Do Tell: Queer Perspectives on Therapist Self-Disclosure–Introduction
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Do Tell:
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Self-Disclosure–
Introduction

To tell or not to tell? In the world of lesbian, gay, bisexual, and transgendered (LGBT) people, the question refers to whether or not one should come out and reveal one’s sexual identity. Those of us who are LGBT wrestle with the issue of where and when to come out on a daily basis. However, this is not an issue that stirs many heterosexuals. Heterosexuals in general, and heterosexual therapists in particular, are often unaccustomed to the need for directly declaring their sexual identities.

In the world of psychotherapy, and particularly in the world of psychoanalysis, “to tell or not to tell” has taken on a different meaning. In the classical tradition, psychoanalytically-oriented psychotherapy aimed toward an ideal of maintaining a surgeon-like objectivity (Freud, 1912). A technical stance informed by anonymity, abstinence and neutrality were thought to be the optimal way to achieve this. With contributions of the therapist kept to a minimum, the transference would be more easily discerned and analyzed, and the focus of the work kept more sharply on the needs of the patient.

This approach, however, has not always suited all therapists or their clients. In the century since Freud’s initial contributions, many psychoanalytic theorists have offered a systematic rethinking of these technical ideals. For example, one of Freud’s protégés, the Hungarian Sandor Ferenczi (1932), experimented with a highly self-revealing form of “mutual analysis.” The American Interpersonalist, Harry Stack Sullivan, adopted a psychoanalytic perspective influenced by social sciences, viewing the therapist’s role as that of a “participant/observer” (1940). Sullivan’s work presaged an epistemological shift that would resonate with many psychoanalysts in the latter part of the twentieth century.
Following WWII, and the increasing usage of analytically oriented therapy, Freud’s technical recommendations were often reconsidered in order to make it possible for a wider range of clients to benefit from treatment. For some narcissistically vulnerable patients, for example, the frustrations of the strictly classical model were not tolerable (Stone, 1954). The maintenance of strict neutrality—defined by Anna Freud (1966) as a position equidistant between the ego, the id, and the super-ego—was, in some cases, abandoned, in situations where a client’s impulsivity is placing him or others at risk (Searles, 1986).

As psychoanalytic technique evolved, many clinicians felt it necessary to be more affectively expressive, departing from a strict (and often caricatured) “anonymity.” Instead of abstaining from telling clients some information, certain disclosures were judged to be necessary: for example, revealing the therapist’s whereabouts during an absence if a client was unable to maintain a “good-enough” inner representation of the therapist. For analysts in the classical tradition, deviations from the traditional model arising out of clinical need were referred to as “parameters” (Eissler, 1953). “Even the most orthodox [psychoanalysts], however, may be led in particular cases—especially cases involving anxiety in children, the psychoses and certain perversions—to waive the rule of complete neutrality on the grounds of its being neither desirable nor practicable” (Laplanche and Pontalis, 1973, p. 272). Psychoanalysts in this tradition, however, considered such activities a form of “psychotherapy,” and defined these practices as distinct from (and perhaps of lesser value than) “the pure gold” of psychoanalysis.

On the other hand, contemporary analysts working within a postmodern point of view no longer believe it is possible to maintain an “objective” point of view distinct from the patient. With this skepticism toward a reliably objective point of view, it has become necessary to rethink other aspects of technique, including self-disclosure. From these new “relational” perspectives, self-disclosure is not an occasional option, but an inevitability (Aron, 1991; Greenberg, 1995).

In the traditional psychoanalytic perspective, the openly gay therapist could only exist as a countertransferential enactment that would interfere with effective treatment (Drescher, 1998). In response to those limitations, some lesbian and gay analysts have been among the vanguard of clinicians re-examining the traditional technical advice on disclosure, particularly around the question of sexual orientation. Historically, the psychoanalytic position was that all therapists were heterosexuals. If they were not, they had to pretend that they were. Gay therapists had to hide their true sexual identities or risk professional
ostracism and disgrace (Drescher, 1995; Isay, 1996; Lewes, 2002; Magee and Miller, 1997). When it came to knowing the sexual identity of the therapist, the blank screen model suited heterosexuals who did not want to know anything about gay therapists, as well as gay therapists who did not wish to reveal themselves.

In order to counteract the deleterious effects of heterosexism that for so long distorted psychoanalytic theory and technique, many lesbian and gay therapists came out, both publicly and to their patients. In doing so, they sought to make therapy a more readily viable choice for those who have felt shunned and pathologized by those who purported to offer them help. As Frommer (1994) pointed out, analytic neutrality functions within a heterosexist culture, and the absence of communication about sexual orientation does not necessarily communicate neutrality. The assumption that a heterosexual orientation is the “norm” or “default” outcome of psychosexual development is still widely held.

However, through the pioneering efforts of many analytically oriented therapists, such as Richard Isay (1996), Kenneth Lewes (1988), Bertram Schaffner (Goldman, 1995), and heterosexual colleagues such as the late Judd Marmor (Rosario, 2003), (all of whom have served as members of this journal’s editorial board) psychoanalysis as a field has changed a great deal. It may not be too idealistic to imagine a time when the sexual orientation of a psychotherapist is not automatically thought to be heterosexual. Perhaps in such a time sexual orientation will have stopped being a remarkable aspect of any person’s life, and what will occupy the clinician and her client is not who, but how one loves. Until that day, however, clinicians continue to encounter situations in which prospective clients, or even clients of long standing, may assert a pressing need to know the sexual orientation of their therapist, or perhaps other aspects of the therapist’s private life. Because this kind of question remains charged with various meanings, these moments are often challenging.

