and feels threatened by the therapist's divided attention between fellow-patients. The therapist recalls a specific moment when the patient was angered by the fact that should she not arrive for therapy, and the therapist could use this time for another patient.

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The therapist senses that she might have been responding to the patient's feelings by feeling the need to reassure her of her significance and the fact that she does emerge in her awareness beyond the immediate encounter. The therapist is uncertain about whether the interviewer has grasped what she is saying.

(I) unfolding relational matrix for S-D:

patient's anger at therapist's involvement with other patients - angered and frustrated by the therapist's involvement with fellow-patients.

(I) emerging relational matrix for S-D:

therapist's awareness of need to affirm patient's personal significance - senses that she could have been responding to the patient's need for affirmation of her importance.

46. (aware of enmeshment?) **Yes, I am.... it's unusual for me.. she's the patient I've struggled with the most to keep separate from me because she's very needy, and very dependant. She's the kind that when I suggested we take it to two times a week, because she was coping and doing better, she resisted and she was upset with me and felt that she couldn't cope and I felt scared to tell her, I was reluctant to say to her: "Look really you can cope. I can't be here for you, I'm not your mother". I mean I didn't say it to her in those words.**

The emotional and relational confluence of this therapeutic contact stands out as atypical in the therapist's awareness. The therapist has had to forcibly maintain distance by keeping the patient's need for more involvement at bay. The therapist's attempts to separate and to create more distance in terms of frequency of contacts have been met with resistance. The therapist is fearful and hesitant to directly state her unwillingness to fulfil a mothering and nurturing role for the patient's dependency needs.

(I) unfolding relational matrix for S-D:

patient's resistance to securing therapeutic boundaries -

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whenever the therapist has attempted to confirm therapeutic boundaries the patient has resisted;
<u>therapist's anxieties about relational enmeshment</u> - fearful to disconfirm mothering and nurturing role.

47. **.....Other people are much better, you know I can say: "You're doing really well and maybe we have to think about terminating". But with her I struggle because she's been very suicidal at times and she's very serious in her acting out and she's not unlikeable, she not a nasty girl, so she's... so there's something that makes me very defensive about her.**

The therapist recalls other patients with whom it has been an inevitable, natural, and spontaneous process to reduce the frequency of contacts. With this particular patient, the therapist has difficulty in limiting contacts and she (the therapist) is ambivalent and uncertain about the extent of her involvement and her feelings about the patient. The patient often overtly expresses her inner conflicts and emotion and has threatened to commit suicide. The therapist experiences an inexplicable and undefined pull to protect the patient.

(I) unfolding relational matrix for S-D:
<u>patient's disruptive expression of inner turmoil</u> - overtly expresses inner conflicts and insecurities;
<u>therapist's defensive attitude towards patient</u> - the therapist experiences a pull to nurture patient, yet fears patient's resentment at separating.

48. **So it is an unusual... it's probably the most problematic therapy in terms of the countertransference...**

This therapeutic contact stands out in its prominence in terms of the therapist's involvement within the therapeutic alliance.

(I) unfolding therapeutic constellation for S-D:
<u>therapist's comparative view of complexity of therapeutic encounter</u> - the therapist considers this therapeutic

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relationship to be the most complicated in terms of her involvement.

49. **There are times she has made me angry... (ever told her?) Yes, once I told her that I thought that she was sabotaging the therapy, and that she needed to spoil things. But I didn't say that I was angry about it, I didn't tell her that I had been angry with her.** The therapist has felt angered by the patient. She recalls an incident when she revealed to the patient that she was of the opinion that the patient had a need to damage the therapeutic process. She did not explicitly reveal her immediate experience, namely anger, at what the patient was doing.
(EI-R) S-D incident:

therapist's expression of patient's disruptive impact - reveals opinions about patient's needs, but does not directly convey affect.

50. **But there was an incident when I told her that she was sabotaging the therapy, and that she was needing to make me bad. I said that I was refusing to be that and that it was her choice what she wanted to do.**
The therapist recalls an incident during which she sensed that the patient was attempting to damage the therapeutic process by destroying the therapist's image. The therapist revealed that she was not going to fall victim by assuming this negative image, and gave the patient the option to manage the transaction as she desired.
(EI-R) S-D incident:

experiencing the patient's destructive attitudes refusing to be the object of patient's destructive attitudes - the therapist shared with the patient her experience of being negatively perceived and placed the onus on the patient to manage the situation

51. **She was threatening to terminate, she took an overdose even, and she was never going to come back and see**

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me and I had betrayed her trust forever and ever and basically what I said is: "Your time is here and I'll be waiting for you. If you come, you come, it you don't you phone and tell me you can't come, and then we'll think about terminating".

The patient was outraged, revengeful, and attempted to place within the therapeutic field the possibility of terminating the relationship. The therapist confirmed the structural boundaries of the therapeutic situation and placed a choice within the therapeutic space for the patient to muse over. The confirmation provided the patient with a choice to either return or to abandon. The therapist short-circuited the patient's rage.

(EI-R) effect of S-D:

patient's outrage at therapist's withdrawal from role-assumption - the patient was outraged and threatened to sever the therapeutic bond.

therapist's management of patient's outrage - secured the therapeutic structure and boundaries.

52. **Of course, she came, eventually about a week's... or two weeks worth of trauma....**

The patient returned to the psychotherapeutic contact.

(EI-R) effect of S-D:

patient's reaction to therapist's containment - the patient resumed therapy.

53. (?) **Well, I've told her if she's made me feel protective of her. I once said that she was making me feel quite protective of her and I wondered what that was about and I think that was because she was telling me a story of where she was a victim, and I said I wondered if she needed people to feel sorry for her... protective... because I had felt quite protective when she was telling the story,**

The therapist has acknowledged feeling defensive of protective of the patient. This constituted a disclosure in terms of the therapist's immediate experiencing. This

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constituted therapeutic data in that the therapist's experience was weighed in terms of extra-therapeutic relationships in the patient's life-world.

(EI-R) S-D incident:

sharing need to protect patient - the therapist acknowledged that she was feeling protective of the patient, and questioned the effect that the patient has on people generally.

54. **and once she said to me I looked sleepy. I can't remember what it was. There had been a long, long silence in the therapy. It was late, it was one of those evening sessions. I was so cold, I think I yawned or I moved, and she said: "You're bored!" and I said: "No, I think I'm falling asleep!" You know I didn't really lie, I just said I was scared I was going to fall asleep or something, and I think she knew because it was late and she'd been quiet for about an hour (laugh) about forty minutes of the session... she like muttered and she like didn't have much to say, it was hard to talk, and she was bored.**

The therapist recalls an incident where the patient told her that she appeared sleepy. This was preceded by a period of silence. The therapist can recall feeling cold and having either yawned or shifted. The patient then confronted her and suggested that she was bored. The therapist refuted this and said that she was afraid that she was going to fall asleep. The therapist sensed that the patient would realize this due to the nature of the particular session in which she (the patient) had not participated enthusiastically.

(EI-P) emerging therapeutic constellation for S-D:

passive, no -communicative therapeutic contact - silent session, patient non-communicative, expressed boredom.

(EI-P) S-D incident:

patient confrontation of therapist's boredom - accuses therapist of being bored;

therapist's response to confrontation - disconfirms patient's perception and acknowledges being fearful of

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falling asleep.

