The Intimate Self-Disclosure

By Betsy Cohen

I have always felt that an important function of the interpretation is the establishment of the limit of the analyst's understanding.
-D. W. Winnicott1

There are two basic types of self-disclosure on the part of the analyst. The most common is the analyst/therapist statement revealing something factual about her personal life, personal demographic information. The second, and perhaps more important, is the relational interpretation, which may involve a disclosure about the analyst/patient relationship where the analyst shares her experience of being with the patient in the moment. Both can be intimate or not, depending on the context. The majority of recent research studies on therapist self-disclosure (qualitative and quantitative) reveal a positive link with treatment outcome. Even though used infrequently, it is viewed by the patient as one of the most helpful responses of the therapist.

I will provide a brief history of the use of self-disclosure and discuss why there has been a great resistance to accepting it as a useful and important analytic technique. I will look at the ethics of self-disclosure, explore reasons to self-disclose, examine what is an intimate self-disclosure and why I believe that intimate self-

disclosures are important and potentially transformative for the patient.

The history of psychoanalytic technique tells us that the original rigid guidelines against the analyst's self-disclosure are easing as analysts slowly become more comfortable with what was once forbidden. My personal experience as a therapist using self-disclosure parallels this historical development. Thirty years after my initial training, I now firmly believe that self-disclosure can be an essential element of a meaningful and life-altering analysis. Self-contain-ment on the analyst's part is of course fundamental to the therapeutic process, but here we will explore the paradox between self-dis-closure and self-containment.

We are always self-disclosing, even if we imagine that we are not.

Ethics

Here's a dilemma: intimate self-disclosures, in that they might cause harm, may create ethical violations, yet they may at the same time be the most effective way to reach the patient and create change.

There are two considerations to examine. First, since you must not harm your patient, does the disclosure aid the patient's therapy, or is it used for the benefit and narcissistic needs of the therapist? Second, is what you reveal the kind of communication that should

be disclosed to a patient with that particular type of diagnosis or issue?2

Without the restriction of anonymity the therapist is faced with new decisions. Which of the therapist's thoughts, feelings and personal details will be consciously disclosed; which are helpful to the patient, and which are not? Is it useful to the patient, and what is our motive? Yet how does one know one's motive for the self-disclosure? We have learned that there is never one motive for behavior; motives are multi-determined. Also, since we are not to cause harm, how do we know if the self-disclosure causes harm until we self-disclose? Caution is important even if your emotional expression aims to model spontaneity. One can over- and under-self-disclose, each of which can also be harmful to a patient.

Brief History

During the first eighty years of psychotherapy, self-disclosure was bogged down by rules of technique not considered individually (or wisely) for the particular patient or the analyst.

The problem began with Sigmund Freud's beliefs about how the psychoanalyst was to cure the patient. He was immersed in technique and in 1915 wrote his Recommendations to Physicians Practicing Psychoanalysis. Most analysts believe we desperately needed these rigid guidelines as we embarked on the delicate art and science of examining the unconscious of another human being. Freud believed that the only true and effective way to carry out the

"surgical" procedure of analyzing the unconscious and transferences was through the three pillars of his analytic stance: anonymity, abstinence, and neutrality.3

In the first seventy years since Freud there were few challengers to his theory that the patient is to show and tell everything, the therapist as little as possible. In 1932, seventeen years after Freud's dictum, Sandor Ferenczi had the courage to become the first challenger to Freud's taboo on self-disclosure.4

The well-known psychoanalyst Ralph Greenson in 1967 admitted that his patient actually figured out that Dr. Greenson (or, his analyst) was a liberal Democrat. Greenson, who thought he was practicing anonymity, asked, "How is that?" The patient explained that when he mentioned anything positive about Roosevelt, Greenson was silent. If the patient said anything negative about Roosevelt, Greenson asked for his associations, implying that not liking Roosevelt was an infantile feeling. Also, when the patient said anything positive about a Republican, Greenson asked for associations and when the patient mentioned something negative about a Republican, Greenson never asked for associations, as if in agreement with his patient. Greenson's response to being discovered was both chagrin and the realization that pure anonymity is impossible. However, in his allegiance to Freud, Greenson did not conclude that self-disclosure could be an essential tool for analytic work.5

