This article is an effort to integrate contemporary psychoanalytic and existential perspectives on intentional therapist self-disclosure. It offers a two-stage decision-making model that considers self-disclosure from the vantage points of style and internalization. Clinical and research findings are presented to support the notion that the meanings a patient attributes to a particular self-disclosure, and its power to move him or her towards greater health, is the product of a fluctuating matrix of interpersonal and intra-psychic variables. Special consideration is given to the challenges that arise during the early and termination stages of treatment and to the psychotherapy of therapists. © 2003 Wiley Periodicals, Inc. J Clin Psychol/In Session 59: 541–554, 2003.

Keywords: patient self-disclosure; therapist self-disclosure; psychoanalytic psychotherapy; existential psychotherapy; authenticity; internalization; style

I like two types of conversations—gossip and real talk.  
Jimmy Cannon

In this article, I will present interrelated ideas that I have been using to think about the following questions: When is it therapeutically beneficial to choose self-disclosure as the means of performing particular psychological functions on a patient’s behalf? What stylistic choices are required to individualize, as far as possible, the content of my communications? Are there occasions when revealing personal information can accomplish therapeutic aims that may not be possible otherwise?

I begin by embedding my views within a historical context. Then I will introduce a two-stage decision-making framework that distinguishes between the mental activities that enter into the decision to pursue certain therapeutic goals and the mental activities that enter into the choice of self-disclosure, rather than another verbal response, to try bringing about these goals. A central assumption is that a full understanding of therapist self-disclosure cannot be achieved by isolating that interaction outside the sequence.
of interactions when patients speak and therapists listen. The remaining sections of the article offer a sampling of the contextual factors that impact on my choices about when, what, and how to say something personal about myself to a patient. In the spirit of integration, I rely on clinical observations, clinical vignettes, and research findings to argue that the meanings a patient attributes to a particular self-disclosure, and its power to move him or her towards health, is the product of a fluctuating matrix of intrapsychic and interpersonal variables.

An Evolving Perspective on Therapist Self-Disclosure

This article grows out of my ongoing efforts to reconcile existential–humanistic and contemporary psychoanalytic perspectives on the tasks and division of labor required to realize the goals of long-term expressive-exploratory psychotherapy (Geller, 1984, 1987, 1989, 1996, 1998).

A historical overview of the literature reveals an ongoing struggle on the part of successive generations of psychoanalytically informed therapists to grapple with Freud’s (1912/1958) prophetic mandate: “The analyst should remain opaque to his patients, like a mirror and show them nothing but what is shown to him” (p. 118), and his warning against too much intimacy on the part of the analyst. Freud’s own writings about technique are at best skeletal in terms of what they have to say about therapist self-disclosure. Moreover, by his own admission, Freud’s technical recommendations were essentially negative. In a letter to Sandor Ferenczi, who was at the time experimenting with “mutual analyses,” Freud wrote:

I thought it most important to stress what one should not do, to point out the temptations that run counter to analysis. Almost everything one should do in a positive sense I left to tact. What I achieved thereby was that the obedient submitted to those admonitions as if they were taboos and did not notice their elasticity. This would have to be revised someday but without setting aside the obligations. (Grubricht-Simitis, 1986, p. 270)

I began my psychotherapy training in the late 1950s. During that era, therapists tended to read Freud’s “recommendations” as obligating them to verbally disclose as little personal information as possible, and to limit their expressivity as far as possible. My earliest readings focused on the dangers and pitfalls of revealing personal information to patients. Like many contemporary psychoanalytic therapists (e.g., Davies, 1994; Renik, 1995), I have gradually and cautiously liberated myself from the view that I ought to present myself as a blank screen upon which patients project their sexual and aggressive impulses and fantasies. Classical interpretations of such notions as abstinence, neutrality, and analytic anonymity no longer play a starring role in determining what I do and do not reveal about myself to psychotherapy patients.

My basic stance is primarily shaped by concepts such as reciprocity, mutuality, responsiveness, symmetry, and by a concern with the intersubjective aspects of the therapeutic relationship (Aron, 1996). Advocacy of these relational principles is congruent with a commitment to a therapeutic stance marked by authenticity, transparency, realness, and egalitarianism. These are the standards against which my existential teachers encouraged me to judge the quality of my work (Yalom, 1980).