55. **I have sometimes said what she's done to me, not always interpreted it, just said it... or just left it there for her to take up, but also to be real but....**
because I could have said to her: "No I'm not bored" why does she think I'm bored. *But I was,* **I was like restless, I was feeling tired, it was late, it was the end of the week. And I thought, look if I lied to her, pretend to her...**
The therapist has often revealed the patient's impact on her with the purpose of being authentic. The therapist realizes that she could have disowned her immediate experience and queried its validity in terms of the patient's experiencing.
(EI-P) unfolding relational matrix for S-D:
existing incidents of sharing to be authentic
(EI-P) emerging therapeutic constellation for S-D:
therapist's tiresome experience of encounter - the therapist felt restless and experienced the encounter as tiresome;
(EI-P) therapist's contextual reflection on S-D:
awareness of possibility to deny experience - the therapist is aware that she could have denied her experience and deflected it onto the patient to question her perceptions.

56. **That's one of the issues, like sometimes when a patient asks: "Are you cross with me?" and you are cross with them. Sometimes it's not useful to say to them: "Well why do you think that?" and make them doubt their reality, 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.**
The therapist is aware that it might not be therapeutically beneficial to deny one's own experience. To question their perception is especially not advisable for borderline personality disordered patients. The therapist feels that it might be more beneficial to them to confirm their perceptions

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of the situation, and to confirm their sense of reality if it is accurate and not based on self-centred assumptions.

(P) therapist's established position:

<u>confirming patients' perceptions of therapist</u> - more advisable to confirm reality testing especially with borderline disordered personalities.

57. (confirm) **Ja, just to sometimes be real because with borderline patients particularly, their sense of reality is not always good and they judge reality in such idiosyncratic or egocentric ways so they think you're angry when you aren't, but if they say: "Are you irritated with me?" and you are irritated with them and that reflects it accurately, maybe it's not always useful to make them doubt themselves, make them own it all when it is actually also your feeling sometimes as well.**

The therapist has discovered that borderline personality patients assess reality in self-centred, individual and peculiar ways. For this reason she suggests that one not repudiate one's immediate experiencing if such a patient has perceived and reflected this accurately.

(P) therapist's established position:

<u>authentic patient responsiveness to accurate patient perceptions</u> - the therapist suggests that one confirm perceptions of borderline patients so as to assist their reality testing.

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Protocol four, therapist D: Female therapist, 20 years experience.

T: I'm aware of times where a patient, um, tells you something or communicates something which touches very closely on a personal experience and where one would share that personal experience if it were a friend, um but it's very difficult now to think of an example.

R: That's okay..

T: I am aware of controlling that, I'm also aware that in my work I very much try to think about my response, whether it is an overt or an internal response so I'm aware of the fact that I'm wondering **why** at this point, um, I'm wanting to share something, um, you know that sometimes it's almost a way, um, a way of....sometimes it's an empathic thing and sometimes maybe it's a defensive thing you know that one almost **could** detract from the pain of something that's happening or your own feelings of helplessness in what is happening, um, and sometimes I think it's even quite a narcissistic thing in the sense on the therapist's part as if to say: "Well, you know I managed it in this way..." um you know, and to be able to then think what is being communicated to me at this moment that **I'm** responding in a way that I want to bring myself into the picture. But, um, so I can speak about it again generally. I know that all sorts of things are happening when those self-disclosures happen but it's very difficult to think of an example to give you....

R: Well, you can speak generally, and maybe you will..you may hit on something, or recall a specific person and then you can tell me. Because I hear what you're saying. You're sort of internally evaluate **why** you feel this need or urge to self-disclose. You work through these issues with yourself.

T: Yes, yes.

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R: Could we refer back to that helplessness that you spoke of earlier. Does this refer to you as the therapist?

T: Yes, yes, well I think it was... again it would be more helpful to you if I could give you an example but I think it's very often that I am...... I mean that when that happens it can actually be quite useful because it makes me think about how helpless the patient is feeling which is making, you know I'm introjecting something. Something's been projected into me of the patient's helplessness. I'm then wanting to, I'm feeling helpless, I'm then wanting to **do** something, you know, whether it's self-disclosure or whether it's even making some kind of suggestion about behaviour, which then if I.... if I can give myself, time to think about that in the work in the session can allow me then to er to reflect to the patient maybe how helpless he or she is feeling or sometimes you know if I'm very clear about it and I think this is a thornier issue that she's wanting me to feel as helpless as she felt, or he felt in a particular situation, you know, that I become that helpless child or the mother who is making me feel helpless. I mean, not that I'm saying that I am feeling helpless to the patient but that I would say: "Perhaps you're wanting me to..... you know the only way of communicating you feeling is that you want me to feel as helpless as you were feeling..".... um because I don't believe that self-disclosure is, um, helpful to the patient. I think it burdens the patient with you know...but perhaps there is an indirect way of doing it and that is with you know things like: "It seems you're wanting me to be angry with you" or "you're wanting me to punish you or to retaliate....." you know...

R: Yes, in a sense it's sort of indirect disclosure but with the focus still on the patient, ...on the interaction...

T: yes, yes

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R: ...so you're talking about the case where you sense what you're feeling to try to detect what's happening in the therapeutic field.

T: Yes.

R: So if you think of self-disclosure, that's what comes to your mind.

T: Mmm, mmm.

R: Are there maybe specific patients that you could think of?

T: (pause). It's difficult to think off-hand, you know, because it happens now and again. It's not something that I'm struggling with all of the time, by any means or struggling with all the time with a particular patient. I think there are moments in the therapy where something.... you know where you almost have to .. where I almost have to bite my tongue, you know, um, I think also I have had to struggle in my work with the fact that I used to be a teacher so you know I have to... just as a medical person becoming a therapist has to struggle with you know telling the patient what to do. I have to struggle with being didactic. There's a kind of inclination to teach, to be didactic, which is also very unhelpful, and sometimes one can use one's own experience to say you know this and this is what happened, and so it's something I'm aware of over the years, I've had to sort of, um, monitor in myself.

R: It's been a whole process for you to change from one mode of relating to the other?

T: Yes, yes.

R: I see. So do you find that this is in your mind as well when self-disclosure comes to the fore.

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T: Yes it almost seems like a self-disclosure would be a way of um directing the patient towards something. The other thing I think that also comes up in self-disclosure is um sometimes one feels very warmly towards the patient you know um for instance, um, er, I was married to a man who had custody of his children so I was a step-mother for many years so when I have worked with people who are in that situation and are being a step-mother or step-father and I'm feeling very sympathetic to their situation but also aware of ways in which I solved that problem or didn't solve that problem for that matter, you know again in a normal social situation one would share that...

R: Yes..

T:..and it seems almost at times **withholding** not to, and yet 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. But there are moments when it, you know, where it certainly occurs to me what has happened to me, or you know, or that it would almost ..or it feels almost as if it would be helpful, but I know only too well it wouldn't be.

R: And generally you would refrain from..

T: Yes, oh definitely

R: What is the sort of issue, that makes you decide I'm not going to do it?

T: Oh I think it's my theoretical understanding. It's not an issue at that time or an issue at another time. It's really my theoretical understanding. I work in an object relations way. I work in terms of the transference and I feel that it's very unhelpful to a patient. I think the patient's

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fantasies about you and about what goes on in your life are what you work with and I think it's really not helpful, so..I **know** that and I **believe** it, you know. Sometimes when it has happened in the past I know patients would say: "I was so glad when you told me that because it felt that you were human..." and they would sort of feel a kind of a warm chummy-chummy thing with me which again is not...

