Playing One's Cards Face up in Analysis: An Approach to the Problem of Self-Disclosure

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A policy of consistent willingness on the analyst's part to make his or her own views explicitly available to the patient is discussed and illustrated by clinical vignettes. Playing one's cards face up is contrasted with contemporary conceptions of selective self-disclosure by the analyst, especially with respect to the way ground rules for the analytic treatment relationship get established. The objective of the analyst playing his or her cards face up is to create a candid dialogue, thus facilitating maximally effective collaboration between analyst and patient. Concerns about the analyst's self-disclosure foreclosing exploration of the patient's unconscious fantasies and transferences, or intruding upon the patient's autonomy, are addressed, as is the relation between self-disclosure and an individual analyst's personal style.

I think we can say that there is by now significant consensus among contemporary analysts concerning at least some aspects of the problem of self-disclosure. It's widely agreed that we need to re-think what we even mean by an analyst's self-disclosure, given that everything an analyst does is self-disclosing somehow or other, and given as well that every purposeful effort by an analyst at self-disclosure is likely to obscure some things about the analyst while it reveals others (e.g., Greenberg 1995; Renik 1995; Singer 1977). At the same time, it's widely agreed that intentional self-disclosure by an analyst, however
we conceptualize it, is an important element of clinical method (Miletic 1998). Clearly, we need to develop ways of thinking systematically about what, when, and how an analyst optimally discloses; but generalizations concerning this subject always elicit concern. No one wants to lose sight of the importance of taking into account case-specific factors and judgments particular to the clinical moment (e.g., Aron 1991; Cooper 1998; Rosenbloom 1998).

Analysts, overall, are reluctant to unequivocally endorse self-disclosure (Moroda 1997). Nonetheless, my own experience has been that clinical work benefits when the analyst takes a stance from which self-disclosure, rather than anonymity, is the norm. When I analyze, I try as best I can to play my cards face up: that is to say, I'm consistently willing to make my own views—especially my own experience of clinical events, including my participation in them—explicitly available to the patient. I find that it is crucial for an analyst to have what Frank (1997) calls “an attitude of willingness to be known by the patient” (p. 309). This attitude toward self-disclosure directly contradicts not only the long-standing, traditional technical principle of analytic anonymity, but the more contemporary idea that it is helpful for the analyst to be “selective” about self-disclosure, thereby maintaining a “relative anonymity” (e.g., Jacobs 1999).

I mean to propose that playing one's cards face up in analysis is a useful overall policy, a general principle that best directs an analyst's conduct in the clinical situation. Commitment to this policy can be difficult and requires discipline. An analyst's personal values—tensions between the analyst's narcissistic and altruistic interests, for example—are fundamentally and decisively implicated in the effort to play one's cards face up. Ehrenberg (1995, 1996) speaks directly to this aspect of analytic self-disclosure when she discusses it in relation to the analyst's emotional availability and vulnerability. Often, what is at stake for the analyst in describing his or her own experience is exposure to a kind of explicit, unameliorated scrutiny by the patient that can be most distressing. A willingness to self-disclose, in these moments, involves a choice for the patient's welfare over the analyst's comfort.

However, while there are ethical aspects to decisions concerning
self-disclosure, the main virtues of playing one's cards face up in analysis are practical. The attitude toward self-disclosure that I want to discuss is consistent with any number of trends in contemporary analytic thinking that take the analyst off a pedestal and permit the patient to claim greater authority, thus expanding the patient's functioning in the treatment situation. More and more, we have been leveling the clinical analytic playing field; and an important part of this process has been the discovery that explicit communication by an analyst of his or her experience is crucial to the sort of cooperation between analyst and patient that permits honest and open-minded clinical investigation. As Gerson (1996) puts it, “By allowing the patient access to himself or herself as a subject in the analysis, the analyst reveals a process of knowing rather than a known product” (p. 642).