Identifying myself with these principles has exerted two influences on my inclination to self-disclose: first, my inclination to use intentional self-disclosure as a therapeutic technique, and second, on my nonlinguistic contributions to the therapeutic dialogue. I conceive of my emotional expressivity as operating both as a vital source of information
for my patients and as a simultaneous contributor to an interpersonal context that anticipates and modifies the manner in which any particular self-disclosure is expressed and experienced.

I believe that I self-disclose more frequently than the prototypical psychoanalytically informed therapist. Still, for me, self-disclosure remains a low-frequency intervention. I believe that self-disclosures are all the more powerful if used sparingly. Less is (sometimes) more.

In contrast to previous generations of psychoanalytic therapists, I do not regard my commitment to using self-disclosure sparingly as obligating me to be muscularly vigilant or to inhibit the nonlinguistic expressions of my emotional reactions. For me, entering into an authentic dialogue has more to do with presenting myself in a way that is congruent with what I am feeling than with absolute verbal honesty. I believe that a therapeutic stance that combines judicious self-disclosure and relaxed, warm, spontaneous behavior yields an optimal therapist-relationship style. The distinction I am making is comparable to the difference between adopting a supportive posture/attitude towards a patient and deciding to use a supportive technique (e.g., reassurance) with him or her on a particular occasion.

I recognize that my style is only partly predictable from my theoretical allegiances. Data from various sources indicate that the personal styles and character traits of therapists who share the same theoretical point of view lead to substantial differences in our application of basic principles and techniques, including self-disclosure.

Thinking About Self-Disclosing

Intentional self-disclosures require interpersonal skills such as tact, timing, patience, humility, perseverance, and sensitivity. These soft skills cannot be learned from a manual. What can be taught are the precepts, rules, criteria, and cognitive processes that guide effective clinical decision making. Towards this end, I have been developing a two-stage decision-making model that considers the interaction between intentional self-disclosures and the expressive styles from which they emerge and in which they are embedded. For purposes of analysis, I follow Rosen (1977) in defining style, in the sense of craftsmanship, as a “... progressing synthesis of form and content in an individually typical manner and according to the individual’s sense of appropriateness” (p. 288).

I conceive of self-disclosure as a form of communication, in its own right (Geller, 1984). Self-disclosure plays a role comparable to clarifications, interpretations, and questions in the repertoire of therapeutic tools. It is one more way to deliver a message, and perhaps as adaptable as traditionally recognized therapeutic techniques. As used here, therapeutic techniques exist independently of the particular contents or messages that they communicate. Self-disclosure understood in this way offers the possibility of uncoupling its use from decisions that are made primarily on the basis of questions regarding content. Self-disclosures are both a what and a how. They can be used in the service of making interpretations, clarifying patients’ experiences, and posing questions.

Figure 1 illustrates the first phase of the decision making and the hypothesis that internalized representations of the therapeutic dialogue, like the communicative exchanges from which they arise, can serve a wide range of psychological functions (Geller & Farber, 1993). As can be seen, the outer circles contain the names of a broad spectrum of therapeutic aims and purposes, which range from those that are more closely identified with the definable “projects” that characterize a particular approach to therapy (e.g., co-creating insights, meanings, and narratives) to those that are of agreed-upon transtheoretical importance (e.g., conveying empathic understanding). A review of the literature
would reveal that psychotherapists have called upon self-disclosures to serve most, if not all, of the communicative and psychological functions found in Figure 1.

According to this conceptual rationale, a therapist first decides which treatment goals have priority and then selects from among various techniques in an effort to realize these goals. In my two-stage decision-making model, questions relevant to the intentional use of self-disclosure enter the picture after a therapist decides which treatment goals should be given priority. So conceived, choosing self-disclosure is the assertion of a stylistic preference.

Therapists who have found their own voice may experience the coming together of these conceptually distinguishable stages of decision making as an organic event. One can experience the decision to self-disclose as inherent in the decision to pursue a particular treatment goal. Beginners, by contrast, often find themselves trying to choose between conflicting modes of realizing a particular goal, all of which feel as if they have a legitimate claim.