By the beginning of the l990s the relational/interpersonal model of psychoanalysis was fully entrenched in psychology schools and training programs. The idea of the anonymous analyst has almost vanished, and the analyst/therapist is now a participating observer or an observing participant, a co-creator of the therapy. Because of this enormous shift, therapists are left with many questions: what to disclose, when, how much, and the true impact on the patient.6

Historical Resistance to Accepting Self-Disclosure as a Valuable Technique

Especially in the last fifteen years therapists have come to accept the transference/countertransference as the engine of the therapy. Why did the challengers to Freud encounter such difficulty accepting the inevitable use of self-disclosures?

The first reason is the enormous idealization of Freud and, with it, the rigidity of his beliefs. Also, the transferences and pa-tient's projections may call attention to qualities within the analyst that she wants to disown. Another resistance is due to the anxieties, temptations, and feelings that are inevitable in a close relationship between therapist and patient.7 One way to manage these feelings is to outlaw self-disclosure.

Clearly, the analyst has a need for safety, but safety from what? From seeming to be out of control or exposed? Perhaps it was the fear of appearing to be vulnerable that encouraged analysts to hide their feelings. Therapists feared that the patient would be intruded

upon and burdened if they revealed their true feelings, and some analysts feared it would appear to the patient that their own analysis had been incomplete.8

Further, an analyst may like being idealized, and without self-disclosure the patient is implicitly urged to join in the adulation.9

Why to Self-Disclose

1. Modeling

The therapist models an easy expression of unwanted or uncomfortable feelings and thoughts, and this modeling can encourage a safety in saying what feels hard to express. The analyst's emotional engagement can help encourage a patient's emotional en-gagement.The therapist shows it is acceptable to respond with emotional intensity, to feel deeply, and to cope with life's difficulties with less denial.10

Especially in archetypal areas such as love, grief, loss, death, and illness, the therapist is able to universalize what's collective. By responding, "I'd feel the same way," the therapist is able to model the acceptability of a range of feelings, from rage to joy-filled love. Modeling also helps the patient realize the therapist's human failings.

2. Creating the therapeutic alliance

The therapist creates an atmosphere where self-revelation is acceptable and valued, and inherent in the process. One way to help the patient feel secure, connected, held, and comfortable is for the therapist (when asked) to reveal personal demographics. Withholding information may create anxiety and be experienced by the patient as demeaning and damaging.

An example is when the patient asks the therapist, either out of need or curiosity, "Where are you going on vacation?" If the therapist does not self-disclose and answers, "Where do you think I might be going?" this therapist might be experienced by the patient as just plain rude.

Sometimes not answering personal questions can re-trauma-tize the patient rather than create a safe therapeutic container. Not answering may further unnecessarily stimulate the patient's curiosity and, perhaps, feelings of unimportance and rejection.

Heinz Kohut reminded us that disruptions in the treatment are not always due to the patient's resistance, but often to the therapist's empathic failures. He understood that the therapist's self-disclosure could be a necessary ingredient of an empathic stance.11

3. Validating reality

Without consensual validation of reality, the patient can become confused about what she thinks to be true. For example, two weeks

ago I was sitting listening to a patient and my back was feeling particularly painful. My patient asked, "Are you feeling uncomfortable?" In my typical therapist style I answered, "No, I am not feeling uncomfortable with what you are saying. Why do you ask?" She stayed with it, "No," she said, "I mean are you feeling physically uncomfortable?" "Oh, that!" I smiled. "Yes, my back is hurting." She suggested that I stand up and walk around for a while, and I did so. If I had denied her accurate perception, I would have denied an important aspect of her perceptiveness and caring, perhaps injured her self-esteem, and certainly distanced us.