R: You're not comfortable with that relationship in therapy

T: No, no, I don't think it's helpful.. I'm **not** my patient's friend in a different way. I'm hopefully on my patient's side which doesn't mean siding ***with***, but you know, I think it's..I think it's very often a ...ultimately quite a narcissistic thing on the part of the therapist. You know having to bring herself, or himself into the picture.

R: I understand. If we can get back to earlier about the projective identification that transference-countertransference reaction that you spoke about, it seems to me that, that is where you would interact, from yourself, with a patient, indirectly.

T: Indirectly, yes indirectly

R: So that would be your way of working..

T: But I think that one has to be very careful in interpreting projective identification because again you know you have to really be very sure about it, it could be your own stuff, you know the patient may have trod on a sensitive spot where you are feeling hurt or angry or um helpless or whatever, it may entirely be your stuff, and it's terribly important to give yourself time to think about it before coming out with: "You're wanting me to feel ...." which you know you're somewhere feeling....(pause)

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R: So in that sense it seems as though the disclosure constitutes part of the interpretation?

T: (pause)..in the sense that if you make projective identification interpretation the patient may may well feel that you are feeling helpless or that you are feeling angry but the difference about that is, and now we're talking about self-disclosure of an emotion rather than self-disclosure of some experience that you have had yourself okay. The patient may well feel that you have felt angry or have felt helpless....

R: Yes..

T: .....but the difference of course is that again hopefully, if you have chosen your moment correctly, if you are right about it, if you have genuinely processed that feeling and are not somewhere using it in a retaliatory way, um, the patient is able to feel that something real is happening between the two of you but that you are not using it against the patient or using it in a defensive way.

R: Right, so it's quite a delicate balance to attain that stance..

T: I can give you a good ex...I use the couch a lot, okay

R: Okay..

T: So um, I had a patient who was somehow, who seemed really to be using the therapy. She was...her relationship with her parents was changing, her relationship with her, um, with her husband was changing, and yet something wasn't changing in the room. Um she would come in and talk a great deal and I found myself very, very sleepy. In fact, on one or two occasions I actually nodded off, you know, but her voice would sort of bring me back. I would sort of nod off for a

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split second but it was a hell of an effort staying awake,.....staying with her. Now.... (pause) and I was thinking, I was trying to understand this but I was so sleepy that I almost couldn't think in the session, so one way of doing it would have been to say in the session if it was a self-disclosing thing: " I am feeling very sleepy" you know, which might have made the patient feel I am very boring, okay....

R: Right, right..

T: But I was able to think about if afterwards and what I realised was happening.... because I really couldn't think about it in the session.... it was as if I wasn't able to think, was that in order to deal with her family situation she had had to distance herself from her parents, and that what was happening, that although there was all this talk it was a way of distancing herself. It was also a way of protecting herself from any silence because she was a very, um, parental child in the family. And the next time it happened I was able to say and of course because I thought about it, means I was thinking I wasn't so sleepy, but I was also....you know, I was able to say: "I'm aware of the fact that you hardly give me a word in edgeways in the session and I wonder whether somewhere it is, that although you express a lot of appreciation of the work and talk about feeling safe with me, I don't think you really do and I think you're having to distance yourself from me in the way that you had to distance yourself from your mother, and that your sexual difficulties with your husband whom you love and depend on enormously are a way of your perhaps....", well I didn't say this all at once, but I could link it afterwards.

R: Yes

T; You know in all of her relationships there was a point beyond which she was afraid to go and it was happening in the

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therapy, which would have been, which was much more useful than to say: "I am feeling sleepy" or "You make me..*You make me* fall asleep!", you see. But I'd actually had to think about it outside of the session.

R: So you processed what was happening in terms of the projective identification. Were you becoming her?

T: Where I become the her who doesn't feel as if she can contact the mother.

R: So in a sense it was a disclosure. You were sharing quite a lot of your thought with her..

T: Yes, except that I was processing I was saying... I mean she could obviously interpret from that that I feel distanced from her, but I was saying... I wasn't saying: "I feel I have to push you away!" or "I feel I have to fall asleep!" I was saying, you know: "..you need....you're having to distance yourself.."

R: Did that ever become explicit, your feeling tired.

T: Yes, oh yes! Oh you mean with her?

R: Yes.

T: No, oh no, no. I think it would of if she had been facing me, because my eyes would have, you know I think she would have you know, and that's why I think it's valuable to not be facing the patient. I don't advocate this for everybody, because I think it's a... it's a way of working which I don't think you should not use if you have not been on the couch yourself in your own therapy to know what that feels like, but it does allow for much more um for the patient to focus on their fantasies and on their internal world much more, you know..

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becoming fearful of the intimacy?

T: Mmm, mmm. I think that what was happening was that she was able to acknowledge her fear of the intimacy and she was able to acknowledge and really understand in a way that she hadn't up to then what was happening between her and her husband.

R: Right. So your use of self in the therapy really made all of these issues explicit and workable.

T: Mmm. Another example that I can give you of involuntary self-disclosure is um it still happens sometimes but it used to happen a great deal and when I was facing the patient, okay, and why I say it was involuntary was because I could do nothing about it. I found that if a patient was telling me something very sad, a sad story, but telling it to me in a very matter-of-fact way and a very kind of cut-off way that I would become very tearful, and in the beginning of my work I used to feel very bad about this. I used to feel that it was very intrusive and very um interfering in what was going on until I was able to understand that that really was a very powerful projective identification. It was, you know, projective identification can be a way of communicating and it can be a way of getting rid of unacceptable feelings, in other words, a splitting of something off into the therapist and that's how I understood it and once I could understand that.... once I was able to say, um, you know: "It's as though the sadness of that event is so unbearable that it's almost as though I have to feel it for you", which again was, you know, it was again putting the emphasis on what the patient was feeling. You know: "I'm feeling it for you" rather than: "Oh I'm so sad, this is such a sad story". It's still a self-disclosure and it's a self-disclosure that you can't avoid and when that happens to me that a patient is on the couch where the patient can't see the tears rolling down my face, um, I can nevertheless use it in the same way. You

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R: Yes.

T: I mean it's very hard to keep an absolutely straight face, and I don't think it's necessarily appropriate in facing a patient. The patient might be thinking that something they've said has shocked you, but you don't look shocked so they immediately reassure themselves and they don't even deal with the fact that that you might have been shocked at what they told you, whereas if they're not facing you and they can't check it out on your face.....

R: Yes, I'd just like to clarify something about that self-disclosure. You said that you didn't say it all at once. Is this something that extended over sessions, this disclosure?

T: I can't remember, but certainly I did say all at once that she was distancing herself from me and that she had had to distance herself from her mother that way. She also, um, ended the therapy before I felt she was ready to end the therapy and we were both able to acknowledge that in fact she was frightened of the intimacy that was developing between us and that she needed at that point to end the therapy, but with an understanding also that.. that...that certain issues had not been worked through, that she was very aware of them, and in fact after that session she.. she.. didn't talk so much, but she could also talk about the fact that she wanted to talk, you know. So it was helpful but it was also....um, I mean I don't think the only reason she stopped the therapy at that point was to do with the fact that, you know, of the intimacy of our relationship. It also had to do with the fact that she was pregnant and very occupied with her pregnancy.

R: So it seemed to be quite a crucial point in the therapy, your acknowledging your feelings? What sort of an impact did this have on the relationship? Was there a growing intimacy? Why I'm asking this is because you had mentioned that she was

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becoming fearful of the intimacy?