To illustrate the distinction between form and content, let us consider the decision to provide a patient with feedback regarding his or her impact on others, including the psychotherapist. It would be hard to find a contemporary therapist who disagrees that pursuing this goal can make a vital contribution to psychotherapy. What remains after prioritizing this goal is whether self-disclosure represents the optimal form to reach this laudable goal. Here are contrasting forms of confronting a patient with the consequences of his or her verbosity: “If I’m to speak, I feel I have to interrupt you,” “I feel shut out by

---

Figure 1. Internalization of the therapeutic dialogue. The lines connecting the circles indicate that a single efficacious communication can simultaneously serve multiple therapeutic functions.
your nonstop talking.” “You speak like a runaway train that no one can stop.” “Are you afraid to stop talking?” There are patients who react negatively to self-involving statements, irrespective of their content. They object to the form, itself. I take such (aesthetic) preferences into account when selecting the combinations of forms of communicative exchanges that I encourage during therapy sessions.

Forms of Patient Self-Disclosure

In one form or another, psychotherapists ask their patients to reveal personal information about themselves. The medium of communication most frequently authorized is spoken language. Patients tend to use only those modes of communication that their therapists have explicitly or implicitly authorized for use. Patients taking the talking cure tend to limit themselves to syntactically organized words. Creative arts therapists do not share this bias. They authorize patients to self-disclose in many different formats. For example, dance therapists view expressive movements as an alternative mode of communication rather than as an accessory or as preliminary to verbal self-disclosure. Similarly, art therapists do not regard thought and communication in images as more primitive than thinking and speaking in words.

Their work has strengthened my conviction that personal disclosures and the creation of meaning through the symbolization of experience can occur in any medium or channel of communication. Words are only part of the communicative exchanges that take place during therapy sessions. So much of what is communicated in therapy is visual or nonverbal. These truths have encouraged me to explore the therapeutic possibilities of looking at family pictures with my patients, having them draw the rooms they lived in as children, and inviting them to take on the postures, gestures, and facial expressions of their parents.

In varying degrees, the content of psychotherapy is furnished by patients’ narrative accounts of the personal and private lives of others. Therapists are told things about others that these others might prefer to keep hidden. In other words, psychotherapists are privy to what in ordinary conversations would be considered the classic form of gossip. In a smoothly flowing therapeutic dialogue, talk about the flaws, limitations, and morally suspect activities of others steadily mutates into open-ended exploration and acceptance of one’s own secrets and foibles. But therapies rarely run smoothly, not by any means.

Talking about others is one way of taking the spotlight off the self. It can be a means of trying to persuade or convince the therapist to accept and emotionally participate in one’s personal evaluation of the other. When the content is related to a moral offense, talking about others may be an invitation to share in something forbidden. The sharing and keeping of secrets is also a way of establishing closeness. The sociologist Simmel (1950) observed with respect to secrets that they “put a barrier between men . . . but at the same time create the tempting challenge to break through it, by gossiping or confessing” (p. 123).

To discover ways of transforming patients’ portraits of others into vehicles for their gaining intimate knowledge of their own personal experiences, I listen to revelations about others with Richter’s (1962) aphorism somewhere active in my mind: “A man never reveals his character more vividly than when portraying the character of another” (p. 80). For example, I will listen with a mind towards understanding the extent to which the patient is capable of experiencing his or her parents as unique, complex, flawed persons, existing external to the self, and as having an inner life and a history, and not merely as sources of gratification and frustration. My attentiveness is rooted in the assumption that bringing to awareness these aspects of patients’ internalized representations of
caregivers and authority figures and subjecting them to constructive modification is an important agent of change (Geller, 1987).

Resistances to Self-Disclosure

One of the few things that unites the different versions of psychotherapy is a belief that patients resist self-disclosure and self-exploration vigorously, persistently, and often with great subtlety. In the usual sense of the word, resistance connotes oppositionality. What distinguishes psychoanalytic therapy is that patients are told, instructed, exhorted to disclose, to the therapist, everything that comes to mind regardless of how insignificant or shameful it might be. No other therapy so explicitly and so authoritatively tells patients what and how they are required to communicate during therapy sessions. In place of free association, existential–humanistic therapists prescribe another kind of verbal honesty—speaking authentically (Yalom, 1980). By definition, a dialogue ceases to be authentic if one or both participants present themselves at variance with what they are feeling.

To narrow the gap between experience as it is experienced and experience as it is described, I begin by listening for what a patient considers to be the subject matter or conversational content of therapy. By leaving their task with respect to self-disclosure ambiguous, I have a chance to gradually expand my patients’ conception of what constitutes therapeutic material. Some enter therapy assuming we are only interested in what is sick, wrong, or sinful about them.