Not self-disclosing may be a violation of professional ethics. It can be damaging if the therapist does not reveal a life-threatening illness, or if the therapist is in training and the therapy is time-limited, or if the therapist is planning on retiring or leaving the area.13

4. Encouraging the patient's feeling of equality

Disclosure is part of a relationship between equals. Creating a feeling of equality with a patient is a matter of theoretical orientation and fundamental belief about the patient/therapist relationship. Do you want to help the patient feel more equal, more respected, within the basic asymmetry of the relationship? To convey that the patient matters to the therapist, that the therapist wants closeness with the patient? Of course it takes internal structural change for the patient to feel equal to the therapist, but is it also helpful to reassure the patient that he or she is equal?

What does the patient need to know (and not know) about the therapist not to feel shamefully one down?

5. Mitigating therapeutic impasse

If the therapist reveals not feeling understood or shows an openness to mistakes she may have made, the patient may gain a new perspective on what felt like an impasse in the treatment process. When the patient feels mistreated, it is important to understand the problem from the patient's point of view and to disclose what may have created this misunderstanding or misattunement.

6. Repairing developmental deficits

If a patient who was merged with the therapist begins to separate and show curiosity and ask questions of the therapist, it might be damaging if the therapist simply reflected, "Oh, I see you are interested in such and such about me," and not answer the questions. This patient may not have been allowed as a child to express curiosity about his parents, and the therapist might explain why it is important that this patient try out new behavior.14

7. Being there for a moment of humanity

The saddest and most dramatic moment I have had as a therapist is when my patient of three years, "Deborah," came to her appointment ten minutes after receiving a phone call that her 28-

year-old daughter had been killed in a car crash. Deborah also brought her 20-year-old son to the session, a young man I had never met.

She and her son sat huddled on the couch, crying, holding each other, sharing the details of this tragic event and memories of their loved one. I pulled my chair close to them and felt a part of their unit. I spontaneously revealed that my first husband had died and what that felt like to my then eight-year-old son. I was blessed to have been that close to their grief. In the next session Deborah told me she had appreciated my openness with her; she felt I understood some of her experience.

8. Helping the patient learn about what has been split off from awareness

The key resistance to the therapy is not to the analyst's knowing about the patient, but to the patient's discovering a disavowed part of the self. The patient recognizes and learns to accept previously hidden and forbidden parts. The self ultimately discloses to the self.15

Christopher Bollas in The Shadow of the Object reminds us that

Since so much of the psychic life in the clinical setting is within the analyst, the analysis is enhanced when the analyst makes certain split-off elements of the patient available for knowing and analyzing.16

Self-disclosure often accompanies the analyst's revealing what he has taken in from the patient, for how does he know for sure whose material he is making available to the patient?

The Limits of Self-Disclosure

Being the therapist can be very gratifying. But when the focus of the therapy becomes the therapist and not the patient, the ther-apist's narcissistic self-indulgence may dominate. This occurs when the therapist needs the patient in order to be idealized, validated or applauded.

I have often been curious about restaurants where the patient dined, movies viewed, places visited on vacation. I have sometimes intruded into the therapy with my own needs to find out what matters to me but not to the patient, and I have clearly derailed the patient's agenda. Analyst self-disclosure is also type-driven. I am a more extraverted feeling type, and perhaps an introverted thinking type would be less comfortable with self-disclosure even if it would be helpful to the patient.

When the patient primarily needs mirroring from the therapist, it is generally better not to intrude. If the patient is one who overly focuses on others' needs and wants to know too much about the therapist, or if the questions of the patient seem aggressive, rhetorical, defensive or intrusive, or if the therapist feels pressured to reveal what he doesn't want to reveal, the therapist needs to

comment more on the process than to answer the question. Sometimes the patient's needs for closeness feel frightening or cloying to the therapist. Again, these are times not to disclose.