Some colleagues have understood these developments to stem from a Zeitgeist—a movement toward greater democracy in the culture at large, a post-modern turn in intellectual life (e.g., Bader 1998). I don't agree. Over the years, there has been an evolution toward less self-importance and more candid self-exposure by analysts, and we fail to appreciate its significance if we dismiss it as determined by political aims or academic fashion. We have every reason to think that it has been motivated by immediate, pragmatic considerations: analysts have been learning how to establish a more collaborative treatment relationship with their patients because it yields better clinical results. My impression, which I would like to discuss and illustrate in some detail, is that playing one's cards face up is a more effective clinical practice than the deliberate pursuit of even relative anonymity.

**Negotiating Self-Disclosure**

Of course, questions have been raised about the utility of purposeful self-disclosure by an analyst. One often-expressed, understandable concern is that too much emphasis on the merits of the analyst's self-disclosure disposes to an intrusive clinical approach (e.g., Mitchell 1997). Actually, I don't think the problem of intrusiveness by an analyst is specific to the activity of self-disclosure. Any aspect of an analyst's
method (whether it arises from the analyst's preferred theory, the analyst's character, or, very likely, both), whatever its virtues, will also have the liability of impinging upon the patient's freedom one way or another, and constraining analytic investigation. The only safeguard against intrusion by an analyst, I believe, is for the analyst to remain open to input from the patient about his or her technique. Certainly, a policy that directs the analyst toward self-disclosure has to be accompanied by a willingness on the analyst's part to pay careful attention to his or her decisions concerning self-disclosure and to deal with them collaboratively within the treatment relationship. The following still holds for me.

I would say that an analyst should try to articulate and communicate everything that, in the analyst's view, will help the patient understand where the analyst thinks he or she is coming from and plans to go with the patient... I emphasize in the analyst's view because, clearly, patient and analyst may disagree about what it is useful for an analyst to disclose, in which case the matter becomes open for consideration—neither the analyst's nor the patient's view being privileged a priori...

By acknowledging that an analyst's judgments concerning what constitutes relevant...disclosure on his or her part are subjective, we indicate a role for the patient as constructive critic of those judgments. This is a reciprocal of the analyst's familiar role as critic of the patient's self-disclosure. We know that when a patient tries to say everything that comes to mind, an analyst is able to point out things the patient overlooked. Similarly, when an analyst tries to make his or her analytic activity as comprehensible as possible, a patient is able to point out things the analyst overlooked. [Renik 1995 pp. 485-488]

In my observation, self-disclosure by an analyst does not lead to undue focus of attention upon the analyst at the patient's expense. In fact, just the opposite is the case: the more an analyst acknowledges and is willing to discuss his or her personal presence in the treatment situation, the less room the analyst takes up and the more he or she
leaves for the patient. A reticent analyst looms large, occupying center stage as a mysterious object of interest. The patient remains very well aware of being engaged in an encounter with another individual human being; and the patient's need to know the analyst's intentions, assumptions, values—the patient's need to know about the person with whom he or she is actually dealing—does not go away, even if the analyst deems it irrelevant to exploration of so-called “psychic reality” (see Renik 1998). I think we are all familiar with how a game of “Guess What's on My Mind” tends to be initiated when an analyst tries to remain even relatively anonymous. Too many patients have wasted too much time playing that game. My experience has been that, ironically, self-disclosure helps an analyst avoid becoming an intrusion. Here is an example.

Anne

In her analysis, Anne repeatedly seemed to need to relinquish critical thoughts about her husband when they arose, turning to self-doubt instead. Growing up, Anne had experienced her mother as loving, but quite controlling and intolerant of independence, let alone contradiction from her children. Anne and I discussed the possibility that her difficulty in feeling critical of her husband might connect to a sense of danger that she had learned in relation to her mother.

Anne was a TV journalist whose career was really starting to take off. One day, she described how her husband had seemed conspicuously uninterested when she was telling him, with great excitement, about a story she was working on. Anne considered that her husband might be threatened by her success; but after a time, she decided instead that there must have been something about the way she had been talking to her husband that turned him off.

After listening to her account, I said, “I'm confused. What gives you the impression that your way of talking turned your husband off?” Anne responded, with slight irritation, “I don't think you're confused, Owen. I think you have a view of what's going on. Why don't you just say what you think?” Well, of course, Anne was right. I wasn't really
confused. My hypothesis was that Anne had once more felt the need to criticize herself instead of her husband. However, I didn't know for sure that Anne was abdicating her critical capacities, and I expressed myself inconclusively because I wanted to leave room for the possibility that in this instance she might actually have been perceiving something about herself that warranted her self-criticism. I explained this to Anne.