I find it useful to think of self-revelation and self-concealment as co-occurring inclinations that stand in a dialectical relationship. Patients simultaneously approach and avoid the ideals of authenticity and free associating. Therefore, our comments on resisting should not be phrased as if self-revelation and self-concealment were polar principles. Statements beginning “You seem to be avoiding” . . . are half-truths, at best. Conflicts are inevitable, given the degree of candor and affective freedom expected of patients. To honor the structure of conflict, sentence constructions like “On the one hand . . . yet, on the other hand . . . ,” are required. For example, I once told a patient who was struggling to protect his precarious sense of autonomy while trying to be cooperative that he repeated my questions before answering them: “On the one hand, you always try to answer my questions conscientiously. On the other hand, by restating them out loud, before answering them, you seem to be trying to answer your own questions: I feel as if I am overhearing a conversation you are having with yourself.” With him I took care to acknowledge that resistances are a function of the interdependent aspects of the therapeutic relationship, and phrased my comments so as not to convey the impression that I “know more” and he “knew less” about himself: “It seems as if we are getting into power struggles about who is right and who is wrong.” What do you make of this?“

The Temporal Context of Self-Disclosure

As previously stated, my working assumption is that the meaning and value of self-disclosures only can be understood in context. Beginnings and endings are temporal contexts. Psychotherapists approach self-disclosure differently during the opening and closing phases of therapy.

I am particularly attentive to the communicative importance of my vocal qualities and facial expressions during the early stages of therapy. Early in therapy, patients may be too anxious to take in the lexical/conceptual meanings of a therapist’s communications. They may hear and remember little more than the acoustic properties of their
therapists’ voices or the information written on their therapists’ faces. To accommodate to
the idiosyncratic communicative requirements of “listening challenged” patients (Geller,
1996), I am prepared to adjust the ways in which I space silence and sound, stillness and
movement. Winnicott clearly appreciated the communicative significance of the flow of
sound and silence. He demonstrated this appreciation when he told his prospective patient,
Harry Guntrip (1975, p. 152), near the end of their initial interview, “I’ve nothing par-
ticular to say yet, but if I don’t say something, you may begin to feel I’m not here.”

I have found variations of “If I . . . you will . . .” a valuable format in which to
express my reactions to the kinds of impact patients have on me, especially if they are
bringing about the very hurt they are trying to avoid. One of my patients watched me,
hypervigilantly, for feedback about how his performance as a patient was being evalu-
ated. At the same time, with characteristic worry, he scrutinized me to detect whether I
was physically present, but emotionally absent. Before we were ready to submit the
meanings and origins of these inclinations to therapeutic scrutiny, I used the following
self-involving statements to acknowledge their consequences for our relationship: “I fear
that if I don’t completely agree with you, you will feel as if I am insulting your intelli-
gence,” and “I fear that if I don’t say I’m sorry, my attention lapsed for a second, you’ll
think you were boring me.”

The Listening Cure

During the early stages of therapy, I limit myself to self-disclosures that are meant to
convey acceptance, empathy, and encouragement. This task was successfully accom-
plished when I revealed to a distraught mother/patient of a handicapped child how dif-
ficult it was to raise my deaf daughter, Jenny (Geller, 1996). Moreover, I did not try to
conceal the tears that spontaneously welled up in my eyes when she spoke, stoically, of
her father’s death. She lost him when she was a child. I have noticed that I am sometimes
brought to visible tears when a patient describes, unemotionally, his or her own legitimate
suffering. Analogously, when a patient persistently describes painful feelings in terms of
raw bodily sensations, I will name the painful feelings that I associate with my somatic
reactions. For example, when a hypochondriacal, panic-stricken, and alexythymic divor-
cee told me: “I thought my pounding heart was going to explode when I saw my
ex-husband,” I recall saying, “I take it as a sign that I am feeling anxiety or fear when my
heart pounds.”

But as I have come to learn, there are no risk-free self-disclosures, nor is there such
a thing as just listening in psychotherapy. This commonly heard phrase implies that it is
possible to “not communicate” when in the role of listener. Therapists convey as much
comprehensible content about themselves when listening as when they are talking. Each
therapist unavoidably and uniquely reveals who he or she is in ways of being and listen-
ing that are publicly observable.