Further Limitations of Freud's Theory

By believing in the illusion that we are not self-disclosing or that we should not self-disclose, we walk a thin tightrope as therapists. In struggling to maintain Freud's goals, which we have now discovered are impossible, the analyst will not be able to listen, observe or interpret as attentively, nor be as able to make corrections in behavior or admit mistakes. If one is attached to rules it is harder to be self-aware in the moment and I believe there will be more enactments on the part of therapists, who may end up saying more than is helpful to the patient.

Worrying about these rules might cause the analyst to feel constricted, constrained, restrained, controlled, unemotional, forced, unnatural, guarded and ultimately tied up in knots.

How do we unbind ourselves? The dictum of the do-not-self-disclose technique created fear and guilt-feelings in many analysts. The absence of self-disclosure assured us that the temenos, the container of the therapy, was secured and not defiled. The problem is that in the illusory quest not to alter the container, the frame of the therapy, we create a particular kind of frame. By not self-disclosing, by not answering simple questions about who we are or how we are, we may create anxiety in the patient, or seem arrogant

or unavailable. In so doing, we shape a situation that drifts far from the goal of analytic neutrality.

What has always interested me about the fear that self-disclo-sure will influence the transference is that, if the transference is such a big and powerful force, why would the smallest detail of the ana-lyst's life interrupt it? Why would an analyst's admission of where he is going on vacation hurt the establishment of a needed transference? Why could this knowledge alter, say, the patient's need to idealize his therapist? As the psychoanalyst Theodore Jacobs says, "Sure the patient might know I'm going skiing but he can either imagine me falling in the snowdrifts or slaloming down the slopes. Self-disclosure does not stop fantasy."17

Karen Maroda underlines that there is no change in analysis unless there is an affective communication and change between both therapist and patient.18 In 1954, fifty years before Karen Maroda, Carl Jung told us that unless the unconsciouses of both participants is affected, there is no change. He said that in the transference neurosis, there is a "combination" of the two psyches, and both are altered. The doctor "takes over" the sufferings of his patient.19 We know this. Freud also knew this. In 1915 he asserted, "It's remarkable that the Ucs. of one human being can react upon that of another, without passing through the Cs."20 This is why we're always self-disclosing even if we pretend we're not.

In contrast to Freud, Jung wanted to experience countertransference. He believed that the analyst and patient

needed to enter the bath of therapy together, to mix it up and through the mix to create an analytic third, a new thing, and a new connection to the self for both participants.

The Intimate Self-Disclosure

I believe that in order to change the patient's experience of herself and her behavior, she needs an intimate connection with her therapist and consequently with herself.

Intimate self-disclosure is often what propels the work we do with our patients. It affects the patient in a deep and lasting way and provides a model of intimacy. It is what patients remember when the therapy is over–an unusual act of kindness on the analyst's part, such as lending the patient an umbrella, or an expression of feeling by the analyst–certainly more than brilliant interpretations.

We need to understand what an intimate self-disclosure is. At best, intimacy is saying the hard stuff, with your heart open. But there must be a sense of fit, mutuality, and empathy. When we disclose our feelings, either patient or analyst, there is a real and spontaneously alive experience in the moment. We have upped the ante, the power and effect of what has been disclosed. We allow for a spontaneous, comfortable and authentic relationship.

Self-disclosure stands in sharp contrast to clever interpretations, which have unfortunately often been used to show off narcissism,

to prove that the analyst is a smart big deal, and which can have a castrating impact on the patient.

What is intimate to one patient may be an intrusion to another. The therapist Eda Goldstein tells us that her first analyst revealed that the analyst and she shared the same birthday. After this disclosure Goldstein felt more positive toward her analyst, shared more of her inner life and consequently her depression began to lift. She had actually been searching for a common bond between them and the memory of this common bond is what still stands out from her therapy twenty-five years later.