She considered. "That makes sense," she said. "I can understand where you were coming from. But why didn't you just explain your concerns? Instead, you presented yourself as confused, and that wasn't really true—not to mention that it goes against your policy, which you've explained to me, of making your thinking explicit so that we can discuss it if we need to. Not that it's such a big deal, but why did you bullshit like that?"

Good question, I thought, and said as much to Anne. I told her what came to my mind. I was aware of not wanting to seem controlling like Anne's mother. The kind of presumptuousness that Anne felt she got from her mother was something I particularly dislike, so I was taking pains to be sure Anne experienced me differently. As the hour ended, I was thinking out loud in this vein in response to Anne's question.

The next day Anne began by saying how useful the previous session had been. She was curious about my personal reasons for reacting as I did; but the really interesting thing to her, the more she thought about it, was that I had been, in a way, intimidated by her—sufficiently concerned about her disapproval to even misrepresent myself a bit. She had never considered that I might be worried about her opinion of me. She always thought of me as completely self-confident and self-sufficient. She thought of her husband in the same way, but revising her view of me made her question her view of him too. Last evening she told her husband what had happened in her analysis and asked him whether he worried about having her approval. He told her he did. For example, he said, when she talked about her work, he was very reluctant to say anything because she frequently seemed to think that he was leaping to conclusions about what she was telling him.

So, Anne pointed out to me, there was something she did that
made other people back off from her. In that sense, she had been right the day
before when she had distrusted the idea that her husband was too competitive
to be interested in her work, and had wondered instead whether something
about her way of talking to her husband had been the problem. Similarly,
Anne went on, whatever my susceptibilities were, she realized that she had
played a role in my becoming so careful with her that I pretended to be
confused when I wasn't. Anne continued to elaborate how useful it had been
for her to recognize that she could inadvertently intimidate other people by
communicating her exaggerated sensitivities. She and her husband had gone
on to have a very long talk about it last night, and afterward they'd made love
more intimately and passionately than they had in years. Sexually, too, Anne
felt, she'd been shutting her husband down without realizing it. Obviously, she
concluded, she was too ready to assume that the people she cared about
would treat her the way her mother had, and this expectation was having
unintended, destructive effects in her personal relationships.

Discussion

To begin with, I hope I have illustrated what I mean by playing one's cards
face up in analysis. At a couple of points during the session, Anne asked me,
essentially, what I thought I was doing: first when she challenged my
statement that I was confused; then, after I explained my understanding of why
I'd said that I was confused, when she pressed me to explain my motivation
for misrepresenting my state of mind. Each time Anne asked for my view of
what I was up to, I gave it to her. I didn't decline to answer her questions, or
even defer answering them, suggesting that Anne reflect upon her reasons for
asking me what I thought I was doing. Instead, I responded to her
inquiry as a
constructive request for information that would be useful for her to consider,
and we took it from there. Clearly, I was not striving for even relative
anonymity. On the contrary, my aim was to be as explicit as possible about my
own view of my participation in events.

Although I talked quite a bit about my own experience of events,
there was no evidence that Anne experienced me as intrusive. Actually, she and I collaborated on the nature and extent of my self-disclosure. Sometimes Anne asked me to say more about what was on my mind; at other times, she was explicit about feeling that it was not useful for her to inquire further about my thinking. Anne established her own need to know, and it seemed to work out very well. She certainly did a lot of profitable self-investigation, much of which could be described as transference analysis.