One patient interpreted my relative stillness while listening as signifying “selfless
devotion” to her welfare. She felt I had given her a gift when I told her the destination of
my vacation. By contrast, another patient told me “You just sit there like a bump on a
log,” and resented my telling him that I was going to a Caribbean island he had previ-
ously visited. As we subsequently learned, he feared that I would die in a plane crash and
wanted to avoid recognition of the ways in which we were alike. It is important to iden-
tify early on those patients who feel burdened by the responsibilities that accompany
knowing about their therapist’s private life. In my experience, they tend to be the same
patients who cannot take in positive feedback about their impact on people, including
therapists, without feeling “intruded upon,” “invaded,” “penetrated,” or “engulfed.”
There are many reasons why a patient might not express any curiosity about the therapist. Some patients are only interested in what their therapists can do for them while in the role of therapist. Some are afraid that their curiosity will be experienced as an invasion of their therapist’s privacy and as an act of disrespect. Still others bring to therapy the unformulated assumption that there are prohibitions or taboos about asking therapists personal questions.

A related, unwritten rule is that patients are to explore their reasons for asking personal questions before answering them. Insisting on this sequence is not technically correct. It is rigid. There are clearly patients with whom one should first answer a question, and then if possible, try to understand its associated meanings. This stance was first recommended as a way of dealing with the special challenges posed by adolescents as well as by paranoid and narcissistically vulnerable individuals (Miletic, 1998). My patients usually have an accurate sense of the limits beyond which I will not disclose information in response to a request. I have come to expect that their questions are linked to their implicit theories of healing. I take it as a sign that I am with a deeply disturbed person if his or her questions betray a disordered or deficient guiding sense of the appropriate.

Therapists are perhaps most in doubt about what is the “right” thing to do when a patient asks their opinion about their personal characteristics: “Am I pretty?” “Am I smart?” “Am I talented?” “Am I sexy?” “Was I right?” When it comes to any intervention, the best safeguard against making a mistake is choosing a response that reflects the individuality of each patient. Necessary first steps are taken in this direction by demonstrating a willingness to learn from and with a patient through dialogue and by relinquishing the need to be “right.” Moreover, educated therapists have devoted serious study to the question, “What personal questions evoke in me defensiveness, hostility, and withdrawal?” Until this inquiry has been conducted, it is very difficult to distinguish between evasiveness and a grounded decision to reflect a personal question.

Given the limits of understanding human specificity, therapeutic mistakes are inevitable. But there is no more powerful way of demonstrating that therapy is a process of mutual discovery than by openly acknowledging one’s mistakes. It is therefore encouraging to note that preliminary data indicate that revealing one’s mistakes is a common practice among psychotherapists (Geller & Farber, 1997). This practice is compatible with the widely held view that a consistent focus on threats to and ruptures of the therapeutic alliance contributes to the success of therapy.

Timing and Self-Disclosure

An essential prerequisite for the effectiveness of any therapeutic intervention is timing. I have found that it is inadvisable to wait to make one’s first self-disclosure until one is doing so as a means of dealing with a difficult resistance. Patients’ reactions to the novelty of the event may override their reactions to the message’s content. If a novel stimulus is too novel, it will be experienced as frightening and noxious. By contrast, individuals tend to move towards and explore with pleasure moderately novel stimuli.

Whenever highly charged feelings are involved, I check their strength and persistence before searching for words to describe them. The inclination to self-disclose must return several times during a session after it has been dismissed or has dissipated before I give it serious consideration. The disciplined practice of psychotherapy requires finding the optimal balance between restraint and relaxed spontaneity. So-called “spontaneous disclosures” often are made in the throes of a disturbing countertransference reaction. They are blurted out when a therapist has reached the limits of tolerance of what is going
on in therapy. At these times, the inclinations to self-disclose may be a form of self-indulgence. When it comes to countertransference disclosures, it is best to “strike when the iron is cold.”