T: Mmm, mmm. I think that what was happening was that she was able to acknowledge her fear of the intimacy and she was able to acknowledge and really understand in a way that she hadn't up to then what was happening between her and her husband.

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know: "You're telling me something in a very matter-of-fact way and you know then I can say something like: "Perhaps you're wanting me to feel..." or um: "It's as if those feelings are so unbearable that you can't express them" but you know I wouldn't say that I'm aware of the pain, but simply that: "....the feelings are so unbearable that you have to talk about it in this cut-off kind of way"

R: Right, and then once again you've got your data to work with.

T: Yes, yes.

R: You seem to be very comfortable with these kinds of disclosure, they seem to be in harmony with your way of working.

T: Mmm, mmm, ...and there are times, you know, where something's been told in a very congruent way, where the patient is very sad, where that is communicated to you very powerfully to you. You are very sad and you are facing the patient and the patient's wiping their eyes and you are wiping your eyes because it just is very sad, and there's .... there's .... there's nothing really to be said about it. It's just, you know, I think both are experiencing that there's a real communication going on, but in some cases of course, very early in therapy very often, if I become teary the patient sometimes feels as if they've upset you, they've done something very bad and then you have to deal with that. You sort of see that they kind of you know look at you quite uncomfortably. They suddenly become uncomfortable, so you can then pick up on the discomfort that it feels somewhere that if their feelings have affected you that somehow that feels like it's a bad thing or destructive thing, that you can then work with that, that it's not okay for someone to respond in an empathic way to what you are feeling....

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R: You're not aware of a specific patient while talking about this tearfulness?

T: (pause) It's happened a few times in my work and I can't think.... you know.... I mean people come into therapy, so much the issue is their feelings have not been accepted, which means they can't accept your feelings either, or they feel that if they've affected you in some way, you know, that they've done something terrible, you know, that you can't be sad without being damaged or injured and then you know then you have to work with that and it's actually quite helpful. I remember one patient actually ..... acknowledging that he felt envious of the fact that I could be tearful, that I could feel without shame, and without having to apologize for it and that he wasn't able to cry about something...

R: He was actually able to interpret it himself

T: Yes, interpreted what that feeling was arousing for him.

R: Did that allow for any disclosure on your part... his insight?

T: No, other than than to work about how painful it was, that he was not able to..to..obviously the history of it, that feelings were somehow.... negative, sad feelings were, ... just not acceptable.

R: Is there anything else about self-disclosure still in your mind, in your awareness?

T: (pause)......Yes, something very specific, not so much to do with the therapy but with unexpected situations, okay. I've been in practice for a very long time and there are some patients who have been with me for five or seven years and I've never cancelled a session, because I also happen to be lucky, I'm a fairly healthy person, so um because I will

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never cancel a session just for convenience even I won't even change someone's time you know unless there's a very, very good reason. So, some patients, say I have had to go to a funeral, okay or um, um, I remember one situation in which my mother had an accident in Cape Town, and I had to fly down, she had broken her hip. So I had to cancel work. Once I was in an accident myself. On the Thursday I cancelled Friday's work and I was back at work on the Monday. The Monday, Tuesday, Wednesday people didn't know anything, and the Thursday, Friday people, or the Friday people were cancelled. Now, um, it's been my experience...in the past I would have said something like: "I'm sorry I have to cancel this session, I have to go to a funeral" but um more and more what I do is I would say: "I'm very sorry I have to cancel this session, I'll see you next week" Some patients will say something because it's so unusual, "Are you okay?", and I will say yes without saying what it's about because the moment you say it's a funeral then it could be somebody very close to you and the patient has to deal with the fact that they're angry that they've cancelled but that they feel they've got to be nice to you because something awful has happened, whereas if you cancel and you don't give a reason, and obviously you would do that if you were just cancelling for one session. It's a very different thing if you cancel over a long time, I mean if you really were in an accident and you were in hospital for a week or two, and we'll talk about that in a moment, but in a situation like that you give the patient room to be angry about the cancellation. Clearly you phone and say that you were alright, you said you would see them next week so you were alright, *so what the hell are you doing cancelling?* Whereas if you give some reason such as I was in an accident, or I went to a funeral you are um, you are, um getting in the way of the patient dealing with their fantasies, and their anger, let's say, or it could just be an over-reactive worry and concern for you.

R: so you're pretty anonymous in that sense...with these

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external issues?

T: Yes, yes

R: You said that you would mention something about..

T: Yes, I think that you know, it's never happened to me to have to cancel for a week or even for a few days because some patients come twice a week or some patients come even three times a week so if I was taking off a week then they would know that I was taking off a week and not just a session, but it's never happened but I think in that case you know, let's say I had to go in for an emergency operation or something then I would, I think I would say, you know, I have to cancel this week. Even then if it was a week I might not give a reason, I've never been faced with that but if it were a longer time I think I might say I have to have some surgery I will see you in three weeks time so the person knows you know...I also have a patient whose previous therapy ..... therapist had died, so I always tell patients, well, I mean now it's easier because I now tell patients at the beginning of the year the times when I'll be away because I hold them responsible for their sessions. So if they cancel a session in the time that I'm working, they pay for that session, okay. My part of the bargain is that I give them the times during the year that I will be away. But there was a time when I would say give people three or two months notice that I was going away. Now in this particular case of this patient whose therapist had died and who was very frightened of losing me, she needed to know that I wasn't taking off three weeks to go and have a major operation. And in her case I would say to her: "I'm going on holiday....", you know, because I felt it was too cruel to leave her with the..you know to just work in the transference and with her fantasies by my not disclosing the fact that I'm having an operation. So it was..I would pre-empt that, and simply say, you know ...... you know ..... but that was when ...and I

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think it occurred with her because I'm just thinking I stopped working with her about a year ago, and by that time I was already giving times that I would be away, and even with her and even on that basis she would sometimes still be anxious and I had to spell it out that I was going on holiday.

R: So her dynamics allowed you to give her more factual information?

T: Yes, yes.

R: That's interesting. You didn't think to sort of give her fantasies free reign and then...

T: Well, we knew what her fantasies were, you know, it had come up on a few occasions, so we already knew. It was, you know...I mean I would say, "I'll be away in two months time", and she'd say "Are you alright?". Her immediate response would be, are you alright? you know, and then I would simply say: "You are very frightened of losing me, and I think..for that reason I'm telling you that I'm going on holiday ...."

R: I see. So it seems that the bigger the disruption, the more factual information you would give?

T: Yes, but not necessarily always spell it out in detail. I mean I'm thinking about, of an analyst friend of mine whose mother died. He lives in London and his mother died here in South Africa, and he suddenly had to cancel, you know, a weeks work, and he told his patients: "I've had a family bereavement and I have to go away for a week" He was still functioning, okay, and it might in that case, and he would have to deal, when he came back, with on the one hand their concern for him but on the other hand, their anger that their therapy was interrupted.

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R: This reminds me of what one encounters in the literature, particularly Langs at this stage, that if one has done something like this, one should work through it afterwards. It sort of gives one data.

T: Yes, yes.

R: Okay, I don't know if there's anything else you'd like to share with me..

T: I remember a while back saying something, and it's interesting that I can't remember what it was (laugh). I'm having to block it from my mind but I remember saying something to a patient who's been with me say for about three or four years and there was something in what I had said that was some sort of a disclosure..and she was very disturbed by it, she said: "I wondered why you told me that and it made me think that you know that maybe something had upset you that you were working differently", um and you know all I did was say: "Well it really did disturb you and it wasn't helpful", you know, um um, you know, rather than: "Well I thought it would be helpful.." rather than to become defensive and justify what I had done. It was somewhere an interference, you know ....