I find that I am able, by and large, to establish an atmosphere in which my patients feel free to ask me to say more if they think I need to explain myself further, or to say less, if they think I'm talking too much; an atmosphere in which I, in turn, can inquire into a patient's motivation if the patient appears to me either excessively interested in hearing from me, or conspicuously incurious about my ideas. Anne and I operated in such an atmosphere, and in my opinion, it is a sine qua non for honest, unfettered, and consequential analytic inquiry. Needless to say, there are times when collaboration about the analyst's self-disclosure is hard to achieve, and when this happens, the reasons for it are invariably worth understanding. It has been my experience, however, that my willingness to self-disclose elicits in my patients neither an insatiable curiosity about me, nor a wish to learn my opinions so that they can be taken as received wisdom. My impression is that in general, patients do not want to be intruded upon, and are happy to collaborate with their analysts to avoid being intruded upon, given the chance.

In this respect, the interchange with Anne that I've described has to be understood in the context of the history of her analysis. I intend my vignette to portray not only a particular clinical moment, illustrative of a policy of playing one's cards face up in analysis, but the effect of operating on the basis of that policy over time. Anne obviously felt quite free to confront me with her observations and inferences about my participation because from previous experience with me, she anticipated that if she did, she would get an accounting from me, and we would continue to discuss what we were doing—as each of us saw it—as long as that seemed useful. Had I been less forthcoming all along in her treatment, I doubt that Anne would have been as able to
inquire into my view of my own activity as she was in the hours I've reported.

**Authorizing the Patient as Collaborator**

It should go without saying that an analyst's view of his or her own participation in clinical events is irreducibly subjective. I think Greenberg (1995) sums up the situation perfectly when he says: “I am not necessarily in a privileged position to know, much less to reveal, everything that I think and feel” (p. 197). An analyst cannot reliably give an accurate, complete account of his or her participation in clinical events. Therefore, the point of an analyst's willingness to self-disclose is not that it provides the patient with an accurate, complete account of the analyst's activity. (For example, I was unable to explain myself very satisfactorily to Anne, as she was quick to point out!) Rather, the benefit of an analyst's willingness to self-disclose is that it establishes the analyst's fallible view of his or her own participation in the analysis as an appropriate subject for collaborative investigation—something analyst and patient can and should talk about explicitly together. This makes it possible for the patient to open up analytic opportunities by calling to the analyst's attention aspects of the analyst's functioning of which the analyst would otherwise not be aware. Anne's inquiry into my claim to be confused is an excellent instance in point.

Precisely for this reason, colleagues influenced by Sullivan and the interpersonalist school have for years been advocating the virtues of actively soliciting the patient's observations about the analyst's personal functioning within the treatment relationship (e.g., Aron 1991). However, they have tended not to recommend that the analyst respond with reciprocal self-disclosure to the patient's input. The assumption has been that an analyst's “…self-revelation can foreclose full exploration of the patient's observations and his reactions to them…” (Greenberg 1991p. 70).

My clinical experience has led me to a very different conclusion. I have found that when a patient makes a pointed comment or inquiry
about an analyst, if the analyst does not respond by giving his or her own view about what the patient is bringing up, if the analyst is unwilling to pursue an explicit exchange of views with the patient, as needed, then the patient concludes that the analyst is not really interested in receiving active consultation. When a patient calls an analyst's attention to aspects of his or her participation in treatment that the patient feels are significant, even problematic, and the analyst, instead of saying what he or she thinks about the patient's observations, encourages the patient toward further self-reflection, the patient learns that offering his or her observations will not be interpersonally consequential, and the patient becomes much less interested and willing to offer them. I find that when an analyst does not operate according to an ethic of self-disclosure, the analyst, despite claims to the contrary, discourages free confrontation and questioning by the patient. The analyst's unwillingness to make his or her own views available conveys to the patient that the analyst wishes to protect him-or herself by avoiding scrutiny. Usually the patient complies.

A willingness to self-disclose on the analyst's part facilitates self-disclosure by the patient, and therefore productive dialectical interchange between analyst and patient is maximized. When, on the other hand, an analyst refrains from making his or her own views fully available, for whatever ostensible reason, the patient eventually responds in kind and dialectical interchange between patient and analyst is constrained. It takes a second analysis for the patient to fully say what he or she thought about the first analyst, and a third analysis to say what he or she thought about the second analyst, and so on. In order for a patient to want to volunteer his or her interpretations of an analyst's experience (Hoffman 1983), the patient needs to have responses to his or her interpretations from the analyst.