In an effort to open up this contemporary debate, this issue of the Journal of Gay & Lesbian Psychotherapy presents some queer perspectives on the subject of therapist self-disclosure. In doing so, we bring together several divergent points of view concerning disclosures of intimate material: sexual orientation, transgendered status, and HIV seropositivity.

The first paper, “Disclosure, HIV, and the Dialectic of Sameness and Difference,” concerns a therapist’s disclosure of HIV seropositivity. The case was originally discussed in Gilbert Cole, PhD’s book, Infecting the Treatment: Being an HIV Positive Analyst. This paper, however,
elaborates upon the book’s case material. Cole advocates paying close attention to the dialectical relationship of themes of sameness and difference leading to and away from disclosures in general. Cole’s book, and this paper in particular, are discussed, in turn, by Robin Steier Goldberg, PhD, Owen Renik, MD, and Thomas Domenici, PhD.

In her discussion, Dr. Goldberg notes that the dichotomy often made between the disclosure of countertransference affects and the disclosure of facts is an oversimplification. She sees the disclosure of HIV positive serostatus as “more than just a fact,” and as “filled with transcendental meaning.” While there are aspects of having positive serostatus that are unique to HIV, the dialectic between uniqueness and commonality is also important in understanding this process. She sees Cole’s disclosure of his positive HIV serostatus to his patient as “inadvertent”—and inadvertent disclosure as entirely different from answering a question about a fact that a patient may fantasize about, but about which he has no actual knowledge. Goldberg feels it is important to confirm for a patient something that the patient already knows, but does not want to know. To do otherwise is to potentially retraumatize a patient.

Dr. Renik believes that all therapists have to offer to their patients is their own subjective experience. What the patient wants and needs is a careful, thoughtful and honest account of the therapist’s experience of him. This can help the patient draw his own conclusions about himself. Renik sees Cole’s work as demonstrating the relation between the particular and the universal in psychoanalysis. The specific subject is the situation of the HIV-positive psychoanalyst. Yet, for all its dramatic specialness, being an HIV-positive analyst is not necessarily more special than any individual, idiosyncratic aspect of any analyst’s subjectivity is special. Renik notes that one learns from sharing Cole’s experience applies to all therapists.

In his discussion, Dr. Domenici provides some personal reflections on the outbreak of AIDS and the impact it had upon his work as a psychotherapist. Using the example of psychoanalytic strictures regarding self-disclosure, Domenici argues that self-disclosure is more likely to be adhered to in theory than it is in practice. This leads him to agree with Cole that non-disclosure is often a technique used by analysts to hide, rather than provide a therapeutic field of action. The specific case of therapists hiding their antihomosexuality when working with lesbians and gay men is used to illustrate this perspective. Domenici commends Cole’s work for opening a debate on how to use countertransference and self-disclosure as tools which widen and enrich the therapeutic relationship.
In his response to the commentaries by Goldberg, Renik, and Domenici, Cole discusses the subjective experiences of illness, vulnerability, and the vicissitudes encountered in training and developing as a clinician.

The next contribution, “Disclosing the Therapist’s Sexual Orientation: The Meaning of Disclosure in Working with Gay, Lesbian, and Bisexual Patients,” is by Clayton Guthrie, PsyD. It is written from a relational point of view, in which the clinician, while not neglecting in any way the patient’s history or fantasy life, nevertheless is quite likely to respond readily to the way the “here and now” transference unfolds. Guthrie asserts that therapists’ decision to disclose their sexual orientation must be considered on a case-by-case basis, rather than operating according to a general rule.

In “Different Ways of Knowing: The Complexities of Therapist Disclosure,” Glenda Russell, PhD offers a subtle examination and differentiation of ways that clients learn more about their therapists’ lives than they might wish to acknowledge. Describing a case where a client inadvertently learned of her therapist’s sexual orientation, Russell offers a theory of “dialogic,” in contrast to “overt” disclosures. As is perhaps clear from this brief description, Russell’s theoretical orientation involves a close connection with the client’s affective state, in the manifest as well as dream material that they work with.

The next paper is “Gay Patient, Gay Analyst: Is It All About Sex? Clinical Case Notes from a Contemporary Freudian View,” by Neil Herlands, CSW. Rather than emphasizing technical rules as a means of maintaining a position for the therapist, he argues for the importance of technical ideals as means of safeguarding the therapist’s analyzing function. For Herlands, anonymity, abstinence and neutrality work almost as a kind of lever, lifting the therapist out of a transference/countertransference stalemate, enabling the therapeutic dyad to return to their work of analyzing the patient’s material.

The final paper in this issue, “Self-Disclosure: A Dance of the Heart and a Ballet of the Mind” is by Robin Mathy, MSW, Msc. She discusses guidelines for self-disclosure by an “ethnically diverse, lesbian female clinician who is a former male-to-female transsexual.” Mathy sees self-disclosure as akin to a ballet of the mind, in which clients’ abilities to maintain their balance while learning a new performance may depend upon the clinicians’ abilities to do the same.

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REFERENCES