R: You can't remember..

T: I can't remember what it was, but I do remember recently with a patient who's very unsophisticated, very, very unsophisticated psychologically, and I think my exasperation with something, was revealed in my using his name, because I don't use patients' names .... I find it quite a seductive thing if I say "You know, Anne, ..". So I don't use patients' names other than when it's appropriate like when you think of yourself as Anne, but I wouldn't sort of say, you know like when you're talking to somebody, you might say, "Well, you know, Linda.. I wouldn't say: "Well, you know

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because you know, it's ... and I used his name, and he **picked it up immediately** and he said: "That's the first time you're using my name!" and I could then pick up that something different had happened and that it disturbing to him, so I with the best intention in the world we are human and we put our foot in it from time to time and as you say we have to work with that and try and understand it and certainly er acknowledge the patient's experience of what it is that happened whether the patient's experience was a positive or a negative one, you know and sometimes if it was a negative one it's almost easier to work with. Because if it's a positive .. you know: "I felt that you were human and that you really cared about me" you know then you have to work with how withholding they experience you because why you're not doing that at other times, you know.

R: Yes, it's almost as if you create a way of working and they expect it to always be like that.

T: Yes.

T: (Starts to ask researcher questions about her training as a therapist, discussion pursues for a few minutes. The researcher feels that it would be inappropriate not to answer such questions in the light of the respondents pursuit of candour when responding to the research question. The therapist then expresses a wish to terminate the interview due to time pressures)

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

1. **I'm aware of times where a patient, um, tells you something or communicates something which touches very closely on a personal experience and where one would share that personal experience if it were a friend, um but it's very difficult now to think of an example.**

The therapist is aware of moments where facets of a patient's

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narration co-incide with her own experience. The self-disclosure or non-disclosure distinguishes the therapeutic relationship from a friendship, where within the therapeutic relationship, the therapist refrains from sharing the experience. The therapist has difficulty in recalling a specific incident.

(P) therapist's original positioning:

difficulty in recalling an incident - *the therapist experiences difficulty in summoning to awareness an incident;*

distinguishing friendship- from therapeutic relationships to share personal experience - *when the therapist's personal experience presents itself in her awareness, she would share on a personal level if the relationship were a friendship.*

2. **I am very aware of controlling that, I'm also aware that in my work I very much try to think about my response, whether it is an overt or an internal response so I'm aware of the fact that I'm wondering *why* at this point, um, I'm wanting to share something.**

The therapist monitors her internal responsiveness. This could be an external response or a private experiencing and she extricates herself from the immediate encounter and reflects upon her need to share something with the patient.

(P) therapist's reflective positioning:

visible and obscured therapist responses

assessing reasons for the felt sense to share - *reflecting on her work experience, the therapist is intimately aware that upon awareness of the need to share on a personal level, she extricates herself from immediate encounter to engage an inner dialogue. She deliberates upon and assesses her felt sense to share on a personal level.*

3. **um, you know that sometimes it's almost a way, um, of.... sometimes it's an empathic thing and sometimes maybe it's a**

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defensive thing you know that one almost *could* detract from the pain of something that's happening or your own feelings of helplessness in what is happening, um, and sometimes I think it's even quite a narcissistic thing in the sense on the therapist's part as if to say: "Well you know, I managed it in this way..." um you know, and to be able to then think what is being communicated to me at this moment that I'm responding in a way that I want to bring myself into the picture.

Self-disclosure constitutes many functions that pertain to the needs of the therapist. It could convey the therapist's empathy, it could avert the intensity of immediate experiencing, or it could detract from the therapist's immediate feelings of helplessness and powerlessness within the immediate encounter. It could also represent a need to convey mastery which gratifies the therapist's self interest. With the emerging awareness of the immediate need to share something with a patient, the therapist interrogates all of these possibilities, and questions her need to impinge upon the therapeutic space.

(P) therapist's contextual positioning:

<u>functions of S-D serving the therapist</u> - there are various functions that serve the therapist, namely, S-D could constitute empathic responding, it could detract from the therapist's experiencing, and it could gratify the therapist's self-interest by conveying mastery;

<u>containing- and interrogating the felt sense to share in terms of its functions</u> - upon awareness of the felt sense to self-disclose the therapist intellectually interrogates the need in terms of the functions that S-D could serve.

4. **But, um, so I can speak about it again generally. I know that all sorts of things are happening when those self-disclosures happen but it's very difficult to think of an example to give you....**

The therapist finds it difficult to recall a specific

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incident and speak about self-disclosure generally. She is aware that at the moment of disclosure many variables culminate and interact.

(P) therapist's contextual positioning:

difficulty in recalling an incident of S-D - the therapist experiences difficulty in recalling specific incidents and examples, but can speak generally.

(P) therapist's established position:

co-existence of S-D and various experiences - the therapist is cognitively aware of the culmination, co-existence, and interacting of many variables at the moment of disclosure.

5. (helplessness?) **Yes, yes, well I think it was.... again it would be more helpful to you if I could give you an example but I think it's very often that I am... I mean that when that happens it can actually be quite useful because it makes me think about how helpless the patient is feeling which is making, you know I'm introjecting something. Something's been projected into me of the patient's helplessness.**

The therapist acknowledges that examples of clinical material could assist the discussion. When the therapist experiences feelings of helplessness in the immediate therapeutic encounter, she utilizes these emotions to understand the patient's immediate experiencing with the awareness that what she is experiencing has been disowned by the patient.

(P) therapist's contextual positioning:

realizing the illustrative capacity of citing incidents - the therapist realizes that examples of S-D would be helpful in illustrating her stance as well as her management of her immediate experience within the encounter.

(P) therapist's reflective positioning:

implementing encounter experience to clarify ownership of feeling - the therapist uses her immediate experience of helplessness to clarify the ownership of the feeling.

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This assists in understanding and grasping the patient's dis-owned emotionality.

6. **I'm then wanting to, I'm feeling helpless, I'm then wanting to do something, you know, whether it's self-disclosure or whether it's even making some kind of suggestion about behaviour,**
The therapist feels internally pressured to react to her feelings of helplessness. This reaction could constitute either a disclosure or a form of guidance about behaviour.
(P) therapist's reflective positioning:
experiencing helplessness within the therapeutic encounter -
helplessness as initiating experience to implement a suggestion or S-D - Upon experiencing helplessness, the therapist feels pressured to rescue the therapeutic alliance. This could constitute a S-D.

7. **which then if I.... if I can give myself time to think about that in the work in the session can allow me then to, er, to reflect to the patient maybe how helpless he or she is feeling or sometimes you know if I'm very clear about it and I think this is a thornier issue that she's wanting me to feel as helpless as she felt, or he felt in a particular situation, you know, that I become that helpless child or the mother who is making me feel helpless.**
The therapist needs to extricate herself from the immediacy of therapeutic encounter to understand the patient's experiencing which is not immediately evident. This can then be reflected to the patient. The therapist is also aware of a more delicate situation during which she assumes a role responsiveness representative of the patient's atherapeutic relational configuration/matrix.
(P) therapist's reflective positioning:
disentanglement- and intellectual deliberation on encounter experience - the therapist deliberates upon her emotional experiencing within the temporal and physical

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confines of the therapeutic situation;

presenting felt experience to patient - upon deliberation, the therapist reflects her encounter experience to the patient;

unfolding awareness of a role-responsiveness - the therapist's immediate experience could bring to awareness that she is assuming a role responsiveness within the therapeutic encounter. This illuminates the nature of the patient's external relational constellations.