I should note that by emphasizing the patient's role as a consultant to the analyst, I am diminishing neither the importance of the analyst's self-analysis nor the utility of obtaining consultation from colleagues. Both of these practices have been highly recommended and much discussed in our literature, with good reason. However, even if we regard the analyst's self-analysis as a central, ongoing aspect of clinical work, we can acknowledge its limitations. There is
significant truth, after all, to the old joke that the problem with self-analysis is the countertransference. Consultation with colleagues, too, while it is a valuable resource, is not a cure-all. An analyst only seeks consultation when he or she feels it is needed, and even the shrewdest consultant cannot proceed very far beyond what the treating analyst presents. The patient, however, is in a position to offer uniquely informed, in-the-moment consultation, even if the analyst has not identified a need for it. Had Anne not picked up on my claim to be confused, for example, I would never have noted it, let alone thought that it was worth looking into.

**Self-Disclosure and the Analyst's Style**

My own style as a person, and therefore as an analyst, is toward the active, exhibitionistic rather than the reserved end of the spectrum. All things being equal, I usually prefer to mix it up with a patient and field the consequences rather than risk missing out on an opportunity for productive interchange. By suggesting that the analyst play his or her cards face up, however, I am not rationalizing my personal style or elevating it into a technical principle. Willingness to self-disclose, as a policy, can and should apply across the individual styles of various analysts. In fact, whatever an analyst's particular style, by playing his or her cards face up, the analyst increases the probability that he or she will receive consultation concerning his or her personal style from a patient—which is exactly what an analyst is most likely to need, inasmuch as it is our personal styles that generate our blind spots.

When Anne inquired into my way of expressing myself, eventually exposing a subtle hypocrisy on my part, she was analyzing a component of my personal style. Even more salient was the patient who said to me, explaining how she felt I was getting in her way, “You know, Owen, I think you believe it's important for an analyst to be open and non-authoritarian, that you try to be that way with me, and that it has been very helpful overall. But besides that, I think you have
a personal stake in not being seen as domineering and unfair, so that when I see you that way, rightly or wrongly, you're quick to react and to try to sort it out; and that gets in the way of you being able to listen to me sometimes. So, ironically, you can wind up doing the very thing you're trying to avoid” (Renik 1998p. 572). There I was, the analyst hoisted by his own petard: the atmosphere created by me playing my cards face up permitted my patient to constructively criticize me for a tendency on my part to explain myself too much! Thus, a disconcerting but exemplary consultation from a patient, which illustrates that a policy of willingness to self-disclose does not direct the analyst to talk about him-or herself all the time, but instead permits collaboration between analyst and patient concerning how much and what the analyst says about him-or herself.

Apropos this last example of the benefits of an analyst's willingness to self-disclose, I'd like to consider the relation between playing one's cards face up in analysis and idealization of the analyst by the patient. When an analyst adopts a posture of anonymity, it invites idealization of the analyst by the patient, posing an important obstacle to analytic work (see Renik 1995). On the other hand, an analyst's willingness to self-disclose obviously does not prevent idealization of the analyst by the patient, since it is at least as easy for an analyst to be idealized for being open, candid, or forthcoming as for any other reason. (There's a well-known story that makes the point. It's about the old Jewish man who gazed at himself in the mirror and mused, “You know, I'm not very good-looking; and I'm not very smart; and I'm not very rich; but boy, am I humble!”) Furthermore, we know that idealization of the analyst by the patient is a crucial, useful phase in certain analyses—perhaps, to some degree, in all analyses—so that for an analyst to be intolerant of being idealized can be as much of a problem as for an analyst to require being idealized. I want to emphasize, therefore, that although I think we should not systematically encourage idealization of the analyst by the patient via a stance of analytic anonymity, the purpose of playing one's cards face up in analysis is not to discourage idealization of the analyst by the patient. Rather, the purpose of an analyst playing his or her cards face up is to facilitate examination and revision, when necessary, of the analyst's modus operandi, whatever
it is—whether, for example, the analyst is too impatient with being idealized, or too eager to be idealized.