In contrast, a fairly new patient of Goldstein's announced it was her birthday and the therapist "impulsively revealed that coincidentally it was mine too."21 The patient became angry and bitter and accused the doctor of trying to detract from the patient's sense of specialness. Goldstein admitted she was mortified by her narcissistic lack of attunement.

Psychoanalyst Theodore Jacobs spent years treating a depressed young man who, after Jacobs missed a session, expressed his anger at him by withdrawal and remoteness. During this young man's adolescence his father had been seriously hurt in an accident and afterwards became a distant, silent, pacing, and extremely hard-to-reach chain-smoker. When Jacobs' patient became unapproachable the analyst would try the usual and appropriate interpretations. He interpreted the patient's rage at being abandoned, the anger behind the patient's subsequent withdrawal, and how the patient's behavior

resembled that of the rejecting and insensitive father. To each of these accurate interpretations the patient would nod in assertion, but neither his behavior nor his mood would change.

Once after a short vacation, Jacobs was met by the same pas-sive-aggressive behavior. Jacobs went down an untraveled road. He told the patient, "When you go into one of your periods of withdrawal, as you are doing now, I feel shut out and helpless. I experience myself as completely cut off from you as though a wall of steel has come between us. I know that no matter what I say or do, there is no way that I can reach you. You have become the father sitting in the darkness, the father who, in his hurt and anger, shut out the world."22

To Jacobs' surprise, the patient wept for several minutes, a most unusual response for him. So what had happened? The patient later explained that he finally felt understood. He believed Jacobs was authentic and real, that Jacobs' feelings said more than his words were able. The patient, whose behavior began to change after Jacobs' authentic self-disclosure, explained, "The fact that you made it personal and told me how I was affecting you had a big impact on me." The patient admitted that at last he had reached his doctor, had pierced through the doctor's defenses, and also was able to realize that his silence (in response to the vacations) was an identification with the aggressor, a sadistic get-back, just as his father had done to him when his father was angry.

Darlene Ehrenberg wrote in 1992 that the actual words the therapist uses may not be as important as whether the therapist is involved or indifferent, tender or careless, patronizing or respectful, authentic or inauthentic.23 Many self-disclosures clearly are non-verbal. For Ehrenberg a goal of the therapy is to make it possible for anxieties, feelings, and fears about intimacy to be identified, commented on, and addressed, rather than smoothed over and obscured.

In an example of her work, Ehrenberg describes a time when she cancelled a session with a patient. He came in next time looking menacing and estranged. She said she was uncomfortable in the presence of a stranger she didn't know and couldn't reach. She acknowledged she was frightened, and told him she almost felt abandoned by a person with whom she thought she had a relationship. His response was dramatic, and he realized he had tried to abandon her for abandoning him. Ehrenberg believed her openness about her reaction, instead of interpreting, was powerful for the patient. It allowed him to experience his own power when he was feeling so powerless.24

Karen Maroda also believes that change relies more on emotion than intellect. She asserts that without intense affective experience for both parties, there is no deep and permanent change.25 The therapist, in the new arena of therapeutic mutuality, is supposed to reveal her emotional reactions about the patient to the patient in the moment. No more than that.

Maroda states that in many instances the analyst's hiding of negative emotions is actually more harmful than acknowledging them. It is perhaps more useful to our patients if we own our personal weaknesses and our feelings of shame, vulnerability, or the fear of being out of control.

A Continuum: Hiding–Self-Containing–Self-Disclosing

The analyst has many choices for responding on the continuum between hiding and deliberate self-disclosure. "Hiding" may be running away from truth, faking neutrality, pretending, perhaps defending against what you can't tolerate in yourself or the patient. Instead of hiding or self-disclosing, the analyst is usually striving to occupy a mid-ground, containing but being aware of his experience. One can be present in a neutral way to the moment, with "evenly hovering attention" to the patient's conflicts, but judiciously choose to remain silent. The analyst might be aware of multiple perspectives and that the possibility of saying one particular thing and not another would misrepresent the complexity of the patient's or the analyst's inner experience.