Patients need to be prepared to listen to self-involving statements that bring the resisted aspects of their experience of therapy to awareness, without hearing them as “uncomplimentary.” There are various ways of preparing a patient to receive more intimate self-disclosures. Providing patients with information about one’s training and method of treatment can serve this function and enables them to make more informed decisions about whether to continue in therapy. Revealing some “innocuous” details of one’s life early in therapy (e.g., vacation plans, age) is especially important if one anticipates revealing a “special event” (e.g., pregnancy and birth, serious illness in the therapist) during the course of therapy. If a patient has difficulty with my revealing any personal information, I rely on two alternative modes of preparation. The first way is to describe a decisive moment in the life of a prominent public figure. I do so to indicate that we are members of the same community and to concretize otherwise abstract ideas. For example, I recently told an author whose inability to tolerate the excitement and anxiety that accompany the striving to create about Philip Roth’s telling an audience that he was having a panic attack, how he left the stage uncertain if he would return, and how he came back and finished his lecture. Recounting scenes from emblematic films and television programs known to the patient and myself is another form of quasi-self-disclosure. An emotionally isolated ex-addict, who reflexively reacted against my describing a parallel experience to his in my own life, accepted our common humanity when we discovered that we were both moved by a son’s longing for a respected father, as portrayed in the film Field of Dreams. Like many men, he confused fearfulness and cowardice. To highlight my respect for his courage, and to clarify what courage means to me, I recounted the following scene from the film The Three Kings. An Army sergeant, fighting in the Gulf War, asks an inexperienced private: “You’re scared, right?” Reluctantly, the private answers “Maybe,” to which the sergeant replies “The way this thing works is you do the thing you’re scared shitless of and you get the courage afterwards, not before you do it.”

There is always something I admire, effortlessly, about my psychotherapy patients. When they find it unacceptable to be self-congratulatory or self-promoting, I will be on the lookout for opportunities to praise their accomplishments in therapy and elsewhere. Moreover, my offerings of praise are typically voiced personally (e.g., “That’s great”) rather than impersonally (e.g., You must be very proud of yourself”). Similar considerations enter into my work with patients who disqualify or invalidate their own feelings. With them, I will find occasions to say such things as “I like the way you put it,” “You hit the nail on the head,” “Can I quote you on this one,” “You’re oh so right,” and “It’s so true.”

Knowing About and Experiential Knowing

Broadly speaking, patients have two potential sources of knowledge about their therapists: knowledge that is dependent on what the therapist chooses to verbally reveal and the knowledge that is dependent on receiving the information that is available to the senses during therapy sessions. Therapists have less conscious awareness of and control over the messages conveyed by their characteristic level of expressivity than over the messages conveyed by intentional self-disclosures. Analogously, patients have far less awareness of what they are learning about their therapists by receiving information during therapy sessions. In other words, the knowledge that patients acquire from encounters
with the “perceptual reality” of their therapist often remains at a tacit or subliminal level. Consequently, a patient may know much more than he or she knows about the therapist than either of them is willing to acknowledge.

I draw on this distinction to deal with a variety of technical challenges. There are patients who benefit from feeling understood, but who react negatively if they are supplied with knowledge about themselves. Similarly, there are patients who can accept their therapist’s empathic understandings, but who have a reduced ability to feel safe if autobiographical information about their therapist is known to them. During the course of exploring a patient’s complaint that I volunteer too little personal information about myself, I will try to inquire how the patient is feeling about what he or she does know about me. Such inquiries are a valuable source of information about a patient’s prevailing capacity to recall, use, and identify with influential representations of our therapeutic dialogue. I take this capacity as an important sign that a great deal of significant therapeutic work has been accomplished.

Self-Disclosure and the Therapist-Patient

Psychotherapy with patients who are themselves psychotherapists offers a unique perspective from which to examine questions about therapist self-disclosure. Therapists have less control over what their therapist-patients know about their private lives than they do with lay patients. Nontherapist-patients usually begin therapy not knowing very much about their therapists. In some cities, therapist-patients begin their own treatment uneasy about the “information” they already have about their therapist’s reputation, life style, marital history, and the like. If they live and work in the same community as their therapists, therapist-patients are likely to know if their therapist’s status is that of teacher, supervisor, administrator, scholar, guru, or sage. In some professional communities, therapist-patients have the opportunity to observe their therapists at conferences, business meetings, and parties. Moreover, much more than is true for lay patients, therapist-patients have posttermination social and professional contact with their therapists. There is a tradition in psychoanalytic circles for therapist-patients to transform their therapy relationships into supervisory relationships and vice versa.

Therapist-patients whom I have treated are frequently perplexed about how to talk about what they have been told about me, in confidence, when “gossiping” with colleagues. They also have acknowledged feeling awkward about expressing opinions about people we know in common, especially if they assume we hold conflicting opinions. In short, the therapy of therapist-patients takes place in interpersonal and organizational contexts different from those encountered with lay patients.