**Forms of Self-Disclosure**

In speaking of playing one's cards face up in analysis, I am referring to a consistent policy of willingness on the analyst's part to self-disclose. I mean to contrast playing one's cards face up with notions of selective self-disclosure (see, e.g., Jacobs 1999) which direct the analyst to consider non-disclosure his or her default position and self-disclosure an exceptional activity. I want to make clear, however, that an analyst's systematic willingness to self-disclose does not prevent the analyst from taking into account case-specific factors and judgments relevant to a particular clinical moment. Case-specific factors and judgments relevant to a particular clinical moment never mitigate against self-disclosure; they determine the form of an analyst's self-disclosure. The problem is not whether to self-disclose, but how to self-disclose.

Sometimes, playing one's cards face up in particular clinical circumstances seems a relatively straightforward matter. For example, when I awoke one morning, bone-tired with a very sore throat, I immediately telephoned Anne, who was my first patient of the day. “I'm sorry for the short notice,” I said, “but I'm going to have to cancel our appointment today. It's nothing serious. I think I've got that twenty-four-hour virus that's been going around, so I hope to be in tomorrow.” Anne thanked me for calling and wished me a speedy recovery.

Now, it is very rare that I cancel an hour on short notice, and I thought it likely Anne would worry if I didn't explain the reasons for my cancellation. I'm sure some colleagues would argue that by reassuring Anne, I foreclosed a useful opportunity for her to investigate her fantasies about my cancellation—for example, fantasies expressing hostile wishes toward me. I don't think so. In my view, had I cancelled without explanation, it would have been a contrived and mysterious act. Anne's reaction to such unnatural behavior would have afforded her little opportunity to investigate her manner of participation.
Actually, we did meet the next day, and Anne began her hour by reporting a dream from the night before, following my cancellation. The dream was that she was lying on a couch, reading a book by Faulkner. Her first association to the dream was the title of one of Faulkner's novels, *As I Lay Dying*; and it made her remember that after my call, she'd had the thought that maybe I was sicker than I realized. Anne was embarrassed to recall thinking that because she felt it reflected her childish anger at me for not keeping our appointment. She was dying to see me, and I should drop dead for canceling! Clearly, my reassurance did not prevent Anne from entertaining a hostile fantasy. I would suggest that, in fact, having had my explanation for the cancellation available to her facilitated Anne's recognition that imagining me gravely ill was an expression of her own anger. If she had been left in the dark about why I cancelled, she could have more easily chalked up her *As I Lay Dying* dream to realistic concerns.

There are times, on the other hand, when the direction indicated by a policy of playing one's cards face up is not self-evident. One summer day, Anne walked into my office wearing a short dress made of thin, silky material that clung to her body, revealing every curve to advantage. Did a willingness to self-disclose direct me to tell her what was on my mind? Of course not. For an analyst to play his or her cards face up doesn't mean that the analyst free-associates. What it means is that the analyst does not keep his or her thoughts private as a matter of analytic principle. When an analyst chooses not to say something to a patient, the choice is made on the same basis as it would be in any conversation: What is the purpose of the communication? Is it likely to be understood as intended? I could not see that anything helpful would be achieved by telling Anne that I was turned on to her; in fact, I could imagine some negative consequences. I decided to keep my sexual feelings to myself for the same kinds of reasons that would lead me not to express sexual feelings stimulated by, let's say, my teenage daughter or one of her friends.

Now, as it happened, things became more complex when Anne, obviously aware that she had made an impression, asked coyly as she
entered my office, “Like the dress?” I said simply, “You look terrific.” She smiled and thanked me. During the hour, her thoughts returned a number of times to my appreciation of her as a woman and my apparent comfort in acknowledging it. Various implications that this interaction had for her came to mind, especially in relation to what she had experienced as her father's rigid defenses against the anxiety stirred up in him when she began to mature sexually.

