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The Therapist's Self Disclosure in Cross-Cultural Treatment

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***Abstract*—**The argument that self-disclosure will change the psychoanalytic process into a socio-cultural niche distorting the therapeutic alliance and compromise therapeutic effectiveness is still the widely held belief amongst many psychotherapists. This paper considers the issues surrounding culture, disclosure and concealment since they remain largely untheorized and clinically problematic. The first part of the paper will critically examine the theory and practice of psychoanalysis across cultures, and explore the reasons for culturally diverse patients to conceal rather than disclose their feelings and thoughts in the transference. This is followed by a discussion on how immigrant analysts' anonymity is difficult to maintain since diverse nationalities, language and accents provide clues to the therapist's and patient's origins. Through personal clinical examples of one the author's (who is an immigrant) the paper analyses the transference-countertransference paradigm and how it reflects in the analyst's self-revelation.

***Keywords*—**Self-disclosure, cross-cultural, transference-countertransference, immigrant therapist.

I. Introduction

SINCE Freud's [1] early comments on methods of treatment in which he argues that therapists ought to be impenetrable, mirror-like and reflecting nothing back to the patients of themselves we have found ourselves, the therapists, selecting to self-disclose. The purpose of this paper is to explore implicit and explicit forms of self-disclosure by the therapist which is an essential ingredient of the discursive practices within psychotherapy.

Traditionally, the norm in psychoanalytic psychotherapy has been to self-disclose little or not at all. For example, our mannerisms, body language, dress codes, the décor of our practice, are all part of the complexity within which the patient and therapist situate themselves and which eventually constructs the intersubjective relationship in the therapy. Clearly, what we manifest in this manner does have therapeutic meaning. It is an ineradicable constant that pervades the analytic setting for both participants.

In the post-colonial West the mirror as well as the image that stands in front of the mirror has been constructed in the context of a socio-cultural history of race, gender and ethnicity [2]. And it is this context that determines the perceptions and preconceptions of the gaze of the therapist, in the midst of a semiotics of self and other.

The issues of judicious, empathic or seductive disclosure on the part of the therapist have generated much research and commentary through analogue studies [3]-[4], single case analysis [5], and survey research of therapist self-report [6]. Many of these studies on disclosure, according to Constantine and Kwan [7], have been conducted with White or European American individuals. However, there is a growing trend in more recent research that appears to be looking at self-disclosure in a cross-cultural context [8]-[9]-[10]-[11]-[12]. In general, the research findings suggest that minority patients tend to disclose much more to racially, ethnically or culturally similar therapists [13]-[14]-[15]-[16]. The studies on disclosure suggest that issues such as trust and mistrust, racism, sexist and cultural hegemony were found to be key variables that influence the therapeutic relationship and the nature of disclosure [17]-[18]. Indeed, disclosure occurs in the context of a theory of interaction and intersubjectivity so that self disclosure is less about technique and more about the infinite ways in which therapists express personal information about themselves to the patient [19], and much of this depends on the socio-cultural meanings that are attached to the transference-countertransference relationship [20].

II. Social Identities, Multiple Self Disclosures and Therapist's Anonymity

Despite the difficulties that post-structuralism offers in terms of the constructions of the self, psychotherapists are becoming more accepting of the fact that our identities in terms of race, gender, and sexual orientations are constructed as part of the intersubjective relationship between the individual and his/ her environment. Our social identities are constantly evolving and changing and as a consequence our ideas about ourselves and what we disclose to the others will also change. For example, Meissner [21] describes different types of self-disclosures: answering questions, revealing personal emotions of the analyst, expressing countertransference, or dealing with real personal factors in the analyst's life. And, Jacobs, noting the heterogeneity of forms of self-disclosure, comments that "each instance of self-disclosure must be evaluated on its own terms in the light of the clinical situation in which it occurs and its effect on the analytic process" [21]. Renik [22], critically reviews the principle of analytic anonymity and argues that prevailing conceptions about analytic anonymity serve different and less constructive purposes than previously believed. He suggested how self-disclosures can be therapeutically helpful in certain cases. The therapist must strike a therapeutically effective

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balance between rigid self-distancing and formality and unnecessary exuberant self-disclosures concerning personal feelings that can influence the patient the wrong way (e.g., attempts at seduction). Every intervention by the therapist (including silence) reveals something personal about the therapist and whether he/she regards the patient as a real partner in the working alliance. Renik believed that self-disclosure for the purposes of self-explanation facilitates the analysis of transference by establishing an atmosphere of authentic candor. Nevertheless, psychoanalysis has traditionally given precedence to neutrality and anonymity, over genuineness and responsiveness.