8. **I mean, not that I'm saying that I am feeling helpless to the patient but that I would say: "Perhaps you're wanting me to.... you know the only way of communicating your feeling is that you want me to feel as helpless as you were feeling...".**
The therapist does not directly convey her experience of the immediate encounter to the patient. She indirectly conveys her experience by means of an interpretive statement from which the therapist's immediate experiential flow can be inferred.

(P) therapist's reflective positioning:

shifting therapist's affected-ness onto patient - the therapist's encounter experience is conveyed indirectly, the therapist's feeling could be inferred by patient.

9. **um, because I don't believe that self-disclosure is, um, helpful to the patient. I think it burdens the patient with you know.... but perhaps there is an indirect way of doing it and that is with you know, things like: "It seems you're wanting me to be angry with you" or "You're wanting me to to to punish you or to retaliate......" you know..**
The therapist believes that therapist self-disclosure is not beneficial to a patient, and that it places undue concern upon a patient. It can employed in an indirect way which is not confrontational and is presented to the patient as his/her need.

(P) therapist's established position:

burdening effect on patient

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(P) therapist's contextual positioning:

<u>conveyance of therapist's encounter experience as patient's need</u> - could be conveyed indirectly referring to the patient's needs.

10. **It's difficult to think off-hand, you know, because it happens now and again. It's not something that I'm struggling with all of the time, by any means, or struggling with all the time with a particular patient.**

The therapist finds it difficult to quickly summon an incident as it is an isolated event within her psychotherapeutic lived-world. Self-disclosure does not represent a phenomenon that she is constantly perturbed by.

(P) therapist's contextual positioning:

<u>difficulty in recalling incidents</u> - the therapist finds difficulty in summoning examples to illustrate her positioning.

(P) therapist's reflective positioning:

<u>successful integration of S-D</u> - the therapist does not find herself having difficulty in dealing with S-D, there is no indwelling and over-riding inner conflict pertaining to sharing with patients.

11. **I think there are moments in the therapy where something... you know where you almost have to ... where I almost have to bite my tongue,**

The therapist is aware of moments when self-disclosure is so imminent that she has to seize control and refrain.

(P) therapist's reflective positioning:

<u>instances of imminent S-D requiring forced control</u> - the therapist on occasion has to seize control and deliberately refrain from self-disclosing.

12. **you know, um, I think also I have had to struggle in my work with the fact that I used to be a teacher so you know I have to... just as a medical person becoming a therapist has to struggle with, you know, telling the patient what to do.**

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I have to struggle with being didactic. There's a kind of inclination to teach, to be didactic, which is also very unhelpful,

The therapist has had to deliberately disentangle herself from a previous occupation where she assumed an instructional stance. She compares this situation to where a medical person becomes a therapist, and in the process struggles with being instructional with patients. This she considers to be unbeneficial.

(P) therapist's reflective positioning:

<u>shift from didactic stance</u> - the therapist has shifted from a didactic stance where she was inclined to directly assist a patient in the form of instruction and guidance.

13. **and sometimes one can use one's own experience to say you know this and this is what happened, and so it's something I'm aware of over the years, I've had to sort of, um, monitor in myself.**

The therapist is aware that one could draw upon one's experience and share this with a patient. The therapist has continually been aware of this and has needed to exercise control over this form of participation.

(P) therapist's reflective positioning:

<u>temporal extension of monitoring awareness to share</u> - the therapist has continually monitoring the felt need to share personal experience.

14. (?) **Yes, it almost seems like a self-disclosure would be a way of, um, directing the patient towards something.**

Self-disclosure could point the patient in a specific direction.

(P) therapist's contextual positioning:

<u>S-D as directive for patient</u> - S-D could serve the patient by steering him/her in a specific direction. :

15. **The other thing I think that also comes up in self-disclosure is, um, sometimes one feels very warmly towards**

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the patient you know, um, er, I was married to a man who had custody of his children so I was a step-mother for many years, so when I have worked with people who are in that situation and are being a step-mother or step-father and I'm feeling very sympathetic to their situation but also aware of the ways in which I solved that problem or didn't solve that problem for that matter, you know again in a normal social situation one would share that....

The therapist at times experiences an emotional disposition towards a patient. Having been a step-mother she experiences sympathy towards patients in similar situations and is aware of her own managing of the same situation whether her management was successful or not. In social situations the therapist would be inclined to share her personal experience.

(P) therapist's reflective positioning:

recalling instances of a felt disposition upon consideration of S-D - *Upon consideration of S-D, the therapist is aware that one could experience a warm disposition towards certain patients;*

shared life contexts and experiencing affinity towards patients - *the therapist experiences sympathy and a warm emotional disposition towards patients who share similar life contexts;*

revealing a shared life context in social situations - *the therapist does not share personal past experience in therapeutic relationships.*

16. **...and it seems almost at times *withholding* not to, and yet 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.**

It seems deliberately forced and unnatural not to share one's personal experience. This experience is not negated or denied awareness. It is denied spoken status but is implemented to add depth to the therapist's understanding and

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empathy. This use remains private.

(P) therapist's contextual positioning:

unvoiced, empathic use of previous experience - private implementation to enrich and enhance empathic responsiveness.

17. **Oh, I think it's my theoretical understanding. It's not an issue at that time or an issue at another time. It's really my theoretical understanding. I work in an object relations way. I work in the transference and I feel that it's very unhelpful to a patient. I think the patient's fantasies about you and about what goes on in your life are what you work with and I think it's really not helpful, so I *know* that and I** *believe* it, you know

The therapist has a principled perception of the constitution of the therapeutic field that is pervasive, indwelling, and invariant. This therapeutic environment negates the use of self-disclosure, and has as primary working data the patient's speculations and images about the therapist. The therapist is convinced that self-disclosure is not helpful to the patient within this therapeutic field.

(P) therapist's established position:

pervasiveness of theoretical principles-

theoretical principles and restricted S-D use - S-D not considered beneficial, does not harmonize with pre-established notions and principles pertaining to therapeutic field;

patient's fantasies and assumptions as primary working data

18. **Sometimes when it has happened in the past I know patients would say: "I was so glad when you told me that because it felt that you were human..." and they would sort of feel a kind of a warm chummy-chummy thing with me which again is not...**

The therapist has self-disclosed in the past, and this was acknowledged by patients who experienced a human contact and

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warm disposition towards the therapist.

(P) therapist's reflective positioning:

<u>S-D, patient's evidencing therapist's humanity</u> - experienced therapist as human and felt a warm disposition towards disclosing therapist.

19. (comfortable - relationship) **No, no I don't think it's helpful... I'm not my patient's friend in a different way. I'm hopefully on my patient's side which doesn't mean siding with,**

Within the therapeutic encounter, the therapist does not want to be present to her patient as a friend. She feels disposed towards being therapeutically available, but not in the way of being an ally.

(P) therapist's established position:

<u>S-D not therapeutically beneficial</u>

<u>asocial disposition towards patients</u> - therapist does not want to present as an ally, but is therapeutically available.

20. **but you know, I think it's... I think it's very often a.... ultimately quite a narcissistic thing on the part of the therapist. You know having to bring herself or himself into the picture.**

The therapist believes that a therapist is self-invested if he/she experiences the need to impinge upon the therapeutic space.