I chose to respond to Anne's flirtatious inquiry with a direct, but circumscribed description of my response to her. It seemed to work out very well. Of course, other ways of handling the situation might have worked out equally well or better. My point is only that while playing one's cards face up means that the analyst makes every effort to render his or her experience available to the patient, the particular way an analyst chooses to communicate his or her experience is determined by ordinary, pragmatic considerations. There was nothing specifically psychoanalytic about the aims and concerns that led me to limit as I did what I disclosed to Anne. I agree with Fitzpatrick's (1999) summary of the issues involved in dealing with the erotic aspects of the treatment relationship:

While dangers of exploitation and overstimulation from disclosure of sexual and loving feelings by the analyst are well known, they may be counterposed by less obvious but equally strong dangers of confusion and seductiveness when the subject of the analyst's feelings remains taboo. We need a way of discussing these vital responses to our patients that will be neither exploitive nor withholding, but clarifying. [p. 124]

**The Analyst's Self-Disclosure and Collaboration Within the Treatment Relationship**

Elsewhere (Renik 1998) I have discussed what I see as the disadvantages of various versions of the concept of a special, psychoanalytical
reality. I think it is of the utmost importance that we acknowledge that the clinical psychoanalytic situation is ordinarily real. What the analytic treatment relationship can be, within ordinary reality, however, is extraordinarily candid. That requires courage on the part of both participants. In order to be candid, a patient needs candor from his or her analyst.

Of what does an analyst's candor consist? As I mentioned at the beginning of these remarks, inasmuch as an analyst's activity is always determined in part by unconscious motivations, the concept of self-disclosure by an analyst is problematic. No matter how hard an analyst tries to play his or her cards face up, some cards will remain face down—and the analyst cannot know which ones, or how many. In other words, an analyst's effort to play his or her cards face up does not provide the patient with a reliable account of the analyst's activities. What I've suggested, however, is that an analyst's willingness to engage in self-disclosure does establish ground rules that make for a more truly collaborative, mutually candid interchange between analyst and patient about the treatment relationship than can take place when the analyst pursues a policy of even relative analytic anonymity.

I realize that a radical policy of willingness to self-disclose goes against long-standing, even currently prevailing, views in our field. I submit that self-disclosure by the analyst is an issue about which we can benefit from consultation from our patients—perhaps an issue about which we are especially in need of consultation from our patients. Most of all, I would say that we should be interested in the judgment of those patients who come to us simply to be healed, without any ambition to become analysts themselves. For example, Anatole Broyard (1992), fiction writer and essayist, in his extraordinary memoir entitled Intoxicated by My Illness, described what he wanted in the way of an interchange with his doctor. Broyard was reflecting upon the healing relationship in general, but I think what he had to say applies very well to clinical psychoanalysis in particular.

While he inevitably feels superior to me because he is the doctor and I am the patient, I would like him to know that I feel superior to him, too, that he is my patient also and that
I have my diagnosis of him. There should be a place where our respective superiorities can meet and frolic together. [p. 45]

Does this sound like the kind of treatment relationship that is facilitated by cautious self-expression on an analyst's part, designed to preserve a degree of anonymity? I don't think so. Broyard goes on to make the following recommendation:

...In responding to [the patient], the doctor may save himself. But first he must become a student again; he must dissect the cadaver of his professional persona; he must see that his silence and neutrality are unnatural... [p. 57]

My impression is that Broyard speaks eloquently and cogently for most patients, and I think we are obliged to take what he has to say very seriously. If we believe, as Hoffman (1983) suggests, that the patient is a legitimate interpreter of the analyst's experience, then we need to listen to and respect the thinking not only of the patients we treat, but of those (the overwhelming majority) whose objections to clinical analysis are such that they do not come to analysts for treatment.

According to the popular view, an effective therapist is candid and forthcoming—like the ones we see in Ordinary People or Good Will Hunting. I agree with the popular view, the naive idealization that characterizes movie portrayals of psychotherapists notwithstanding. It seems to me that we are justified in recommending to analysts a policy of playing one's cards face up because, as a general rule, self-disclosure by an analyst is in the patient's best interest; and, in my opinion, the burden of proof is on an analyst who chooses to adopt a stance of even relative anonymity to show that the analyst is not protecting him-or herself at the patient's expense. When an analyst is consistently willing to self-disclose, the patient is more fully authorized as a collaborator in the clinical work. The patient's active participation may require the analyst to endure a measure of disconcerting exposure, but the analyst may also discover that he or she is no longer practicing an impossible profession.

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References