III. Intersubjectivity and Therapist's Self Disclosure

Intersubjective understandings of self-disclosure, is theorized around the post-modern view of the subject arguing that the subjective self and its annunciations are a co-construction with the other. The self and the other are intertwined and subjectivity is constructed in the intersubjective relationship. The therapist's countertransference responses are already a part of the patient, as much as transference is a co-construction of the therapist. Relational theorists, who subscribe to the idea of multiple selves may even ask which self-state is doing the disclosing and to whom [19]. The intersubjective and relational model appears to be an interesting way in which to conceptualize just exactly what is going on when it comes to therapist self-disclosure. The intersubjective process between the two people in therapy as an oscillation of the psyche of the therapist and the psyche of the patient within which there is a cross over of each other's psyches. Therapist self-disclosure can become an integral part of this two-way communication. The internal and external worlds of both therapist and patients while are separate and independent of each other in constellation with each other to produce a dynamic relationship between the social notions of identity and the inner workings of the psyche [23].

IV. Clinical Vignettes: The Immigrant Therapist (One of the Authors)

I would like to briefly address the often overlooked issue of the cultural background of the analyst. I am a white, non-practicing Jewish woman, Spanish speaker, who migrated to USA as a young adult from South America. This information can help the reader understand the dynamics of the vignettes that follow.

To begin with, in the consulting room, different nationalities, cultures and languages are communicated, as dialects, accents and intonations offer clues to the therapist's and patient's origins. In the Spanish-speaking world certain accents are associated to regions such as Spain, Central and South America or the Caribbean. In my case, as soon as I open my mouth to speak, patients know that I am an immigrant and that I obviously have an accent. When working with Spanish-speaking patients, some recognize easily where I come from. However, my last name can be bewildering. I may not be Hispanic. This indicates how last names may or may not be indicative of the person's origin. Therefore, the patient's question: "where are you from?" is based in an uncertainty but also a statement that both patient and therapist are foreigners and, as such, upon meeting, the dictate is to specify origin Conversely, as my language usage can be a point for similarity and collective identification, my name can be a potential point for difference. The issue of self-disclosure is at stake here. Revealing personal information can bring some emotional closeness and identification: patient and analyst both speak a pre-oedipal language, which is the language of attachment and intimacy, the mother tongue. This, however, conflicts with another set of cultural norms, those of psychodynamic theory and technique, in which ideally the neutral therapist is the receptacle of fantasy and projection and becomes the vehicle for understanding transferential enactments [24].

As a young clinician, the most conflictive countertransferential moments were when I saw a recent immigrant patient. It was difficult for me to have emotional distance or cultural neutrality since internally I could identify with the patient's nostalgia [25]-[15]-[26]. This female patient, Julie, from Argentina that had recently migrated, immediately recognized my accent and asked me the town I was born. I responded telling her and we turned out to be of the same city. This fact created an immediate idealizing transference. The patient talked about her struggles with the language, and missing her known environment. At those times, I felt sad for the patient. I sensed her feelings of isolation and not having choices, her feeling stuck in this new environment. Working with her, reminded me of my personal experiences when I initially migrated to US. I likewise identified with her longing for her family and friends. I wanted to tell her that I had felt the same when I initially came to US. I decided to remain silent for fear of losing my neutral stance. I felt uncomfortable thinking that I could leak my countertransference. Her idealization of me, due to same background was based on a perceived shared minority status. This was emphasized by being of the same country and the same town.