(P) therapist's contextual positioning:

<u>S-D gratifying therapist's self-interest</u> - S-D serves the need for self-interest by impinging upon the therapeutic space.

21. **But I think that one has to be very careful in interpreting projective identification because again you know you have to really be very sure about it, it could be your own stuff, you know the patient may have trod on a sensitive spot where you are feeling hurt or angry or um, helpless or**

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whatever, it may entirely be your stuff, and it's terribly important to give yourself time to think about it before coming out with: "You're wanting me to feel..." which you know you're somewhere feeling....

The therapist believes that before interpreting one's experience of the encounter and the meaning of one's role responsiveness, one should first purge this response of its individually peculiar ramifications. The therapist deems it essential to take time to monitor and deliberate on her internal reacting before implementing it as interpretive material.

(P) therapist's established position:

expending time and deliberation to purge therapist's encounter experience before intervening - cautionary interlude, time required to deliberate upon encounter experience to assess the ownership of feeling and content.

22. (disclosure constitutes interpretation?) **.... in the sense that if you make projective identification interpretation the patient may may well feel that you are feeling helpless or that you are feeling angry but the difference about that is, and now we're talking about self-disclosure of an emotion rather than self-disclosure of some experience that you have had yourself okay. The patient may well feel that you have felt angry or have felt helpless...**

When explicating the nature of the interaction and its meaning, the disclosure is indirect and the revelation lies in the inferences that the patient could make about the therapist's experience. The therapist distinguishes between two types of self-disclosure. The one pertains to the therapist's emotionality within the immediate encounter, and the other to external experiences of the therapist.

(P) therapist's contextual positioning:

distinguishing S-D of affect - the therapist clarifies that self-disclosure could pertain to the therapist's experienced emotionality;

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distinguishing S-D of past experience - *the therapist is aware of self-disclosure that reveals a past experience and disclosures that comment on the therapist's immediate experience within the encounter;*

patient's inferences about therapist's affected-ness within encounter - *the therapist's immediate experience can be inferred by the patient.*

23. **But the difference of course is that again hopefully, if you have chosen your moment correctly, if you are right about it, if you have genuinely processed that feeling and are not somewhere using it in a retaliatory way, um, the patient is able to feel that something real is happening between the two of you but that you are not using it against the patient or using it in a defensive way.**

The temporal location of the intervention as well as the purging of the therapist's affect is deemed essential by the therapist. If the therapist's experience is accurately assimilated the patient will experience a genuine and actual encounter rather than feeling that the therapist is defensive or retaliatory.

(P) therapist's contextual positioning:

purging and assimilating therapist's encounter affected-ness - *therapist's inner experience must be purged of personal material that is unrelated to the therapeutic encounter, and the timing of the intervention is also paramount;*

patient's experience of real encounter upon purged and well-timed intervention

24. **I can give you a good ex... I use the couch a lot okay**

The therapist often utilizes the couch in therapy.

(P) therapist's established position:

implementing an obscured stance - *the therapist frequently utilizes the couch.*

25. **So, um, I had a patient who was somehow, who seemed**

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really to be using the therapy. She was.. her relationship with her parents was changing, her relationship with her, um, with her husband was changing, and yet something wasn't changing in the room.

The therapist recalls a specific patient who was utilizing the therapy beyond the therapeutic frame- and relationship. Her relationship with her parents was changing and her relationship with her husband was changing but no change was evident within the therapeutic relationship.

(I) unfolding therapeutic constellation for S-D:

patient's extra-therapeutic interpersonal progress - *patient's external interpersonal relationships were changing;*

therapeutic stagnation - *no change was evident within the therapeutic encounter.*

26. **Um she would come in a talk a great deal and I found myself very, very sleepy. In fact, on one or two occasions I actually nodded off, you know, but her voice would sort of bring me back. I would sort of nod off for a split second but it was a hell of an effort staying awake.. staying with her.**

Pre-reflectively the therapist experienced overwhelming sleepiness and she experienced difficulty retaining focus on the patient.

(I) unfolding therapeutic constellation for S-D:

therapist's sleepy encounter experience - *overwhelmingly sleepy, difficulty in maintaining focus.*

27. **Now, and I was thinking, I was trying to understand this but I was so sleepy that I almost couldn't think in the session, so one way of doing it would have been to say in the session if it was a self-disclosing thing: "I am feeling very sleepy" you know, which might have made the patient feel I am very boring okay...**

The therapist was so overwhelmed by her immediate experiencing of the encounter that her cognitive and

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reflective capacities were impaired. She could not disengage to assess, monitor, evaluate or confront what was transpiring in the therapeutic field. One option would be to acknowledge this experiencing to the patient which let the patient feel she was boring, thus causing the therapist to feel sleepy.

(I) unfolding therapeutic constellation for S-D:

therapist's overwhelming and pervasive sleepiness - so overwhelming that the therapist could not disentangle herself to reflect upon the meaning and implications of her experience.

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

awareness to have directly conveyed sleepiness - a possibility would be to directly acknowledge the therapist's immediate experience;

anticipated burdening effect on patient - the patient could assume undue responsibility for the therapist's experience of the encounter and could feel blamed.

28. **But I was able to think about it afterwards and what I realized was happening... because I really couldn't think about it in the session... it was as if I wasn't able to think, was that in order to deal with her family situation she had had to distance herself from her parents, and that what was happening, that although there was all this talk it was a way of distancing herself. It was also a way of protecting herself from any silence because she was a very, um, parental child in the family.**

Due to the overwhelming nature of her immediate encounter experience, the therapist needed to extricate herself for deliberation beyond the temporal and physical confines of the therapeutic frame. This disentanglement assisted the realization that the patient's talking served a defensive function of creating distance. The therapeutic interaction mirrored the patient's external relational configurations.

(I) emerging therapeutic constellation for S-D:

formulating the relational implications of therapist's sleepiness beyond the therapeutic situation - occurred

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beyond the immediate therapeutic frame, therapist deliberated on the meaning of the relational matrix within and beyond the encounter;

linking the therapeutic constellation to patient's external relational matrix - therapist had been assuming a stance to assist the patient's interpersonal defences.

29. **And the next time it happened I was able to say and of course because I thought about it, means I was thinking I wasn't so sleepy, but I was also.... you know, I was able to say: "I'm aware of the fact that you hardly give me a word in edgeways in the session and I wonder whether somewhere it is, that although you express a lot of appreciation of the work and talk about feeling safe with me, I don't think you really do and I think you're having to distance yourself from me in the way that you had to distance yourself from your mother, and that your sexual difficulties with your husband whom you love and depend on enormously are a way of your perhaps...."** The therapist's processed, mediated, reflective, and cognitive awareness of what had been transpiring in the therapeutic situation assisted her to overcome the immediate pull to shut herself off. The therapist formulated her interpretation which indirectly conveyed her experience of the therapeutic contact. This was explained in terms of it's meaning in the patient's lived-world. The therapist through her experience and indirect revelation of it linked the patient's previous experiencing with a significant other, namely her mother with the immediate therapeutic relationship with the therapist.

(I) emerging therapeutic constellation for S-D:

therapist's pre-empting of numbing response - due to mediation the therapist could pre-empt her shutting-off and sleepiness.

(I) S-D incident:

juxtaposing the patient's relational matrix and the therapeutic relational configuration - the therapist linked the patient's mode of relating with the

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therapeutic relational configuration.

30. **well I didn't say this all at once, but I could link it afterwards.**

The therapist's interpretation extended beyond the immediate moment of disclosure into subsequent therapeutic sessions, but it was continually fed back to join all of the experiences.