But if the analyst "hides," the patient will respond in kind and the work will not progress. When the analyst hides, the patient will not be found, uncovered, revealed to either himself or the analyst. If the analyst self-discloses to a patient who is not present or receiving, this analyst will feel hidden despite his willingness to disclose. Obviously, if the analyst is unboundaried, uncontained, "spills" or over-discloses, the work also may not progress.

The analytic myth used to be the oversimplification that containment is good, self-disclosing is bad. Containment or self-disclo-sure can be useful/helpful/good or not useful/not helpful/bad–or somewhere in between. Self-disclosure can be anything from a simple fact about one's life to more complex personal demographics, to inadvertent self-disclosures, to relational interpretations, to affectively shared moments of personally intimate and archetypal issues. Intimacy can occur when revealing simple personal facts, but it is more likely in vulnerable moments of openhearted mutuality.

Case Example

My own five-year, three-times-a-week psychoanalysis with Dr. X, in the mid seventies, very much shaped my thinking about self-disclosure and who I became as a therapist. My development also parallels the history of psychoanalytic thought about self-disclosure and the birth of the relational school in the l980s. Concurrent with the analysis, in a psychiatric residency program at Herrick Hospital in Berkeley, California, I was trained never, ever to self-disclose; to show nothing of myself as a person; never even to laugh at a pa-tient's joke, for laughing was not an anonymous response. This particular type of training did not fit my personality, and I took a personal dislike to it. Because of the training, I believed my analyst's rigid psychoanalytic style was the correct analytic response.

I slowly began to realize that Dr. X, in his cold, withholding and hiding manner, was inadvertently self-disclosing, revealing that at least part of him could be non-responsive and dismissive. Although then in my mid-twenties and without the vocabulary to describe this experience, I also recognized that I was spending much time in analysis dealing with his inadvertent self-disclosures and how he altered the frame of the therapy,

Dr. X and I would often arrive in the downstairs lobby of his building at the same 7:55 a.m. time and ascend in the elevator together for our 8 a.m. appointment. I would say "Hello, Dr. X" and he would not respond. This happened each time we took the elevator journey together and I would begin the therapy feeling hurt and rejected. He would deny any responsibility for my mood and ask the usual transference question: "Whom do I remind you of?" We both knew the answer was my father, and this dance was becoming tedious.

Another example of his inadvertent self-disclosure happened when I got up from the couch to help myself to some Kleenex in a different part of the room. (He would never offer me Kleenex as that would have self-disclosed kindness or concern.) I observed he was doodling on his note pad, not actually writing down what I was saying, as I had thought he was doing when I heard his pencil scribbling. When I returned to the couch, I dutifully commented on the doodling. "Why were you looking at what I was writing?" I felt shamed by his accusation. I realized later that the good parent

would have been honest about his doodling and responded to my curiosity or insecurity in a less humiliating way.

The termination is the third example I will give, but obviously there were examples of his inadvertent self-disclosure in every session for five years. For the length of the analysis I lay on the couch, per Dr. X 's recommendation. I did not like lying down unable to see him. He was convinced that my reaction was because my mother became an invalid when I was eleven and I did not want to be like her. I agreed with his obvious conclusion, but he rejected any other reason I offered. After almost five years I believed I would connect more with my own authority if I sat up. I wanted a more personal connection to him and wanted to face him, look directly at him. "Absolutely not," he again asserted. My reasons were unacceptable. "I will not be able to continue seeing you if you insist on sitting up," he told me. It was then, after a one-month termination phase, that I quit the therapy.

I was clearly influenced by my analyst's theoretical orientation. Upon leaving the therapy, I determined, "I will never do to a patient what was done to me" and decided that the lack of self-disclosure could be harmful, wounding and rude.