I also struggled with self-disclosure, anonymity and the psychoadynamic culture when working with my first Chinese patient, Mary. She was also an immigrant and she had also migrated here as a young adult as me. Mary was curious about my name and I revealed its origins. The fact that we were both immigrants made her feel culturally understood. However, I was conflicted when I realized that my analytic role had to be different than with other patients. My experience was similar to the concepts that Tang [27] portrayed in her paper. Tang noted that her Chinese patients born in China, continue to be centrally involved in the original extended family; therefore the relationship with the therapist is a marginal one, it is functional and pragmatic in nature. The therapist is a teacher who patiently guides the patient to reason akin to how a parent would guide a child. Considering that Asian experience a great deal of stigma in talking about personal problems, explains why certain responses may appear as resistance. In addition to this, for some Asians a sudden display of painful emotions is likely to be experienced as a loss of control, leaving the

patient with feelings of shame [28]. Primarily I had to be the teacher, not the therapist. I also struggled to reveal to her my sadness for her "cultural" inability to express her feelings more openly. Here my personal ideas about expression of affect were present. I explored with her the idea of expressing her emotions more vividly. Mary responded that it could be shameful for her to do that.

Another example was of a Jewish patient, a daughter of holocaust survivors. She was concerned if I was German due to my last name and was fearful of starting treatment with me. Here, again, I shared my Jewish identity and my last name's origin, to be able to work together.

For some English-speaking patients, my accent brought other issues. Early in my work in an inner city clinic, a few patients questioned my accent and my immigrant status (if I was legal and how did I get my job in the clinic). Another handful of patients were not sure of my ability to help them and questioned my training. I remember a case in which the patient requested being transferred to another therapist because of this issue.

On the other hand in my private practice, some English-speaking patients were excited that I was a foreigner as they perceived me as more sophisticated than them. At times, this brought up issues of jealousy and envy (I was more "worldly" than they were), at other times, it brought admiration to my ability to be bilingual. With most of these patients, my last name and my accent was what they were curious about.

These examples demonstrate that countertransference responses are additionally significant when the analyst and patient are of different cultural backgrounds. These examples corroborate previous clinical evidence [29]-[30]-[31]-[32]-[33]-[15]-[16]-[34]-[35].

V. Discussion

The immigrant analyst's case vignettes demonstrate a number of issues when we think about therapist self disclosure. Were the therapist's interventions motivated by her needs more than the patient's? Were there instances in that self-disclosure was a need to continue the treatment? Were some interpretations based on the therapist's wish to revisit aspects of her own history? How being the therapist "the other" affected the interventions?

In cross-cultural and cross-linguistic dyads projection, resistance and transference occurs more readily since personal aspects of the patient-analyst dyad are more obvious. Countertransference occurring in cross-cultural and cross-linguistic dyads is significant in that the analyst's identity may become more vulnerable. For example, issues of discrimination, prejudice, identification with the patient and even hate, can be easily triggered by the patient. With this in mind we can question the concept of the selective nature of clinical listening. Since culture shapes individuals' senses of self and other, developmental and social histories, and cognitive and emotional styles, clinicians' subjectivities are not only irreducibly personal, but are also irreducibly cultural. Clinicians' cultural subjectivities inform their selective attention to patients' disclosures, so that they listen for material that fits their cultural categories and supports their cultural experiences, before organizing it into patterns that confirm their cultural logics. Because clinicians' cultural identities, histories, assumptions, and locations significantly shape what they listen for and how they hear, clinical listening is constantly and inevitably cultural [36]. For some patients, similarity threatens the sense of self. Perceived differences can become a reassurance that the patient-therapist boundary is secure. For others, similarity can be a source of comfort.

Self-disclosure and its contents / discontents cannot merely be seen as a technical feature of clinical work but rather it has deeper meanings emerging from the relational matrix with the patient and its labyrinthine formations of what is possible in any given movement and movement in therapy.

Self-revelation also brings unforeseen limitations where under the guise of an elaborate fantasy, patients are invited to re-enter that dark abyss in the psyche before they are ready or willing to. Thus, a 'not knowing' of the intentions of their origin creates anxiety and terror of the 'unknown' of difference, especially in cross-cultural settings. In this sense when therapists engage in explicit self-disclosures across cross-cultures they enter a space within which they can emulate the socio-cultural material relations of the society in which they live in. In other words, the therapist self-disclosure can be unwittingly seductive inviting the patient into the same reality of gendered or racial and hegemonic cultural oppression prevalent in society today. The countertransference responses are left open to the adventures of a sociological and cultural ethnography. When this happens, are therapists self-disclosing to avoid the fear of the unknown or are they at the same time deploying these self-disclosures to conceal the complex autobiographies of race, culture and ethnicity.