(I) S-D incident:

unfolding of S-D over therapeutic contacts - the therapist's disclosure did not occur during one therapeutic contact, but extended to future therapeutic contacts. Subsequent components of the disclosure were traced back to the original point of departure of the formulated disclosure.

31. **You know in all of her relationships there was a point beyond which she was afraid to go and it was happening in the therapy, which would have been, which was much more useful than to say: "I am feeling sleepy" or "You make me..*You make me* fall asleep!", you see. But I'd actually had to think about it outside of the session.**

The therapeutic relationship followed the same course as the patient's extra-therapeutic relationships. These relationships had reached a crucial point beyond which she felt threatened to proceed, and at which point she would detach herself. The disclosure did not constitute a direct confrontation but rather an indirect interpretation of the therapist's pre-reflective experience which is considered more useful. The therapist had had to consider this therapeutic intervention outside of the immediate encounter.

(I) unfolding relational matrix for S-D:

mirroring of interpersonal rupture within therapeutic relational matrix - the patient consistently and typically would reach a critical point beyond which she would not facilitate relational growth.

(I) emerging therapeutic constellation:

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deliberating on disclosure beyond the therapeutic frame

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

awareness of an alternative and confronting S-D - the therapist is aware that she could have confronted the patient with her encounter experience and shifted the blame but sees this as less helpful.

32. **Where I become the her who doesn't feel as if she can contact the mother. Yes, except that I was processing I was saying,... I mean she could obviously interpret from that that I feel distanced from her, but I was saying... I wasn't saying: "I feel I have to push you away!" or "I feel I have to fall asleep!" I was saying, you know: "..you need....you're having to distance yourself.."**

The therapist's awakening awareness assisted her in grasping the role that she was assuming within the therapeutic field. The content of the intervention which served to explicate the therapeutic transaction shifted the focus onto the patient's experiencing. From this the patient could infer the therapist's experience, namely the feeling of distance and detachment.

(I) emerging relational matrix for S-D:

awakening awareness of role assumption - assumes a role where, within the encounter, experiences the patient's inability to reach her mother.

(I) S-D incident:

shifting therapist's affect onto patient - not confrontational, focus directed onto patient's experiencing within therapeutic relationship.

(I) effect of S-D:

patient's sensing of therapist's felt detachment - the therapist senses that the patient could infer that the therapist was feeling detached.

33. (Did that ever become explicit, your feeling tired?) **No, oh no, no. I think it would of if she had been facing me, because my eyes would have, you know I think she would have**

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you know, and that's why I think it's valuable to not be facing the patient.

The therapist never explicitly acknowledged feeling tired or sleepy. Had she been facing the patient, her experiencing would have been immediately evident. The therapist believes that it is valuable to be obscured from the patient's vision.

(I) S-D incident:

concealment of therapist's sleepiness - therapist never directly acknowledged this.

(P) therapist's established position:

belief about therapist's obscurity - therapist believes that it is therapeutically valuable to be obscured from the patient's vision.

34. **I don't advocate this for everybody, because I think it's a... it's a way of working which I don't think you should not use if you have not been on the couch yourself in your own therapy to know what that feels like, but it does allow for much more um for the patient to focus on their fantasies and on their internal world much more, you know..**

The therapist believes that one should only implement the couch if one has experienced this as a patient oneself. This stance allows for the patient to remain focused on his/her unique experiential flow and assumptions without interference.

(P) therapist's established position:

belief about obscurity and having assumed patient's role - before implementing a stance where one is obscured from the patient's vision, one should have experienced this as a patient oneself;

detached stance and primacy of patient's assumptions - the working data is constituted by the patient's fantasies and assumptions about the therapist.

35. **I mean it's very hard to keep an absolutely straight face, and I don't think it's necessarily appropriate in facing a patient. The patient might be thinking that**

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something they've said has shocked you, but you don't look shocked so they immediately reassure themselves and they don't even deal with the fact that that you might have been shocked at what they told you, whereas if they're not facing you and they can't check it out on your face.....

The therapist finds it difficult to remain expressionless and believes that this is not appropriate when being visible to a patient. The patient could anticipate a certain response or reaction from the therapist, for instance, shock. By not conveying any response or reaction could allow the patient to console himself/herself that the therapist is not shocked. This prevents the patient from dealing with the effect that he/she has had on the therapist. If the patient cannot see the therapist, then he/she must rely on his/her own assumptions about the therapist's responsiveness. This opens up many possibilities pertaining to therapeutic working material.

(P) therapist's established position:

<u>therapist's difficulty in remaining expressionless</u> - the therapist finds it difficult not to exhibit a felt responsiveness;

<u>being visibly unaffected and by-passing the management of elicited effect</u> - the therapist is aware that if one visibly conceals responsiveness, the patient would never deal with his/her effect on the therapist;

<u>therapist detachment and patient's fantasies as primary working data</u> - the therapist is aware that if one is detached and reactivity obscured, the patient's fantasies comprise the working data.

36. **I can't remember, but certainly I did say all at once that she was distancing herself from me and that she had had to distance herself from her mother that way.**

The therapist cannot accurately recall the extent of the disclosure but she is certain that she did immediately bring to the patient's awareness that the immediate therapeutic transaction mirrored the transaction with her mother.

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

<u>clarity of recollection of S-D nucleus</u> - the therapist can accurately recall the essential and primary constituent of the disclosure.

(I) S-D incident:

<u>juxtaposing patient's interpersonal positioning from mother and therapist.</u>

37. **She also, um, ended the therapy before I felt she was ready to end the therapy and we were both able to acknowledge that in fact she was frightened of the intimacy that was developing between us and that she needed at that point to end the therapy, but with an understanding also that.. that...that certain issues had not been worked through, that she was very aware of them, and in fact after that session she.. she.. didn't talk so much, but she could also talk about the fact that she wanted to talk, you know. So it was helpful but it was also....um, I mean I don't think the only reason she stopped the therapy at that point was to do with the fact that, you know, of the intimacy of our relationship. It also had to do with the fact that she was pregnant and very occupied with her pregnancy.**

The patient terminated the therapy before the therapist deemed it appropriate. It was acknowledged within the therapeutic space that the patient was threatened by the interpersonal intimacy that was intensifying. Subsequent to the therapeutic session in which the self-disclosure occurred, the patient verbalized less, but acknowledged that she had the need to talk. It was not only the fear of intimacy that prompted the patient to terminate therapy, but also the fact that she was preoccupied with her pregnancy.

(I) post-incidental therapeutic situation:

<u>premature termination</u> - the patient terminated the therapy before therapist deemed it appropriate;

<u>patient's growing fear of interpersonal encounter intimacy</u>

(I) effect of S-D:

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patient's cessation of excessive verbalization - *the patient verbalized less;*
patient's awareness of need to verbalize - *patient could acknowledge the need to talk.*

(I) therapist's contextual reflection on S-D:
positively assessing usefulness of S-D

38. **Mmm, Mmm. I think that what was happening was that she was able to acknowledge her fear of the intimacy and she was able to acknowledge and really understand in a way that she hadn't up to then what was happening between her and her husband.**
The patient could explicate her fear of the intensifying intimacy within the therapeutic encounter. She could also grasp with greater clarity the relationship between herself and her spouse.

(I) effect of S-D:
patient's awakening interpersonal insight - *could acknowledge her interpersonal anxiety within the therapeutic encounter and could deeply acknowledge and grasp the relational configuration with her husband.*

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