I recognize that these differences influence my decisions regarding the expressiveness of my conversational style and the use of self-disclosure. The findings from our national study of psychologists’ experiences conducting psychotherapy with mental health professionals (Norcross, Geller, & Kurzawa, 2001) indicated that my experience overlaps with that of “therapists-therapists.” In contrast to therapists who treat mental health professionals rarely or intermittently, the self-designated therapist-therapists in our study tended to be more forthcoming about personal information and more emotionally expressive with their therapist-patients. Statistical analyses revealed that therapist-therapists are more likely to disclose information about their own therapy and to apologize for mistakes and technical errors when treating therapist-patients. The therapist-therapists also characterized their self-presentation as being less guarded as well as more collaborative and egalitarian when the patient is a fellow therapist. Even those therapists who claimed to be no more self-disclosing with their therapist-patients than with lay patients of comparable
intelligence, socioeconomic status, and diagnosis reported feeling less detached from, friendlier towards, and as enjoying being with therapist-patients more than their nontherapist-patients.

Whether or not they share the same profession, my patients have described the occasions on which I spoke of my own experiences as a patient as dramatic, intense, and memorable. They also have frequently characterized these exchanges as turning points in the course of their therapy. I recall one patient who was able to speak for the first time without knowing exactly what he was going to say when I told him about how I had rehearsed what I was going to tell my first therapist.

Psychologists in our study acknowledged that they were more likely to discuss research and professional matters with their therapist-patients than with lay patients. If excessive intellectualizations that might be used defensively are avoided, frank discussions of scientific issues are a respectful way of dealing with the inherent tension between the formal roles of therapist and patient and the collegial aspects of the relationship. Like shoptalk and inside jokes, there are self-disclosures that make reference to the practice of psychotherapy itself that only a fellow therapist would fully understand. For example, a colleague was able to counteract the interfering consequences of his therapist-patients overidealizing transference—she thought he would make the ideal husband—by saying “As you know, we present our best selves when in the role of therapist.” A cognitive-behavior therapist deeply appreciated and benefited from my quoting his mentor, Marsha Linehan, when he bitterly blamed himself for resisting making progress in therapy: “You are doing as well as you can and you can do a lot better.”

Self-disclosures about affiliating with different theoretical orientations also can lead to fruitful and emotionally charged interactions. In the second year of therapy, I said to a therapist-patient who espoused a theoretical orientation other than my own: “Somehow when we talk about our ideas about therapy, you seem to not only need to be right, but right in such a way as to prove me wrong.” I encouraged him to notice how frequently he began sentences with “Yes, but . . .” rather than “Yes, and . . .” when discussing matters of theory and practice with his colleagues. What he discovered was that he was antagonizing his colleagues by structuring scientific conversations as if they were debates between adversaries.

That self-disclosure is particular to the treatment of patients who are themselves therapists is consistent with my argument that self-disclosures should be relative to the specific context and the individual patient. The psychotherapy of therapists also offers a unique perspective from which to examine a question that is relevant to the psychotherapy of all types of patients: Does access to information about one’s therapist’s personal affairs interfere with the development and observation of transference reactions? My own view is that ambiguity is far more capable of stimulating analyzable fantasies than the total absence of information.

Self-Disclosure and Termination

Owing to a variety of reasons, for therapists the inclination to self-disclose intensifies during the termination phase of therapy. Some therapists advocate becoming more self-revealing for technical reasons. They call upon self-disclosures to facilitate a working through of the transferential aspects of the relationship. This strategy is premised on the assumption that self-disclosures are required to narrow the role mediated and emotional distance separating therapist and patient.

By contrast, like the majority of therapists we have interviewed (Greene & Geller, 1981), I am naturally inclined to move closer to my patients and to democratize the
relationship as the final sessions approach. I am temperamentally given to deepening my involvement with persons with whom I am saying goodbye, especially if we have had a warm, meaningful and productive relationship. Self-awareness and restraint are required to modify this generalized orientation to ending relationships according to the needs of one’s patients. Failure to manage this task undermines a therapist’s ability to be intimate with a patient while in role.

Concurrently, over the years I have come to trust that an increase in my readiness to become more spontaneous and self-disclosing is a sign that I am becoming for the patient more of a “real person” to remember and identify with. I believe that the entire therapeutic process, if effective, leads inevitably to the patient’s perception of the therapist-as-he/she-is. I further believe that, like the verse and obverse of a coin, the achievement of this therapeutic goal goes hand in hand with the approaching realization of a patient’s life goals.