My Jungian analytic training also encouraged me to be a person in the room with the patient. During my first fifteen years as a therapist, when I self-disclosed to a patient, I would feel very guilty. I often dreamt I was sitting in front of the Sanhedrin of psychoanalysts who were in a row at a long table, frowning and

judging my bad behavior. Self-disclosures instilled much fear in me until I learned about the relational school of psychoanalysis.

What I learned from the relational/interpersonal model is what I always intuitively knew. Dr. X and I were in a deep relationship, and both of us needed to reveal who we were and how we were reacting to one another in order for the therapy to be successful. What I learned from Dr. X is that he did not have the objective truth he thought he had as to who I was as a person. Nor do I have objective truth about my patients. I honor how the patient impacts me and am willing continually to change as a result of my experience with the patient, in order to be useful. I admit that I am more often human, weak and vulnerable. I no longer believe the illusion that Dr. X wanted me to accept, that the therapist is strong, sure and authoritative.

Conclusion

Owen Renik reminds us that the therapist who believes in the healing interaction of the therapy more than the pursuit of insight doesn't need to worry so much about what he discloses.26

I agree. If we as therapists accept that what we have to say is only one educated opinion, not objective truth, and that the pa-tient's view is of equal import, then we don't have to worry as much about whether what we reveal or say is absolutely right or wrong. The psychoanalyst Donald Marcus comments that self-disclosure as well as silence-actually, every intervention-has the potential to be toxic

to the patient. As seen in my analysis with Dr. X, what can be equally toxic is the lack of emotional intimacy. A patient of Marcus's told him that her previous analysis, although helpful, had lacked an essential element.

She had not been able to bring her spirit into intimate contact with the spirit of the analyst. She felt that he hid his spirit or true self behind a wall of theory and she could not find him. She felt that only if their true selves made emotional contact could she learn about herself. I believe she is describing poetically what needs to happen in all good analyses (and of course between mother and baby). Some of us analysts try to make this emotional contact however we can, including self-disclosure. . . . Each analytic dyad, if the analysis is to be successful, must find a way to allow their spirits to touch.27

Self-disclosure is not a guarantee of attunement, of bringing into consciousness the deep connection that is (or at least is possible) in the room. Sometimes the disclosure actively intrudes. But neither is hiding a guarantee. And sometimes containing, holding back from intruding is the healing balm. Self-disclosure can be in the service of spirits touching or not, yet our hope is that the intimate self-disclosure, when expressed to a patient we trust to receive it, will deepen our connection.

Author's note: After writing this paper, I sent a copy to Dr. X. He was willing to meet to discuss it. He explained that he was being trained in the rigid, classical psychoanalytic model at the time of

our therapy thirty years ago, and it was a difficult model for him, as well. He, too, has been influenced by a more relational, human approach to doing psychotherapy. He no longer practices in the classical model. I could see Jung smiling in the distance.

ENDNOTES

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ABSTRACT
Betsy Cohen, “The Intimate Self-Disclosure,” The San Francisco Jung Institute Library Journal, 2004, 24:2, 31-46. This paper discusses the controversial topic of the analyst’s use of self-disclosure. The author examines reasons for, types, limits, ethics, and a brief history of self-disclosure. Sigmund Freud warned against its use in

1912. C. G. Jung, in contrast, understood the necessary mutuality between doctor and patient in the analytic relationship. The relational school of psychoanalysis in the l980s hesitantly embraced the concept of self-dis-closure and slowly adapted its usage. The author explores her basic tenet: that an intimate self-disclosure on the part of the analyst helps further and perhaps transform the work. She uses case material based on her personal analysis in the mid- seventies, where her analyst's putative refusal to self-disclose both framed and impeded the therapy.

KEY WORDS

Self-disclosure, anonymity, abstinence, neutrality, intimacy, psychoanalytic technique, transference, countertransference, relational school of psychotherapy, Sigmund Freud, C. G. Jung.