Clinicians who maintain that explicit self-disclosing is unethical and ought not be part of the treatment argue that indulging in self- disclosure will alienate and distort the therapeutic relationship causing 'alliance ruptures' [37] that lead to hindering the process of uncovering and resolving transference issues. Furthermore, it is argued that intimate disclosures on the part of the therapist will create fluidity in the boundaries which could easily lead to 'acting-out' fantasies or falling into any traps of the unconscious by both patient and therapist. Is there an answer here for the safety of cross-cultural work or ought we to follow the philosophy of the humanistic-existential practitioners who suggest that self-disclosure will demystify psychotherapy [38], challenge the power arrangements between patients and therapists [5], and promote therapist authenticity and genuineness [39]. For others, such as Geller [40], 'disclosure plays a role comparable to clarifications, interpretations and questions in the repertoire of therapeutic tools'. However, whether a self-disclosure will further or hinder the development of the treatment process is ultimately determined by the unique qualities the participants, as well as where they are in the course of treatment [41].In cross-cultural work it seems poignant to remind analysts and therapists that the clinical terrain is in a continuous flux between the interiority and exteriority of the self. The gaze inwards towards the psychic also leads outwards towards the

geography of the socio-cultural milieu that constitutes the self.

VI. Conclusion

Until not long ago, it was considered axiomatic that therapists must remain relatively anonymous in order for psychoanalytic psychotherapy to proceed. The idea was that confronting the patient with the reality of the therapist's self, forecloses the possibilities for fantasy and contaminates the transference. The lack of direct knowledge about the therapist fosters the development of illusions, which, according to Khan [35], are necessary for the use of language in therapy to lead to insight. Essentially, what is not known leads to fantasy, conjecture, and the development of a shared reality; what is known can no longer be an object of interest.

More recently a growing minority of therapists have questioned this belief. Renik [22] in particular, has been outspoken in stating that self-disclosure on the part of the analyst furthers rather than hinders the development of the transference and, ultimately, of the analytic work. Renik, however, is concerned primarily with the disclosure of the analyst's thoughts and reactions during the analysis, rather than details of her/his personal life. While he has suggested that the patient's knowledge of some details of the analyst's personal life does not interfere with the development of the transference, he does not advocate the disclosure of such information [35]. On the other hand, Miletic [42] states that the analyst can question whether self-disclosing something to a patient at a particular time helps to convey a willingness to enter into something emotionally meaningful with the patient that may later result in the patient's having greater freedom of access to his or her mind.

One of the problems with the disclosure of personal data is the fact that these tend to be enduring aspects of the therapist's social self; once they are known, they can never be unknown. This is in contrast with the disclosure of one's thoughts or feelings, which are transitory and situation specific [35]. However, in the case vignettes presented here, the author believes that the self-disclosure was a necessity, not a choice. This self-disclosure with some of the patients described before was based on a rationale akin to Jacobs, in Gediman [43] advocating that such non-countertransferential self-disclosures might help the patient to have a real impact not only on the therapist but also on others in his life outside the treatment situation. Therefore, self-disclosure can be a useful form of interactive intervention subject to a set of guiding principles that contribute to the patient's benefit and the therapeutic process [43]. As Shill [44] states, neutrality and abstinence provide a mental space where the analyst can "rehearse," by trial thinking in fantasy, any intentions and wishes about a patient without compromising the latter's safety. In the absence of this use of signal anxiety by the analyst to facilitate neutrality and abstinence, self-disclosure can amount to interpreting the patient's wishes as a rationalization for action that renders the therapist's unrecognized sexual or aggressive urges toward the patient safety.

Finally, in whatever way we hold that part of us which is also part of the other, therapist self-disclosure will offer both therapists and patients the opportunity to experience the 'rawness of the human encounter' and the 'jouissance of being with the other', particularly in North America given its history and culture of the "other".

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