During the ending phase of therapy, self-disclosures are called upon to serve a different constellation of tasks than those that predominated during earlier stages. During the middle phases of therapy, self-involving statements play a vital role in identifying those problematic aspects of the therapeutic relationship that prevent the realization of treatment goals. It is quite a different order of things to self-disclose to celebrate the achievement of these goals, to reciprocate the tender feelings expressed by an appreciative patient, and to say goodbye. Intimacy replaces power and authority as the focal point of therapist self-disclosures during termination. Within this context, the question “Is it appropriate for me to ask my patients to risk sharing their most intimate feelings if I am unwilling to take the same risk?” takes on new meaning.

The cumulative effect of these changes is to increase uncertainties about the optimal location and management of the boundary between the “professional self” and the personal self. The tension between spontaneity and restraint peaks once the decision to terminate has been made. I would not be surprised if fears of saying and doing more than one intended become more salient when ending a therapeutic relationship that is emotionally charged for both participants. Worries about overstepping the ethical boundaries of contact with patients can lead to a defensive avoidance of the ambiguities of intimacy. Resisting the temptation to express loving feelings for technical reasons and the fear of boundary violations must be clearly distinguished. This is no easy task, for as Rieff (1961) concluded, “Freud conceived of abstinence both as a scientific principle and as a moral injunction” (p. 23).

The Fate of Self-Disclosures After Termination

Patients usually remember very little of what was actually said during a course of therapy. Our studies suggest that therapist self-disclosures tend to be among the few utterances that can be recalled by patients after they have terminated (Wzontek, Geller, & Farber, 1995). Moreover, as the following example illustrates, therapist self-disclosures can have a delayed or continuing influence on patients after termination.

When interviewed one year after he had ended a therapy which he regarded as “successful” but “incomplete,” an obsessional lawyer and film buff recalled with great vividness that “Dr.__ recommended that I go see Albert Brooks’ movie entitled Defending My Life . . . I took it as a sign of trust in me.” He savors and benefits from the assumption that his therapist knew he would enjoy the film and find it instructive. Yet, he still hasn’t watched the movie. He explained “I feel like it’s like dessert, like you know, sometimes you want to save dessert, and I feel I’m not quite ready to give myself that pleasure.”
Conclusion and Summary

In this article, I have reasoned that competent use of self-disclosure in psychoanalytic–existential psychotherapy depends on a therapist’s ability to flexibly accommodate his or her activity level, depth of involvement, and expressivity to meet the idiosyncratic requirements of individual patients at each phase of therapy. I have sampled a few of the intrapsychic and interpersonal variables that have an immediate impact on patients’ and therapists’ attitudes toward self-disclosure.

Before concluding, let me place the therapeutic situation in its broader cultural context. Very different attitudes toward privacy and modesty held sway when Freud formulated his notions of repression, resistance, and anonymity. His early discoveries were made during a time when people’s erotic secrets were a walled-off realm. We live in a culture that encourages public displays of real and imagined openness. Baring it all is a staple of today’s television shows, movies, memoirs, and novels. Human suffering has increasingly become a source of entertainment. In one media after another, the unsavory secrets of our leaders, heroes, and celebrities surface as gossip. Have these changes in our sociocultural attitudes between what is public and what is private weakened the constraints that inhibit confessing personal secrets in psychotherapy? Have they increased the probability of patients talking about the intentionally concealed secrets of others? Have they weakened therapists’ efforts to resist the temptations of gossiping?

Professional codes and oaths have very little to say about the circumstances that justify overriding the principle of confidentiality when talking with a colleague. Although they would be loath to acknowledge it, what would otherwise be deemed as gossip in other contexts clearly takes place when mental health staffs gather behind closed doors. Concurrently, new forms of interagency collaboration and new forms of record keeping are making it ever more difficult for therapists to keep the secrets they have been entrusted with by their patients from third parties.

One hundred years from now, how will psychotherapists evaluate our efforts to maximize the therapeutic potential of the intentional use of self-disclosure? Hopefully, they too will be guided by the proposition that deciding what, when, and how to reveal one’s self to patients is not something we can get straight once and for all, but an ongoing task of reaching toward ever more exact formulations in an ever-changing field.

Select References/Recommended Readings


